

The County of Santa Cruz

Integrated Community Health Center Commission

AGENDA

November 9, 2017 @ 12:30 pm

Meeting Location: 1080 Emeline Avenue, Admin Conference Room (Second Floor), Santa Cruz, CA 95060

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. August 10th, 2017 Meeting Minutes – Recommend for Approval
4. Substance Abuse Presentation – Shaina Zura, Licensed Clinic Social Worker and Chief of Substance Use Disorder Services
5. Quality Management Committee Update
6. Policies and Procedure – Recommend for Approval

	Policy #:	Policy Name:
1	100.03	Billing Department and Front Office Policies and Procedures
2	100.07	Women's Reproductive Health Services
3	500.01	Confidentiality and Access of the Medical Record
4	610.01	Consent for Treatment
5	610.02	Consent for Treatment of a Minor
6	610.03	Consent for Immunizations
7	700.01	Emergency Procedures

7. Budget/Financial Update
8. CEO Update
9. Executive Session – Public Employee Performance Evaluation - Recommend for Approval
Public Employee Performance Evaluation of Chief Executive Officer pursuant to subdivision (b) of Government Code section 54957

Action Items from Previous Meetings:

Action Item	Person(s) Responsible	Date Completed	Comments
<i>Action Item 1: Presentation on Drug-MediCal</i>	Amy Peeler		

Next meeting: December 14th 12:30 pm-2:30 pm (1080 Emeline Ave, Building D (DOC Conference Room, Second Floor) Santa Cruz, CA)

The County of Santa Cruz Integrated Community Health Center Commission

Minute Taker: Jessica McElveny

Minutes of the meeting held *August 10th, 2017*

1.	Attendance																
Rahn Garcia	Vice-Chair																
Christina Berberich	Member																
Pam Hammond	Member																
Kristin Meyer	Member																
Dinah Phillips	Member																
Len Finocchio	Member																
Amy Peeler	County of Santa Cruz, Health Services, CEO of Clinics																
Raquel Ramirez Ruiz	County of Santa Cruz, Health Services, Sr. Health Services Manager																
Jeanette Garcia	County of Santa Cruz, Health Services, Administrative Services Manager																
Jessica McElveny	County of Santa Cruz, Health Services, Admin Aide																
Lunamar Harter	County of Santa Cruz, Health Services, Typist Clerk																
Meeting commenced at 12:50 pm and concluded at 2:30 pm.																	
2.	Excused/Absent																
Excused: Rama Khalsa Absent: Nicole Pfeil, Fernando Alcantar and Gustavo Mendoza																	
3.	Oral Communications																
4.	Review of June 8 th , 2017 Meeting Minutes – Recommend for Approval																
Christina Berberich motioned for the acceptance of the minutes, the motion was seconded by Kristin Meyer. The rest of the members present were in favor.																	
5.	Quality Management Committee Update																
Raquel Ramirez Ruiz reported on the Draft Quality Management Work Plan for fiscal year 2017-2018 and presented the Uniform Data System (UDS) Clinical Measures progress graph.																	
6.	Policies and Procedures – Recommend for Approval																
Rahn Garcia requested that the review and approval for the policies be moved to September for further feedback. The members present were in favor.																	
1	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Policy #:</th> <th style="text-align: left;">Policy Name:</th> </tr> </thead> <tbody> <tr> <td>100.03</td> <td>Billing Department and Front Office Policies and Procedures</td> </tr> <tr> <td>100.07</td> <td>Women's Reproductive Health Services</td> </tr> <tr> <td>500.01</td> <td>Confidentiality and Access of the Medical Record</td> </tr> <tr> <td>610.01</td> <td>Consent for Treatment</td> </tr> <tr> <td>610.02</td> <td>Consent for Treatment of a Minor</td> </tr> <tr> <td>610.03</td> <td>Consent for Immunizations</td> </tr> <tr> <td>700.01</td> <td>Emergency Procedures</td> </tr> </tbody> </table>	Policy #:	Policy Name:	100.03	Billing Department and Front Office Policies and Procedures	100.07	Women's Reproductive Health Services	500.01	Confidentiality and Access of the Medical Record	610.01	Consent for Treatment	610.02	Consent for Treatment of a Minor	610.03	Consent for Immunizations	700.01	Emergency Procedures
Policy #:	Policy Name:																
100.03	Billing Department and Front Office Policies and Procedures																
100.07	Women's Reproductive Health Services																
500.01	Confidentiality and Access of the Medical Record																
610.01	Consent for Treatment																
610.02	Consent for Treatment of a Minor																
610.03	Consent for Immunizations																
700.01	Emergency Procedures																
7.	Expanded Hours at Santa Cruz Health Center (Emeline) – Recommend for Approval																
Amy Peeler requested approval to proceed with the process to expand the hours at the Emeline clinic. Kristen Myer motioned for the approval to proceed, the motion was seconded by Dinah Phillips. The rest of the members present were in favor.																	
8.	Budget/Financial Update																
Amy Peeler presented the final fiscal year 16-17 closing financials.																	
9.	CEO Update																
Amy Peeler provided an update on space issues for staff as the result of multiple recent grant awards and National Health Center Week.																	

10. Executive Session – Public Employee Performance Evaluation – Recommend for Approval

The commission members held a closed door session at 1:48 pm regarding the Public Employee Performance Evaluation of Chief Executive Officer pursuant to subdivision (b) of Government Code section 54957.

Action Item 1: Rahn Garcia requested a presentation on Drug-MediCal.

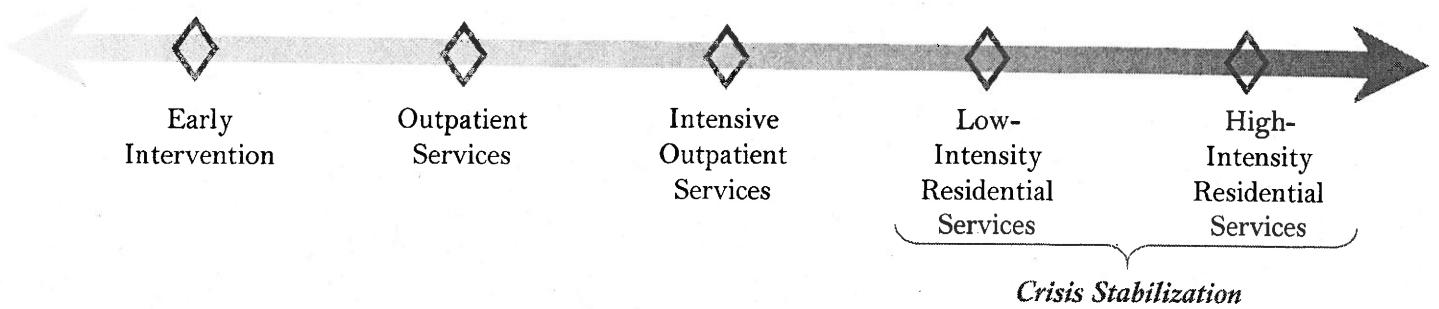
Next Meeting: September 14th, 2017 – 12:30pm – 2:30 pm – 1080 Emeline Ave (Second Floor DOC)

Minutes approved _____ / /
(Signature of Board Chair or Co-Chair) (Date)

Drug Medi-Cal Organized Delivery System

- ◇ New paradigm for Substance Use Disorder treatment
- ◇ Provides a continuum of care model using ASAM criteria for providers and beneficiaries
- ◇ Connects all providers at all levels of care across the County
- ◇ Increases administrative oversight
- ◇ Improves care and efficiency through utilization controls
- ◇ Requires use of evidence-based models

