

QUALITY IMPROVEMENT

Interpretive Guidelines



~~Twentieth~~ 21st Edition
July ~~2012~~ 2013

Tennessee Department of Health
Office of Quality Improvement

Interpretive Guidelines Table of Contents

Administration Questions 1-4	Page 3
Administration Questions 5-7	Page 9
Availability	Page 17
Comprehensive Medical Record	Page 20
Fiscal	Page 53
Risk Minimization	Page 58
Title VI	Page 82
WIC	Page 84

Office of Quality Improvement Program-Interpretative Guidelines

Administration Questions 1-4

GUIDELINES/STANDARDS	GUIDANCE TO REVIEWER
<p>1. Employees are aware of the Policies and Procedures Manual for the Division of Community Health Services Administration and are able to access an up-to-date hardcopy or access it electronically. CHSA Policy 3.7.c</p>	<p>Ask county director, office manager or nurse supervisor to demonstrate how they would access the Division of Community Health Services Administration (CHSA) Policy & Procedure Manual. Ask any random Department of Health employee if they are aware of the CHSA Policy and Procedures Manual and how they would access it if needed. CHSA Policy Manual: http://hsaintranet.health.tn.gov/default.asp</p>
EMPLOYEE ORIENTATION	
<p>2. Each new employee of the Division of Community Health Services Administration has an orientation class according to the Policies and Procedures Manual and Regional Policies. CHSA Policy 3.7.c or Metro Policies and Procedures</p>	<p>Orientation Packets are received from the Office of Human Resources on each new state employee. Information is covered that is contained in the New Employee Handbook dated November 2014 within three weeks after the employee reports to work. To access the handbook, go to the following link: http://www.state.tn.us/dohr/employees/pdf/Employee_Handbook.pdf</p> <p>Mark Standard 2a-2c NA if no new employees were hired since last Administration 1-4 Review date at the review site.</p>
<p>A. Regional staff in charge of Human Resource matters are responsible for conducting orientation classes for new county and regional staff every month (within 30 days of hire), or when necessary, using material developed by the Office of Human Resources.</p>	<p>Ask Regional Human Resources Officer to give you a list of new employees. Request documentation of dates and content of orientation classes. Classes should be every month except when there are no new employees.</p>

B. Content of the classes will include information on:	Check to see if the content of the class includes items listed.
1) Material contained in the New Employee Orientation Package distributed to new employees by the Office of Human Resources of the Department of Health.	All information contained in this packet is completely covered by the Human Resources Officer in the new employee orientation session.
2) State Human Resources policies and employee benefits.	All information contained in this packet is completely covered by the Human Resources Officer in the new employee orientation session, including all information on applicable state insurance benefits, all questions are answered, all forms completed and submitted to Human Resources within three weeks after new employee reports to work.
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:	A scheduled orientation is set up by the appropriate supervisor with program staff after initial employment to discuss specific program information. The New Employee handbook , (revision November 2011) is on line at: http://www.state.tn.us/dohr/employees/pdf/Employee_Handbook.pdf
1) Detailed description of the divisions, offices, sections and programs within the Division of Community Health Services and the services provided by each.	Copy of this information is contained in the new employee packet and discussed with employee during orientation.
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.	The mission statement of the Tennessee Department of Health is covered as well as the relationships between Local, Regional, and Central offices during the new employee orientation.
3) Policies and procedures of the Division of Community Health Services Administration as well as specific program policies.	Employees are provided access to a hard copy or electronic version of the CHSA Policies and Procedures Manual : http://hsaintranet.health.tn.gov/default.asp Each Program is responsible for providing/reviewing all program policies (if applicable) with employee.
4) Employee HIPAA and confidentiality requirements.	Copy of 6 in 1 form is given to all new employees to read and sign. A copy is placed in each employee's Human Resources file.
5) Quality Improvement and other specific program standards.	QI standards are located in QI Manual in the Regional Office and each local health department and/or on line. Ask any staff member or supervisor to access the current copy. The QI Manual intranet link is: http://hsaintranet.health.tn.gov/default.asp
EMPLOYEE RECORDS	

<p>3. Employee records are maintained at designated base worksite and/or Regional Office in an assigned secure location with limited access. CHSA Policy 3.9</p>	<p>Human Resources files of all employees are kept in a designated secure location at the Regional Office and in the Central Office. The files must be locked and in a secured location. CHSA Policy Manual: <u>http://hsaintranet.health.tn.gov/default.asp</u></p>
<p>A. Human Resources files – CHSA Policy 3.9</p>	<p>Human Resources files are in an assigned secure location with limited access. Ask the Human Resources Officer, Section Chief, County Director, Clerical Consultant, or Office Manager to show you where they are kept, ensuring security.</p>
<p>B. Attendance and leave records http://www.tn.gov/dohr/tech_svrs/pdf/Attendance%20and%20leave%20manual.pdf</p>	<p>Attendance and leave records are within the Edison Project computerized system or in an assigned secure location with limited access. Ask the Human Resources Officer, Section Chief, County Director, Clerical Consultant, or Office Manager to show you where they are kept, ensuring security. Attendance and Leave Policies and Procedures Manual October 2011 version</p>
<p>C. Travel reimbursement claims http://tennessee.gov/finance/act/documents/policy8.pdf</p>	<p>Travel reimbursement claims are within the Edison Project computerized system for state employees or are in an assigned secure location with limited access. Ask the Human Resources Officer or a site supervisor to show you where they are kept to assess security. Department of Finance and Administration Policy 8 Comprehensive Travel Regulations Revised May 1, 2011 August, 2012 version</p>
POSTERS	
<p>4. Required posters are present in the appropriate area. P=Display in Public Area E=Display in Employee Area ◇ = Required State Posters ◆ = Required Federal Posters</p>	<p>All required posters/memorandums of information are posted as directed in the Central Office, Regional Offices, and at all local Health Departments.</p>
<p>The state and federally required posters may be combined in a commercially prepared laminated poster which contains 9-12 multiple posters-or more. These posters can also be obtained free online and be posted individually.</p>	<p>The multiple (9-12) in one poster may be used and can be purchased from Labor Law Center, at www.GovDocs.com or each individual poster may be posted. These required federal posters can be obtained free at the following link: http://www.dol.gov/oasam/programs/osdbu/sbrefa/poster/matrix.htm or from the Workforce Development representative in your area. For office locations go to (updated 2/14/11): http://www.state.tn.us/labor-wfd/weoc_map2.pdf http://www.tennessee.gov/labor-wfd/et_dw_map.pdf Required state posters can be obtained free at the following link: http://www.tn.gov/labor-wfd/poster.htm</p>
<p>1. ◆ “Equal Employment Opportunity is the Law” (P) August 2008 with supplement or 11/2009 revision</p>	<p>This information is to be posted in a public area. http://www.dol.gov/ofccp/regs/compliance/posters/pdf/eeopost.pdf</p>

2. ♦ <u>"Your Rights Under the Family and Medical Leave Act of 1993"</u> 2/2013 <u>http://www.dol.gov/whd/regs/compliance/posters/fmlaen.pdf</u> http://www.dol.gov/whd/regs/compliance/posters/fmlaen.pdf (P)	This information is to be posted in a public area. The Military Family Leave insert is to be printed off and added to the FMLA poster area.
3. ♦ <u>"Employee Rights Under the Fair Labor Standards Act"</u> July 2009 (P) <u>www.dol.gov/whd/regs/compliance/posters/minwage.pdf</u>	This information is to be posted in a public area. Please note that the July 2007 revision of the minimum wage poster, reflecting the 2007 amendments to the Fair Labor Standards Act, is still valid and employers may continue to post them. (Shows the \$7.25 7/24/09 minimum wage)
4. ◇ <u>"It's The Law! You Have a Right to a Safe and Healthful Workplace."</u> 11/1/2000 (E) <u>www.state.tn.us/labor-wfd/newtoshaposter.pdf</u>	Post the <u>Tennessee TOSHA poster</u> instead of the OSHA poster which may be included on the 9/12-in-one commercially obtained multi -poster. This information is to be posted in an employee area.
5. ◇ <u>"Tennessee Law Prohibits Discrimination in Employment"</u> 10/2008 (P) <u>http://state.tn.us/humanrights/publications/employment_poster.pdf</u>	TN Human Rights Commission, (615) 741-5825 Department of Labor & Workforce Development. This information is to be posted in a public area.
6. <u>State of Tennessee Executive Order by the Governor #3</u> , An Order Concerning Equal Employment Opportunity. (P) <u>http://www.state.tn.us/sos/pub/execorders/exec-orders-haslam3.pdf</u>	This information is to be posted in a public area. Poster is dated January 15, 2011 and is by Governor Haslam. (615) 741-3245 TN Dept. of Human Resources, Equal Employment Opportunity.
7. "Your Rights Under the Americans with Disabilities Act of 1990" 1993 (P)	This information is to be posted in a public area. TN Department of Human Resources, (615) 741-6350 ADA Act of 1990 Publication: http://www.ada.gov/pubs/adastatute08.htm
8. TennCare Poster – "Having problems getting health care from TennCare" 6/7/2011 (P)	Poster should be posted in public area. http://tennessee.gov/tenncare/forms/medicalappeal.pdf
9. Comptroller's Hotline Number 4/2013 (P) 1-800-232-5454 or (615) 741-2775 2504	This information is to be posted in a public area. New 4/2013 poster to be distributed after 7/1/13 accept older version until regional supply of 4/2013 poster is received.
10. Fair Hearing Procedure/WIC (P)	This information is to be posted in a public area. Contact Regional WIC Director
11. "And Justice for All" USDA Form AD-475C 9/2006 12/1999 (P) http://www.rma.usda.gov/aboutrma/civilrights/AD-475C.pdf	This information is to be posted in a public area. "And Justice for All" posters are to be displayed in a specific size: 11" width x 17" height. USDA reprinting is suspended at this time indefinitely so the 1999 poster is to be accepted. Contact Regional WIC Director http://www.fns.usda.gov/cr/justice-translations/475C.pdf
12. Services are available on a sliding fee scale basis. (P)	Posted in reception area. CHSA Policies <u>7.9</u> and <u>7.22</u>

http://hsaintranet.health.tn.gov/default.asp	
<p>13. Clinic Hours and Names of Direct Care Staff on Duty (P) http://hsaintranet.health.tn.gov/default.asp <u>CHSA Policy 3.10</u></p>	<p>Clinic hours are posted on the front door or in front window of each Local or Regional Health Department site to be visible from the outside of the building. Each health department facility is required to have in public view for each clinic session, an up-to-date roster of direct health providers who staff the clinic.</p>
<p>14. Name and telephone number of nearest Poison Control Center Tennessee Poison Center 1-800-222-1222 http://www.mc.vanderbilt.edu/root/vumc.php?site=poisoncenter</p>	<p>This information is to be posted in a public area.</p>
<p>15. Equal Opportunity is The Law, Title VI Section 601, of the Civil Rights Act of 1964, Department of Health</p>	<p>This information is to be posted in a public area. Office of Title VI/Non-Discriminatory Compliance and Diversity Business, Luvenia H. Butler, MS, Director, (615) 741-9421</p>
<p>16. 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>	<p>This information is to be posted in a public area. Poster was generated by CHSA Central Office and distributed through Regional Directors in 2007.</p>
<p>17. Position Vacancy Notices — State and Contract Agencies (P)</p>	<p>“Whenever a vacancy occurs within your division, office, region, county or unit, a system will be utilized in order that the vacancy notice is circulated and posted in a location accessed by all 10 days prior to a register being requested and worked to fill the position.” Posted by the Human Resources Officer.</p>
<p>18. Complaint process forms for Civil Rights Act of 1964 Tennessee Department of Health Title VI Compliance Director (615) 741-9421</p>	<p>Does not have to be posted on the wall but must be visible and available to the public without asking. This information is to be present in a public area.</p>
<p>19. “NO SMOKING” signs are posted in patient waiting rooms and other appropriate areas <u>CHSA Policy 7.2</u> (P) and (E)</p>	<p>“Smoking of cigarettes, cigars, and pipes is not permitted in any portion of any Local Health Department or Regional Office used routinely for the delivery of services to children if the services are funded directly or indirectly with federal dollars. If clinical services are not provided at the facility, a “designated smoking area” indoors must be provided.” This information is to be posted in an employee and a public area. (<u>CHSA Policy 7.2</u>) “No Smoking” signs must be posted at each entrance specifying that smoking is not permitted within 50 feet of any entrance.</p>
<p>20. Copy of the Department’s Non-Discrimination Affirmative Action Policy Statement will be distributed to all agency employees and posted on bulletin boards. (P) and (E)</p>	<p>This information is to be posted in an employee and a public area. Check to see if the Commissioner’s memorandum regarding Affirmative Action is posted. This memorandum is updated as needed by each Commissioner of Health in the State of Tennessee Department of Health Affirmative Action Plan (March 1, 2012 most recent memo).</p>

21. <u>"Workplace Harassment Policy"</u> Revised 4/12/11-12/4/12 (P) and (E)	This information is to be posted in an employee and a public area. Tennessee Department of Human Resources (615) 741-6350
22. ◇ <u>TN Unemployment Insurance Poster</u> 12/2005 4/2013 6/2013 (E) http://www.state.tn.us/labor-wfd/uiposterab1.pdf	This information is to be posted in an employee area.
23. ◇ <u>Workers' Compensation Posting Notice</u> Revised 3/2012 http://www.tn.gov/labor-wfd/forms/WC_Certificate_3_12.pdf (E)	This information is to be posted in an employee area. Department of Labor & Workforce Development
24. <u>OSHA 300 Summary Form</u> to be posted each February, March and April. http://osha.gov/recordkeeping/new-osha300form1-1-04.pdf (E)	Log is to be posted on employee bulletin board in each section in central office, and in each health department, or regional office. Respective information regarding incidents occurring on site should be reflected on form. Department of Labor & Workforce Development
25. ♦ <u>Your Rights Under USERRA, the Uniformed Services Employment and Reemployment Rights Act.</u> October 2008 http://www.dol.gov/vets/programs/userra/USERRA_Private.pdf (E)	This information is to be posted in an employee area. U.S. Department of Labor, VETS
26. State Regulations for Protection Against Radiation – "Notice to Employees" Form RHS 8-3 http://www.tn.gov/sos/rules/1200/1200-02/1200-02-04.20111208.pdf (E)	This document should be posted as required by law in the x-ray employee area. See page 16 of the linked document, December 2011 revision (no changes in poster from 2/11 version) http://www.tn.gov/sos/rules/0400/0400-20/0400-20-04.20120522.pdf Page 15, Revised 5/2012
27. ♦ <u>Know Your Rights Under the Recovery Act! - Federal Whistle Blower</u> poster http://www.recovery.gov/Contact/ReportFraud/Documents/WhistleblowerPoster.pdf (E)	This July 2009 poster (poster is not dated) is to be posted in the employee area. Link to the Recovery and Reinvestment Act of 2009 document: http://www.oig.dot.gov/sites/dot/files/Recovery_Act.pdf This poster is not available in Spanish (3/13/12 as of 5/13/13)
28. ◇ <u>Reporting TennCare Fraud and Abuse</u> 12/2005 (P)	TennDent Health Department providers can either post this poster or the notice letter from TennDent dated 5/13/11. Both are not required. Required only in TennDent provider sites. Write-in-as comment only presence or absence. Contact State QI Director for Spanish copies of this poster. TennDent contracted services will be replaced by DentaQuest 10/1/13. Do not review for this poster after this date. Posting requirements from DentaQuest have not been received as of 7/1/13.

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.

Administrative Questions 5-7

DEPARTING EMPLOYEES	http://hsaintranet.health.tn.gov/default.asp
<p>5. Notification of an employee's departure from our employment is to be submitted in writing to the Office of Human Resources along with all required accompanying paperwork. (CHSA Policy 3.17)</p>	<p>Ask the Regional Human Resources Officer to give you a list of all departing employees for the review site since the last review period. Check to see if the policy and procedures were followed.</p>
<p>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.</p>	<p>Paperwork including the PRT-3 form (state employees), is completed and submitted to the Office of Human Resources (OHR). A copy is placed in the employees' Human Resources file. OHR is asking for something in writing from the employee when they plan to transfer, retire or resign. Files are kept 3 years after the employee leaves state service for audit purposes.</p>
<p>B. Human Resources officer should forward the PRT-3 form, the employee's resignation letter and all required paperwork to the Office of Human Resources.</p>	<p>This policy is required for all <u>state</u> employees. A copy of the paperwork is placed in the employee's Human Resources file and kept for 3 years.</p>
<p>C. The supervisor/Human Resources officer must obtain the following items upon notification of impending resignation or transfer of an employee. <i>Note that not all of these items will pertain to every employee.</i></p>	<p>This policy is required for all <u>state</u> employees. A copy of the paperwork is placed in the employee's Human Resources file and kept for 3 years.</p>
<p>1) Letter of resignation</p>	<p>A copy of the paperwork is placed in the employee's Human Resources file and kept for 3 years.</p>
<p>2) State ID card</p>	<p>The Human Resources Officer (once received from the employee) retains the State ID card in the employee's Human Resources file.</p>
<p>3) Photo ID card</p>	<p>The Human Resources Officer (once received from the employee) retains the State Photo ID card in the employee's Human Resources file. Central Office photo ID's are given to the OHR</p>
<p>4) State parking decal</p>	<p>The Human Resources Officer (once received from the employee) sends the State parking decal to the Regional Human Resources Officer. This transaction is documented in the employee's Human Resources file.</p>
<p>5) Keys to all property (building, locks in cubicle, moneybox, etc.)</p>	<p>Return of all keys by any departing employee (state, county, or contract) should be documented on the pertinent key log by the Supervisor or person that received the returned keys.</p>
<p>6) Security number/password to voice mail</p>	<p>Employees are instructed to change their password back to the original phone number before leaving.</p>
<p>7) All password and identification/security numbers assigned</p>	<p>It is the responsibility of each Human Resources Officer to report all</p>

for systems access (i.e. email, Edison User Separation form, RACF/ provider number, Health Separation form)	terminated employees to the appropriate Systems management staff who are responsible for terminating all computer security access numbers.
8) Computer software and respective manuals	These manuals are left at the work site where the computer is located. The Systems Managers collect these items once the employee terminates.
9) State credit card	It is the responsibility of the Human Resources Officer to collect the card and cut it up. The destroyed card is to be sent to Sharon D. King. A call must also be placed to the Division of Administrative Services Office/Sharon D. King (615) 741-0948 to notify her of the employee's card number and date of their termination as early as possible
10) State telephone credit card	It is the responsibility of the Human Resources Officer to collect the state issued telephone credit card and cut it up. The destroyed card is to be sent to Faye Barrett. A call must be placed to the Division of Administrative Services Office /Faye Barrett (615) 532-7763 to notify her of the employee's card number and date of their termination as early as possible.
11) State owned equipment (e.g. cell phone, pager, laptop computer, etc.)	All equipment is to be returned to the work site where the employee was based. Check for equipment list documentation (if applicable) showing return of all equipment issued during employment by the departing employee.
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.	The Regional Human Resources Officer always notifies System Administrators of departing employees and informs them of the employee's RACF ID number so that the number can be de-activated. In some regions you may verify this by looking in PTBMIS on the provider screen list to see if provider number has been terminated timely or contact Regional IT department for confirmation of deactivation of provider numbers. Final timesheet must be faxed to Human Resources by Human Resources Officer.

