

QUALITY IMPROVEMENT MANUAL



**Twenty First Edition
July 2013**

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

**Tennessee Department of Health
Office of Quality Improvement
2013-2014**

Community Health Services Administration

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The Contact individuals listed in this manual with a Cordell Hull address will be relocating to the Andrew Johnson Building after 9/1/13. Telephone numbers are to remain the same. The address will then be:

Andrew Johnson Building
7th Floor (Dental, Lab, OSHA/TOSHA, Pharmacy)
3rd Floor (TB and Immunizations)
710 James Robertson Parkway
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TABLE OF CONTENTS

	<u>PAGE</u>
Quality Improvement Plan -----	1
I. Quality Improvement Goals and Objectives -----	1
1.1 Goal -----	1
1.2 Objectives -----	1
1.3 Scope -----	1
1.4 Specific Activities -----	1
1.5 Performance Cycle -----	2
1.6 Peer/Provider Review -----	3
II. Quality Improvement Process -----	3
2.1 Regional/Local Practice Guidelines -----	3
2.2 Analysis of Clinical Care -----	4
2.3 Plan of Action -----	5
2.4 Action Plan Effectiveness -----	7
2.5 Annual Quality Improvement Reports -----	7
III. Quality Improvement Oversight -----	7
IV. Quality Improvement Structure -----	8
V. Provider Training and Participation -----	10
VI. Internal Administration Systems -----	10
6.1 Personnel Records -----	10
6.2 Leave and Attendance Records -----	10
6.3 Training and Orientation -----	10
6.4 Credentialing and Re-credentialing -----	10
6.5 Posters -----	10
6.6 Administration Standards – New employee orientation / Posters -----	11
6.7 Administration Standards – Personnel/time/travel/ Credentials -----	13
VII. Availability of Services and Patient Rights -----	16
7.1 Availability Standards -----	16
VIII. Medical Records Systems -----	17
8.1 Medical Records -----	17
8.2 Recordkeeping -----	17
8.3 Medical Record Standards/Encounter Data -----	17
8.4 Record Review Process -----	17
8.5 Comprehensive Health Maintenance Standards and Performance Indicators-----	18
8.5.1 Encounter Medical -----	19
IX. Internal Financial Systems -----	20
9.1 Fiscal Review Standards -----	20
X. Risk Minimization -----	22
10.1 Risk Minimization Standards -----	22
10.1.1 Laboratory -----	22
10.1.2 Medication/Vaccine -----	23
10.1.3 Medical X-Ray -----	23
10.1.4 Occupational Health/Infection Control -----	24
10.1.5 Safety and Security -----	25
10.1.6 Medical Risk -----	26
XI. Title VI -----	27
11.1 Title VI Standards -----	27
XII. WIC Voucher Control -----	28
12.1 WIC Standards -----	28
XIII. Coordination with General Management -----	29
Appendix A	
Sample Design -----	31
Random Sample Size grid -----	32
Appendix B - Patient Satisfaction Survey	
2006 English version -----	34
2006 Spanish version -----	36
Appendix C - Immunization Schedules & VIS Links	
Quality Improvement	

Internet Links to access schedules and VIS Information -----	39
Vaccine Information Statements and Acceptable Version Dates (sample) -----	40
Appendix D	
Periodicity Chart -----	43
Appendix E	
Central Office Contact List -----	45
Appendix F	
High and Low TB Incidence Countries -----	47
Appendix G	
PHN Public Health Drug Formulary -----	55

Tennessee Department of Health Office of Quality Improvement

Mission Statement: To protect, promote and improve the health and prosperity of people in Tennessee.

Quality Improvement Plan

I. Quality Improvement Goals and Objectives

1.1 Goal

The Office of Quality Improvement establishes a foundation for continuous evaluation and facilitates the process of continuous improvement of Public Health services in all ninety-five Tennessee counties, including the metropolitan areas. Quality Improvement (QI) strives to link evaluation, accountability, quality improvement, and the practices of science.

1.2 Objectives

1. To evaluate the public health system
2. To hold the public health system accountable to set standards
3. To use best-practices and evidence-based science in all aspects of the public health system
4. To pursue opportunities for improvement on a continuous basis in order to assure and enhance the quality of the public health system both centrally and locally in Tennessee.

1.3 Scope:

1. The QI Plan addresses and evaluates components of clinical care, emphasizing the following specific clinical areas twice each fiscal year:
 - Childhood/Adult Immunizations
 - Comprehensive Program medical record reviews involving all ages and clinical programs
 - Risk Minimization - Lab clinical policies and procedures, i.e. quality control testing, assessment of lab/dental supplies
 - Additional evaluations may be conducted at state, regional and/or local discretion.
2. The QI Plan measures other clinical and non-clinical aspects of service annually, including the following areas:
 - Administration
 - Availability of Services and Patient Rights
 - Comprehensive Medical record and Encounter review follow-up
 - Fiscal
 - Risk Minimization – Lab, Pharmacy/vaccine, x-rays, occupational health/infection control, safety/security, medical risk control
 - Title VI
 - WIC Vouchers

1.4 Specific Activities

Individuals are to be identified as the Quality Improvement Directors or Coordinators for each Regional Office. Coordination of Quality Improvement in sections, offices and divisions of the Tennessee Department of Health will be dependent upon review cycles [CHSA Policy 6.2](#). Clinical quality of care studies and reviews of non-clinical aspects of service will operate on a continual basis throughout the review cycle. Quality Improvement activities will include one or more of the following:

Data Collection

Peer/provider reviews
Encounter/Medical Record reviews

Focus studies
Patient flow analysis
Patient satisfaction surveys
Computer generated reports

Analysis

Analysis of appropriateness of care
Identification of health outcomes
Compliance with established policies, procedures and program guidelines

Planning

Plan for corrective actions
Implementation of corrective action plans

Evaluation

Assessment of corrective action appropriateness and efficacy

Regional Quality Improvement Directors/Coordinators are to maintain in addition to the current fiscal year's QI databases, reports and responses, at a minimum, the 3 most recent fiscal year databases along with the generated reports and responses to reviews. This allows for analysis and comparison of compliance and the efficacy of corrective actions implemented. Other staff members that assist with or complete QI reviews such as Administration and Fiscal Specialists, WIC Directors, or Human Resources Officers are to also maintain their files as stated above. Coordination of data sharing from these reviews by other staff members is the oversight of the Regional Quality Improvement Director/Coordinator. Databases are to be routinely backed up according to regional Office of Information Technology (OIT) instructions and all printed reports should be maintained in a secure location of limited access. Printed reports should be shredded as method of disposal.

The Quality Improvement staff across the state is not responsible for the initial creation of procedures, policies or standards but is to review for these directives as developed by Federal, State, the Division of Community Health Services Administration and/or by the individual Department of Health Program Directors and staff. The Office of Quality Improvement's participation in the planning and development of any policy, procedure or standard is always available on the local, Regional or State level upon request.

1.5 Performance Cycle

QI reviews will occur continually for all health services delivered in regional and local sites. Other special areas for review may be identified according to patient populations and focus study concerns. All results will be statistically analyzed with appropriate trends and actions identified.

Reviews are usually conducted on the following schedule but may be conducted at the discretion of the Regional Quality Improvement Director, as long as all reviews are completed and submitted annually:

Reviews:	July – Dec. Cycle	Jan. – Jun Cycle	Date Due in to Central Office
Administration Review 1-4	Reviewer's Choice	Reviewer's Choice	July 15th
Administration Review 5-7 (Metros are excused from this review)	Reviewer's Choice	Reviewer's Choice	July 15th
Availability of Services	Reviewer's Choice	Reviewer's Choice	July 15th
Comprehensive Medical Record Review - Focus 01 (Query of all programs)	X		Jan. 15th
Comprehensive Medical Record Review - Focus 02 (Follow-up or select program review of 10 records)		X	July 15th
Encounter/Medical (completed with any Comprehensive Medical Record Review)	X	X	Jan. 15 th and July 15th
Fiscal Metros are excused from this review	Reviewer's Choice	Reviewer's Choice	July 15th
Patient Satisfaction Survey (Metros may use their own tool) 5 clinic days of each calendar year CHSA Policy 7.19	Reviewer's Choice	Reviewer's Choice	December 31
Risk Lab Follow-up	X		Jan. 15 th
Risk Minimization		X	July 15PP ^{trpp}
Title VI	Reviewer's Choice	Reviewer's Choice	July 15 th
WIC Medical Record Review - 10 Records are reviewed in each WIC Clinic annually - WIC Manual section 6 page 16	Reviewer's Choice	Reviewer's Choice	July 15 th
WIC Voucher Review - WIC Manual section 6 page 16	Reviewer's Choice	Reviewer's Choice	July 15 th

1.6 Peer/Provider Review

The Quality Improvement plan utilizes a peer/provider review process, which includes all support staff, health professionals and health care providers involved in service delivery. Peer/provider reviews will be designed to establish feedback to health professionals and health care providers concerning (1) adherence to practice guidelines and (2) appropriateness of care.

II. Quality Improvement Process

2.1 Regional/Local Practice Guidelines

QI studies will assess service provision against practice guidelines specified for each identified standard area of review. The following public health practice guidelines will be utilized in the evaluation process. Manuals on the CHSA Manual Webpage are available at this link unless referred to another source location: <http://hsaintranet.health.tn.gov/default.asp>

- ◆ [Attendance and Leave Policies and Procedures](#) – current version available from the [Department of Human Resources](#) website
- ◆ [Breast and Cervical Cancer Guidelines](#), Current revision

- ◆ Care Coordination Manual – CSS and Care Coordination Policy Manual 2005 with 2009 and 2011 updates
- ◆ Child & Adolescent Health Manual – 2002
- ◆ Contraceptive Technology – current version
- ◆ Current Procedural Technology (CPT) Manual – Current Year
- ◆ [Standards of Practice for Dental Public Health](#) – 2011 or more current version
- ◆ Early Childhood Caries Prevention, A [Fluoride Varnish Program for Public Health Nurses](#), current version on line
- ◆ [EPSDT Manual](#) - current on line version (2009 or later)
- ◆ Ferri's Clinical Advisor (current edition but not older than 2 years)
- ◆ [CHSA Policies & Procedures Manual/Regional Policies & Procedures Manual](#) – current edition on line
- ◆ [HUGS Program Guidelines](#), current edition on line – Sept. 2011 or later
- ◆ ICD-9 Coding Manual – current calendar year version
- ◆ [Advisory Committee on Immunization Practices \(ACIP\), standards for Adult, Child and Adolescent Immunizations](#)
- ◆ [Infection Control Manual](#), 5th edition 2002 or current edition on line
- ◆ Laboratory Manual – current edition
- ◆ Tennessee Department of Health [New Employee Handbook](#)
- ◆ [Public Health Nurse Protocols](#) – current edition on line on CHSA Manual Webpage
- ◆ [Public Health Nursing Orientation & Practice Manual](#) – on line is 2005 version, current hard copy edition (2007)
- ◆ [Primary Care Services Guidelines](#) on line – May 2010
- ◆ [Quality Improvement Guidelines](#) 21st edition – 7/2013
- ◆ [HIV/STD Prevention Program Guidelines](#), current edition on line 5/2012
- ◆ [STD Treatment Guidelines](#), current version on STD Website 2010
- ◆ Department Of Finance and Administration Policy 8 - [Comprehensive Travel Regulations](#) – August 2012
- ◆ [Tennessee Code Annotated](#)
- ◆ [Tuberculosis Elimination Guidelines](#) - current edition 9/2004
- ◆ [WIC Manual](#) – current edition on line
- ◆ [Family Planning Clinical Guidelines](#), January 2011– current edition on line
- ◆ [PTBMIS Codes Manual](#) – 5/2010 edition on line
- ◆ [Vaccines for Children \(VFC\) Program Protocol](#) January, 2013 (updated annually)
- ◆ [Vaccine Storage and Handling Guide](#), current edition November 2012
- ◆ [Record retention and destruction information](#) – statewide 3/28/2011 RDA information

These public health practice guidelines are continually reviewed and updated by appropriate provider levels and programs. The guidelines focus on appropriateness of service and optimum health status. The practice guidelines are available to all health professionals in all clinic sites.

