

QUALITY IMPROVEMENT APPENDICES

21st Edition



AUDIT TOOLS AND PLAN OF ACTION FORMS

July 2013

**Tennessee Department of Health
Office of Quality Improvement**

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**TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF QUALITY IMPROVEMENT
2013-2014
Summary of Strengths and Concerns Report**

County Name:

Site Number:

Region Name:

Review Date:

Exit Conference Date:

Reviewer(s):

Reviews:

Summary of Strengths:

Summary of Concerns:

COMMENT SECTION

County Name:

Site Number:

Region Name:

Review Date:

Exit Conference Date:

Reviewer(s):

Reviews:

**TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF QUALITY IMPROVEMENT
2013-2014
COUNTY PLAN OF ACTION
2 Day Report**

Date of Review:

Date of Response:

Region Name:

County Name:

Site Number:

Review completed by:

Remove this statement prior to presentation to reviewed site: Please list the Review Standard, the deficiency according to the review, and the immediate Plan of Action/Correction taken. Please indicate any patient/employee impact caused by the deficiency and/or steps being taken to identify the patients impacted.)

Corrective Action to be taken: (Please establish measurable goals)

Person(s) Responsible for Corrective Action Plan development and implementation:
(List name, title and date of approval)

- 1.
- 2.
- 3.

This plan should be written in consultation with the Regional Director, Regional Medical Director and Regional Nursing Director along with regional program Directors that are affected such as Pharmacy, Immunizations, and OSHA. The completed report is to be emailed to Regional and State QI Directors, Regional Director, Regional Medical Officer, Regional and State Nursing Directors and State Medical Officer, to include when appropriate, State Pharmacy Director, State Lab/OSHA Coordinator and state program directors that are affected such as TB, Immunizations, etc.

**TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF QUALITY IMPROVEMENT
2013-2014
COUNTY/REGIONAL PLAN OF ACTION
One Month Report**

Region Name:

County Name:

Site Number:

Review Date:

Exit Conference Date:

Report Due Date:

Reviewer(s):

Reviews completed: **Remove this statement prior to presentation to reviewed site:**

(Please list any of the following below: Standard(s) determined to be less than 90% met; any item(s) which have a major impact upon patients; any item(s) with legal aspect or any other issues the county/regional office would like to address.) Please list Review, standard(s) of concern, percentage met, and how standards were not met.

Corrective action to be taken:

Person(s) Responsible for Corrective Action Plan development and implementation:
(List name, title and date of approval)

- 1.
- 2.
- 3.

The completed report is to be emailed to Regional and State QI Directors, Regional Director, Regional Medical Officer, Regional Nursing Director and Regional Clerical Consultant. Copies of the report should also be sent to programs impacted by standards requiring 2 day Plans of Action Reports. Plan of Action Report is due to the Regional Office 30 days from the date of the exit conference.

**TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF QUALITY IMPROVEMENT
2013-2014
COUNTY/REGIONAL PLAN OF ACTION
3 Month Follow-up Report**

Region Name:

County Name:

Site Number:

Review Date:

Exit Conference Date:

Report Due Date:

Reviewer(s):

Reviews Completed: (Check appropriate line)

<input type="checkbox"/> Administration Questions 1-4	<input type="checkbox"/> Risk Minimization
<input type="checkbox"/> Administration Questions 5-7	<input type="checkbox"/> Lab Risk Follow-up
<input type="checkbox"/> Availability	<input type="checkbox"/> WIC Voucher / Reports
<input type="checkbox"/> Comprehensive Health Maintenance:	<input type="checkbox"/> Focus 01 <input type="checkbox"/> Focus 02
<input type="checkbox"/> Title VI	

Priority Concerns identified at the time of the review:

Follow-up method and findings:

Was original Plan of Action successful in addressing deficiencies? (Yes or no):
If no, please document your revised Plan of Action with measurable goals:

Person(s) Responsible for Corrective Action Plan development and implementation:
(List name, title and date of approval)

- 1.
- 2.
- 3.

The completed report is to be emailed to Regional QI Director, Regional Director, Regional Medical Officer, Regional Nursing Director and Regional Clerical Consultant. Plan of Action is due to the Regional Office 3 months from the date of the exit conference. 3 month Plan of Action Report is sent to State QI Director only upon special request.

**QUALITY IMPROVEMENT
REGIONAL PLAN OF ACTION
July 2013 – June 2014**

Region Name:

Report Date:

Administrative

Standard	Plan of Correction and Comments

Availability of Service/Patient Rights

Comprehensive Medical Record and Encounter Medical Review Focus 01/02

Fiscal

Risk Minimization

Title VI

WIC Voucher

List any additional regional focus studies conducted during this fiscal year; note findings, corrective action taken and any comments. (i.e. additional Lab, Pharmacy, EPSDT, family planning audits, travel/time, etc.)

Person(s) responsible for the Regional Plan of Action Report development and implementation:

(List name, title and date of approval)

- 1.
- 2.
- 3.

**TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF QUALITY IMPROVEMENT
ADMINISTRATION, QUESTIONS 1-4
Review Tool**

COUNTY/SITE #: _____ DATE: _____

REVIEWER(S): _____

Evaluation Code: X=Met, O=Not Met, NA=Not Applicable

<u>Policies and Procedures</u>	X,O,NA
1. Employees are aware of the Policies and Procedures Manual for the Division of Community Health Services Administration and are able to access an up-to-date hardcopy or access it electronically. CHSA Policy 3.7.c http://hsaintranet.health.tn.gov	
<u>Orientation</u>	
2. Each new employee of the Division of Community Health Services Administration has an orientation class according to the Policies and Procedures Manual and Regional Policies. (CHSA Policy 3.7.c or Metro Policies and Procedures) New Employee Handbook	
If any of the indicators below are not met then standard 2 above is not met.	
A. Regional staff in charge of Human Resource matters are responsible for conducting orientation classes for new county and regional staff every month (within 30 days of hire), or when necessary, using material developed by the Office of Human Resources.	
B. Content of the classes will include information on: 1) Material contained in the New Employee Orientation Package distributed to new employees by the Office of Human Resources of the Department of Health. 2) State Human Resources policies and employee benefits.	
C. Each new employee in the Central Office, Regional Office, and Local Health Department should also receive an orientation to the Division of Community Health Services. Depending upon the actual location of the new employee, it will be the responsibility of the Regional Director, Section Chief, or their designee, to ensure that each new employee receives information on:	
1) Detailed description of the division, sections and programs within the Division of Community of Health Services and the services provided by each. 2) The relationship between the Central Office, Regional Office and Local Health Departments and the overall mission of the Division of Community Health Services. 3) Policies and procedures of the Division of Community Health Services Administration as well as specific program policies. 4) Employee HIPAA and confidentiality requirements. 5) Quality Improvement and other specific program standards.	
<u>Employee Records</u>	
3. Employee records are maintained at designated base worksite and/or Regional Office in an assigned secure location with limited access.	
If any of the indicators below are not met then standard 3 above is not met.	
A. Human Resources files – CHSA Policy 3.9 http://hsaintranet.health.tn.gov	
B. Attendance and leave record- Attendance and Leave Policies and Procedures Manual	
C. Travel reimbursement claims - http://tennessee.gov/finance/act/documents/policy8.pdf	

Posters: Resources are listed to obtain replacements or additional posters as needed.		
4. Required posters are present in the appropriate area. P = Display in Public Area E = Display in Employee Area ◇ = Required State Posters ◆ = Required Federal Posters		
The state and federal posters may be combined in a commercially prepared laminated poster that contains multiple posters.		
1) ◆ Equal Employment Opportunity is the Law 11/2009	(P)	
2) ◆ Your Rights Under the Family and Medical Leave Act of 1993 2/2013	(P)	
3) ◆ Employee Rights Under the Fair Labor Standards Act July 2009	(P)	
4) ◇ It's The Law! You Have a Right to a Safe and Healthful Workplace Post the Tennessee TOSHA poster instead of the OSHA poster which is included in the purchased laminated poster. 11/1/2000	(E)	
5) ◇ Tennessee Law Prohibits Discrimination in Employment 10/2008 TN Human Rights Commission, (615)741-5825 Dept. of Labor & Workforce Development	(P)	
6) State of Tennessee Executive Order by the Governor #3 , An Order Concerning Equal Employment Opportunity. TN Dept. of Human Resources, Equal Employment Opportunity, (615) 741-1646	(P)	
7) TennCare Poster – Having problems getting health care from TennCare 6/7/2011	(P)	
8) Comptroller's Hotline Number- 1-800-232-5454 or (615) 741-2775 4/2013	(P)	
9) Fair Hearing Procedure/WIC - Regional WIC Director	(P)	
10) And Justice for All USDA Form AD-475C 9/2006 Regional WIC Director (12/1999 poster is acceptable)	(P)	
11) Services are available on a sliding fee scale basis. Post in reception area. CHSA Policy 7.9 & 7.22	(P)	
12) Clinic Hours and Names of Direct Care Staff on Duty CHSA Policy 3.10	(P)	
13) Name and telephone number of nearest Poison Control Center 1-800-222-1222 Tennessee Poison Center http://www.mc.vanderbilt.edu/root/vumc.php?site=poisoncenter	(P)	
14) Equal Opportunity is The Law, Title VI Section 601, of the Civil Rights Act of 1964, Department of Health, Office of Title VI/Non-Discriminatory Compliance and Diversity Business, Luvenia H. Butler, MS, Director, (615) 741-9421	(P)	
15) Abuse Notice Regarding Chapter Number 804 of the Public Acts of 2006 and Chapter Number 446 of the Public Acts of 2007. Effective 7/1/2007	(P)	
16) Complaint process forms for Civil Rights Act of 1964 TDH Title VI Compliance Director (615) 741-9421 Does not have to be posted on the wall but must be visible and available to the public without asking.	(P)	
17) No Smoking signs are posted in patient waiting rooms and other appropriate areas. CHSA Policy 7.2 http://hsaintranet.health.tn.gov	(P) and (E)	

18)	Copy of the Department's Non-Discrimination Affirmative Action Policy Statement 3/1/12. Department of Health's Affirmative Action Plan	(P) and (E)	
19)	Workplace Harassment Policy Revised 12/4/2012 TN Department of Human Resources (615) 741-6350	(P) and (E)	
20)	◇ TN Unemployment Insurance Poster 6/2013 Department of Labor & Workforce Development http://www.state.tn.us/labor-wfd/uiposterab1.pdf	(E)	
21)	◇ Workers' Compensation Posting Notice Revised 3/2012 Department of Labor & Workforce Development http://www.state.tn.us/labor-wfd/forms/WC_Certificate.pdf	(E)	
22)	OSHA 300A Summary Form to be posted each February, March and April. Department of Labor & Workforce Development http://osha.gov/recordkeeping/new-osha300form1-1-04.pdf	(E)	
23)	◆ Your Rights Under USERRA, the Uniformed Services Employment and Reemployment Rights Act. U.S. Dept. of Labor, VETS October 2008 http://www.dol.gov/vets/programs/userra/USERRA_Private.pdf	(E)	
24)	State Regulations for Protection Against Radiation- "Notice to Employees" Form RHS 8-3 is posted as required by law in x-ray employee Area http://www.tn.gov/sos/rules/0400/0400-20/0400-20-04.20120522.pdf Page 15, Revised 5/2012	(E)	
25)	◆ Know Your Rights Under the Recovery Act! - Federal Whistle Blower poster http://www.recovery.gov/Contact/ReportFraud/Documents/WhistleblowerPoster.pdf July 2009 This poster is not available in Spanish (5/13/13)	(E)	
26)	◇ Reporting TennCare Fraud and Abuse 12/2005 (TennDent sites only) OIG Poster or TennDent memo notice dated 5/13/11 is to be posted - both are not required. Contact State QI Director for Spanish copies of this poster.	(P)	

