

The County of Santa Cruz Integrated Community Health Center Commission

AGENDA

March 9th, 2017 @ 12:30 pm

Meeting Location:

1080 Emeline Avenue, Small Auditorium (basement), Santa Cruz, CA 95060
3645 Nottingham Dr NW Rochester, MN 55901

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. Review and Accept February 9th, 2016 Meeting Minutes
4. Community Health Center Presentation – Drug Medi-Cal
5. Budget/Financial Update
6. Policies and Procedures – Vote
7. CEO Update
8. Quality Management Committee Update


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		
<i>Action Item 2: The Commission would like a speaker on Drug Medi-Cal.</i>	Amy Peeler		

Next meeting: April 13th 12:30 pm-2:30 pm (Ag Extension, 1430 Freedom Blvd, Watsonville, CA)

February 2017

	Sum of Budget	Sum of Actual	Sum of Est. Actuals	Variance	Variance %
EXPENDITURES					
CLINIC ADMINISTRATION	5,436,296.00	3,015,783.37	5,737,972.77	301,676.77	6%
CORAL STREET CLINIC (HPHP)	4,116,199.00	1,943,691.36	3,636,624.33	(479,574.67)	-12%
EMELINE CLINIC	7,040,887.00	3,768,538.60	5,974,022.41	(1,066,864.59)	-15%
FORENSIC SERVICES	98,831.00	41,130.94	74,451.62	(24,379.38)	-25%
MENTAL HEALTH FQHC	10,961,603.00	570.23	6,728,157.00	(4,233,446.00)	-39%
WATSONVILLE CLINIC	6,332,655.00	3,456,655.27	5,788,539.04	(544,115.96)	-9%
WATSONVILLE DENTAL	2,150,000.00	479,088.41	2,045,429.90	(104,570.10)	-5%
TOTALS	36,136,471.00	12,705,458.18	29,985,197.07	(6,151,273.93)	-17%
REVENUES					
CORAL STREET CLINIC (HPHP)	4,344,154.00	858,927.01	4,492,673.00	148,519.00	3%
EMELINE CLINIC	7,223,564.00	2,001,258.36	5,872,772.00	(1,350,792.00)	-19%
MENTAL HEALTH FQHC	12,061,603.00	4,668,128.83	7,828,157.00	(4,233,446.00)	-35%
WATSONVILLE CLINIC	7,310,966.00	3,955,503.46	7,950,293.00	639,327.00	9%
WATSONVILLE DENTAL	2,656,785.00	1,013,222.54	2,045,430.00	(611,355.00)	-23%
TOTALS	33,597,072.00	12,497,040.20	28,189,325.00	(5,407,747.00)	-16%
Grand Total	2,539,399.00	208,417.98	1,795,872.07	(743,526.93)	-29%

<p>SUBJECT: Line of Responsibility</p> <p>SERIES: 100 Administration</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.:</p> <p style="text-align: center;">100.02</p> <p>PAGE: 1 OF 1</p> <p>EFFECTIVE DATE: July 2001</p> <p>REVISED: February 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:

The line of authority will clearly be defined in the organizational charts for the Clinics.

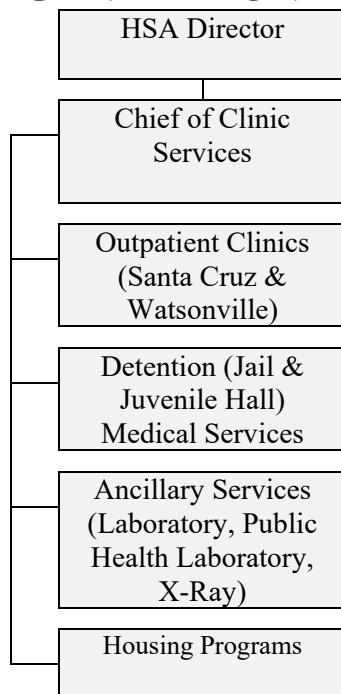
POLICY STATEMENT:


It is the policy of the County of Santa Cruz Health Services Agency to clearly define the line of authority and responsibility for the Clinics and Ancillary Services to allow for orderly operation.

PROCEDURE:

**COUNTY OF SANTA CRUZ – HEALTH SERVICES AGENCY
Clinics Division**

ORGANIZATIONAL CHART



<p>SUBJECT: Job Descriptions: Clinic Services</p> <p>SERIES: 200 Personnel</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.:</p> <p style="text-align: center;">200.01</p> <p>PAGE: 1 OF 1</p> <p>EFFECTIVE DATE: July 2001</p> <p>REVISED: June 2003 February 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:

Job descriptions are available, through the County of Santa Cruz Personnel, for each staff position class utilized in the clinic services.

POLICY STATEMENT:


It is the policy of the County of Santa Cruz to provide professional, qualified staff in the care of community members in clinic services.

REFERENCE:

County of Santa Cruz Personnel Specification forms.

ATTACHED JOB DESCRIPTIONS:

1. Chief of Clinics Services
2. Health Center Manager
3. Clinic Nurse I and II
4. Clinic Nurse III
5. Medical Assistant
6. Community Health Worker I and II

<p>SUBJECT: Credentialing and Privileging</p> <p>SERIES: 200 Personnel</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.:</p> <p style="text-align: center;">200.03</p> <p>PAGE: 1 OF 9</p> <p>EFFECTIVE DATE: July 2001</p> <p>REVISED: February 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:

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

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

Privileging defines an independent, licensed practitioner’s scope of practice and the clinical services he or she may provide.

POLICY STATEMENT:

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

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

KEY DEFINITIONS:

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

Credentials Verification Organization (CVO): A contracted organization that performs verification of a variety of primary and secondary sources.

Privileging: The process of authorizing a licensed or certified health care practitioner’s specific scope and content of patient care services. This is performed in conjunction with an evaluation of an individual’s clinical qualification and/or performance.

SUBJECT:
Credentialing and
Privileging

POLICY NO.:

200.03

PAGE: 2 OF 9



Licensed, Independent Practitioner (LIP): A physician, dentist, physician assistant, nurse practitioner, psychiatrist, or psychologist permitted by law to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.

Other Licensed or Certified Practitioner: An individual who is licensed, registered or certified but is not permitted by law to provide patient care services without direction or supervision; this includes laboratory technicians, licensed clinical social workers (LCSW), medical assistants (MA), licensed practical nurses (LPN), registered nurses (RN), public health nurses (PHN), registered dietitians (RD), and registered dental assistants (RDA)

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

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

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

FORMS:

Credentialing/ Re-Credentialing Checklist

PROCEDURES:

Verification of credentials will occur by obtaining Primary Source or Secondary Source Verification using accepted national verification sites. Credentialing documents requiring verification and the verification sites for licensed, registered and certified staff are included in the Credentialing/Re-

SUBJECT:
Credentialing and
Privileging

POLICY NO.:

200.03

PAGE: 3 OF 9




credentialing Checklist (ATTACHMENT 1). The candidate must submit applicable documentation for review.

Through a formal contract between Health Services Agency and Dignity Health patients can be admitted by the Emergency Department physician and will be followed by a hospitalist.

RESPONSIBILITIES:

The completed Credentialing Checklist and additional materials will be reviewed by the hiring manager for completeness and forwarded to the Credentials Verification Organization (CVO) for verification. Any missing information will be requested from the applicant. The additional requested materials must be returned within two weeks to hiring manager or designee.

1. CVO verifies credentials and forwards information to the hiring manager or designee. The hiring manager maintains the credentialing spreadsheet to accurately track all practitioners' credentials.
2. County Personnel Department will complete query of Department of Justice (DOJ) and Federal Bureau of Investigation (FBI) criminal index systems pursuant to standard process. LIPs additionally have a query of the National Practitioner Data Bank (NPDB) and Medi-Cal Suspended and Ineligible Provider List completed by the CVO. Clearance of query is filed in the Practitioner's credentialing file. The Practitioner bears the burden of establishing and resolving any reasonable doubts about his/her qualifications. Failure to meet this burden may result in denial of the application.
3. All adverse information found on the background check is evaluated by the Medical Director and Peer Review Committee.
4. A pre-employment physical is completed in accordance with County Personnel Procedures.
5. The Supervising Practitioner completes proctoring of twenty patient encounters for LIPs and LCSWs during initial evaluation of competency. Peer chart audits are completed biannually thereafter. All other licensed, registered and certified practitioners will have clinical competencies evaluated during orientation and biannually thereafter. The evaluation data shall be provided to the HSA designated staff for placement into practitioner's credentialing file.
6. Practitioner shall complete a Clinical Privileges/Procedure Application (ATTACHMENT 2) prior to providing clinical services. Practitioners, employed and contracted, shall have the burden of producing all necessary information in a timely manner for an adequate evaluation

<p>SUBJECT: Credentialing and Privileging</p>	<p>POLICY NO.: 200.03 PAGE: 4 OF 9</p>	
---	---	---

of their qualifications and suitability for clinical privileges. The applicant's failure to sustain this burden may be grounds for denial or termination of privileges.

APPROVAL PROCESS

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

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

RE-CREDENTIALING AND RE-PRIVILEGING:

Credentialing and privileging of current LIPs and other Licensed or Certified Practitioners shall be reviewed at a minimum of every two years. Application for reappointment will be sent to practitioner six months prior to their appointment expiration day. The Practitioner shall complete attestation for completion of continuing education and attestation questionnaire. Primary source verification of expiring or expired credentials shall be completed by HSA staff on an on-going basis. A performance evaluation shall be completed annually by the Supervising Practitioner. All reappointment information will be forwarded to the Medical Director for review. The Peer Review Committee meets annually to review credentials, privileges, chart audit results, and any relevant clinical information of current LIPs and Other Licensed or Certified Practitioners.

TEMPORARY PRIVILEGING:

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

EXPIRED LICENSURE:

Each month, HSA staff, will audit the database to determine which providers have a California Professional License, DEA Certificate, or current Board certification that will be expiring in sixty (60)

SUBJECT:
Credentialing and
Privileging

POLICY NO.:

200.03

PAGE: 5 OF 9



and thirty (30) days. An e-mail notice is sent to the provider 60 days prior to expiration and a final notice is sent 30 days prior to expiration. E-mail notifications are copied to their Center Managers and the Medical Director. A copy of the e-mails are printed and placed in the file.

If provider fails to respond and the license expires the Medical Director will have the provider perform limited duties, if possible, until the next steps are coordinated with the Personnel Department.

ATTACHMENT 1: Credentialing/ Re-Credentialing Checklist

- Initial Credentialing
- Re-Credentialing (required every two years)

Provider Name: _____

Provider Type: _____

Licensed Independent Provider (LIP)

- Physician
- Physician Assistant
- Nurse Practitioner
- Psychiatrist

Other Licensed or Certified Practitioner

- Licensed Marriage and Family Therapy
- Licensed Clinical Social Worker
- Clinical Psychologist
- Registered Nurse (RN, PHN, LPN)
- Medical Assistants
- Public Health Microbiologist
- Clinical Lab Scientist
- Laboratory Assistant (Phlebotomist)
- Radiologic Technologist
- Pharmacist

Credentialing Requirement	Practitioner Type	Verification Type	Verification Source	Date Verified or Reviewed	Initials of Person Whom Verified or Reviewed
Licensure, Registration, or Certification	All Practitioner Types	Primary Source	Perform internet verification with licensing board or telephone verification. <ul style="list-style-type: none"> • MD/DO: Medical Board of California • NP/PHN/RN: Board of Registered Nursing • PA: Physician Assistant Committee • LCSW: Board of Behavioral Sciences • Lab Scientist: CA Department of Public Health Laboratory Personnel License 		

			<ul style="list-style-type: none"> • MA: Telephone Verification 		
Curriculum Vitae (For re-credentialing obtain attestation by practitioner that CV has not changed since initial credentialing)	Licensed Independent Practitioners	Not applicable	Copy of Curriculum Vitae		
Education/Training <ol style="list-style-type: none"> 1. Graduation from Medical School 2. Residency 3. Board Cert, if applicable 	Licensed Independent Practitioners	Primary Source	<ul style="list-style-type: none"> • Education Commission for Foreign Medical Graduates • American Board of Medical Specialists • American Osteopathic Association Physician Database • American Medical Association Masterfile <p>Alternatively, perform direct correspondence or telephone verification</p>		
	Other Licensed or Certified Health Care Practitioners	Secondary Source	Copy of Credential (made from the original)		
Board Certification, if applicable	MD and DO	Primary Source	Perform internet verification by specialty at the Board site (e.g. American Board of Internal Medicine or American Board of Family Medicine)		
Current Competence to Practice	Licensed Independent Practitioners	Primary Source	Complete through proctoring of first 20 patient encounters by Supervising Practitioner for new County Employees and Contracted LIPs. Established LIPs have peer chart reviews completed biannually.		

	Other Licensed or Certified Health Care Practitioners	Primary Source	Completed through a review of clinical competency and performance by the Supervisor during orientation for new employees. Established employees have clinical competency reviewed biannually by the Supervisor.		
Government Issued Picture ID	All Practitioner Types	Secondary Source	Copy of ID (made from the original)		
DEA	Licensed Independent Practitioners, as applicable	Secondary	Notarized copy or copy of credential (made from the original)		
NPDB Query		Required, if reportable	NPDB		
Background Check	All Practitioners Types	Primary Source	Completed by Personnel Department: <ul style="list-style-type: none"> Processing of fingerprints through the Department of Justice (DOJ) and Federal Bureau of Investigation (FBI) criminal index systems 		
	Licensed Independent Practitioners	Primary Source	Completed by HSA Staff/ CVO: <ul style="list-style-type: none"> National Practitioner Data Bank (NPDB) query completed Medi-Cal Suspended and Ineligible Provider List query completed 		
Immunization/PPD Status Current	All Practitioners Types	Secondary Source	Copy of immunization record (made from the original) or statement from Occupational Health Program of immunization and PPD status in accordance with CAL OSHA Aerosolized Transmissible Diseases (ATD) vaccine requirements submitted at the time of the pre-employment physical.		
Health/Fitness	Licensed Independent Practitioners	Primary Source	Pre-employment physical signed by the Occupational Health Provider. Must have ability to perform requested privileges.		

Medical Director Review

Date Medical Director Review Credentials: _____

Medical Director Signature: _____

Medical Director Recommendation

- Recommend approval of credentialing to Health Services Agency Co-Applicant Board**
- Do not recommend approval of credentialing to Health Services Agency Co-Applicant Board**

Governing Body Review

Health Services Agency Co-Applicant Board Review Date: _____

-

CHIEF OF CLINIC SERVICES

Job Specifications

Class Code: PK9

Analyst: JS

Date Originated: 7/95

COUNTY OF SANTA CRUZ**DEFINITION**

Under general direction, plan, organize, and direct the services of the County's outpatient medical clinics, detention medical services and clinic support services; and perform other duties as required.