Continuum of Care Levels



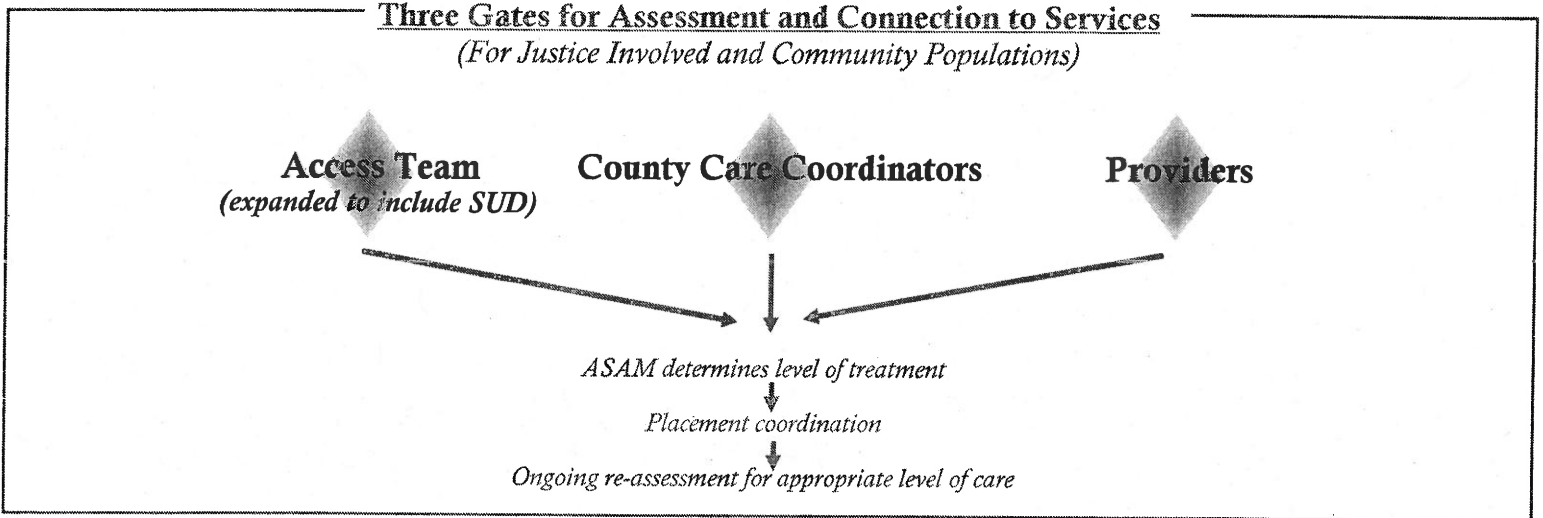
ASAM Six Dimensional Beneficiary Assessment

- | | |
|--|---------------------------------------|
| ◇ Acute Intoxication and/or Withdrawal Potential | ◇ Biomedical Conditions/Complications |
| ◇ Emotional, Behavioral, or Cognitive Conditions and Complications | ◇ Readiness to Change |
| ◇ Relapse, Continued Use, or Continued Problem Potential | ◇ Recovery/Living Environment |

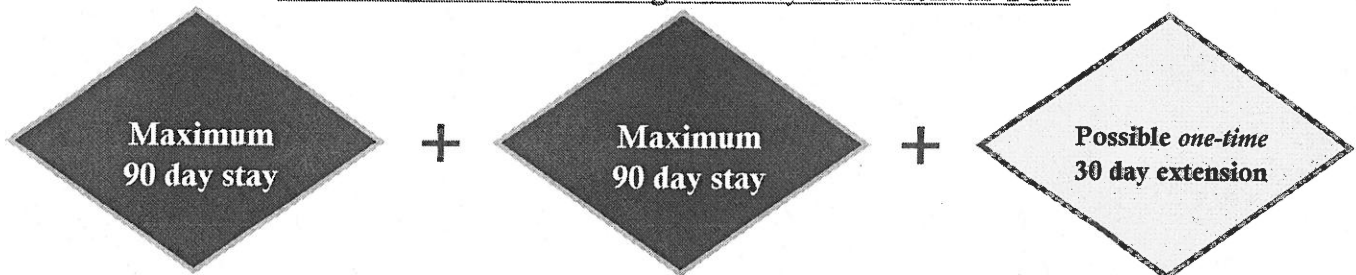
(ASAM to be conducted by an LPHA or by a Substance Use Disorder Counselor with signature by an LPHA)

Three Gates for Assessment and Connection to Services

(For Justice Involved and Community Populations)



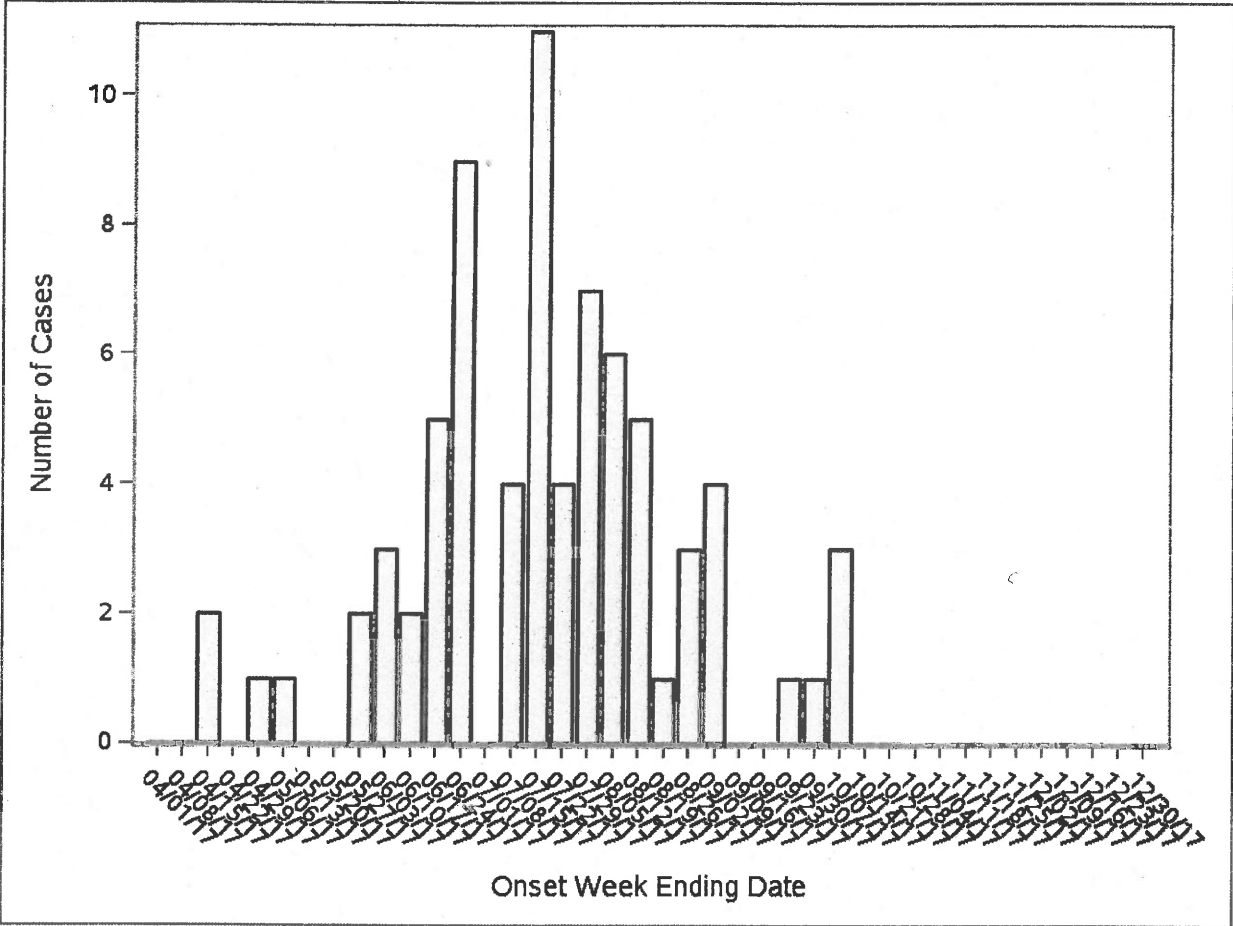
Maximum Residential Length of Stay Per Calendar Year



Reported Hepatitis A Cases in Santa Cruz County by Resolution Status

The FREQ Procedure

RStatus	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Confirmed	74	98.67	74	98.67
Probable	1	1.33	75	100.00



Confirmed and Probable Hepatitis A Cases in Santa Cruz County

The FREQ Procedure

Age	Frequency	Percent	Cumulative Frequency	Cumulative Percent
21-30	19	25.33	19	25.33
31-40	32	42.67	51	68.00
41-50	9	12.00	60	80.00
>51	15	20.00	75	100.00

Sex	Frequency	Percent	Cumulative Frequency	Cumulative Percent
F	28	37.33	28	37.33
M	47	62.67	75	100.00