2.2 Analysis of Clinical Care and Non Clinical activities

Appropriate health professionals will evaluate quality through studies and analysis of the identified clinical areas of concern and related services.

Multidisciplinary teams composed of local, regional and central office members will address problems and problem resolution. Clinical areas of concern requiring improvement will be identified and resolved at the service delivery level through interactive plans of action.

Non clinical areas of related services such as Administration and Fiscal will be evaluated by appropriately trained individuals through the QI review processes and any areas of concern will be addressed by local, regional and central office supervisory staff. Areas for improvement identified through studies and analysis will be resolved at the service delivery area through interactive plans of action.

2.3 Plan of Action

The reviewer is to provide the county/site a Summary of Strengths and Concerns along with the statistical review reports prior to or during the exit conference. A separate comment section may be used by the reviewer to more fully document findings. These reports will be presented in an organized manner to the reviewed Local Health Department's supervisory staff to include the County Director, Nursing Supervisor and Public Health Office Supervisor (or those available) for the local health departments. Copies of the reports are to be provided to the Regional Supervisory staff and the State QI Director. Regional Office review reports should be presented to the Regional Director, Regional Medical Officer, Regional Nursing Director and the Regional Clerical Consultant and the State QI Director. Additional participants may be invited to the exit conference at the discretion of the supervisory staff of the reviewed site/regional office. Participation by the entire reviewed site's supervisory staff is encouraged but participation may be limited due to scheduling conflicts. The exit conference should be scheduled as soon as possible following the completion of each review. The method for the exit conference can be face-to-face (preferred), teleconference, webinar, or by telephone. The reviewed site should be consulted as to their desired method for the exit conference and every effort made by the reviewer to comply with the site's preferences and scheduling needs.

A plan of action will be developed by the county/site supervisory staff or designated personnel for situations identified by the reviewer to be met at less than 90% or which require improvement. The county/site will develop a plan of action report which is due into the regional office within 30 days of receipt of review results provided during the exit conference. Challenges to any review findings should be addressed in writing to the reviewer prior to the 30 day report date. Actions to be taken will be specified along with expected timelines of resolution, expected facilitators and resources clearly identified. The plan of action report will be sent electronically to the Regional Quality Improvement staff and State Quality Improvement Director. The exception to the 30 day report is in the case of identified dental and lab deficiencies, TOSHA deficiencies and pharmaceutical/vaccine deficiencies reported for the standards listed below. An immediate verbal plan of action is to be given at the time of the reported findings and a written plan of action report is to be submitted electronically within two working days addressing these critical issues.

The plan of action for any 2 day required response should indicate if any patients or employees were affected, what steps were involved in correcting this situation, how patients or employees were notified, and what corrective action was taken to prevent this in the future. Should identifying patients and calling them in for any additional testing or evaluations take more than two days, state on your two day plan of action report what steps you have taken up to that point and that further information will be sent in a following document.

LAB OR DENTAL DEFICIENCIES:

Lab or dental standards requiring an **immediate verbal plan of action when found deficient are:**

4. Quality control tests are performed and documented according to the current lab manual.

13. Only laboratory and dental supplies with valid dates are available for use.

Quality Improvement Staff should notify Clinical Services and Disease Management's Lab Coordinator, the Regional Medical Officer, Regional Director and Regional Nursing Director immediately upon finding the deficiency. The Regional Dental Director is to be notified when expired dental supplies are found. (See Appendix E for state contact list)

This verbal plan of action is to be followed by a written plan of action report within two working days and should be prepared in consultation with and copied to the Regional Lab Director or Regional Dental Director, Regional Director, Regional Medical Officer, Regional Nursing Director, and Regional Quality Improvement Director. A Copy of the 2 day written report is to be sent electronically to the Clinical Services and Disease Management

Medical Director, State Director of Nursing, State Quality Improvement Director, and State Lab Coordinator and/or State Dental Director (See Appendix E for state contact list).

MEDICATIONS / VACCINES/TB SKIN TEST:

Drug room/Regional Pharmacy and vaccine standards (This would include the proper storage and maintenance of the TB Mantoux solutions.) that require an **immediate verbal plan of action when found deficient are:**

15. Medications/vaccines are stored under proper conditions of sanitation, temperature, light, moisture, ventilation and refrigeration.

19. Medications/vaccines are inspected for removal of expired or deteriorated drugs, damaged labels and excess quantities of medications/vaccines.

Quality Improvement Staff should notify Regional Director of Pharmacy, Regional Immunization Coordinator (if vaccine related), Central Office VFC/Affix Coordinator (if vaccine related), State Director of Pharmacy, the Regional Medical Officer, Regional Director, Regional Nursing Director, State Quality Improvement Director, **immediately** upon finding the deficiency along with any other regional and state programs (i.e.TB) that were affected. (See Appendix E for state contact list)

This verbal plan of action is to be followed by a written plan of action report within two working days and should be prepared in consultation with and copied to the Regional Director, Regional Medical Officer, Regional Nursing Director, Regional Immunization Coordinator (if vaccine related), Regional Pharmacist, and the Regional Quality Improvement Director. A Copy of the 2 day written report is to be sent electronically to the Clinical Services and Disease Management Medical Director, State Director of Nursing, State Director of Quality Improvement, State Director of Pharmacy, the Central Office VFC/Affix Coordinator and State Medical Director for Immunization Program (if vaccine related), along with regional and state programs that were affected. (See Appendix E for state contact list)

TOSHA DEFICIENCIES:

TOSHA standards that require an **immediate verbal plan of action when found deficient are:**

33. Post exposure incidents are handled according to Regional Exposure Control Plan.

34. Sharps are immediately discarded into appropriate sharps containers, which must be readily accessible.

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 workday. The spill kit is fully stocked and readily accessible to staff.

Quality Improvement Staff should notify State Clinical Services and Disease Management OSHA/TOSHA Coordinator, the Regional Director, Regional Medical Officer and Regional Nursing Director immediately upon finding the deficiency.

This verbal plan of action is to be followed by a written plan of action report within two working days and should be prepared in consultation with and copied to the Regional Safety Coordinator, Regional Director, Regional Nursing Director, Regional Medical Officer and Regional Quality Improvement Director. A Copy of the 2 day written report is to be sent electronically to the State Director of Nursing, Clinical Services and Disease Management Medical Officer, State Quality Improvement Director and Clinical Services and Disease Management OSHA/TOSHA Coordinator. (See Appendix E for state contact list)

ALL DEFICIENCIES:

Less than the usual thirty (30) day report response may be requested by the Regional or State Quality Improvement Director for any standard if deficiencies persist. Any standard that shows persistent deficiencies could require a similar two-day plan of action at the discretion of the State Quality Council.

Action planning will occur at the appropriate Quality Improvement level, with total oversight for unresolved areas of concern the responsibility of the State Quality Council. Feedback will routinely be disseminated to all appropriate levels of staff. All 2 day and 1 month County and Regional Plan of Action Reports should be sent electronically to State Director of Quality Improvement. A three month follow up report showing the efficacy of the one month plan of action is to be sent electronically to the Regional Director, Regional Nursing Director, Regional Medical Officer, Regional Clerical Consultant, and Regional Quality Improvement Director. This report is due to the Regional Directors 3 months from the receipt of the review results at the time of the exit conference. The annual Regional Plan of Action is due into the State Quality Improvement Director by August 15th of the current year. The Regional Plan of Action Report is created by the Regional Directors, Consultants, Coordinators and Officers with assistance from others within the region as deemed appropriate.

2.4 Action Plan Effectiveness

Plans of actions will be monitored by the Quality Improvement Directors/Coordinators to assure changes have been made and that the changes have, in fact, resolved the situation. In instances where resolution is less than optimum as evidenced in the one and/or three month Plan of Action Reports, county/sites and the Regional Committee may be instructed to develop additional corrective action plans or revise the current plan of action.

2.5 Annual Quality Improvement Reports

Annually, Central Office and regional Quality Improvement staff will generate summary Quality Improvement reports. Specific analyses and trends will be identified, as well as action plans initiated during the review cycle. Demonstrated improvements will be highlighted along with areas requiring further improvement. This report will be presented at the annual meeting of the State Quality Council in a timely manner.

III. Quality Improvement Oversight

The Division of Community Health Services Administration (CHSA) has established membership of the State Quality Council, which will provide Quality Improvement oversight, along with Central Office Quality Improvement staff. Regional Quality Teams have been established to facilitate and coordinate Quality Improvement activities at regional and local levels. Quality Units are functional at local levels with team members empowered to resolve problems whenever possible.

The State Quality Council will review, on an annual basis, State Summary reports of Quality Improvement activities, including aggregate trends and recommendations from Quality Units and Quality Teams. Modifications to the Quality Improvement Plan may occur as a result of the review process.

IV. Quality Improvement Structure

Local Quality Units

(Meet as needed)

County Director, Nursing Supervisor,
Public Health Office Supervisor, etc.

Regional Quality Teams

(Meet quarterly or as needed)

(Appointed by Regional
Director)

Regional Director, Regional Health Officer,
Regional Nursing Director, Regional Clerical
Consultant, Regional QI staff, and
Representation from Medical, Nursing, Fiscal,
Administrative, Nutrition, Dental, Programs, etc.

State Quality Council

(Meet annually)

Assistant Commissioner for CHSA, CHSA
Medical Officer, CHSA Nursing Director,
Appointed by CHSA and CHSA Division/Section
Chiefs, Regional and Local Health Director,
Regional State QI Director and/or County
Representatives (Directors, Nursing Supervisors,
Clerical Consultants/Supervisors and QI Directors),
and others as appointed annually

Quality Staff

(Meet quarterly or minimally
face-to-face June and
December)

Central Office Support Staff for Regions and
Programs as indicated, Regional QI
Directors/Coordinators and team members,
State QI Director

Travel restrictions may limit or alter above meeting participants, intervals or require meetings to be held as teleconferences or webinars instead of face-to-face meetings on an as needed basis. Attendance of all Regional QI Directors/Coordinators is expected at State Quality Staff meetings. If attendance is not possible by the Regional QI Director, a Regional representative can be selected by the Regional Supervisory staff to attend the meeting in place of the Regional QI Director. The State QI Director should be notified as soon as possible when substitutions are planned.

Office of Quality Improvement Structure

Division of Community Health Services Administration

Local Quality Unit



**Regional Quality
Committee**



**State Quality
Council**

V. Provider Training and Participation

Central Office and Regional Quality Improvement staff will inform all providers about the Quality Improvement Plan with continual updates as necessary. Orientation for new Regional Quality Improvement Directors/Coordinators will be provided by the State Quality Improvement Director. The State Quality Improvement Director will also be available to provide QI review training to any support staff within a region upon request. The current [Quality Improvement Manual](#), [Appendices](#), and [Interpretive Guidelines](#) will be readily available to all providers in hard copy or on the CHSA Intranet link: <http://hsaintranet.health.tn.gov/default.asp>

VI. Internal Administration Systems

Designated members of the Quality Team will conduct internal administration system evaluations. Items to be reviewed include the following:

- 6.1 Personnel records will be evaluated against Human Resources policies and procedures issued by the Office of Human Resources and Department of Health, Division of Community Health Services Administrative Policies and Procedures.
- 6.2 Leave and attendance records will be evaluated against [Attendance and Leave Policies and Procedures Manual](#) issued by the Office of Human Resources and the Department of Health, Division of Community Health Services Administrative Policies and Procedures and any local guidelines applicable to county, contract or other non-state employees.
- 6.3 Training and Orientation
- 6.4 Credentialing and Re-credentialing
- 6.5 Posters

The standards and references to be used for the Administration Review follow with the list of required posters and qualifications for credentials.