DISTINGUISHING CHARACTERISTICS

This single position class reports to the Medical Services Director/Health Officer and is responsible for the administration and operation of the County's outpatient medical clinics, clinic nursing services and detention medical services. This position directs through the subordinate level managers, Health Center Manager, Senior Public Health Program Manager, and Medical Director-Health Services Clinic. Though the Chief of Clinic Services is responsible for the overall direction of clinics, the Medical Director-Health Services Clinic directs the medical quality assurance and medical management of a variety of clinicians, while the Chief of Clinic Services directs the administrative operations and nursing support of the outpatient clinics and detention medical facilities.

The Chief of Clinic Services differs from the classification of Chief of Public Health in that the latter directs a broad range of specialized public health programs which serve the community, while the Chief of Clinic Services directs health care programs which provide individualized medical care.

TYPICAL TASKS

Plan, organize, and direct through subordinates, the work of staff engaged in providing medical services, ancillary services (such as the laboratory, x-ray, and pharmacy), and support services (such as the business office, reception, medical records, and clerical services) in the County's outpatient clinics and detention medical facilities; insure that programs comply with state, federal, and local regulations; evaluate clinic policies, procedures, operations and programs and implement changes as needed; work with staff of other divisions, departments, and agencies in the development of joint procedures, program planning, and resolution of administrative problems; work with Agency staff to develop, monitor and control the clinic budgets; work with Agency staff to develop and implement medical policies and protocols for the outpatient clinics and the detention facilities; monitor changes in rules and regulations of funding revenue resources; inform supervisor of changes and problems pertaining to various clinic operation and services; select, assign and evaluate the performance of subordinate staff; attend meetings and conferences; and prepare reports and correspondence.

EMPLOYMENT STANDARDS**Knowledge of:**

Thorough knowledge of:

- Principles and practices of medical clinic administration.
- Federal, state, and private sources of clinic revenues and funding sources.
- Federal and state laws and regulations concerning medical clinic services and medical services in a detention facility.
- Principles of supervision and personnel management.

Working knowledge of:

- Clinic business office and billing procedures.
- Budgetary procedures and finance.
- Interrelationships of service among local, public and private medical care service providers.

Some knowledge of:

- Application and use of computer-based information systems.

Ability to:

- Plan, implement and direct a broad range of medical service programs.
- Resolve difficult administrative, technical and personnel related problems.
- Coordinate activities with other divisions, departments, agencies and organizations.
- Establish and maintain effective working relationships.
- Prepare and present clear, concise and effective oral and written reports and presentations.
- Develop, analyze, and monitor budgets and funding sources.
- Analyze evaluate, plan and implement a variety of medical service programs.

Education and Experience:

Any combination of education and experience which would provide the required knowledges and abilities is qualifying, unless otherwise specified. A typical way to obtain the knowledges and abilities would be:

Five years of progressively responsible administrative experience in medical clinic services, including one year of clinic program development and evaluation, and two years of supervisory experience which does not need to be in a clinic setting. A Master's degree in business or public administration may be substituted for one of the five years of required administrative experience.

Special Requirements/Conditions:

- License: Possession of a valid class C driver license.
- Background Investigation: Fingerprinting is required.

PREVIOUS CLASS TITLES: None

Bargaining Unit: 06

EEOC Job Category: 01

Occupational Grouping: 57

Workers' Comp Code: 0290

HEALTH CENTER MANAGER

Job Specification

Class Code: UW6 Analyst: KT	Date Originated: 2/88 Date Revised: 11/94
--------------------------------	--

COUNTY OF SANTA CRUZ

DEFINITION

Under direction, plans, organizes, supervises, coordinates and administratively directs the services of the County's outpatient public health clinics and ancillary services; performs service delivery planning, evaluation and program policy development; and performs other work as required.

DISTINGUISHING CHARACTERISTICS

This single position class works under the direction of the Chief of Public Health. It is distinguished from the latter which is responsible for planning, organizing and directing the public health programs and services for the Division of Public Health.

TYPICAL TASKS

Plan, organize, supervise and administratively direct clinic staff and services, such as the pharmacy, laboratory and X-ray services; manage the clinic business office, including accounting and billing, admitting, medical records and vital statistics; serve in a lead capacity to other clinic managers to evaluate, recommend and implement improvements in outpatient clinic organization and services; interpret, recommend and implement clinic policies and procedures; jointly supervise the Occupational Health physician with the County Personnel Director; provide on-site integration of the Occupational Health Program with the Sr. Public Health Program Manager; plan, develop and implement clinic public health programs; monitor grantfunded programs; develop, recommend and monitor the operating budget including revenue projections and expenditure authorizations; evaluate the clinic management information system components in coordination with the agency systems manager; in coordination with the Sr. Public Health Program Manager and Medical Directors, negotiate, prepare and monitor medical provider and service contracts; act as liaison with State agencies to ensure compliance with State regulations governing the operations of medical clinics; review legislation and program requirements and ensure implementation and compliance as needed; maintain policy and procedural manuals; act as liaison with community organizations and local agencies to coordinate medical services and respond to community medical needs; resolve administrative problems and patient complaints; coordinate the administrative role of clinic physicians and other clinicians; work with the Sr. Public Health Program Manager and Medical Directors to maintain clinic staffing levels; implement and integrate the quality assurance recommendations of the Medical Director and Sr. Public Health Program Manager; work with the Facilities Manager to ensure facility maintenance; review and approve fixed asset purchases proposed by the clinic leadership group; select and supervise staff; prepare proposals; make recommendations and provide input on grant applications; prepare correspondence and reports; participate in various public health committees; coordinate community meetings, staff meetings and conferences; interpret agency policies, programs and procedures to others.

EMPLOYMENT STANDARDS**Knowledge of:****Thorough knowledge of:**

- Management practices and procedures and office organization.
- Principles and techniques of supervision and training.
- Principles of public health practices and administration.

Working knowledge of:

- Fiscal management and budgets, grant proposal writing, funding sources, and program evaluation.
- Laws pertaining to the practice of medicine and of public health in the State of California.
- Application of data processing to office automation.
- Principles and procedures for planning, organizing and directing public health programs.

Some knowledge of:

- Principles of administrative survey and basic statistical analysis.
- Functions and services of community health services, organizations and public health clinics.

Ability to:

- Plan, organize, direct, supervise and evaluate outpatient medical clinics and ancillary services.
- Design and deliver in-service training programs.
- Assume a leadership role in the community's health delivery system.
- Analyze, evaluate and solve complex administrative problems.
- Understand, interpret, explain and apply laws, regulations, policies and written and oral directions.
- Supervise, train and evaluate the work of subordinate staff.
- Write effective and comprehensive reports and recommendations.
- Make oral presentations to small and large groups of diverse audiences.
- Prepare and analyze grant proposals, service contracts, budgetary documents and financial statements.
- Establish and maintain cooperative working relationships with staff, representatives of community organizations and the public.
- Input, access and analyze data using a computer terminal.

Education and Experience:

Any combination of education and experience, which would provide the necessary knowledges and abilities, is qualifying. A typical way to obtain such training and experience would be:

Equivalent to graduation from a four year college in business administration, health science, social science or a related field AND three years professional administrative experience in a primary or public health care delivery setting which included budget development and operations analysis. One year of experience must have included supervisory responsibility. Substitution: A Master's Degree in Public Health may be substituted for one year of non-supervisory professional administrative experience in a health care delivery setting.

Special Requirements/Conditions:

License Requirement: Possession of a valid California class C driver license or the ability to provide suitable transportation which is approved by the appointing authority.

PREVIOUS TITLES: Sr. Health Services Clinic Manager

Bargaining Unit: Mid Management

EEOC Job Category: 02

Occupational Grouping: 85

Worker's Comp Code: 0290

Clinic Nurse II/I

Series Specification

SANTA CRUZ COUNTY

Class Code: PG3,PG5	Date Originated: 11/87
Analyst: JAD, CE, GLD	Date Revised: 9/01,11/03

DEFINITION

Under general supervision, to provide nursing services in public health clinics and other settings, and to do other work as required.

DISTINGUISHING CHARACTERISTICS

Clinic Nurse I is the trainee entry-level class. Incumbents initially work under close supervision in public health clinics that are highly structured and supervised. After incumbents have been fully trained and have demonstrated expertise in clinic services and programs, incumbents would be eligible for promotion to Clinic Nurse II.

Clinic Nurse II is the fully qualified generalist class for clinic assignments or the trainee class for public health specialized field or clinic assignments. Clinic Nurses who work as trainees in a public health setting are expected to continue their education to obtain a Public Health Certificate in order to promote into the Public Health Nursing series. Normally, continuing education could be completed within three years.

TYPICAL TASKS

Assists with clinic operations by monitoring clinic flow, by maintaining and checking charts and records, and by making referrals and follow-up appointments; coordinates with other agency divisions to schedule tests and other services; answers patients questions about procedures, diseases, and medical care concerns; provides informational literature and educates patient on medical care, health issues and need for follow-up; provides skilled nursing services, treatments, administers dressings, medications and immunizations; draws blood, fits orthopedic equipment, irrigates ears and provides other skilled nursing services; reads TB skin tests; coordinates the blood pressure clinic, and the pre-employment and base line physical examination program; performs audiometry and spirometry testing; keeps test records required by the state and federal government; provides counseling for patients including sexually transmitted disease follow-up; orients clinic physicians, mid-level care providers and support personnel to specific clinic operations; maintains the emergency cart, medical supplies and medications; acts as liaison to pharmaceutical representatives, sets up training sessions concerning new drugs and secures samples; in the public health assignment, provides nursing services in specialized clinics, conducts epidemiological investigations of communicable diseases, makes home visits to clients with health risks, makes health care assessments, consults with physicians, counsels clients and their families concerning sensitive health care issues, develops care plans, acts as a patient advocate; may serve as a consultant for nursing issues to staff; maintains clinic equipment; may act in the triage role in general medical clinic which includes scheduling work, prioritizing cases, making complex referrals, providing test results and problem-solving complex cases; attends meetings and in-service training programs; maintains automated and manual record keeping systems; inputs, accesses and analyzes data using a computer terminal; prepares reports, charts, records and other required documentation.

EMPLOYMENT STANDARDS**Knowledge:****Clinic Nurse I****Working knowledge of:**

- Nursing principles, practices and procedures;
- Administration of medications, treatments and therapies;
- Uses, effects and adverse reactions to medications and drugs;

- Care and use of medical supplies and equipment;

Some knowledge of:

- Clinic routines;
- Legal environment of nursing.

Clinic Nurse II

The above, plus some knowledge of:

- Epidemiological investigations, handicapping conditions and the care of chronic and communicable diseases;
- Community resources as related to public health nursing;
- Cultural, environmental, sociological and physiological differences and problems encountered in nursing;
- Prevention, detection, reporting and treatment of child abuse and neglect;
- Interviewing, counseling and teaching techniques.

Ability to:

Clinic Nurse I

- Evaluate and assess health care/medical service needs;
- Provide nursing services in a clinic setting and administer treatments and medications;
- Anticipate physicians and patients needs;
- Establish and maintain effective working relationships;
- Learn clinic routines;
- Deal with sensitivity to the needs of people with different cultural, environmental and social backgrounds;
- Maintain charts and records;
- Learn to input, access and analyze data using a computer terminal.

Clinic Nurse II

The above, plus:

- Learn to assess health care, physical and psycho-social needs and develop and implement care plans may be required for certain positions;
- Learn to provide public health nursing services and case management may be required for certain positions;
- Conduct audiometry and spirometry tests may be required for certain positions;
- Assign and schedule work of staff may be required for certain positions;
- Refer patients to appropriate resources;
- Prepare written reports and procedures.

Education and Experience:

Any combination of training and experience which would provide the required knowledge and abilities is qualifying. A typical way to obtain these knowledge and abilities would be:

- Clinic Nurse I - No Experience required.
- Clinic Nurse II - Two years of clinic or community nursing experience which would provide the knowledge and abilities listed above.

Special Requirements/Conditions**License Requirements:**

- Clinic Nurse I - Possess and maintain a license/permit issued by the State of California to practice nursing, or possession of a provisional license issued by the State of California to practice nursing;

- Clinic Nurse II - Possession of a valid California Registered Nurse license.

Some positions require possession and maintenance of a valid California Class C Driver's license

Background Investigation: Fingerprinting is required

PREVIOUS CLASS TITLES:

Bargaining Unit: 41

EEOC Job Category: 02

Occupational Grouping: 58

Workers Comp Code: 0290

CLINIC NURSE III

Job Specifications

Class Code: PG7

Analyst: LW

Date Originated: 4/91

Dates Revised: 7/87, 9/88, 4/97, 10/98

DEFINITION

Under direction, to serve as a lead and to assist a program manager in the direction, evaluation, and supervision of a General Medical Clinic and other clinics; and to do other work as required.

DISTINGUISHING CHARACTERISTICS

Positions in this class provide lead direction for an assigned major medical clinic, including screening patients for medical need and arranging for follow-up care as directed; scheduling and training subordinate staff; assuring quality of care; and coordinating clinic services with other providers and programs.

This class is distinguished from the class of Public Health Nurse III in that the latter class is responsible for a full range of public health duties and supervision of public health nursing professional staff. This class is distinguished from the next lower class of Clinic Nurse II in that while both classes provide direct nursing care to clients, the Clinic Nurse III also coordinates clinic activities, while a Clinic Nurse II may perform field assignments.

Incumbents are encouraged to continue their education to be eligible for Public Health Nursing certification.

TYPICAL TASKS

Plans, assigns and schedules and may supervise the day-to-day activities of a major public health medical clinic; screens patients for the urgency of their medical needs, determining which to refer to a physician, and arranging for medical services; reviews charts and patient care for completeness, compliance with clinic protocols and professional standards; reports legally defined illnesses and conditions to the proper authorities; acting under medical orders provided by County physicians, refers General Medical Clinic clients for specialty services; coordinates clinic nursing function, including oversight of work of nursing support staff; ensures that the clinic is stocked, clean and adheres to Infection Control Policy; attends designated staff meetings; keeps current with changing standards of practice; assists to implement nursing components of clinic functions; and provides training and in-service education to other staff members.

EMPLOYMENT STANDARDS**Knowledges**

- Thorough knowledge of nursing principles, practices and procedures;
- Working knowledge of technical nursing procedures, and medical terminology;
- Working knowledge of the administration of medications, treatments and therapies, and the uses, effects and adverse reactions to medications and drugs;
- Working knowledge of the care and use of medical supplies and equipment;
- Working knowledge of clinic routines;
- Working knowledge of interviewing, counseling and teaching techniques in a medical setting;
- Working knowledge of prevention, detection, reporting and treatment of
 - child abuse and neglect;
- Working knowledge of epidemiologic investigation, control and care of chronic and communicable diseases and illnesses, handicapping conditions and mental illness;
- Some knowledge of availability of community resources, specialists and services.

