

The County of Santa Cruz

Integrated Community Health Center Commission

AGENDA

August 10th, 2017 @ 12:30 pm

Meeting Location:

1080 Emeline Avenue, DOC 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. June 8th, 2017 Meeting Minutes – Recommend for Approval
4. Quality Management Committee Update
5. 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

6. Expanded Hours at Santa Cruz Health Center (Emeline) - Recommend for Approval
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: Invite Santa Cruz Aids Project (SCAP) to a presentation</i>	Amy Peeler		

Next meeting: September 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: Lunamar Harter

Minutes of the meeting held *June 6th, 2017*

1. Attendance		
Rahn Garcia	Vice-Chair	
Christina Berberich	Member	
Pam Hammond	Member	
Len Finocchio	Member	
Gustavo Mendoza	Member	
Kristin Meyer	Member	
Nicole Pfeil	Member	
Dinah Phillips	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, Health Center Manager	
Lunamar Harter	County of Santa Cruz, Health Services, Typist Clerk	
Meeting Commenced at 12:05 pm and concluded at 1:55pm		
2. Excused/Absent		
Excused: Rama Khalsa		
Absent: Fernando Alcantar		
3. Oral Communications		
4. Review of May 11th, 2017 minutes		
Kristin Meyer motioned for the acceptance of the minutes, the motion was seconded by Gustavo Mendoza. The rest of the members present were in favor.		
5. Policies and procedure – Recommend for Approval		
Dinah Phillips motioned for the acceptance of six policies and procedures, the motion was seconded by Pamela Hammond. The rest of the members present were in favor. One policy and procedure was not approved and will be brought back to the commission for approval after the requested clarification and changes are made.		
Policy #	Policy Name	Approved
300.13	Language Interpreters	Yes
300.24	After Hours Clinic Advice by Telephone	Yes
300.28	Exam Room Infection Control	Yes
400.02	Overdue Lab & Imaging Results	Yes
410.07	Back Office Direct Strep QuickVue In-Line Strep A (LS943)	Yes
410.08	Conducting Rapid Tests	Yes
610.01	Consent for Treatment	No
6. Budget/Financial Update		
Amy Peeler presented the proposed budget for FY 17-18. Gustavo Mendoza motioned to approve. The motion was seconded by Dinah Phillips and the rest of the members present were in favor. Amy Peeler reported on the year to date financials for the current FY 16-17.		
7. CEO Update		
Amy Peeler reported the Health Services Agency was awarded a \$20.8 million grant for services not covered by MediCal for targeted case management. Christina Berberich requested that a summary of the Whole Person Care proposal be sent to the commission. Dinah Phillips motioned to send a congratulatory letter to the team that worked on the Whole Person Care proposal. The motion was seconded by Len Finocchio and the rest of the members were in favor. Rahn Garcia requested that a question regarding the pharmacy be added to next the Patient Satisfaction Survey.		

8. Quality Management Committee Update

Raquel Ramirez Ruiz reported on the Quality Management Committees tentative work objectives. She also reported the Peer Review Committee is meeting to discuss chart audits and other Quality Management oversight. Raquel Ramirez-Ruiz is researching best practices on Risk Management Committee and will return to the Quality Management Committee with recommendations on establishing a Risk Management Committee.