6.6 ADMINISTRATION STANDARDS for Administration Reviews

Review Questions 1-4

Policies and Procedures

1. Employees are aware of the Policies and Procedures Manual for the Division of Community Health Services Administration (CHSA) and are able to access an up-to-date hardcopy or access it electronically. [CHSA Policy 3.7.c](#)

Orientation

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 Policies and Procedures Manual 3.7.c](#) or Metro Policies and Procedures)
 - A. Regional staff in charge of Human Resources 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, offices, sections and programs within the Division of Community 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 Administration.
 - 3) Policies and procedures of the Division of Community Health Services Administration as well as specific program policies. <http://hsaintranet.health.tn.gov/default.asp>
 - 4) Employee HIPAA and confidentiality requirements.
 - 5) Quality Improvement standards and other specific program standards.

Employee Records

3. Employee records are maintained at designated base worksite and/or Regional Office in an assigned secure location with limited access.
 - A. Human Resources files. ([CHSA Policy 3.9](#))
 - B. Attendance and Leave records. [Attendance and Leave Policies and Procedures Manual](#)
 - C. Travel reimbursement claims. <http://tennessee.gov/finance/act/documents/policy8.pdf>

Posters

4. Required posters are present in appropriate area.

P = Display in Public Area

E = Display in Employee Area

◇ = Required State Poster

◆ = Required Federal Poster

The state and federally required posters may be combined in a commercially prepared laminated poster which contains multiple posters. The Federal posters can also be obtained free online by going to the following link: <http://www.dol.gov/oasam/programs/osdbu/sbrefa/poster/matrix.htm> and be posted individually and the state required poster may be obtained free online by going to the following link: <http://www.tn.gov/labor-wfd/poster.htm>

The laminated poster can be purchased from Labor Law Center, at www.GovDocs.com. Needed posters may be able to be obtained by contacting the Workforce Development representative in your area. http://www.tennessee.gov/labor-wfd/et_dw_map.pdf

These posters are hyperlinked or listed with resources to contact when replacements or additional posters are needed. CHSA Policies are hyperlinked or you may access the entire [CHSA Policy](http://hsaintranet.health.tn.gov/default.asp) manual at: <http://hsaintranet.health.tn.gov/default.asp>

- 1) ♦ [“Equal Employment Opportunity is the Law”](#) 11/2009 (P)
- 2) ♦ [“Your Rights Under the Family and Medical Leave Act of 1993”](#) revised 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 may be included on the commercially obtained multi-poster. 11/1/2000 (E)
- 5) ◇ [“Tennessee Law Prohibits Discrimination in Employment”](#) 10/2008 (P)
TN Human Rights Commission, (615) 741-5825 Dept. of Labor & Workforce Development
- 6) [State of Tennessee Executive Order by the Governor #3](#), An Order Concerning Equal Employment Opportunity. 1/15/2011 (TN Department 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 (P)
- 11) Services are available on a sliding fee scale basis. Post in reception area. ([CHSA Policy 7.9](#)) ([CHSA Policy 7.22](#)) (P)
- 12) Clinic Hours and Names of Direct Care Staff on Duty ([CHSA Policy 3.10](#)) <http://hsaintranet.health.tn.gov/Login.asp> (P)
- 13) Name and telephone number of nearest Poison Control Center [Tennessee Poison Center](#) – 1-800-222-1222 (P)
- 14) Equal Opportunity is The Law, Title VI Section 601, of the Civil Rights Act of 1964, Dept. 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 Tennessee Department of Health 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](#) (P) and (E)
- 18) Copy of the Department’s Non-Discrimination Affirmative Action Policy Quality Improvement (P) and (E)
7/1/13

Statement. Department of Health's Affirmative Action Plan

- 19) ["Workplace Harassment Policy"](#) Revised December 4, 2012 (P) and (E)
TN Department of Human Resources (615) 741-6350
- 20) ◇ [TN Unemployment Insurance Poster](#) 6/2013 (E)
Dept. of Labor & Workforce Development
- 21) ◇ [Workers' Compensation Posting Notice](#) – Revised 3/2012 (E)
Dept. of Labor & Workforce Development
- 22) [OSHA 300A Summary Form](#) to be posted each February, March and April. (E)
TN Department of Labor & Workforce Development, (615) 532-1345
- 23) ♦ [Your Rights Under USERRA, the Uniformed Services Employment and Reemployment Rights Act.](#) U.S. Dept. of Labor, VETS October 2008 (E)
- 24) [State Regulations for Protection Against Radiation \("Notice to Employees"\)](#), (E)
Form RHS 8-3 is posted as required by law. See page 15 of linked document
Revised 5/2012.
- 25) ♦ [Know Your Rights Under the Recovery Act! - Federal Whistle Blower poster](#) (E)
(for copy of the [Recovery Act](#), activate Recovery Act link) Not available at this
time in Spanish language as of 5/13/13.
- 26) ◇ [Reporting TennCare Fraud and Abuse](#) - TennDent sites required to post either (P)
poster or TennDent notice memo dated 5/13/2011 - both are not required

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.

6.7 ADMINISTRATION STANDARDS for Administration Reviews

Review Questions 5-7

Departing Employees

5. **Notification of an employee's departure from our employment is to be submitted in writing to the Division Office along with all required accompanying paperwork.** [CHSA Policy 3.17](#)
<http://hsaintranet.health.tn.gov/default.asp>
 - 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. These documents may be retained in the local/regional personnel record or sent to the Central Office Human Resources officer. These

documents are to be retained for a minimum of 3 years. *Note that not all of these items will pertain to every employee.*

- 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.

Attendance and Leave

6. Employees' (state, local, contract) attendance and leave/time distribution reports are current and accurate. [CHSA Policies and Procedures Manual 3.3](#) and [Attendance and Leave Manual](#), Tennessee Department of Human Resources State employees' attendance and leave will be self-entered into the Edison Project system for Supervisor approval and management. Edison Project files are not accessible by the QI Reviewers.

- A. Copies are present at the site where leave is keyed, for all pay periods (3 years)
- B. The current attendance and leave form shows:
 - 1) Daily hours worked.
 - 2) Accurate pay period calculations.
 - 3) Fully completed and accurate footings where applicable.
 - 4) Signatures of employee, supervisor, and timekeeper (optional) for all pay periods.
- C. The current attendance and leave form correlates with travel claims.
- D. Approved documentation for changes in regularly assigned workweek is present.

Personnel File

7. Each state, local or contract employee's personnel file contains copies of relevant documents. (Every file will not contain every document.) [CHSA Policy 3.9](#)

◆ = documents that are not required for non-state employees (but may be present or these may be held in the county government's personnel department and not available for review).

The Edison Project system will contain some of these documents. The use of some forms may be discontinued as they are replaced by Edison processes.

- 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; or copies of emails. ◆
 - 2) EEO form with appropriate committee signatures-PH 1454. (1987) ◆
 - 3) If hired on or after November 7, 1986, Employment eligibility verification, including copies of proof-I-9. ◆
- C. Title VI of the Civil Rights Act of 1964 (9/2003) and/or Title VI Completion Certificate (4/2013) ◆
- D. A copy of the completed PRT-3 form showing the employee's report information ◆
- E. A copy of the employee's current Job Performance Plan. (signed) This document is held in the Edison system for state employees. ◆
- F. Copies of the employee's Performance Evaluation Forms with proper signatures and dates. This document is held in the Edison system for state employees. ◆
- G. PH-2003 flexible work schedule form for the employee (applicable only for employees working a schedule other than 8-4:30 with supervisor's approval). (8/99) ◆

- H. A copy signed 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), and 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 (4/05)
- J. Acceptable Use Policy Version 1.13, April 9, 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 # for those whose name is on billing statements only). See CHSA Policies [3.9](#), [3.18](#), [8.6.b](#) and credential checklist.
 - 1) This employee requires licensure or certification renewal at specific intervals.
 - 2) A copy of current license or certificate has been provided.
 - 3) Renewal date of license or certificate is:

CREDENTIALS CHECKLIST

At the time of employment, individuals must meet the experience and academic qualifications as stated in the State Job Specifications for the job for which they are employed. In addition, some disciplines require licensure and certification at specific intervals. [CHSA Policy 8.6.b](#)

DISCIPLINE AND PROGRAM REQUIREMENTS:

AUDIOLOGIST

Master's degree in Audiology including practicum

DENTIST

- A. Tennessee Dental License
- B. Annual registration for re-licensure
- C. DEA Number
- D. NPI Number

DENTAL HYGIENIST

- A. Tennessee Dental Hygienist License
- B. Annual registration for re-licensure

NURSE

- A. Licensed personnel maintain current renewal certificates to practice in Tennessee.
- B. Licensed personnel who are required to be certified to practice maintain certification.
- C. Nurse practitioner who prescribe and/or issue drugs, must have a Certificate of Fitness from the Tennessee Board of Nursing and current Board Certification.
- D. NPI Number

PHYSICIAN

- A. MD/OD/DO License
- B. Renewal and registration of license as required by T.C.A.
- C. DEA Number
- D. NPI Number

PHARMACIST

Current Tennessee license

RADIOLOGICAL TECHNICIAN

Current certification

REGISTERED DIETITIAN

Current ADA Registration for Registered Dietitian

VII. Availability of Services and Patient Rights

All individuals will be made aware of their rights, such as the right to equal access, the right to quality care, and the right to make suggestions. Individuals have a responsibility to be active participants in developing and implementing their plan of care. Patient Satisfaction Surveys are conducted annually. Health services will be available for routine care, referral and follow-up. The standards and references to be used for this review follow.

7.1 AVAILABILITY OF SERVICES AND PATIENT RIGHTS REVIEW STANDARDS

1. **A patient satisfaction survey system is conducted each calendar year for a period of 5 working days.** [CHSA Policy 7.19](#) <http://hsaintranet.health.tn.gov/default.asp>
2. **State and local governments give people with disabilities an equal opportunity to benefit from all of their programs, services and activities.** (American Disabilities Act)
<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 [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.a](#), [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](#)
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, page 1-2.1
 - D. STD services are readily available.
 - E. Clients applying for WIC are seen in an appropriate time [WIC Manual](#) Section 1 page 4, Federal Processing Standards [[7CFR 246.7 \(t\) \(2\) \(iii\) \(A\)](#)]
 - 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 are within 48 hours for urgent care. (Citation: both a and b are from the TennCare Contract, Attachment IX, Terms and Conditions for Access)

VIII. Medical Records Systems

8.1 Medical Records

Medical records are available to health care professionals at each clinic site according to the Division of Community Health Services Administrative Policies and Procedures Manual. Medical Records include paper and electronic mediums. [CHSA Policy 5.1.a](#)

8.2 Recordkeeping

Medical records may be on paper, electronic or a combination format. Medical records are in regionally determined sequence. Entries must be legible and in chronological order. Approved state/regional abbreviations and methods of correction in documentation are to be used.

8.3 Medical Record Standards and Encounter Data

Medical records and/or encounters shall include the following: (as indicated by PHN Protocols and the appropriate system/program guidelines)

1. Patient identification information
2. Personal/biographical data
3. Date of service
4. Provider identification
5. Legible documentation
6. Interval and past medical history appropriate to the type of visit
7. Appropriate allergy documentation
8. Immunizations
9. Assessments as appropriate
10. Identification of current problems or chief complaint
11. Examinations as appropriate
12. Medication information
13. Diagnostic information and any diagnostics performed
14. Anticipatory guidance/patient education
15. Referrals when indicated
16. Plan of care
17. Therapies and prescribed regimens
18. Follow up visit information
19. Record is in appropriate format
20. Appropriately completed consent forms
21. Required program forms
22. Appropriate coding and posting of procedures, diagnosis codes, medications, provider numbers, etc. to the encounters supporting and validating visit documentation

8.4 Medical Record Review Process

The medical record review process is a continuous endeavor utilizing [Community Health Services Administrative \(CHSA\) Policies and Procedures](#), the [PTBMIS Codes Manual](#), specific Program Guidelines, [PHN Protocol](#), Regional Recordkeeping Guidelines, in addition to Quality Improvement Guidelines. The standards and resources to be used for medical record and encounter reviews follow. Each review tool is completed for a single program from a single encounter for each medical record date of service that is reviewed. Reviewers may choose to review one program from the encounter or review a selection of the programs listed for that date of service. On line [Manual web page](#) access

8.5 COMPREHENSIVE HEALTH MAINTENANCE REVIEW STANDARDS AND PERFORMANCE INDICATORS

- 1. Program eligibility criteria met**
- 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
 - F. Psychosocial
 - G. Tobacco Survey Assessment (TSA)
- 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**
- 8. Sensory screening**
 - A. Vision
 - B. Hearing
- 9. Developmental/behavioral screening**
- 10. Appropriate laboratory procedures are followed and documented per protocols, program guidelines and standards in the Laboratory Manual, current edition.**
 - A. Testing appropriate to documented assessment and diagnosis.
 - B. Appropriate test completed according to program guidelines and standards.
- 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. See [CHSA Policy 8.9](#)
 - D. Sites of all immunization injections given 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 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. Documentation is updated according to Section V page 7 and Section VII page 46 of the [Primary Care Guidelines](#).