Homeless	Frequency	Percent	Cumulative Frequency	Cumulative Percent
N	20	26.67	20	26.67
U	1	1.33	21	28.00
Y	54	72.00	75	100.00

IllicitDrugUse				
IllicitDrugUse	Frequency	Percent	Cumulative Frequency	Cumulative Percent
N	21	28.00	21	28.00
U	4	5.33	25	33.33
Y	50	66.67	75	100.00

HomelessOrDrugs	Frequency	Percent	Cumulative Frequency	Cumulative Percent
1. Homeless and Drug Use	45	60.00	45	60.00
2. Homeless Only	7	9.33	52	69.33
3. Homeless, Drug Use Unknown	2	2.67	54	72.00
4. Drug Use Only	5	6.67	59	78.67
6. Neither	14	18.67	73	97.33
7. Unknown	2	2.67	75	100.00

ER				
ER	Frequency	Percent	Cumulative Frequency	Cumulative Percent
N	14	18.67	14	18.67
Y	61	81.33	75	100.00

Confirmed and Probable Hepatitis A Cases in Santa Cruz County

The FREQ Procedure

Hospitalized				
Hospitalized	Frequency	Percent	Cumulative Frequency	Cumulative Percent
N	42	56.00	42	56.00
Y	33	44.00	75	100.00

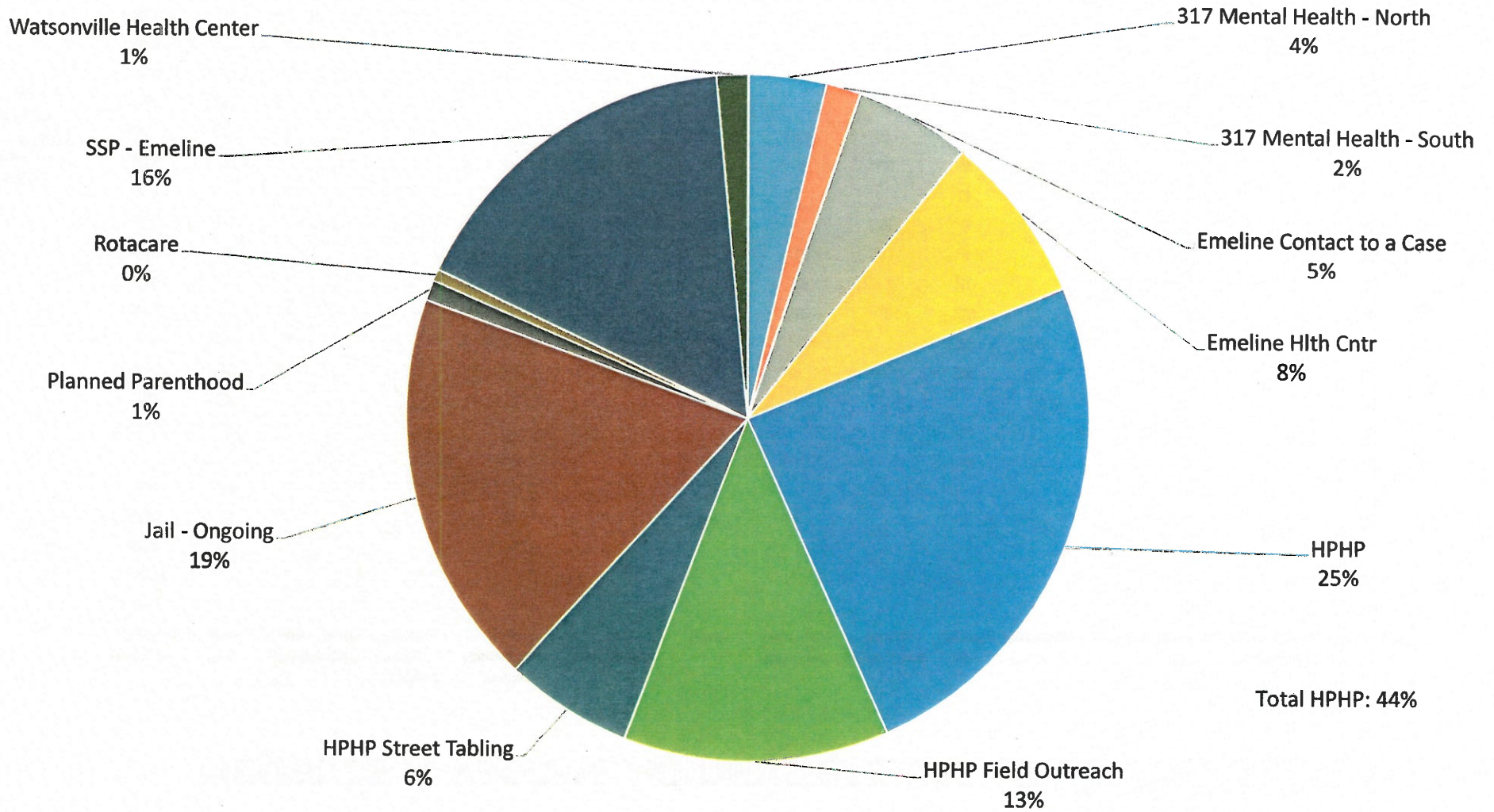
Death	Frequency	Percent	Cumulative Frequency	Cumulative Percent
N	75	100.00	75	100.00

AntiHCVResult	Frequency	Percent	Cumulative Frequency	Cumulative Percent
NOT	45	60.00	45	60.00
POS	30	40.00	75	100.00

HepBSurfaceAntigen	Frequency	Percent	Cumulative Frequency	Cumulative Percent
NOT	75	100.00	75	100.00

AntiHBCResult				
AntiHBCResult	Frequency	Percent	Cumulative Frequency	Cumulative Percent
NEG	2	2.67	2	2.67
NOT	31	41.33	33	44.00
POS	2	2.67	35	46.67
UNK	40	53.33	75	100.00


Hepatitis A Vaccinations by Ongoing Clinic



Hepatitis A Vaccine Administered as of 10/25/2017

Week Ending	Row Labels	317 Mental Health - North	317 Mental Health - South	Emeline Contact to a Case	Emeline Hlth Cntr	HPHP	HPHP Field Outreach	HPHP Street Tabling	Jail - Ongoing	Planned Parenthood	Rotacare	SSP - Emeline	Watsonville Health Center	Grand Total
6/3	22											21		21
6/10	23											11		11
6/17	24											33		33
6/24	25			5		28						15		48
7/1	26					27						5	1	33
7/8	27			1		29			18			7		55
7/15	28								11			7		18
7/22	29									1		9		10
7/29	30			5	1	21			28			2		57
8/5	31			1	1	28			23	1		1		55
8/12	32			1		7	19	8	10			1		46
8/19	33					9	12		10			1		32
8/26	34					6	13		4					23
9/2	35				3	3		9	3	1		1		20
9/9	36			1		5			3	1			1	11
9/16	37			4	16	3	4	11	5	1		3		47
9/23	38			1	8	5	13	7	11			1	2	48
9/30	39	5			9	1		3	2			2		22
10/7	40	5		18	15	5	20			1		1	4	69
10/14	41	8		3	5	3		6	8	1	4		2	40
10/21	42	4	11				11						1	27
10/28	43	5	1											6
	Grand Total	27	12	40	58	180	92	44	136	7	4	121	11	732

Dominican Hospital
(as of 10/18/17)
• 360 staff
• 15 patients

<p>SUBJECT: Billing Department and Front Office Operations Policies and Procedures</p> <p>SERIES: 100 Administration</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.: 100.03</p> <p>PAGE: 1 OF 13</p> <p>EFFECTIVE DATE: October 2014</p> <p>REVISED: August 2017</p>	 <p>COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <hr/> <p>Clinics and Ancillary Services</p>
--	--	---

POLICY STATEMENT:

The Health Services Agency (HSA) Clinic Services Division operates 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.

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 HSA Director and 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. Screening will include exploration of patient's possible qualification for specialized payer programs. Staff will encourage patients to apply for appropriate funding programs and facilitate an application when appropriate.
3. The Business Office Manager and Health Center Managers are authorized to waive patient fees due to expressed financial hardship or disputes.