Required state and federal posters would need to be posted in the appropriate language according to the Title VI guidelines for translation of vital documents. Those posters designated by ◆ and ◇ are required by the state and federal government to be posted in the public area. If the LEP % for that site met the criteria to require that vital documents be translated into a given language, for example Spanish, then the state and federal posters that are required to be posted in the public areas of the clinic, would also have to be posted in Spanish.

**TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF QUALITY IMPROVEMENT
ADMINISTRATION QUESTIONS 5, 6 & 7
Review Tool**

COUNTY/SITE #: _____ DATE: _____

REVIEWER(S): _____ Employee ID or initials: _____

Type: (state, county, contract) _____ Hire/Re-class Date: _____

Evaluation Code: X=Met, O=Not Met, NA=Not Applicable

<u>Departing Employees</u>	X, O, NA
5. Notification of an employee's departure from our employment is to be submitted in writing to the Office of Human Resources along with all required accompanying paperwork. CHSA Policy 3.17 http://hsaintranet.health.tn.gov	X, O, NA
If any of the indicators below are not met then standard 5 above is not met.	
A. All employees leaving our employment (including separation, transfer, and retirement) must submit in writing a letter of intent to transfer, retire or resign to their supervisor. It is the supervisor's responsibility to submit this information to the Human Resources Officer.	
B. Human Resources officer should forward the state employee's PRT-3 form, the employee's resignation letter and all required paperwork to the Office of Human Resources.	
C. The supervisor/Human Resources officer must obtain the following items upon notification of impending resignation or transfer of an employee. <i>Note that not all of these items will pertain to every employee.</i>	
1) Letter of resignation	
2) State ID card	
3) Photo ID card	
4) State parking decal	
5) Keys to all property (building, locks in cubicle, moneybox, etc.)	
6) Security number/password to voice mail.	
7) All password and identification/security numbers assigned for systems access (i.e. email, Edison User Separation form, RACF/Provider number, Health Separation form)	
8) Computer software and respective manuals	
9) State credit card	
10) State telephone credit card	
11) State owned equipment (e.g. cell phone, pager, laptop computer, etc.)	
D. Supervisor/Human Resources Officer should also share information re: departing employees with their Systems Administrator to ensure that all provider numbers previously assigned to the employee are de-activated.	
<u>Attendance and Leave</u>	X,O,NA
6. Employees' (state, local, contract) attendance and leave/time distribution reports are current and accurate. CHSA Policy and Procedures Manual 3.3 http://hsaintranet.health.tn.gov and Attendance and Leave Manual, Tennessee Department of Human Resources. Current online version http://www.tn.gov/dohr/tech_svrs/pdf/Attendance%20and%20leave%20manual.pdf	
A. Copies are present at the Human Resources site where leave is keyed, for all pay periods.	
B. The current attendance and leave forms or Edison entries show:	

1)Daily hours worked.	
2)Accurate pay period calculations.	
3)Fully completed and accurate footings where applicable.	
4)Signatures with dates of employee, supervisor, and timekeeper (optional) for all pay periods.	
C. The current attendance and leave form correlates with travel claim(s).	
D. Approved documentation for changes in regularly assigned workweek is present.	
Personnel File	
7. Each state, local or contract employee's personnel file contains <u>copies</u> of relevant documents. (Every file will not contain every document.) (CHSA Policy 3.9) http://hsaintranet.health.tn.gov ♦ = documents that are not <u>required</u> (but may be present) for non-state employees (these may be held in the county government's personnel department).	
A. A copy of the worked register Certification of Eligibles or referral listing after 10/2012♦	
B. Copies of documents for completion of appointment♦	
1) Letters sent; undelivered envelopes; copies of emails ♦	
2) EEO form with appropriate signatures PH-1454 (1987) ♦	
3) If hired after November 6, 1986, Employment eligibility verification, including copies of proof per I-9 criteria. ♦	
C. Title VI of the Civil Rights Act of 1964 (Sept. 2003) and/or Title VI Completion Certificate (4/2013). ♦	
D. PRT-3 form - (completed) showing employee report information. ♦	
E. Signed and dated job performance plan - (current) ♦	
F. Performance Evaluation form with proper signatures and dates ♦	
G. If applicable, Flexible work schedule (PH-2003) (8/1999) ♦	
H. A signed copy of PH-3131 (3/2007) (6 in 1 form) The form includes HIPAA & Human Resources Confidentiality Statement (2003), Drug Free Workplace (1988), Workplace Harassment (2005), Conflict of Interest Policy Acknowledgment (1995), Operation of Motor Vehicles by State Employees Policy (2003), and Acceptable Use Policy (2006).	
I. TennCare Impartiality Statement, CHSA 3.16 , PH-3496 (3/97)	
J. Acceptable Use Policy Version 1.13, FA-0984 April 2009	
K. Signed copy of the Computer Access Security Agreement (PH 3601)(RACF)	
L. Copies of appropriate credentials (diploma, certificate, license, annual or biennial license renewal, NPI # only for those whose name is on billing statements). See CHSA Policies 3.9 , 3.18 , 8.6.b and credential checklist. http://hsaintranet.health.tn.gov http://health.state.tn.us/Licensure/default.aspx	
1) This employee requires licensure or certification renewal at specific intervals. This is either Yes or NA	Yes/NA
2) A copy of current license or certificate has been provided.	
3) Renewal date of license or certificate is: _____ (enter date: dd/mm/yy)	

**TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF QUALITY IMPROVEMENT
AVAILABILITY OF SERVICES AND PATIENT RIGHTS
Review Tool**

County/Site #: _____ Date: _____ Reviewer(s): _____

Evaluation Code: X=Met, O=Not Met, NA=Not Applicable

Resource: CHSA Policies and Procedures Manual: <http://hsaintranet.health.tn.gov>

1.	A Patient Satisfaction Survey system is conducted each calendar year for a period of 5 working days. CHSA Policy 7.19		
2.	State and local governments give people with disabilities an equal opportunity to benefit from all of their programs, services and activities. (ADA) http://www.access-board.gov/adaag/html/adaag.htm		
	A. The clinic has handicapped access or has an alternate service site.		
	B. Designated handicapped parking		
	C. Designated handicapped toilet facilities		
3.	The atmosphere of the clinic promotes patient privacy.		
	A. Patients should be treated in a manner which preserves patient's dignity and privacy. CHSA Policies and Procedures Manual 7.9 and 7.24 HIPAA		
	B. Medical Records are secured and appropriate privacy HIPAA measures are observed. CHSA Policies 5.1.a , 5.2 , 7.24		
4.	Health departments are open during lunch and normal business hours. CHSA Policy 3.3.h .		
5.	Individuals are able to identify personnel by name and title. CHSA Policy 3.10 and 8.11 . Enter number met and not met	Met	Not Met
6.	There is reasonable access to basic public health services.		
	A. Available appointments for appropriate visits		
	B. Immunization services are readily available. (Child & Adolescent Health Manual, 2002, pg. 1-2.0)		
	C. Providers co-schedule immunization appointments in conjunction with appointments for other child health services. (Child & Adolescent Health Manual, 2002, pg. 1-2.1)		
	D. STD services are readily available.		
	E. Clients applying for WIC are seen in appropriate time. WIC Manual Section 1 page 4, WIC Manual: http://hsaintranet.health.tn.gov		
	1) Within 10 calendar days for pregnant women		
	2) Within 10 calendar days for infants under six months		
	3) Within 10 calendar days for migrants		
	4) Within 20 calendar days for all others		
7.	There is reasonable access to Department of Health Primary Care Providers (Applies only to those county health departments that have MCO/TennCare Contracts to provide PCP services).		
	A. Appointments are not to exceed 3 weeks from date of a patient's request for regular appointments		
	B. Appointments within 48 hours for urgent care (Citation: both a and b are from the TennCare Contract, Attachment IX, Terms and Conditions for Access)		

**TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF QUALITY IMPROVEMENT
COMPREHENSIVE HEALTH MAINTENANCE
Review Tool**

County/Site: _____ Date: _____ Reviewer: _____

Review Period: _____ Medical Record# _____ Date of Service _____

Access [Current PHN Protocols](http://hsaintranet.health.tn.gov) or other program manuals: <http://hsaintranet.health.tn.gov>

PROGRAMS (mark single program that is reviewed)

AP=Aids Prevention	HUGS	Primary Care MH DM
AR=Aids Ryan White	Immunization – adult	Primary Care WH DM
Breast & Cervical	Immunization – child	Smoking Cessation - QT
Breast Feeding	Men’s Health (age 21>)	STD
Child Health - CH	Nutrition	TB
CHAD	Prenatal	WIC
CSS	Primary Care CH	Women’s Health (age 21 >)
EPSDT	Primary Care MH	Other Program:
EPSDT/FP	Primary Care WH	
Family Planning	Primary Care CH DM	

Evaluation Code: X=Met, O=Not Met, NA=Not Applicable

EPSDT Component	Standards and Performance Indicators	X,O,NA	Comments, Reasons not met
	1. Program eligibility criteria Met		
I.	2. Appropriate medical histories taken		
	A. Initial medical history is completed upon the first comprehensive clinic visit and updated annually or as indicated at each periodicity scheduled visit thereafter.		
	B. Family history is completed upon the initial comprehensive clinic visit and updated annually or as indicated at each periodicity scheduled visit thereafter.		
	C. Interval history is documented each clinic visit.		
	3. Allergies documented appropriately		
	4. Appropriate assessments completed per protocol and program guidelines		
	A. Nutritional assessment B. Health status assessment C. TB Risk Assessment (RAT) D. Cholesterol assessment E. Lead Risk assessment (6mos. Thru 72 mos.) F. Psychosocial G. Tobacco Survey Assessment (TSA)		
II.	5. Physical exam		
	A. Comprehensive unclothed physical exam		
	B. Problem focused exam		
	6. Growth measures		
	A. Weight		
	B. Stature		
	C. Weight for Height/BMI		
	D. Head circumference (thru 24 mos.)		
	E. Plotted correctly		
	7. Other measures, vital signs		
III.	8. Sensory screening		