Abilities

- Evaluate and assess medical needs of patients and determine medical urgency and necessity.
- Recognize and report legally defined illnesses and conditions, and instances of suspected abuse.
- Deal with sensitivity to the needs of people with different cultural, environmental and social backgrounds.
- Plan, assign and schedule day-to-day work in a major medical clinic;
- Teach and supervise other health care professionals, workers and volunteers;
- Understand, interpret, explain and apply laws, regulations, policies and written and oral direction;

- Develop and revise nursing protocols;
- Establish and maintain effective working relationships with others.

Training and Experience

Any combination of training and experience which would provide the required knowledges and abilities is qualifying. A typical way to obtain these knowledges and abilities is:

- One year of experience performing duties equivalent to a Clinic Nurse II in Santa Cruz County and six months lead or supervisory experience.

SPECIAL REQUIREMENTS

- Possession of a valid California Registered Nurse license issued by the State of California.
- Possess and maintain a valid California Class C Driver's license.

Bargaining Unit: General Rep

EEOC Job Category: 02

Occupational Grouping:

58 Worker's Comp Code: 0290

MEDICAL ASSISTANT

Job Specifications

Class Code: NW7	Date Originated: 05/99
Analyst: CE, CH	Date Revised: 09/16

SANTA CRUZ COUNTY

DEFINITION

Under supervision, provides direct patient care and technical support services to physicians or other licensed medical professionals.

DISTINGUISHING CHARACTERISTICS

This class is distinguished from the lower class of Community Health Worker II in that incumbents in the latter class are not trained and certified to administer medications by injection or draw blood. This class is distinguished from the next higher classes of Public Health Nurse, Clinical Nurse (RN), Detention LVN and LVN in that these classes are responsible for providing professional skilled nursing services and required license through the State Board of Nursing.

TYPICAL TASKS

Administer medication by intradermal, subcutaneous or intramuscular injection. Perform venipuncture or skin puncture for the purpose of withdrawing a blood sample. Perform ear lavage. Collect by non-invasive techniques and pressure specimens for testing including urine, sputum, semen and stool. Administer medication orally, sublingually, topically, vaginally, rectally or by providing a single dose to a patient for immediate self-administration. Administer medication by inhalation, if medication is identified as patient specific and order has been received by the physician. Perform electrocardiogram (EKG). Apply and/or remove bandages and dressings. Apply orthopedic appliances, such as: knee immobilizer and envelope arm sling. Remove casts, splints and other external devices. Select, adjust and instruct patient in proper use of crutches. Remove sutures or staples from superficial incisions or lacerations. Assist patients in ambulation and transfers to and from exam table, wheel chair, etc. Prepare patient for procedure with provider by positioning, draping, shaving and disinfecting treatment site. Take patients vital signs: temperature, blood pressure, pulse and respiration. Accurately record vital sign results in patient's medical record. Weigh and measure patient and accurately record results in patient's medical records. Perform vision and hearing screening and accurately record results in patient's medical record. Prepare equipment and instruments for sterilization and/or disinfection. Interview patients prior to provider examination, confirming the following data points: drug allergy history, record reason for visit/examination, record patient's symptoms, assure that results of all previously ordered tests are present in the medical record. Prepare equipment/instruments needed by provider for a specific identified procedure or test. Assist in setting up and dismantling clinics, CHDP, Occupational Health, Family Planning, IZ, Ortho and DMC. Disinfect and clean exam rooms as appropriate following patient procedures, tests or examinations. Dispose of contaminated materials according to infectious waste policy and procedure. Dispose of needles and syringes in accordance with sharps policy and procedures. Stock examination rooms and other clinic areas with appropriate medical supplies, forms and equipment. Order and maintain supplies in the clinic. Schedule patient referral appointments. Take phone calls and deliver messages related to clinic business as needed. Keep Nursing Supervisor and/or Lead Nurse informed of clinic or patient issues, such as patient flow, coverage problems, etc. Keep records and documentation of all patient interactions and encounters. Provide assistance and support to provider in the course of patient procedure and examination.

EMPLOYMENT STANDARDS**Knowledge:**

Thorough knowledge of:

- The use of measuring instruments.
- English grammar, spelling and punctuation.
- Medical terminology.
- Safety precautions necessary to move and position patients.
- Drug and medication interaction and counter indication when administering injections and/or oral and inhaled substances.

- Safety procedures when using specialized medical equipment.
- Universal precautions.

Working knowledge of:

- Rules and procedures of sanitation and safety as applied to the disinfection of examination rooms and medical equipment and disposal of contaminated waste.
- Scope of responsibilities and treatment techniques within the required certification.

Ability to:

- Administer medication using proper clinical techniques.
- Accurately operate medical equipment.
- Assist provider and patients in course of medical examinations.
- Draw blood samples using proper clinical techniques.
- Interact with patients and providers in a professional manner.
- Handle needle syringes and contaminated materials using established universal precaution.
- Use and operate cast cutter.
- Understand and follow verbal and written instructions.
- Accurately record and keep legible records and documentation.
- Adjust work pace to changes in workflow and assignments.
- Support or restrain patients as needed.
- Push a patient in a wheelchair or medical equipment, supplies and medical records through clinical unit on supply carts.
- Convert measurements and readings.
- Write instructions/directions for patients, providers and/or staff.
- Disinfect examination rooms and medical equipment.
- Move/ambulate and position patients.
- Establish and provide a sympathetic atmosphere for injured and ill patients from diverse social and cultural backgrounds.
- Establish and maintain cooperative working relationships with those contacted in the course of work.
- Recognize and evaluate situations which call for the immediate attention of a physician, physician assistant/nurse practitioner or other nursing staff.
- Manage manipulative, hostile and sociopathic behavior effectively.
- Maintain confidentiality of patient information.

Education and Experience:

Any combination of education and experience, which would provide the required knowledge and abilities is qualifying, unless otherwise specified. A typical way to obtain the knowledge and abilities would be:

Completion of medical assistant training pursuant to standards established by the Division of Allied Health Professionals Business and Professions Code of the Medical Practice Act, Medical Board of California.

Special Requirements, Conditions:

License Requirements: Possession of a valid California class C driver license, or the ability to provide suitable transportation which is approved by the appointing authority.

Possession of a valid professional medical assistant certificate issued by 1) American Association of Medical Assistants, 2) The American Medical Technologist, 3) California Certifying Board of Medical Assistants, 4) Multiskilled Medical Certification Institute, Inc., or, 5) National Healthcareer Association.

Background Investigation: Fingerprinting and a background investigation.

Other Special Requirements: In accordance with the Medical Practice Act of the Business and Professions Code, incumbents must be at least 18 years of age. Must possess the physical stamina and mobility to walk, stand, stoop, reach, bend and lift for long periods of time to treat patients.

Special Working Conditions: Exposure to: Allergens such as latex and soaps from frequent hand washing. Crying hysterical children and potentially hostile clients. Airborne and blood borne infections which might cause chronic disease or death. Odors such as unwashed clients, vomit, feces, urine and draining abscesses, fumes from cleaning supplies and solvents.

PREVIOUS CLASS TITLES: None.

Bargaining Unit: 41

EEOC Job Category: 03

Occupational Grouping: 44

Workers Comp Code: 0290

COMMUNITY HEALTH WORKER I**COMMUNITY HEALTH WORKER II**

(Series Specifications)

Class Code:	Date Originated:
Analyst: MM	Date Revised: 9/81

DEFINITION

Under supervision, to provide nonprofessional nursing services in community clinics and schools; and to do other work as required.

DISTINGUISHING CHARACTERISTICS

Community Health Worker I: This is the trainee level. Incumbents work under close supervision, performing a wide variety of routine tasks. Incumbents are expected to learn departmental organizational structure and services and basic nursing care and techniques.

Community Health Worker II: This is the journey level. Incumbents work under supervision performing a variety of nursing care services. Incumbents may handle a small caseload of patients and/or assist with special projects.

TYPICAL TASKS

Assists in clinics, such as: general medicine, family planning, immunization, child health in preparation of patients for examination; sets up clinic rooms, vision room and hearing test rooms; prepares patient history; takes height and weight information; assists in administering a variety of tests; enters information on charts; orders and maintains supplies; assist the physicians and patients; under supervision, may participate in school health education projects; record and maintains charts, records and statistics; screens individuals and interviews patients.

Special Requirements

Possession of an appropriate California operator's license issued by the State Department of Motor Vehicles, or employee must be able to provide suitable transportation which is approved by the appointing authority.

EMPLOYMENT STANDARDS**Knowledge:****Community Health Worker II**

- Working knowledge of nonprofessional nursing care and techniques.

Community Health Worker I & II

- Some knowledge of clinic organization.
- Some knowledge of basic clerical practices or procedures.

Ability to:**Community Health Worker I**

- Read and write.
- Understand and carry out oral and written directions.
- Establish and maintain cooperative working relationships.
- Learn basic principles of department services.
- Keep simple records.

Community Health Worker II

- Provide basic, nonprofessional nursing services in clinics and patient's home.

- Assist medical staff in performance of patient care duties. Maintain patient records and other medical and administrative records.

Training and Experience:


Any combination of training and experience, which would provide the required knowledge and abilities, is qualifying. A typical way to obtain these knowledge and abilities would be:

Community Health Worker I

No experience required.

Community Health Worker II

One year of experience equivalent to a Community Health Worker I in Santa Cruz County or in a related health agency or institution.

<p>SUBJECT: Community Health Workers Supervision by Registered Nurse</p> <p>SERIES: 200 Personnel</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.:</p> <p style="text-align: center;">210.02</p> <p>PAGE: 1 OF 3</p> <p>EFFECTIVE DATE: July 2001</p> <p>REVISED: February 2017</p>	<div style="text-align: center;">  <p>1850 THE GREAT SEAL OF THE COUNTY OF SANTA CRUZ EURE PRÆIUDICIUM</p> <hr/> <p>COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <p>Clinics and Ancillary Services</p> </div>
---	--	---

GENERAL STATEMENT:

The Community Health Worker is under supervision to provide nonprofessional nursing services in community clinics and schools; and to do other work as required.

POLICY STATEMENT:

It is the policy of the County of Santa Cruz Health Services Agency to provide Registered Nurse supervision of Community Health Workers registered to the Clinic.

REFERENCE:

200.1 Job Descriptions

PROCEDURE:

I. Under the Supervision of the Registered Nurse, the Community Health Worker May Perform Simple Tasks:

A. Supervision shall be defined as:

1. Initial training/evaluation of skill level
2. Documentation of competency
3. Annual evaluation of skill level as needed

B. Annual review of competence

II. Typical Tasks:

A. Assist in Clinics:

SUBJECT:

Community Health Workers
Supervision by Registered
Nurse

POLICY NO.:

210.02

PAGE: 2 OF 3



1. General Medicine
 2. Family Planning
 3. Immunization
 4. Child Health
 5. Ortho
- B. In preparation of patients for examination:
1. Sets up clinic rooms
 2. Sets up vision room and hearing test rooms
 3. Prepares room for procedures:
 - a. Pelvic
 - b. Incision & Drainage (I&D)
 - c. Suturing
- C. Prepares patient history:
1. Takes height and weight information with vital signs and chief complaint with respect to privacy
 2. Assists in administrating and variety of tests
 3. Enters information on charts
 4. Orders and maintains supplies
 5. Assist the providers and patients

SUBJECT:

Community Health Workers
Supervision by Registered
Nurse

POLICY NO.:

210.02


PAGE: 3 OF 3



6. Provides patient education

D. Under supervision may:

1. Record and maintain charts
2. Records and Statistics
3. Screens individuals
4. Interviews patients

<p>SUBJECT: General Medical Clinic Nurse Responsibilities</p> <p>SERIES: 200 Personnel</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.:</p> <p style="text-align: center;">230.01</p> <p>PAGE: 1 OF 4</p> <p>EFFECTIVE DATE: July 2001</p> <p>REVISED: April 2003 February 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:

Specific tasks will be assigned to the General Clinic Nurse.

POLICY STATEMENT:

It is the policy of the County of Santa Cruz Health Services Agency to provide professional, trained nursing personnel in the Clinic areas.

REFERENCE:

Policy 300.10 “Lab Results Review.”

PROCEDURE:

- I. Lead Nurse Tasks:
 - A. Lead Clinic and Prioritize:
 - 1. Direct Community Health Worker (CHW)/Medical Assistant (MA) staff and delegate tasks.
 - 2. Direct patient flow, including, but not limited to:
 - a. Fill in slots for no-show appointments
 - b. Prioritize patients if appropriate (chest pain/shortness of breath, etc.)
 - c. Make sure patients are ready to see provider. Check to see if room or patients need special set-up or consent signed
 - d. Get tests done before seen by provider (i.e., urine, vision, etc.)
 - 3. Assessment of patient’s condition:
 - a. Check on out of range vitals or blood sugars
 - b. Consult with provider for immediate orders (i.e., high blood pressure, high glucose – insulin, etc.)
 - B. Tasks and Procedures
 - 1. Give Medications:

SUBJECT:
General Medical Clinic
Nurse Responsibilities

POLICY NO.:

230.01

PAGE: 2 OF 4



- a. Oral
 - b. Injectable
 - c. Inhalation
2. Procedures including, but not limited to:
- a. Spirometer
 - b. O2 saturation
 - c. Orthostatic blood pressure and pulse
3. Dressings including, but not limited to:
- a. Ulcer wound care
 - b. Wet to dry
4. Assisting providers including, but not limited to:
- a. Incision and drainage
 - b. Suturing
 - c. Pap smears
 - d. Lumbar punctures
5. Chart review:
- a. Next day chart review:
 - i. Check for ordered Lab reports/results. (See policy 300.10.)
 - ii. Check for ordered special procedures, reports and calling for fax if results not in chart
 - b. Discharge:
 - i. Take provider orders from chart
 - ii. Reviewing charts discharged by CHW/MA:

SUBJECT:
General Medical Clinic
Nurse Responsibilities

POLICY NO.:

230.01

PAGE: 3 OF 4



- A. Check billing/diagnosis sheets for completeness
 - B. Check discharge plan to see that orders have been checked off
 - C. Check to see that forms are complete
6. Patient education including, but not limited to:
- a. Giving information on diagnosis
 - b. Instructing patient in:
 - i. Inhaler use
 - ii. Injection technique
 - iii. Use of crutches or canes
 - c. Answer patient questions
7. Stock Medications:
- a. Monthly check of all meds in clinic for outdates and re-orders
 - b. Check oxygen tank weekly and order if needed
 - c. Check emergency box for outdates & re-orders
 - d. Check sample cupboard for outdates:
8. Employee education example, but not limited to:
- a. Teaching of new procedures to staff
9. Coordinating with other departments including but not limited to:
- a. Care Team
 - b. HPHP
- C. Breast Cancer Early Detection Program (BCEDP):
- 1. Document and keep lists current of all BCEDP patient appointments that come through our clinic – those kept and missed by month.