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:

SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 2 OF 13	
---	---	---

- 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 a dependent of an aged and/or disabled person.
 4. Private Insurance: Contracted with Blue Shield PPO. Courtesy billing for other PPO insurances is available; however 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 who are uninsured/underinsured. 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 undocumented patients who fall at or below 100% of the Federal Poverty Level. Patients fill out an application and provide verification documents.

SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 3 OF 13	
---	---	---

D. Self-Pay Payers

1. Uninsured patients, or patients with non-contracted insurance types, are responsible to pay for visit costs, including ancillary services. Uninsured patients are encouraged to apply for the Ability to Pay (Sliding Fee) Program, if eligible.

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, 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 (CAAH)

- a. Eligibility Verification: Information regarding 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 patient is assigned to another provider, they may only be seen by our office for a sensitive service or under 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.

SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 4 OF 13	
---	---	---

- b. **Benefits Determination:** Co-insurances are due on the date of service. Normally Medicare requires an annual deductible that must be met prior to accessing benefits; however HSA's FQHC 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 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.
 - iv. **MediCruz** covers specialty care on a temporary and episodic basis.

5. Commercial Insurance

- 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. **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

SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 5 OF 13	
---	---	---

HSA is a Qualified Provider allowed to screen, verify, and enroll uninsured and underinsured 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 a 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.
- b. 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 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

SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 6 OF 13	
---	---	---

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 annual cap on charges related to HIV care will be followed:

Individual Income	Maximum Charge
At or below 100 percent of FPL	\$0
101 to 200 percent of FPL	No more than 5 percent of annual gross income
201 to 300 percent of FPL	No more than 7 percent of annual gross income
Over 300 percent of FPL	No more than 10 percent of annual gross income


G. Patient Information Policy

1. Exchange of Information

- a. Registration forms are maintained by Registration staff. Patients are 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. Patient address/phone number must be confirmed at each visit. Registration form information is 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. Reason for requesting to be seen will be requested to determine appointment type and duration.

SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 7 OF 13	
---	---	---

3. No Show and Late Cancels Defined


- a. No Show Appointment: Patient does not arrive for a scheduled appointment.
- b. Late Cancel Appointment: 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. Ability to Pay Program

1. Ability to Pay is a sliding fee program available to uninsured or underinsured patients who qualify according to family size and income (individuals/families living at or below 200% of the Federal Poverty Level (FPL). Patients must first be screened for other public insurance eligibility. Nominal fee charges apply to individuals and families with annual incomes at or below 100% of the Federal Poverty Guidelines. Nominal fees shall be waived for patients who are experiencing homelessness.
2. Patients interested in applying for this program are required to complete an application and provide proof of household income and identification. Registration staff collects preliminary income and family size documentation for each applicant, then enters the information into the appropriate EPIC module for payment range determination in accordance with FPL. Self-declaration of income and household information will be accepted for the first 30 days; however, supporting documentation must be submitted for full qualification (one year). If required documentation is not submitted within 30 days, full visit charges will be applied.
3. For full program qualification, patients must provide photo identification and income verification documents to support their application, such as:
 - a. Most recent Federal tax return
 - b. IRS form W-2 or 1099
 - c. 2 recent consecutive paystubs


SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 8 OF 13	
---	---	---

- d. Social Security, disability or pension benefit statements
- e. Documentation of other governmental assistance
- f. Verification of Student status and FAFSA form
- g. Unemployment Benefits / Workman's Compensation

I. 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


SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 9 OF 13	
---	---	---

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 HSA receives insurance payments in two forms: electronic funds transfer and paper checks. All payments are reconciled to 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. For accounting checks and balances, a separate BO staff person typically performs the final daily deposit.
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.

J. 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 Board of Supervisors approval of the Unified Fee Schedule.
2. Encounter to Claim Process
 - a. HSA Medical Providers consist 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.

SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 10 OF 13	
---	--	---


- 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. 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 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

SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 11 OF 13	
---	--	---


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

7. Write-off Adjustments by Payer

- a. Medicare - Use uncollectible adjustment code
 - Write off balances over one year from Date of Service (DOS) when Medicare is primary.
 - Write off balances over 18 months from DOS when Medicare is secondary.
- b. Commercial Insurance - Use uncollectible adjustment code
 - Write off balances over one year from the DOS when insurance is primary.
 - Write off balances over 18 months from the DOS when insurance is secondary.
- c. EWC - Use uncollectible adjustment code
 - Write off any balance over a year from DOS.
- d. Family PACT - Use uncollectible adjustment code
 - Write off any balance over one year from DOS.
 - Write off any unpaid lab work balance over 6 months.
- e. CHDP - Use uncollectible adjustment code
 - Write off any balance over a year from DOS.
 - Write off any unpaid lab work balance over 6 months.
- f. Medi-Cal - Use uncollectible adjustment code


SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 12 OF 13	
---	--	---

- Write off any balance over a year old.
- g. CCAH - Use uncollectible adjustment code
- Write off any unpaid lab work balance over 6 months old.
 - Write off any balance over a year from DOS.
 - Write off any balance over 18 months from the DOS when Alliance is secondary.
- h. Self-Pay - Use bad debt adjustment code
- Write off any balance over one year old.
 - Write off any balance for patients not assigned to HSA following RAF denial or denial for out of county managed care.
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.
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.

SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 13 OF 13	 The seal of Santa Cruz County, California, featuring a central figure holding a scale, surrounded by the text "THE GREAT SEAL OF THE COUNTY OF SANTA CRUZ" and "1850".
---	--	--

- 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.

<p>SUBJECT: Women's Reproductive Health Services</p> <p>SERIES: 100 Administration</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.: 100.07</p> <p>PAGE: 1 OF 4</p> <p>EFFECTIVE DATE: July 2017</p> <p>REVISED:</p>	<div style="text-align: center;">  <p>COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <p>Clinics and Ancillary Services</p> </div>
--	--	--

GENERAL STATEMENT:

The Health Services Agency Clinic Services Division is committed to high standards and compliance with all applicable laws and regulations.

REFERENCE:

Hyde Amendment
Title X
Section 330 of the Public Health Service Act

PROCEDURE:

A. Statement of Purpose and Policy

The purpose of the Women's Reproductive Health Services Policy and Procedure is to provide safeguards to ensure Health Center's compliance with laws and regulations relating to the provision of women's reproductive health services affecting health centers that receive federal grant funds under Section 330 of the Public Health Service Act ("Section 330") through the U.S. Department of Health and Human Services ("HHS").


Compliance with Section 330

Under Section 330, Health Center is required to provide, either directly or through contracts or formal written referral arrangements, voluntary family planning services. HRSA defines voluntary family services in the Service Descriptor Guide as the following:

"Voluntary family planning services are appropriate counseling on available reproductive options consistent with Federal, state, local laws and regulations. These services may include management/treatment and procedures for a patient's chosen method (e.g., vasectomy, subdermal contraceptive placement, IUD placement, tubal ligation)."

As neither "appropriate counseling" nor "available reproductive options" are defined in Section 330, the implementing regulations, or HHS Health Resources and Services Administration ("HRSA") guidance, Health Center will use the criteria established under the Family Planning Program regulations authorized under Title X of the Public Health Service Act for guidance on how best to provide appropriate family planning options counseling to Health Center's patients.

Compliance with the Hyde Amendment

SUBJECT: Women's Reproductive Health Services	POLICY NO.: 100.07 PAGE: 2 OF 4	
---	--	---

In providing women's reproductive health services as a component of its Section 330-supported health center program, Health Center will assure compliance with the Hyde Amendment. The Hyde Amendment is a statutory provision included as part of the annual HHS Appropriations legislation, which prohibits health centers from using federal funds to provide abortions (except in cases of rape or incest, or where a woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed). The Hyde Amendment prohibits the performance of abortion procedures, as well as the administration of drugs and devices that are used for "medication" abortions that terminate an early pregnancy (up to 70 days from the date of the woman's last menstrual cycle) rather than prevent implantation, including, but are not limited to, administration of the combination of RU-486 (Mifepristone or Mifeprex) and Misoprostol, unless the abortion procedure or medication abortion fits within one of those explicit Hyde Amendment exceptions.

