# The County of Santa Cruz
# Integrated Community Health Center Commission
# MEETING AGENDA

**March 6, 2024 @ 4:00pm - 5:00pm**

**MEETING LOCATION: In-Person** - 1430 Freedom Blvd., Suite F, Watsonville, Ca 95076 and 1080 Emeline Ave., Bldg. D, Admin Conference Room, Santa Cruz, CA 95060 will connect through Microsoft Teams Meeting or call in (audio only) +1 916-318-9542, 500021499# United States, Sacramento Phone Conference ID: **500 021 499#**

ORAL COMMUNICATIONS - Any person may address the Commission during its Oral Communications period. Presentations must not exceed three (3) minutes in length, and individuals may speak only once during Oral Communications. All Oral Communications must be directed to an item not listed on today's Agenda and must be within the jurisdiction of the Commission. Commission members will not take actions or respond immediately to any Oral Communications presented but may choose to follow up at a later time, either individually, or on a subsequent Commission Agenda.

1. Welcome/Introductions
2. Oral Communications
3. February 7, 2024, Meeting Minutes – Action Required
4. Policy 100.03 - Update to Business Office - Action Required
5. Policy 200.03 - Credentialing and Privileging – Action Required
6. Policy 300.24 – Outside of Normal Business Hours Advice by Telephone – Action Required
7. Policy 300.05 – Patient F/U Upon Discharge – Action Required
8. Policy 520.05 – After-Hours Availability of Medical Records – Action Required
9. Policy 700.01 – Medical Emergencies – Action Required
10. My Chart Presentation – Jessica McElveny
11. Quality Management Update
12. Financial Update
13. CEO/COVID-19 Update

| Action Items from Previous Meetings: Action Item | Person(s) Responsible | Date Completed | Comments |
|---|---|---|---|
| | | | |

**Next meeting:** Wednesday, April 3, 2024, 4:00pm - 5:00pm **Meeting Location: In-Person -** 1430 Freedom Blvd., Suite F, Watsonville, Ca 95076 and 1080 Emeline Ave., Bldg. D, Admin Conference Room, Santa Cruz, CA 95060. Commission will connect through Microsoft Teams Meeting or call in (audio only) United States, Sacramento Phone Conference ID: **500 021 499#**

# The County of Santa Cruz Integrated Community Health Center Commission

**Minute Taker: Mary Olivares**

Minutes of the meeting held February 7, 2024

TELECOMMUNICATION MEETING: Microsoft Teams Meeting - or call-in number +1 916-318-9542 – PIN# 500021499#

| Attendance | |
|---|---|
| Christina Berberich | Chair Officer |
| Rahn Garcia | Member |
| Marco Martinez-Galarce | Member |
| Maximus Grisso | Member |
| Michael Angulo | Member |
| Tammi Rose | Member |
| Gidget Martinez | Member |
| Monica Morales | County of Santa Cruz, Director HSA |
| Miku Sodhi | County of Santa Cruz, Asst. Director of HSA |
| Amy Peeler | County of Santa Cruz, Chief of Clinics |
| Raquel Ramirez Ruiz | County of Santa Cruz, Sr. Health Services Manager |
| Julian Wren | County of Santa Cruz, Admin Services Manager |
| Mary Olivares | County of Santa Cruz, Admin Aide |
| **Meeting Commenced at 4:03 pm and concluded at 4:55 pm** | |

| |
|---|
| Excused/Absent: |
| Excused: Len Finocchio<br>Excused: Dinah Phillips<br>Absent: Michelle Morton |
| 1. Welcome/Introductions |
| Commissioner Marco Martinez-Galarce stated was elected to be a member on the board of Dientes. |
| 2. Oral Communications: |
| None |
| 3. January 3, 2024, Meeting Minutes – Action Required |
| Review of January 3, 2024, Meeting Minutes – Recommended for Approval. Rahn moved to accept minutes as presented. Marco second, and the rest of the members present were all in favor. Christina abstained as she was not in attendance at the last meeting. |
| 4. 100.03 HSA Billing FO Policy Procedures – Action Required |
| Julian presented policy 100.03 HSA Billing FO Policy Procedures; he stated only minor corrections to policy were made. Tammi moved to accept policy with minor corrections. Marco second, and the rest of the members present were all in favor. |
| 5. 100.04 HSA Billing FO Policy Procedures – Action Required |
| Julian presented policy 100.04 HSA Billing FO Policy Procedures. He stated no changes need to be done to sliding fee discount and this needs to be reviewed and approved every three years. Tammi moved to accept policy as presented. Marco second, and the rest of the members present were all in favor. |
| 6. Stipends for Commissioners |
| Raquel reported commissioners are now eligible for $75.00 stipends. Mary will be sending out an e-mail with details. |
| 7. Board Composition and Meeting Times |
| Raquel presented survey results that were submitted, there were seven responses to survey. A majority of the commission stated they had no conflict with keeping the same date and time. Mary to send out e-mail to those not in attendance to see what dates and times work for them. |
| 8. Quality Management Update |
| Raquel reported that the quality management committee met and reported on the following. She stated that the Watsonville Health Center reported on their improvement project, well childcare visits and are continuing focusing on immunizations. Raquel also reported that the Central California Alliance for Health reviewed the based incentives, and they will be adding lead screening in children and will be retiring body mass index assessments and adult immunizations. Raquel reported and shared results of the |

staff satisfaction survey she stated this is done on an annual basis. Lastly, Raquel reported on some of the QI Projects they are working on such as:

- Seek regular feedback-i.e. suggestion box, prioritize (grouping) projects to address feedback concerns, QR code to gather ideas and concerns on a regular basis-monthly, individual, in huddles, blocked time, team specific meetings.
- More part-time opportunities.
- QI subcommittee to address responses.
- Appreciation/Recognitions
- Closing the loop with various projects, survey results-verbal or written updates
- Burn out-giving resources

9. Financial Update

Julian reported currently the estimated actuals are $6,100,00.00 over budget in expenditures. Julian reported some of the things that they are looking at to help in spending are analyzing current spending, prioritizing critical spending, and deferring non-essential expenses. They are reviewing subscriptions, memberships, and other recurring costs for potential savings and negotiating with vendors for better pricing or payment terms. Julain reported he is evaluating cash flow by implementing automation, prioritizing projects that contribute directly to revenue generation, and identifying areas for streamlining processes. Julian reported some of the smart targets they are looking at are 45 days in accounts receivable (AR) by June 30, 2024, 30 days by January 31, 2025, increase average clinician (MDs/PA/NP) daily completed visits by 35% to 13.5 visits by June 30, 2024, and increase payments by 35% to $3,731,650 a month by June 30, 2024.

10. CEO/COVID 19 update

Raquel reported on Amy's behalf. She stated that Health Resources and Service Administration (HRSA) will be coming May 14, 15, and 16 2024. Commissioners are invited to attend. Raquel will report back on oversite at next meeting.