13. Anticipatory guidance/patient education:

Provided based upon the assessment of patient or parental current or anticipated needs and development per protocols and program guidelines.

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 format

- 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 regional/state standards.
- H. Adherence to standard regional format
- I. Appropriate consent forms are completed
- J. Required program forms are present

8.5.1 ENCOUNTER MEDICAL

18. Correct provider numbers are posted.

19. Correct program codes are posted.

20. Correct diagnosis codes are posted.

21. Correct payor codes are coded.

22. Correct service and procedure codes are posted per [PTBMIS Codes Manual](#) and current American Medical Association CPT Manual.

23. Services and procedures billed for are documented in the medical record.

24. Drugs issued to patients will be entered into the pharmacy module of PTBMIS by the end of business day.

25. Documentation supports Level I (99401T) or Level II (99402T) TennCare Advocacy.

IX. Internal Financial Systems

Designated members of the Quality Team will conduct internal financial systems evaluations. Items to be reviewed include but are not limited to the following:

- A. Cash Funds, Cash Receipts, Revenues and Deposits
- B. Negotiables

The standards and references to be used for the fiscal review follow. * Numbers in parentheses () reference policies in the *CHSA Policies and Procedures Manual*.
<http://hsaintranet.health.tn.gov/default.asp>

9.1 FISCAL REVIEW STANDARDS

Control Structure

1. Duties are segregated to the extent possible for collections, billings, bank deposits, purchases, patient encounters and mail opening. (2.3)*

Cash Counts

2. Cash box is secure 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. (2.11.5 and 2.11.7)
5. No employee checks or IOUs are in the cash fund box. (2.11.7) [Exception: checks for payment of services.]
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)

Cash Receipts and Certificates of Deposit (CD)

7. Copies of all receipts are maintained and attached to CD including manual, computer and voided receipts. The numbers 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.
10. Issuer signs manual receipts. (2.13)
11. Manual receipts are logged in from the Region and are stored in a locked file/closet. (2.13)
12. Voided receipts are accounted for with an explanation and 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. The time for running the cash drawer and making deposits is to include as much of the business day's transactions as possible; yet is to allow for Cash Drawer closeout and a deposit to the bank within the same workday. Bank date may conflict with the receipt date because of the bank's policy to change the date before the end of the workday. The deposit receipt from the bank must be retained with the State of Tennessee Deposit Slip. (2.9)
15. Fees collected by Local Health Departments and Regional Office Clinics must 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 (cash received = cash deposited; checks received = checks deposited). (2.11.6)
19. Checks are restrictively written for the exact amount owed or a portion thereof and endorsed upon receipt. (2.11.9)

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”.
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).

Revenues

24. Voided encounters, credit memos, debit memos and payment corrections are handled according to procedure. ([2.3](#)) ([2.11.11](#))

Accounts Receivable

25. The Division of Administrative Services’ policy on Accounts Receivable is followed. (2.7.a-h)
<http://hsaintranet.health.tn.gov/default.asp>
 - a. 3rd Party and Individual Patient Billing ([2.7.a](#))
 - b. Collecting 3rd Party deductibles ([2.7.b](#))
 - c. Collecting 3rd Party Co-payments ([2.7.c](#))
 - d. Billing for Patients who have TennCare and private insurance ([2.7.d](#))
 - e. Patients requesting local services in lieu of receiving services from their assigned/network provider ([2.7.e](#))
 - f. Collection and write-off of Accounts Receivable ([2.7.f](#))
 - g. Claim for refund ([2.7.g](#))
 - h. Waiving private insurance billing non TennCare enrollees ([2.7.h](#))

X. Risk Minimization

- A. Quality control reviews will be conducted at least yearly
 - 1) Laboratory guidelines will be utilized to assure laboratory compliance with external Quality Control criteria. Ongoing observations by supervisory staff will be routinely performed.
 - 2) Drug Room/Regional Pharmacy operations will be evaluated against Tennessee Board of Pharmacy regulations and State/Regional Public Health Formularies.
 - 3) Radiology operation will be evaluated against established practice guidelines and State Regulations.
- B. Infection control reviews will be conducted at least yearly utilizing the appropriate guidelines. [Infection Control Manual](#)
- C. Safety and Security reviews will be conducted at least yearly utilizing appropriate guidelines.
- D. Medical Risk reviews will be conducted at least yearly utilizing the appropriate guidelines.
- E. If new criteria and/or identified problems arise, new or more frequent evaluations may occur.

The standards and references to be used for the risk minimization review follow.

10.1 RISK MINIMIZATION REVIEW STANDARDS

Quality control policies and procedures are in place for in-house ancillary areas (lab, x-ray and drug room/regional pharmacy).

10.1.1 LABORATORY

Source for the following standards: Laboratory Policies and Procedures Manual for Local Health Departments.

1. **A current copy of the Laboratory Policies and Procedures Manual for Local Health Departments or Metro Lab Manual is maintained in the laboratory area.**
2. **Public Health Clinic Laboratory Practitioners perform on-site basic laboratory tests according to policies and procedures.**
3. **A lab training certificate is available for each employee who performs lab procedures.**
4. **Quality control tests are performed and documented according to the Laboratory Policies and Procedures Manual for Local Health Departments or Metro Lab Manual, with results maintained for at least 2 years. (Lab Manual, Section 5, pg. 14) Controls must be applicable to the brand of product being used. Product package inserts will be retained with the applicable control test documentation. Product package inserts will be followed regarding appropriate performance of tests or controls and correct storage of devices and control solutions. If the reviewer determines that this standard is not met, a 2 day plan of action including patient impact is required.**
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. Laboratory Policies and Procedures Manual for Local Health Departments, Section 1, page 5.**
7. **Manufacturer operation instructions/owner's manuals for laboratory equipment are available and followed. These instructions are to be retained 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 and 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. Manufacturer's instructions will be followed for calibration of digital devices such as scales, thermometers, blood pressure machines as well as other laboratory or patient care equipment.** (Child & Adolescent Health Manual 11-3.0)
10. **Preventive maintenance and repair logs for equipment are kept as long as the equipment is in use.** Laboratory Policies and Procedures Manual for Local Health Departments. See Appendices V page 21 for log form.
11. **Laboratory specimens are collected, labeled and stored according to acceptable Lab Manual 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.** (Lab Manual, Appendices 5, pg. 19 PH-3283)
13. **Only laboratory and dental supplies with valid dates are available for use.** If the reviewer determines that this standard is not met, a 2 day plan of action including patient impact is required.

10.1.2 MEDICATION/VACCINE

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) Vaccine storage temperature logs are to be retained for at least 3 years. If the reviewer determines that this standard is not met, a 2 day plan of action including patient impact is required.
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](#).
18. **When drug samples are allowed by regional policy, they are included in an inventory system.** CHSA Policy [8.3.c](#)
19. **Medications/vaccines are inspected for removal of expired or and deteriorated drugs, damaged labels and excess quantities of medications/vaccines.** [CHSA Policy 8.3.b](#) and [CHSA Policy 8.3.d](#). If the reviewer determines that this standard is not met, a 2 day plan of action including patient impact is required.
20. **Adverse drug events and vaccine adverse events are reported appropriately.**
21. **Vaccine Information Statements available in the clinic are current according to [CDC Guidelines](#).**

10.1.3 MEDICAL X-RAYS

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 major adjustments of x-ray equipment.**

25. X-ray equipment is inspected by a health physicist through the Division of Radiological Health. (every two (2) years for medical x-ray and every 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 manufacturers' recommendations.
30. Monitoring devices are worn by all employees while taking x-rays.
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.

10.1.4 OCCUPATIONAL HEALTH/INFECTION CONTROL

32. The site complies with the Regional Exposure Control Plan and [Infection Control Manual](#) which outlines procedures for eliminating or minimizing employee exposure to blood or other potentially infectious material in the work place. [CHSA Policy 8.2.b](#)
33. Post Exposure incidents are handled according to Regional Exposure Control Policy. CHSA Policies [3.4](#) & [8.2.b](#). If the reviewer determines that this standard is not met, a 2 day corrective plan of action including patient impact is required.
34. Sharps are immediately discarded into appropriate sharps containers, which must be readily accessible. [CHSA Infection Control Guidelines](#), Section IV. If the reviewer determines that this standard is not met, a 2 day corrective plan of action including patient impact is required.
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 workday. The spill kit is fully stocked and readily accessible to staff. [CHSA Infection Control Guidelines](#). If the reviewer determines that this standard is not met, a 2 day corrective plan of action including patient impact is required.
36. Protective coverings, such as impervious paper used to cover patient assessment tables should be changed after each patient. On work surfaces, it is replaced routinely and as soon as feasible when contaminated [CHSA Infection Control Guidelines](#), Appendices General Housekeeping
37. All regulated wastes are contained in closable, leak proof, puncture resistant, and biohazard labeled or color-coded containers. [CHSA Infection Control Guidelines](#), page 34
38. Biohazard labels are used appropriately. [CHSA Infection Control Guidelines](#), page 54.
39. Autoclave is used appropriately and cleaned regularly per manufacturer's instructions. The required biological indicator testing is done each week the autoclave is used. Autoclaves are inspected annually. [CHSA Infection Control Guidelines](#), Section IV page 30
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 [CHSA Infection Control Guidelines](#), Section IV page 31
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 Policy [3.9](#) & [8.2.b](#) – <http://hsaintranet.health.tn.gov/default.asp>

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 re-vaccinated with 3-dose series. [TOSHA CPL 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. [CHSA Policy 8.2.a](#) The Regional Health Officer shall determine the risk of effective exposure. – <http://hsaintranet.health.tn.gov/default.asp>
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](#) – <http://hsaintranet.health.tn.gov/default.asp>
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 Manual](#) – Current edition
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. Sate of TN Hazardous Chemical Right To Know Law, [T.C.A. 50-3-2001](#)

10.1.5 SAFETY/SECURITY

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](#) – <http://hsaintranet.health.tn.gov/default.asp>
 - 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 staff is 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. Exits 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](http://hsaintranet.health.tn.gov/default.asp) – <http://hsaintranet.health.tn.gov/default.asp>
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](http://hsaintranet.health.tn.gov/default.asp) – <http://hsaintranet.health.tn.gov/default.asp>
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](http://hsaintranet.health.tn.gov/default.asp) <http://hsaintranet.health.tn.gov/default.asp>
 - A. Each site shall establish written plans indicating measure 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 crises 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.