SUBJECT:
General Medical Clinic
Nurse Responsibilities

POLICY NO.:

230.01


PAGE: 4 OF 4



2. Notifying Breast Cancer Early Detection Program (BCEDP) of patients with cancer
3. Trouble shoot and connect with cancer services

D. Additional RN Tasks:

1. Manage and direct, teach CHW/MA staff as needed
2. Give patients directions - patient teaching
3. Intake patients when necessary
4. Sign off on injection prepared by MA's
5. Respond promptly to providers requests
6. Decide which child immunizations should be given and when
7. Give and record immunizations given
8. Answer clinic phones and take messages for providers
9. Read email once a day
10. Listen to and process patient's complaints

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

GENERAL STATEMENT:

The care team performs care management activities for high-risk or complex patients.

POLICY STATEMENT:

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

PROCEDURE:

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

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

The HSA Clinic staff provide the patient or the patient’s family with a written care plan tailored for the patient’s use at home and to the patient’s understanding.

SUBJECT:

Patient Follow-Up Upon
Discharge From Clinic

POLICY NO.:

300.05

PAGE: 2 OF 2




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

The HSA Clinic staff provide the patient a written clinical after visit summary at each relevant visit. The clinical summary is made available via secure electronic communication, but can be printed in the office at the request of the patient.

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

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

<p>SUBJECT: Referral Tracking</p> <p>SERIES: 300 Patient Care and Treatment</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.: 300.08</p> <p>PAGE: 1 OF 7</p> <p>EFFECTIVE DATE: February 2017</p> <p>REVISED:</p>	 <p>COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <hr/> <p>Clinics and Ancillary Services</p>
---	--	--

GENERAL STATEMENT:

This policy is to promote continuity of patient care and standardize the process for initiating arranging, following up, establishing reasonable time frames and documenting patient referrals. Health Service Agency (HSA) strives to facilitate timely referral appointments for our patients with appropriate specialists. We track those referral orders through to receiving consult notes/results, providing that information to providers, and scanning results into the electronic health record (EHR). HSA will maintain a referral process in accordance with industry standards to assure quality of care for our patients.

POLICY STATEMENT:


Our policy is to maintain a highly reliable, closed-loop referral tracking system to ensure appropriate care for our patients with a focus on reducing missed and delayed diagnoses. We strive to refer patients for services deemed important to ensure accurate diagnosis and treatment as well as for services indicated by practice guidelines. We aim to coordinate the care of our patients with shared care partners in ways that facilitate prompt and reliable exchange of information, assist patients with navigating the healthcare system, and track all referrals through to provider acknowledgement, cancellation or patient no-show (and unable to reschedule).

DEFINITIONS:

Referrals are defined as services that are initiated and ordered by a licensed healthcare provider to be completed by the patient at a facility outside of the primary care clinic they attend. This includes diagnostic studies, consults with specialists and any other services the primary care physician (PCP) considers necessary for the health and well-being of the patient. For the purpose of this policy, the referral procedures are for full referrals and not merely recommended services (e.g., Alcoholics Anonymous (AA), Women, Infants & Children (WIC), dental referrals).

Urgent Referrals: referrals that must be processed (described below) by the medical assistant (MA) within 24 hours, preferably prior to the patient leaving the clinic, and the patient is scheduled. MA must notify the provider if patient is not scheduled within 24 hours or other timeframe specified by the provider.

Routine Referrals: referrals that must be processed (described below) within 10 business days. All patients with routine referrals must be scheduled within 60 days of the referral order date. The

SUBJECT: Referral Tracking	POLICY NO.: 300.08 PAGE: 2 OF 7	
--------------------------------------	--	---

medical assistant (MA) must notify the provider if unable to schedule a patient within the 60-day timeframe. Our goal is to close Routine referrals within 120 days.

Processed Referrals:

1. Prior authorization documented, if required; and
2. Information faxed to specialist/servicing provider; and
3. Referral status updated to appropriate status – see Table 1

TABLE 1 – Referral Status Options

Referral Status Options in Epic for both Urgent and Routine Referrals	
Open	Referral order has been entered into Epic by ordering PCP and signed
Pending Financial Review	Pending verification and documentation of insurance coverage
Pending Authorization	Pending insurance approval to cover specialist/servicing provider visit or procedure
Pending Schedule	Processed, but appointment date has not been scheduled
Scheduled	Appointment scheduled and documented on Scheduling/External appointment in the Epic referral module OR notation made that patient must call to schedule OR that the referral partner will call to schedule patient. Patient notified of appointment date/time OR need to call and schedule OR that referral partner will call patient to schedule an appointment.
Authorization Not Required	Services that do not require prior authorization such as Medicare, private pay, internal referrals (i.e. Ortho, Radiology, TB, IBH, etc.)
Authorized	Processed, and approved authorization received from insurance.
Authorized and Schedule	Processed, approved and appointment made
Closed	Any of the following: <ol style="list-style-type: none"> 1. Consult report placed in provider box 2. Consult report received in Epic 3. Patient no-shows twice to scheduled appointment (documented in Epic and ordering provider is notified) 4. Patient declines (documented in Epic and ordering provider is notified) 5. Unable to contact patient after two calls and a letter


SUBJECT: Referral Tracking	POLICY NO.: 300.08 PAGE: 3 OF 7	
--------------------------------------	--	---

TABLE 2 – Scheduling Status Options

Scheduling Status Options in Epic for both Urgent and Routine Referrals
Awaiting Patient Call back
Called 1X
Called 2X
Do Not Schedule
Letter Sent
Patient Refusal
Unable to Contact

No-Show: patient fails to call or reschedule appointment and does not show up for appointment with the specialist/servicing provider.

Patient Declined: having been informed of the risks, benefits and alternatives, the patient declines the referral exercising their freedom to decide.

PROCEDURE/POLICY:

A. INITIATING A REFERRAL ORDER:

1. When the provider determines that a patient needs a referral, a referral order will be entered into Epic and will automatically fall into the referral queue once the order is signed by the provider. The provider will designate the priority of the referral as urgent or routine.
2. The medical assistant (MA) referrals staff reviews the referral queue on a daily basis and identifies the priority level of the referral.
 - a. If the referral is prioritized as urgent, the referral must be processed within 24 hours.
 - i. Appointments for urgent referrals should be made by the MA prior to the patient leaving the clinic.
 - ii. If the referral is made when the patient is not in the clinic, the MA referrals staff must call and speak to the patient or their representative/guardian. MA referrals staff can leave a voice message with the following information: “My name is _____ from Watsonville Health Center. Please have _____ (patient’s name and last name) return our call to 763-_____” “Mi nombre es _____ del centro de Salud

SUBJECT:
Referral Tracking

POLICY NO.:

300.08

PAGE: 4 OF 7



de Watsonville. Por favor _____ (nombre y apellido del paciente) regresar nuestra llamada al teléfono 763- _____”

- iii. Medical assistant (MA) referrals staff must ensure that the patient is informed of the referral appointment, location, phone number, date and time. If the MA referrals staff is unable to speak to the patient or patient’s representative, the MA referrals staff must inform the referring provider verbally and in basket message to the provider.
- b. If the referral is ordered as routine, the MA referrals staff must process the referral within 10 business days.
 - i. If the patient schedules own appointment, the MA referrals staff will generate a Referral Authorization Form, which will be sent to the appropriate payer (i.e., Central California Alliance for Health) and faxed to the referral site. The MA referrals staff will inform patients to contact specialist/servicing provider within 10 business days to schedule an appointment and to call the Referral Center with appointment, which will be documented in the Epic.
 - ii. If the MA referrals staff makes the appointment, the MA referrals staff must ensure that the patient is informed of the referral appointment location, phone number, date and time. MA referrals staff will change status of the referral to Scheduled and will document the appointment on Scheduling/External appointment in the Epic referral module.
3. The patient must receive the referral information necessary to follow-through on their appointment – location, phone number, date and time, and this must be documented in the Epic Referral Module. The MA must also note when and how the patient was given the referral information in the Epic Referral Module.
 - a. The patient may be told in person, prior to leaving the clinic, or by telephone and/or mailed letter after leaving the clinic.
 - b. The communication must be documented on the “General Referral Note Section” in Epic. These notes can be seen by the provider when the referral is opened through chart review.

SUBJECT:
Referral Tracking

POLICY NO.:

300.08

PAGE: 5 OF 7



- c. The instructions to the patient shall include: the office or facility of the referral, the street address, the telephone number, the fax number, the date and time of the appointment.
 - d. The patient shall be advised it is their responsibility to contact the office they are referred to if they are unable to keep their appointment, running late or to re-schedule.
 - e. Patient shall be advised to contact referring provider's clinic if appointment was rescheduled or canceled.
4. The medical assistant (MA) referrals staff will verify that the demographic information, medication list, problem list and any specific information required by specialist/servicing provider is included as part of the referral.
 5. The Referral Authorization Form from payer (i.e. Central California Alliance for Health), clinical referral, and the clinical summary will be faxed to the specialist/servicing provider by the MA referrals staff (or MA is processing Urgent referrals). Copies will be given to the patient to hand carry to their appointment, if the appointment is made while they are in the clinic. Not all referrals require prior authorization from payer.

B. REFERRAL CENTER

1. Tracking and Status Reports

- a. On a monthly basis Health Center Management (HCM) will provide MA referrals staff with two reports:
 - i. Percentage open > 90 days
 - ii. Total referrals, open referrals and new referrals.
- b. On a quarterly basis HCM will provide Medical Director, Nurse Supervisor, and MA referrals staff with quarterly versions of the reports described above.
- c. If indicated, a report will be provided to the MA referrals staff with all any or all of the following:
 - i. Referrals not processed within 10 business days

SUBJECT:
Referral Tracking

POLICY NO.:

300.08

PAGE: 6 OF 7



- ii. Referrals not scheduled within 90 days
 - iii. Referrals open beyond 120 days
 - d. If necessary, the medical assistant (MA) referrals staff will report back to Health Center Management (HCM) with explanations of why any of the categories of referrals exceeded acceptable timeframes as outlined in this policy and procedure.
2. Referral Queue Workflow
- a. The MA referrals staff will work the Epic referral queue on a daily basis.
 - i. “Pending Schedule” – by ascertaining both specialist and patient availability, get patient scheduled and ensure patient has the necessary information. Document in referral notes on Scheduling Status/external appointment in the Epic referral module. Change the status from “Pending Schedule” to the correct option from table 1.
 - ii. “Scheduled” – check if report has arrived or if it is accessible through SCHIE or Care Everywhere (and has been routed to provider), change status from “Scheduled to Closed”; enter general note stating report received and routed to provider who ordered the referral.
 - iii. If no consult note/results within 10 days of appointment, MA referrals staff will call the specialist/service provider to request that note/results get faxed to (831) 763-8201.
 - b. Consult notes/results received via fax
 - i. MA referrals staff will affix ordering provider’s stamp and write patient Medical Record Number on document. Report will be routed to ordering provider.
 - ii. Within 10 business days, the ordering provider will review, sign and date in space designated by the stamp and send report to be scanned, if necessary.

SUBJECT:
Referral Tracking


POLICY NO.:

300.08

PAGE: 7 OF 7



- iii. Within five business days, signed reports from ordering provider will be scanned by Medical Records (MR) into the patient chart. MR will notify the medical assistant (MA) referrals staff if that goal cannot be reached.
- c. Goal is to ensure that all consult notes/results are faxed to one fax machine: (831) 763-8201.
 - d. “No-Shows” and “Declines”
 - i. For the first “No Show”, the MA referrals staff will call patient at least two times and ask if they intend to go to the specialist/servicing provider. The MA will facilitate rescheduling if patient is interested. The MA referrals staff will send letter to patient requesting they call the Referral Center within the next week. If no response to letter within two weeks, MA referrals staff will close the referral and notify referring provider via in basket and wait for instructions. (Use options from Table 2)
 - ii. If patient did not show for their appointment for second time, the MA referrals staff will close the referral and include a notation of why the referral was closed. The MA will send a letter to the patient, and notify the referring provider via in basket message that the referral has been closed and why. The provider may then decide on the next step.
 - iii. If the patient declines, the MA referrals staff will notify referring provider via in basket message, document in the medical record and close referral. If patient decides to proceed with the consulting specialist/servicing provider, the MA referrals staff will instruct patient to schedule own appointment, assist patient if necessary and document in the patient chart, as above. (Use options from Table 2)
 - e. All pending/scheduled referrals will be identified as a part of pre-visit planning. The care team will engage the patient, as appropriate, for all outstanding referrals. If the patient confirms they have been seen by the specialist/servicing provider, the MA will check the health information exchange (HIE) first. If the referral report is in the HIE, the MA will move it into the chart. If Urgent referral, the MA will call the specialist/servicing provider for consult notes/referral and will change the status to Closed, if/when the documents are received and given to ordering provider for review. If Routine referral, the MA will notify the MA referrals staff to obtain the note/results.

<p>SUBJECT: Lab Results Review Radiology & Diagnostic Tests</p> <p>SERIES: 300 Patient Care and Treatment</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.:</p> <p style="text-align: center;">300.10</p> <p>PAGE: 1 OF 2</p> <p>EFFECTIVE DATE: July 2001</p> <p>REVISED: November 2003 February 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:

The Health Service Agency (HSA) Clinics tracks test ordering and notification for patients.

POLICY STATEMENT:

It is the policy of the HSA Clinics to document and monitor all tests ordered, including laboratory and radiology. The patient’s provider is notified of all unfilled orders in a timely manner.

It is the policy of the HSA Clinics to document and monitor all test results. Results are documented, and the patient’s provider is notified of the results. All orders are monitored for successful completion of results.

It is the policy of the HSA Clinics that patients are notified of their test results in a timely manner. The notification and all relevant communication are documented in a manner that is consistent with medical and legal prudence.


PROCEDURE:

The HSA Clinics strives to electronically communicate with testing facilities, to include laboratories and imaging. The communication includes both ordering tests and retrieving results.

In the event that an electronic communication cannot be achieved, the HSA Clinics establishes protocols regarding ordering tests and retrieving results (e.g., by facsimile).

The HSA Clinics tracks the orders of all laboratory and imaging tests, regardless of the location (internal or external) of the test. All results are tracked through completion (e.g., receipt of results). The HSA Clinics flags all outstanding orders, based on a designated period of expected turnaround time for the test as determined by the specific test. Flagging is a systematic method of manually or electronically drawing attention to results that are outstanding manually or electronically.

The Health Services Agency (HSA) Clinics utilizes the electronic health record (EHR) system to order tests and monitor outstanding results. In the event that a test is outstanding after the designated time frame of expected results notification, the clinical support staff assigned to the patient’s provider contacts the

SUBJECT: Lab Results Review Radiology & Diagnostic Tests	POLICY NO.: 300.10 PAGE: 2 OF 2	 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".
---	---	---


laboratory or diagnostic facility to determine the status of the results. If necessary, the patient is contacted. For pediatric patients, the clinical support staff follow up with the appropriate hospital regarding newborn hearing and blood-spot screening. These communications are documented in a manner that is consistent with medical and legal prudence.