	A. Vision		
	B. Hearing		
IV.	9. Developmental/behavioral screening		
V.	10. Laboratory test		
	A. Testing appropriate to documented assessment and diagnosis.		
	B. Appropriate test completed according to program guidelines and standards.		
VI.	11. Immunizations		
	A. Immunizations are given at designated times as per protocols and standards.		
	B. There are no missed opportunities.		
	C. Assessment of immunization status is documented. CHSA Policy 8.9		
	D. Sites of all immunization injections are documented according to protocols and standards.		
	E. Immunizations are documented per protocols and standards, including documentation of the VIS revision date.		
	12. Medications		
	A. Medications are given and documented at designated times as per protocols and standards.		
	B. Dose, site, route and frequency are documented appropriately for medications given or prescribed.		
	C. Medications documented on the Primary Care Problem List and Medication Summary form are current.		
VII.	13. Anticipatory guidance/education		
	14. Dental referral		
	15. Plan of care		
	A. Assessment is documented.		
	B. Addresses findings in the assessment		
	C. Problems are:		
	1) Treated by the appropriate provider		
	2) Referred if indicated		
	3) Follow-up is done or scheduled according to protocol and/or program guidelines.		
	D. Plan documentation includes a plan of action for a return visit to address any items omitted from this visit, including PCP letter.		
	16. There are no missed EPSDT opportunities		
	17. Medical records		
	A. Name or medical record number		
	B. Personal/biographical data is updated appropriately.		
	C. Date of service		
	D. Provider identification		
	E. Legibility		
	F. Regional/State approved abbreviations are used		
	G. There are no documentation errors or errors are corrected according to state/regional standards.		
	H. Adherence to standard regional format		
	I. Appropriate consent forms are completed		
	J. Required program forms are present		

**TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF QUALITY IMPROVEMENT
FISCAL REVIEW TOOL**

COUNTY/ SITE #: _____ DATE: _____

REVIEWER(S): _____

Evaluation Code: X=Met, O=Not Met, NA=Not Applicable

	http://hsaintranet.health.tn.gov/default.asp	Yes	No	NA
1.	Duties are segregated to the extent possible. *(2.3)			
2.	Cash box is secured at all times and is kept in a locked storage facility whenever unattended or after hours. (2.11.2 and 2.11.3)			
3.	The cash fund custodian and employees having access to cash funds are identified. (2.11.12 and 2.11.14)			
4.	Change fund equals authorized balance and is only used for making change for patients who pay in cash for services received.			
5.	No employee checks or IOUs are in the cash fund box. (2.11)			
6.	Cash drawer and manual reconciliation totals match cash on hand and any difference is noted, explained, dated and signed on the cash drawer. (2.11.5)			
	Insert number met, number not met, or number not applicable	Met	Not Met	NA
7.	Copies of all receipts are maintained and attached to CD including manual, computer and voided receipts. The number and category of all receipts used will be recorded on the CD. (2.13)			
8.	Any manual receipts issued are reconciled with PTBMIS generated receipts and both copies are retained when monies are for services posted in PTBMIS. (2.13)			
9.	Refunds are provided from receipts only as directed by the Division of Administrative Services. (2.11)			
10.	Issuer signs manual receipts. (2.13)			
11.	Manual receipts are logged in from the Region and are stored in a locked file or closet. (2.13)			
12.	Voided receipts are accounted for with an explanation and are approved by a supervisor. (2.11.11)			
13.	All shortages are reported to the Regional Accountant or Regional Director according to policy. (2.11.5 and 2.11.15)			
14.	Cash Drawer close-out and a deposit to the bank is done in accordance to policy. (2.9)			
15.	Fees collected shall be deposited at least two times a week or within 24 hours after \$100 in funds has been accumulated whichever comes first. All funds not deposited the same day of receipt must be secured under lock. (2.9)			
16.	CD forms are used in sequence. (2.9)			
17.	CDs are voided according to procedure. (2.14)			
18.	The money deposited will match the CD. (2.11)			
19.	Checks are restrictively written for the exact amount owed or a portion thereof and endorsed upon receipt. (2.11)			
20.	All checks are to be scanned in iNovah and should match the CD, the deposit slip in PeopleSoft and the PTBMIS "Cash Drawer Report". iNovah Cashiering Manual			
21.	Returned checks are handled according to procedure outlined by the Division of Fiscal Services of the Department of Health. (2.11.10)			
22.	No third-party checks written on personal bank accounts are accepted. (2.11)			
23.	Credit card payments are to be reconciled to the PTBMIS "Summary of Credit Payments Received Report" (CredSum Report).			
24.	Voided encounters, credit memos, debit memos and payment corrections are handled according to procedure. (2.3) (2.11.11)			
25.	The Division of Administrative Services' policy on Accounts Receivable is followed (2.7)			
	a. 3 rd Party and Individual Patient Billing			
	b. Collecting 3 rd Party deductibles			
	c. Collecting 3 rd Party Co-payments			
	d. Billing for patients who have TennCare and private insurance			
	e. Patients requesting local health department services in lieu of receiving services from their assigned/network provider.			
	f. Collection and write-off of Accounts Receivable			
	g. Claim for refund			
	h. Waiving private insurance billing non TennCare enrollees.			