Next meeting: March 6, 2024, 4:00pm - 5:00pm

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☐ Minutes approved _____ ___/___/___

(Signature of Board Chair or Co-Chair) (Date)

Health Centers Division

# Quality Management Report

March 2024

## Quality Management Committee

- Quarterly Quality Improvement Presentation- Emeline Health Center. (Child and Adolescents Well Child-Care Visits)
- Revenue Cycle and Increase Access to Care Workplan
  - Reduce days in Accounts Receivables (AR)
  - Increase patient access to care
  - Increase schedule utilization to include TeleMed
- Ryan White Committee Update

## Peer Review & Risk Management Committee

- In Basket Management
- Clinical Supervision of Nurse Practitioners and Physician Assistants.
- Quarterly Quality Reports
- Mortality Review
  - 13 Chart audits completed all received appropriate care. 3 were overdoses or complications with a substance use disorder

Health Centers Division

# FY 23-24 Monthly Budget Presentation

March 6, 2024

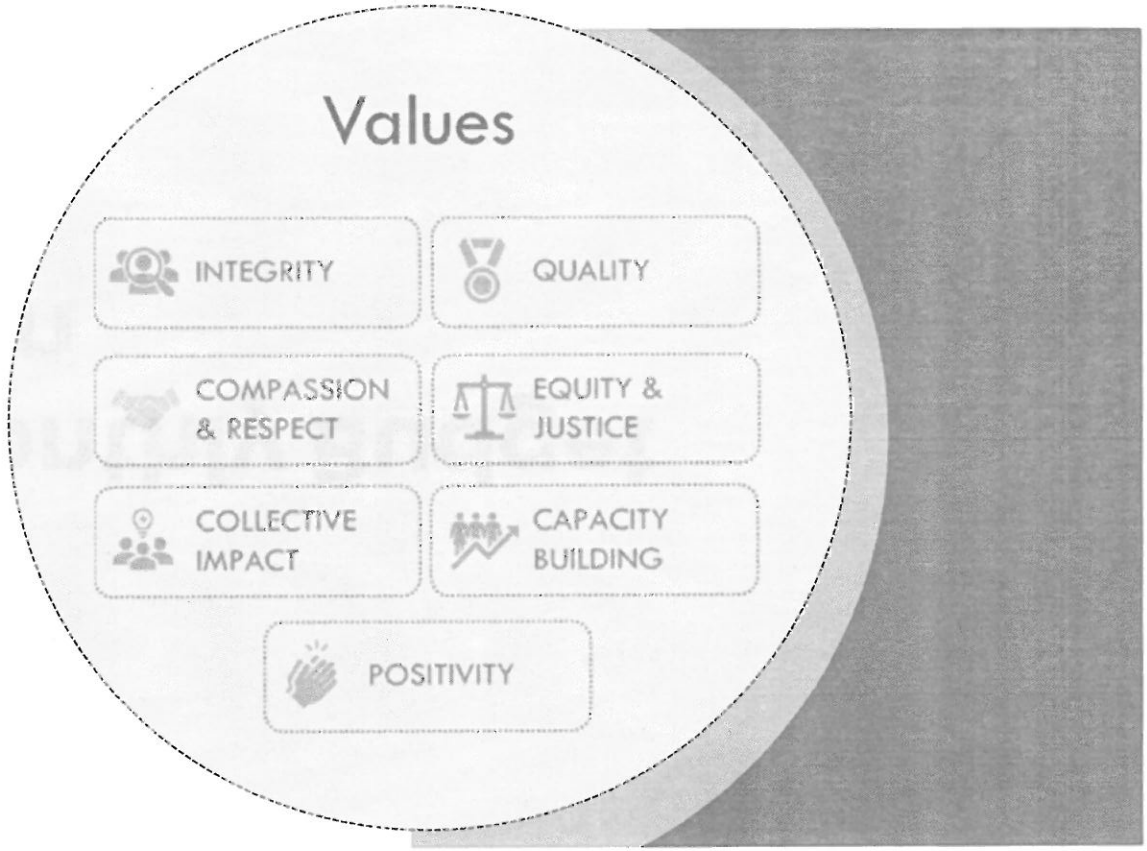
## Vision

**Santa Cruz County is a healthy, safe and thriving community for everyone.**

## Mission

To promote and ensure a healthy community and environment by providing education, outreach and comprehensive health services in an inclusive and accessible manner.

## Values



County of Santa Cruz (HSA)
FY 23/24 HEALTH CENTERS(Multiple Items)
As of 12.31.23

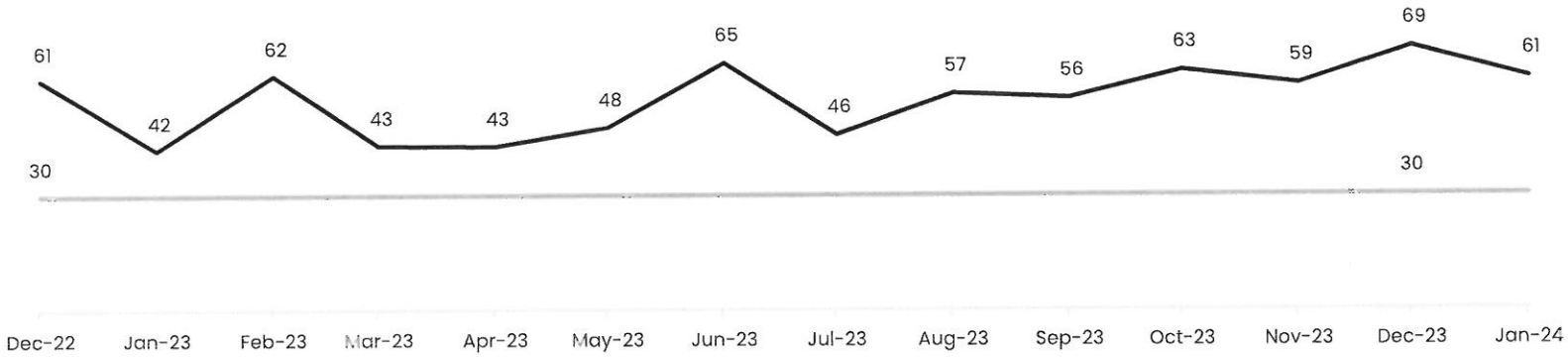
Click on a number in the pivot table
Click on Pivot Table Analyze (Above)
Click on Refresh All (Above)

Division
GLKey

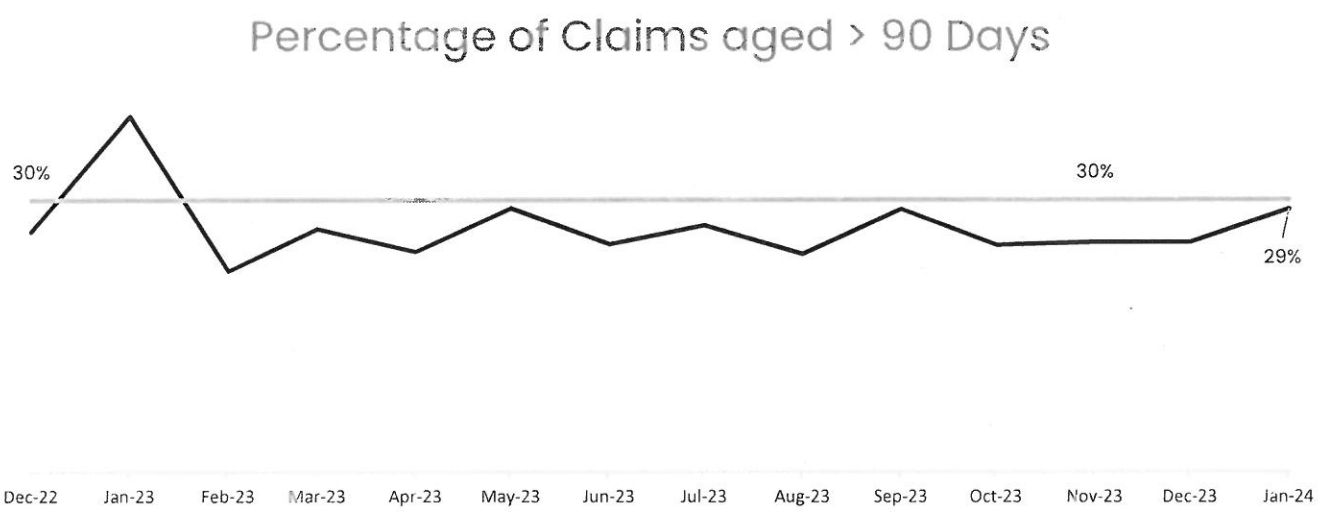
| Row Labels | Adjusted Budget | Actual | Division EA's 2.12.24 Updated | |
|---|---|---|---|---|
| ⊟REVENUE | (58,866,253) | (14,082,558) | (45,702,175) | |
| ⊞05-LICENSES, PERMITS AND FRANCHIS | 0 | 0 | 0 | |
| ⊞15-INTERGOVERNMENTAL REVENUES | (7,638,506) | (1,169,560) | (4,511,740) | |
| ⊞19-CHARGES FOR SERVICES | (50,520,875) | (12,203,798) | (40,126,752) | |
| ⊞23-MISC. REVENUES | (706,872) | (709,200) | (1,063,683) | |
| ⊟EXPENDITURE | 56,898,410 | 22,877,056 | 47,853,042 | |
| ⊞50-SALARIES AND EMPLOYEE BENEF | 35,382,386 | 16,079,346 | 31,357,846 | |
| ⊞60-SERVICES AND SUPPLIES | 7,417,619 | 4,388,731 | 8,753,182 | |
| ⊞70-OTHER CHARGES | 4,508,292 | 28,235 | 4,508,292 | |
| ⊞80-FIXED ASSETS | 734,388 | 8,926 | 630,393 | |
| ⊞90-OTHER FINANCING USES | 97,875 | 0 | 0 | |
| ⊞95-INTRAFUND TRANSFERS | 8,757,850 | 2,371,818 | 2,603,329 | |
| Grand Total | (1,967,843) | 8,794,497 | 2,150,867 | 4,118,710 |