Compliance with Public Health Service Regulations

HSA Clinic Services does not furnish abortion services in any circumstances

Compliance with Prohibition on Coercion

In providing women's reproductive health services as a component of its Section 330-supported health center program, Health Center will assure compliance with statutory requirements, as set forth in 42 U.S.C. §300a-8, which prohibits all Health Center employed and contracted staff from coercing or endeavoring to coerce any person to undergo an abortion by threatening such person with the loss of, or disqualification for the receipt of, any benefit or other health center services. Health Center will also assure that Health Center employed and contracted staff do not coerce or endeavor to coerce any person not to undergo an abortion by threatening such person with the loss of, or disqualification for the receipt of, any benefit or other health center services.


Providing Access to FDA-Approved Contraceptive Methods

Health Center will ensure that its patients have access to the full range of Food and Drug Administration ("FDA")-approved contraceptive methods designed to prevent a pregnancy.

B. Procedure

1. Voluntary Family Planning Services Training.

All Health Center Staff, regardless of their specific job or position descriptions, duties performed or services provided, will be trained on Section 330 requirements applicable to voluntary family planning services including, but not limited to, the required scope of voluntary family planning services, as well as prohibitions and limitations on providing abortions within the Section 330-supported health center program and coercing or endeavoring to coerce any person to undergo an abortion. Health Center shall maintain

SUBJECT: Women's Reproductive Health Services	POLICY NO.: 100.07 PAGE: 3 OF 4	 The seal of Santa Cruz County, California, featuring a central figure holding a scale, surrounded by the text "THE GREAT SEAL OF THE COUNTY OF SANTA CRUZ" and "1850".
--	--	--

records indicating the completion of such training in each employee's and contractor's personnel file.

2. Complying with the Hyde Amendment

All Health Center Staff agree that Health Center shall not provide abortion services, either directly or by contract, within Health Center's Section 330-supported health center program, unless the abortion fits within a Hyde Amendment exception, as described in Section II(3). All Health Center Staff agree that this prohibition includes the administration of "medication" abortions that terminate an early pregnancy (up to 70 days from the date of the woman's last menstrual cycle) rather than prevent implantation. Medication abortions include, but are not limited to, administering the combination of RU-486 (Mifepristone or Mifeprex) and Misoprostol which results in the termination of a pregnancy.

3. Options Counseling.


Health Center Staff providing options counseling shall offer pregnant women the opportunity to be provided information and counseling regarding each of the following options:

- a. prenatal care and delivery;
- b. infant care, foster care, or adoption; and
- c. pregnancy termination.

If requested to provide such information and counseling, Health Center Staff will provide neutral, factual information and nondirective counseling on each of the options, and referral upon request (subject to Section 7 below), except with respect to any option(s) about which the pregnant woman indicates that she does not wish to receive such information and counseling.

4. Prohibition on Coercion.

Health Center Staff are strictly prohibited from coercing or endeavoring to coerce any person to undergo or not to undergo an abortion by threatening such person with the loss of, or disqualification for the receipt of, any benefit or other health center services.

SUBJECT: Women's Reproductive Health Services	POLICY NO.: 100.07 PAGE: 4 OF 4	
--	--	---


5. Contraceptive Methods.

Health Center Staff, upon request, will provide patients with information regarding the management/treatment, as appropriate, for a patient's chosen family planning method. Such management/treatment information may address vasectomy, tubal ligation, and placement of long-acting reversible contraception (e.g., IUDs and implants). In addition, Health Center Staff will ensure that its patients have access to the full range of FDA-approved contraceptive methods designed to prevent a pregnancy.

6. Referrals for Abortion Services.

- a. If a patient requests an abortion either for a pregnancy resulting from rape or incest or because the patient suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the patient in danger of death unless an abortion is performed, in accordance with the Hyde Amendment exceptions, and the health center does not furnish abortions in such limited circumstances, Health Center Staff will provide the patient with a referral to another medical facility.
- b. In the event that a patient's pregnancy is not the result of rape or incest, or the pregnancy does not endanger the life of the woman (as defined in Section II (7)(a) above), and accordingly does not meet a Hyde Amendment exception, and the pregnant woman requests a referral to an abortion provider, Health Center Staff offering referral assistance may provide the name, address, telephone number, and other relevant information (such as whether the provider accepts Medicaid, charges, etc.) about an abortion provider. Such Health Center Staff will not take further affirmative action (such as negotiating a fee reduction, making an appointment, providing transportation) to secure abortion services for the requesting patient.

The Women's Reproductive Health Services Policy and Procedure shall be reviewed periodically and updated consistent with the requirements established by the Board of Directors, Health Center's senior management, federal and state law and regulations, and applicable accrediting and review organizations.

<p>SUBJECT: Confidentiality of the Medical Record</p> <p>SERIES: 500 Medical Records</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.: 500.01</p> <p>PAGE: 1 OF 5</p> <p>EFFECTIVE DATE: July 2001</p> <p>REVISED: November 2003 August 2017</p>	<div style="text-align: center;">  <p>COUNTY OF SANTA CRUZ</p> <hr/> <p>HEALTH SERVICES AGENCY</p> <p>Clinics and Ancillary Services</p> </div>
--	--	---

GENERAL STATEMENT:

This policy is intended to establish guidelines for the contents, maintenance, and confidentiality of patient Medical Records that meet the requirements set forth in Federal and State laws and regulations, and to define the portion of an individual's healthcare information, whether in paper or electronic format, that comprises the medical/dental record.

POLICY STATEMENT:

HSA Clinic Services ensures that the medical and dental patient protected health record is maintains in a manner that is consistent with the legal requirements, current, standardized, detailed, organized, available to practitioners at each patient encounter; facilitating coordination and continuity of care, and permits effective, timely, quality review care and service.

REFERENCE:

Health Insurance Portability and Accountability Act (HIPAA) Privacy & Security Rule, 45 CFR 160-164.524

COMIA - California Confidentiality of Medical Information Act, California Civil Code Section 56 – 56.16


Medicare Conditions of Participation, 42 CFR Sections 482.24

Title 22 California Code of Regulations, Sections 70749, 70751, 71527, and 71549

Business Records Exception, Federal Evidence 803(6)

Section 13101 - 13424 of Title XIII (Health Information Technology for Economic and Clinical Health Act) of the American Recovery and Reinvestment Act of 2009

HIPAA – Health Insurance Portability and accountability Act of 1996; Section 500 “MEDICAL RECORDS”

SUBJECT: Confidentiality of the Medical Record	POLICY NO.: 500.01 PAGE: 2 OF 5	
---	--	---

PROCEDURE:

A. Confidentiality

All personnel having access to patient protected health records must sign the Health Center confidentiality statement.

B. Medical /Dental Health Information may not be disclosed without the consent of the patient.

Patients will be afforded the opportunity to consent to or deny the release of identifiable medical or other information except as require by law.

Each patient protected health record will be filed, stored, restricted from public access, utilizing standardized and centralized medical group network tracking system. This system will assure ease of retrieval, availability and accessibility as well as confidentiality of the patient protected health record.

All patients will have the ability to review, inspect and/or obtain a copy of their Protected Health Information in their Medical and Dental Health Record.

C. Designated Record Set


An individual record is maintained for each patient. To ensure that all Medical Electronic Health Record and Dental Health Record are maintained in a manner that is consistent with the legal requirements and current standards facilitating effective, timely, quality review of patient care and services.

D. Patient Access Definitions

To provide definitions to terms found in the Patient Access and Security Rules under HIPAA. Understanding of these definitions will enable all medical staff to ensure all Patient Protected Health Information (PHI) is secure.

E. Document Identification

All documents must be identified so that proper filing will be completed accurately.

SUBJECT: Confidentiality of the Medical Record	POLICY NO.: 500.01 PAGE: 3 OF 5	
---	--	---

All documents should have a patient label clearly identifying the patient so that all documents are placed in the correct patient Medical or Dental Patient Health Record.

F. Patient Access to Protected Health Information

All patients will have the ability to review, inspect and/or obtain a copy of their Protected Health Information in their Medical/Dental record.

Patients may request to review and inspect their Medical/Dental Records at any time. A patient does not have the right to immediate access to his or her medical/dental record under the HIPAA Privacy Rule.

G. Patient Release of Protected Health

To provide practices protecting the confidentiality, privacy, and security of all Protected Health Information in compliance with patient expectations, regulations, and community standards; including but not limited to the Confidentiality of Medical Information Act and Health Insurance Portability and Accountability Act (HIPAA).