ATTENDANCE AND LEAVE	
<p>6. Employees' (state, local, contract) attendance and leave/time distribution reports are current and accurate. CHSA Policy 3.3 http://hsaintranet.health.tn.gov/default.asp and the Attendance and Leave Manual, Tennessee Department of Health Office of Human Resources) http://www.tennessee.gov/dohr/employees/pdf/attendance&leave.PDF http://www.tn.gov/dohr/tech_svrs/pdf/Attendance%20and%20leave%20manual.pdf</p>	<p>Reviewer will look at all employees' attendance and leave reports and select three months of reports to review. The reviewer will decide at random which three months they will select. Regional Human Resources Officer will provide information held in Edison as previously arranged with Regional Director and Regional QI Director. Attendance and Leave Manual current version is October 2014 on-line version is not dated. State employees' attendance and leave will be self-entered into the Edison Project system for Supervisor approval and management. Edison Project files are not directly accessible by the QI Directors Reviewers.</p>
<p>A. Copies (3 years) are present at the site where leave is keyed, for all pay periods.</p>	<p>Ask to see where files are kept and determine if three years of information is present. State employee: information is held within the Edison Project System electronic files. Mark met</p>
<p>B. The current attendance and leave form shows:</p>	<p>State employee: All entries are made into and all calculations are made by the Edison Project System and are not accessible to the QI Director for confirmation. Mark met Non-State employee - Ask the timekeeper for information regarding the forms used in documentation of attendance and leave and the accrual rates for non-state employees based in that site. Each county may have different forms, documentation requirements, and accrual rates for non-state employees.</p>
<p>1) Daily hours worked.</p>	<p>State employee: All entries are made into and all calculations are made by the Edison Project System and are not accessible to the QI Director for confirmation. Mark met Non-State employee – Review each individual non-state employee's time sheet for the selected 3 months. Determine that each day worked is correctly documented and calculated. Note: Forms and documentation requirements may vary greatly by type and method for non-state employees.</p>

<p>2) Accurate pay period calculations.</p>	<p><u>State employee</u>: All entries are made into and all calculations are made by the Edison Project System and are not accessible to the QI Director for confirmation. Mark met <u>Non-State employee</u> – Review each employee’s time sheet for the selected 3 months to determine that the pay period total is correctly calculated to include all overtime and leave considerations. Entries made for labor distribution should equate to total time reported as worked.</p>
<p>3) Fully completed and accurate footings where applicable.</p>	<p><u>State employee</u>: All entries are made into and all calculations are made by the Edison Project System and are not accessible to the QI Director for confirmation. Mark Met <u>Non-State employee</u> – Assess that mathematical calculations are correct for the appropriate accrual rates as designated by the time keeper. If forms do not contain accrual footing documentation, mark this standard as NA.</p>
<p>4) Signatures with dates of employee, supervisor, and time-keeper (optional) for all pay periods.</p>	<p>All electronic signatures for state employees’ attendance and leave will be within Edison documentation. County specific forms may/may not require the same signatures as listed. Mark this standard NA for State employees or any non-state employee forms that do not require signatures.</p>
<p>C. The current attendance and leave form correlates with travel claim(s).</p>	<p>The Human Resources Officer is to provide information to the QI Director regarding non-state employees for this standard. The reviewer is to compare travel claims for the same time period that the time sheets are reviewed to determine that no travel is claimed when the employee has claimed a full day of leave. If the employee did not have any travel claimed, mark the standard NA. Mark this standard NA for state employees whose time and travel are entered into Edison since this data is may not be available to the HR Officer or to the reviewer. Comprehensive Travel Regulations</p>
<p>D. Approved documentation for changes in regularly assigned workweek is present.</p>	<p><u>State employee</u>: All entries are made into and all calculations are made by the Edison Project System and are not accessible to the QI Director for confirmation. Mark Met <u>Non-State employee</u> – Note: Forms and documentation requirements may vary greatly by type and method for non-state employees and may or may not require this documentation. Mark the standard NA if no such documentation is required for that site.</p>

HUMAN RESOURCES FILES	http://hsaintranet.health.tn.gov/default.asp
<p>7. Each state, local, and contract employee's file will contain copies of relevant documents: CHSA Policy 3.9 ♦ = Documents that are not <u>required</u> (but may be present) for non-state employees.</p>	<p>Every file will not contain every document. The documents marked with ♦ may be held in the county government's personnel department and are not subject to QI review.</p>
<p>A. ♦A copy of the worked register, Certification of Eligibles or referral listing after 10/2012.</p>	<p>A copy of the worked register is to be in the Human Resources file of all civil service state employees as denoted in block 22 of the PNF-204 if hired prior to September 2008. The distribution of all PNF-204's was discontinued with the Edison Project. The register is a list of the eligible people that have applied for a state position. A worked Register copy is not required for non-state employees. Employees hired prior to use of register should have an appointment letter on file. Certification of Eligibles or referral listing is required for new state employees hired after 10/1/2012.</p>
<p>B. ♦Copies of documents for completion of appointment</p>	
<p>1) ♦Letters sent; undelivered envelopes; copies of emails</p>	<p>Required for state employees only. Letters are the ones sent to people listed on the worked register to determine interest in the open position. There may also be copies of emails sent to people listed on the register.</p>
<p>2) ♦EEO form with appropriate signatures PH-1454 (1987)</p>	<p>This form must be filed in the Human Resources record of all state employees hired on or after November 7, 1986.</p>
<p>3) ♦If hired after November 6, 1986, Employment eligibility verification, including copies of proof per I-9 criteria. (1986)</p>	<p>Required for employees hired after November 6, 1986. Copies of the documents used to verify employment eligibility should also be present. Documents acceptable for proof are listed on the I-9 form. Forms for non-state employees may be in a separate location if eligibility determination was done at a site other than in the health department's Human Resources office. I-9 forms only have to be retained for 3 years after hire or one year after the date employment ends, whichever is later. (Form revision 8/7/2009)</p>
<p>C. ♦If applicable, a copy of the approved PNF-201 form on the appointment. (10/1971)</p>	<p>Required for state employees hired after October 1971. The PNF-201 showing the appointment to the position will have a "01" in the "Type" box under the section numbered #48 and titled "Previous Transaction". PNF-201 form was discontinued with the Edison Project. This standard will be marked NA for those state employees hired after 9/1/2008</p>
<p>C. ♦ Title VI of the Civil Rights Act of 1964 (9/2003) and/or Title VI Completion Certificate (4/2013).</p>	<p>Title VI Training is mandatory. Signed and dated statement of training is to be present in all Human Resources records. Title VI Completion Certificates for training in 2013 should be present.</p>

<p>D. ♦A copy of the completed PRT-3 form showing the employee's report to work information.</p>	<p>Required for state employees hired after 10/1975 only. The form PH-0078 (Revised 6/2009) will have Human Resources Request-3 in the top right corner of the page. (There also are PRT-1 and PRT-2 forms that you may see in the Human Resources record dated prior to the PRT-3 form's completion)</p>
<p>E. ♦A copy of the employee's current Job Performance Plan signed and dated. (7/1983)</p>	<p>Job plans should be completed and signed by employees at the beginning of each evaluation cycle. All job plans for state employees are now documented in Edison as of 9/18/08 and in the SMART format as of 6/30/12. The Regional Human Resources Officer is to provide the QI Director with the name of any state employee whose Job Plan is not current. When there is a change of supervisor for a state employee, an updated Job Plan is to be completed within 30 days by the new supervisor. Supervisors must complete a job performance plan for all career and executive service employees by June 30, 2012. Non-state employees' job plan format is a regional decision. Executive service employees' job plans will be on paper and not in Edison until after 7/1/13.</p>
<p>F. ♦Copies of the employee's current Performance Evaluation forms with proper signatures and dates. (7/1983)</p>	<p>All PE's for state employees will be in the Edison System. The Regional Human Resources Officer is to provide the QI Director with the name of any state employee whose Performance Evaluation is not current. Supervisor has to be in the position of supervision of the employee for 3 months prior to evaluating the employee. SMART Memo 5/1/12 – All supervisors must complete 2 interim reviews during the yearlong PE cycle and complete a formal evaluation on each employee by 6/30/13 7/31/13. The first interim review is to be completed by 10/31/12 and the second is to be completed by 2/28/13. Executive service employees' performance evaluations will be on paper and not in Edison until after 7/1/13.</p>
<p>G. ♦PH-2003 flexible work schedule for the employee, applicable only if schedule is other than 8 – 4:30. (8/99)</p>	<p>Any employee assigned to work a schedule other than 8-4:30, as evidenced by review of their time sheets, is required to have the approval of their first and second level supervisor documented and placed in their Human Resources record.</p>

<p>H. A signed copy of PH-3131 (6 in 1) (3/2007).*</p>	<p>All employee records should have a signed copy of the 3/2007 6 in 1 PH-3131 form. The older individual forms may be present also. The 6-in-1 form was revised 3/2007). PH-3131 includes HIPAA and Human Resources Confidentiality Statement (2003), Drug Free Workplace (1988), Workplace Harassment (2005), Conflict of Interest Policy Acknowledgment (1995), Operation of Motor Vehicles by State Employees Policy (2003) and Acceptable Use Policy (2006). The Workplace Harassment Policy revision dated 12/4/12) receipt acknowledgement is to be signed by any new employee hired after 4/2011-12/4/12. Older forms in current employee's files are acceptable per Tina Harris, HR Manager, Employee Relations.</p>
<p>I. TennCare Impartiality Statement, CHSA 3.16, PH-3496 (4/05)</p>	<p>All applicable employees; state, contract, or county are required to read and sign the PH-3496 for inclusion in their personnel record. Policy states: A TennCare Impartiality Statement must be signed by all employees who are involved in the TennCare program in any manner. The completed statement shall be filed in the employee's personnel file after the supervisor signs it.</p>
<p>J. Acceptable Use Policy version 1.13, April 9, 2009 FA-0984*</p>	<p>All employees, state, county, or contract are required to read and sign this policy prior to using the Internet services of the Department of Health. The signed form will be filed in their Human Resources record. Updates to the Acceptable Use Policy 1.13 have been minor to the extent NOT to require employees to re-sign if 1.10 version is present.</p>
<p>K. Signed copy of the Computer Access Security Agreement PH-3601 RACF*</p>	<p>The reviewer will need to determine the regional policy for assigning of RACF numbers. The numbers may be assigned to all employees or just on the basis of need. Reviewer will need to ask either the County Director or the System Administrator for a list of people in each site that have been assigned a RACF number and look in the appropriate Human Resources records for the signed agreement. Watch for an Edison Project update for this form.</p>
<p>L. Copies of appropriate credentials (diploma, certificate, license, annual or biennial license renewal, other). NPI # only for those whose name is on billing statements. See CHSA Policies 3.9, 3.18, 8.6.b and credential checklist. http://hsaintranet.health.tn.gov/default.asp</p>	<p>Copies of Credentials that are required for specific positions or job classifications are to be present in the Human Resources record. You may look for license verification on Health Care facilities web page, http://health.state.tn.us/Licensure/default.aspx Dental: Current unrestricted DEA number certificate for dentists. This document will be found in the employee's HR record. The licenses for all dental staff must be displayed.</p>

1) This employee requires licensure or certification renewal at specific intervals.	This question is either yes or NA. If yes, the reviewer is to determine current licensure status.
2) A copy of current license or certification has been provided.	If applicable, a copy of the license or certification should be present in the Human Resources record.
3) Renewal date of license or certificate is: _____	If applicable, the renewal date for licensure or certification should be entered (dd/mm/yy).
M-	

*The Computer Access Security Agreement PH-3601, Acceptable Use Agreement Form FA-0984 (Version 1.13) and the 6-in-one PH-3131 forms are ALL required for employees with computer access.

Availability

GUIDELINES/STANDARDS	GUIDANCE TO REVIEWER
1. Patient satisfaction survey system is conducted each calendar year for a period of 5 working days. http://hsaintranet.health.tn.gov/default.asp	Verify a patient satisfaction survey was completed within the last 12 months. Verify the director has implemented a plan to address negative patient complaints. See CHSA Policy 7.19
Disability Rights	
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	“State and local governments are required to follow specific architectural standards in the new construction and alteration of their buildings. They also must relocate programs or otherwise provide access in inaccessible older buildings, and communicate effectively with people who have hearing, vision, or speech disabilities. Public entities are not required to take actions that would result in undue financial and administrative burdens. They are required to make reasonable modifications to policies, practices, and procedures where necessary to avoid discrimination, unless they can demonstrate that doing so would fundamentally alter the nature of the service, program, or activity being provided.” ADA Title II: State and Local Government Activities
A. The clinic has handicapped access or has alternate service site.	If site does not have handicapped access, there is an alternate service site available.
B. Designated handicapped parking.	Observe that there is designated parking and space for a handicapped person to park with appropriate signage.
C. Designated handicapped toilet facilities.	Observe that there are designated toilet facilities that are appropriately equipped with proper door widths, handrails, sinks and lighting etc. as specified by the American Disabilities Act.
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 Policy 7.9 and 7.24 HIPAA CHSA Policy Manual: http://hsaintranet.health.tn.gov/default.asp	Observe staff interacting with patients and their representatives in a professional manner. Observe for visual and auditory privacy (closed doors, front desk and clinic room telephone conversations, etc.). Computer monitors should be positioned so they cannot be viewed by unauthorized persons. Sign-in sheets should not ask for “reason for visit”. Identifying signs should be removed (i.e., sign that says Family Planning, STD, TB exam room placed right outside to identify the type of patient being seen.)
B. Medical records are secured and appropriate HIPAA privacy measures are observed. CHSA Policies 5.1.a , 5.2.a , and 7.24	Medical records should be placed so identifying information is not viewed. Medical records in wall-holders should have PHI facing the door. Medical records, lab slips, or lab specimens should not be left in clinic room or lab area where next patient can view. Medical

	records should be returned to the centralized filing system area at the end of the day. An “out” guide should be used when records are removed from central filing for any reason other than clinic visit that day. HIPAA Policies and Procedures Manual http://intranet.health.nash.tenn/intranet/LinkClick.aspx?fileticket=t60OGDIjS-U%3d&tabid=359&mid=792
4. Health departments are open during lunch and normal business hours. CHSA Policy 3.3.h	Observe that staff are present during regular working hours, the building is unlocked to permit client access and patient’s are given appointments during lunch time 11:00 am until 1:00 PM (except in a 1 nurse county). Review profiles and clinic rosters for compliance.
5. Individuals are able to identify personnel by name and title. CHSA Policy 3.10 and 8.11	<ol style="list-style-type: none"> 1. Review CHSA Policy 3.10 and 8.11 Tenn. Code Ann. § 63-1-109 2. This guideline is determined by observation. During the review period, count how many of the direct health providers and clerical personnel you see with their name tags on while in the public area. Determine the medical doctors, osteopathic physicians, dentists, and advanced practice nurses who deliver direct patient care at the review site and assess site compliance with posting regulations of CHSA Policy 8.11. 3. Document the numbers of staff that were met and not met.
6. There is reasonable access to basic public health services.	Pull up or have a PHOA pull up the first available appointments in PTBMIS for Family Planning, WIC, STD, Pregnancy test, Immunizations, etc. or review PTBMIS system for the site’s various clinic rosters. What is their walk-in policy?
A. Available appointments for appropriate visits.	<p>Pregnancy testing- to be seen day of request or per nursing judgment or regional policy. If site is open access with no appointments scheduled, this standard is NA.</p> <p>Dental: Dental emergencies – Ask the clerical staff or dental staff how patient requests for dental emergency visits are handled in each dental clinic. Dental emergencies are to be seen on the same day they call if at all possible. If they walk-in they are to be seen that day. See Standards of Practice for Dental Public Health Section 1 page 17 (2011 version): Emergency Services. They cannot be turned away if they show up. Mobile Dental Units are marked N/A to this standard.</p>
B. Immunization services are readily available. (Child & Adolescent Health Manual, 2002, pg. 1-2.0)	Immunizations- visits are readily available, there are no barriers or prerequisites

C. Providers co-schedule immunization appointments in conjunction with appointments for other child health services. (Child & Adolescent Health Manual, 2002, pg. 1-2.0)	Per regional policy and specific program guidelines, various appointment types are available and co-scheduled when appropriate. For open access sites, review that immunizations are available in conjunction with other services on the same visit day.
D. STD services are readily available.	Sexually Transmitted Diseases- a case or contact is treated the day the person is contacted or contacts the Health Department. http://health.state.tn.us/STD/professionals.shtml
E. Clients applying for WIC are seen in appropriate time (WIC Manual 2011-2012 2012-2013 version) http://hsaintranet.health.tn.gov/default.asp	WIC - pregnant women, infants under 6 months and migrants within 10 <u>calendar</u> days all other requests for WIC services will be honored within 20 <u>calendar</u> days. Does the site “work in” a patient within the mandated time period if no appointment is available on the profile? If so, standard is met. 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	PCP sites will provide urgent care visits within 48 hours and preventive visits within 3 weeks of request. This 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	Pull up or have a PHOA pull up first available appointments in PTBMIS for primary care visit.
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)	Ask staff to relate how urgent care visits are addressed.

Comprehensive Health Maintenance

GUIDELINES/STANDARDS	GUIDANCE TO REVIEWER
<p>1. Program eligibility criteria met</p> <p>http://hsaintranet.health.tn.gov/default.asp</p>	<p>This standard will never be NA. The following Health Department programs have eligibility guidelines.</p> <p>4. Breast and Cervical Screening Program: Female at or below 250 percent of poverty – See current program manual for program eligibility criteria. uninsured or underinsured (either no coverage for services covered by TBCSP or no coverage for screening diagnosis and/or treatment of breast or cervical cancer) and not on TennCare—patient qualifies for free breast screening and/or diagnostic services if she is between the ages of 50 – 64; between the ages of 40 – 49 and has one of the following: 1. A personal history of breast cancer. 2. A mother, daughter or sister who has had breast cancer. 3. A clinical breast exam that is suspicious for breast cancer. Women under the age of 40 with one or more of the following symptoms: 1. Discrete palpable breast mass. 2. Nipple discharge 3. Nipple changes 4. Skin changes of the breast.</p> <p>The patient qualifies for free cervical cancer screening and or diagnostic services provided by the TBCSP if she is: 40-64; women under 40 who need diagnostic services after initial Pap results by another provider or program has been received. TBCSP is to be the payor of last resort. Resource: Tennessee Breast and Cervical Screening Program Manual September 2010 version</p> <p>2. CHAD. CHAD services are for those families at risk of abuse and/or neglect residing in one of the counties specified as a CHAD county. Recipient of AFDC or SSI – Children who are abused or neglected or are at risk of abuse or neglect are eligible without regard to income if they need the service – persons whose gross income is within the income standards, as defined in the poverty level income standard. Children- The need for service is established when a child under six years of age has a verified handicap, a manifested developmental delay or is considered to be at risk of developmental delay, either</p>

<http://hsaintranet.health.tn.gov/default.asp>

because of biological factors or because of environmental factors. **Expectant Mothers** – Women under the age of 18 who are pregnant can be enrolled in CHAD with CSA approval. Women age 18 and over cannot be enrolled in CHAD due to technical interpretation of DCS guidelines. The need for service is established when an expectant minor mother is at risk of delivering a developmentally delayed child because of biological factors. The need for service is also established when the unborn child is at risk of becoming developmentally delayed because of environmental factors.