When results are received, they are documented in a manner that is consistent with medical and legal prudence. The Health Services Agency (HSA) Clinics strives to receive results electronically from testing facilities, with the data presented in a structured format. For imaging studies, the HSA Clinics endeavors to electronically integrate the image into the patient's medical record either directly or via an Adobe PDF document that can be retrieved and reviewed.

The HSA Clinics flags all abnormal (positive) laboratory and imaging test results. Abnormal results are immediately sent to the patient's provider via an electronic alert. If appropriate, the provider is alerted in person.

The HSA Clinics notifies the patient (or the patient's family) of all test results. Normal test results may be communicated to patients via telephone, in writing, or via the preferred method of secure electronic communication. Abnormal test results may be communicated to patients via telephone, although face-to-face appointments are encouraged where appropriate.

The HSA Clinics notifies all patients of their test results within a timely manner unless there are extenuating circumstances (e.g., the patient is out of the country and cannot be reached).

<p>SUBJECT: End of Life Option Act</p> <p>SERIES: 300 Patient Care & Treatment</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.: 300.22</p> <p>PAGE: 1 OF 13</p> <p>EFFECTIVE DATE: November 2016</p> <p>REVISED:</p>	 <p>COUNTY OF SANTA CRUZ</p> <hr/> <p>HEALTH SERVICES AGENCY</p> <p>Clinics and Ancillary Services</p>
---	--	---

GENERAL POLICY STATEMENT:

- A. The California End of Life Option Act authorizes medical aid in dying and allows an adult patient with capacity, who has been diagnosed with a terminal disease with a prognosis of six months or less, and who meets other requirements, to request a prescription for a drug (aid-in-dying drug) for the purpose of shortening a prolonged dying process through self-administration of the aid-in-dying drug.
- B. The purpose of this policy is to describe the requirements and procedures for compliance with The California End of Life Option Act and to provide guidelines for responding to patient requests for information about aid-in-dying drugs in accordance with federal and state laws and regulations.

REFERENCE:

- A. California Health and Safety Code section 443 et seq. (End of Life Option Act)
- B. California Probate Code section 4609

KEY DEFINITIONS:

- A. **Aid-In-Dying Drug:** a drug determined and prescribed by a physician for a qualified patient, which the qualified patient may choose to self-administer to bring about his or her death due to a terminal disease.
- B. **Attending Physician:** the physician who has primary responsibility for the health care of the patient and treatment of the patient’s terminal disease. The attending physician may not serve as a witness to the patient’s written request for aid-in-dying drug.
- C. **Capacity to Make Medical Decisions:** A patient who, in the opinion of the patient’s attending physician, consulting physician or psychiatrist, pursuant to Probate Code section 4609, has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives and the ability to make and communicate an “informed decision” (defined herein) to health care providers.
- D. **Consulting Physician:** A physician who is qualified by specialty or experience to make a professional diagnosis regarding a patient’s terminal illness.

SUBJECT:
End of Life Option Act

POLICY NO.:

300.22

PAGE: 2 OF 13



- E. **Informed decision:** A decision by a patient with a terminal disease to request and obtain a prescription for a drug that the patient may self-administer to shorten a prolonged dying process, that is based on an understanding and acknowledgement of the relevant facts, and that is made after being fully informed by the attending physician of all of the following:
1. The patient's medical diagnosis and prognosis;
 2. The potential risks associated with taking the drug to be prescribed;
 3. The probable result of taking the drug to be prescribed;
 4. The possibility that the individual may choose not to obtain the drug or may obtain the drug but may decide not to ingest it; and
 5. The feasible alternatives or additional treatment opportunities, including, but not limited to, comfort care, hospice care, palliative care, and pain control.
- F. **Mental Health Specialist:** only a licensed psychiatrist or licensed psychologist may act as a mental health specialist.
- G. **Self-Administer:** a qualified patient's affirmative, conscious, and physical act of administering and ingesting the aid-in-dying drug to shorten a prolonged dying.
- H. **Terminal Disease:** an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.

FORMS:

HSA Form A - ATTENDING PHYSICIAN CHECKLIST & COMPLIANCE FORM

HSA Form B – CONSULTING PHYSICIAN COMPLIANCE FORM

HSA Form C – ATTENDING PHYSICIAN FOLLOW-UP FORM

HSA Form D – FINAL ATTESTATION FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A DIGNIFIED MANNER

HSA Form E – REQUEST FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

HSA Form F – REQUEST FOR AN AID-IN-DYING – INTERPRETER DECLARATION

SUBJECT:
End of Life Option Act

POLICY NO.:

300.22

PAGE: 3 OF 13



POLICY:

- A. The End of Life Option Act (herein after the “Act”) allows adult (18 years or older) terminally ill patients, with capacity to make health care decisions, seeking to mitigate suffering and shorten a prolonged dying process, to request aid-in-dying drugs from an attending physician. These terminally ill patients must be California residents (as defined herein) who will, within reasonable medical judgment, die within 6 months. Patients requesting an aid-in-dying drug must satisfy all requirements of the Act in order to obtain the prescription for that drug. Such a request must be initiated by the patient and cannot be made through utilization of an Advance Health Care Directive, or other document. The request cannot be made through the patient’s surrogate (or other designee). The patient may use an interpreter to make the request.
- B. County of Santa Cruz Health Services Agency (HSA) allows its physicians and other health care providers who are permitted under the Act to participate in activities authorized by the End of Life Option Act, if they so choose. HSA physicians and other health care providers may, as applicable and as defined in the Act and herein:
1. Perform the duties of an attending physician.
 2. Perform the duties of a consulting physician.
 3. Perform the duties of a mental health specialist.
 4. Prescribe drugs under this Act.
 5. Be present when the qualified patient self-administers the aid-in-dying drug provided that the physician does not participate or assist the patient in self-administering the life-ending drugs.
 6. Participate in patient or provider support related to the Act.
- C. HSA neither encourages nor discourages participation in the Act; participation is entirely voluntary. Only those providers or other staff who are willing and desire to participate should do so. Those persons who do choose to participate are reminded that the overall goal is to support the patient’s end-of-life wishes, and that participation may not necessarily result in aid-in-dying drugs being prescribed if the patient’s needs can be met in other ways (e.g. pain management, hospice or palliative care).
- D. An HSA physician, staff or employee who elects not to engage in activities authorized by the Act is not required to take any action in support of a patient’s request for a prescription for an aid-in-dying drug, including but not limited to, referral to another provider who participates in such activities.

SUBJECT:
End of Life Option Act

POLICY NO.:

300.22

PAGE: 4 OF 13



PROCEDURES

A. Requirements of the California End of Life Option Act

1. Patients eligible to request aid-in-dying drugs from their physician: HSA adult patients who have capacity to make health care decisions and who have a terminal disease with a prognosis of six months or less.
2. Patients are qualified to receive a prescription for an aid-in-dying drug if all of the following conditions are met:
 - a. The patient meets the eligibility requirements;
 - b. The patient has voluntarily requested an aid-in-dying drug on three separate occasions as described herein;
 - c. The attending physician determines that the patient has capacity to make medical decisions, is making an informed decision and has fully informed the patient of all their available end-of-life options;
 - d. A consulting physician has provided a confirming opinion on the eligibility of the patient for a prescription for an aid-in-dying drug, and has confirmed that the person is acting voluntarily and making an informed decision.
 - e. The patient has the physical and mental capacity to self-administer the aid-in-dying drugs;
 - f. The patient is a California resident and is able to establish residency through at least one of the following:
 - i. Possession of a California Driver license or ID card issued by the State of California.
 - ii. Registration to vote in California.
 - iii. Evidence that the patient owns, rents or leases property in California.
 - iv. The filing of a California tax return for the most recent tax year.
 - g. A patient must not be considered a “qualified individual”

SUBJECT:
End of Life Option Act

POLICY NO.:

300.22

PAGE: 5 OF 13



under the Act solely because of age or disability.

- h. The attending physician has fulfilled all the requirements of the law as set forth in the Attending Physician Checklist & Compliance form (HSA Form A).
3. Method of request for aid-in-dying drug and documentation requirements: Requests for aid-in-dying drugs must come directly and solely from the patient who will self-administer the drugs. Such requests cannot not be made by a patient's surrogate or by the patient's health care provider. See section 8 for use of an interpreter.

To make a request for a prescription for an aid-in-dying drug, the patient must directly submit to his or her attending physician:

- a. Two oral requests (made in person) that are made a minimum of 15 days apart. Patients who are unable to speak because of their medical condition shall communicate their request in a manner consistent with their inability to speak, such as through sign language. The attending physician must document these requests in the medical record (the Act does not specify any particular language); AND
- b. A written request using the form required by the State of California: "Request for an Aid-in-Dying Drug to End My Life in a Humane and Dignified Manner" (HSA Form E). This form must be placed in the patient's medical record. Form E sets forth the following conditions:
 - i. The written request form (Form E) must be signed and dated, in the presence of two witnesses, by the patient seeking the aid-in-dying drug.
 - ii. The witnesses must also sign the form and by so doing attest that to the best of their knowledge and belief the patient is all of the following:
 - (a) An individual who is personally known to them or has provided proof of identity.
 - (b) An individual who voluntarily signed the request in their presence.
 - (c) An individual whom they believe to be of

SUBJECT:
End of Life Option Act

POLICY NO.:

300.22

PAGE: 6 OF 13



sound mind and not under duress, fraud or undue influence.

- c. The patient's attending physician, consulting physician and mental health specialist cannot serve as witnesses. Additionally, only one witness may be related to the requesting patient by blood, marriage, registered domestic partnership or adoption or be entitled to a portion of the requesting patient's estate upon death or own, operate or be employed by a health care facility where the patient is receiving medical care or resides.
 - d. At least 48 hours prior to self-administration of the aid-in-dying drug, the patient must complete the State of California issued form "Final Attestation for an Aid-in-Dying Drug to End my Life in a Humane and Dignified Manner" (HSA Form D). If the attending physician receives this document, he or she is required to put it in the patient's medical record.
4. Responsibility of the attending physician: The responsibilities of an attending physician are non-delegable. Before prescribing the aid-in-dying drug, the attending physician must do all of the following:
- a. Make the initial determination about whether the patient is eligible under the Act as described in section A 1 above, including determination that:
 - i. The adult patient has capacity to make health care decisions.
 - ii. The patient has a terminal disease with a prognosis of six months or less, medically confirmed by a consulting physician.
 - b. Make additional determinations that:
 - i. The patient has made a voluntary request for an aid-in-dying drug, including completion of witness attestations that the patient is of sound mind and not under fraud, duress or undue influence.
 - ii. The patient's request does not arise from coercion or undue influence. The physician must do this by discussing with the patient, outside the presence of any other person (except for a HSA-provided

SUBJECT:
End of Life Option Act

POLICY NO.:

300.22

PAGE: 7 OF 13



interpreter as described in Section 8 below) whether or not the patient is feeling coerced or unduly influenced by another person. Family members or friends of the patient cannot act as interpreters.

- iii. The patient has met the residency requirements of the Act.
 - iv. The patient is making an informed decision as defined herein.
- c. Refer the patient to a consulting physician.
- d. If the attending or consulting physician determines that the patient has indications of a mental disorder that impairs judgment, the patient must be referred for a mental health assessment. This assessment must be documented in the patient's medical record. Patients with depression are not automatically excluded. The Mental Health Specialist assesses the patient's capacity for medical decisions and determines whether the individual is suffering from impaired judgement due to a mental disorder.
- e. Counsel the patient about the importance of:
- i. Having another person present when he or she ingests the aid-in- dying drug.
 - ii. Not ingesting the aid-in-dying drug in a public place. "Public place" means any street, alley, park, public building, or any place of business or assembly open to or frequented by the public, and any other place that is open to the public view, or to which the public has access.
 - iii. Notifying the next of kin of his or her request for an aid- in-dying drug. A patient who declines or is unable to notify next of kin must not have his or her request denied for that reason.
 - iv. Participating in a hospice program.
 - v. Maintaining the aid-in-dying drug in a safe and secure location until the patient takes it.

SUBJECT:
End of Life Option Act

POLICY NO.:

300.22

PAGE: 8 OF 13



- f. Inform the patient that he or she may withdraw or rescind the request for an aid-in-dying drug at any time and in any manner. The patient has the right to change his or her mind without regard to his or her mental state. Therefore, if a patient makes a request for an aid-in-dying drug while having capacity to make health care decisions, then loses his or her capacity, the patient can still decide not to take the aid-in- dying drug.
 - g. Offer the patient an opportunity to withdraw or rescind the request for an aid-in-dying drug before prescribing the drug.
 - h. Verify, for a second time, immediately before writing the prescription for an aid-in-dying drug, that the patient is making an informed decision.
 - i. Confirm that all requirements are met and all appropriate steps are carried out in accordance with the law (as outlined in this policy) before writing a prescription for an aid-in-dying drug.
 - j. Fulfill all the documentation requirements (see Section 7 below).
 - k. Complete the Attending Physician Checklist & Compliance form (HSA Form A) and place it as well as the completed Consulting Physician Compliance form (HSA Form B) in the patient's medical record. Arrange for the forms submittal to the California Department of Public Health (CDPH) by the Health Center Manager.
 - l. Give the requesting patient the Final Attestation form (HSA Form D) and instruct the patient on how to complete it.
 - m. Complete the Attending Physician Follow-up form (HSA Form C) and submit it to CDPH through the Health Center Manager.
5. Responsibility of consulting physician: A physician who chooses to act as a consulting physician must not be directly involved in the patient's health care and must do all the following:

SUBJECT:
End of Life Option Act

POLICY NO.:

300.22

PAGE: 9 OF 13



- a. Examine the patient and his or her relevant medical records.
 - b. Confirm in writing the attending physician's diagnosis and prognosis.
 - c. Determine that the individual has the capacity to make medical decisions, is acting voluntarily and has made an informed decision.
 - d. If the attending or consulting physician determines that the patient has indications of a mental disorder that causes impaired judgment, the patient must be referred for a mental health assessment. No aid-in-dying drugs shall be prescribed until the mental health specialist determines that the individual has capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder. This assessment must be documented in the patient's medical record.
 - e. Fulfill the documentation requirements (see section 7 below).
 - f. Complete the State of California form "End of Life Option Act Consulting Physician Compliance form (HSA Form B).
6. Responsibility of mental health specialist: Protecting mentally ill patients, or patients lacking capacity, from receiving prescriptions for aid-in-dying drugs and to ensure a vigilant and systematic examination for physical or mental health conditions that could be interfering with informed decision making. A psychiatrist or psychologist who chooses to act as a mental health specialist must conduct one or more consultations with the patient and do all of the following:
- a. Examine the qualified patient and his or her relevant medical records.
 - b. Determine whether the patient has the mental capacity to make medical decisions, act voluntarily, and make an informed decision.
 - c. Determine whether the patient is suffering from impaired judgment due to a mental disorder. Patients with depression are not automatically excluded. A

SUBJECT:
End of Life Option Act

POLICY NO.:

300.22

PAGE: 10 OF 13



patient with depression or other mental illness but who has capacity to make medication decisions and is otherwise eligible will not be denied an aid-in-dying drug solely due to their mental illness diagnosis.