Medical Records Staff will never under any circumstances release Medical/Dental Record Information without a signed Authorization for Use and/or Disclosure of Protected Health Information Form.

Patients may request a copy of their Medical/Dental Health Information record by completing and signing an Authorization for Use and/or Disclosure of Protected Health Information Form. All patient Medical/dental Health Information requests will be completed within 10 business days.

Copies of medical records will be provided at a cost of 25 cents per page (or, if the copies are made from microfilm, 50 cents per page). A patient or patient's representative may receive one free copy of the relevant portion of the patient's record if a written request is presented along with proof that the records are needed to support an appeal of eligibility for Medi-Cal, Social Security disability insurance benefits, and Supplemental Security Income/State Supplementary Program for the Aged, Blind and Disabled (SSI/SSP) benefits. (See Health & Saf. Code, § 123110.)

H. Patient Referral and Tracking

Patient referral and tracking is an overlapping protocol with clinical protocols for referrals to specialty care. Each facility will need to develop this section in the policy and protocols to match clinical protocols.

SUBJECT: Confidentiality of the Medical Record	POLICY NO.: 500.01 PAGE: 4 OF 5	
---	--	---

I. Patient Requested Amendment to Protected Health Information

The HIPAA Privacy Rule requires HSA Clinic Services, to act upon a patient's request to amend Protected Health Information about them that they believe is incorrect or erroneous that we keep in a "designated record set," medical and dental health record.

Requests for amendments to Protected Health Information must be acted on within 60 days of receipt of request. Up to an additional 30 day extension is allowable if HSA Clinic Services is unable to act on the request within the deadline, but HSA Clinic Services must provide the patient a written reason for the delay and the date by which HSA Clinic Services will complete the action on the request. This written statement describing the reason must be provided within the standard deadline. HSA Clinic Services may only extend the deadline once per request for amendment.

J. Confidentiality Breach Allegation

To provide guidelines for handling a patient's complaint or allegation of confidentiality breach.


HSA Clinic Services assures the patient that the health center will honor the patient's right to file a complaint and will not retaliate against them or deny services based on filing a claim.

HSA Clinic Services, Notice of Privacy Practices, informs our patients of their rights under HIPAA's Privacy Rule to file a complaint with our Medical Records Supervisor/Privacy Officer and the Office of Civil Rights (OCR) when they have reason to believe we have violated their privacy rights.

The Medical Records Supervisor/Privacy Officer or appointed designee will take all complaints and/or allegations of non-compliance seriously and will fully investigate the allegations to determine what course of corrective action, if any, needs to be taken. The Medical Records Supervisor/Privacy Officer or appointed designee will notify the patient in writing the outcome of the investigation and what corrective action, if any, was taken within 60 days.

K. Retention of Medical/Dental Record

HSA Clinic Services must maintain medical/dental records on all patients in accordance with accepted professional standards and practices. The medical/dental records are completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information.


SUBJECT: Confidentiality of the Medical Record	POLICY NO.: 500.01 PAGE: 5 OF 5	
---	--	---

HSA Clinic Services recognizes the confidentiality of medical/dental record information and provides safeguards against loss, destruction, or unauthorized use. Written procedures govern the use and removal of records and the conditions for release of information.

L. Destruction of Medical/Dental Record

To provide guidelines on the removal, destruction or recycling of paper and electronic medical/dental records properly. To ensure that during the destruction process the patients' Protected Health Information is not improperly disclosed.

HSA Clinic Services has a duty to protect the confidentiality and integrity of confidential medical/dental information as required by law, professional ethics, and accreditation requirements. Protected Health Information may only be disposed of by means that assure that it will not be accidentally released to an outside party.

<p>SUBJECT: Consent for Treatment</p> <p>SERIES: 600 Required Reporting</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.: 610.01</p> <p>PAGE: 1 OF 3</p> <p>EFFECTIVE DATE: July 2001</p> <p>REVISED: August 2017</p>	 <p>COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <hr/> <p>Clinics and Ancillary Services</p>
---	--	---

POLICY STATEMENT:

It is the policy of the Health Services Agency of the County of Santa Cruz to support the two separate aspects of patient consent. First, a patient has the right to consent (or refuse consent) to any recommended medical procedure. Second, a patient has the right to sufficient information to make that consent meaningful.

REFERENCE:


California Health & Safety Code Section 24173

FORMS:

Consent for Treatment Form & Consent for the Exchange of Confidential Medical, Mental Health, & Substance Abuse Disorder Treatment Information

PROCEDURE:

- A. HSA Clinics Staff must comply with the following guidelines:
 - 1. All adults, aged 18 years and older, must sign a Consent to Treat form;
 - 2. Consent to treat minors (patients younger than 18 years old) must be obtained.
- B. The provider must document informed consent in the medical record and/or on the informed consent form.
- C. The provider must obtain informed consent by giving the patient the following:
 - 1. Information about the diagnosis
 - 2. The nature and purpose of the proposed treatment

SUBJECT: Consent for Treatment	POLICY NO.: 610.01 PAGE: 2 OF 3	
--	--	---


3. The known risks and consequences of the proposed treatment
4. The benefits to be expected from the proposed treatment, with an assessment of the likelihood that the benefits can be realized
5. All alternative treatment modes that might reasonably be applied; and
6. The prognosis if no treatment is given

D. Providers must obtain informed consent for the following:

1. Major or minor surgery involving an entry into the body, either through an incision or through a natural body opening
2. All procedures in which anesthesia is used, except in cases when local infiltration is used in repairing wounds incurred outside of the Clinic
3. Non-surgical procedures, including the administration of medicines and immunizations that involve more than a slight risk of harm to the patient or that may cause a change in the patient's body structure or scarring
4. All forms of radiological therapy
5. All experimental procedures
6. All repairs of facial wounds
7. All procedures, including cryotherapy, that have a possible risk of infection or scarring


E. Providers do not need to obtain consent or informed consent in the following situations:

1. Emergencies. When there is immediate risk of death or serious bodily harm
2. Waiver. When a patient insists on not being informed of the nature of the procedure or the accompanying risks. The patient is required to sign a "waiver of informed consent"

SUBJECT: Consent for Treatment	POLICY NO.: 610.01 PAGE: 3 OF 3	
--	--	---

3. Legal Process. Comply with terms of court and agency orders. If uncertain what is authorized, consult the court and/or legal counsel for clarification

F. All patients wishing to receive Integrated Behavioral Health Services (IBH) &/or Medication Assisted Treatment (MAT) for substance use disorders must complete and sign the Exchange of Confidential Medical, Mental Health, & Substance Abuse Disorder Treatment Information form. If a patient refuses to sign the form a priority message must be placed in the patient's medical record stating, "DOES NOT CONSENT TO IBH OR MAT SERVICES" and patient should be referred elsewhere for IBH or MAT services.

<p>SUBJECT: Consent for Treatment of a Minor</p> <p>SERIES: 600 Medical / Legal</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.: 610.02</p> <p>PAGE: 1 OF 8</p> <p>EFFECTIVE DATE: November 1995</p> <p>REVISED: November 2003 August 2017</p>	<div style="text-align: center;">  </div> <hr/> <p style="text-align: center;">COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <p style="text-align: center;">Clinics and Ancillary Services</p>
---	--	--

GENERAL STATEMENT:

The Health Services Agency (HSA) Clinic Services is committed to ensuring that adolescents receive high quality care based on current standards of adolescent practice. This includes a strength-based approach that respects adolescents' rights, provides a safe and respectful environment, involves families, and includes holistic assessments. Confidentiality plays a significant role in adolescents' willingness to seek care and communicate openly with health professionals.

REFERENCE:

Family Code Section 6924


Health & Safety Code Section 124260

PROCEDURE:

GUIDING PRINCIPLES FOR DEPARTMENT OF PUBLIC HEALTH PROVIDERS AND CONTRACTORS

A. Adolescents

1. Adolescence typically describes the years between ages 13 and 19 and can be considered the transitional stage from childhood to adulthood.
2. Adolescent populations are vulnerable to the impact of a number of preventable health conditions, many of which have both immediate and long-term impact on health and well-being. This is compounded by the fact that adolescents are at risk of being underserved by the health system, in many cases because they are un- or underinsured.
3. During adolescence, tremendous developmental changes occur; these changes can produce fragile relationships, conflict, and confusion. It is critical during this period for adolescents to have easy access to adult guidance and support in health settings.