3. **CSS** – Medical Services are available to individuals who meet diagnostic and financial criteria as outlined in program policy. – Financial eligibility for the CSS Program requires the family income be equal to or less than 200% of the Federal Poverty Level. Children must meet diagnostic criteria based on program policy. – CSS application for re-certification completed annually (may be up to 4 to 8 weeks early). – Must document reason for delay of re-certification.
4. **Dental Varnish** – Target population 0-5 yrs. Will accept up to age 21. This is a voluntary program. Resource: [Fluoride Varnish Program Manual](#)
5. **EPSD&T – Well Child** – Birth to 21 years of age and a TennCare patient [EPSDT Manual \(5/30/09 version on line\)](#)
6. **Family Planning** – Of reproductive age and desires FP Program services. Resource: [Family Planning Clinical Guidelines](#) January 2011 version
7. **HUGS** – Enrollment in the program has minimal eligibility requirements. There are no financial eligibility criteria.
 - Prenatal and postpartum women with an identified need for care coordination including postpartum women who have lost a child by miscarriage, stillbirth, prematurity, SIDS, etc.
 - Children birth through 5 years of age with an identified need for care coordination/home visiting services.
Reference: [HUGS Program Guidelines](#) July 2011 version
8. **Vaccine VFC** – **Follow current Immunization Program guidelines for vaccine eligibilities for VFC/Adult, insured and uninsured. Contact Regional Immunization Director for**

<p>http://hsaintranet.health.tn.gov/default.asp</p>	<p>current guidelines. Birth through 18 years of age, uninsured, American Indians, Alaska Native and Medicaid eligible and underinsured (Covered by a health plan that does not cover the cost of vaccines).</p> <p>9. Primary Care – Age 19 through 64 years of age patients that are uninsured or underinsured. Underinsured: Their current insurance does not cover the condition for which they are being seen in the health department. For PCP sites, primary care patients may be any age and on TennCare. Patients with Medicare are allowed if they have Part A only. Reference: 2010 Primary Care Program Guidelines</p> <p>10. WIC (women, infants , children) Categorical eligibility pregnant, breastfeeding, postpartum, infants, children 1 –5 years old, income eligible (see program guidelines) – nutritional risk eligibility- physical presence- identity- residency eligibility Reference: WIC Manual</p>
<p>2. Appropriate medical histories taken</p> <p>A. Initial medical history is completed upon the first comprehensive clinic visit and updated annually or as indicated at each periodicity scheduled visit thereafter. Primary Care sites should follow current Primary Care Guidelines.</p> <p>B. Family history is completed upon the initial comprehensive clinic visit and updated annually or as indicated at each periodicity scheduled visit thereafter.</p> <p>C. Interval history is documented each clinic visit.</p>	<p>This standard will never be NA. The extent of the history is dependent upon clinical judgment and on the nature of the presenting problems(s). The levels of Evaluation and Management (E/M) services recognize four types of history: problem focused, expanded problem focused, detailed, and comprehensive. See 2012 CPT Manual page 9 for descriptions of the components of each history level. History may be documented on a history form or in narrative documentation.</p> <p>Program requirements regarding histories: If the information is not available, state the reason why.</p> <ol style="list-style-type: none"> Breast and Cervical Cancer – initial and family updated annually, interval – see Tennessee Breast and Cervical Screening Program Manual CH - Exams – initial and family updated annually, interval CHAD Program - initial health history within 60 days CSS – initial, family, developmental, interval histories documented on the Family Service Plan (FSP). The initial assessment requires face to face contact with parent / guardian. The Health and Developmental status page of the FSP is required on all patients / clients. EPSD&T – initial and family updated annually, interval EPSDT

<p>http://hsaintranet.health.tn.gov/default.asp</p>	<p>Manual</p> <ol style="list-style-type: none"> 6. Family Planning - initial and family updated annually, interval and reproductive history as indicated 7. HUGS - Medical Home Assessment (Verification Form)/ immunization status assessment within 60 days. 8. Immunization –met if Immunization Clinic Record signed and dated by PHN. Interval: Any difficulty, restrictions, precautions regarding the administration of immunizations past and present should be documented. 9. Men’s Health – initial and family updated annually, interval: assessment of ability to perform activities of daily living and Advanced Directives information is signed and dated (PCP sites) 10. Prenatal – Basic – Initial – last menses, unprotected sex, signs and symptoms of pregnancy 11. Prenatal Full Service – initial and family updated annually, interval /genetic and pregnancy histories 12. Primary Care – initial and family updated annually, interval: updates are completed on subsequent visits. 13. Sick Visit Child – initial and family updated annually, interval: if relates to child’s condition. 14. STD - information should contain information such as lesions / rash when it first appeared, current meds, lower abdominal pain, last menses, drug allergies, dysuria, previous STDs, STD exposed to, sites exposed, discharge and number of days, number of partners, as indicated. Reference: STD Treatment Guideline 15. TB - initial and family updated annually, interval 16. WIC – see WIC forms regarding interval history WIC Manual 17. Women’s Health – initial and family updated annually, interval: assessment of ability to perform activities of daily living, Advanced Directives information signed and dated (PCP sites)
<p>3. Allergies documented appropriately.</p>	<p>This standard will never be NA. Documentation of allergies is required on the Immunization Clinic Record and is to be and can be documented by any the Health Care Provider. The Medical Section Committee (MSEC) now known as the Medical Leadership Team (MLT), passed that allergy documentation is only "required" to be on the Immunization Clinic Record. This went into effect 1/1/09. If</p>

	<p>no allergies are identified, documentation in the medical alert box of the Immunization Clinic Record must include NKA or NKDA and is not to be left blank. If no changes have occurred, no annual update documentation is required. If there is a change in allergy status, document change, date and initial the change in documentation. It is not a deficiency if allergy documentation is not present on any of the other forms with areas for allergy documentation.</p>
<p>4. Appropriate assessments completed per protocol and program guidelines</p> <p>http://hsaintranet.health.tn.gov/default.asp</p>	<p>This standard will be NA if <u>program</u> visit reviewed does not require these specific assessments. See TB Risk Assessment for exceptions.</p> <p>CHAD Program - If the required assessments have been completed by other service programs and they are current (within the last year), additional assessments do not need to be done.</p> <p>HUGS Program – HUGS Program Guidelines (2011 version) page 15: Assessments</p> <ol style="list-style-type: none"> The Initial Assessment Form is to be completed: <ul style="list-style-type: none"> On all active core family members within 60 days of the date of referral When a pregnant woman gives birth and becomes post-partum When an infant is born When a woman becomes pregnant The Continuous Questionnaire Assessment Form should be completed for all active core family members every 6 months.
<p>A. Nutritional assessment</p> <p>http://hsaintranet.health.tn.gov/default.asp</p>	<p>Note program guidelines where a nutritional assessment is required:</p> <ol style="list-style-type: none"> CHAD Program – assessment required within 60 days of admission EPSD&T – Well Child – Dietary history is to be obtained at each well child visit. This may be obtained using one or more tools such as appropriate questions about usual intake. EPSDT Manual HUGS Program – HUGS Program Guidelines page 19 Within 60 days the date of referral the home visitor must document at least ONE of the following: <ul style="list-style-type: none"> Food security (on Initial Assessment Form) Currently receiving WIC services (in Progress Notes, on Initial Assessment Form, or HUGS Documentation Record) Referral to food services - WIC, TANF, CSFP, Food bank,

	<p>etc. (in Referral Tracker)</p> <ol style="list-style-type: none"> 4. Men's Health – As relates to visit, see protocol and standards 5. Prenatal Full – 24-hour diet recall, eating patterns, eating disorder, special diet, food intolerance, multivitamin which includes folic acid, nutritional habits (caffeine, artificial sweeteners, etc.) 6. Sick Child – if applicable - ex. vomiting, or no appetite 7. WIC – complete nutrition assessment using VENA guidelines. <ul style="list-style-type: none"> • Infants/Children: Nutrition assessment (as indicated or at least every three months if on therapeutic formula) • Women: Nutrition assessment as indicated <p style="text-align: center;">WIC Manual</p> 8. Women's Health – As relates to visit, see protocol and standards.
<p>B. Health status assessment</p> <p>http://hsaintranet.health.tn.gov/default.asp</p>	<ol style="list-style-type: none"> 1. CHAD Program - identify any medical problems that might negatively affect the child and pregnant mom. The goal plan should address these problems. The health assessments must include a determination of whether or not the child is up-to-date on immunizations and well child exams and for the pregnant mom, assess if she has had regular prenatal care. Due within 60 days. 2. HUGS Program HUGS Program Guidelines page 18 <ul style="list-style-type: none"> • Medical Verification Form/ Immunization Status for Infants/ Children is required within 60 days of date of referral, and at 7, 13, 24, 36, and 48 months, unless documented otherwise. • Medical Verification for Prenatal/ Postpartum women is required within 60 days of date of referral, each prenatal trimester, and the 6 week postpartum check, unless documented otherwise.
<p>C. TB Risk Assessment</p>	<p>Follow current TB Program guidelines (See 4/1/13 Dr. Warkentin memo) and PHN Protocol 3.460A (4/8/13) regarding shortages of PPD solutions. A TB Risk factor assessment (LTB/TB Screening Tool) is completed on Tuberculosis cases/suspects. The Risk Assessment tool (RAT) should be used for any person that staff are considering offering a PPD in the health department or in the community, including persons who request one for employer requirements. No RAT is required for health department employees. A RAT should be present if the patient is born in or is from a high-</p>

	risk country regardless of the program services they are seeking from the health department. Exception: Dental, where children are bused into the local health department with a consent form only authorizing dental services. The RAT will be on the TBS screen of PTBMIS and can be accessed with the DTBS command from any patient screen. Reference: Tuberculosis Elimination Guidelines
D. Cholesterol assessment	Per Nursing Protocol & EPSDT Guidelines - If the child is receiving a well child or an EPSDT exam, and is two years of age and older, assess the potential of being at high risk for elevated cholesterol levels by using questions in protocol. EPSDT Manual
E. Lead risk assessment	Per Nursing Protocol & EPSDT Guidelines – Assess all children (6 months to 72 months) at each well child check up for lead exposure using the Blood Lead Risk Assessment Questionnaire and document positive risk factors in the medical record. EPSDT Manual
F. Psychosocial	CHAD Program – required prior to enrollment for any family entering the program.
G. Tobacco Survey Assessment http://hsaintranet.health.tn.gov/default.asp	All health department patients aged 13 years and older receiving clinical services should be asked the basic tobacco data questions. The survey should be completed if yes is answered to either of the data questions. The survey should be completed every 12 months. It is not required for mass clinics, Administrative encounters, DNA , or Quick WIC visits. HUGS Program: The survey is to be completed every 12 months HUGS Program Guidelines
5. Physical exam	Mark this standard NA if the visit does not and should not contain any type of exam component. Any visit with an office visit coded to the encounter should have some level of exam documented.
A. Comprehensive unclothed physical exam	Review record for documentation of physical exam for date of service being reviewed. Documentation should be in SOAP format. 1. EPSDT: physical examination must be performed with the child unclothed but suitably draped, must include examination of the following: HEENT, Cardio-vascular, Respiratory, Musculoskeletal, Neurological, Skin, Genitourinary, and Abdomen. Exam should be performed according to the AAP Periodicity Schedule. EPSDT Manual 2. CHAD Program: Well child exams are conducted by the child's

	<p>primary care physician or health department providers of EPSDT. Staff insures that children receive physical examinations at least every 6 months if they are under one year of age and annually if they are over one year of age.</p> <p>3. Family Planning: Initial - Male clients requesting temporary methods of contraception are not required to undergo physical exams, but should be offered this service. Females using prescriptive methods of contraception must have a general physical exam. Females using non-prescriptive methods or diaphragms should have a general physical exam at least every 2 years. Deferred exams should not be deferred beyond 3 months after the initial visit and in no case may be deferred beyond 6 months unless in the provider's judgment there is a compelling reason for extending the deferral. All deferrals, including the reason for deferral, must be documented in the medical record. A deferred visit is coded as a supply visit in PTBMIS. See FP Clinical Guidelines (1/2011) page 16.</p> <p>Annual - An annual exam is described in the FP Clinical Guidelines page 16</p> <p>Medical Revisit - patient has returned for follow-up care and receives one or more of the medical services which requires placing her on the exam table. FP Clinical Guidelines page 16</p> <p>4. MH/WH: preventive health exams should follow PHN Protocol 3.360</p> <p>5. Prenatal Full Service: Exam to include fundal height, fetal movement, ultrasound — per site protocol</p>
<p>B. Problem focused exam</p> <p>http://hsaintranet.health.tn.gov/default.asp</p>	<p>1. Family Planning: Documentation of a problem focused FP visit must follow program guidelines for a medical Family Planning revisit (FP Clinical Guidelines 01/2011 page 16) and include chief complaint, ROS related to the complaint/history update, an appropriate gyn-related exam and labs, assessment and treatment that may include medications, other tests and/or referral. Counseling or education in relation to the complaint must also be documented.</p> <p>2. Primary Care: Exam documentation should show appropriate system examination related to the chief complaint or primary diagnosis. Diabetes driven visits should include visual foot inspection documentation quarterly and annual documentation of</p>

	<p>BMI documented each visit. Primary Care Guidelines</p> <p>7. WIC- assess accuracy in plotting. Prenatal grid- Weight for gestational age is plotted at the correct week's gestation according to gestation wheel and documented EDD. Plotting the prenatal grid is required at initial certification and recommended at subsequent visits. WIC Manual section 3 page 25 30. Hospital and referral measures must be plotted and indicate hospital or referral; length/height at each certification for teens and initial prenatal certification for women 20 and over. Birth measures should be plotted: weight and length. For age 2 and above weight, stature and BMI should be plotted at each certification visit and as indicated following WIC protocols and standards. BMI calculation should be correct. Automated Growth Charts may be in use as well.</p> <p>8. Women's Health – height, weight, body mass index procedures followed per PHN Protocol3.360</p>
<p>7. Other measures, vital signs</p> <p>http://hsaintranet.health.tn.gov/default.asp</p>	<p>Mark this standard NA if the visit does not and should not contain documentation of vital signs. Temperature, pulse, respiration (TPR) as indicated. Blood pressure (B/P) begins at age 3. Note the following guidelines that are program specific per periodicity chart.</p> <ol style="list-style-type: none"> 1. Child Health Sick Visit – TPR as indicated and B/P if appropriate 2. EPSD&T -Well Child – B/P: begins at 3 years EPSDT Manual 3. Family Planning- B/P at initial, medical, re-supply, annual. 4. Men's Health – TPR as indicated and B/P 5. Prenatal Basic – B/P 6. Prenatal Full Service – pulse and respirations, and B/P, fetal heart tone – each visit. 7. Primary Care – Diabetes driven visit - B/P each visit. Primary Care Guidelines 8. TB: Case or suspect -Measure height, weight, and vital signs initially and every month. PHN Protocol 3.480 (Provide follow-up) 9. Women's Health – TPR as indicated and B/P
<p>8. Sensory screening</p> <p>A. Vision</p> <p>B. Hearing</p>	<p>Mark this standard NA if the visit does not and should not contain documentation of sensory subjective or objective screenings. Note the following guidelines that are program specific per periodicity</p>

<p>http://hsaintranet.health.tn.gov/default.asp</p>	<p>chart. Observe that method of measurement is documented.</p> <ol style="list-style-type: none"> 1. EPSD&T -Well Child –Vision: Objective vision tests should be done at ages 3,4,5,6,8,10,12,15,18. Subjective should be completed at all other ages. Hearing: Newborns may have an objective or subjective hearing test prior to discharge from the hospital. If not they should be referred to a facility that does either auditory brainstem response (ABR) or otoacoustic emissions (OAE) testing. Objective testing should be conducted at ages 4, 5, 6, 8, and 10. Subjective testing should be for all other ages. EPSDT Manual 2. Family Planning with EPSDT Exam- EPSDT Guidelines “If a TennCare child (under the age of 21) receives the major components of a Child Health/EPSDT exam through the health department’s women’s health clinic, she should also receive developmental, vision, and hearing screening (according to the current Periodicity Schedule) in order to complete the recommended AAP standards for preventive health care.” EPSDT Manual 3. Men’s Health – Vision – initial, every 2 years between ages 40-70+. Hearing every 2 –3 years if exposed to excessive noise, after age 65 years every 2 years. PHN Protocol 3.360 4. TB – Vision – all patients on Ethambutol have a preliminary assessment of visual acuity and red – green color discrimination every month and post treatment. Hearing with Streptomycin, Kanamycin, Capreomycin. Tuberculosis Elimination Guidelines 5. Women’s Health – Vision – initial, every 2 years between ages 40-70+. Hearing every 2 –3 years if exposed to excessive noise, after age 65 years every 2 years. PHN Protocol 3.360
<p>9. Developmental/behavioral screening</p>	<p>Mark this standard NA if the visit does not and should not contain documentation of developmental screening.</p> <ol style="list-style-type: none"> 1. HUGS Program - The Ages and Stages Questionnaire is to be performed on all active family members under the age of 6 years at: <ul style="list-style-type: none"> • 4, 8, 12, 18, 24, 30, 36, and 48 months • Within 60 days of entry into the HUGS program (excluding infants less than 3 months) HUGS Program Guidelines 2. EPSDT – assessment required according to the current AAP Periodicity Schedule. 0 to 4 years of age use Parents’

	<p>Evaluation of Developmental Status (PEDS); 4 thru 18 years of age use Pediatric Symptom checklist (PSC-17); 19 to 21 years of age - use Older Adolescent Questionnaire. EPSDT Manual</p> <p>3. CHAD Program – assessment required at least once every six months up to the child's 2nd birthday. Assessments are required yearly after age 2.</p> <p>4. Women's Health Clinic Visits (Family Planning, Prenatal, and General Women's Health) "If a TennCare child (under the age of 21) receives the major components of a Child Health/EPST exam through the health department's women's health clinic, she should also receive developmental, vision, and hearing screening in order to complete the recommended AAP standards for preventive health care." EPSDT Manual</p>
<p>10. Appropriate laboratory procedures are followed and documented per protocols, program guidelines and standards in the Laboratory Manual, current edition.</p>	<p>Mark this standard NA if the visit does not and should not contain documentation of laboratory testing. The following Department of Health Programs have lab requirements:</p>
<p>A. Testing appropriate to documented assessment/diagnosis.</p> <p>B. Appropriate test completed according to program guidelines and standards.</p> <p>http://hsaintranet.health.tn.gov/default.asp</p> <p>PHN Protocol</p> <p>Bright Futures Periodicity chart</p>	<p>1. BREAST& CERVICAL SCREENING PROGRAM - Mammogram, Pap smear & Colposcopy according to current program guidelines.</p> <p>2. CHILD HEALTH SICK VISIT - Lab tests as indicated per symptoms</p> <p>3. EPST&T EPSDT Manual and see current periodicity schedule in the PHN Protocol Manual 3.350 for required lab tests</p> <ul style="list-style-type: none"> • Hgb – see current periodicity schedule. • Newborn screen • Lead: Ages 12 & 24 months and children ages 36-72 months that do not have a previously documented blood test. • Pap smear: all sexually active girls should have screening for cervical dysplasia as part of a pelvic exam beginning within 3 years of onset of sexual activity or age 21 (whichever comes first) • STI Testing: (RPR, Gen probe, HIV) All sexually active patients should be screened for sexually transmitted infections (STI's). • Cholesterol: see current periodicity schedule <p>FAMILY PLANNING: The following required laboratory procedures that must be provided to clients if required in the provision of a contraceptive method and may be provided for the maintenance of health status and/or diagnostic purposes</p>

<http://hsaintranet.health.tn.gov/default.asp>

either on-site or by referral are to be found in the [Family Planning Clinical Guidelines](#) and [PHN Protocol](#)

- **HGB**— as indicated
- **Urinalysis**—As medically indicated
- **Pregnancy Test**—As medically indicated
- **Wet Mount**—As medically indicated
- **Colorectal cancer screening**—As medically indicated, annually, females age 50 years and over
- **RPR**—as medically indicated.
- **Gen probe**—Screen at the routine initial/annual exam:
 - All clients less than age 26
 - All clients ages 26-29 who receive FP services in a county with a Chlamydia positivity rate of 3 percent or higher (*See below for these counties.)
 - For clients ages 26 and over (regardless of county where family planning services are received), only screen the following:
 1. A client being prepared for IUD insertion
 2. A client with documented NEW signs or symptoms
 3. A client named as a contact
 4. A client using drugs
 5. A client exchanging sex for money or drugs
 - Regardless of age, a female client who has been treated for a positive Chlamydia test should be retested 3 months after treatment or whenever she next seeks medical care within the following 3-12 months regard-less of whether the client believes her partner was treated.

The sites with positivity rates of 3 percent or higher in women ages 26 through 29 are:

Northeast Region	Johnson and Unicoi
East Tennessee Region	Anderson, Jefferson, Campbell, Cocke, Grainger and Sevier
Southeast	Franklin and Marion
Upper Cumberland	Overton and Smith
Mid Cumberland	Sumner, Cheatham and Dickson

South-Central	Giles, Lawrence and Marshall
West-Tennessee	Chester, Crockett, Dyer, Fayette, Gibson, Hardeman, Haywood, Henry, Lake, Lauderdale, Obion, Tipton, and Weakley
Memphis/Shelby County	Health department clinics
Jackson/Madison County	Health department clinics
Knoxville/Knox County	Health department clinics
Nashville/Davidson County	Health department clinics

- ~~• HIV—as medically indicated~~
- ~~• Sickle Cell on initial visit if medically indicated.~~
- ~~• Rubella Titer—initial visit if medically indicated.~~
- ~~• Documentation of a problem focused FP visit must follow program guidelines for a medical family planning revisit (FP Clinical Guidelines 01/2011 page 16) and include appropriate gyn-related labs.~~

~~**Pap Smear**—In accordance with the December 2009 ACOG recommendations, cervical cancer screening in Tennessee Health Department clinics should be carried out as follows:~~

- ~~1. Annual cervical cytology screening should begin at age 21 years.~~
- ~~2. Women ages 21-29 should undergo cervical cytology screening with conventional cytology or with liquid-based cytology every 2 years.~~
- ~~3. Women age 30 years and older who have had three consecutive (not to exceed 60 months) negative cervical cytology screening test results and who have no history of CIN 2 or CIN 3, are not immunocompromised, are not HIV infected, and were not exposed to diethylstilbestrol (DES) in utero will extend the interval between cervical cytology examinations to every 3 years.~~
- ~~4. Women with a history of CIN 2 or CIN 3, or who are immunocompromised, or who are HIV infected, or who were exposed to diethylstilbestrol (DES) in utero, are at increased risk of cervical cancer and will need annual or more frequent Pap testing.~~

5. Both liquid-based cytology and conventional cytology are acceptable for screening.
6. Women who have undergone hysterectomy with removal of the cervix for benign indications and who have no prior history of CIN 2 or CIN 3 or worse may discontinue routine cytology testing.
7. Women with an abnormal Pap result have special Pap frequency requirements. See the appropriate Pap algorithm for follow-up requirements. These can be found in the Tennessee Cervical Cancer Screening Guidelines, the Tennessee FP Clinical Guidelines, and also in the Statewide PHN Protocol.

Exceptions to the cervical cancer screening schedule is as follows:

1. Clients who have a documented Pap test (either type) with another provider within the appropriate age-based time frame.
2. Clients who are menstruating or who have douched or had sexual intercourse within the past 48 hours. In these situations, the Pap test (either type) can be delayed. An appointment for the Pap should be made within 3-6 months.
3. Clients who request to delay the physical exam and Pap test until a later date. The exam and Pap test can be delayed 3-6 months. An appointment should be scheduled for the exam and test.
4. Clients with obvious signs of infection should be treated first and receive their Pap test at another visit.