MEASUREABLE &
CONTINUOUS PROCESS
IMPROVEMENT

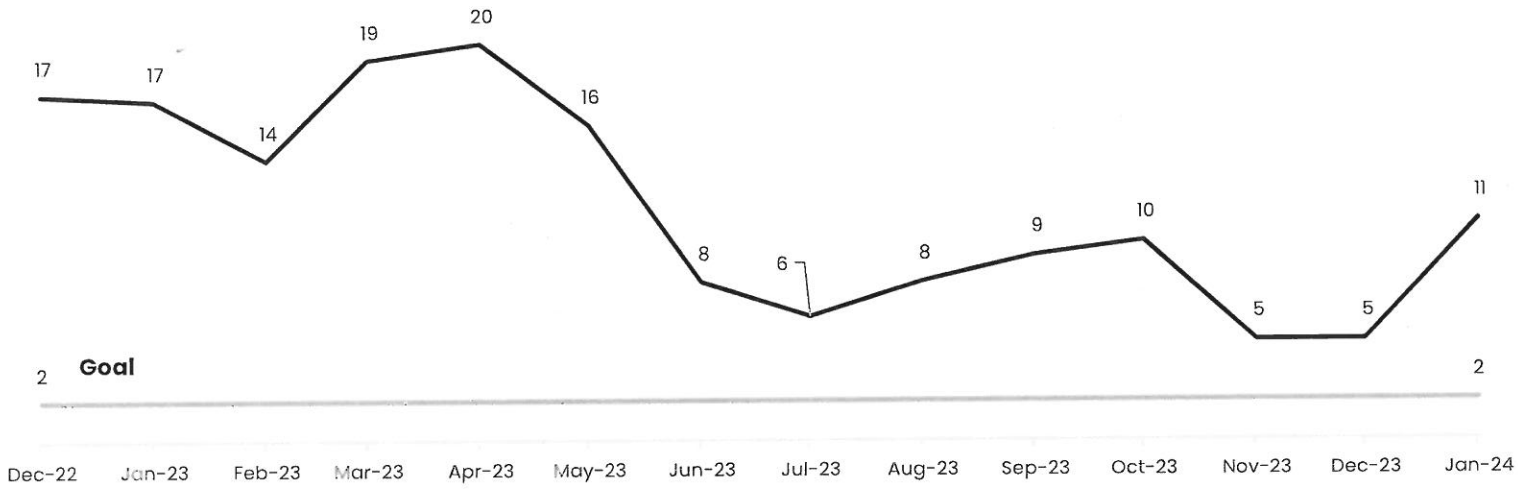
# Days in Account Receivable (AR)



*MEASUREABLE & CONTINUOUS*
*PROCESS IMPROVEMENT*



# Charge Review Days



## Completed Visits have increased 3% between January and February 2022 and 2023

**July-Feb 2023 59,571**

**July-Feb 2024 61,421**

**Overall Accounts Receivable increased 26% between January and February**

**January $4,945,963**

**February $6,257,551**

| | | |
|---|---|---|
| **SUBJECT:**<br>Billing Department and Front Office Operations Policies and Procedures<br><br>**SERIES:** **100**<br>Administration<br><br>**APPROVED BY:**<br>Amy Peeler, Chief of Clinic Services | **POLICY NO.:**<br>**100.03**<br><br>**PAGE:** 1 **OF** 12<br><br>**EFFECTIVE DATE:**<br>August 2014<br><br>**REVISED:**<br>February 2024<br>January 2024<br>June 2021<br>February 2020<br>August 2018<br>August 2017 | COUNTY OF SANTA CRUZ<br>HEALTH SERVICES AGENCY<br><br>**Clinics and Ancillary Services** |

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**POLICY STATEMENT:**

The Health Services Agency (HSA) Clinic Services Division operates Santa Cruz County-run community health centers. The purpose of this policy is to describe all billing policies and procedures currently in use for ensuring assets are safeguarded, guidelines of grantors are complied with, and finances are managed with accuracy, efficiency, and transparency.

The Health Services Agency (HSA) will ensure access to health care services by families and individuals regardless of the patient's ability to pay. At no time will a patient be denied services because of an inability to pay, as described in the Sliding Fee Scale Discount Program policy #100.04.

HSA staff with a role in the management of billing operations are expected to comply with the policies and procedures in this manual.

These policies will be reviewed annually and revised as needed by the staff and approved by the Chief of Clinic Services.

**PROCEDURE:**

A. Billing Overview: Clinic Services Division will provide methods for appropriate and sensitive evaluation of each patient's ability to pay for services rendered.

1. Financial screening of each patient shall not impact health care delivery.

2. The ability to pay (Sliding Fee Discount Program) is available for all patients to apply.

3. The screening will include exploration of the patient's possible qualification for specialized payer programs and is based only on income and family size. Staff will encourage patients to apply for appropriate funding programs and facilitate an application when appropriate.

4. Patients who are unable to pay for services due to special circumstances may request for fees to be waived. All fee waivers must be reviewed and approved by the Business Office Manager and/or Health Center Managers. The Business Office staff, or the registration desk staff will request the waiver from the Health Center Manager or the Business Office Manager prior to waiving of any fees either through email, in person, or by telephone.

B. General Payers

1. Medi-Cal: Most Medi-Cal patients are insured through Santa Cruz County's local managed care provider, Central California Alliance for Health (CCAH). CCAH members must be:

   a. Assigned to HSA for their primary care; or

   b. Within their first 30 days of CCAH membership and therefore not yet formally assigned to a care provider (administrative member); or

   c. Pre-authorized to be seen by an HSA provider.

2. Patients who have State Medi-Cal are generally patients with restricted benefits or transitioning to the managed care program.

3. Medicare: (non-managed care type) Recipients may qualify due to age and/or disability or may be dependent of an aged and/or disabled person.