10.1.6 MEDICAL RISK CONTROL

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 inspections are documented monthly and expiring supplies are replaced in a timely manner. [CHSA Policy 8.4.a](http://hsaintranet.health.tn.gov/default.asp) - <http://hsaintranet.health.tn.gov/default.asp>
60. An unannounced patient emergency drill will be held at least annually with 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](http://hsaintranet.health.tn.gov/default.asp)
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](http://hsaintranet.health.tn.gov/default.asp)
62. Provisions are made to conduct annual fit testing and any additional respirator fit tests in the event of physical changes in the employee that may affect respirator fit or damage. Masks are stored appropriately. [Division of Community Health Services Respiratory Protection Program Manual](#)

XI. Title VI

Designated members of the QI team will conduct Title VI reviews. The standards and references to be used during the Title VI review follow. [CHSA Policy 7.21 http://hsaintranet.health.tn.gov/default.asp](http://hsaintranet.health.tn.gov/default.asp)

11.1 TITLE VI REVIEW STANDARDS

- 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 who English is not the primary language:**
 - Number served by language**
 - 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 required posters, and educational materials) are updated as needed for LEP groups that constitute five percent (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.**

XII. WIC Voucher Control

Designated members of the QI team will conduct WIC Voucher reviews. The standards and references to be used for the WIC voucher review follow. [WIC Manual http://hsaintranet.health.tn.gov/default.asp](http://hsaintranet.health.tn.gov/default.asp)

12.1 WIC REVIEW STANDARDS

- 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 signs off or secures the room anytime the terminal is left unattended by or out of the site of that user (even if other staff is present.)
 - C. Printer is left loaded with voucher stock only 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.**
 - 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 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 "Transfer of Participants" of the current [WIC Manual](#) for 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.

- 3. Voided vouchers are documented in compliance with federal regulations and central office instructions.**
 - A. "VOID" is stamped or written on the face of each voided voucher.
 - B. Voided vouchers match the Void Voucher 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.

- 4. Voucher reports and accountability are maintained in compliance with federal regulations and central office instructions.**
 - A. Voucher Receipt Reports are run every day or include every day of the week. Time locked days may be excluded.
 - B. Void 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 Voided Voucher Reports are filed first by date and then by user ID. Reports are held in clinic until approved disposal.
 - 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.

XIII. Coordination with General Management

- 13.1 The Quality Improvement Plan implementation will incorporate the philosophies of Continuous Quality Improvement (CQI).
- 13.2 Focus studies may be utilized for special studies, whenever critical problems are identified or as follow-up to special education initiatives. Any levels within the Quality Improvement structure may request focus studies.
- 13.3 Training needs identified by the Quality Improvement process will be brought to the attention of the Quality Unit, Quality Team and/or Quality Council for resolution.

SAMPLE DESIGN

Appendix A

Sample Design Office of Quality Improvement

In order to evaluate specific components of clinical care being provided in the local health departments, the Office of Quality Improvement will review medical records for a random sample of patients. The Quality Improvement studies will monitor service quality against practice guidelines specified for each identified area of review. Based on previous quality reviews, it is expected that at least 90 percent of the records will reflect that care provided matches the practice guidelines.

The sample size will be calculated such that there is a five percent chance of drawing a non-representative sample (or a 95 percent chance that the sample is representative of the true population of medical records). The true percentage of records that match the guidelines should lie within 10 percent of the sample percentage. For example, if 90 percent of the records in the sample of records match the practice guidelines, the percentage in the entire population that match should lie within the range (90 – 10) and (90 + 10) or between 80 – 100 percent.

The size of the sample based on these assumptions is calculated as:

$$n = \frac{(1.96)^2 \times (90) \times (10)}{(10)^2} = 35$$

Where 1.96 is the abscissa of the normal curve that cuts off .05 in each tail, 90 is the estimated proportion of the records that match the guidelines, 10 is the estimated proportion of records that do not match the practice guidelines and 10 percent is the margin of error in the estimate that has been agreed will be acceptable.

Therefore, the sample should include 35 records from each of the selected groups in order to make estimates of the proportion of records (or items included in records) that match the guidelines.

Because we will be sampling from finite populations of various sizes, the finite population correction factor should be applied to the initial calculations of the sample sizes.

If n_0 = the original calculation of the sample size, the corrected sample size is calculated as:

$$n = \frac{n_0}{1 + \frac{n_0}{n}}$$

For example if the population or records for a given county is 150 for the selected group, the sample for that county will be calculated as:

$$n = \frac{35}{1 + \frac{35}{150}}$$

which equals 28 records.

Alpha Numeric list method for obtaining Sample size Population:

After the sample size is calculated, the actual sample will be drawn from a computer list of the medical records in the county. The records for each of the selected groups should be listed separately. A systematic sample will be drawn from each group.

First, the number of records to be included in the sample is divided by the total number of records in the list for the age group to be sampled. For example, if the list includes 150 records and the sample should include 28 records, 150 is divided by 28 and the result (5.36) is rounded to the nearest whole number, 5. Therefore,

we will randomly select a beginning number and then take every 5th number. The beginning number will be selected as a number between 1 and 5.

In general the sampling factor, k, is calculated by dividing the number to be included in the sample by the total number of records in the population from which the sample is to be drawn. Beginning with a randomly selected number between 1 and k, every kth record is selected from the list. The easiest way to select the sample is to write the numbers 1 through k on separate pieces of paper, fold them, place them in a hat, and draw one of the numbers out of the hat. Use this number as the beginning number.

Query method to obtain Sample size population:

A query is to be generated that will provide a list that is populated with all patients seen in the site of review for a given period of time, generally one full standard clinic week. Weeks that include holidays and or mass clinics are discouraged as this will artificially increase or decrease the query population results. The query is to be generated from encounters that include the medical programs serviced by the site with the exception of the Dental program. TennCare Outreach phone call contacts, VAOP – voluntary acknowledgment of paternity, Environmental encounters, vital record encounters, and mass files, where an individual patient medical record is not generated, are not to be included in the population sample size. When the query is presented to the reviewer in a randomized list, the records of the selected groups can be chosen for review as they fall numerically on the list.

Office of Quality Improvement Random Sample Size

<u>Total Number of Records</u>	<u>Number of Records to be Reviewed</u>
1 - 13	All
14 - 21	13
22 - 24	14
25 - 27	15
28 - 31	16
32 - 34	17
35 - 39	18
40 - 44	19
45 - 49	20
50 - 55	21
56 - 62	22
63 - 71	23
72 - 81	24
82 - 93	25
94 - 109	26
110 - 128	27
129 - 153	28
154 - 187	29
188 - 237	30
238 - 314	31
315 - 454	32
455 - 750	33
751 - 1000	34
1001 or more	35

PATIENT SATISFACTION SURVEY
English and Spanish
2006 version

Appendix B

Tennessee Department of Health
 Division of Community Health Services
 425 5th Ave. North
 Cordell Hull Building
 Nashville, TN 37243



Patient Satisfaction Survey

Date: _____ County/Site _____

Dear patient: We want to know about the care you received during your visit today. Please express your satisfaction/dissatisfaction with the services you received. Your answers will be confidential. Thank you!

Why are you here TODAY? _____
 (write in or circle below)

- Birth/Death Certificate Dental Environmental EPSDT Family Planning Prenatal
 Shots Sexually Transmitted Disease Sick Visit TN Breast & Cerv. Tuberculosis
 WIC Pharmacy

Who did you see today? (write in or circle below) _____

- Doctor Nurse Practitioner Nurse Dentist Dental Assistant Receptionist Nutritionist
 Social Counselor Case Manager Pharmacist Public Health Rep. Environmentalist WIC/Voucher Clerk

Was the waiting time for service satisfactory? Yes No Did you have an appointment? Yes No

How long did you wait before you were seen today? _____

How was calling in to get an appointment? NA Poor Fair Good Excellent

Based upon your visit today how satisfied are you with the following?

(Circle questions that apply to the staff you saw today.)

	Not Applicable	CLINIC			RATING
1. Respecting your privacy	NA	Poor	Fair	Good	Excellent
2. Courteous treatment	NA	Poor	Fair	Good	Excellent
3. Cleanliness of Building	NA	Poor	Fair	Good	Excellent
4. Clinic Hours met your needs	NA	Poor	Fair	Good	Excellent
5. Experience with Receptionist	NA	Poor	Fair	Good	Excellent
6. Experience with Doctor	NA	Poor	Fair	Good	Excellent
7. Experience with Nurse Practitioner	NA	Poor	Fair	Good	Excellent
8. Experience with Nurse	NA	Poor	Fair	Good	Excellent
9. Experience with Dentist	NA	Poor	Fair	Good	Excellent
10. Experience with Dental Assistant	NA	Poor	Fair	Good	Excellent
11. Experience with WIC clerk	NA	Poor	Fair	Good	Excellent
12. Experience with Nutritionist	NA	Poor	Fair	Good	Excellent
Experience with other: Write in:	NA	Poor	Fair	Good	Excellent

How would you rate your overall satisfaction of today's visit? Circle

Not Satisfied

Extremely Satisfied

1

2

3

4

5

If you wish: Name _____ Phone# _____

May we contact you regarding the survey? Yes No

Please feel free to give us any comments. You may use the back of the form to write them. _____



**ENCUESTA SOBRE LA
 SATISFACCIÓN DEL PACIENTE**

Fecha: _____ **Condado/Sitio:** _____

Sr. /Sra. paciente: Queremos saber sobre el tratamiento que ha recibido Ud. hoy en su visita. Por favor, díganos si está satisfecho con los servicios que recibió. Todas las respuestas son confidenciales. ¡Gracias!

¿Para qué vino Ud. HOY? _____
 (Escriba la respuesta aquí o márkela abajo)

- Acta de nacimiento/acta de muerte Dentista Ambiental Chequeo regular de la niñez
 Planificación Familiar Chequeo Prenatal Vacunas Enfermedades sexuales
 Cita para un enfermo TN Cáncer del seno/cuello uterino Tuberculosis WIC Farmacia

¿Quién le vio hoy? (Escriba la respuesta aquí o márkela abajo) _____

- Doctor Enfermero/a especialista Enfermera/o Dentista Ayudante dental
 Recepcionista Nutricionista Consejero/a social Administrador/a de Caso
 Farmacéutico/a Representante de salud pública Ambientalista WIC/oficinista

¿El tiempo que tuvo que esperar fue satisfactorio? Sí No ¿Tuvo Ud. una cita? Sí No

¿Cuánto tiempo usted estuvo que esperar antes que lo viera hoy? _____

¿Cuánto tiempo esperó con su llamada para hacer cita? NA Maolo Regular Bueno Excelente

De la visita de HOY ¿cuán satisfecho está Ud. con los siguientes?
 (Marque solo las preguntas que tienen que ver con el personal que Ud. vio hoy.)

	No Aplica	Valoración de la clínica			
		Malo	Regular	Bueno	Excelente
1. Respeto de la privacidad	NA	Malo	Regular	Bueno	Excelente
2. Trato cortés	NA	Malo	Regular	Bueno	Excelente
3. Limpieza del edificio	NA	Malo	Regular	Bueno	Excelente
4. El horario de la clínica	NA	Malo	Regular	Bueno	Excelente
5. Experiencia con la recepcionista	NA	Malo	Regular	Bueno	Excelente
6. Experiencia con el doctor	NA	Malo	Regular	Bueno	Excelente
7. Experiencia con la enfermera especialista	NA	Malo	Regular	Bueno	Excelente
8. Experiencia con la enfermera	NA	Malo	Regular	Bueno	Excelente
9. Experiencia con el dentista	NA	Malo	Regular	Bueno	Excelente
10. Experiencia con el ayudante dental	NA	Malo	Regular	Bueno	Excelente
11. Experiencia con la oficinista en WIC	NA	Malo	Regular	Bueno	Excelente
12. Experiencia con la nutricionista	NA	Malo	Regular	Bueno	Excelente
13. Experiencia con otro: Especifique:	NA	Malo	Regular	Bueno	Excelente

¿Cómo valora por lo general la visita de hoy? (Circule el grado de satisfacción que corresponda)

No estoy satisfecho

Estoy muy satisfecho

1

2

3

4

5

Si Ud. desea: Nombre _____ Teléfono _____

¿Podemos llamarle sobre esta encuesta? Sí No

Anote cualquier comentario a continuación. Se puede usar el otro lado si se necesita. _____

IMMUNIZATION SCHEDULES And VIS Links

Appendix C

2013 LINKS TO IMMUNIZATION SCHEDULES AND VIS INFORMATION

Go to CDC web site: <http://www.cdc.gov/vaccines/schedules/index.html>
to choose the desired schedule or go to the individual link listed below.