Documentation should be present to state the reason the Pap test was delayed.

- Upon return from the laboratory, all Pap test reports and HPV tests are reviewed by the designated local Public Health Nurse (PHN). The PHN will pull all abnormal findings for review by the APN or the MD. The APN or MD will write the plan for follow-up of the abnormal finding.
- A tracking system is established by regional policy and maintained at each site for follow-up of abnormal Pap tests and HPV tests. If a region can demonstrate that a computerized tracking system is in place that facilitates

<http://hsaintranet.health.tn.gov/default.asp>

assurance that Pap test results and HPV results are followed, that region will be exempt from the requirement of a manual tracking system. In this circumstance, written regional policies concerning the use of such a computerized tracking system must be in place and documentation must be made available upon request that would enable quality management staff to determine whether or not the system is being utilized in accordance with policy.

- The attempts to contact the client may include phone calls, direct contact during a Family Planning clinic visit or a home visit, or by mail. Clients may also be contacted during any clinic visit, i.e., WIC visit, primary care visit, etc. Flag the chart or use the note field on the PTBMIS screen to alert staff that at the next clinic visit, Pap test or HPV follow-up is indicated. (It is suggested that when a letter is returned undeliverable, check the correctness of the address. If the address is correct, call the emergency contact to get a forwarding address. If a forwarding address is unavailable, flag the chart.)
- The designated PHN is responsible for recording Pap test and HPV results in accordance with regional policy. "Negative for intraepithelial lesion or malignancy" lab results slips may be discarded once results are posted. HPV tests that are negative for high-risk HPV may also be discarded once results are posted. Refer to CHSA Policy 5.3.c, Disposal of negative slips should be a regional decision, covered by regional policy.

Minimum Requirements for Pap and HPV Follow-up

- Family Planning Clinical Guidelines January 2011 34 Federal Title X Guidelines state, "a procedure must be established to allow for client notification and adequate follow-up of abnormal laboratory results." Pap test and HPV follow-up guidelines are to be used when clients have stated that they may be contacted by phone or at home. Use the regional policy for notifying confidential clients.
- Abnormal Pap test and positive HPV tests are reviewed by the nurse-practitioner or physician. Follow-up orders are given to the assigned public health nurse(s) for follow-up and tracking. Recommendations by the pathologist are taken into consideration. Follow-up and tracking must comply with regional protocols and must be documented in the chart and/or

<http://hsaintranet.health.tn.gov/default.asp>

in the electronic record (i.e., tracking).

Client Notification

- A regional policy must be established for notification of "negative for intraepithelial lesion or malignancy" or "negative for high-risk HPV".
- For Pap test results indicating the presence of an organism or condition that the practitioner or physician wishes to address or treat (such as yeast, numerous red blood cells or shift in bacterial flora), a minimum of two documented attempts to contact the client are required.
- Clients, who have been referred to colposcopy and subsequently return to the health department, are managed in accordance with the instructions given by the colposcopist.
- For Pap test results indicating the presence of an organism or condition that the practitioner or physician wishes to address or treat (such as yeast, numerous red blood cells or shift in bacterial flora), a minimum of two documented attempts to contact the client are required.
- For Pap test reports indicating atypical squamous cells of undetermined significance or greater, two documented attempts to contact the client are required.
- For Pap test reports or HPV tests indicating the need for referral to colposcopy, a minimum of two documented attempts to contact the client are required. The sequence of attempts to contact the client proceeds as follows:
 1. First attempt: Phone call, letter sent by first class mail, or direct contact during a clinic or home visit.
 2. Second attempt: Registered letter or direct contact in clinic or by home visit.
 3. Document all phone calls and letters in the chart or the electronic record. Regional policy determines the type of documentation related to the sending of the letters. Also regional policy determines whether further follow-up should occur if the client does not respond. However further follow-up including extra phone calls and letters and possibly a home visit, are encouraged as may be needed.
 4. Extra effort should be made to contact clients with epithelial cell abnormalities of high grade squamous intraepithelial lesion (HSIL), squamous cell carcinoma,

~~atypical glandular cells, endocervical adenocarcinoma in situ, or any other malignant neoplasm. These clients are to be contacted within 5 working days from the receipt of the lab report or the call from lab. Clients in this category who do not respond to phone call or registered letter, should receive a home visit if at all possible.~~

- ~~5. Within 6 weeks of the date the Pap test or the HPV test was reported by the lab, clinics should have an appropriate referral in place (client informed and appointment made). Clinics are to document and facilitate any recommended follow-up. Clinics must not coerce clients to undergo any consultation or procedure. However, clients must understand the importance of follow-up and the possible consequences of failure to comply with recommendations.~~

5. MEN'S HEALTH – See current periodicity schedule - see [PHN Protocol 3.360](#)

- ▲ **Cholesterol/HDL:** All men aged 35 and older should be screened routinely.
- ▲ **Colorectal Cancer Screening** – Annually for all persons 50 years of age and older. Begin at age 40 if high risk.

6. PRENATAL BASIC – patient presenting for pregnancy testing

- **Pregnancy Test** - As indicated.
- **Urine test for GC/Chlamydia** - for clients under age 30.

~~**7. PRENATAL FULL SERVICE:** See Guidelines for Prenatal/Postpartum Clinical Services 2009~~

- ▲ ~~**HGB**~~ On initial visit, and 26-28 weeks gestation, and 34-36 weeks gestation.
- ▲ ~~**RPR**~~ Initial visit, and between 34-36 wks gestation
- ▲ ~~**GC/Chlamydia**~~ Initial visit, and 34-36 wks gestation
- ▲ ~~**Blood group/Rh type**~~ initial, repeat ABS @ 26-28 wks for RH Negative patients only
- ▲ ~~**Glucose**~~ screen at 26-28 weeks
- ▲ ~~**HBsAg**~~ – initial
- ▲ ~~**Wet mount**~~ as indicated
- ▲ ~~**UA**~~ dipstick for protein and glucose initial and each visit
- ▲ ~~**Urine Culture**~~ – initial
- ▲ ~~**Rubella antibody titer**~~ – initial (unless previous immunity documented.)
- ▲ ~~**Pap Smear**~~ Initial visit, and as indicated

<http://hsaintranet.health.tn.gov/default.asp>

- ~~HIV initial visit and per clinic site protocol. In 2007, Tennessee amended TCA 68-5-703 that requires that all pregnant women receive testing for HIV as early as possible in the pregnancy AND AGAIN in the third trimester (34-36 weeks) of pregnancy unless she refuses such testing in writing and per clinic site protocol.~~
- ~~MSAFP 15-20 wks gestation~~
- ~~Group B Streptococcal (GBS) – Screen at 34-36 weeks' gestation with a vaginal and rectal swab for Group B Streptococcal (GBS). If the client is GBS positive and if the client is allergic to penicillin (drug of choice), the laboratory will be notified, and sensitivity testing for clindamycin will be done. The client must be treated during labor. Thus, GBS test results must be discussed with the client and transmitted to her delivery site. Pregnant women who are positive for GBS bacteriuria during their pregnancy or pregnant women with a previous infant infected with GBS will not receive a screening test because they are to be treated automatically during labor. This information also must be discussed with the patient and transmitted to her delivery site.~~

8. Primary Care – Any lab work should be supported by documentation and tied to the appropriate diagnosis code.
Diabetes driven visits: should have documentation (test or evidence in outside records of prior testing) of the following tests. [Primary Care Guidelines](#) Testing done more frequently than below is not considered deficient but is the provider's prerogative:

- **Hgb A1C** if: Equal or < 7 – quarterly
- **Microalbumin/Creatinine ratio**– annually
- **Serum Creatinine** - annually
- **GFR (calculated)** - annually
- **Lipid profile** – annually

9. STD: per program/visit guidelines [STD Treatment Guideline](#)

- **Pregnancy test** if indicated by history (codes to CH/AH).
- **Wet Mount** Symptoms characterized by discharge (done by MD, APN or RNES only)
- **RPR**
- **GC/ Chlamydia** – cervical or urethral DNA Probe swabs; cervical, urethral, vaginal, oropharynx, anal cultures, or urine

<http://hsaintranet.health.tn.gov/default.asp>

~~samples according to program guidelines.~~

- ~~• Pap per regional protocol~~
- ~~• HIV~~
- ~~• Herpes Culture as indicated~~
- ~~• Hep B as indicated~~

10. TB – per program guidelines and [PHN Protocol](#). [Tuberculosis Elimination Guidelines](#)

- Follow current TB Program guidelines (See 4/1/13 Dr. Warkentin memo) and PHN Protocol 3.460A (4/8/13) regarding shortages of PPD solutions.
- **Pregnancy test** if medically indicated (codes to CHAWH).
- **Other labs** per Protocol.
- **Sputum Culture and Smear** – 3 specimens (1 per day X 3 consecutive days)
- **HIV** offer to all adults over 18 yrs of age on TB treatment.
- **TB skin tests** are given at designated times as per protocol. If assessment is high risk, a TBST should have been done along with the millimeters documented in PTBMIS results field. Results not read will have an “N” in the status field. If a skin test is not placed on a HR patient, an explanation of why this patient did not receive a skin test should be documented in the chart. There are situations when the field may not place a skin test on a HR patient, such as the patient refuses to receive the test or the patient shows proof of being a prior positive. Tests may not be applied on the day of visit because of delayed ability to read due to holidays or clinic closures. Delay in application reason should be documented in the medical record and the patient reappointed for test application as soon as possible.

11. WIC - [WIC Manual](#)

- **Hgb** At each certification: Section II page 4- 6
 - ◆ Infants: 9-12 months of age and 15-18 months
 - ◆ Children: Annually if within normal limits at 18 month certification.
 - ◆ Women: at each certification
- **Pregnancy Test**-Proof of pregnancy required if pregnancy not obvious.

12. WOMEN'S HEALTH - See current periodicity schedule -

	<p>PHN Protocol 3.360.</p> <ul style="list-style-type: none"> • Cholesterol – All women age 45 and older should be screened routinely • Colorectal Cancer Screening – Annually for all persons 50 years of age and older. Begin at age 40 if high risk • HGB – Every 5-10 years for non-pregnant women until menopause • Mammogram – Every 1-2 years for women age 40 and older. (referral is the minimum requirement, patient may choose not to obtain) See current periodicity schedule • Pap – Liquid based pap every 2 years after age 21 or 3 years after becoming sexually active, which ever comes first. See current periodicity schedule.
<p>11. Immunizations:</p> <ul style="list-style-type: none"> 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 D. Sites of all immunization injections are documented according to protocols and standards E. Immunizations are documented per protocols and standards, including documentation of the VIS revision date. <p>http://hsaintranet.health.tn.gov/default.asp</p>	<p>This standard is reviewed for all types of visits according to Immunization Program Guidelines and should not be marked NA unless there is no chart documentation expected for the visit such as WIC group education visits when the chart is not pulled (see WIC Manual section 3, page5) or when a single visit of multiple programs is under review where any deficiency found would be marked only on one audit tool.</p> <p>11a. Immunizations should be documented as given following PHN Protocol for appropriate interval, frequency, and method of delivery.</p> <p>11b. If immunizations are due according to documented dates and available information within the medical record, documentation should state why immunizations due were not given or it will be counted as a missed opportunity. It is not a missed opportunity if the needed vaccines were not available in the clinic for the date of service under review.</p> <p>11c. Check that immunizations are documented correctly according to CHSA Policy 8.9. Check for documentation of immunizations on Immunization Clinic Record and corresponding immunization documentation in PTBMIS. Documentation by TDOH staff in PTBMIS and the chart is to match on all children's records. If documentation is found on the Immunization screen that is not reflected on the Immunization Clinic Record, this could be a TWIS entry from an outside provider. Outside provider given immunizations entered on TWIS appearing on the Immunization screen in PTBMIS should</p>

	<p>be assessed for needed documentation on the Immunization Clinic Record of children.</p> <p>11d. Injection sites of immunizations given are to be documented appropriately on the Immunization Clinic Record.</p> <p>11e. Vaccines given are to be documented on the Immunization Clinic Record and include vaccine dose number, age of patient, date, manufacturer, vaccine lot number and VIS version date that was given to the patient that date of service.</p> <p>CHAD & HUGS Program – Home Visitors will review/facilitate/verify immunization status, according to current CDC Immunization Guidelines within 60 working days of enrollment and will continue to facilitate/verify that immunizations are up to date according to CDC Immunization Guidelines. HUGS Program Guidelines pages 17 and 26. &</p> <p>All Programs – assessment of immunization status is required each visit if documentation of immunization dates show that the patient is not up to date or there are no dates of immunizations documented.</p>
<p>12. Medications</p> <p>A. Medications are given at designated times as per protocols and standards.</p> <p>B. Dose, site, route and frequency are documented appropriately for medications given or prescribed.</p> <p>C. Medications documented on the Primary Care Problem List and Medication Summary form are current.</p>	<p>Mark this standard NA if the visit does not and should not contain documentation of medications being given or prescribed for the date of service being reviewed. Documentation in record is on all appropriate program forms. Program Protocols should be followed for visit being reviewed.</p> <p>Documentation of all medications dispensed or prescribed should indicate medication name, dose, route, and frequency. Site of administration of any injection should also be documented. If refills are allowed, the number should be clearly documented.</p> <p>Family Planning: for an initial and annual FP visit documentation will include method of contraception, dose, route frequency; and the resupply frequency.</p> <p>Primary Care: The Problem List and Medication Summary form is current according to Primary Care Guidelines Section V page 7 and Section VII page 46.</p>
<p>13. Anticipatory guidance/patient education</p>	<p>Education applies to most visit types and will not generally be NA. Check Program Guidelines or Protocols: Anticipatory guidance and counseling are provided based upon patient or parental current or</p>

<http://hsaintranet.health.tn.gov/default.asp>

anticipated needs and development.

EPSDT/Well Child – Required at each visit. Topics should be age appropriate. [EPSDT Manual](#)

Family Planning: **follow** current program guidelines for required FP counseling/education topics, optional counseling topics and contraception method counseling. [FP Clinical Guidelines](#)

- ~~An initial and annual FP visit will include documentation of education and counseling on the Teaching Table found on the back of the History form [PH 1522, 1522S, or 3566 3566(S)]~~
- ~~Documentation of a problem focused FP visit must follow program guidelines for a medical Family Planning revisit (FP Clinical Guidelines 01/2011 page 16) and include counseling or education in relation to the complaint.~~

~~–Required FP counseling/education topics:~~

- ~~Purpose and sequence of clinic procedures including the return visit schedule~~
- ~~Health Department services (can be given in writing)~~
- ~~Importance of recommended tests and screenings~~
- ~~Information necessary to be able to give informed consent~~
- ~~Information about all contraceptive methods, including fertility awareness-based methods and abstinence, (can be given to the client in writing)~~
- ~~Information necessary to be able to use the chosen contraceptive method correctly and consistently including how to discontinue the method, back-up methods, and ECPs.~~
- ~~Information necessary to be able to identify adverse reactions, common side effects and possible complications of the method selected and what to do in case any of these occur~~
- ~~Education regarding safer sex, STDs and the importance of HIV/AIDS testing~~
- ~~Reproductive Life Planning~~
- ~~The importance of family involvement (all adolescents on first visit)~~
- ~~How to recognize and resist sexual coercion (all adolescents on first visit)~~
- ~~Self breast exam for females and self-testicular exam for~~

males (can be given in writing)

- Emergency contraception (ECPs)
- Results of the history, physical examination, laboratory studies or instructions as to when test results will be available
- Emergency 24-hour telephone number and where emergency services can be obtained
- Appropriate referrals for additional services as needed

–Optional counseling topics:

- Nutrition
- High-risk sexual behaviors related to STDs
- Pap smear testing and cervical cancer
- Disease prevention and maintenance of health
- Instructions regarding calcium supplementation as a precaution against osteoporosis (adolescents and young adults, 1200-1500 mg/day; adults aged 25-50, 1000 mg/day; postmenopausal women, 1000-1500 mg/day)
- Instructions regarding folic acid supplementation (400 mcg daily)
- Counseling regarding avoidance of tobacco products
- Counseling regarding the adverse effects of alcohol and drug abuse
- Domestic violence and personal safety
- Unintended pregnancy prevention and its value in maintaining individual, child and family health
- Basic female and male anatomy and physiology (can be given in writing)

–Contraceptive Method Counseling:

- Assure the client knows results of the history, physical examination, and laboratory studies.
- Assure the client knows how to use the contraceptive method selected and is comfortable with its use.
- Assure the client knows common side effects and possible complications of the method selected and what to do in case they occur.
- Assure the client understands the return visit schedule and mechanism for obtaining next appointment.
- Assure the client knows the emergency 24-hour telephone number and location where emergency services can be

<http://hsaintranet.health.tn.gov/default.asp>

	<p>obtained-</p> <ul style="list-style-type: none"> Assure the client receives appropriate referral for additional services as needed- <p>Prenatal – See the Prenatal Services Manual</p> <p>HUGS: Anticipatory Guidance/Client Education is provided per individual client needs. HUGS Program Guidelines</p> <p>Primary Care: Diabetes driven visit – There should be documentation of diet or nutrition management and physical activity or weight management education in the last 12 months. Primary Care Guidelines</p>
<p>14. Dental referral</p>	<p>Mark this standard NA if the visit does not and should not contain documentation regarding a dental referral.</p> <p>Dental Varnish – refer if indicated</p> <p>EPSDT/Well Child – Oral Health Guidance from the AAP Periodicity Table: Dental risk assessment/dental home referral is to begin at 6 months (see Comment #21 below) Medically necessary dental referrals may be made at any age. EPSDT Manual See PHN Protocol 3.350 Comments #21 and 22 from the AAP Periodicity Table below:</p> <p><i>21. Referral to dental home, if available. Otherwise, administer oral health risk assessment. If the primary water source is deficient in fluoride, consider oral fluoride supplementation.</i></p> <p><i>22. At the visits for 3 years and 6 years of age, it should be determined whether the patient has a dental home. If the patient does not have a dental home, a referral should be made to one. If the primary water source is deficient in fluoride, consider oral fluoride supplementation.</i></p> <p>Prenatal: All prenatal clients should be referred to a dental provider for screening. PHN Protocol 2.110</p> <p>Primary Care: Primary Care Guidelines Diabetes driven visit – Documentation of a dental referral addressed within the last 12 months</p>
<p>15. Plan of care</p>	<p>This standard will never be NA. Look for documentation in record. Plan of care should be appropriate for assessment and follow the APN/PHN Protocols and program guidelines.</p>
<p>A. Assessment is documented B. Addresses findings in the Assessment C. Problems are:</p>	<p>The treatment should be provided by the appropriate provider according to protocols, program guidelines, and state licensure regulations.</p>

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.

<http://hsaintranet.health.tn.gov/default.asp>

CHAD - Service/Goal plan (updated every 6 months)

Dental Varnish – refer if indicated – documentation of service should state “ Fluoride Varnish Application” (FVA)

Family Planning - [FP Clinical Guidelines](#)

- Documentation of a problem focused FP visit must follow program guidelines for a medical Family Planning revisit (FP Clinical Guidelines 01/2011 page 16 assessment and treatment that may include medications, other tests and/or referral.
- Plan of care for an initial and annual FP visit will include method of contraception, treatment of STDs or minor gyn or urinary complaints; referral for problems not managed on site; and the time frame in which the client should return to clinic.