4. Third-Party Insurance (Private Insurance): Contracted with Blue Shield PPO. Courtesy billing for other PPO insurance is available, however, the patient is responsible for any costs not covered by non-contracted insurance providers.

C. Specialized Payers

1. The following payer types are government-funded program and require application screening to determine eligibility:

   a. Family Planning, Access, Care and Treatment (Family PACT) program: State program for family planning services. Covers annual exams, sexually transmitted infection (STI) checks, birth control methods and emergency contraception.

b. Every Woman Counts (EWC): Breast and cervical cancer screening and diagnostic services. Covers clinical breast exam, screening and diagnostic mammogram, pelvic exam and pap.

c. Child Health and Disability Prevention (CHDP) Program: Well care visits, including immunizations, for children. The age limit is 18 years and 11 months. Grants 60 days of full Medi-Cal benefits while the family formally applies for on-going insurance.

d. MediCruz: Locally funded program that provides specialty care to patients who fall at or below 100% of the Federal Poverty Level and are not eligible for Medi-Cal. Patients fill out an application and provide verification documents.

D. Self-Pay Payers

1. The Ability to Pay (Sliding Fee Discount Program) is available for all patients to apply. Patients with non-contracted insurance types, are responsible to pay for visit costs, including ancillary services. Patients are encouraged to apply for the Ability to Pay (Sliding Fee Discount Program), if eligible. Refer to the Ability to Pay (Sliding Fee Scale Discount Program) policy and procedure, #100.04.

E. Verification of Eligibility and Benefits Determination by Payer

1. Medi-Cal

a. Eligibility Verification: Verification of coverage, restrictions, and cost-share must be obtained through the Medi-Cal website. Patients who may be eligible for Medi-Cal, but are not enrolled, will be encouraged to apply

b. Benefits Determination: Once the eligibility is verified, the benefit type must be reviewed. There are several types of Medi-Cal benefits, ranging from full scope to restricted services. For additional information, the Medi-Cal provider manual can be referenced for benefit rulings. If coverage indicates that the patient is a member of CCAH, then eligibility and assignment must be verified via the CCAH website.

2. Central California Alliance for Health (CCAH)

a. Eligibility Verification: Information regarding the eligibility of coverage must be obtained through the CCAH provider web portal.

b. Benefits Determination: All Medi-Cal benefit rulings apply to CCAH patients assigned to HSA; however, CCAH may offer more benefits than State Medi-Cal (see CCAH provider manual). If the patient is assigned to another provider, they may only be seen by our office for a sensitive service or under the authorization from their assigned primary care provider. A list of sensitive services can be found on the CCAH website.

3. Medicare

a. Eligibility Verification: Medicare eligibility may be verified on-line through the Trizetto Gateway EDI website or by phone. Some Medicare patients have supplemental insurance coverage that may include commercial insurance or Medi-Cal coverage.

b. Benefits Determination: Co-~~insurance~~ pay is due on the date of service. Normally Medicare requires an annual deductible that must be met prior to accessing benefits, however, HSA's Federally Qualified Health Center status allows waiver of the deductible.

4. Other Government Funded Programs

a. Eligibility Verification: Government Funded Programs have eligibility period limitations, ranging from one day to one year. Eligibility periods for Family PACT, EWC, and CHDP Medi-Cal can be obtained through the Medi-Cal eligibility portal. MediCruz eligibility may be determined via the County's MediCruz Office.

b. Benefits Determination

i. Family PACT: covers all birth control methods offered at the HSA clinics, STI screenings, and treatments as part of the primary benefits. For secondary benefits, review the Family PACT Benefits Grid located on the Medi-Cal website.

ii. EWC: covers annual cervical and breast cancer screenings as part of the primary benefits. For secondary benefits, review the covered procedure list located on the Medi-Cal website.

iii. CHDP: grants full-scope Medi-Cal benefits on a temporary basis to allow application processing for Medi-Cal.

5. MediCruz covers specialty care on a temporary and episodic basis.

    a. Eligibility Verification: Eligibility will be verified with contracted insurances using the insurance company's website or via the telephone number provided on the patient's insurance card.

    b. Benefits Determination: As insurance plan benefits vary significantly, it is the patient's responsibility to understand their insurance benefits prior to obtaining services. Since understanding health insurance benefits can be challenging, as a courtesy, HSA staff may assist patients with obtaining coverage information.

F. Enrollment: Other State Funded Programs

HSA is a Qualified Provider allowed to screen, verify, and enroll patients in State Funded Programs using the guidelines set forth by each of the following programs:

1. CHDP

    a. The CHDP program provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. A health assessment consists of health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment.

    In accordance with current CHDP guidelines, HSA staff will pre-screen patients for program eligibility and provide a program application to eligible patients. Staff enters the completed application via the CHDP Gateway and prints two paper cards, with one card signed by the participant's parent and retained at HSA. The other card is provided to the participant's parent, along with a verbal explanation from HSA staff that the child is fully covered by Medi-Cal until the expiration date printed on the card. It is the parent's responsibility to follow-up with County Human Services regarding further application requirements for ongoing Medi-Cal eligibility.

2. Family PACT

    a. Family PACT clients are residents of California that demonstrate a need for family planning services, but have no other source of family planning coverage, and qualify for the program based on family income. Medi-Cal clients with an unmet cost-share may also be eligible. In accordance with Family PACT guidelines, eligibility determination and enrollment are conducted by HSA staff (patient completes an application) with the point of service activation, granting the applicant up to one year of benefits for family planning and reproductive health services. Qualified applicants are given a membership card and informed about program benefits, state-wide access, as well as the renewal process.

3. Every Woman Counts (EWC)

    a. EWC provides free clinical breast exams, mammograms, pelvic exams, and Pap tests to California's underserved women. The mission of the EWC is to save lives by preventing and reducing the devastating effects of cancer for Californians through education, early detection, diagnosis and treatment, and integrated preventive services, with special emphasis on the underserved. Income qualification and age-related service information are available at the EWC website.

    b. HSA Clinics staff will screen patients for eligibility in accordance with program guidelines. The EWC application packet is completed by the patient, and the completed application is processed by HSA staff via the online portal. Patients are issued a paper membership card granting up to one year of benefits for breast and/or cervical services and given information regarding program benefits and the program renewal process. They are also instructed to present their membership card when obtaining services outside of HSA, such as a mammogram.

4. Ryan White HIV/AIDS Program (RWHAP)

    a. For patients receiving Ryan White HIV/AIDS Program funded services the following process on charges related to HIV care will be followed: Patients receiving Ryan White HIV/AIDS Program funded services will not be charged fees related to care. The office visit fees will be waived (see section A, #4).

G. Patient Information Policy

1. Exchange of Information

   a. Registration forms are maintained by Registration staff. Patients are either offered forms or questions are asked verbally, depending on patient preference. Information is collected on all new patients and updated at least every 12 months. All information on the registration form must be collected. The patient address/phone number must be confirmed at each visit. The registration form is also used to collect demographic information necessary for program and agency-wide reporting purposes.

2. Patient Scheduling

   a. Appointment requests may be made in person or over the phone. At the time of an appointment request, staff will confirm the patient's name, date of birth, and phone number. The patient's reason for the appointment should be requested to determine appointment type and duration.

3. No Show and Late Cancels Defined

   a. No Show Appointment: The patient does not arrive for a scheduled appointment.

   b. Late Cancel Appointment: The patient cancels appointment less than 24 hours prior.

4. Follow-up

   a. If deemed necessary by the medical provider, HSA staff will follow up with patients unable to attend a previously scheduled appointment in order to schedule another appointment or determine if the health issue has been resolved.