Adult schedule:

<http://www.cdc.gov/vaccines/schedules/downloads/adult/adult-schedule-easy-read.pdf>

Child age birth - 18 years schedule:

<http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-schedule.pdf>

Catch up schedule age 4 months – 18 years:

<http://www.cdc.gov/vaccines/schedules/downloads/child/catchup-schedule-pr.pdf>

Vaccine Information Statements: <http://www.cdc.gov/vaccines/pubs/vis/default.htm>

Vaccine Information Statement acceptable version dates list: <http://www.cdc.gov/vaccines/pubs/vis/vis-news.htm>

Following is an example document and is current as of 5/9/13. This document may be updated at any time by the Immunization Program. Confirmation of its current status should be confirmed with the Immunization Program before it is used as guidance for review of VIS documents within the health departments for acceptable dates.

Example



STATE OF TENNESSEE
 DEPARTMENT OF HEALTH
 COMMUNICABLE AND ENVIRONMENTAL DISEASE SERVICES SECTION
 IMMUNIZATION PROGRAM
 VACCINES FOR CHILDREN (VFC) PROGRAM
 CORDELL HULL BUILDING, 1st FLOOR
 425 5th AVENUE NORTH
NASHVILLE, TENNESSEE 37243

List of Vaccine Information Statements (VISs) and Acceptable Version Dates

<u>Type of Vaccination</u>	<u>VIS Date</u>	<u>Final or Interim</u>	<u>Location</u>
DTaP/DT/DTP	05/17/2007	Final	Central Stores
Hepatitis A	10/25/2011	Interim	Central Stores
Hepatitis B	02/02/2012	Interim	Central Stores
Human Papillomavirus (HPV)	02/22/2012	Interim	Central Stores
HIB	12/16/1998	Interim	Central Stores
Influenza (LAIV)	07/02/2012	Interim	Printed Annually
Influenza (TIV)	07/02/2012	Final	Printed Annually
Japanese Encephalitis	12/07/2011	Interim	CDC Website
Meningococcal	10/14/2011	Interim	Central Stores
MMR	04/20/2012	Interim	Central Stores
PCV	02/27/2013	Interim	Central Stores
PPV	10/06/2009	Final	Dept of Health

<u>Type of Vaccination</u>	<u>VIS Date</u>	<u>Final or Interim</u>	<u>Location</u>
Polio	11/08/2011	Final	Central Stores
Rabies	10/06/2009	Final	CDC Website
Rotavirus	12/06/2010	Final	Central Stores
Shingles*	10/06/2009	Interim	CDC Website
Td/Tdap	01/24/12	Interim	Central Stores
Tdap	05/09/13	Interim	Central Stores
Varicella	03/13/2008	Interim	Central Stores
Yellow Fever	03/30/2011	Final	CDC Website
Multiple Vaccine**	11/16/2012	Interim	Central Stores

* The Shingles VIS has never been printed by TIP.

** This VIS may be used as an optional substitute for any or all of the routine birth-6 month vaccine VISs. (DTaP, IPV, Hib, PCV, Hepatitis B, and Rotavirus)** note to update most current VIS for any vaccine if using multi vaccine VIS and more current version available than 09/18/08.

When do providers have to start using a new VIS?

The date for a new VISs required use is announced when the final draft is published in the Federal Register. Ideally, providers will begin using a new VIS immediately. This is particularly important for a VIS for a new vaccine, or it is a revision of an existing VIS, if the vaccine's contraindications or adverse event profile have changed significantly.

<http://www.cdc.gov/vaccines/pubs/vis/default.htm>

May 9, 2013

Tdap/TD

A new VIS for Tdap, incorporating updated recommendations for pregnant women, is now available. The existing Td/Tdap VIS should continue to be used for patients receiving Td, until an updated Td VIS is available.

Please note there is also a 3 page addendum for providers about Tdap updates dated 05/09/13.

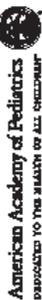
Last updated: 05/09/13-

PERIODICITY CHART

Appendix D

Link to current Periodicity Chart:

<http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf>



Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics



Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are reaching component parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may be necessary if circumstances suggest variations from normal.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking the utmost individual circumstances, may be appropriate.

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AGE	INFANCY					EARLY CHILDHOOD					MIDDLE CHILDHOOD					ADOLESCENCE							
	18 mo	24 mo	30 mo	36 mo	48 mo	5 yr	6 yr	7 yr	8 yr	9 yr	10 yr	11 yr	12 yr	13 yr	14 yr	15 yr	16 yr	17 yr	18 yr	19 yr	20 yr	21 yr	
HISTORY																							
Initial/Interval	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
MEASUREMENTS																							
Length/Height and Weight	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head Circumference	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Weight for Length	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Body Mass Index	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Blood Pressure*	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
SENSORY SCREENING																							
Vision	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Hearing	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																							
Developmental Screening†	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Autism Screening†	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Developmental Surveillance†	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Psychosocial/Behavioral Assessment	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Alcohol and Drug Use Assessment	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PHYSICAL EXAMINATION*																							
PROCEDURES*																							
Newborn Metabolic/Hemoglobin Screenings†	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Irritant/antibiotic†	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Hemostatic† or Hemoglobin†	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Lead Screening†	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Tuberculin Test†	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Dyslipidemic Screening†	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
STI Screenings†	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Cervical Dysplasia Screenings†	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
ORAL HEALTH**																							
Anticipatory Guidance†	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•

1. It is difficult to make precise statements for the best time of age point on the schedule, as 2-year-olds are not accomplished at the majority of tasks. A general rule is to schedule a visit at 18 months, 24 months, 30 months, and 36 months, and for those who require a schedule of visits. The period with the most frequent visits is between 18 months and 36 months, and a duration of 6 months of visits is recommended for most children. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

2. Every child should have a minimum of two visits per year, including preventive and diagnostic visits, and a separate visit for acute illness. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

3. These procedures are recommended for all children with special needs. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

4. These procedures are recommended for all children with special needs. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

5. These procedures are recommended for all children with special needs. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

6. These procedures are recommended for all children with special needs. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

7. These procedures are recommended for all children with special needs. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

8. These procedures are recommended for all children with special needs. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

9. These procedures are recommended for all children with special needs. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

10. These procedures are recommended for all children with special needs. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

11. These procedures are recommended for all children with special needs. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

12. These procedures are recommended for all children with special needs. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

13. These procedures are recommended for all children with special needs. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

14. These procedures are recommended for all children with special needs. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

15. These procedures are recommended for all children with special needs. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

16. These procedures are recommended for all children with special needs. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

17. These procedures are recommended for all children with special needs. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

18. These procedures are recommended for all children with special needs. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

19. These procedures are recommended for all children with special needs. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

20. These procedures are recommended for all children with special needs. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

21. These procedures are recommended for all children with special needs. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

22. These procedures are recommended for all children with special needs. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

23. These procedures are recommended for all children with special needs. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

24. These procedures are recommended for all children with special needs. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

25. These procedures are recommended for all children with special needs. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased. For children with special needs, the frequency of visits may be increased.

KEY
 • = to be performed • = not recommended • = optional • = range during which a service may be provided, with the symbol indicating the preferred age

**TENNESSEE DEPARTMENT OF HEALTH
CENTRAL OFFICE
CONTACT LIST**

Appendix E

CENTRAL OFFICE CONTACT LIST

<p>Dental 425 5th Ave. North, 4th Floor Cordell Hull Bldg. Nashville, TN 37243</p>	<p>Suzanne Hayes, DDS Director Oral Health Services Phone: 615-741-8618 Fax : 615-532-2785 Email: Suzanne.Hayes@tn.gov</p>
<p>LAB and OSHA/TOSHA 425 5th Ave. North, 4th Floor Cordell Hull Bldg. Nashville, TN 37243</p>	<p>Donna Hurst, MS, BS, RN Phone: 615-741-5225 Fax: 615-532-2785 Email: TTDonna.Hurst@tn.gov</p>
<p>Pharmacy - Drug Room Medications/Vaccines/TB Skin Test</p> <p>Fax: 615-532-2785 425 5th Ave. North, 4th Floor Cordell Hull Bldg. Nashville, TN 37243</p>	<p>Calita Richards, Pharm. D, MPH State Director of Pharmacy Phone: 615-253-2311 Email: TTCalita.Richards@tn.gov</p> <p>Robin Gibson, Pharm. D. Assistant State Director of Pharmacy Phone: 615-741-0241 Email: Robin.Gibson@tn.gov</p>
<p>TB Skin Test/other TB Drugs</p> <p>1-800-404-3006 (After hours emergency hotline)</p> <p>Fax: 615-253-1370 425 5th Ave. North, 1st Floor Cordell Hull Bldg. Nashville, TN 37243.</p> <p>If Regional TB Nurse Consultants are not available, ask for TB Program staff.</p>	<p>Gayle Canfield, R.N. - PHNC Manager, Tuberculosis Elimination Program Phone: 615-741-5885 Email: Gayle.Canfield@tn.gov</p> <p>Jon Warkentin, M.D., M.P.H. - Medical Director, Tuberculosis Elimination Program Phone: 615-253-1364 Email: Jon.Warkentin@tn.gov</p> <p>Wilfred Rabi - Program Manager, Tuberculosis Elimination Program Phone: 615-253-1397 Email: Wilfred.Rabi@tn.gov</p>
<p>Vaccines/Immunizations</p> <p>425 5th Avenue North, 1st Floor Cordell Hull Building Nashville, TN 37243</p>	<p>VFC/AFIX Coordinator or any Immunization Program Staff Toll Free: 1-800-404-3006 Local: 615-741-7247</p> <p>Kelly L. Moore, MD, MPH Medical Director, TN Immunization Program(TIP)</p> <p>Mary Katherine Fortner, RN,CRRN,CCM TIP VFC/AFIX Quality Coordinator</p> <p>Susanne Powell TIP Manager</p>

HIGH/LOW TB INCIDENCE COUNTRIES

Appendix F

HIGH/LOW TB INCIDENCE COUNTRIES AND PTBMIS CODES

Tuberculosis Elimination Program Approved List for use 2013-2014

Country	PTBMIS Code	Incidence
Afghanistan	001	High
Albania	002	Low
Algeria	003	High
American Samoa	004	Low
Andorra	005	Low
Angola	006	High
Anguilla	007	High
Antarctica	008	No data
Antigua and Barbuda	009	Low
Argentina	010	High
Armenia	224	High
Aruba	251	Low
Australia	011	Low
Austria	012	Low
Azerbaijan	225	High
Bahamas	013	Low
Bahrain	014	Low
Bangladesh	015	High
Barbados	016	No data
Belarus	226	High
Belgium	017	Low
Belize	018	High
Benin	019	High
Bermuda	020	Low
Bhutan	021	High
Bolivia (Plurinational State of)	022	High
Bonaire, Saint Eustatius and Saba	253	Low
Bosnia and Herzegovina	227	High
Botswana	023	High
Bouvet Island	024	No data
Brazil	025	High
British Indian Ocean Territories	026	No data
British Virgin Islands	027	Low
Brunei Darussalam	028	High
Bulgaria	029	High
Burkina Faso (Upper Volta)	247	High

Burma (Myanmar)	030	High
Burundi	031	High
Cambodia (Kampuchea)	228	High
Cameroon	032	High
Canada	033	Low
Cape Verde	034	High
Cayman Islands	035	Low
Central African Republic	036	High
Chad	037	High
Chile	038	High
China	039	High
China (Taiwan)	040	No data
China, Hong Kong SAR	087	High
China, Macao SAR	116	High
Christmas Island	041	No data
Cocos (Keeling) Islands	042	No data
Colombia	043	High
Comoros	044	High
Congo	045	High
Cook Islands	046	Low
Costa Rica	047	Low
Cote d'Ivoire (Ivory Coast)	098	High
Croatia	229	Low
Cuba	048	Low
Curacao	255	Low
Cyprus	049	Low
Czech Republic	230	Low
Czechoslovakia	050	No data
Democratic People's Republic of Korea (North Korea)	106	High
Democratic Republic of the Congo	257	High
Denmark	051	Low
Djibouti	052	High
Dominica	053	Low
Dominican Republic	054	High
East Germany	071	Low
Ecuador	055	High
Egypt	056	Low
El Salvador	057	High
England (United Kingdom of Great Britain and Northern Ireland)	204	Low
Equatorial Guinea	058	High
Eritrea	259	High
Estonia	231	High
Ethiopia	059	High