HUGS - Initial home visits must be made within 15 working days from date the referral was received. An individualized Service Plan must be initiated or implemented within 60 working days of enrollment and updated every 6 months or when circumstances change. Interventions are designed to address problems/issues identified from an analysis of assessment data. Frequency of visits and duration of services are provided per individual client needs. [HUGS Program Guidelines](#)

Primary Care: [Primary Care Guidelines](#) **Diabetes driven visit** –

1. Eye referral within the last 12 months (referral or evidence in outside records of prior referral)
2. Blood pressures >130/80 x 3 visits – addressed in the assessment
3. BMI >30 – addressed
4. If visual foot exam is documented as abnormal – Documentation should show it was addressed

WIC: ~~“All participants will have a VENA care plan developed in the SOAP format. The VENA care plan includes information such as the participant’s level of understanding, stage of change, client centered goal, plan of action, and referrals.”~~
 “All participants will have a care plan developed in the SOAP format. The care plan includes information such as the participant’s level of understanding, stage of change, client-

	centered goal, plan of action, and referrals.” (Section 3 Page 11 48 WIC Manual)
16. There are no missed EPSDT opportunities	Mark this standard NA if the patient is not a child with TennCare under the age of 21. Check record to see if patient was in health department for other services and an opportunity for EPSDT services was missed per periodicity schedule. If record indicates patient up-to-date on exams, mark record met. If patient not up-to-date and no documentation is present to indicate why an exam was not done, mark not met. Applies only to patients with TennCare under 21 years old.
17. Medical records	These standards will never be NA.
Includes:	Must have either the name of the patient or the medical record number on each item in record. Use of a label is acceptable.
A. Name or medical record number	
B. Personal/biographical data is updated appropriately.	Registration screen is to be updated periodically in PTBMIS.
C. Date of service	Must be documented and should correlate with the PTBMIS encounter date. HUGS – Exception for attempted home visits, PTBMIS documentation alone is sufficient. HUGS Program Guidelines
D. Provider identification	Provider signature required on date of service. According to Public Health Nursing Orientation & Practice Manual , Section II-17. “Use proper signature on medical record- first initial, last name, and provider status (e.g. J. Doe, R.N.)”
E. Legibility	Documentation must be legible to the reviewer.
F. Regional/State approved abbreviations are used	Only approved abbreviations are used. Check regional and state approved list.
G. There are no documentation errors or errors are corrected according to state/regional standards.	Errors in documentation are corrected appropriately with single line through, CID, initials and date (if corrected at a date other than the time of initial documentation). If there are no corrections present in the documentation being reviewed or corrections in documentation are done appropriately , the standard is met.
H. Adherence to standard regional format	Request a copy of the current regional format and determine that record is in the regionally approved format. Primary Care: Primary Care records will follow the Primary Care Guidelines for Chart Format. Primary Care Guidelines
I. Appropriate consent forms are completed	The Informed Consent Signature Sheet is to be updated and signed each WIC Certification for WIC participants and every 6 months for all other patients presenting for services. All consent forms required by program (check Program Standards for required forms)

<p>http://hsaintranet.health.tn.gov/default.asp</p>	<p>are present, signed, and dated with witness to signature. CHSA Policy 7.9</p> <p>CSS - The application for CSS also acts as the consent to release of information and should be on the chart as soon as the patient/parent has signed the document. If financial information is pending, a copy of the application with the appropriate signature should be placed in the medical record showing a signed consent has been obtained.</p> <p>Family Planning - FP Clinical Guidelines Family Planning requires a general consent to cover providing care for any (unexpected) emergency that might occur in the clinic and a method specific consent. A Family Planning method specific consent form is required upon admission to FP, if the patient changes her contraceptive method or is readmitted to the program.</p> <p>Primary Care - General Consent form. Primary Care Guidelines- Page 30</p>
<p>J. Required program forms are present</p> <p>http://hsaintranet.health.tn.gov/default.asp</p>	<p>Check Appropriate Program/Regional Guidelines for required forms.</p> <p>Immunization Clinic Record: the VIS date recorded should be current for that visit. See a list of current VIS statements at CDC web site: http://www.cdc.gov/vaccines/pubs/vis/default.htm or approved interim http://www.cdc.gov/vaccines/pubs/vis/vis-news.htm to determine the most appropriate VIS date for the visit date reviewed.</p> <p>CHAD/HUGS - See program guidelines for required forms and completion time requirements.</p> <p>CSS - The Family Service Plan should be on the chart within 2 weeks of admission to the program.</p> <p>EPSDT - Growth Charts and Immunization Clinic Records are required to be on the chart. EPSDT Manual</p> <p>Family Planning -FP Clinical Guidelines Family Planning requires a history form, a physical form, a general consent, a method specific consent and a referral form whenever a referral is made.</p> <p>HIPAA - A copy of the current “Notice of Privacy Practices” will be provided to any client who requests a copy. However, where the Department of Health (DOH) is a direct provider to the client, DOH is required to give a copy of the notice to the client on the first date that they receive services on or after 4/14/03. DOH must have each client who receives direct care from</p>

	<p>DOH sign an acknowledgment of receiving the notice on their first date of service. If DOH cannot get a signed acknowledgment, then documentation as to the reason why one was not received must be made in the client's record. TDQH HIPAA Policies and Procedures Manual, page 9. Consult with Regional Clerical Consultant as to regional directives for the method and location of the client's signed acknowledgment.</p> <p>Prenatal Full Service - See Guidelines for Prenatal/Postpartum Clinical Services 2009 and site protocol</p> <p>Primary Care - Problem List/Medication Summary form, see form instructions from the Primary Care Guidelines, Diabetes and Anticoagulation Checklists if applicable, form instructions page 27. Visit documentation may appear on an exam visit form or as a SOAP note on a Progress Note form. Primary Care Guidelines page 7</p> <p>TB - See program guidelines for required forms and completion time requirements. Tuberculosis Elimination Guidelines</p> <p>WIC - Appropriate forms should be present according to program guidelines for each visit. Growth Charts are required. WIC Manual section II-7—page 8</p>
--	--

Encounter Medical

GUIDELINES/STANDARDS	GUIDANCE TO REVIEWER
<p>18. Correct provider numbers are posted.</p>	<p>This standard will never be NA. Obtain current employee list with user ID for the review site or you may also go on PTBMIS and type: TAD space PROVIDER, #### (the Provider number) and the provider list will display. If coded provider name and documented provider do not match a deficiency is cited. An example would be if the lab test done by the RN or NA was coded to the APN. This would be a deficiency if the documentation showed the RN or NA actually did the lab test.</p>
<p>19. Correct program codes are posted.</p> <p>http://hsaintranet.health.tn.gov/default.asp</p>	<p>This standard will never be NA. Visit documentation and the Encounter Screen are compared to the PTBMIS Codes Manual to determine if correct program codes are used.</p>
<p>20. Correct diagnosis codes are posted.</p>	<p>This standard will never be NA. After the visit documentation is read, and the reason for visit determined: Type: TAD(space) Diag, (comma)##### (diagnosis code) enter (TAD DIAG,V202). The</p>

	<p>diagnosis codes table will display. If it matches visit documentation this standard is met. If it is not supported by visit documentation then a deficiency is cited. It is also important to assess if the correct diagnosis code is linked to the procedure code. Examples: Procedure GENP should be tied to Diagnosis #2 (V016) instead of sinus infection; MOVO should be tied to V689 not V079 (immunization) diagnosis code. A procedure can tie to as many as 3 diagnosis codes. The Diag field on the encounter screen in PTBMIS would show 123 indicating that the procedure tied to diagnosis 1, 2 and 3</p>
21. Correct payor codes are coded.	<p>This standard will never be NA. Look at reimbursement code on Encounter Screen and compare to FI screen and ledger (LE screen). If patient has dual coverage verify that secondary payor has been billed if services were denied by primary payor. All reimbursement possibilities must be considered. i.e., Breast and Cervical Cancer program, special county specific arrangements (contracted school physicals to be billed to county funding sources).</p>
<p>22. Correct services and procedures codes are posted per PTBMIS Codes Manual and current American Medical Association CPT Manual.</p> <p>http://hsaintranet.health.tn.gov/default.asp</p>	<p>This standard will never be NA. Compare visit documentation in patient's medical record with PTBMIS encounter screen for the visit date reviewed and see that services and procedures listed in medical record are coded and posted to the encounter correctly. Pharmacy Services are noted in standard 24. Deficiency can be omission of procedure codes documented as done or incorrect code posted to encounter for a documented procedure.</p>
23. Services and procedures billed for are documented in the medical record.	<p>This standard will never be NA. Verify by comparing Encounter Screen with medical record to assure services and procedures billed are documented as done in the record. A deficiency is marked when a code on the encounter screen is not appropriately supported by visit documentation. For example: (1) TennCare Advocacy is coded but there is no documentation by the provider on the Advocacy Tool or in the visit documentation. (2) GenProbe coded as done on STD patient but no documentation present of GenProbe obtained and no test results in the computer. Give a copy of each encounter screen reviewed (at least the ones with coding deficiencies) to the supervisor so that the site can correct the billing, when possible, and instruct the appropriate staff member regarding any chart documentation corrections that may be needed.</p>
24. Drugs issued to patients will be entered into the pharmacy	<p>Mark this standard NA if the visit does not and should not contain</p>

<p>module of PTBMIS by the end of business day.</p>	<p>documentation regarding coding medications onto the Pharmacy module of PTBMIS.</p> <p>Compare visit documentation in patient's medical record with PTBMIS PR (pharmacy) screen for visit date reviewed and check to see that pharmacy services listed in medical record are posted to the PR screen correctly. PR screen information should be correct for medication, amount dispensed, days supplied, Program coded to and payor code.</p>
<p>25. Documentation supports Level I (99401T) or Level II (99402T) TennCare Advocacy.</p> <p>http://hsaintranet.health.tn.gov/default.asp</p>	<p>Mark this standard NA if the visit does not and should not contain documentation regarding TennCare Advocacy. If Advocacy has been coded but there is no supporting documentation, mark this standard NA and mark deficiency under standard 23. Review chart documentation for appropriate references to advocacy activities for the patient regarding their TennCare services. Documentation can be either in narrative portion of visit documentation or on the TennCare Advocacy Tool and should tie to the patient's TennCare Activities. Multiple providers may provide advocacy during a visit but each advocacy level is to appear only once on the encounter. Level 1 advocacy does not need to be coded by the highest provider but must be documented by the provider whose code appears on the encounter. Any provider (except CSS/HUGS case workers) can code level I advocacy. Level II can only be coded by an RN, APRN, or MD and requires supporting narrative documentation. This Level II Advocacy requires assessment, judgment, and justification in order to actually obtain the needed TennCare service. See the PTBMIS Codes Manual Section 200 for further information.</p>

Fiscal

(* Numbers in () refer to the [CHSA Policies and Procedures Manual Fiscal Section](#)) <http://hsaintranet.health.tn.gov/default.asp>

<p style="text-align: center;">GUIDELINES/STANDARDS</p> <p>It to be the region's choice if the Fiscal Review is to be an announced or unannounced review. Schedule of reviews should be shared with the Regional Director where unannounced reviews are performed.</p>	<p style="text-align: center;">GUIDANCE TO REVIEWER</p> <p>Any finding that is beyond the ability of the reviewed site's control either due to length of time passed, system limitations/requirements, etc. should be listed as an FYI comment and not marked as a deficiency. If unsure if this applies to your finding, contact State QI Director for guidance.</p>
<p>1. Duties are segregated to the extent possible for collections, billings, bank deposits, purchases, patient encounters and mail opening. (2.3)*</p>	<p>1. Review Policy 2.3.</p> <p>2. Ask for to see the written plan and list of for segregation of duties. The plan should have the Regional Director's approval.</p> <p>3. Sample: Review 10 most recent batches in iNovah to show staff is not approving their own actions.</p> <p>4. When assessing standard compliance and purchases, a deficiency occurs only when there is direct evidence of inappropriate segregation of duties.</p> <p>5. Duties can be performed by staff not listed on the Segregation of Duties Plan as a method of compensating controls but revision of the plan with Regional Director's approval is indicated for staff routinely assigned these duties. Revision needs should be made as an FYI comment, not a deficiency during the review.</p> <p>6. Observation of Review check log to ensure the same person is not recording the checks, receipt the checks into PTBMIS, entering the checks into iNovah, and taking the deposit to the bank. The check log is not a standardized state form.</p> <p>7. Review the receipt book to ensure the manual receipt books are the ones assigned from the regional office.</p> <p>8. Review cash drawer reports: the cash drawer production run should be reconciled, dated and signed. Policy 2.11.5</p> <p>9. Discuss observations with on-site Office Supervisor or County Director for explanations for low staff days or other days when and how compensating controls were</p>

	<p>needed are to be implemented.</p> <p>10. Every item does not need to be assessed (collections, billings, bank deposits, purchases, pt. encounters and mail opening) in order to consider this standard met or not met.</p>
<p>2. Cash box is locked secure at all times except when in use and is kept in a locked storage facility whenever unattended or after hours. (2.11.2 and 2.11.3)</p>	<p>1. Review Policy 2.11.</p> <p>2. Observation upon initial entry into the health department.</p> <p>3. Ask to see where cash box is located to ensure evaluate if that it is in a secure location.</p> <p>4. Determine by observation, if possible, that the cash box is locked when unattended.</p> <p>5. Ask the Office Supervisor or County Director office manager where the box is kept after hours to assure it is in a locked storage facility. and observe the procedures.</p> <p>6. Mark this standard NA if the site does not have a cash box.</p>
<p>3. Cash box is kept in a locked storage facility whenever unattended or after hours. (2.11)</p>	<p>1. Review Policy 2.11.</p> <p>2. Ask the office manager where the box is kept after hours and observe the procedures.</p>
<p>4. After hours night deposit is used, if available and needed. (2.11)</p>	<p>1. Review Policy 2.11.</p> <p>2. A file cabinet or secure storage facility will be used to secure the locked cash box after business hours or the night deposit at the bank may be used to store the funds after business hours. Inquire if the night deposit is available and used. Night deposit use is not required daily but only as needed according to policy</p>
<p>5. There is a cash fund custodian and employees having access to cash funds are identified. (2.11.12 and 2.11.14)</p>	<p>1. Review Policy 2.11.</p> <p>2. Compare Determine the name of the site's cash fund custodian on from the list submitted to the Division of Administrative Services Regional Segregation of Duties Plan with the person who actually has control of the cash fund.</p> <p>3. Obtain list of all employees having access to the cash funds</p> <p>4. Identify these employees having access to the cash funds and assure the information on personnel is current. Outdated information would not constitute a deficiency but a comment that update of information is needed.</p>
<p>6. Employees having access to cash funds are identified.</p>	<p>1. Review Policy 2.11.</p>

	<ol style="list-style-type: none"> 2. Obtain list of all employees having access to the cash funds. 3. Identify these employees and check for any updated information on personnel.
<p>7. 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)</p>	<ol style="list-style-type: none"> 1. Review Policy 2.11. 2. Ask for a Test Production Run (Daily cash Drawer Report) to be printed. 3. The content of the cash box is to be counted. The reviewer can count the contents in front of the staff or have the staff count as the reviewer watches. Do not remove the cash box or the contents of the cash box out of the presence of the custodian. 4. List the checks 5. Add these two and subtract the authorized balance 6. Record the amount of cash, check, and total funds in the cash box and the number of checks on the test cash drawer report. Compare receipts in the box to the production run and compare the cash balance. 7. Add the checks and cash and subtract the amount of the change fund for a cash total. Reconcile the cash total to either the test production run report or the total of PTBMIS receipts 8. When you count and reconcile the change fund, ensure it is the correct amount assigned to the site, i.e. \$25, \$50, or \$100. 9. Ask staff how the change fund is used.
<p>8. No employee checks or IOUs are in the cash fund box. (2.11) [Exception: checks for payment of services.]</p>	<ol style="list-style-type: none"> 1. Review Policy 2.11. 2. Review all checks in the cash fund and verify that each has a corresponding receipt. 3. If there are checks on employees, verify that the services are billed accordingly. 4. If there are checks on employees, compare the check to the receipt and note any exception to policy. 5. Mark this standard met if there are no IOU's and any employee checks are for services received.
<p>9. Cash drawer and manual reconciliation totals match cash on hand and any difference is noted, explained, dated and signed. (2.11.5)</p>	<ol style="list-style-type: none"> 1. Review Policy 2.11. 2. Count cash fund and compare to the cash drawer and daily cash drawer report less authorized cash fund balance See guidance (5) for standard #4 above. 3. Any differences are noted and documented to support any changes. Lack of appropriate documentation of any

	differences would be counted as a deficiency.
NOTE: Twenty (20) consecutive CD's will be selected for #7- 20.	http://hsaintranet.health.tn.gov/default.asp
10. Any difference is noted, explained, dated and signed on the cash drawer. (2.11)	1. Review Policy 2.11. 2. Any differences are noted and documented to support any changes.
11. Copies of all receipts are maintained in numeric order 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) http://hsaintranet.health.tn.gov/default.asp	1. Review Policy 2.13 . 2. Prepare a schedule of CD's for test period. 3. Verify that every receipt (including manual, computer and voided receipts) listed on the cash drawer is attached to the CD and that there are no breaks in sequence. Breaks in sequence are obvious when looking at the receipt range on the production run of the cash drawer. The last receipt on the CD should be sequential to the next receipt on the next CD. 4. Verify that all receipts are original and not reprints unless an explanation is given. Documentation should be present when a reprint receipt is present instead of the original receipt. 5. Record the number of receipts reviewed and indicate the number met and not met.
12. 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)	1. Review Policy 2.13 . 2. List Review 20 CD sample for all manual receipts listed and confirm the manual and PTBMIS receipts are both attached to CD. 3. Reconcile the manual receipts with PTBMIS generated receipts and both copies are retained when monies are for services posted in PTBMIS 4. Record the numbers of manual receipts reviewed and indicate the number met and not met. 5. Mark this NA if there are no manual receipts.
13. No refunds are made from receipts. Refunds are provided from receipts only as directed by the Division of Administrative Services. (2.11)	1. Review Policy 2.11.11 and Policy 2.11.13 . 2. Verify that total cash and total checks listed on the CD equals total cash and total check amount listed on the cash drawer. 3. Refunds are not made by the health department 4. Review voided manual receipts and explanations to determine if monies have been refunded after a manual receipt has been issued. only as directed Assess compliance with directions by from the Office of Administrative Services.
14. Issuer signs manual receipts. (2.13)	1. Review Policy 2.13 . 2. Review manual receipt books for signatures generated since

	<p>date of last QI review.</p> <p>3. Count is to be the number of individual manual receipts reviewed.</p>
<p>15. Manual receipts are logged in from the region and are stored in a locked file/closet. (2.13)</p>	<p>1. Review Policy 2.13.</p> <p>2. Review manual receipt log to ensure that all manual receipts books are logged. The lack of a Manual Receipt Log should be marked as a deficiency</p> <p>3. Record whether met, not met, or NA.</p> <p>4. Mark this NA if there have been no new manual receipt books received since the last review. (equals no change). Count should reflect number of books assessed at this review.</p> <p>5. Determine where the manual receipt books are kept at night. Verify that the receipts books are in a locked storage area when not in use or at night.</p>
<p>16. Manual receipts are logged in from the Region .(2.13)</p>	<p>1. Review Policy 2.13.</p> <p>2. Review manual receipt log to ensure that all manual — receipts are logged.</p> <p>3. Record whether met, not met, or NA (equals no change).</p>
<p>17. Voided receipts are accounted for with an explanation and approved by a supervisor. (2.11.11)</p>	<p>1. Review Policy 2.11.11.</p> <p>2. Mark this standard NA if there are no voided receipts indicated on the CDs- for 20 CD sample size.</p> <p>3. Review the all voided receipts of sample to verify that all copies of the voided receipts are accounted for with explanation for voiding and approval of the office supervisor/manager or their supervisor (if voided by supervisor/office manager).</p> <p>4. Deleted procedures from an encounter or payment corrections are not considered</p> <p>5. Record the number voided receipts reviewed and state whether met or not met.</p>
<p>18. Significant All shortages are reported to the Regional Accountant or Regional Director according to policy. Office of Audit and Investigations of the Department of Health by sending a “Lost or Stolen Property Report.” (2.11.5 and 2.11.15)</p>	<p>1. Review Policy 2.11.5 and Policy 2.11.15</p> <p>2. Ask the Regional Accountant or determine staff if any shortages have been reported occurred since the last review. monitoring visit or during the past year.</p> <p>3. If there have been no shortages since the time of the last review, mark this standard NA.</p> <p>4. If any shortages have occurred, were they reported to the Regional Accountant or Regional Director according to policy</p>

	<ul style="list-style-type: none"> 5. Review CD's for codes indicating shortages on deposits. 6. Review records to see what procedure was performed
NOTE: Twenty (20) consecutive CD's will be selected for # 19-24.	http://hsaintranet.health.tn.gov/default.asp
19. Appropriate revenue codes are used on the State of Tennessee Deposit Slip. (2.9)	<ul style="list-style-type: none"> 1. Review Policy 2.9. 2. Review sub-program codes on Cash Drawer Report. 3. Select a sample of receipts from 20 CDs with the sample size determined by the QI random sample size formula found in the QI Manual page 34-36.
20. The established cut-off time for running the cash drawer and making deposits is as late in the day as possible to include as much of the business day's transactions as possible; yet is early enough in the day 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)	<ul style="list-style-type: none"> 1. Review Policy 2.9. 2. Review the time that the production run of the Cash Drawer report is run. 3. Compare log entry dates on check logs to receipts for twenty (20) CD's to ensure that monies are deposited in a timely manner. 4. It is acceptable to do this process first thing in the morning of the following day to compensate for staffing or bank related accessibility.
24. 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 and key . (2.9)	<ul style="list-style-type: none"> 1. Review Policy 2.9. 2. Compare the date and time of the CD to the date and time of the deposit per bank. 3. Look at a calendar to ensure that deposits were made at least twice weekly. Calculate for each of the sample CDs when a deposit should have been made by looking at the PBMS receipts and looking at the check log to determine when a mailed check was received for the \$100 calculations. 4. Check to Ensure that un-deposited funds are kept under lock and key.
22. CD forms are used in sequence. (2.9)	<ul style="list-style-type: none"> 1. Review Policy 2.9. 2. Review the sampling of CD's to ensure that CD forms are used in sequence.
23. CDs are voided according to procedure. (2.14)	<ul style="list-style-type: none"> 1. Review Policy 2.14. 2. Review the procedure used for voiding CD's if any voids occurred in the sample. 3. "VOID" is to be written on the CD with supervisor signature and date. 4. CDs must be voided when an error is made in the line entitled "DEPOSIT TOTAL" on the CD, or the CD may be voided for