H. Financial Policies

1. Accepted Forms of Payment

a. Cash: Cash is counted in front of the patient, payments are posted on the patient account (via Epic), and a receipt is printed for the patient.

b. Credit/Debit Card: Charge information is submitted via the credit card merchant services portal. Payment is then posted on the patient account (via Epic), and a receipt is printed for the patient.

c. Personal Checks: Checks are verified with the patient's name; the back of the check is stamped with the Santa Cruz County Bank account information for deposit. Payments are posted on the patient account (via Epic), and a receipt is printed for the patient.

d. Money Orders: Money order backside is stamped with HSA Bank account information for deposit. Payments are posted on the patient account (via Epic), and a receipt is printed for the patient.

2. Payment Agreements: Payment agreements may be negotiated between the patient and BO staff, providing up to three payment installments for past due charges (over 30 days).

3. Refunds: Patient refunds are requested by BO staff using the appropriate County form and require BO Manager approval. Once approved, the request for a refund check is submitted to HSA Finance. Once prepared, the check is forwarded to the BO for delivery coordination with the patient. BO staff documents the refund in the patient account.

4. Non-sufficient Funds (NSF) Returned Checks: NSF Returned Checks are received by mail, email, or identified via bank account review by HSA Finance. The payment is reversed on the patient's account: a new billing claim is created and the County's NSF fee charge of $40 is posted and billed to the patient.

5. Insurance Payments: HSA receives insurance payments in two forms: electronic funds transfer and paper checks. All payments are reconciled to the Explanation of Benefits (EOB), Remittance Advice (RA), or Electronic Remittance Advice (ERA). EOB, RA, and ERA all provide detailed information about the payment.

6. Payments Received by Mail: BO staff are responsible for opening and sorting business office mail. Insurance checks received by mail will be distributed to appropriate BO staff members for processing and deposit preparation, following established County procedures. Payment detail may be posted manually using the correlated EOB via upload to the practice management system through an ERA. The final daily deposit should be completed by a different BO staff member.

7. Direct Deposits: Most direct deposits from third party insurances are accompanied by an ERA uploaded to the practice management system. The biller will reconcile the bank account direct deposits with the ERAs received.

I. Billing Procedures

1. Encounter Development and Management

   a. ICD, CPT, and HCPCS Code Upgrades: ICD and CPT codes are updated as needed by HSA's practice management system vendor. Periodic manual updates are made by BO staff as necessary, and at the request of the medical team. Fees are updated at the beginning of each fiscal year, as applicable, following the Board of Supervisors approval of the Unified Fee Schedule.

2. Encounter to Claim Process

   a. HSA Medical Providers consists of physicians, nurse practitioners, physician assistants, and registered nurses. Providers select CPT and ICD codes for every outpatient face-to-face encounter. CPT codes include but are not limited to: evaluation and management (E&M) codes, preventative care codes, and/or procedure codes depending on the type of service provided. Additional information regarding coding, including program/payer specifications, can be found in HSA's BO Operations Manual. Once providers complete documentation of an encounter, a claim is generated.

   b. Claims that do not automatically transmit are retained in a billing work queue for review by the BO. Following review, the claim is either corrected by a biller or coder as appropriate or returned to the provider for consideration of chart level correction. Following these reviews and possible changes, the claim is then submitted for processing.

   c. Claims are submitted through the payment clearinghouse in batches grouped by payer type. The clearinghouse then forwards claims to the prospective payers. Claim batches are tracked weekly for transmission and payer acceptance.

3. Collections: HSA makes every reasonable effort to collect reimbursement for services provided to patients. This includes collection at time of service, as well as follow-up collection methods including statement dispatch and account notes.

4. Denial Management Procedure

a. Information regarding denied claims are uploaded into the practice management system electronically or entered manually. BO staff are responsible for researching, correcting, and resubmitting (or appealing) clean claims within a 30-day period upon receipt of denial information. Researching may involve contact with the payer, patient, or clearinghouse. A review of the payer-provider manual may also serve as a resource for denied claims.

b. Discoveries may include: patient responsibility for all or part of the charges; incorrect or incomplete information originally submitted to the payer; claim and EOB information must be forwarded to another insurance through a crossover claim process. Correcting the claim may require provider review, CPT or ICD code update within the practice management system, and/or submission to a secondary or tertiary insurance. As soon as the claim is corrected it may be resubmitted with the next batch of claims. If a crossover claim, then required documentation is submitted to the secondary payer.

5. Patient Account Balances: Patient's with account balances of $15 or more are sent a monthly statement. Patients with unpaid balances are flagged during the appointment registration process and directed to the Business Office.

6. Uncollectable and Bad Debt Adjustments

   a. Under the direction of the Business Office Manager, staff will adhere to the following write-off guidelines. The Business Office Manager has the authority to approve write-offs. Write-offs will be measured by HSA Fiscal Department after the month-end close and accounts will be audited as part of standard fiscal year-end practice.

7. Write-off Adjustments

   a. All balances surpassing the Timely Filing Deadline, regardless of payor, will be written off. A chart outlining the specific write-off timelines and adjustment codes for each payor is provided at the end of this section. Refer to the Write-Off Chart for detailed instructions on write-off timing and adjustment codes for each payor.

   b. The timely Filing Deadline will be based on the posted Date of Service.

   c. Exception: In the event the patient has a secondary insurance, and the primary insurance has provided a denial prior to the timely filling date, and the correction is timely, then there is no need for a write-off.

d. Write-Off Chart for Business Office (See addendum)

8. Other Adjustments

   a. Billing Error (BE) – For duplicate claims, when a non-payable charge is billed to an insurance, or a split claim is erroneously created.

   b. Professional Courtesy (PC) – For charges disputed by patients or hardship waiver (see section A, #4).

9. Month End Closing Procedure: The month-end closing is performed at the end of each month and involves the reconciliation of payments and charges for that period.

   a. Reconciliation: For every insurance payment received, BO staff will log the payment on a spreadsheet titled Record of Receipt (ROR) and E-remit tracking prior to posting the payment in the practice management system. At the end of the month, assigned staff will reconcile the payments deposited into HSA's bank account with the ROR entered onto the spreadsheet, and the payments posted in the practice management system. Discrepancies will be reported to HSA Fiscal staff assigned to HSA.

   b. All patient payments will be collected by BO staff and reconciled on a daily basis in the practice management prior to deposit. Any discrepancies will be reported to the Business Office Manager and HSA Fiscal.

   c. Claim dates will be reconciled by date of service. All charges to third party insurances must be submitted prior to the month-end closing.

10. Vaccines for Children (VFC) Billing Policy

   a. Introduction

This policy outlines the billing practices for the Vaccines for Children (VFC) Program at HSA Health Centers. We are committed to complying with all VFC program regulations and ensuring all eligible children receive VFC vaccines at no cost.

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b. VFC Vaccine Cost

- VFC vaccines are provided **free of charge** to all eligible children.
- **No charges** for the vaccine itself can be billed to the patient, their insurance, or any other payer.

c. Vaccine Administration Fees

- Medicaid-eligible children: We will bill Medicaid for the vaccine administration fee according to their guidelines.
- Non-Medicaid VFC-eligible children:
  - We may choose to charge the **patient** for the vaccine administration fee on the day of the vaccination only.
  - The fee must be within the **state/territory cap** established by the Centers for Medicare and Medicaid Services (CMS).
  - Patients cannot be:
    - Denied vaccination due to inability to pay the administration fee.
    - Reported to collections for non-payment of the administration fee.

d. Billing Procedures

- Medicaid claims: Billing for Medicaid-eligible children will follow the standard Medicaid billing procedures.
- Non-Medicaid claims:
  - To ensure compliance with California's VFC program regulations, any VFC administration fee not paid on the day of vaccination will be written off by the business office.