* Numbers in parentheses () reference policies in the *Division of Community Health Services Policies and Procedures Manual*. Access CHSA Policy and Procedures Manual: <http://hsaintranet.health.tn.gov>

**TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF QUALITY IMPROVEMENT
RISK MINIMIZATION
Review Tool**

COUNTY/SITE#: _____ DATE: _____

REVIEWER(S): _____

 **2 Day Response required** Evaluation Code: X=Met, O=Not Met, NA=Not Applicable

Risk Minimization Guidelines	X, O, NA
<u>LABORATORY</u>	
1. A current copy of the <u>Laboratory Policies and Procedures Manual for Local Health Departments</u> is maintained in the laboratory area.	
2. Public Health Clinic Laboratory Practitioners perform on-site basic laboratory tests according to policies and procedures.	
3. Lab training certificate is available for each employee who performs lab procedures.	
4. Quality control tests are performed and documented according to the <u>Laboratory Policies and Procedures Manual for Local Health Departments</u> , with results maintained for at least 2 years. <u>Controls must be applicable to the brand of product being used.</u> Product package inserts will be retained with the applicable control test documentation. Package inserts will be followed regarding appropriate performance of tests or controls and correct storage of control solutions.	
5. Quality control results are documented as monitored weekly by the supervisor. Any errors noted will have appropriate corrective action taken and documented.	
6. Competency Evaluation and Proficiency testing or Comparison testing are performed appropriately for the clinic laboratory with a CLIA Provider Performed Microscopy (PPM) Certificate.	
7. Manufacturer operation instructions (owner's manuals) for laboratory equipment are available and followed as long as the equipment is in use.	
8. Correct holding temperatures for lab supplies and specimens requiring temperature sensitive storage are maintained and recorded. Temperature logs for lab supplies/specimen storage are retained for at least 2 years.	
9. Calibration is performed according to manufacturer's instructions to assure standardization of machines. Note: Scales will be calibrated at least quarterly. Follow owner's manual instructions for calibration requirements of digital devices such as scales, thermometers, blood pressure machines, other laboratory or patient care equipment.	
10. Preventive maintenance and repair logs for equipment are kept as long as the equipment is in use. Effective April 2000 <u>Laboratory Policies and Procedures Manual for Local Health Departments</u> . Appendices V page 21	
11. Laboratory specimens are collected, labeled and stored according to acceptable procedures prior to mailing or courier pick up. There is a system in place to track disposition of lab results. Lab request forms are completed correctly.	
12. Laboratory logs (hardcopy or electronic) are kept for all specimens mailed or forwarded to any laboratory for at least two years. <u>Laboratory Policies and Procedures Manual Appendices V page 19 PH-3283</u>	
13. Only laboratory and dental supplies with valid dates are available for use.	

<u>MEDICATION/VACCINE</u>	
14. All medications and vaccines are kept under lock except when authorized personnel are in attendance.	
15. Medications/vaccines are stored under proper conditions of sanitation, temperature, light, moisture, ventilation and refrigeration. CDC, Vaccine Storage and Management Toolkit November 2012	
16. Internal medications, injectables and topical preparations are stored separately from disinfectants and poisons.	
17. Drug labeling, packaging, movement and inventory procedures are performed appropriately. CHSA Policy 8.3.b and 8.3.c . http://hsaintranet.health.tn.gov	
18. When drug samples are allowed by regional policy, they are included in an inventory system.	
19. Medications /vaccines are inspected for removal of expired or deteriorated drugs, damaged labels and excess quantities of medications/vaccines. CHSA Policy 8.3.d http://hsaintranet.health.tn.gov	
20. Adverse drug events and vaccine adverse events are reported appropriately.	
21. Vaccine Information Statements (VIS) available in the clinic are current according to CDC Guidelines .	
<u>MEDICAL/DENTAL X-RAYS</u>	
Reference: Department of Environment and Conservation Division of Radiological Health Chapters 0400-20-04 , 0400-20-05 and 0400-20-06 and TB Guidelines, TDH, 2004	
22. All procedures are performed on request of a physician, dentist, nurse practitioner or follow specific program guidelines.	
23. Precautions are taken to expose only the portion of the body being x-rayed.	
24. Qualified service personnel do major maintenance and adjustments of x-ray equipment.	
25. X-ray equipment is inspected by a health physicist through the Division of Radiological Health every 2 years for medical x-ray and ever 4 years for dental x-ray.	
26. Proper storage of film and chemicals is maintained at all times.	
27. Film disposal is in accordance with regional/county contract with company.	
28. To ensure proper exposures, a technique chart is available and utilized for medical x-ray exams, except for photo timed exposures.	
29. Perform film development or digital receptor imaging according to the manufacturer's recommendations.	
30. Monitoring devices are worn by all employees while taking x-rays. (Not required for Dental employees)	
31. No woman who is known to be pregnant is x-rayed unless there is a written request by a physician who is aware of her pregnancy.	
<u>OCCUPATIONAL HEALTH/INFECTION CONTROL</u>	
Reference: Basic Guidelines of Infection Control for Regional and Local Health Departments , current edition http://hsaintranet.health.tn.gov	
32. The site complies with the Regional Exposure Control Plan and Infection Control Manual CHSA Policy 8.2.b	
33. Post Exposure incidents are handled according to Regional Exposure Control Policy. CHSA Policies 3.4 & 8.2.b	
34. Sharps are immediately discarded into appropriate sharps containers, which must be readily accessible. CHSA Infection Control Guidelines , Section IV	
35. Cleaning and disinfecting are done according to a written schedule. All equipment and contaminated work surfaces are decontaminated with an appropriate disinfectant as soon as feasible, as well as after any spill, and at the end of the work day. The spill kit is fully stocked and readily accessible to staff. CHSA Infection Control Guidelines , Appendices, General Housekeeping.	
36. Protective coverings, such as impervious paper used to cover patient assessment tables should be replaced after each patient. On work surfaces, it is replaced routinely and as soon as feasible when contaminated.	
37. All regulated wastes are contained in closable, leak proof, puncture resistant, and biohazard labeled or color-coded containers. CHSA Infection Control Guidelines	
38. Biohazard labels are used appropriately. CHSA Infection Control Guidelines	