	<p>other reasons at the discretion of the office supervisor.</p> <p>5. Determine if any CD should have been voided but was not.</p>
<p>24. The money deposited will match the CD (cash received = cash deposited; checks received = checks deposited). (2.11.6)</p>	<p>1. Review Policy 2.11.6.</p> <p>2. Compare the amounts of the cash drawer (cash and check) to the actual amount on the CD.</p>
<p>25. Checks are restrictively written/endorsed upon receipt. (2.11)</p>	<p>1. Review Policy 2.11.</p> <p>2. Review the checks in the cash box for an endorsement stamp.</p> <p>3. Observe the staff opening mail if possible.</p> <p>4.</p>
<p>26. Checks are restrictively written for the exact amount owed or a portion thereof and endorsed upon receipt. (2.11.9)</p>	<p>1. Review Policy 2.11.9.</p> <p>2. Compare all checks received to the cash drawer report patient accounts or PTBMIS production report.</p> <p>3. Review all the checks in the cash box for an endorsement stamp.</p> <p>4. Observe the staff opening mail if possible.</p> <p>5. In iNovah, review the checks for exact amounts owed or portion thereof and also check endorsement on the back of checks.</p>
<p>27. All checks are to be scanned in iNovah and should match the CD, the deposit slip in PeopleSoft and the PTBMIS "Cash Drawer Report"</p>	<p>1. Review iNovah Cashiering Manual</p> <p>2. Review selected 20 CD sample of scanned checks to verify for clarity in iNovah.</p> <p>3. Review selected sample to verify scanned CD's and deposit slips for clarity in PeopleSoft.</p> <p>4. The total checks (in iNovah) should match PeopleSoft and the PTBMIS "Cash Drawer Report"</p> <p>5. The lack of a check image due to a scanning process failure will require manual entry of the check information and should not be counted as a deficiency.</p>
<p>28. Returned checks are handled according to procedure outlined by the Division of Fiscal Services of the Department of Health. (2.11.10)</p>	<p>1. Review Policy 2.11.10.</p> <p>2. Ask office supervisor or Regional Accountant for the returned check file/list since the last monitoring Fiscal review visit and review the documentation to assure collection attempts have been documented.</p> <p>3. Was the site aware of the returned check</p> <p>4. Count would be number of returned checks</p> <p>5. If no returned checks, count the standard NA</p>
<p>29. No third party checks written on personal bank accounts are accepted. (2.11)</p>	<p>1. Review Policy 2.11.</p> <p>2. Review checks in the cash fund and review the "payee" listed</p>

	<p>and compare to the cash drawer report.</p> <p>3. Mark this standard met (1) if there are no 3rd party checks present in the cash box.</p>
<p>30. Credit card payments are to be reconciled to the PTBMIS “Summary of Credit Payments Received Report”) CredSum Report</p>	<p>Review a random sample of credit card payments:</p> <ol style="list-style-type: none"> Ask site for the CredSum Report for the 20 CD sample period. The credit card report and receipts should be filed as a separate batch in iNovah and in file. The total for the day should be the same in iNovah, PTBMIS, and the credit card receipts The <u>original</u> receipt should be signed and filed with the patient’s PTBMIS statement. Cancellations, voids and refunds would follow the same procedure as would a refund of a check after the fact and voids should be documented the same way as other voids.
<p>34. Voided encounters, credit memos, debit memos and payment corrections are handled according to procedure. (2.3 and 2.11.11)</p>	<ol style="list-style-type: none"> Review Policy 2.3 and 2.11.11. Review the PTBMIS Audit Documentation forms for a one-month period and compare them to patient ledgers on PTBMIS. Request the Report from the Regional System Administrator (some regions have this report run automatically from daily to monthly) of voided encounters, credit memos, debit memos and payment corrections for a same 20 CD sample period. The report is to be run and worked appropriately. Review the PTBMIS Audit Documentation forms (forms are not standardized across the regions) for a one-month same sample period and compare them to patient ledgers on PTBMIS. Audit documentation is required voided encounters and for all code 70 Payment corrections but not credit memos or debit memos. VOIDS code is 2 or 4. Credit Memo is code 83, Debit memo is code 93 and payment correction is code 70 in the PTBMIS audit documentation. Do not review the CENCs or 94 contractual adjustments.
<p>32. The Division of Administrative Services’ policy on Accounts Receivable is followed. (2.7)</p> <ol style="list-style-type: none"> 3rd Party and Individual Patient Billing - RO Collecting 3rd Party deductibles - LHD 	<ol style="list-style-type: none"> Review Policy 2.7 Sample is to be drawn from up to 2 weeks of recent remits. It is the reviewer’s choice to determine how many remits to review from that time frame. In a small county this may be a

<p>c. Collecting 3rd Party Co-payments - LHD</p> <p>d. Billing for Patients who have TennCare and private insurance - LHD</p> <p>e. Patients requesting local health department services in lieu of receiving services from their assigned/network provider. - LHD</p> <p>f. Collection and write-off of Accounts Receivable - RO</p> <p>g. Claim for refund - LHD</p> <p>h. Waiving private insurance billing non-TennCare enrollees. – RO Decision</p>	<p>very small number of remits with only one entry and in a large county/regional office, the choice can be to sample from only one remit that has hundreds of entries. It is not necessary to review remits of each staff member.</p> <ol style="list-style-type: none"> 3. Patients cannot be billed as payor 6 for any disallowed TennCare services (contract stipulation). This also applies to patients that are “retro” approved for TennCare if we bill TennCare 4. Amerigroup does not assess copays. 5. TennCare has no deductibles. TennCare copays are billed back to payor 6 and are set to not slide. 6. Patients with private insurance and TennCare, any deductible will be billed to TennCare. 7. Review Remittance Advice (RA) sample from TennCare, Medicare and private insurance for a one-month period to patient ledgers and PTBMIS to determine if accounts were adjusted correctly. 8. Review outstanding claims for a one-month period to determine if appropriate follow-up has been done and documented. 9. Review copies of billings for a one month period to determine if statements have been sent. 10. Review Aged Accounts Receivable Report and look for negative balances within the last 12 months, balances over one year but no more than three years and invalid payors. <p>LHD=Local Health Department; RO= Regional Office Review for these at the indicated sites and mark NA otherwise.</p>
<p>32. Patient is billed based on the sliding fee scale as appropriate. (2-7)</p> <p>—————http://hsaintranet.health.tn.gov/default.asp</p>	<ol style="list-style-type: none"> 1. Review <u>Policy 2.7</u>. 2. Review an encounter listing for a week and use the QI random sample size instructions listed in the QI Manual on pages 33-35. 3. Review the number required on the random sample size grid according to the number of encounters done in this week. 4. Compare the FI screen to ensure it is updated as appropriate. 5. Compare the Informed Consent Signature form in the patient's record to the FI screen on PTBMIS for accuracy.

Risk Minimization Guidelines

Standards that require 2 day written plans of action

GUIDELINES/STANDARDS	GUIDANCE TO REVIEWER
LABORATORY	Mark standards 1-13 NA if the site does not have a laboratory.
1. A current copy of the <u>Laboratory Policies and Procedures Manual for Local Health Departments</u> or Metro Lab Manual is maintained in the laboratory area.	Lab Manual, Section 1 page 6 Procedure Manual 1. Check site for current copy of Lab Manual with appropriate updates listed. Ask an employee to show you the location of the Lab Manual. 2. The manual should be readily accessible to any performing any Lab procedures.
2. Public Health Clinic Laboratory Practitioners perform on-site basic laboratory tests according to policies and procedures.	Lab Manual, Section 1 page 4 Certification/ Laboratory Inspection/ Personnel The local health department clinic laboratory maintains a current CLIA certificate. The site has a system in place for supervisory observation of staff performing lab test. Ask supervisory staff to describe system.
3. Lab training certificate is available for each employee who performs lab procedures.	Lab Manual, Section 1 page 5 Training Ask for a list of employees performing lab testing and request the lab certificates on site to verify against the employee list. New employees, who haven't had a chance to attend lab training, should not be marked deficient. Lab Training Certificate copies for traveling employees should be present in all sites they work.
4. Quality control tests are performed and documented according to the <u>Laboratory Policies and Procedures Manual for Local Health Departments</u> , with results maintained for at least 2 years. <u>Controls must be applicable to the brand of product being used.</u> Product package inserts will be retained with the applicable control test documentation. Package inserts will be followed regarding appropriate performance of tests or controls and correct storage of control solutions.	Lab Manual, Section 1 page 6-10 Quality Control 1. Observe Specimen/ Quality Control (QC) Log for acceptable, non-acceptable findings and corrective action taken for control tests completed since last review. 2. Observe that Specimen/ Quality Control Log form is completed correctly for the test. 3. Observe that controls are applicable to the brand of product being used. 4. Observe that controls used were in date and were run by specified frequency as outlined in the current Lab Manual and/or package insert. 5. Observe that QC logs are maintained for 2 years. 6. An immediate verbal plan of action is required for any deficiencies noted for this standard.
5. Quality control results are documented as monitored weekly by the supervisor. Any errors noted will have appropriate corrective action taken and documented.	Lab Manual, Section 1 page 7 Quality Control Testing Procedures 1. Observe for documentation of weekly monitoring by the supervisor (or designee) with initials and date. Documentation

	<p>may be on the individual Control Logs for each test or on a separate log that shows weekly entries designated by the initials of the person that reviewed the logs for accuracy and indicates the date the logs were reviewed.</p> <p>2. Corrective action is completed according to Laboratory Quality Control Model. (Lab Manual Section 1 page 9)</p>
<p>6. Competency Evaluation and Proficiency testing or Comparison testing are performed appropriately for the clinic laboratory with a CLIA Provider Performed Microscopy (PPM) Certificate.</p>	<p>Lab Manual – Section 1 page 5 Competency Evaluation and Proficiency Testing or Comparison Testing</p> <p>Comparison testing or CLIA approved proficiency testing for moderate complex / PPM tests (urine microscopy and vaginal wet mount tests) is performed for clinics with a CLIA Provider Performed Microscopy (PPM) Certificate. Competency and comparison testing can be done at the same time. Documentation of these activities is required.</p> <p>Competency evaluation of personnel: is done every 6 months during the first year of employment and annually thereafter.</p> <p>CLIA approved Proficiency Testing: Proficiency Testing is used to monitor the performance and quality of laboratory testing. Results of tabulation and grading must be reviewed by the laboratory director, supervisor and individuals performing the tests. If one or more challenges are missed, corrective action must be taken. Check documentation of test results on the proficiency testing control log.</p> <ol style="list-style-type: none"> 1. Determine that tests were conducted and returned in a timely manner to the Proficiency Testing Program. 2. Were all sites represented according to testing schedule? 3. Were results satisfactory? Ask to see results from provider. 4. If indicated, was corrective action performed. 5. If indicated, were Q.C. tests performed to demonstrate that problems have been corrected. 6. Maintain proficiency testing results and corrective action documentation for 2 years. <p>Comparison testing: when a proficiency testing program is not available, comparison testing is to be done twice annually.</p>
<p>7. Manufacturer operation instructions for laboratory equipment are available and followed as long as the equipment is in use.</p>	<p>Lab Manual, Section 1 page 11-12 Instrument Care and Preventive Maintenance Schedule for Equipment</p> <ol style="list-style-type: none"> 1. Determine applicable equipment.

	<ol style="list-style-type: none"> 2. Ask to see manufacturer's operating instructions 3. Observe staff operating or question staff regarding practices.
8. Correct holding temperatures for lab supplies and specimens requiring temperature sensitive storage are maintained and recorded. Temperature logs for lab supplies/specimen storage are retained for at least 2 years.	<p>Lab Manual, Section V page 23 Equipment Temperature Record Instructions</p> <ol style="list-style-type: none"> 1. Obtain list of correct holding temperatures 2. Check current temperature process and ask for log with recorded temperatures listed. 3. Check temperature log for any drops in temperature and corrective action taken. Logs are retained at least 2 years. 4. Incubator temperature and Lab refrigerator temperatures are to be read and documented on a Temperature Log daily.
9. Calibration is performed to assure standardization of machines. "Scales will be calibrated quarterly at a minimum except digital scales where manufacturer's instructions should be followed." Other items: Laboratory/Patient Care Equipment	<p>Lab Manual, Section I page 7</p> <p>Review equipment available at each site to determine which equipment requires routine calibration then review maintenance record for compliance with manufacturer's guidelines. This standard applies to all laboratory and patient care equipment. Any non-NIST thermometers are to be calibrated annually for example the Attest Biological Indicator incubator (crockpot) thermometer. See Lab Manual section V page 24 Thermometer Calibration</p>
10. Preventive maintenance and repair logs for lab equipment are kept for as long as the equipment is in use. (Effective April 2000 <u>Laboratory Policies and Procedures Manual for Local Health Departments.</u>)	<p>Lab Manual, Section 1 page 11 Preventive Maintenance</p> <ol style="list-style-type: none"> 1. Determine Lab equipment in use 2. Determine presence of a Lab Equipment Maintenance Log for each piece of lab equipment. See Section V page 21 of the 2000 Lab Manual for blank form. 3. Documentation should show any outside maintenance performed as directed by the equipment owner's manual. This does not refer to any in-house maintenance or cleaning action.
11. Laboratory specimens are collected, labeled, and stored according to acceptable procedures prior to mailing or courier pick up. A system is in place to track disposition of lab results. Lab request forms are completed correctly.	<p>Lab Manual, Section 1 page 6 Laboratory Testing</p> <ol style="list-style-type: none"> 1. Observe staff collect, label and store various specimens (when possible). Observe storage of specimens for courier pick up. Lab specimens are to be stored below any vaccine in the refrigerator. Vaccine Storage and Management Toolkit November 2012 Vaccine Storage and Handling Guide , December 2014 (General Information – page 6 61) 2. Compare procedure to Lab manual guidelines 3. When observation is not possible, staff can be asked to relate

	<p>procedure verbally.</p> <ol style="list-style-type: none"> Review lab request slips while doing chart review for completion of documentation. Determine by observation or ask staff the method for tracking disposition of lab results.
12. Laboratory logs (hardcopy or electronic) are kept for all specimens mailed or forwarded to any laboratory for at least two years.	<p>Lab Manual, Section 5 page 19-20 Generic Laboratory Log for Specimens Mailed or Forwarded Instructions</p> <p>Check to see if lab logs are kept for two years. If they are computerized, make sure there is access for up to two years.</p>
<p>13. Only laboratory and dental supplies with valid dates are available for use.</p> <p style="text-align: center;"></p> <p style="text-align: center;">Standards of Practice for Dental Public Health</p>	<p>Lab Manual, Section 1 page 6-7 Quality Control</p> <ol style="list-style-type: none"> Examine all areas of the laboratory, work-up areas, clinic rooms, and storage closets for stock rotation and expiration dates of all lab supplies or any supplies used to obtain, run tests or store lab specimens. (for examples – see below) <p>Culture plates Normal Saline Control solutions Viral cultures Blood tubes KOH HemoCue cuvettes Dipsticks Tuberculin syringes EKG electrodes Vacutainer needles Distilled Water</p> <p>Dental:</p> <ol style="list-style-type: none"> Examine all areas of the dental clinic and dental storage closets for expiration dates of all dental supplies and appropriate stock rotation. (for examples – see below) <p>Anesthetic (is not required to be locked) Dental filling materials Cleaning materials Distilled Water Dycal Temp bond Sealant materials</p> <p>An immediate verbal plan of action is required for any lab or dental related deficiency noted for this standard.</p>
<u>MEDICATION /VACCINE</u>	<p>Mark standards 14-21 NA if the site does not have a drug room or pharmacy.</p>
14. All medications and vaccines are kept under lock and key except when authorized personnel are in attendance.	<p>Observe the drug room/regional pharmacy casually at many different times while at the site to see if the door remains locked. Note the location of the key to determine if the key is in a secure location. Remember, this is for all medications and vaccines, including vitamins, inhalants, injectables and samples.</p>
15. Medications/vaccines are stored under proper conditions of sanitation, temperature, light, moisture, ventilation and refrigeration. (CDC - Vaccine Storage and Management Toolkit)	<ol style="list-style-type: none"> An immediate verbal plan of action is to be obtained for any deficiency noted for this standard where no or inappropriate corrective action has been taken. Assess for potential

November 2012 Vaccine Storage and Handling Guide,
December 2014)



patient impact.

2. Temperatures in all vaccine storage units should be recorded twice a day (morning and afternoon) on work days.
3. Ask the individual who records the temperatures to demonstrate this. It has been found that the Sensaphone data is being recorded and the calibrated thermometers are not being read. Ambient temperature for the drug room/regional pharmacy should be between 59-77° Fahrenheit (15-25° C). Ambient thermometers should be read daily and recorded. If not recorded, list this in the comments section. However, this is not a review deficiency. Review internal refrigerator temperature logs from the last review date forward for temperature excursions. Acceptable refrigerator range is 2°C – 8°C (35°F – 46° F); acceptable freezer range is –15° C (+5°F), or lower. If the site has continuous recording thermometer disks, review recorded temperatures for any temperature excursions and determine how long the vaccine was out of range. If a Sensaphone device is in place, determine if notification of excursion was sent to the appropriate person in a timely manner. Out of range temperatures require immediate corrective action. Note: Vaccine storage temperature logs should be maintained in a file for three years. CDC MMWR, Oct. 24, 2003/52(42);1023-1025.
4. Assess documentation of corrective action taken when readings were outside of acceptable range. Documentation should include
 1. Was the Supervisor notified?
 2. What action was taken?
 3. Was the action taken appropriate?
 4. Was the thermostat adjusted in the refrigerator/freezer and temperature re-checked and documented within range?
 5. Was the temperature measured with a different thermometer to check accuracy of original reading?
 6. Was vaccine relocated to a different refrigerator/freezer?
 7. Is the new location documented?
 8. Was the relocated vaccine maintained at the proper temperature during transfer?
 9. Was the State Immunization Program called for assistance?
 10. Was there no action taken?