SUBJECT: Consent for Treatment of a Minor	POLICY NO.: 610.02 PAGE: 2 OF 8	
--	--	---

4. Confidentiality plays a significant role in adolescents' willingness to seek care and communicate openly with health professionals.

B. Parents & Families


1. Parents/guardians play an important role in influencing their adolescent's behavior. The higher the quality of the relationship between parent and child, the greater the likelihood that the young person will display high self-esteem, do well in school, and engage in healthy behavior.
2. For some families, for a variety of reasons, the parent/legal guardian may be estranged from, or unavailable to, their adolescent children. In many cases, support from the health community can benefit the family.

C. Providers and Health Care Systems

1. Prevention must be a significant focus of adolescent clinical practice.
2. Coordinating behavioral health services with primary care services is essential, and can improve access and quality of the services provided.

ACCESS TO CARE (PRIMARY CARE & BEHAVIORAL HEALTH)


- A. HSA clinics are required to provide a primary care and/or behavioral health assessment to all persons under 18 years of age ("minor") who request services. As part of this assessment, the legal status of a minor will be established to determine who has authority to consent for treatment.
- B. Procedure/Confidentiality: HSA clinics will give minors access to a health care provider with or without a parent/guardian present.
 1. When a minor presents on their own, the provider/healthcare team will:
 - a. Determine why the minor is visiting the health center;
 - b. Determine if the minor's condition is an emergency;
 - c. Determine the legal status of the minor;

SUBJECT: Consent for Treatment of a Minor	POLICY NO.: 610.02 PAGE: 3 OF 8	
--	--	---

- d. Conduct an assessment to determine presenting issues and consent; and,
 - e. Inform the minor of his/her health care rights including minor consent services and confidentiality.
- C. Completing an initial assessment and determining eligibility for behavioral health minor consent services may take multiple sessions. In those cases, the charting should clearly describe why the clinician believes that the minor may qualify for minor consent under Family Code Section 6924 or Health & Safety Code Section 124260 and this policy. If criteria cannot be established within the next few sessions, please consult with a supervisor. Please see section "CONSENT TO BEHAVIORAL HEALTH SERVICES" later in this policy.
1. Reproductive health care services should always be billed to Family Pact to ensure client confidentiality.

PROVISION OF PRIMARY CARE SERVICES BY MINORS OF ANY AGE

- A. Minors of any age may consent to the following procedures or items:
1. Medical care related to the prevention or treatment of pregnancy (except sterilization);
 2. Birth control;
 3. Abortion;
 4. Medical care related to the diagnosis, treatment and the collection of medical evidence related to a sexual assault or rape;
 5. Skeletal x-ray to diagnose child abuse or neglect; and
 6. Emergency care.
- B. Procedure/Confidentiality: When a minor consents to any of the procedures listed below, the health provider is not permitted to inform a parent or legal guardian, without the minor's authorization:
1. Medical care related to the prevention or treatment of pregnancy (except sterilization);

SUBJECT: Consent for Treatment of a Minor	POLICY NO.: 610.02 PAGE: 4 OF 8	
---	--	---

2. Birth control; and/or
3. Abortion.

C. In the case of treatment for sexual assault or rape of a minor under 12 years old, the health care provider must attempt to contact the minor's parent/guardian. If unable to contact a parent/guardian, treatment should proceed. The clinician must note in the minor's record the day and time of the attempted contact and whether it was successful. This provision does not apply if the treating professional reasonably believes that the parent/guardian committed the assault or rape. In the case of rape services for a minor who is 12 years of age or older, the healthcare provider is not permitted to inform a parent or legal guardian without the minor's authorization.


1. In the case of a skeletal x-ray to diagnose child abuse or neglect, neither the physician-patient privilege nor the psychotherapist-patient privilege applies to information reported.
2. In the case of emergency treatment, the health care provider shall inform the minor's parent or guardian.
3. Mandated reporting laws must be followed.

CONSENT TO PRIMARY CARE SERVICES BY MINORS - 12 YEARS OF AGE OR OLDER

A. Minors 12 years or older may consent to the following procedures:

1. Medical care related to the diagnosis or treatment of an infectious, contagious or communicable disease, if the disease is one that is required by law to be reported.
2. Medical care related to the diagnosis or treatment of a sexually transmitted disease.
3. An HIV test (with written consent) and the diagnosis and treatment of HIV/AIDS.

B. Procedure/Confidentiality: When a minor of 12 years or older consents to the following procedures, the health care provider is not permitted to inform a parent or legal guardian without minor's authorization. The provider can only share the minor's medical records with the signed authorization of the minor:

SUBJECT: Consent for Treatment of a Minor	POLICY NO.: <p style="text-align: center;">610.02</p> PAGE: 5 OF 8	
---	--	---

1. Medical care related to the diagnosis or treatment of an infectious, contagious, or communicable disease, if the disease is one that is required by law to be reported;
2. Medical care related to the diagnosis or treatment of a sexually transmitted disease;
3. An HIV test and the diagnosis and treatment of HIV/AIDS.

CONSENT TO PRIMARY CARE SERVICES BY MINORS OF 15 YEARS OF AGE OR OLDER


- A. Independent minors, 15 years or older, may consent to medical or dental care if they meet the “self-sufficient minor” definition.
- B. Procedure/Confidentiality: When a minor of 15 years or older consents to medical care or dental care, a physician, surgeon or dentist may alert the minor’s parent or guardian of the treatment needed or given. This can be done if the physician, surgeon, or dentist has reason to know, on the basis of information given by the minor, the whereabouts of the parent or guardian. This action can be taken without the consent of the minor patient.
 1. Such disclosure is discretionary, not mandatory. It is recommended that the self-sufficient minor be consulted regarding parental notification.

CONSENT TO PRIMARY CARE AND BEHAVIORAL HEALTH SERVICES BY EMANCIPATED MINORS

- A. Emancipated minors may consent to medical, behavioral health, or dental care without parental consent, knowledge, or liability.
- B. Procedure/Confidentiality: When an emancipated minor consents to medical, behavioral health, or dental care, the health care provider is not permitted to inform a parent or legal guardian without that minor’s authorization. The provider can only share the minor’s medical records with signed authorization from the minor.

CONSENT TO BEHAVIORAL HEALTH SERVICES


- A. A minor who is 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis, or to residential shelter services, under Health & Safety Code Section 124260 if condition (1) below is satisfied, or under Family Code Section 6924 if conditions (1) and (2) are both satisfied.

SUBJECT: Consent for Treatment of a Minor	POLICY NO.: 610.02 PAGE: 6 OF 8	
--	--	---

1. The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services; and
 2. The minor:
 - a. Would present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling or residential shelter services; or
 - b. Is the alleged victim of incest or child abuse.
 3. A minor may not consent to receive convulsive therapy, psychosurgery or psychotropic drugs without the consent of a parent or guardian.
- B. Procedure/Confidentiality: When a minor who is 12 years of age or older consents to mental health treatment or counseling on an outpatient basis, the health care provider is required to involve a parent or guardian unless the provider decides that the involvement is inappropriate. This decision must be documented in the minor's record.
- a. The parent/guardian of a minor shall not be entitled to inspect or obtain copies of the minor's patient records, without the minor's authorization.

CONSENT TO DRUG & ALCOHOL ABUSE TREATMENT


- A. Minors 12 years of age or older may consent to medical care and counseling relating to the diagnosis and treatment of a drug or alcohol related problem.
1. Minors 12 years of age or older may not consent to replacement narcotic abuse treatment without the consent of their parent or guardian. However, if in the physician's judgment replacement narcotic abuse treatment is necessary due to pregnancy, the physician should consult a supervisor who may contact legal counsel. Reason(s) for recommending treatment without parental consent must be documented in the minor's medical record.
 2. Minors 12 years of age or older may not refuse medical care and counseling for a drug or alcohol-related problem, by law, when the minor's parent or guardian consents to that treatment. However, a minor cannot be forced to accept treatment.
- B. Procedure/Confidentiality: Federal confidentiality law applies to any individual, program, or facility that meets the following criteria:

SUBJECT: Consent for Treatment of a Minor	POLICY NO.: 610.02 PAGE: 7 OF 8	
--	--	---


1. The individual, program, or facility is authorized, certified, licensed, or funded in whole or in part by any department of the federal government (this applies to all HSA programs); and
2. The individual or provider must be one of the following:
 - a. A program or individual that provides alcohol or drug abuse diagnosis, treatment, or referral;
 - b. A staff member at a general medical facility who is identified as, and whose primary function is, providing drug and alcohol abuse diagnosis, treatment or referral; or
 - c. A unit at a general medical facility that provides alcohol or drug abuse diagnosis, treatment, or referral.
3. For individuals and programs meeting these criteria, federal law prohibits disclosing any information to parents without a minor's written consent. One exception, however, is that an individual or program may share information with parents if the individual or program director determines the following three conditions are met:
 - a. The minor's situation poses a substantial threat to the life or physical well-being of the minor or another;
 - b. This threat may be reduced by communicating relevant facts to the minor's parents; and
 - c. The minor lacks the capacity because of extreme youth or a mental or physical condition to make a rational decision on whether to disclose to his/her parents.
4. The parent/guardian of a minor shall not be entitled to inspect or obtain copies of the minor's patient records, without the minor's authorization.