39. Autoclave is used appropriately and cleaned regularly per manufacturer's instructions, and the required biological indicator testing is done each week the autoclave is used. Autoclaves are inspected annually. Infection Control Guidelines	
40. Sterilized items are appropriately wrapped, labeled, dated and stored to maintain sterility, and are within date. Sterilized items with expired dates are processed according to the Division of Community CHSA Infection Control Guidelines , Section 4	
41. Hepatitis B Vaccine is made available at no cost to all employees who have occupational exposure to blood or other potentially infectious materials within 10 working days of assignment. (Federal Register 29 CFR 1910.1030) "At risk" employees must sign an OSHA approved Declination Form if the choice is not to receive Hepatitis B vaccine. CHSA Policies 3.9 & 8.2.b	
42. One to 2 months after completion of the 3-dose vaccination series, employees are tested for antibody to hepatitis B surface antigen and non-responders (<10 mIU/ml) are revaccinated with a 3-dose series. TOSHA CL 02-02-069	
43. All employees, including part-time, contractual, and volunteers who have patient contact and are at risk of effective exposure, shall be screened for Tuberculosis. The Regional Health Officer shall determine the risk of effective exposure. CHSA Policy 8.2.a	
44. All employees, including part-time, contractual, and volunteers, born in 1957 or later shall show proof of immunity to measles, mumps and rubella viruses or be offered MMR immunization. CHSA Policy 8.2.c	
45. All employees, including part-time, contractual and volunteers, shall provide proof of immunity to Varicella. Those employees who are not immune shall be offered Varicella vaccine. CHSA Policy 8.2.d	
46. Manifests from hazardous waste disposal company are kept on file to document the hazardous wastes are removed from the clinic and discarded as per guidelines. All biohazard waste must be removed from the site by a licensed approved biohazard waste company. CHSA Infection Control Guidelines	
47. All appropriate public health staff are to be trained in Blood-borne Pathogens (OSHA) on an annual basis. The employer shall provide a training program to employees who have no prior experience in handling human pathogens. All training must be documented and retained for 3 years from the date on which the training occurred. (Federal Register 29 CFR 1910.1030).	
48. All appropriate public health staff are to receive MSDS training yearly. The employer shall provide a training program to new or newly assigned employees prior to their working in a work area containing hazardous chemicals. State of TN Hazardous Chemical Right To Know Law, T.C.A. 50-3-2001	☺
<u>SAFETY/SECURITY</u>	
49. The clinical facility promotes patient safety, i.e. cleaning supplies, sharps containers or other potential hazards are out of reach of children and electric plugs are covered. Rooms and closets do not contain discarded hazardous materials or other materials which pose a fire hazard.	
50. Appropriate public health staff must be prepared to respond to all disasters affecting the site. CHSA Policy 8.4.b	
If any of the indicators below are not met then #50 above is not met.	
A. A written plan must be in place describing response roles and responsibilities for responding to tornadoes, fires, earthquakes, ice storms, floods, etc.	
B. An Emergency Response Coordinator and back-up coordinator shall be named for each region and for each local health department site to coordinate any disaster affecting the site.	
C. All Local Health Department and Regional Office staffs are informed of necessary procedures for responding to site disasters.	
D. Simulated disaster drill (tornadoes, earthquakes, ice storms, flood, etc.) will be conducted every two years.	
51. Exit signs are clearly marked, tested and properly maintained. NFPA 101 Life Safety Code 2009	
52. Safety inspections are current for fire extinguishers. CHSA Policy 8.4.b	
53. Doors and hallways are free from obstructions. ADA Accessibility	
54. A fire drill is held at least annually. CHSA Policy 8.4.b	

55. Each site will be inspected annually by the local fire inspector and deficiencies requiring major financial expenditures shall be reported to the appropriate county and/or state authority. CHSA Policy 8.4.b	
56. Each site shall post in public, patient and staff areas an evacuation plan of that facility, complete with a floor plan indicating rooms, exits and location of fire extinguishers. CHSA Policy 8.4.b	
57. All appropriate public health staff must be prepared to respond to violence, threats of violence, harassment and other disruptive behavior. CHSA Policy 8.4.c	
If any of the indicators below are not met then #57 above is not met.	
A. Each site shall establish written plans indicating measures to be taken to maintain patient, public and staff safety from those who present a hazard to themselves or others.	
B. Protocols are in place for notifying response staff of a crisis and the need for immediate assistance.	
C. Police, emergency room and mobile crisis team numbers are to be readily available.	
D. All Local Health Department and Regional Office staffs are informed of procedures to manage workplace violence, threats and other disruptive behavior at the site.	
E. A simulated drill for responding to violence in the workplace will be conducted every two years.	
<u>MEDICAL RISK CONTROL</u>	
58. Standards of practice and protocols are developed, reviewed annually, updated when appropriate, approved by appropriate professional and administrative staff and signed by individuals practicing under the standard for each discipline providing clinical patient services.	
59. Emergency equipment/supplies are fully stocked and routine inspections are documented monthly. Expiring supplies are replaced in a timely manner. CHSA Policy 8.4.a	
60. An unannounced patient emergency drill will be held at least annually with a check sheet used for evaluation. The emergency kit and oxygen equipment will be at the site of an emergency within one (1) minute. CHSA Policy 8.4.a	
61. All licensed staff will maintain current certification in an approved cardiopulmonary resuscitation (CPR) course. Other health department staff will receive instruction in CPR as determined by each Regional Health officer. CHSA Policy 8.4.a	
62. Provisions are made to conduct annual fit testing of respirators and any additional fit tests in the event of physical changes in the employee that may affect respirator fit or in the event of damage to respirators in use. Masks are stored appropriately. Division of Community Health Services Respiratory Protection Program Manual	☺



Standards with this mark, if found deficient, require an immediate verbal response from the site supervisors indicating corrective plan of action. This is to be followed up with a written plan of action within 2 working days. See QI manual for guidance.