11. Did the provider document the action taken on the temperature log or elsewhere?

~~An immediate verbal plan of action is to be obtained for any deficiency noted for this standard where no or inappropriate corrective action has been taken. Assess for potential patient impact.~~

5. Examine the vaccine freezer and refrigerator for cleanliness. Is food stored in the vaccine refrigerator or freezer? [Vaccine Storage and Management Toolkit November 2012 page 60](#) Are vaccines stored in the doors of any refrigerator or freezer? Are bottles of water placed in all refrigerators and ice packs in all freezers to stabilize the internal temperatures of the storage area? Is vaccine stacked with air space between, on the sides and behind each large block or tray of all units to allow cold air to circulate around the vaccine? Only MMR vaccine may be stored near the cold-air outlet from freezer - others can become too cold in that location. Is there a “DO NOT DISCONNECT” sign on every outlet where a refrigerator or freezer is connected? Is there a “DO NOT DISCONNECT” sign on the circuit breaker? [Vaccine Storage and Management Toolkit November 2012 page 49](#)
6. Are thermometers placed in the middle of the refrigerator and freezer? Is the sensaphone probe placed in the middle of the refrigerator or freezer? Thermometers are to be NIST calibrated thermometers in both the vaccine refrigerator and freezer.
7. If you find any temperatures out of range not previously reported, either too high or too low, call the State Immunization Program immediately for guidance on appropriate corrective action. The toll free general number is 1-800-404-3006. Ask for VFC AFIX coordinator or available Immunization Program staff. The Central Office staff will call the Regional Immunization Representatives to assist as needed.
8. Checking Cold Chain – Start with the clerk and ask her what she does when vaccines arrive. Ask the person that the clerk stated she called and ask them what they do when vaccines arrive. Continue until the entire receiving process is reviewed and assess how much time passes from receipt to placement in the

<p>http://hsaintranet.health.tn.gov/default.asp</p>	<p>refrigerator or freezer. The staff should be explaining how the vaccine arrives, how the condition is assessed, what process is for short-dated products, the process for rejecting or returning vaccine and how it is stored (rotated). See email dated 3/14/07 written by Kevin Eidson, former Tennessee Department of Health Director of Pharmacy Shipments of vaccine should be inspected prior to signing to assure that the vaccines are shipped according to proper storage and handling procedures. Any product that gives the appearance of not being shipped under proper storage and handling procedures should not be accepted by the facility and not signed as received. If this occurs, it is acceptable to reject the shipment and therefore, it will be returned to the supplier. Please contact Dr. Calita Richards, current Director of Pharmacy, with any questions.</p> <p>9. In the written two-day plan of action, it should be noted if patients (or employees) are involved and need to be identified. Have the staff send the two-day plan of action stating the steps they are taking to identify and locate patients. A follow-up report may detail the outcome of the patient contact. All two-day plans should be completed in consultation with the Regional Director, Regional Medical Officer, Regional Nursing Director, the Regional Pharmacist and Regional Immunization Program Director.</p> <p>10. Medications and Pharmacy Products - See PHN Public Health Drug Formulary for Storage Requirements for the various products QI Manual - Appendix G</p>
<p>16. Internal medications, injectables, and topical preparations are stored separately from disinfectants and poisons.</p>	<p>Examine the drug room/Regional Pharmacy shelves to determine that no cleaning supplies or other agents are stored beside pharmaceuticals.</p>
<p>17. Drug labeling, packaging, movement and inventory procedures are performed appropriately. CHSA Policy 8.3.b and 8.3.c</p>	<ol style="list-style-type: none"> 1. Ask staff or supervisor to explain medication issuing and vaccine administration process from labeling to inventory. 2. Examine vaccine log to determine that stock in use in the clinics has been signed out. 3. Examine drug movement sheets for proper completion. 4. Determine the person responsible for maintaining inventory by asking any staff member that is not typically assigned that duty. 5. Examine the drug room for any evidence of repackaging of medications, as repackaging is not allowed in the clinics. 6. Inspect pharmacy stock labels to assure labels are intact and

	legible.
18. When drug samples are allowed by regional policy, they are included in an inventory system.	Mark this standard NA if no samples are in use in the site. 1. Compare any samples present to inventory logs. 2. Compare quantity present with stock amount documented on the log. Review lot numbers and expiration dates for correlation with log.
19. Medications/vaccines are inspected for removal of expired or deteriorated drugs, damaged labels and excess quantities of medications/vaccines. CHSA Policy 8.3.d and CHSA Policy 8.3.b 	1. Examine all contents of the drug room/Regional Pharmacy for expired stock. 2. Assess stock rotation, quantity, and condition. 3. An immediate verbal plan of action is required for any deficiency noted for this standard.
20. Adverse drug events and vaccine adverse events are reported appropriately.	Request to see all medication adverse event reports and vaccine adverse event reports (VAERS) that have occurred since last review. If no adverse events reported, mark standard NA and have Nursing Supervisor explain actions that would be taken if adverse events had occurred.
21. Vaccine Information Statements (VIS) available in the clinic are current according to CDC guidelines. http://hsaintranet.health.tn.gov/default.asp	VIS forms should be current. Reference the CDC website: http://www.cdc.gov/vaccines/pubs/vis/default.htm or approved interim http://www.cdc.gov/vaccines/pubs/vis/vis-news.htm to determine the most appropriate VIS date for the visit date reviewed. Ask where they keep their supply of VIS forms and check for appropriate revision dates. Randomly check exam rooms for current VIS forms where immunizations are given. (Be aware that some CDC changes are minor and sites are allowed to "use up old forms".) Contact Regional Immunization Director with any concerns regarding dates of VIS forms available in clinic.
MEDICAL/DENTAL X-RAYS	Mark standards 22-31 NA if the review site does not have x-ray equipment.
Reference: Department of Environment and Conservation Division of Radiological Health, Dec. 2011, Chapters 1200-2-4, March 2010 1200-2-5 and March 2010 1200-2-6 revision 05/2012 Chapter 0400-20-40 , Chapter 0400-20-05 , and Chapter 0400-20-06 and TB Guidelines , TDH, 2004.	Dental: Non operational dental sites are not subject to review. Mark these standards NA for sites that are not in use. Obtain operational status of dental sites within your region from the Regional Dental Director. Standards of Practice for Dental Public Health
22. All procedures are performed on request of a physician, dentist, nurse practitioner or follow specific program guidelines.	Observe documentation in the record of verbal order and/or TB Guidelines for chest x-ray are followed. pg. VII-pages 2 and 3. This can be confirmed during medical record review.

<p>23. Precautions are taken to expose only the portion of the body being x-rayed.</p>	<ol style="list-style-type: none"> 1. Have x-ray tech describe procedure used to set manual collimation for chest size or body part size. 2. Observe that lead apron is available and have employee describe use. A lead apron with thyroid collar should be available for dental use. Lead aprons should be in good condition with no deep creases, tears or holes.
<p>24. Qualified service personnel do major maintenance and major adjustments of x-ray equipment.</p>	<ol style="list-style-type: none"> 1. Observe record log of contracting maintenance service company for monthly maintenance of x-ray equipment and processor. 2. Processor is maintained as specified by service contract and manufacturer's instructions. 3. Warm-up time and temperature check are in accordance with the manufacturer's instructions. This is part of the monthly maintenance check by the contracting maintenance service company. It is an automatic procedure and a light will appear when machine is ready. 4. Monthly maintenance by an outside source is not required for Dental x-ray equipment.
<p>25. X-ray equipment is inspected by a health physicist through the Division of Radiological Health.</p>	<p>Clinical: Observe report of last inspection and the date it was completed. (every two (2) years for medical x-ray)</p> <p>Dental:</p> <ol style="list-style-type: none"> 1. Dental X-ray Equipment – Observe report of last inspection and the date it was completed. This report will be kept in the front of the Standards of Practice for Dental Public Health Manual or posted in the dental x-ray area. 2. Dental X-ray inspections are required every 4 years. This may be an automatic visit rotation for both clinical and dental x-ray services if overseen by the Division of Radiological Health and does not require local scheduling. This is not an automatically scheduled service when inspections are contracted with a private provider.
<p>26. Proper storage of film and chemicals is maintained at all times.</p>	<ol style="list-style-type: none"> 1. Observe that film is shielded from radiation and light. 2. Observe storage of chemicals in a secure area.
<p>27. Film disposal is in accordance with regional/county contract with company.</p>	<ol style="list-style-type: none"> 1. Observe contract for film disposal to a qualified company. 2. Film disposal is done according to Policy and Procedure manual Section 5.3b. (Retention of X-ray Film) <p>Dental: Standards of Practice for Dental Public Health</p> <ol style="list-style-type: none"> 1. Dental recycling of lead foil packets is to done in every clinic.

	<p>There will be a container in the processing area that contains lead foils waiting to be recycled. Presence of this container is confirmation that the recycling standard of lead foil is met.</p> <p>2. This standard does not apply in dental clinics where digital X-ray units are being used and should be marked NA.</p>
28. To ensure proper exposures, a technique chart is available and utilized for medical x-ray exams, except for phototimed exposures.	Mark NA if all equipment is phototimed.
29. Perform film development or digital receptor imaging according to the manufacturer's recommendations.	Manufacturer's recommendations for film development or digital receptor imaging should be on hand and followed.
30. Monitoring devices are worn by all employees while taking x-rays.	<ol style="list-style-type: none"> 1. Monitoring device is available for each individual performing x-rays. Not required for Dental employees 2. Ask to see individual records of cumulative exposure for each employee performing x-rays. 3. Cumulative radiation exposure is monitored.
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.	<ol style="list-style-type: none"> 1. Ask employee of policy regarding x-ray of pregnant women. 2. Observe for sign in x-ray area stating " PREGNANT? IF YOU ARE PREGNANT TELL YOUR DOCTOR BEFORE X-RAY OR GET A PRESCRIPTION" 3. Comprehensive Record Review will reveal documentation of pregnancy question being asked.
<u>OCCUPATIONAL HEALTH/INFECTION CONTROL</u>	
Reference: Basic Guidelines of Infection Control for Regional and Local Health Departments , current edition	http://hsaintranet.health.tn.gov/default.asp
32. The site complies with the Regional Exposure Control Plan and Infection Control Manual. CHSA Policy 8.2.b	<ol style="list-style-type: none"> 1. Ask to see Exposure Control Plan 2. Ask to see Infection Control Manual 3. Observe that appropriate PPE (personal protective equipment) are available in the clinics for hazardous tasks – Staff can be questioned about tasks (randomly select a few), can tell which PPE should be used. 4. Food - No food or drinks should be in the clinical / lab areas. – Lab Manual, Section I, page 2 Policies for Laboratory Services, #9: "Food is not stored in refrigerators used for specimens or reagents." Infection Control Manual: Pg 8, 3e. "Eating, drinking, applying cosmetics and handling contact lenses are prohibited in areas

	<p>where there is reasonable likelihood of occupational exposure.”</p> <p>Dental: Standards of Practice for Dental Public Health</p> <ol style="list-style-type: none"> 1. Dental Exposure Control Plan is up to date and kept in the dental clinic area in a red binder. 2. The exposure control manual pages 1-4, 1-18 & 1-27 must be completed with current staff information. 3. Employers must document annually that they have considered and implemented safer medical devices and that they have solicited input from frontline workers in evaluating & selecting engineering controls, i.e. self-sheathing needles and sharps containers. <ul style="list-style-type: none"> • Forms are found in Section 1 of the ECP Manual pages 1-28 – 1-30. • Each region will annually designate a dentist to test self-sheathing needles and complete evaluation forms. Copies of completed forms will be forwarded to each Health Department Dental Clinic in the respective region, to the Regional Dental Director and a copy will be sent to Central Office, Oral Health Services. 4. Blood borne Pathogen training will be provided on a yearly basis and must be documented on the Blood borne Pathogens Standard Employee Training Record, found in the Exposure Control Manual, Tab 1, Appendix 8. 5. All of the above dental information is required on Mobile Dental Units that are in operation.
<p>33. Post Exposure incidents are handled according to Regional Exposure Control Policy. CHSA Policies 3.4 & 8.2.b</p>  <p>http://hsaintranet.health.tn.gov/default.asp</p>	<ol style="list-style-type: none"> 1. Question the clinic supervisor and random employees about the procedure to be followed if a hazardous exposure incident occurs (if you get a needle stick what happens?). 2. Employees involved in a blood exposure to any known or possibly hazardous or infectious substances through needle sticks, chemical splashes, etc., or employees who have a TB skin test that converts to positive should complete an Accident Report (Worker’s Comp) even if they have no immediate plan to file for Worker’s Comp. Under these special circumstances both the completed Incident/Accident Investigation Report and the Accident Report are to be submitted to Division of Community Health Services TOSHA Representative, Donna Hurst, RN. 3. In any incident/accident that involves blood borne exposure,

	<p>OSHA mandates that strict limitations be placed on the circulation of medical information. Therefore, in these instances, both the Incident/Accident Investigation Report and the Accident Report (Worker's Comp) should contain only information specified in OSHA regulations. The health professional evaluating and managing the exposed employee should place all confidential medical information in a sealed envelope in a locked file.</p> <ol style="list-style-type: none"> 4. Copies of all Incident/Accident Investigation Reports are to be retained locally for a period of two (2) years, except for those occurrences involving exposure to hazardous or infectious substances. In these cases, the form must be kept 30 years from the date of termination from employment. 5. Review paperwork to determine that Post exposure follow-up was completed according to policy. 6. An immediate verbal plan of action is required for any deficiency noted for this standard.
<p>34. Sharps are immediately discarded into appropriate sharps containers, which must be readily accessible.</p> <p style="text-align: right;"></p> <p style="text-align: center;">http://hsaintranet.health.tn.gov/default.asp</p>	<p>CHSA Infection Control Guidelines, Section IV, page 27</p> <ol style="list-style-type: none"> 1. Observe work areas for proper placement of appropriate sharps containers (out of reach of children). 2. Observe for any overfilled or inappropriate sharps containers. Red boxes need to be accessible and available, not over filled. 3. An immediate verbal plan of action is required for any deficiency noted for this standard.
<p>35. Cleaning and disinfecting are done according to a written schedule. All equipment and contaminated work surfaces are decontaminated with an appropriate disinfectant as soon as feasible, as well as after any spill, and at the end of the work day. The spill kit is fully stocked and readily accessible to staff.</p> <p style="text-align: right;"></p>	<p>CHSA Infection Control Guidelines, Section IV (all) and Section VII, Appendices, General Housekeeping, page 54</p> <ol style="list-style-type: none"> 1. Check equipment cleaning logs (HemoCue, glucose monitor, microscope, etc.) to confirm if required cleaning is performed. 2. Observe if 10% bleach solution is available, labeled and changed each day clinic is open. 4. Randomly question staff regarding cleaning of equipment or surfaces to confirm knowledge/practice regarding these. 5. Check Respirators for cleaning & disinfecting. Recommendation on cleaning and disinfections differ among manufacturers. See manufacturer's recommendations. Respirators are cleaned and disinfected, as often as necessary when issued for the exclusive use of one employee; before

	<p>being worn by different individuals, after each use for emergency use respirators; and after each use for respirators used for fit testing and training.</p> <p>6. An immediate verbal plan of action is required for any deficiency noted for this standard.</p>
<p>36. Protective coverings, such as impervious paper used to cover patient assessment tables should be replaced after each patient. On work surfaces, it is replaced routinely and as soon as feasible when contaminated.</p>	<p>CHSA Infection Control Guidelines, Section VII, Appendices, General Housekeeping, page 54</p> <p>1. Observe if paper present on examination tables, and if possible, that it is changed after each patient and when visibly contaminated (question staff about this if unable to observe).</p>
<p>37. All regulated wastes are contained in closable, leak proof, puncture resistant, and biohazard labeled or color-coded containers.</p>	<p>CHSA Infection Control Guidelines, Section V page 34-41</p> <p>1. Observe if appropriate containers (that meet guidelines) are present in the clinic rooms red bags. etc.</p> <p>2. Observe if biohazard containers are kept closed and not easily accessed by children.</p> <p>3. Observe if the dedicated enclosure for storage of containers awaiting pick-up is secured to deny access to unauthorized persons and provides protection from animals, rodents, insects and other natural elements, and an appropriate warning sign is in place on the door.</p> <p>4. Immediately after use, used metal speculums are to be placed to soak in a covered leak proof container containing an EPA approved disinfectant or bleach, rated as tuberculocidal, and timed according to the manufacturer's instructions. (30 minutes for a 10% bleach solution)</p>
<p>38. Biohazard labels are used appropriately.</p> <p>http://hsaintranet.health.tn.gov/default.asp</p>	<p>CHSA Infection Control Guidelines, Section I, page 13 - Communication of Hazards</p> <p>1. Biohazard label is observed on any container used to store or discard biohazardous materials [blood or other potentially infectious materials (OPIM)].</p> <p>2. Biohazard label is observed on any refrigerator, closet or lab specimen container where biohazardous or OPIM materials are kept.</p>
<p>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.</p>	<p>Mark this standard NA if the review site does not have or use an autoclave. CHSA Infection Control Guidelines, Section IV, page 30</p> <p>1. Check autoclave logs to confirm if cleaning cycles are run per manufacturer's instructions and correctly documented.</p>

[Standards of Practice for Dental Public Health](#)

2. Check autoclave logs for record that Attest biological indicator testing is done, incubated at the correct temperature for the correct length of time, and correctly documented, per protocol, for each week the autoclave is used.
 3. Determine that water is added/changed according to manufacturer's instructions.
- Dental:** Dental Guidelines for Infection Control in Dental Health-Care Settings – 2003, found in the Standards of Practice for Dental Public Health-July 2010: pages 97-101 and in Section 2 of the Infection Control Manual, are to be found in the dental clinic area.
1. Findings from the **Weekly** spore test are kept in the spore test autoclave log. Findings include the date the test was run, the date the test was put in the incubator, the date the test was read and the result of the test. The sterilization load label must be placed on the spore test log.
 2. Attest Spore test indicators can either be 1261P or 1262P. The 1261P can be read after 24 hours and the 1262P can be read after 48 hours of incubation.
 3. An entry must be made in the log if the sterilizer is not in use for a week, i.e. Christmas break or vacation, or if it fails the spore test. The entry must state in the comments section that the autoclave was not in use or that the autoclave failed the spore test and what action has been taken. Every week has to be accounted for either with a spore test result or that the autoclave was not in use.
 4. Some clinics will send their spore tests to a company that will run the tests. The results will either be faxed to the clinic or the clinic staff can go to a website and obtain the results. Results are documented the same way. For those that send in spore tests, results should be obtained and documented within 2 weeks of the run date.
 5. The log must be maintained in the Dental clinic (sterilization area). Biological Indicator logs must be kept for 2 years.

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.

Mark this standard NA if the review site does not have any sterilized items to be reviewed. (Items autoclaved)
[CHSA Infection Control Guidelines](#), Section IV, page 31
1. Examine sterilized packages for integrity and evidence of

<http://hsaintranet.health.tn.gov/default.asp>

- appropriate sterilization procedure (i.e. appropriate color change for steam autoclave tape).
2. Muslin and paper wrapped sterilized supplies expire after 30 days, if kept dry and the package integrity is maintained.
3. Heat-sealed supplies are considered sterile for one year from the date sterilized.
4. Commercially prepared sterile supplies may have an expiration date for more than one year or no expiration date. **This would include all commercially sterile items such as sutures, prepackaged instrument sets, Fluoride varnish kits, etc.**
5. Metal speculums after use are cleaned and autoclaved per [Infection Control Manual](#), Section IV, page 24, “should be stored in clean dry cabinet ...” Do not mark deficient for sterilization dates over 1 year for metal speculums. They are not required to be kept in a sterile state and do not need an expiration date.

Dental: Dental Instrument Storage Guidelines are found in the Guidelines for Infection Control in Dental Health-Care Settings – 2003, found in the [Standards of Practice for Dental Public Health](#) Manual -July 2010: pages 96-101.

1. Examine sterilized packages for integrity and evidence of appropriate sterilization procedure (i.e. appropriate color change on external and internal chemical indicators).
2. Each package must contain an internal sterilization indicator, either built into the package or placed inside the package prior to sterilization.
3. Each package must have the date of sterilization including the month, day and year.
4. Heat-sealed items are considered sterile for one year from date of sterilization.
5. Commercially prepared sterile supplies may have an expiration date for more than one year or no expiration date.
6. Sterilized bags must be rebagged and resterilized after 1 year from date on package.
7. This standard applies to the dental mobile units if operational.