DEFINITIONS OF MINOR CONSENT TERMINOLOGY

- A. Minor: All persons under 18 years of age.

SUBJECT: Consent for Treatment of a Minor	POLICY NO.: 610.02 PAGE: 8 OF 8	
--	--	---

- B. Emergency: A situation requiring immediate services for alleviation of severe pain or immediate diagnosis of unforeseeable medical conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death.
- C. Self Sufficient Minor: Minors of 15 years or older are considered “self-sufficient,” if:
1. The minor is living separately and apart from the minor’s parents or guardian, with or without the consent of a parent or guardian, and regardless of the duration of the separation; and
 2. The minor is managing their own financial affairs, regardless of the source of the minor’s income.
- D. Emancipated minor: A person under 18 years of age is considered to be an emancipated minor if one or more of these conditions are satisfied:
1. The minor has entered into a valid marriage, whether or not the marriage has been dissolved.
 2. The minor is on active duty with the armed forces of the United States.
 3. The minor has received a declaration of emancipation from the court. The minor may obtain a court declaration of emancipation if he/she has met all of these qualifications:
 - a. Age 14 or older;
 - b. Living apart from his/her parents or guardian with their own acquiescence; and
 - c. Managing his/her own finances.

<p>SUBJECT: Consent for Immunizations</p> <p>SERIES: 600 Medical / Legal</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.: 610.03</p> <p>PAGE: 1 OF 2</p> <p>EFFECTIVE DATE: January 2000</p> <p>REVISED: November 2003 August 2017</p>	 <p>COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <hr/> <p>Clinics and Ancillary Services</p>
--	---	---

GENERAL STATEMENT:

California law (California Family Code, sections 6900- 6929) requires that, except in certain very specific situations, the parent or legal guardian consent to medical care (which includes immunization) of the minor. There is no requirement that parent/guardian written consent must be obtained.

The National Childhood Vaccine Injury Act (PL 99-660, 1986 modified by congress in 1988 and in 1993) requires that the health care provider give the patient or parent/guardian the federally designed Vaccine Information Statement (VIS) for each vaccine before each dose. This applies to all vaccines covered by the Act. This law also requires that the health care provider document in the patient's record the VIS edition used and the date it was provided to the parent/guardian. The consent obtained should be based upon an understanding of the inherent risks associated with the vaccine

Since 1980 it has been the Immunization Branch's recommendation that it is not the health department's responsibility to screen each adult accompanying a minor for proof of legal guardianship. However once the immunization provider is informed that the accompanying adult is not the parent or legal guardian the problem of authorization of the immunization must be addressed.

POLICY STATEMENT:

It is the policy of the County of Santa Cruz Primary Care Clinics to obtain consent from the minor's parent/ legal guardian prior to administering vaccinations in Immunization Clinic.

REFERENCE:

Department of Health Services, Immunization Branch; California Family Code, Sections 6900-6929; The National Childhood Vaccine Injury Act, PL 99-660; National Immunization Program, CDC.

PROCEDURE:

- A. Consent by the parent /guardian of a minor must be given before administering vaccines. This includes providing the parent /guardian with the Vaccine Information Sheets (VIS) for all vaccines to be given prior to receiving each dose of vaccine. If it becomes known that the adult


SUBJECT:
Consent for Immunizations

POLICY NO.:
610.03
PAGE: 2 OF 2



accompanying the minor is not the legal/ guardian the one following steps should be taken so that the minor is not sent away unvaccinated.

1. Ask if the accompanying adult has a note from the parent/ guardian giving him/her permission to bring the child in for vaccination. Scan a copy of the note in the chart. Provide the adult with the VIS for the vaccine and have them sign the immunization card.
 2. If the accompanying adult has no note he/she will be asked to sign the "permission form". Have the adult sign the form and provide a driver's license or id number for verification. File this form in the chart and proceed as above.
 3. Call the parent/guardian to get verbal permission. Note in the chart that verbal consent was given for the accompanying adult to bring the child in for immunizations. Proceed as above.
 4. If the accompanying adult is the caregiver of the child and the parent/adult is not available for consent, have the qualifying adult fill out and sign the "Caregivers Authorization Affidavit". See HSA policy and form "Caregivers Authorization Affidavit". Proceed as above.
- B. It is the intent of the HSA Primary Care Clinics not to send minors away without receiving needed immunizations. If staff is unable to fulfill the consent requirement by any of the previous steps they are to call for the supervising nurse or administrator on site to evaluate the individual situation rather than send the minor away unvaccinated.

<p>SUBJECT: Medical Emergency Procedures</p> <p>SERIES: 700 Standing Orders</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.: 700.01</p> <p>PAGE: 1 OF 2</p> <p>EFFECTIVE DATE: March 2000</p> <p>REVISED: November 2003 August 2017</p>	 <p>COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <hr/> <p>Clinics and Ancillary Services</p>
---	---	---

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 to respond to an emergency need while awaiting a 911 emergency medical response.

PROCEDURE:

1. HSA Clinics maintain 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.
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.

SUBJECT: Medical Emergency Procedures	POLICY NO.: 700.01 PAGE: 2 OF 2	 The seal of Santa Cruz County, California, featuring a central figure holding a scale, surrounded by the text "THE GREAT SEAL OF THE COUNTY OF SANTA CRUZ" and "1850".
--	--	--

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. Any actual event requiring resuscitation will be followed within two working days by a meeting of all involved to debrief the event, provide support as needed, and review any suggestions for improvement.

County of Santa Cruz (HSA)
FY 17/18 (All) CLINIC(All)
As of 10-31-2017

GLKey	(All)
Division	CLINIC
Object	(All)

Row Labels	Sum of Budget	Sum of Actual	Sum of Estimated Actuals	Sum of EA Var to Bud
EXPENDITURE	39,762,824	5,864,466	33,414,642	6,348,182.13
CLINIC ADMINISTRATION	5,272,758	971,005	5,948,348	(675,589.79)
CORAL STREET CLINIC (HPHP)	3,827,756	887,678	3,441,603	386,153.04
EMELINE CLINIC	8,444,059	2,014,183	7,323,663	1,120,395.77
FORENSIC SERVICES	0	87,129	(25,266)	25,265.86
MENTAL HEALTH FQHC	13,436,639	2,419	8,726,045	4,710,594.09
WATSONVILLE CLINIC	7,181,612	1,768,265	6,131,474	1,050,138.22
WATSONVILLE DENTAL	1,600,000	133,787	1,868,775	(268,775.06)
REVENUE	(37,415,165)	(6,593,473)	(31,330,445)	(6,084,720.00)
CLINIC ADMINISTRATION	(1,600,000)	(504,175)	(1,600,000)	0.00
CORAL STREET CLINIC (HPHP)	(2,741,051)	108,199	(3,403,906)	662,855.00
EMELINE CLINIC	(8,467,399)	(1,132,654)	(6,412,686)	(2,054,713.00)
MENTAL HEALTH FQHC	(14,536,639)	(2,527,545)	(9,826,045)	(4,710,594.00)
WATSONVILLE CLINIC	(7,870,076)	(2,042,717)	(8,134,640)	264,564.00
WATSONVILLE DENTAL	(2,200,000)	(494,581)	(1,953,168)	(246,832.00)
Grand Total	2,347,659	(729,007)	2,084,197	263,462.13