Falkland Islands	060	No data
Faroe Islands	061	No data
Federated States of Micronesia	245	High
Fiji	062	High
Finland	063	Low
France	064	Low
French Guiana	065	No data
French Polynesia	066	High
French Southern and Antarctic Lands	067	No data
Gabon	068	High
Gambia	069	High
Georgia	232	High
Germany	246	Low
Germany (East)	071	Low
Germany (West)	072	Low
Ghana	073	High
Gibraltar	074	No data
Gilbert Islands (Kiribati)	105	No data
Great Britain (United Kingdom of Great Britain and Northern Ireland)	204	Low
Greece	075	Low
Greenland	076	High
Grenada	077	Low
Guadeloupe	078	No data
Guam	079	High
Guatemala	080	High
Guinea	081	High
Guinea-Bissau	082	High
Guyana	083	High
Haiti	084	High
Heard and McDonald Islands	085	No data
Honduras	086	High
Hong Kong (China, Hong Kong SAR)	087	High
Hungary	088	Low
Iceland	089	Low
India	090	High
Indonesia	091	High
Iran (Islamic Republic of)	092	High
Iraq	093	High
Iraq-Saudi Arabia Neutral Zone	094	No data
Ireland	095	Low
Israel	096	Low
Italy	097	Low
Ivory Coast (Cote d'Ivoire)	098	High

Jamaica	099	Low
Japan	100	High
Johnston Atoll	101	No data
Jordan	102	Low
Kazakhstan	233	High
Kenya	104	High
Kiribati (Gilbert Islands)	105	High
Korea, Democratic People's Republic of (North Korea)	106	High
Korea, Republic of (South Korea)	107	High
Kosovo	248	No data
Kuwait	108	High
Kyrgyzstan	234	High
Lao People's Democratic Republic (Laos)	109	High
Laos (Lao People's Democratic Republic)	109	High
Latvia	235	High
Lebanon	110	Low
Lesotho	111	High
Liberia	112	High
Libya (Libyan Arab Jamahiriya)	113	High
Libyan Arab Jamahiriya	113	No data
Liechtenstein	114	No data
Lithuania	236	High
Luxembourg	115	Low
Macao (China, Macao SAR)	116	High
Macedonia (The Former Yugoslav Republic of Macedonia)	219	High
Madagascar	117	High
Malawi	118	High
Malaysia	119	High
Maldives	120	High
Mali	121	High
Malta	122	Low
Marshall Islands	261	High
Martinique	123	No data
Mauritania	124	High
Mauritius	125	High
Mexico	126	High
Micronesia (Federated States of)	245	High
Midway Islands	127	No data
Moldova (Republic of Moldova)	238	High
Monaco	128	Low
Mongolia	129	High
Montenegro	239	Low
Montserrat	130	Low

Morocco	131	High
Mozambique	132	High
Myanmar (Burma)	030	High
Namibia	133	High
Nauru	134	High
Navassa Island	135	No data
Nepal	136	High
Netherlands	137	Low
Netherlands Antilles	138	No data
New Caledonia	139	High
New Hebrides	140	No data
New Zealand	141	Low
Nicaragua	142	High
Niger	143	High
Nigeria	144	High
Niue	145	High
Norfolk Island	146	No data
North Korea (Democratic People's Republic of Korea)	106	High
Northern Ireland (United Kingdom of Great Britain and Northern Ireland)	204	Low
Northern Mariana Islands	147	High
Norway	148	Low
Oman	149	Low
Pakistan	150	High
Palau	263	High
Panama	151	High
Papua New Guinea	152	High
Paracel Islands	153	No data
Paraguay	154	High
Peru	155	High
Philippines	156	High
Pitcairn Islands	157	No data
Poland	158	High
Portugal	159	High
Puerto Rico	160	Low
Qatar	161	High
Refused Information	998	
Republic of Korea (South Korea)	107	High
Republic of Moldova	238	High
Reunion	162	No data
Romania	163	High
Russian Federation (Russia)	240	High
Rwanda	164	High
Saint Christopher and Nevis (Saint Kitts and Nevis)	165	Low

Saint Kitts and Nevis (Saint Christopher and Nevis)	165	Low
Samoa (Western Samoa)	216	High
San Marino	170	Low
Sao Tome and Principe	171	High
Saudi Arabia	172	Low
Senegal	173	High
Serbia	241	Low
Seychelles	174	High
Sierra Leone	175	High
Singapore	176	High
Sint Maarten (Dutch part)	265	Low
Slovakia	267	Low
Slovenia	242	Low
Solomon Islands	177	High
Somalia	178	High
South Africa	179	High
South Korea (Republic of Korea)	107	High
South Sudan	183	High
Spain	180	Low
Spratly Islands	181	No data
Sri Lanka	182	High
St. Helena	166	No data
St. Lucia	167	Low
St. Pierre and Miquelon	168	No data
St. Vincent and the Grenadines	169	High
Sudan	183	High
Suriname	184	High
Svalbard and Jan Mayen	185	No data
Swaziland	186	High
Sweden	187	Low
Switzerland	188	Low
Syria (Syrian Arab Republic)	189	Low
Syrian Arab Republic (Syria)	189	Low
Taiwan	040	Low
Tajikistan	243	High
Tanzania (United Republic of Tanzania)	190	High
Thailand	191	High
The Former Yugoslav Republic of Macedonia	219	High
Timor-Leste	269	High
Togo	192	High
Tokelau	193	High
Tonga	194	Low
Trinidad and Tobago	195	High

Trust Territory of the Pacific Islands	196	No data
Tunisia	197	High
Turkey	198	High
Turkmenistan	244	High
Turks and Caicos Islands	199	High
Tuvalu	200	High
Uganda	201	High
Ukraine	223	High
Union of Soviet Socialist Republics	202	No data
United Arab Emirates	203	Low
United Kingdom of Great Britain and Northern Ireland	204	Low
United Republic of Tanzania	190	High
United States Mis Pacific islands	206	No data
United States of America	205	Low
Unknown	999	
Upper Volta	207	High
Uruguay	208	High
US Virgin Islands	212	Low
Uzbekistan	246	High
Vanuatu	271	High
Vatican City	209	No data
Venezuela	210	High
Viet Nam	211	High
Wake Island	213	No data
Wallis and Futuna Islands	214	High
West Bank and Gaza Strip	070	Low
West Germany	072	Low
Western Sahara	215	No data
Western Samoa (Samoa)	216	High
Yemen (Aden)	217	High
Yemen (Sana)	218	High
Yugoslavia	219	No data
Zaire	220	No data
Zambia	221	High
Zimbabwe (S. Rhodesia)	222	High
		denotes high TB incidence country
		denotes no TB incidence from WHO
Received 5/9/13		

PHN PUBLIC HEALTH DRUG FORMULARY

Appendix G

PHN PUBLIC HEALTH DRUG FORMULARY

Birth Control Methods	Storage Temperature	Special Notes
Diaphragm	59° - 86°F	Keep out of direct sunlight.
Conceptrol® Gel	≤ 77°F	Protect from freezing temperature and prolonged exposure to heat.
Contraceptive Foam	≤ 77°F	Protect from freezing temperature and prolonged exposure to heat. Do not store or use near heat or open flame. Contents under pressure, do not puncture or incinerate.
Contraceptive Film	≤ 77°F	Protect from freezing temperature and prolonged exposure to heat. Avoid excessive humidity.
Medroxyprogesterone 150 mg/ml	68° - 77°F	
Depo Provera®, 1 ml vial	68° - 77°F	
Depo-Sub Q Provera 104® (prefilled)	68° - 77°F	
Estrostep FE®	59° - 86°F	Avoid exposure to excessive heat and moisture.
Implanon®	59° - 86°F	Protect from light. Avoid direct sunlight.
Loestrin® FE	59° - 86°F	Avoid exposure to excessive heat and moisture.
Lo Ovral® 0.3 mg/30 mcg	59° - 86°F	Avoid exposure to excessive heat and moisture.
Micronor®	59° - 86°F	Avoid exposure to excessive heat and moisture.
Mircette® 15mg/0.03 mg	59° - 86°F	Avoid exposure to excessive heat and moisture.
Mirena® IUD	59° - 86°F	
Modicon®	59° - 86°F	Avoid exposure to excessive heat and moisture.
Next Choice®	59° - 86°F	Avoid exposure to excessive heat and moisture.
NorQD®	59° - 86°F	Avoid exposure to excessive heat and moisture.
Nordette®	59° - 86°F	Avoid exposure to excessive heat and moisture.
NuvaRing®	36° - 46°F	
Ortho Cyclen®	59° - 86°F	Avoid exposure to excessive heat and moisture.
Ortho Evra® Contraceptive Patch	59° - 86°F	
Ortho Novum® 7/7/7	59° - 86°F	Avoid exposure to excessive heat and moisture.
Ortho Novum® 1/50	59° - 86°F	Avoid exposure to excessive heat and moisture.
Ortho Tri-Cyclen® 28s	59° - 86°F	Avoid exposure to excessive heat and moisture.
Ortho Tri-Cyclen Lo® 28s	59° - 86°F	Avoid exposure to excessive heat and moisture.
Ortho-Cept® 28s	59° - 86°F	Avoid exposure to excessive heat and moisture.

Ovcon 35®	59° - 86°F	Avoid exposure to excessive heat and moisture.
Ovcon 50®	59° - 86°F	Avoid exposure to excessive heat and moisture.
ParaGard T380A® IUD	59° - 86°F	
Plan B OneStep®	59° - 86°F	Avoid exposure to excessive heat and moisture.
Seasonale®	59° - 86°F	Avoid exposure to excessive heat and moisture.
Sronyx®	59° - 86°F	Avoid exposure to excessive heat and moisture.
Trivora®	59° - 86°F	Avoid exposure to excessive heat and moisture.
Yasmin®	59° - 86°F	Avoid exposure to excessive heat and moisture.
Yaz®	77°F	Temperatures between 59° - 86°F is permitted for short periods of time. Avoid exposure to excessive heat, humidity and light.
Zovia®	59° - 86°F	Avoid exposure to excessive heat and moisture.
Emergency Medications		
Ammonia Inhalants	59° - 86°F	Avoid excessive heat.
Aspirin 325 mg Tablets	59° - 86°F	Protect from moisture.
Diphenhydramine 50 mg/ml Injection	59° - 86°F	Protect from light and freezing.
Epinephrine Injection	59° - 86°F	Protect from light. Discard if solution is discolored. Do not freeze.
Instant Glucose	59° - 86°F	Protect from excessive heat, light and moisture.
General Medications		
Acetaminophen Elixir	59° - 86°F	Avoid excessive heat and humidity. Protect from freezing.
Acetaminophen Liquid	59° - 86°F	Avoid excessive heat and humidity. Protect from freezing.
Acyclovir 400 mg Capsule	59° - 77°F	Protect from moisture.
Albuterol HFA Inhaler	59° - 77°F	Protect from freezing temperature and prolonged exposure to heat. Do not store or use near heat or open flame. Contents under pressure, do not puncture or incinerate.
Albuterol Nebulizer 0.083%	36° - 77°F	Leave product in foil. Once removed use within 1 week. Protect from light and excessive heat.
Allopurinol 300 mg Tablet	59° - 77°F	Store in dry place and protect from sunlight.
Amitriptyline Tablet	≤ 86° F	Protect from light.
Amoxicillin Capsules and Powder for Reconstitution	≤ 68°F	Once reconstituted, suspension may be refrigerated or stored at room temperature; should be discarded 14 days after reconstitution.
Amoxicillin/Clavulanic Acid Tablet & Powder for Suspension	≤ 77°F	Once reconstituted, suspension should be refrigerated and discarded after 10 days.