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

1. Ask for list of employees whose job classification is at risk for occupational exposure.
2. Confirm that all “at risk” employees on that list were offered the

<p>assignment. (Federal Register 29 CFR 1910.1030)</p> <p>“At risk” employees must sign an OSHA approved Declination Form if the choice is not to receive Hepatitis B vaccine. CHSA Policies Manual 3.9 and 8.2.b http://hsaintranet.health.tn.gov/default.asp</p>	<p>Hepatitis B vaccine series.</p> <ol style="list-style-type: none"> 3. Confirm that all employees, whose job classification puts them at risk for occupational biohazardous exposure, have either received (or are receiving) the 3-dose hepatitis B vaccine series, or have signed a declination form. 4. See Federal Register 29 CFR 1910.1030 1910.1030(f)(1)(i) through 1910.1030(f)(2)(iv)
<p>42. One to 2 months after completion of the 3-dose vaccination series employees are tested for antibody to hepatitis B surface antigen and non-responders (<10 mIU/ml) are revaccinated with 3-dose series. (TOSHA CPL 02-02-069)</p>	<ol style="list-style-type: none"> 1. Check records to confirm that all “at risk” employees hired Feb.15, 2000 or later, who have received the Hepatitis B series have been tested for the antibody to Hepatitis B surface antigen within 1-2 months after completion of the series. 2. Check record to see that all confirmed non-responders (< 10 mIU/ml) were revaccinated with 3 dose series (or offered revaccination).
<p>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.</p>	<p>Have site provide you with skin test date documentation for each employee. Any applicable (not skin test positive by history) at risk employee who has not had the annual skin test, a deficiency for the site is to be marked. Employees with a history of a positive skin test will be followed as directed by the Regional Medical Director regarding need of and/or frequency of chest x-ray tests.</p>
<p>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</p>	<p>Have site provide documentation to confirm that all applicable employees, born in 1957 or later (those born 1/1/1957 or later), have shown proof of immunity to measles, mumps and rubella (serologic lab tests, documentation of rubella, measles and mumps vaccine(s), physician-documentation of illness with measles), received 2 doses of the MMR vaccine, or documentation is present for any refusal of MMR vaccination.</p>
<p>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 http://hsaintranet.health.tn.gov/default.asp</p>	<p>Have site provide documentation to confirm that all applicable employees have confirmed immunity to Varicella, either by reliable report of illness, documentation of Varicella vaccination, or documentation is present for any refusal of Varicella vaccination.</p>
<p>46. Manifests from hazardous waste disposal company are kept on file to document these 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.</p>	<p>Ask to see file where manifests are kept. Note if pickup is regular and at reasonable intervals. CHSA Infection Control Guidelines</p>

<p>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)</p>	<ol style="list-style-type: none"> 1. Review OSHA policy regarding all appropriate staff receiving yearly TRAINING in Blood-borne Pathogens. 2. Training must be DOCUMENTED and retained for 3 years from the date of training. 3. See: Federal Register 29 CFR 1910.1030 - scroll down to 1910.1030(g)(2)(ix)(C)
<p>48. All appropriate public health staff are to receive MSDS training yearly. The employer shall provide a training program to new or newly assigned employees prior to their working in a work area containing hazardous chemicals. (State of TN Hazardous Chemical Right To Know Law, T.C.A. 50-3-2001)</p>	<ol style="list-style-type: none"> 1. Review State of Tennessee Hazardous Chemical Right-To Know Law regarding all appropriate staff to receive annual training in MSDS. 2. Training must be documented and training records retained for the period of employment + 5 years. <p>(MSDS forms are to be kept for as long as the chemical is used or stored; the chemical list is to be maintained for 30 years.)</p> <p>Dental: Standards of Practice for Dental Public Health</p> <ol style="list-style-type: none"> 1. All dental staff is to receive annual MSDS training. Training must be documented on Appendix 2, Hazard Communication Standard Employee Training record found in the Hazard Communication Manual, Tab 6, pg. 1-20 and training records retained for the period of employment + 5 years. 2. The <i>Inventory of Chemicals, Materials and Supplies</i> form in the Hazard Communication Program accurately reflect all the hazardous chemicals that are present on the dental clinic and are to be updated annually. 3. The <i>List of Hazardous Chemicals</i> form in the Hazard Communication Program accurately designates all of the hazardous chemicals and products that are present in the dental clinic and are to be updated annually. 4. MSDS's are to be kept for as long as the chemical is used or stored; the chemical list is to be maintained for 30 years. 5. MSDS's are required on the mobile dental units that are in operation.
<u>SAFETY/SECURITY</u>	
<p>49. The clinical facility promotes patient safety, i.e., cleaning</p>	<p>Visual inspection of the building is required to evaluate this</p>

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.	standard. All electric outlets in the clinical/public areas should have protective covers except outlets on GFI (Ground Fault Interrupter) circuits. Ask the site's County Director for the location of any GFI circuits if an outlet is found uncovered in the clinical area and it is not visually marked as a GFI circuit outlet. Sharps containers should be out of reach for children. Items bagged in red bags ready for pick up should not be held in the laboratory or clinic areas. There should be a 3 foot clearance in front of and to the sides of the electrical service panel.
50. There is a current list of persons having keys to the building. http://hsaintranet.health.tn.gov/default.asp	Keys to applicable property are given to a new employee when hired. Listing is to be maintained specifying who has keys to various properties and updated as needed. Documentation should show return of keys by any departing employee, CHSA Policy 3.17
51. Appropriate public health staff must be prepared to respond to all disasters affecting the site. CHSA Policy 8.4.b	Review CHSA Policy 8.4b or Metro/Region Policy noting it is the Regional Director's (Designee) responsibility for drill.
A. A written plan must be in place describing response roles and responsibilities for responding to tornadoes, fires, earthquakes, ice storms, floods, etc.	Ask to see Regional/Site's WRITTEN Disaster Plan. (Each site should have a written plan accessible to each employee.)
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.	Check regarding name of persons responsible for coordination of disaster services for the Region/Site.
C. All Local Health Department and Regional Office staff are informed of necessary procedures for responding to site disasters.	1. Ask Nursing Supervisor, Human Resources Director, or Designee for documentation (list) of personnel who attended Disaster training. Date of training should be current. 2. Ask a staff member to describe the Disaster plan or ask if member has a copy of the plan and is aware of its contents.
D. Simulated disaster drill (tornadoes, earthquakes, ice storms, flood, etc.) will be conducted every two years.	1. Ask Regional Director, Nursing Supervisor, or Designee for copy of simulated Disaster drill documentation. Drill documentation should include date (within 2 years from last drill date), evaluation of effectiveness and signature of the employee who conducted the drill along with the names of all employees that participated in the drill. 2. If County-wide "mock" disaster drill is held in lieu of site disaster drill, ask that meeting notes be placed in "drill folder" with current date, names of staff who attended, and any other appropriate personnel signatures.
52. Exits signs are clearly marked, tested and properly maintained.	Exits should be clearly marked with lighted signs.

(NFPA 101 Life Safety Code 2009)	
<p>53. Safety inspections are current for fire extinguishers. CHSA Policy 8.4.b</p> <p>http://hsaintranet.health.tn.gov/default.asp</p>	<p>Fire extinguishers should be inspected annually and tagged appropriately. The tag should be labeled with the date of service. OSHA requires visual monitoring of fire extinguishers monthly. http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_tabl e=STANDARDS&p_id=9811</p> <p>Portable extinguishers or hose used in lieu thereof under paragraph (d)(3) of this section shall be visually inspected monthly.</p>
<p>54. Doors and hallways are free from obstructions.</p>	<p>Visual observations of the doors and hallways should be done each day of your review that you are in the clinic. Assure that there are no obstructions around fire exits such as boxes, coat racks, bookcases, etc. and that there is the ADA required 36" clearance in passageways. (See ADA Accessibility link below at 4.3.3) http://www.access-board.gov/adaag/#4.3</p>
<p>55. A fire drill is held at least annually. CHSA Policy 8.4.b</p>	<p>Fire drills are required annually. Drill documentation should include: date, time to evacuate, and a list of the names of all employees that participated.</p>
<p>56. 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</p>	<ol style="list-style-type: none"> 1. An annual inspection by a fire inspector must be done. The form should be kept at the LHD for proof that this assessment has been done. 2. Ask for fire inspector's report noting any deficiencies. Check for correction of deficiencies within the allotted time by inspector. Inspection report should be current (within year) and have appropriate signatures.
<p>57. 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</p>	<ol style="list-style-type: none"> 1. Visual inspection of the building noting the location of the evacuation plans and evaluate to insure that they are in the appropriate locations and that the evacuation plan contains a floor plan , indicating rooms, exits, and the location of the fire extinguishers. 2. Then observe the building to check the accuracy of the evacuation plan noting that updates to the plan have been added. 3. Inspect posted evacuation plans throughout Health Dept/Site. Plans should be current, legible, and have "YOU ARE HERE" designated appropriately on each.

58. 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	Review CHSA Policy 8.4c or Metro/Region Policy noting that it is the Regional Director's or Designee responsibility for drill.
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.	Ask to see the written Violence in the Workplace Plan. (Each site should have a written plan accessible to the employee.) Check regarding name of persons responsible for coordination of safety at Region/Site and that staff assignments include current staff names.
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 staff are informed of procedures to manage workplace violence, threats, and other disruptive behavior at the site.	Ask for list of personnel who attended the most recent Workplace Violence drill (compare with list of employees.) New employees should receive training within a reasonable length of time after starting employment.
E. A simulated drill for responding to violence in the workplace will be conducted every two years.	Ask Regional Director, Nursing Supervisor or Designee for copy of simulated Violence in Workplace Drill documentation. Drill documentation should include date (within 2 years from last drill date), evaluation of effectiveness and signature of the employee who conducted the drill along with names of all employees that participated in the drill.
<u>MEDICAL RISK CONTROL</u>	http://hsaintranet.health.tn.gov/default.asp
59. 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.	<ol style="list-style-type: none"> 1. Ask Nursing Supervisor for copy of current Public Health Nursing Protocol (CHSA or Metro/Region) 2. Ask Nursing Supervisor for copy of current Providers who are employed at the site and would be using Protocol Manual. 3. Check copy of Nursing Protocol Manual for current year, revision dates, copy of Provider signatures, and current signature of Health Officer who approved Protocol. 4. Ask employee to show you location of Protocol Manual. 5. For Nurse Practitioners Yearly Evaluation of protocol reference book "Ferri's Clinical Advisor", book is to be no older than 2 years. Primary Care Manual page 5. 8/6/07 6. Yearly evaluation of current ICD-9 and CPT books in clinical area, books need to be no older than 1 year.

<p>60. Emergency equipment/supplies are fully stocked and routine inspections are documented monthly. Expiring supplies are replaced in a timely manner. CHSA Policy 8.4.a</p> <p>http://hsaintranet.health.tn.gov/default.asp</p>	<ol style="list-style-type: none"> 1. Review CHSA Policy 8.4.a or Metro/Region Policies and Procedure Manual for current list of required equipment for Emergency Box. 2. Ask Nursing Supervisor at Health Dept. or site to show you location of emergency box and oxygen tank. 3. Inspect all medications and supplies in Emergency Box for expiration dates. Expired supplies or medications in the emergency box are to be marked deficient in this standard. 4. Check monthly log sheet for dates and signatures of person responsible for checking Emergency Box. 5. Inspect all equipment in Emergency Box for tears, operational use, etc. (Are batteries in flashlights working; is all equipment in date, etc?) 6. Check oxygen tank for expiration date. Turn on oxygen tank to determine gauge, valve, and tubing are functioning. <p>Dental: This standard applies to all the mobile units in operation and some fixed dental clinics depending on clinic structure.</p> <ol style="list-style-type: none"> 1. Dental oxygen tanks should be checked for expiration dates. Turn on oxygen tank to determine gauge, valve, and tubing are functioning. 2. All dental clinics must have a stethoscope/ sphygmomanometer in the dental area. Only an adult size cuff is required. Inspect blood pressure equipment to determine that it is operational and in good repair. <p>Standards of Practice for Dental Public Health</p>
<p>61. 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</p>	<p>Review the copy of yearly patient-centered emergency DRILL CHECK SHEET. Drill check sheet should include the date (within year), evaluation of effectiveness and signature of the employee who conducted the drill along with the names of all employees that participated in the drill.</p>
<p>62. 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</p>	<p>Licensed staff maintains current CPR certification. CHSA Policies and Procedures Manual 8.4a or check Metro/Region Policies and Procedure Manual. Dental CPR certification documentation: Current CPR certification documentation will be maintained.</p>

63. Provisions are made to conduct annual fit testing of respirators and any additional fit tests in the event of physical changes in the employee that may affect respirator fit or in the event of damage to respirators in use. Masks are stored appropriately.

[Division of Community Health Services Respiratory Protection Program Manual](#)

<http://hsaintranet.health.tn.gov/default.asp>

Annual fit testing of respirators will be conducted on employees who have been identified as being at risk in the TB program and BT program and any other employees identified by the Regional Medical Director.

Fit testing and training is conducted for all employees required to wear tight-fitting face piece respirators as follows: Prior to initial use; whenever an employee switches to a different tight-fitting face piece respirator (for example, a different size, make, model or type); at least annually. The employer shall conduct an additional fit test whenever the employee reports, or the employer, Physician or other health care provider (PLHCP), supervisor, or program administrator makes visual observations of, changes in the employee's physical condition that could affect respirator fit. Such conditions include, but are not limited to facial scarring, dental changes, cosmetic surgery, or an obvious change in body weight. Check with the Nursing Supervisor to get a list of all employees who received annual fit testing, training and dates. Ask Nursing Supervisor to relate procedure for determining when additional fit testing is indicated for employees in the event of physical changes or damage to respirators currently in use.

Observe where the respirators are kept and check to see that they are protected from the elements and from becoming deformed. Disposable N-95 masks should be checked for structural integrity. They should be discarded if there are nicks, abrasions, cuts, or creases in seal area or if the filter material is physically damaged or soiled. PAPRs should have breathing tubes and body of HEPA filter checked for damage. The hood should be examined for physical damage and follow manufacturer's recommendations.

Title VI Limited English Proficiency

<http://hsaintranet.health.tn.gov/default.asp>

GUIDELINES/STANDARDS	GUIDANCE TO REVIEWER
<p>Policy: Title VI of the Civil Rights Act of 1964 provides that no person shall be subjected to discrimination on the basis of race, color or national origin under any program or activity that receives federal financial assistance. A number of programs in the Division of Community Health Services Administration (CHSA) receive federal financial assistance from the Department of Health and Human Services and, therefore, must comply with the provisions of Title VI. This policy deals specifically with assuring that Limited English Proficient (LEP) persons, who are eligible for federally-assisted programs or services, receive the language assistance necessary to afford them meaningful access to public health services.</p>	<p>Review Policy 7.21 of the CHSA Policy and Procedure Manual. http://hsaintranet.health.tn.gov/default.asp</p>
<p>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 patient.</p>	<p>Ask staff to show you in PTBMIS registration screens where the primary language is documented and in the medical record.</p>
<p>2. Within 60 days of the end of each calendar year, a report will be developed, by clinic site, that includes:</p> <ol style="list-style-type: none"> 1) Total number of persons served 2) For those persons for whom English is not the primary language: <ul style="list-style-type: none"> Number served by language Percent of total served by language 	<p>Review the report. An assessment of language needs of the population served should be conducted by March each year.</p>
<p>3. After reviewing the report, a determination will be made concerning the points of contact in each clinic at which interpreter services are needed.</p>	<p>Ask the County Director or representative if a determination has been made regarding points of contact in each clinic at which interpreter services are needed.</p>
<p>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.</p>	<p>Review the plan, mark met if there is a plan and not met if there is not a plan.</p>
<p>5. The written plan should also include procedures for assuring interpreter competency.</p>	<p>Check the plan for procedures for assuring interpreter competency.</p>
<p>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</p>	<p>Ask to review documentation of the staff meeting discussion and the list of the meeting attendees. It should be attached to the plan.</p>

<p>needs of the LEP population. Documentation of the discussion and meeting attendees should be included as an attachment to the plan.</p>	
<p>7. Translated written materials (forms, brochures, state and federal posters, and educational materials) are updated as needed for LEP groups that constitute 5% or 1,000 persons whichever is less. (All posters may not be available in all languages)</p>	<p>Ask to see what written materials have been updated. Revised HHS LEP Guidance, September 17, 2007</p>
<p>8. Notice is provided to the LEP (Limited English Proficiency) person regarding free language interpretive service.</p>	<p>Examples of notice would be: "I Speak _____" cards, signs posted in reception, waiting and treatment areas in the languages regularly encountered.</p>
<p>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.</p>	<p>Ask County Director, representative or staff what procedures are in place to train staff having contact with LEP persons. Ask staff to assess if they are knowledgeable of LEP Policy and Procedures.</p>

WIC Vouchers

<http://hsaintranet.health.tn.gov/default.asp>

Guidelines/Standards	Guidance to Reviewer
<p>1. Voucher printing security is maintained in compliance with federal regulations and central office instructions.</p>	<p>Assess current practices</p>
<p>A. Unopened packages or boxes of voucher paper are stored in a clean, dry and secure location.</p>	<p>WIC Manual, Section IV, page 4 Storage should be out of public area, restricted to employee access only and out of sight.</p>
<p>B. PHOA/Clerk signs off or secures the room anytime the terminal is left unattended by or out of the sight of that user (even if other staff is present.)</p>	<p>WIC Manual, Section IV, page 4 3 Ask PHOA if she signs off the terminal when leaving the area for breaks, use of restroom, or lunch and observe for compliance.</p>
<p>C. Printer is left loaded with voucher stock <u>only</u> if room is locked when no staff person is present. (Also acceptable to place paper tray in a locked closet, file cabinet, drawer, etc.)</p>	<p>Ask about routine practice for voucher stock/ printer drawer with stock at close of day and observe for compliance.</p>
<p>2. Voucher issuance is documented in compliance with federal regulations and central office instructions.</p>	<p>Reviewer may choose either option to obtain a random selection sample by: 1) Physical review of at least one month of receipts and voids or 2) two days of issuance/voids from each month x 12 months along with the corresponding Receipt, Void and Accountability Reports.</p>
<p>A. Voucher receipts match the Voucher Receipt Reports.</p>	<p>WIC Manual, Section IV, page 4–22 Each set of vouchers listed on the receipt report has a receipt present.</p> <p style="text-align: right;">Quantify # met and # not met</p>
<p>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.</p>	<p>WIC Manual, Section IV, page 4 Receipt must be signed in ink (page 9) by the recipient unless all vouchers on receipt are voided. If all vouchers listed on any receipt are voided the word “VOID” must be stamped or written on the receipt, (date and initials of provider who voided the vouchers are not necessary) recipient signature is not required on the receipt. When part of the vouchers on a receipt are issued and part voided: (1) the receipt must be signed in ink by the recipient, (2) the voided voucher numbers clearly indicated with brackets or arrows, (3) and the date voided (4) and the provider’s initials documenting the alteration on the receipt must be documented on the receipt.</p> <p>Section IV page 18 Quantify # met and # not met</p>
<p>C. Receipts for all issued vouchers have proof of ID for person signing.</p>	<p>WIC Manual, Section IV, page 4–10 Proof of ID for recipient must be documented on each signed receipt. Acceptable types of proof include but are not limited to the</p>

	list as shown in the WIC Manual in section 1, pages 9-10. Quantify # met and # not met
D. Receipts are traced to voids and voids to receipts for vouchers printed and voided on the same day.	WIC Manual, Section IV, page 4–22 Receipt report indicates which vouchers were voided in status column with a V. Confirm a one-to-one match between vouchers identified as voided on the receipt report and presence of actual voided voucher.(exception: printer problems or when voucher did not print) Quantification is to indicate the number of receipts (not voided vouchers) Quantify # met and # not met
E. No more than three months of vouchers are issued except at initial certification. http://hsaintranet.health.tn.gov/default.asp	WIC Manual, Section IV, page 4– 9 Identify all instances of more than 3 months voucher issuance in the selected sample by reviewing the receipt report. Determine if issuance was initial certification in PTBMIS using DWICQ history and TVH. (Reference definition of initial certification WIC Manual Chapter 1) Note that the WIC Manual states that vouchers replaced at the same time as new ones issued are not to be counted as exceeding the three months. Quantify # met and # not met
F. Receipts are filed by date, user ID, and then receipt number order. They are held in clinic at least one year until submitted according to instructions.	WIC Manual, Section IV, page 4–10 Observe filing on hand Y/N
3. Voided vouchers are documented in compliance with federal regulations and central office instructions.	Review for the same time frame selected for voucher issuance.
A. “VOID” is stamped or written on the face of each voided voucher.	WIC Manual, Section IV, page 4–23 Examine each voided voucher in the review sample for the word void either hand written or stamped on each voided voucher. Date is not required. Quantify # met and # not met
B. Voided vouchers match the Voided Vouchers Report.	WIC Manual, Section IV, page 4–23 Each voucher listed on the report as voided is present unless voided because voucher was: 1. Lost, Stolen, Destroyed (code 02) 2. Printer problems and voucher did not print (code 3) 3. XBI (exclusively breastfed infant non negotiable and kept on file in clinic) voucher issued prior to report date. Quantify # met and # not met
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.	WIC Manual, Section IV, page 4–21-22 Observe filing on hand. Y/N

<p>4. Voucher reports and accountability are maintained in compliance with federal regulations and central office instructions.</p>	<p>Review for the same time frame selected for voucher issuance.</p>
<p>A. Voucher Receipt Reports are run for every day or include every day of the week. Time locked days may be excluded.</p> <p>http://hsaintranet.health.tn.gov/default.asp</p>	<p>WIC Manual, Section IV, page 4-23 Report is run the following workday for each day vouchers are printed and includes all days since the previous report. Report can be run later than the next day as long as all dates are included in the run. Alternately, report may be run the end of the workday as long as confirmation that last voucher number from previous report is consecutive with first number on new report each time.</p> <p>Quantify # met and # not met</p>
<p>B. Voided Voucher Reports are run for every day or include every day of the week.</p>	<p>WIC Manual, Section IV, page 4-21 Report is run the following workday for each day and includes all days since the previous report. (This report requires all calendar days)</p> <p>Quantify # met and # not met</p>
<p>C. Reports are checked against receipts and voids the same day they are run. They are dated and initialed to document.</p>	<p>WIC Manual, Section IV, page 4-21 The reviewer is required to document on the report: the date of review and their initials as confirmation report was reviewed the date it was run.</p> <p>Quantify # met and # not met</p>
<p>D. Receipt and Void Voucher Reports are filed first by date and then by user ID. Reports are held in clinic until approved disposal.</p>	<p>WIC Manual, Section IV, page 4-22 Observe filing on hand</p> <p>Y/N</p>
<p>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.</p>	<p>WIC Manual, Section IV, page 4-22 The review forms are to be completed timely and contain at least one signature of someone who does not issue vouchers during that month.</p> <p>Y/N</p>