- d. Document in the patient's medical record a report of the outcome and determinations made during the mental health specialist's assessment.
 - e. Fulfill the documentation requirements (see Section 7 below).
7. Documentation requirements: All of the following must be documented in the patient's medical record:
- a. All oral requests for aid-in-dying drugs.
 - b. All written requests for aid-in-dying drugs.
 - c. The attending physician's diagnosis and prognosis, and the determination that the qualified patient has the capacity to make healthcare decisions, is acting voluntarily, and has made an informed decision, or that the attending physician has determined that the individual is not a qualified patient.
 - d. The consulting physician's diagnosis and prognosis and verification that the patient has the capacity to make health care decisions, is acting voluntarily and has made an informed decision, or that the consulting physician has determined that the individual is not a qualified patient.
 - e. If a mental health specialist conducted an assessment, a report of the outcome and determination of the patient's capacity to make medical decisions and whether they are suffering from impaired judgment due to a mental disorder.
 - f. The attending physician's offer to the patient to withdraw or rescind his or her request at the time of second oral request.
 - g. A note by the attending physician indicating that all requirements of the Act have been met and indicating

SUBJECT:
End of Life Option Act

POLICY NO.:

300.22

PAGE: 11 OF 13



the steps taken to carry out the request, including a notation of the aid-in-dying drug prescribed.

- h. Death Certificate: The Act provides that actions taken under the Act shall not, for any purpose, constitute suicide, assisted suicide, homicide or elder abuse. It is HSA policy that the physician reference the patient's underlying medical condition that qualified the patient for the aid-in-dying drug should be reported as the underlying cause of death.

8. Use of an Interpreter: Requirements:

- a. The interpreter must not be related to the patient by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the patient's estate upon death. The interpreter must meet the standards promulgated by the California Healthcare Interpreting Association or the National Council on Interpreting in Health Care or other standards deemed acceptable by CDPH.
- b. If the patient is using an interpreter, the written request (HSA Form F) may be filled out in either of two ways:
 - i. Option 1: The written request form signed by the patient (HSA Form F) must be written in the same language as any conversations, consultations or interpreted conversations or consultations between a patient and his or her attending or consulting physician.
 - ii. Option 2: HSA Form F may be prepared in English even when the conversations or consultations were conducted in a language other than English if the interpreter completes the interpreter attestation on the form.

9. Prescribing or delivering the aid-in-dying drug: After the attending physician has fulfilled his or her responsibilities under the Act, the attending physician may deliver the aid-in-dying drug in any of the following ways:

- a. Dispensing the aid-in-dying drug directly, including ancillary medication intended to minimize the patient's

SUBJECT:
End of Life Option Act

POLICY NO.:

300.22

PAGE: 12 OF 13



discomfort, if the attending physician meets all of the following criteria:

- i. Is authorized to dispense medicine under California law (the Act does not specify which drugs can be used as an aid-in-dying drug);
 - ii. Has a current USDEA certificate; and
 - iii. Complies with any applicable administrative rule or regulation.
- b. With the patient's written consent, contacting a pharmacist, informing the pharmacist of the prescription, and delivering the written prescription personally, by mail, or electronically to the pharmacist. It is not permissible to give the patient a written prescription to take to a pharmacy. The pharmacist may dispense the drug to the patient, the attending physician, or a person expressly designated by the patient. This designation may be delivered to the pharmacist in writing or verbally.
 - c. Delivery of the dispensed drug to the patient, the attending physician, or a person expressly designated by the patient may be made by personal delivery, or with a signature required on delivery by UPS, US Postal Service, Federal Express or other messenger service.
 - d. Physicians should counsel patients that leftover aid-in-dying drugs should be properly disposed of by returning to a facility authorized to dispose or as provided by the Board of Pharmacy.
10. CDPH reporting requirements: Within 30 calendar days of writing a prescription for an aid-in-dying drug, the attending physician must submit the documents listed below to CDPH either by mail or by fax, (916) 440-5209. If mailed, the completed forms should be sent in envelopes marked "confidential" to:

CDPH Public Health Policy and
Research Branch Attention: End of
Life Option Act

MS 5205, P.O. Box 997377

SUBJECT:
End of Life Option Act

POLICY NO.:

300.22

PAGE: 13 OF 13



Sacramento, CA 95899-7377

To protect confidentiality, CDPH has not established an email address for forms submission.

- a. A copy of the qualifying patient's written request: Request for an Aid-in- Dying Drug to End My Life in a Humane and Dignified Manner (HSA Form E);
- b. The End of Life Option Act Attending Physician Checklist & Compliance form (HSA Form A);
- c. The End of Life Option Act Consulting Physician Compliance form (HSA Form B);
- d. Within 30 calendar days following the qualified patient's death from ingesting the aid-in-dying drug, or any other cause, the attending physician (through the Health Center Manager) must submit to CDPH the End of Life Option Act Attending Physician Follow-Up form (HSA Form C). The Act does not specify the attending physician's obligation in the event the physician does not receive this form.

County of Santa Cruz Health Services Agency

ATTENDING PHYSICIAN CHECKLIST & COMPLIANCE FORM

A PATIENT INFORMATION	
PATIENT'S NAME (LAST, FIRST, MI)	DATE OF BIRTH
PATIENT'S RESIDENTIAL ADDRESS (STREET, CITY, ZIP CODE)	

B ATTENDING PHYSICIAN INFORMATION	
PHYSICIAN'S NAME (LAST, FIRST, MI)	TELEPHONE # () -
MAILING ADDRESS (STREET, CITY, ZIP CODE)	
PHYSICIAN'S LICENSE NUMBER	

C CONSULTING PHYSICIAN INFORMATION	
PHYSICIAN'S NAME (LAST, FIRST, MI)	TELEPHONE # () -
MAILING ADDRESS (STREET, CITY, ZIP CODE)	
PHYSICIAN'S LICENSE NUMBER	

D ELIGIBILITY DETERMINATION	
	1. TERMINAL DISEASE:
	2. CHECK BOXES FOR COMPLIANCE:
	<input type="checkbox"/> 1. Determination that the patient has a terminal disease. <input type="checkbox"/> 2. Determination that the patient is a resident of California. <input type="checkbox"/> 3. Determination that the patient has the capacity to make medical decisions. ** <input type="checkbox"/> 4. Determination that the patient is acting voluntarily. <input type="checkbox"/> 5. Determination of capacity by mental health specialist, if necessary. <input type="checkbox"/> 6. Determination that patient has made his/her decision after being fully informed of: <ul style="list-style-type: none"> <input type="checkbox"/> a) His or her medical diagnosis; and <input type="checkbox"/> b) His or her prognosis; and <input type="checkbox"/> c) The potential risks associated with ingesting the requested aid-in-dying drug; <input type="checkbox"/> d) The probable result of ingesting the aid-in-dying drug; <input type="checkbox"/> e) The possibility that he or she may choose to obtain the aid-in-dying drug but not take it.

County of Santa Cruz Health Services Agency

ATTENDING PHYSICIAN CHECKLIST & COMPLIANCE FORM

E	ADDITIONAL COMPLIANCE REQUIREMENTS
	<input type="checkbox"/> 1. Counseled patient about the importance of all of the following: <ul style="list-style-type: none"> <input type="checkbox"/> a) Maintaining the aid-in-dying drug in a safe and secure location until the time the qualified individual will ingest it; <input type="checkbox"/> b) Having another person present when he or she ingests the aid-in-dying drug; <input type="checkbox"/> c) Not ingesting the aid-in-dying drug in a public place; <input type="checkbox"/> d) Notifying the next of kin of his or her request for an aid-in-dying drug. (an individual who declines or is unable to notify next of kin shall not have his or her request denied for that reason); and <input type="checkbox"/> e) Participating in a hospice program or palliative care program. <input type="checkbox"/> 2. Informed patient of right to rescind request (1st time) <input type="checkbox"/> 3. Discussed the feasible alternatives, including, but not limited to comfort care, hospice care, palliative care and pain control. <input type="checkbox"/> 4. Met with patient one-on-one, except in the presence of an interpreter, to confirm the request is not coming from coercion <input type="checkbox"/> 5. First oral request for aid-in-dying: ___/___/___ Attending physician initials: ___ <input type="checkbox"/> 6. Second oral request for aid-in-dying: ___/___/___ Attending physician initials: ___ <input type="checkbox"/> 7. Written request submitted: ___/___/___ Attending physician initials: ___ <input type="checkbox"/> 8. Offered patient right to rescind (2nd time)

F	PATIENT'S MENTAL STATUS
	Check one of the following (required): <ul style="list-style-type: none"> <input type="checkbox"/> I have determined that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder. <input type="checkbox"/> I have referred the patient to the mental health specialist*** listed below for one or more consultations to determine that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder. <input type="checkbox"/> If a referral was made to a mental health specialist, the mental health specialist has determined that the patient is not suffering from impaired judgment due to a mental disorder <p>Mental health specialist's information, if applicable:</p>
	MENTAL HEALTH SPECIALIST NAME
	MENTAL HEALTH SPECIALIST TITLE & LICENSE NUMBER
	MENTAL HEALTH SPECIALIST ADDRESS (STREET,CITY, ZIP CODE)

County of Santa Cruz Health Services Agency

ATTENDING PHYSICIAN CHECKLIST & COMPLIANCE FORM

G MEDICATION PRESCRIBED					
PHARMACIST NAME:	TELEPHONE # () -				
<p>1. Aid-in-dying medication prescribed: <input type="checkbox"/> a. Name: _____ <input type="checkbox"/> b. Dosage: _____</p> <p>2. Antiemetic medication prescribed: <input type="checkbox"/> a. Name: _____ <input type="checkbox"/> b. Dosage: _____</p> <p>3. Method prescription was delivered: <input type="checkbox"/> a. In person <input type="checkbox"/> b. By mail <input type="checkbox"/> c. Electronically</p> <p>4. Date medication was prescribed: ____/____/____</p>					
X	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; padding: 5px;">PHYSICIAN'S SIGNATURE</td> <td style="width: 30%; padding: 5px;">DATE</td> </tr> <tr> <td colspan="2" style="padding: 5px;">NAME (PLEASE PRINT)</td> </tr> </table>	PHYSICIAN'S SIGNATURE	DATE	NAME (PLEASE PRINT)	
PHYSICIAN'S SIGNATURE	DATE				
NAME (PLEASE PRINT)					

***"Capacity to make medical decisions" means that, in the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, the individual has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks and alternatives, and the ability to make and communicate an "informed decision" to healthcare providers.

**** "Mental Health Specialist" means a psychiatrist or a licensed psychologist.

County of Santa Cruz Health Services Agency

CONSULTING PHYSICIAN COMPLIANCE FORM

A PATIENT INFORMATION	
PATIENT'S NAME (LAST, FIRST, MI)	DATE OF BIRTH
PATIENT'S RESIDENTIAL ADDRESS (STREET, CITY, ZIP CODE)	

B ATTENDING PHYSICIAN INFORMATION	
PHYSICIAN'S NAME (LAST, FIRST, MI)	TELEPHONE # () -

C CONSULTING PHYSICIAN'S REPORT	
1. TERMINAL DISEASE:	DATE OF EXAMINATION(S)
<p>2. Check boxes for compliance. <i>(Both the attending physicians must make these determinations)</i></p> <p><input type="checkbox"/> 1. Determination that the patient has a terminal disease.</p> <p><input type="checkbox"/> 2. Determination that the patient has the capacity to make medical decisions. **</p> <p><input type="checkbox"/> 3. Determination that the patient is acting voluntarily.</p> <p><input type="checkbox"/> 4. Determination that patient has made his/her decision after being fully informed of:</p> <p style="margin-left: 20px;"><input type="checkbox"/> a) His or her medical diagnosis; and</p> <p style="margin-left: 20px;"><input type="checkbox"/> b) His or her prognosis; and</p> <p style="margin-left: 20px;"><input type="checkbox"/> c) The potential risks associated with taking the drug to be prescribed; and</p> <p style="margin-left: 20px;"><input type="checkbox"/> d) The potential result of taking the drug to be prescribed; and</p> <p style="margin-left: 20px;"><input type="checkbox"/> e) The feasible alternatives, including but not limited to, comfort care, hospice care, palliative care and pain control.</p>	

D PATIENT'S MENTAL STATUS	
<p>Check one of the following (required):</p> <p><input type="checkbox"/> I have determined that the individual has the capacity to make medical decisions and is not suffering from impaired judgement due to a mental disorder.</p> <p><input type="checkbox"/> I have referred the patient to the mental health specialist*** listed below for one or more consultations to determine that the individual has the capacity to make medical decisions and is not suffering from impaired judgement due to a mental disorder.</p> <p><input type="checkbox"/> If a referral was made to a mental health specialist, the mental health specialist has determined is not suffering from impaired judgement due to a mental disorder.</p>	

County of Santa Cruz Health Services Agency

CONSULTING PHYSICIAN COMPLIANCE FORM

MENTAL HEALTH SPECIALIST'S NAME:	
TELEPHONE # () -	DATE

E CONSULTING PHYSICIAN INFORMATION	
PHYSICIAN'S NAME (LAST, FIRST, MI)	TELEPHONE # () -
MAILING ADDRESS (STREET, CITY, ZIP CODE)	
PHYSICIAN'S LICENSE NUMBER	

***"Capacity to make medical decisions" means that, in the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, the individual has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks and alternatives, and the ability to make and communicate an "informed decision" to healthcare providers.

**** "Mental Health Specialist" means a psychiatrist or a licensed psychologist.

County of Santa Cruz Health Services Agency

ATTENDING PHYSICIAN FOLLOW-UP FORM

The End of Life Option Act requires physicians who write a prescription for an aid-in-dying drug to complete his follow-up form within **30 calendar days** of a patient's death, whether from ingestion of the aid-in-dying drug obtained under the Act or from any other cause.

For the State Department of Public Health to accept this form, it must be signed by the attending physician, whether or not he or she was present at the patient's time of death.

This form should be mailed or sent electronically to the State Department of Public Health. All information is kept strictly confidential.

Date: ____ / ____ / ____

Did the patient die from ingesting the aid-in-dying drug, from their underlying illness, or from another cause such as terminal sedation or ceasing to eat or drink?

Aid-in-dying drug (lethal dose) → Please sign below and go to page 2.

Attending physician signature: _____

Underlying illness → There is no need to complete the rest of the form. Please sign below.