Antacid Liquid	59° - 86°F	Do not freeze; avoid excessive heat and moisture.
Avelox® 400 mg Tablet	59° - 86°F	Avoid high humidity.
Azithromycin Tablet	59° - 86°F	
Bacitracin Ointment	59° - 77°F	
Beclomethasone Inhaler	59° - 86°F	Do not store or use near heat or open flame. Contents under pressure, do not puncture or incinerate.
Bicillin® LA 1.2 MU syringe	36° - 46°F	Do not freeze.
Ceftriaxone Injection, SDV	68° - 77°F	Protect from light. Product reconstituted with lidocaine is stable for 24 hours at room temperature or 3 days if stored in refrigerator.
Cefuroxime Axetil 500 mg Tablet	59° - 86°F	
Cephalexin 500 mg Capsule	68° - 77°F	
Cephalexin Powder for Suspension	59° - 86°F	Refrigerate reconstituted product and discard after 14 days.
Chewable Vitamin Tablet	59° - 86°F	Store in cool dry place, avoid excessive heat.
Ciprofloxacin 500 mg Tablet	≤ 86°F	
Clindamycin 150 mg Capsule	68° - 77°F	
Clindamycin Powder for Suspension	68° - 77°F	Do not refrigerate reconstituted suspension. Discard after 14 days.
Clonidine 0.1 mg Tablet	59° - 86°F	
Dexamethasone 4 mg/ml Injection	59° - 86°F	Sensitive to heat. Protect from freezing and light.
Diphenhydramine 25 mg	59° - 86°F	
Doxycycline 100 mg	≤ 86°F	Protect from light.
Erythromycin Tablet	≤ 86°F	
Ethambutal 400 mg Tablet	68° - 77°F	
Fluconazole 150 mg Tablet	≤ 86°F	
Fluoride Tablet	68° - 77°F	Store away from heat, moisture and light.
Fluoxetine 20 mg	59° - 86°F	
Furosemide 40 mg Tablet	59° - 86°F	Protect from light. Discoloration of tablets caused by exposure to light should not be issued.
Gemfibrozil 600 mg Tablet	68° - 77°F	Protect from light and humidity.
Gentamicin Opth Soln	36° - 86°F	
Glyburide 5 mg Tablet	59° - 86°F	
Guaifenesin 100 mg/5 ml syrup	59° - 86°F	Protect from light and excessive heat.
Guaifenesin DM syrup	59° - 86°F	Protect from light and excessive heat.
Gynazole -1®	59° - 86°F	Avoid freezing.
Hydralazine 50 mg Tablet	59° - 86°F	
Hydrochlorothiazide 25 mg Tablet	59° - 86°F	Protect from light, moisture, and freezing.
Hydrocortisone Cream 1%	59° - 86°F	
Hydrocortisone Oint 2.5%	59° - 86°F	

Hydroxyzine HCl 25 mg/ml Injection	36° - 86°F	
Hydroxyzine Pam 25 mg caps	59° - 86°F	Protect from light.
Ibuprofen Tablet	68° - 77°F	Avoid heat greater than 104°F.
INH Liquid, Tablet	59° - 86°F	Protect from moisture and light.
Iron Supplement, Drops	68° - 77°F	Protect from light and freezing.
Iron Supplement, Tablet	59° - 86°F	
Isosorbide Dinitrate 10 mg Tablet	77°F	Protect from light.
Kenalog - 40 Injection	68° - 77°F	Protect from light and avoid freezing.
Levaquin Tablet	59° - 86°F	
Lidocaine 1% Injection	77°F	Protect from light.
Lidocaine with Epinephrine Injection	77°F	Protect from light.
Lisinopril 10 mg, 20 mg Tablet	59° - 86°F	Protect from light, moisture, and excessive heat.
Lovastatin 40 mg Tablet	41° - 86°F	Protect from light.
Mebendazole Chew 100 mg Tablet	59° - 77°F	
Medroxyprogesterone 5 mg Tablet	68° - 77°F	
Metformin 500 mg Tablet	59° - 86°F	Protect from light, moisture, and excessive heat and humidity.
Metoprolol 50 mg Tablet	59° - 86°F	Protect from light and moisture.
Metronidazole 500 mg Tablet	≤ 77°F	Protect from light.
Miconazole Nitrate	59° - 86°F	Avoid freezing.
Monistat 1®	59° - 86°F	Avoid freezing.
Monistat 7®	59° - 86°F	Avoid freezing.
Mycobutin Capsule	59° - 86°F	
Neo/Gram/PolyB Eye Gtts	77°F	Protect from freezing.
Neo/PolyB/Hydrocortisone Otic Susp	59° - 77°F	
Nitrofurantoin (macro) Monhydrate Capsule	59° - 86°F	Protect from moisture.
Nitroglycerin 0.4 mg Sublingual Tablet	59° - 86°F	Protect from moisture.
Novolin® 70/30 Injection	36° - 46°F	Protect from sunlight; do not freeze. Stable at room temperature for 1 month if excessive heat is avoided.
Novolin® N Injection	36° - 46°F	Protect from sunlight; do not freeze. Stable at room temperature for 1 month if excessive heat is avoided.
Novolin® R Injection	36° - 46°F	Protect from sunlight; do not freeze. Stable at room temperature for 1 month if excessive heat is avoided.
Ortho Gynol II® Jelly	≤ 77°F	Protect from freezing temperature and prolonged exposure to heat.
Penicillin Powder for Suspension	68° - 77°F	Refrigerate reconstituted solution and discard after 14 days.
Penicillin Tablet	68° - 77°F	
Penicillin VK Powder for Suspension	68° - 77°F	Refrigerate reconstituted solution and discard after 14 days.
Penicillin VK Tablet	68° - 77°F	
Permethrin Cream 5%	59° - 77°F	
Permethrin Creme Rinse	59° - 77°F	

Phenytoin ER 100 mg	≤ 86°F	Protect from light, moisture, and freezing.
Podofilox 0.5% Gel, Soln	59° - 86°F	Protect from excessive heat. Do not freeze.
Potassium Chloride 10 meq	59° - 86°F	Protect from light and moisture.
Prednisone 5 mg Tablet	59° - 86°F	
Promethazine Injection 25 mg/ml	68° - 77°F	Protect from light.
Promethazine Supp 25 mg	36° - 46°F	
Promethazine Tablet 25 mg	68° - 77°F	Protect from light and moisture.
Pyridoxine 50 mg Tablet	59° - 86°F	Store away from heat, moisture and light.
Pyrazinamide 500 mg Tablet	59° - 86°F	
Ranitidine 150 mg Tablet	59° - 86°F	Protect from light and moisture.
Rifamate® Capsule	59° - 86°F	Protect from moisture and light.
Rifampin Capsule	59° - 86°F	Store in dry place and avoid excessive heat.
Rifampin Suspension	36° - 77°F	Compounded suspensions are stable for 4 weeks at room temperature or stored in refrigerator.
Seromycin Capsule	59° - 86°F	
Silver Sulfadiazine Cream	59° - 86°F	
Streptomycin Injection	59° - 86°F	Reconstituted solutions may be stored at room temperature for up to 1 week, then discarded.
Terazol® 3 Cream, 20 gm	59° - 86°F	
Terazol® 3 Suppository	59° - 86°F	
Terazol® 7 Cream	59° - 86°F	
Trimethoprim/Sulfamethaxazole DS Tablet	59° - 86°F	Protect from light.
Trazadone 50 mg Tablet	59° - 86°F	
Trecator® - SC	77°F	
Triamterene/Hydrochlorothiazide 37.5/25 mg Tablet	59° - 86°F	Protect from moisture, freezing and excessive heat.
Trichloroacetic acid 80% Solution	59° - 86°F	Avoid excessive heat.
Triple Antibiotic Opth Oint	77°F	Protect from freezing.
Tubersol® Skin Test	35° - 46°F	Protect from light and protect from freezing. Discard product 1 month after opening.
Verapamil 80 mg Tablet	59° - 77°F	Protect from light and moisture.
Verapamil XR 240 mg Tablet	59° - 77°F	Protect from light and moisture.
Vaccines		
DT	35° - 46°F	Do not freeze.
DTaP - Infanrix®, Daptacel®, Tripedia®	35° - 46°F	Do not freeze.
DTaP/HepB/IPV - PEDIARIX®	36° - 46°F	Do not freeze.
DTaP/Hib - TriHIBit®	35° - 46°F	Do not freeze.
DTaP/HiB/IPV - Pentacel®	35° - 46°F	Do not freeze.
DTaP/IPV - Kinrix®	36° - 46°F	Do not freeze.
EIPV - IPOL®	35° - 46°F	Protect from freezing.
HepA Ped - Havrix®, Vaqta®	36° - 46°F	Do not freeze.

HEP B - Engerix®, Recombivax®	36° - 46°F	Do not freeze.
HEP B/HIB - Comvax®	36° - 46°F	Do not freeze.
HIB - ActHIB®	36° - 46°F	Do not freeze. Administer within 24 hours of reconstitution with sodium chloride 0.4%, within 30 minutes if reconstituted with Tripedia®.
HIB - PedVaxHIB®	36° - 46°F	Do not freeze.
HIB - Hiberix®	36° - 46°F	Do not freeze vaccine or diluent; protect from light. Use immediately after reconstitution or can be stored for up to 24 hours between 36° - 46°F. Diluent may be stored with vaccine or at room temperature 68° - 77°F.
HPV - Gardasil®	36° - 46°F	Do not freeze. Protect from light. Can be maintained at temperatures up to 77°F for up to 72 hours before discarding.
Immune Globulin, Hepatitis B- Nabi-HB®, HepaGam®	36° - 46°F	Do not freeze. HepaGam B and Nabi-HB within 6 hours of entering vial. Partially used vials should be discarded.
Immune Globulin, Rabies - Imogam Rabies-HT®, HyperRab S/D®	35° - 46°F	Do not freeze.
Influenza	35° - 46°F	Discard if vaccine has been frozen. Afluria®, Fluvirin®, Fluarix®, FluLaval® should be stored in original box and protected from light. Multidose vials of Afluria® and FluLaval® should be stored at 35° - 46°F and discarded 28 days after vial has been entered.
Meningococcal - Menactra®	35° - 46°F	Protect from freezing.
Meningococcal - Menomune®	35° - 46°F	Discard if vaccine has been frozen. Multidose vials should be used or discarded within 35 days of reconstitution, single dose vials should be used within 30 minutes of reconstitution.
Meningococcal - Menveo®	36° - 46°F	Do not freeze. Protect from light. Reconstituted vaccine can be held at 77°F or below for up to 8 hours.
MMR - MMR® II	36° - 46°F	Protect from light. Reconstituted vaccine should be stored between 36° - 46°F and use within 8 hours. Diluent may be stored with vaccine or at room temperature.
Pneumococcal polysaccharide - Pneumovax®	36° - 46°F	
Rabies - RabAvert®	36° - 46°F	Protect from light. Use immediately after reconstitution.
Rotavirus - Rotarix®	36° - 46°F	Discard if vaccine has been frozen. Protect from light. Reconstituted vaccine may be stored at 36° - 77° F for up to 24 hours.

Rotavirus - Rotateq®	36° - 46°F	Protect from light; should be administered immediately after reconstitution.
S. Pneumonia - Prevnar®	36° - 46°F	Do not freeze.
Td	35° - 46°F	Do not freeze.
Tdap - Adacel®, Boostrix®	35° - 46°F	Do not freeze.
Varicella - Varivax®	≤ 5°F	Protect from light. Administered within 30 minutes of reconstitution or discarded; can be kept unconstituted at 36° - 46°F continuously for 72 hours, then discarded. Diluent should be stored separately in refrigerator or at room temperature 68° - 77°F.
Varicella - Zostavax®	- 58° - 5°F	Protect from light; can be kept unconstituted at 36 - 46 F continuously for 72 hours, then discarded. Diluent should be stored separately in refrigerator or at room temperature 68° - 77° F.
		Revised 6/2011