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e. Recordkeeping

We will maintain accurate records for all VFC vaccinations administered, including:

- Patient information
- VFC eligibility documentation
- Vaccine administered
- Administration fee (if applicable)
- Documentation of any communication with the patient regarding billing

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# ADDENDUM 1

| PAYOR | DESCRIPTION | TIMELY FILING DEADLINE (days) | CODE | REASON CODE |
|---|---|---|---|---|
| Self Pay | No Payor; in addition, write-off any balance for patient not assigned to HSA following Referral Authorization Form (RAF) denial or denial for out of county managed care | 180 | UNCOLLECTABLE SELF PAY (CR ACC) [1864] | N/A |
| Carelon | Behavioral Health Visits | 365 | INSURANCE UNCOLLECTIBLE (CR INS) [1754] | 29 |
| Medicare | Straight Medicare Visits | 365 | INSURANCE UNCOLLECTIBLE (CR INS) [1754] | 29 |
| FAMPACT | Family Planning Visits | 365 | INSURANCE UNCOLLECTIBLE (CR INS) [1754] | 29 |
| O/P Medi-Cal | Straight Medi-Cal | 365 | INSURANCE UNCOLLECTIBLE (CR INS) [1754] | 29 |
| Alliance Medi-Cal | Managed Medi-Cal | 365 | INSURANCE UNCOLLECTIBLE (CR INS) [1754] | 29 |
| Commercial | Commercial | 365 | INSURANCE UNCOLLECTIBLE (CR INS) [1754] | 29 |
| ALT Medi-Cal | Wrap Visits | 365 | INSURANCE UNCOLLECTIBLE (CR INS) [1754] | 29 |
| EWC | Every Women Counts | 365 | INSURANCE UNCOLLECTIBLE (CR INS) [1754] | 29 |
| CHDP | Child Health and Disability Prevention | 365 | INSURANCE UNCOLLECTIBLE (CR INS) [1754] | 29 |

| SUBJECT: Credentialing and Privileging | POLICY NO.: **200.03** | COUNTY OF SANTA CRUZ<br>HEALTH SERVICES AGENCY<br>**Clinics and Ancillary Services** |
|---|---|---|
| **SERIES:** 200<br>Personnel | **EFFECTIVE DATE:**<br>July 2001 | |
| **APPROVED BY:**<br>Amy Peeler, Chief of Clinic Services | **REVISED:**<br>February 2017<br>August 2018<br>September 2018<br>March 2020<br>June 2021<br>September 2021<br>July 2022<br>March 2024 | |

GENERAL STATEMENT:

Credentialing and privileging are processes of formal recognition and attestation that an independent licensed practitioner or other licensed or certified practitioner is both qualified and competent.

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Credentialing verifies that the staff meets standards by reviewing such items as the individual's license, experience, certification, education, training, malpractice and adverse clinical occurrences, clinical judgment and character by investigation and observation, as applicable.

Privileging defines an independent, licensed practitioner's scope of practice and the clinical services the clinician may provide.

**POLICY STATEMENT:**

Health Services Agency ~~Clinic Services~~ Health Centers Division shall credential, and privilege all employed, contracted, locum tenens, or volunteer licensed and certified practitioners in accordance with the Bureau of Primary Health Care (BPHC) guidelines and standards.

Credentialing and privileging shall be conducted without regard to race, ethnicity, national origin, color, gender, age, creed, sexual orientation, or religious preference.

**Reference:**

HRSA Health Center Compliance Manual

**KEY DEFINITIONS:**

**Credentialing:** The process of assessing and confirming the qualifications for a licensed or certified health care practitioner.

**Privileging:** The process of authorizing a licensed or certified health care practitioner's specific scope and

content of patient care services. This is performed in conjunction with an evaluation of an individual's clinical qualification and/or performance.

**Licensed, Independent Practitioner (LIP):** Physician, dentist, physician assistant, nurse practitioner, acupuncturist, psychiatrist, licensed clinical social workers (LCSW), or psychologist permitted by law to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges. This includes contracted practitioners providing care at any ~~Clinic Services~~Health Center Division Health Center.

**Other Licensed or Certified Practitioner (OLCP):** An individual who is licensed, registered, or certified but is not permitted by law to provide patient care services without direction or supervision; ~~this includes~~including but not limited to laboratory technicians, medical assistants (MA), licensed practical nurses (LPN), registered nurses (RN), public health nurses (PHN), mental health client specialist, certified community health worker, radiology technologist, registered dieticians (RD), and registered dental assistants (RDA). This includes contracted OLCPs providing care at any ~~Clinic Services~~Health Center Division Health Center.

**Primary Source Verification (PSV):** Verification by the original source of a specific credential to determine the accuracy of a qualification reported by an individual health care practitioner. PSV methods include direct correspondence, telephone verification, internet verification or reports from credential verification organizations (e.g., American Medical Association (AMA) Masterfile or American Osteopathic Association (AOA) Physician Database).

**Secondary Source Verification (SSV):** Verification of a specific credential by a source other than the original source; SSV is used to verify credentials when PSV is not required. SSV methods include the original credential, a notarized copy of the credential or a copy of the credential (when made from an original by ~~Clinic Services~~Health Center Division staff).

**Peer Review and Risk Management Committee:** The goal of the medical peer review is to improve quality and patient safety by learning from past performance, errors and near misses. Educational peer review, for both the provider and the health center, is a tool for identifying, tracking, and resolving suboptimal inappropriate clinical performance and medical errors in their early stages. Plan, Do, Study Act cycles are used for providing feedback and developing strategies for improvement. Both the medical and educational peer reviews will be conducted annually by the Peer Review and Risk Management Committee made up of the Medical Director and Provider Members of the Quality Management Committee. Aggregated data and summaries of the PDSA cycles will be presented to the Co-Applicant Board.

**PROCEDURES:**

Verification of credentials will occur for all LIPs and OLCPs by obtaining Primary Source or Secondary Source Verification using accepted national verification sites. Credentialing documents requiring verification and the verification sites for licensed, registered, and certified staff are utilized and maintained by the Administrative Services Officer II (ASO). The candidate must submit applicable documentation for

| SUBJECT: Credentialing and Privileging | POLICY NO.: **200.03** | |
|---|---|---|

review.

Through a formal contract between Health Services Agency and Dignity Health patients can be admitted by the Emergency Department physician and will be followed by a hospitalist. (line on Dignity Health's responsibility of staff credentialing and privileging.)

**RESPONSIBILITIES:**

The completed Credentialing Application and additional materials will be reviewed by the ASO for verification. Any missing information will be requested from the applicant. The additional requested materials must be returned within two weeks to the ASO or designee.

1. ASO verifies credentials and enters all documents into the HSA Documents Database (Database). The ASO maintains the database to accurately track all practitioners' credentials.

2. County Personnel Department will complete query of Department of Justice (DOJ) and Federal Bureau of Investigation (FBI) criminal index systems pursuant to standard process. LIPs and OLCP additionally have a query of the National Practitioner Data Bank (NPDB) and Medi-Cal Suspended, and Ineligible Provider List completed by the ASO. Clearance of query is filed in the LIP or OLCP Database. The LIP or OLCP bears the burden of establishing and resolving any reasonable doubts about his/her qualifications. A copy of government issued photo identification is requested by the ASO during the credentialing process and additionally, will be kept in the Database. Failure to meet this burden may result in denial of the application. Verification of Basic Life Support Training for LIPs and OLCPs.

3. All adverse information found on the background check is evaluated by the Chief of Clinic Services, the Medical Director, ASO, and hiring supervisor.