Attending physician signature: _____

Other → There is no need to complete the rest of the form. Please specify the circumstances surrounding the patient's death and sign

Please specify: _____

Attending physician signature: _____

PART A and PART B should only be completed if the patient died from ingesting the lethal dose of the aid-in-dying drug.

Please read carefully the following to determine which situation applies. Check the box that indicates the scenario and complete the remainder of the form accordingly.

The attending physician was present at the time of death.

→ The attending physician must complete this form in its entirety and sign Part A and Part B.

The attending physician was not present at the time of death, but another licensed health care provider was present.

→ The licensed health care provider must complete and sign Part A of this form. The attending physician must complete and sign Part B of the form.

Neither the attending physician nor another licensed health care provider was present at the time of death.

→ Part A may be left blank. The attending physician must complete and sign Part B of the form.

County of Santa Cruz Health Services Agency

ATTENDING PHYSICIAN FOLLOW-UP FORM

PART A: To be completed and signed by the attending physician or another licensed health care provider present at death:

1. Was the attending physician at the patient's bedside when the patient took the aid-in-dying drug?

Yes No

If no: Was another physician or trained health care provider present when the patient ingested the aid-in-dying drug?

- Yes, another physician
- Yes, a trained health-care provider/volunteer
- No
- Unknown

2. Was the attending physician at the patient's bedside at the time of death?

Yes
 No

If no: Was another physician or a licensed health care provider present at the patient's time of death?

- Yes, another physician or licensed health care provider
- No
- Unknown

3. On what day did the patient consume the lethal dose of the aid-in-dying?

Date: ___/___/___ {month/day/year} Unknown

4. On what day did the patient die after consuming the lethal dose of the aid-in-dying drug?

Date: ___/___/___ {month/day/year} Unknown

5. Where did the patient ingest the lethal dose of the aid-in-dying drug?

- Private home
- Assisted-living residence
- Nursing home
- Acute care hospital in-patient
- In-patient hospice resident
- Other (specify)
- Unknown

6. What was the time between the ingestion of the lethal dose of aid-in-dying drug and unconsciousness?

Minutes _____ and/or Hours _____ Unknown

7. What was the time between lethal medication ingestion and death?

Minutes _____ and/or Hours _____ Unknown

County of Santa Cruz Health Services Agency

ATTENDING PHYSICIAN FOLLOW-UP FORM

8. Were there any complications that occurred after the patient took the lethal dose of the aid-in-dying drug?

- Yes- vomiting, emesis
- Yes-regained consciousness
- No Complications
- Other- Please describe: _____
- Unknown

9. Was the Emergency Medical System activated for any reason after ingesting the lethal dose of the aid-in-dying drug?

- Yes- Please describe: _____
- No
- Unknown

10. At the time of ingesting the lethal dose of the aid-in-dying drug was the patient receiving hospice care?

- Yes
- No, refused care
- No, other (specify): _____

Signature of attending physician present at time of death: _____

Name of Licensed Health Care Provider present at time of death if not attending physician: _____

Signature of Licensed Health Care Provider: _____

County of Santa Cruz Health Services Agency

ATTENDING PHYSICIAN FOLLOW-UP FORM

PART B: To be completed and signed by the attending physician

12. On what date was the prescription written for the aid-in-dying drug? Date: ____/____/____

13. When the patient initially requested a prescription for the aid-in-dying drug, was the patient receiving hospice care?

Yes

No, refused care

No, other (specify): _____

What type of health-care coverage did the patient have for their underlying illness? (Check all that apply.)

Medicare

Medi-cal

Covered California

V.A.

Private Insurance

No insurance

Had insurance, don't know type

Possible concerns that may have contributed to the patient's decision to request a prescription for aid-in-dying drug Please check "yes," "no," or "Don't know," depending on whether or not you believe that concern contributed to their request (Please check as many boxes as you think may apply)

A concern about:

- **His or her terminal condition representing a steady loss of autonomy**

Yes

No

Don't Know

- **The decreasing ability to participate in activities that made life enjoyable**

Yes

No

Don't Know

- **The loss of control of bodily functions**

Yes

No

Don't Know

- **Persistent and uncontrollable pain and suffering**

Yes

No

Don't Know

- **A loss of dignity**

Yes

No

Don't Know

- **Other concerns (specify):** _____

Signature of attending physician: _____

REQUEST FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I, _____,
am an adult of sound mind and a resident of the State of California.

I am suffering from _____,
which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I request that my attending physician prescribe an aid-in-dying drug that will end my life in a humane and dignified manner if I choose to take it, and I authorize my attending physician to contact any pharmacist about my request.

INITIAL ONE:

_____ I have informed one or more members of my family of my decision and taken their opinions into consideration.

_____ I have decided not to inform my family of my decision.

_____ I have no family to inform of my decision.

I understand that I have the right to withdraw or rescind this request at any time.

I understand the full import of this request and I expect to die if I take the aid-in-dying drug to be prescribed. My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this request voluntarily, without reservation, and without being coerced.

Signed: _____ Dated: _____

DECLARATION OF WITNESSES

We declare that the person signing this request:

- (a) is personally known to us or has provided proof of identity;
- (b) voluntarily signed this request in our presence;
- (c) is an individual whom we believe to be of sound mind and not under duress, fraud, or undue influence; and
- (d) is not an individual for whom either of us is the attending physician, consulting physician, or mental health specialist.

Witness 1: _____ Date: _____

Witness 2: _____ Date: _____

NOTE: Only one of the two witnesses may be a relative (by blood, marriage, registered domestic partnership, or adoption) of the person signing this request or be entitled to a portion of the person's estate upon death. Only one of the two witnesses may own, operate, or be employed at a health care facility where the person is a patient or resident.

FINAL ATTESTATION FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I, _____,
am an adult of sound mind and a resident of the State of California.

I am suffering from _____,
which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I have received the aid-in-dying drug and am fully aware that this aid-in-dying drug will end my life in a humane and dignified manner.

INITIAL ONE:

_____ I have informed one or more members of my family of my decision and taken their opinions into consideration.

_____ I have decided not to inform my family of my decision.

_____ I have no family to inform of my decision.

My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this decision to ingest the aid-in-dying drug to end my life in a humane and dignified manner. I understand I still may choose not to ingest the drug and by signing this form I am under no obligation to ingest the drug. I understand I may rescind this request at any time.

Signed: _____

Dated: _____

Time: _____

REQUEST FOR AN AID-IN-DYING - INTERPRETER DECLARATION

I, _____, am fluent in English and _____.
NAME OF INTERPRETER TARGET LANGUAGE

On _____ at approximately _____,
DATE TIME

I read the "Request for an Aid-In-Dying Drug to End My Life" to

_____ in _____.
NAME OF PATIENT/QUALIFIED INDIVIDUAL TARGET LANGUAGE

Mr./Ms. _____
NAME OF PATIENT/QUALIFIED INDIVIDUAL

affirmed to me that he/she understood the content of this form and affirmed his/her desire to sign this form under his/her own power and volition and that the request to sign the form followed consultations with an attending and consulting physician.

I declare that I am fluent in English and _____
TARGET LANGUAGE

and further declare under penalty of perjury that the foregoing is true and correct.


Executed at _____, _____, _____
CITY COUNTY STATE

on this _____ of _____, _____.
DAY OF MONTH MONTH YEAR

INTERPRETER SIGNATURE

INTERPRETER PRINTED NAME

INTERPRETER STREET ADDRESS CITY STATE ZIP CODE

<p>SUBJECT: Risk Management Plan</p> <p>SERIES: 600 Risk Management</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.:</p> <p style="text-align: center;">620.03</p> <p>PAGE: 1 OF 8</p> <p>EFFECTIVE DATE: January 2015</p> <p>REVISED: March 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>
---	--	--

PURPOSE

The Risk Management Plan is designed to support the mission and vision of Health Services Agency-Clinics as it pertains to clinical risk and patient safety as well as visitor, third party, volunteer, and employee safety and potential business, operational, and property risks.

GUIDING PRINCIPLES

The Risk Management Plan is an overarching, conceptual framework that guides the development of a program for risk management and patient safety initiatives and activities. The plan is operationalized through a formal, written risk management and patient safety program.

The Patient Safety and Risk Management Program supports the Health Services Agency-Clinics philosophy that patient safety and risk management is everyone’s responsibility. Teamwork and participation among management, providers, volunteers, and staff are essential for an efficient and effective patient safety and risk management program. The program will be implemented through the coordination of multiple organizational functions and the activities of multiple departments.

Health Services Agency-Clinics supports the establishment of a just culture that emphasizes implementing evidence-based best practices, learning from error analysis, and providing constructive feedback, rather than blame and punishment. In a just culture, unsafe conditions and hazards are readily and proactively identified, medical or patient care errors are reported and analyzed, mistakes are openly discussed, and suggestions for systemic improvements are welcomed. Individuals are still held accountable for compliance with patient safety and risk management practices. As such, if evaluation and investigation of an error or event reveal reckless behavior or willful violation of policies, disciplinary actions can be taken.

The Health Services Agency- Clinic Risk Management Plan stimulates the development, review, and revision of the organization’s practices and protocols in light of identified risks and chosen loss prevention and reduction strategies. Principles of the Plan provide the foundation for developing key policies and procedures for day-to-day risk management activities, including:

- Claims management
- Complaint resolution

SUBJECT:
Risk Management Plan

POLICY NO.:

620.03

PAGE: 2 OF 11



- Confidentiality and release of information
- Event investigation, root-cause analysis, and follow-up
- Failure mode and effects analysis
- Provider and staff education, competency validation, and credentialing requirements
- Reporting and management of adverse events and near misses
- Trend analysis of events, near misses, and claims

Governing Body Leadership

The success of the Health Services Agency-Clinic Patient Safety and Risk Management Program requires top-level commitment and support. The governing board authorizes the formal program and adoption of this Plan through a resolution documented in board meeting minutes.

The governing board is committed to promoting the safety of all patients, visitors, employees, volunteers, and other individuals involved in organization operations. The Patient Safety and Risk Management Program is designed to reduce system-related errors and potentially unsafe conditions by implementing continuous improvement strategies to support an organizational culture of safety. The governing body empowers the organization leadership and management teams with the responsibility for implementing performance improvement and risk management strategies.

DEFINITIONS

- **Adverse event or incident:** An undesired outcome or occurrence, not expected within the normal course of care or treatment, disease process, condition of the patient, or delivery of services.
- **Claims management:** Activities undertaken by the risk manager to exert control over potential or filed claims against the organization and/or its providers. These activities include identifying potential claims early, notifying the organization's liability insurance carrier and/or defense counsel of potential claims and lawsuits, evaluating liability and associated costs, identifying and mitigating potential damages, assisting with the defense of claims by scheduling individuals for deposition, providing documents or answers to written interrogatories, implementing alternate dispute-resolution tactics, and investigating adverse events or incidents.

SUBJECT:
Risk Management Plan

POLICY NO.:

620.03

PAGE: 3 OF 11



- **Failure mode and effects analysis:** A proactive method for evaluating a process to identify where and how it might fail and for assessing the relative impact of different failures in order to identify the parts of the process that are most in need of improvement.
- **Loss control/loss reduction:** The minimization of the severity of losses through methods such as claims investigation and administration, early identification and management of events, and minimization of potential loss of reputation.
- **Loss prevention:** The minimization of the likelihood (probability) of a loss through proactive methods such as risk assessment and identification; staff and volunteer education, credentialing, and development; policy and procedure implementation, review, and revision; preventive maintenance; quality/performance review and improvement; root-cause analysis; and others.
- **Near miss:** An event or situation that could have resulted in an accident, injury, or illness but did not, either by chance or through timely intervention (e.g., a procedure almost performed on the wrong patient due to lapse in verification of patient identification but caught at the last minute by chance). Near misses are opportunities for learning and afford the chance to develop preventive strategies and actions. Near misses receive the same level of scrutiny as adverse events that result in actual injury.
- **Potentially compensable event (PCE):** An unusual occurrence or serious injury for which there is neither an active claim nor institution of formal legal action but that, in the organization's judgment, is reportable to the party (or parties) providing the medical malpractice insurance. Examples include a fall with injuries, delay or failure in diagnosing a patient's condition, an adverse reaction to treatment, significant complaints from a patient or family regarding care or treatment, and an attorney request for medical records.
- **Risk analysis:** Determination of the causes, potential probability, and potential harm of an identified risk and alternatives for dealing with the risk. Examples of risk analysis techniques include failure mode and effects analysis, systems analysis, root-cause analysis, and tracking and trending of adverse events and near misses, among others.
- **Risk assessment:** Activities undertaken in order to identify potential risks and unsafe conditions inherent in the organization or within targeted systems or processes.
- **Risk avoidance:** Avoidance of engaging in practices or of hazards that expose the organization to liability.
- **Risk control:** Treatment of risk using methods aimed at eliminating or lowering the probability of an adverse event (i.e., loss prevention) and eliminating, reducing, or minimizing harm to individuals and the financial severity of losses when they occur (i.e., loss reduction).

SUBJECT:
Risk Management Plan

POLICY NO.:

620.03

PAGE: 4 OF 11



- **Risk financing:** Analysis of the cost associated with quantifying risk and funding for it.
- **Risk identification:** The process used to identify situations, policies, or practices that could result in the risk of patient harm and/or financial loss. Sources of information include proactive risk assessments, closed claims data, adverse event reports, past accreditation or licensing surveys, medical records, clinical and risk management research, walk-through inspections, safety and quality improvement committee reports, insurance company claim reports, risk analysis methods such as failure mode and effects analysis and systems analysis, and informal communication with healthcare providers.
- **Risk management:** Clinical and administrative activities undertaken to identify, evaluate, prevent, and control the risk of injury to patients, staff, visitors, volunteers, and others and to reduce the risk of loss to the organization itself. Activities include the process of making and carrying out decisions that will prevent or minimize clinical, business, and operational risks.
- **Root-cause analysis:** A process for identifying the basic or causal factor(s) that underlie the occurrence or possible occurrence of an adverse event.
- **Sentinel event:** Defined by the Joint Commission as an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse event.
- **Trigger methodology:** A method of measuring harm related to the occurrence of adverse events. The method utilizes a clearly defined list of patient events (also known as a “trigger tool”) against which patient medical records are screened. Screening criteria are based on high-risk areas, or those areas identified as “red flags” through event reporting or as a result of a severe adverse event (e.g., new diagnosis of cancer, nursing home placement, use of more than five medications, high-risk pregnancy).
- **Unsafe and/or hazardous condition:** Any set of circumstances (exclusive of a patient’s own disease process or condition) that significantly increases the likelihood of a serious adverse outcome for a patient or of a loss due to an accident or injury to a visitor, employee, volunteer, or other individual.