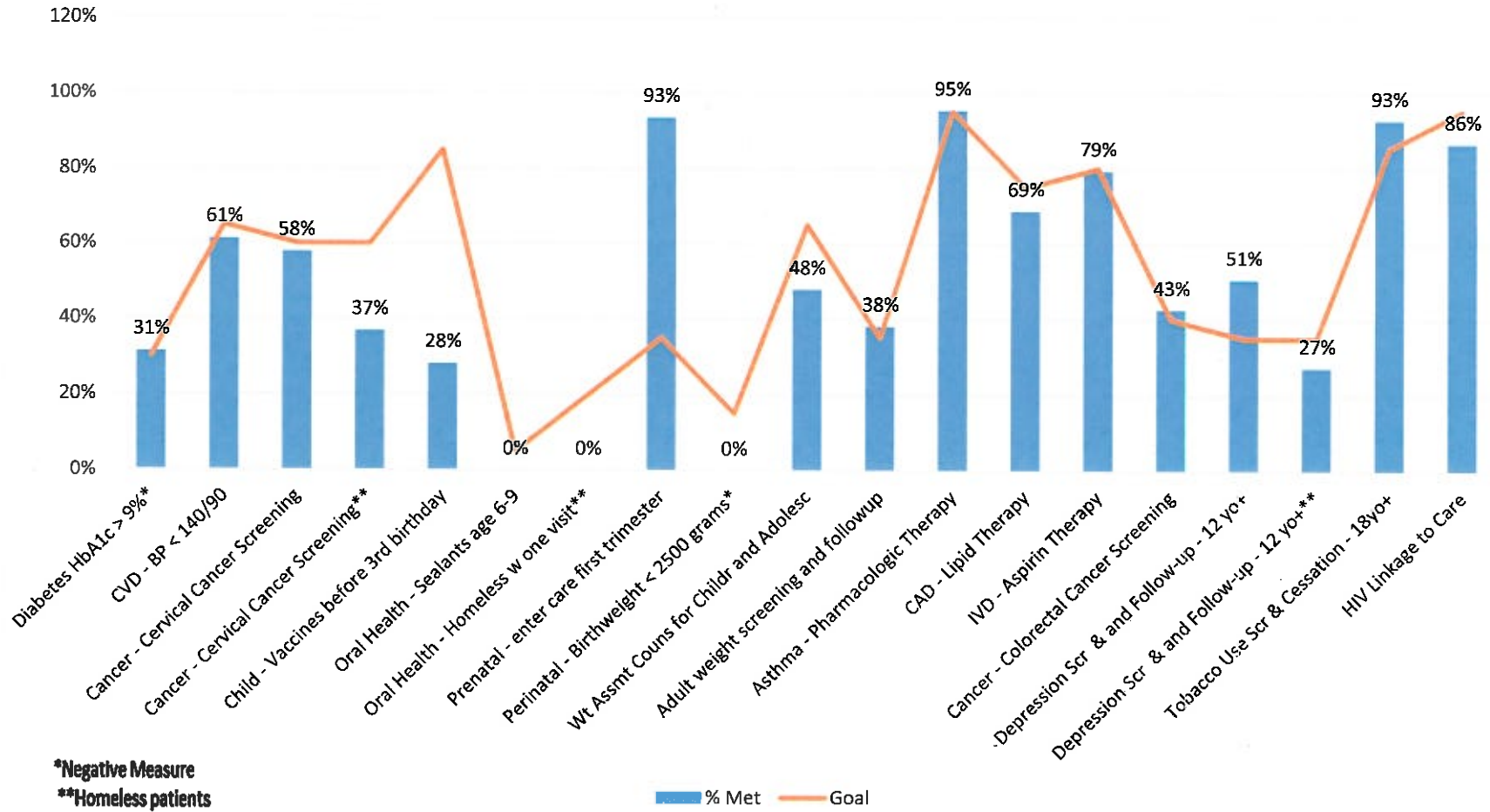
Next Meeting: *July 13th, 2017 12:30 pm at 1080 Emeline Ave Building D (Second Floor DOC), Santa Cruz, CA*


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

DRAFT- QUALITY MANAGEMENT WORK PLAN TEMPLATE FISCAL YEAR 2017-2018

	Expected Activities	Time Frame and Expected Key Outcomes (Clarify Key Indicators)	DATA COLLECTION METHODS	IMPROVE- PDSAs	Actual Outcome Results (to be filled out after PDSA)
PATIENT SATISFACTION	1. Increase patient awareness of after-hours care phone number.	By June 30, 2018, distribute 300 new patient packets with after-hours phone number. By June 30, 2018, distribute 1,000 after-hours cards to existing patients.	Duplication order and inventory		
	2. Increase number of patients on My Chart.	By June 30, 2018, increase patients on My Chart from 7.5% to 15%.	Epic Meaningful Use Reports and Acure Reports		
STAFF SATISFACTION	1. Implement Referral Center.	By Dec 31, 2017, fully staff the Referral Center with a permanent location. By June 30, 2018, decrease referral work queue volume for MA's by 50%.	Personnel Vacancy List Location Identified Epic Work Queue Reports		
	2. Improve Epic Training Satisfaction.	By August 2017, Conduct baseline survey utilizing Survey Monkey filtering out data by clinic. By June 30, 2018, Increase staff satisfaction on Epic Training from x% to x%	Staff Survey		
CLINICAL CARE	1. Increase Access to Medication Assisted Treatment (MAT).	By December 31, 2017, we will maintain a total of 10 X-waivered clinicians including IBH and Mental Health. By January 31, 2018, X-waivered clinicians will treat a minimum of 10 patients each. By June 30, 2018, A clinical team including a Mental Health Client Specialist and Nurse will be designated to support the clinicians.	Epic Patient List		

Uniform Data System (UDS) Clinical Measures- 12 Months Ending 6/30/2017



<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>
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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: 3 OF 13	
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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.