4. A pre-employment physical is completed in accordance with County Personnel Procedures. Fitness for duty is evaluated at time of hire with a physical exam reviewing immunizations and PPD status. Annually, thereafter fitness for duty will be documented in the annual evaluation for LIPs and OLCPs. Additionally, every two years the LIPs and OLCPs will attest they are physically and cognitively able to perform their job duties on the privileging form.

5. The Supervising Practitioner completes proctoring and reviewing of twenty patient encounters for LIPs during initial evaluation of competency. Peer chart audits are completed at least twice a year ~~thereafter at designated Provider meetings~~. Each Practitioner will review up to ten charts to assess current competencies. If issues arise it will be elevated to a supervisory review to determine if corrective action is needed. All other licensed, registered, and certified practitioners will have clinical competencies evaluated during orientation and annually thereafter. The evaluation data shall be provided to the ~~Clinic Services~~Health Center Division designated staff for placement into credentialing database.

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6. Practitioner shall complete a Clinical Privileges/Procedure Application prior to providing clinical

services. Practitioners, employed and contracted, shall have the burden of producing all necessary information in a timely manner for an adequate evaluation of their qualifications and suitability for clinical privileges. The applicant's failure to sustain this burden may be grounds for denial or termination of privileges.

7. At any time based on an incident and competency issues, Medical Director or Supervising Practitioner may revise or revoke privileges of the LIP or OLCP. A corrective action will be issued and LIP or OLCP will have the right to appeal to the Chief of Clinic Services. The Chief of Clinic Services will have five business days to respond to the LIP or OLCP. If revocation is reversed the LIP/OLCP must complete a renewal of privileges document and competencies will be reviewed by the Medical Director at (30 days & 90 days?), six months and then again at twelve months. (Check w/Christa about our limitations in revoking/reassigning job duties – level of reprimand?)

**APPROVAL PROCESS**

Health Services Agency Co-Applicant Board authorizes the Medical Directors, in combination with the appropriate Supervising Practitioner, to approve credentialing and privileging of health care practitioners who meet the standards for verification. The Supervising Practitioner and Medical Directors will assess the credentials of each health care practitioner as outlined in the Credentialing Application.

Upon the final decision by the Medical Directors, the ASO will notify the LIP/OLCP in a timely manner of the approval and the next re-credentialing period. If the Medical Director denies the practitioner's application the Medical Director will work with the Personnel Department on next steps.

**RE-CREDENTIALING AND RE-PRIVILEGING:**

Credentialing and privileging of current LIPs and other Licensed or Certified Practitioners shall be reviewed at a minimum of every two years. Application for reappointment will be sent to LIP/OLCP sixty days prior to their appointment expiration day. The Practitioner shall complete attestation for completion of continuing education and attestation questionnaire. Primary source verification of expiring or expired credentials shall be completed by ASO on an on-going basis. A performance evaluation shall be completed annually by the Supervising Practitioner. All reappointment information will be forwarded to the Medical Director for review.

**TEMPORARY PRIVILEGING:**

Temporary privileges may be granted to a LIP by the Medical Director to fulfill a patient care need. This includes providing temporary privileges to a locum tenens LIP or extra help LIP who is covering for an employed or contracted LIP who is ill or taken a leave of absence. Privileges may be granted to a LIP who has the necessary skills to provide care to a patient that a LIP currently privileged does not possess. Temporary privileges may be granted provided current licensure and current competence has been verified.

| SUBJECT: | POLICY NO.: | |
|---|---|---|
| Credentialing and Privileging | **200.03** | |

**EXPIRED LICENSURE:**

Each month, ~~Clinic Services~~Health Center Division staff, will audit the database to determine which providers have a California Professional License, DEA Certificate, or current Board certification that will be expiring in sixty (60) and thirty (30) days. An e-mail notice is sent to the provider ~~60 days~~ prior to expiration~~, and a final notice is sent 30 days prior to expiration~~. E-mail notifications are copied to their Health Center Managers and the Medical Director.

If LIP/OLCP fails to respond and the license or certification expires the Medical Director will evaluate the appropriateness of full or partial revocation of privileges. The LIP/OLCP's supervisor will determine if limited duties can be performed within the scope of the revised privileges, until the next steps are coordinated with the Personnel Department.

*Employees hired because of the possession of a professional license or certification are required to renew them before they expire. Licensing or certification is based on job classification.*

*It is the responsibility of the employee to renew their license(s) or certification(s) before they expire. Santa Cruz County-HSA Clinics will support them by sending reminders via work email prior to expiration.*

*Failure to renew a license or certification on time will result in immediate separation from clinical duties, meaning no one with an expired license or certification may practice medicine and/or engage in any type of patient care, subject to the final approval by the Medical Director.*

| SUBJECT: Outside Normal Business Hours Advice by Telephone | POLICY NO.: **300.24** PAGE: 1 OF 2 | COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY **Clinics and Ancillary Services** |
|---|---|---|
| **SERIES:** 300 Patient Care & Treatment | **EFFECTIVE DATE:** December 2011 | |
| **APPROVED BY:** Amy Peeler, Chief of Clinic Services | **REVISED:** June 2017 March 2024 | |

## GENERAL STATEMENT:

It is the policy of the County of Santa Cruz Health Services Agency (HSA) that patients have timely access to interactive clinical advice to communicate over the telephone with a provider outside of normal business hours in a manner that is culturally and linguistically appropriate.

It is the policy of the HSA that clinical advice by telephone outside of normal business hours is communicated only to patients who are established with the HSA's clinics.

It is the policy of the HSA's Health Centers that communication outside of normal business hours (and during business hours) by telephone is performed and documented in the patient's medical record in a manner that is consistent with medical and legal prudence.

## PROCEDURE:

Patients can seek and receive clinical advice from an on-call provider employed by HSA by telephone when the office is closed in addition to when the office is open.

HSA establishes a monthly schedule for call providers which can be found on the intranet site.

Patients are informed of the availability of outside of normal business hours coverage service when they establish care with an HSA Health Center, on the front door of the health centers, on the after visit summary, as well as on every appointment reminder card. The number is also stated on the outside of normal business hours message.

When patients call an HSA Health Center during usual operating hours they hear a recording that informs them:

1. Of the Health Center's usual business hours.
2. To call 911 for a medical emergency.
3. Of the telephone number for the on-call provider.

Once the patient is connected to the answering service, the operator on duty at the answering service:

1. Obtains the caller's name, the patient's full name, the patient's date of birth, the primary provider name, and the reason for the call.

2. Identifies the correct provider and contacts him or her.

The provider contacts the patient within 30 minutes of receiving the call. The provider provides the patient with advice related to his or her needs. All communications are documented in the patient's medical record in a manner that is consistent with medical and legal prudence.

If there is no response to the operator's call within 30 minutes from the on-call provider, the operator on duty at the answering service performs one or more of the following steps, listed in sequential order:

1. Calls the provider on call.
2. Attempts to contact the on-call provider at his or her secondary contact number.
3. Calls the appropriate medical director.
4. Contacts the medical director on his or her secondary contact number.

The operator reports unsuccessful attempts to contact the on-call provider to the HSA Clinic Administration email or telephone call the next morning.

If applicable, the operator reports unsuccessful attempts to contact the on-call provider to the HSA Clinic Administration email or telephone call the next morning.

All communication is documented in the patient's record, including the content of the communication, the provider, and date and time.

The HSA Health Centers strive to employ and make available providers who are able to speak in the language of its patients. In the event that a patient cannot be accommodated with a provider fluent in the patient's language, the provider is responsible for initiating a three-way conference call with the HSA's interpreter service. All calls will be handled in a manner that is culturally appropriate.