1. PROGRAM GOALS AND OBJECTIVES

The Patient Safety and Risk Management Program goals and objectives are to:

- Continuously improve patient safety and minimize and/or prevent the occurrence of errors, events, and system breakdowns leading to harm to patients, staff,

SUBJECT:
Risk Management Plan

POLICY NO.:

620.03

PAGE: 5 OF 11



volunteers, visitors, and others through proactive risk management and patient safety activities.

- Minimize adverse effects of errors, events, and system breakdowns when they do occur.
- Minimize losses to the organization overall by proactively identifying, analyzing, preventing, and controlling potential clinical, business, and operational risks.
- Facilitate compliance with regulatory, legal, and accrediting agency requirements
- Protect human and intangible resources (e.g., reputation).

2. SCOPE AND FUNCTIONS OF THE PROGRAM

The Health Services Agency-Clinics Patient Safety and Risk Management Program interfaces with many operational departments and services throughout the organization.

2.1 Functional Interfaces

Functional interfaces with the patient safety and risk management program include the following:

- Buildings and grounds
- Claims management
- Corporate/regulatory compliance
- Credentialing of providers
- Disaster preparation and management
- Employee health
- Event/incident/accident reporting and investigation
- Finance/billing
- Human resources

SUBJECT:
Risk Management Plan

POLICY NO.:

620.03

PAGE: 6 OF 11



- Infection control
- Information technology
- Legal and contracts
- Marketing/advertising/public relations
- Nutritional services
- Patient and family education
- Patient satisfaction
- Pharmaceuticals and therapeutics
- Product/materials management
- Quality/performance assessment and improvement
- Safety and security
- Social service programs
- Staff education
- Volunteers

2.2 Risk Management Program Functions

Risk management functional responsibilities include:

- a) Developing systems for and overseeing the reporting of adverse events, near misses, and potentially unsafe conditions. Reporting responsibilities may include internal reporting as well as external reporting to regulatory, governmental, or voluntary agencies. This includes the development and implementation of event-reporting policies and procedures.
- b) Ensuring the collection and analysis of data to monitor the performance of processes that involve risk or that may result in serious adverse events (e.g., preventive screening, diagnostic testing,

SUBJECT:
Risk Management Plan

POLICY NO.:

620.03

PAGE: 7 OF 11



medication use processes, etc.). Proactive risk assessment can include the use of failure mode and effects analysis, system analysis, and other tools.

c) Overseeing data collection and processing, information analysis, and generation of statistical trend reports for the identification and monitoring of adverse events, claims, finances, and effectiveness of the risk management program.

This system may utilize and include, but is not limited to, the following:

- Attorney requests for medical records, x-rays, laboratory reports
- Committee reports and minutes
- Criteria-based outcome studies
- Event, incident, or near miss reports
- Medical record reviews
- Monitoring systems based on objective criteria
- Notice letters, lawsuits
- Nursing reports
- Patient complaints
- Physician and other medical professionals' input
- Results of failure mode and effects analysis of high risk processes
- Root-cause analyses of sentinel events

d) Analyzing data collected on adverse events, near misses, and potentially unsafe conditions; providing feedback to providers and staff; and using this data to facilitate systems improvements to reduce the probability of occurrence of future related events. Root-cause analysis and systems analysis can be used to identify causes and contributing factors in the occurrence of such events.

SUBJECT:
Risk Management Plan

POLICY NO.:

620.03

PAGE: 8 OF 11



- e) Ensuring compliance with data collection and reporting requirements of governmental, regulatory, and accrediting agencies.

- f) Facilitating and ensuring the implementation of patient safety initiatives such as improved tracking systems for preventive screenings and diagnostic tests, medication safety systems, and falls prevention programs.

- g) Facilitating and ensuring provider and staff participation in educational programs on patient safety and risk management.

- h) Facilitating a culture of safety in the organization that embodies an atmosphere of mutual trust in which all providers and staff members can talk freely about safety problems and potential solutions without fear of retribution. This ordinarily involves performing safety culture surveys and assessments.

- i) Proactively advising the organization on strategies to reduce unsafe situations and improve the overall environmental safety of patients, visitors, staff, and volunteers.

- j) Reducing the probability of events that may result in losses to the physical plant and equipment (e.g., biomedical equipment maintenance, fire prevention).

- k) Preventing and minimizing the risk of liability to the organization, and protecting the financial, human, and other tangible and intangible assets of the organization.

- l) Decreasing the likelihood of claims and lawsuits by developing a patient and family communication and education plan. This includes communicating and disclosing errors and events that occur in the course of patient care with a plan to manage any adverse effects or complications.

- m) Decreasing the likelihood of lawsuits through effective claims management, and investigating and assisting in claim resolution to minimize financial exposure in coordination with the liability insurer and its representatives.

- n) Reporting claims to medical malpractice insurance providers and other insurers in accordance with the requirements of the insurance policy/contract.

- o) Supporting quality assessment and improvement programs throughout the organization.

SUBJECT:
Risk Management Plan

POLICY NO.:

620.03

PAGE: 9 OF 11



p) Implementing programs that fulfill regulatory, legal, and accreditation requirements.

q) Establishing an ongoing patient safety/risk management committee composed of representatives from key clinical and administrative departments and services.

r) Monitoring the effectiveness and performance of risk management and patient safety actions. Performance monitoring data may include:

- Claims and claim trends
- Culture of safety surveys
- Event trending data
- Ongoing risk assessment information
- Patient's and/or family's perceptions of how well the organization meets their needs and expectations
- Quality performance data
- Research data

s) Completing insurance, and deeming applications.

t) Developing and monitoring effective handoff processes for continuity of patient care.

3. ADMINISTRATIVE AND COMMITTEE STRUCTURE AND MECHANISMS FOR COORDINATION

The Patient Safety and Risk Management Program is administered through the risk manager and/or designee, who reports to Chief of Clinic Services. The risk manager interfaces with administration, staff, medical providers, and other professionals and has the authority to cross operational lines in order to meet the goals of the program. The risk manager (or alternate as designated by the Chief of Clinic Services) chairs the activities of the Patient Safety/Risk Management Committee. The committee meets regularly and includes representatives from key clinical and services. The composition of the Patient Safety/Risk Management Committee is designed to facilitate the sharing of risk management knowledge and practices across multiple disciplines and to optimize the use of key

SUBJECT:
Risk Management Plan

POLICY NO.:

620.03

PAGE: 10 OF 11



findings from risk management activities in making recommendations to reduce the overall likelihood of adverse events and improve patient safety. The Committee's activities are an integral part of a patient safety and quality improvement and evaluation system.

Documentation of the designation of the risk manager is contained in the Patient Safety Risk Management Plan. The risk manager is responsible for overseeing day-to-day monitoring of patient safety and risk management activities and for investigating and reporting to the insurance carrier actual or potential clinical, operational, or business claims or lawsuits arising out of the organization, according to requirements specified in the insurance policy and/or contract. The risk manager serves as the primary contact between the organization and other external parties on all matters relative to risk identification, prevention, and control, as well as risk retention and risk transfer. The risk manager oversees the reporting of events to external organizations, per regulations and contracts, and communicates analysis and feedback of reported risk management and patient safety information to the organization for action.

4. MONITORING AND CONTINUOUS IMPROVEMENT

The Patient Safety/Risk Management Committee reviews risk management activities regularly. The risk manager or designee reports activities and outcomes (e.g., claims activity, risk and safety assessment results, event report summaries and trends) regularly to the governing board. This report informs the governing board of efforts made to identify and reduce risks and the success of these activities and communicates outstanding issues that need input and/or support for action or resolution. Data reporting may include event trends, claims analysis, frequency and severity data, credentialing activity, relevant provider and staff education, and risk management/patient safety activities. In accordance with the organization's bylaws, recommendations from the Patient Safety/Risk Management Committee are submitted as needed to the board for action or non-action. Performance improvement goals are developed to remain consistent with the stated risk management and patient safety goals and objectives.

Documentation is in the form of quarterly risk management reports to the administrator/CEO and governing board on risk management activities and outcomes.

5. CONFIDENTIALITY

Any and all documents and records that are part of the patient safety and risk management process shall be privileged and confidential to the extent provided by state and federal law. Confidentiality protections can include attorney client privilege, attorney work product, and peer review protections.

Medical providers may be able to apply the federal privilege and confidentiality protections granted by the Patient Safety and Quality Improvement Act of 2005 to its patient safety events, data, and reports—referred to in the law as patient safety work product—by creating a patient safety evaluation system, through which the organization collects patient safety work product with the intent of providing it to

SUBJECT:
Risk Management Plan

POLICY NO.:

620.03

PAGE: 11 OF 11



one or more patient safety organizations for analysis and feedback. Care must be taken to ensure that the patient safety evaluation system is developed within the context of the provider's state laws for legal privilege and peer review as well as any applicable federal regulations.

County of Santa Cruz Integrated Community Health Center Commission
1080 Emeline Ave., Bldg. D
Santa Cruz, CA 95060

March 9, 2017

Mr. Granlund
PO Box 1870
Santa Cruz, CA 95061-1870

Dear Mr. Granlund,

I am writing to express our Commission's serious concerns about the new parking limitations near our federally qualified health center on 115 Coral St. This clinic provides medical, dental, behavioral health, public health, and housing support services to our community members experiencing homelessness. The parking restrictions are having a disproportionate adverse impact on the most vulnerable among us.

While temporary parking permits are available to our patients, the process for obtaining a temporary permit first and then having to park is extremely inconvenient for many of our clients who have complex medical problems or other disabilities. The impact on our clinic is unclear, but we will track our patient visits pre and post parking changes in the Harvey West Area. We have already received reports that both staff and our patients have received tickets. We were not afforded the chance to provide input on these new restrictions. Plenty of evidence exists documenting the inefficiencies of enforcing vagrancy laws that result in the issuance of citations to homeless populations, which increase costly enforcement and judicial processes, and direct limited resources away from efforts that would effectively and humanely reduce homelessness. The new enforcement of parking around our clinic amounts to another barrier for our patients accessing much needed health care and is resulting in decreased access to our services and subsequent increase in the number of preventable emergency department visits by this population.

We are requesting that the parking restrictions on Coral St. be reversed and that parking on that street be returned to its previous status.

Sincerely,

Rama Khalsa, PhD
Commission Chair

Search

Home > Providers & Partners > County Implementation Plans

Select Language ▼

County Implementation Plans

DHCS Approved

- Contra Costa County Implementation Plan - DHCS Approved
- Los Angeles County Implementation Plan - DHCS Approved
- Marin County Implementation Plan - DHCS Approved
- Monterey County Implementation Plan - DHCS Approved
- San Francisco County Implementation Plan - DHCS Approved
- Riverside County Implementation Plan - DHCS Approved
- San Mateo County Implementation Plan - DHCS Approved
- Santa Clara County Implementation Plan - DHCS Approved
- Santa Cruz County Implementation Plan - DHCS Approved
- Sonoma County Implementation Plan - DHCS Approved
- Ventura County Implementation Plan - DHCS Approved

DRAFT County Implementation Plans

- Alameda County Implementation Plan DRAFT
- Kern County Implementation Plan DRAFT
- Napa County Implementation Plan DRAFT
- Orange County Implementation Plan DRAFT
- San Bernardino Implementation Plan DRAFT
- San Luis Obispo County Implementation Plan DRAFT

Fact Sheets, Frequently Asked Questions & Information Notices

Fact Sheets

- [ASAM Criteria Fact Sheet](#)
- [Drug Medi-Cal Organized Delivery System Pilot Program](#)

Frequently Asked Questions

- [Beneficiary Eligibility Criteria for DMC-ODS Pilot Frequently Asked Questions](#)
- [Beneficiary Protections in the DMC-ODS Pilot Frequently Asked Questions](#)
- [Case Management Frequently Asked Questions](#)
- [Fiscal Considerations Frequently Asked Questions](#)
- [Intensive Outpatient Treatment Frequently Asked Questions](#)
- [Medication Assisted Treatment and the DMC-ODS Pilot Program Frequently Asked Questions](#)
- [Perinatal Beneficiaries Frequently Asked Questions](#)
- [Partial Hospitalization Frequently Asked Questions](#)
- [Recovery Services Frequently Asked Questions](#)
- [Residential Treatment Services in the DMC-ODS Pilot Program Frequently Asked Questions](#)
- [Withdrawal Management \(Detox\) Services Frequently Asked Questions](#)

Waiver Information Notices

No Issued	Subject	Date
17-008	Peer Support Services in the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver <ul style="list-style-type: none"> • Attachment 	2/14/2017
16-057	Drug Medi-Cal Organized Delivery Systems Healthcare Common Procedure Coding System (HCPCS) and Modifiers	11/9/2016
16-050	Drug Medi-Cal Organized Delivery System Waiver County Implementation Fiscal Plan Guide <ul style="list-style-type: none"> • Attachment 	10/4/2016
16-048	Medication Assisted Treatment in Narcotic Treatment Programs Under the Drug Medi-Cal Organized Delivery System Pilot Program <ul style="list-style-type: none"> • Exhibit 	9/27/2016
16-044	Clarifying the Meaning of "Face-to-Face Review" from Standard Terms of Conditions for the Drug Medi-Cal Organized Delivery Systems (DMC-ODS)	9/14/2016
16-042	Residential Treatment Services and Residential Authorizations in the Drug Medi-Cal Organized Delivery System (DMC-ODS) Pilot Program	8/11/2016
16-039	Introduction of Incidental Medical Services	7/29/2016
16-037	Medically Monitored and Medically Managed Detoxification/Withdrawal Management and Residential	7/21/2016

Treatment Services in the DMC-ODS Pilot Program

16-035	Drug Medi-Cal Organized Delivery System Healthcare Common Procedure Coding System (HCPCS) and Modifiers	7/15/2016
16-007	Changing Same Day Billing Requirements for Counties that Opt-In to the Drug Medi-Cal Organized Delivery System (DMC-ODS) 1115 Waiver	2/12/2016
16-006	Drug Medi-Cal Organized Delivery System Waiver County Implementation Fiscal Plan Guide	2/11/2016
16-005	Drug Medi-Cal Organized Delivery System Waiver Implementation Plan Guide	2/18/2016
15-048	Addition of Withdrawal Management (Detox) Services	10/16/2015
15-035	American Society of Addiction Medicine (ASAM) Designation for Residential Facilities	8/26/2015
15-034	Drug Medi-Cal Organized Delivery System Pilot Fiscal Provisions	8/21/2015
15-033	Medications Used in Treatment of Substance Use Disorders in an Outpatient Setting	8/30/2015
15-032	Drug Medi-Cal Organized Delivery System Waiver Approval	8/13/2015

[Home](#) | [Services](#) | [Individuals](#) | [Providers & Partners](#) | [Forms, Laws & Publications](#) | [Data & Statistics](#)

dhcs.ca.gov

[Back to Top](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Accessibility](#) | [Contact Us](#) | [Site Map](#) | [Help](#) | [Download Free Readers](#)
 Copyright © 2017 State of California

Last modified on: 3/7/2017 4:48 PM