Access current CHSA Policy and Procedures Manual: <http://hsaintranet.health.tn.gov>

☺ **Corresponds with the end of computer data entry sections for this review.**

**TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF QUALITY IMPROVEMENT
TITLE VI
Review Tool**

County/Site#: _____ Date: _____

Reviewer(s): _____

Evaluation Code: X=Met, O=Not Met, NA=Not Applicable

Standards and performance indicators	X,O, NA	Comments, reason not met
1. Each clinic site will collect data in PTBMIS throughout the year concerning the primary language spoken by each patient. In addition, this information will be included in a prominent place in the medical record of each LEP (Limited English Proficiency) patient.		
2. Within 60 days of the end of each calendar year, a report will be developed by clinic site that includes: 1) Total number of persons served 2) For those persons for whom English is not the primary language: number served by language and percent of total served by language		
3. After reviewing the report, a determination will be made concerning the points of contact in each clinic at which interpreter services are needed.		
4. A written plan will be developed for each clinic site in order to assure effective oral language interpretation at all points of contact where language assistance is needed.		
5. The written plan should also include procedures for assuring interpreter competency.		
6. At the conclusion of the annual Title VI LEP assessment and planning process, a staff meeting should be held at each clinic site to review assessment results and the plan for meeting the needs of the LEP population. Documentation of the discussion and meeting attendees should be included as an attachment to the plan.		
7. Translated written materials (forms, brochures, state and federal posters, and educational materials) are updated as needed for LEP groups that constitute 5% or 1,000 persons whichever is less. Revised HHS LEP Guidance, September 17, 2007 (All posters may not be available in all languages)		
8. Notice is provided to the LEP person regarding free language interpretive service.		
9. Staff members having contact with LEP persons have been trained and are knowledgeable of LEP policy and procedure and demonstrate the ability to work effectively in person and with telephone interpreters.		

Reference: [CHSA Policy 7.21 http://hsaintranet.health.tn.gov](http://hsaintranet.health.tn.gov)

**TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF QUALITY IMPROVEMENT**

WIC REVIEW TOOL

COUNTY/SITE #: _____ DATE: _____ REVIEWER (S): _____

Evaluation Code: X=Met, O=Not Met, NA=Not Applicable

Guidelines/Standards	X	O	NA
1. Voucher printing security is maintained in compliance with federal regulations and Central Office instructions.			
A. Unopened packages or boxes of voucher paper are stored in a clean, dry and secure location.			
B. PHOA/Clerk signs off or secures the room anytime the terminal is left unattended by or out of the sight of that user (even if other staff is present).			
C. Printer is left loaded with voucher stock <u>only</u> if room is locked when no staff person is present. Acceptable to place paper tray in a locked closet, file cabinet, drawer, etc.			
2. Voucher issuance is documented in compliance with federal regulations and Central Office instructions.	Quantify Answers		
	#Met	#NM	#NA
A. Voucher receipts match the Voucher Receipt Reports.			
B. Receipts are either signed in ink by the recipient or marked "VOID." When part of the set is issued and part voided, the receipt is signed in ink and the voided vouchers are clearly designated as such with brackets or arrows, with the notation dated and initialed.			
C. Receipts for all issued vouchers have proof of ID for person signing.			
D. Receipts are traced to voids and voids to receipts for vouchers printed and voided on the same day.			
E. No more than three months of vouchers are issued except at initial certification. See Chapter 1 page 5 under <u>Transfer of Participants</u> of the current WIC Manual for the definition of initial certification.			
F. Receipts are filed by date, user ID, and then by receipt number order. They are held in clinic at least one year until submitted according to instructions. Met/Not Met			
3. Voided vouchers are documented in compliance with federal regulations and Central Office instructions.	Quantify Answers		
	#Met	#NM	#NA
A. "VOID" is stamped or written on the face of each voided voucher.			
B. Voided vouchers match the Voided Vouchers Report.			
C. Voided vouchers are filed by date, user ID and then the order in which they are listed on the report. They are held in clinic at least one year until submitted according to instructions. Met/Not Met			
4. Voucher reports and Accountability Reports are maintained in compliance with federal regulations and Central Office instructions.	Quantify Answers		
	#Met	#NM	#NA
A. Voucher Receipt Reports are run every day or include every day of the week. Time locked days may be excluded.			
B. Voided Voucher Reports are run every day or include every day of the week.			
C. Reports are checked against receipts and voids the same day they are run. They are dated and initialed to document.			
D. Receipt and Void Voucher Reports are filed first by date and then by user ID. Reports are held in clinic until approved disposal. Met/Not Met			
E. Regular monitoring of voucher receipts and voids is documented on a review form, showing beginning and ending dates, and is signed by someone other than a person who issued vouchers. Met/Not Met			

Access current [WIC Manual](http://hsaintranet.health.tn.gov): <http://hsaintranet.health.tn.gov>