As with any form of patient communication and documentation, unprofessional remarks or comments in telephone communications are prohibited. Confidentiality of patient information is maintained at all times to protect the integrity of protected health information (PHI).

| SUBJECT: Patient Follow-Up Upon Discharge From Clinic | POLICY NO.: **300.05** PAGE: 1 OF 2 | COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY **Clinics and Ancillary Services** |
|---|---|---|
| **SERIES:** 300 Patient Care and Treatment | **EFFECTIVE DATE:** July 2001 | |
| **APPROVED BY:** Amy Peeler, Chief of Clinic Services | **REVISED:** April 2003 November 2016 March 2017 March 2024 | |

## GENERAL STATEMENT:

The care team performs care management activities for all health center patients, including high-risk or complex patients.

## POLICY STATEMENT:

It is the policy of the Health Services Agency (HSA) Health Centers Division to manage all of a patient's care needs. To assure that each patient receives appropriate and individualized care, an individual care plan is created for each patient. Care plans are created by the provider in collaboration with the patient and/or the patient's family. These care plans describe treatment goals, and they are reviewed and updated at each scheduled visit.

## PROCEDURE:

The HSA Health Centers staff gather available medical history and other relevant information before scheduled visits via secure electronic communication, telephone, and/or facsimile from patients and other providers or facilities that have provided care to the patient. Each day, staff conduct pre-visit preparations for patients who are scheduled for the next day. This includes a review of the patient's medical record including the presence of test results, imaging interpretations, operative reports, consultative summaries, and any other relevant documentation needed for the patient's visit. It is the responsibility of the provider to review all available relevant past medical information prior to meeting with the patient. If the information is unavailable, the source (e.g., imaging facility) should be contacted immediately by HSA clinic staff to communicate the results.

During a care visit, the provider, in collaboration with the patient and/or patient's family, develops an individual care plan. The care plan includes treatment goals that are reviewed and updated at each relevant visit. Relevant visits may include visits for chronic conditions, well-child visits, physicals, visits that result in a change in treatment plan or goals, require additional instructions, or provide information to the patient or the patient's family, and visits associated with transitions of care. At each relevant visit, as determined by the patient's provider, the provider uses indicators from evidence-based guidelines to determine the patient's progress with the care plan and treatment goals. The provider documents "no change," if applicable. The provider also documents any deviations from established guidelines and includes the rationale.

The HSA Health Centers staff provide the patient or the patient's family with a written care plan tailored

for the patient's use at home and to the patient's understanding.

The HSA Health Centers staff assess and address barriers when the patient has not met treatment goals. The assessment may include discussions with the patient and/or the patient's family to determine the reasons for limited progress toward treatment goals. The provider and applicable clinic staff helps the patient and/or the patient's family address barriers (e.g., insurance issues or transportation problems). The provider changes the treatment plan or adds treatment, if appropriate.

The HSA Health Centers staff will provide the patient a written clinical after visit summary at each relevant visit. This after visit summary shall include the written care for the patient's use at home as well as information on how to obtain care after normal operating hours. The clinical summary is made available via secure electronic communication but can be printed in the office at the request of the patient.

The HSA Health Centers staff assess and identify patients and patients' families who might benefit from additional care management support, including those who are high risk or complex. The provider refers the patient to internal or external resources, as deemed clinically appropriate. The resources may include disease management or case management programs.

The HSA Health Centers staff assess and identify patients who have missed appointments. The HSA Health Centers staff communicate with patients or the patients' families, if appropriate, in the event that they did not keep an appointment either with an HSA Health Center provider or with an outside provider. The appointments may include a re-check for a chronic problem or a preventive visit. As determined by the provider, the communication is via telephone and/or secure electronic communication. All communications are performed and documented in a manner that is consistent with medical and legal prudence.

| SUBJECT: After-Hours Availability of Medical Record | POLICY NO.: **520.05** | COUNTY OF SANTA CRUZ<br>HEALTH SERVICES AGENCY<br>**Clinics and Ancillary Services** |
|---|---|---|
| **SERIES:** 500<br>Medical Records | **EFFECTIVE DATE:**<br>December 2011 | |
| **APPROVED BY:**<br>Amy Peeler, Chief of Clinic Services | **REVISED:**<br>March 2024 | |

## POLICY STATEMENT:

It is the policy of the County of the Santa Cruz Health Services Agency (HSA) that the medical record is available to clinical providers when the office is closed in order to provide timely and appropriate care to clinic patients.

## PROCEDURE:

Clinical providers are issued a remote log-in and a unique personal identification and password to the electronic health record system, EPIC. Patient clinical information is made available to on-call providers and to other external facilities with appropriate secure internet interfaces for after-hours care. Remote access is limited to those clinical providers who require it. Each clinical provider using the remote access receives training and resources in the secure use of the remote log-in function.

Providers are responsible for creating and maintaining secure passwords according to the HSA's internet security practices.

The Health Center assures that its providers with after-hours access can view the patients' entire electronic health records.

If care is provided by a facility other than HSA's Health Centers, medical records may be accessible through protected health information sharing platforms that local health care facilities participate in. If care is provided by a facility that does not participate in the same health information sharing platforms then the patient would need to make the request for medical records during Health Center business hours, when Health Center staff can work with the patient to request the specific medical records needed.

| SUBJECT: Medical Emergency Procedures | POLICY NO.: **700.01** | COUNTY OF SANTA CRUZ<br>HEALTH SERVICES AGENCY<br>**Clinics and Ancillary Services** |
|---|---|---|
| **SERIES:** 700<br>Standing Orders | **EFFECTIVE DATE:**<br>March 2000 | |
| **APPROVED BY:**<br>Amy Peeler, Chief of Clinic Services | **REVISED:**<br>November 2003<br>August 2017<br>March 2020<br>March 2024 | |

## GENERAL STATEMENT:

Primary care clinics are not equipped to provide sophisticated emergency medical care. The following Standard Procedures are to be used by staff in the instance when specific physician's orders are not immediately available, and while awaiting the 911 emergency medical response.

## POLICY STATEMENT:

It is the policy of the County of Santa Cruz Health Services Agency Health Centers Division to respond to an emergency need while awaiting a 911 emergency medical response.

## PROCEDURE:

1. The Health Centers Division maintains an emergency cart and ensures that all equipment used is accessible and in good working order. The equipment is inventoried monthly and tested according to recommendation of the vendor(s).

2. The first staff member on the scene currently trained in emergency response initiates cardiopulmonary resuscitation (CPR) or basic airway management as required.

3. Any staff member who discovers a patient, visitor, or employee needing emergent care is responsible for activating the emergency medical system. This includes:

    a. Getting appropriate assistance, including notifying an employee who is currently trained in CPR.

    b. Calling 911 or requesting another staff person call 911.

    c. Notifying a provider in the immediate vicinity of the location and type of emergency.

| SUBJECT: Medical Emergency Procedures | POLICY NO.: **700.01** | |
|---|---|---|

4. The first provider on the scene is responsible for managing the emergency situation until paramedics arrive. He or she should then assist as necessary. Until that time, the provider can delegate roles as he or she sees fit for the effective performance of resuscitation.

5. A staff member is assigned to the entrance door to direct paramedics to the emergency location.

6. Thorough documentation of any patient involved in an emergency is required.

7. If the emergency involves a non-patient, a thorough incident report should be completed by the Health Center Manager or provider on scene with input from staff present.

8. For any actual event requiring resuscitation, the health center manager will be required to schedule a debrief within two working days with all involved staff members to debrief the event, provide support as needed, and review any suggestions for improvement