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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

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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


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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.

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- 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: 13 OF 13	 The seal of Santa Cruz County, California, featuring a central figure holding a staff, surrounded by the text "THE GREAT SEAL OF THE COUNTY OF SANTA CRUZ" and the year "1850".
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- 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 data-bbox="1084 163 1268 348" 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>
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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: 3 OF 4	
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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.

<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 HEALTH SERVICES AGENCY</p> <p>Clinics and Ancillary Services</p> </div>
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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 maintained 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: 3 OF 5	
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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: 5 OF 5	 The seal of Santa Cruz County, California, featuring a central figure holding a staff, surrounded by the text "THE GREAT SEAL OF THE COUNTY OF SANTA CRUZ" and the year "1850".
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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>
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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: 3 OF 3	 The seal of Santa Cruz County, California, featuring a landscape with mountains, a river, and a tree, surrounded by the text "THE GREAT SEAL OF THE COUNTY OF SANTA CRUZ" and the year "1850".
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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>	 <p>COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <hr/> <p>Clinics and Ancillary Services</p>
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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

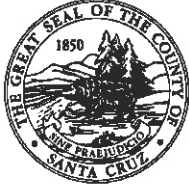
Health & Safety Code Section 124260

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: 3 OF 8	
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- 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: 5 OF 8	
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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

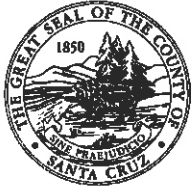
- A. Independent minors, 15 years or older, may consent to medical or dental care if they meet the “self-sufficient minor” definition.
- B. Procedure/Confidentiality: When a minor of 15 years or older consents to medical care or dental care, a physician, surgeon or dentist may alert the minor’s parent 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.

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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.

<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> <p>Clinics and Ancillary Services</p>
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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

<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> <p>Clinics and Ancillary Services</p>
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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.

**COUNTY OF SANTA CRUZ (HSA)
 FY 16/17 CLINIC
 CLINIC SERVICES
 AS OF 06/30/2017**

EXPENDITURES	Sum of Budget	Sum of Actual	Variance	Variance %	Notes
CLINIC ADMINISTRATION	5,480,748.00	5,531,811.29	51,063.29	1%	
CORAL STREET CLINIC (HPHP)	4,100,111.00	3,250,217.92	(849,893.08)	-21%	
EMELINE CLINIC	6,961,322.00	6,380,674.37	(580,647.63)	-8%	
FORENSIC SERVICES	98,831.00	1,236.64	(97,594.36)	-99%	
MENTAL HEALTH FQHC	10,961,603.00	8,559,397.23	(2,402,205.77)	-22%	
WATSONVILLE CLINIC	6,275,760.00	5,668,629.75	(607,130.25)	-10%	
WATSONVILLE DENTAL	2,150,000.00	1,124,786.51	(1,025,213.49)	-48%	
TOTALS	36,028,375.00	30,516,753.71	(5,511,621.29)	-15%	

REVENUES	Sum of Budget	Sum of Actual	Variance	Variance %	Notes
CORAL STREET CLINIC (HPHP)	4,328,066.00	4,735,157.28	407,091.28	9%	
EMELINE CLINIC	7,188,451.00	5,284,015.72	(1,904,435.28)	-26%	
MENTAL HEALTH FQHC	12,061,603.00	9,658,015.89	(2,403,587.11)	-20%	
WATSONVILLE CLINIC	7,254,071.00	7,998,722.77	744,651.77	10%	
WATSONVILLE DENTAL	2,656,785.00	2,028,038.43	(628,746.57)	-24%	
TOTALS	33,488,976.00	29,703,950.09	(3,785,025.91)	-11%	

Grand Total	2,539,399.00	812,803.62	(1,726,595.38)	-68%	
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