KETCHUM HEALTH

Clinic Manual

KETCHUM HEALTH

University Eye Center

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1.0 INTRODUCTION

1.1 HISTORY OF THE UNIVERSITY

Marshall B. Ketchum University was established in April of 2013 as an interprofessional health education institution. The University is named after Marshall B. Ketchum, M.D., the founder of the Los Angeles School of Ophthalmology and Optometry in 1904, the original degree granting education program.

Marshall Bidwell Ketchum was born in Canada in 1856 and became a pharmacist. In order to further his education, he traveled to the United States to study medicine at the Eclectic Medical Institution in Cincinnati, Ohio graduating in 1882. Following graduation, Dr. Ketchum moved to Dallas, Texas to join a private medical practice. In 1896, he became a faculty member at Nebraska's Lincoln Medical College teaching medicine to inspiring young doctors, eventually transitioning to becoming the head and lead instructor of the Lincoln Optical College until 1903. Dr. Ketchum then moved to Los Angeles and established the Los Angeles School of Ophthalmology and Optometry in March of 1904. This was an exciting time for the profession of optometry, as it was just beginning to develop into a distinct profession separate from general medicine. For many years, Dr. Ketchum worked tirelessly to develop the program and merge several schools into the College, which became non-profit in 1938. He served as President of the School until 1920.

Dr. Ketchum was an esteemed member of the medical community during his time and was an early leader of the profession of optometry. He strived to create a college with the highest possible quality of education and felt that practitioners of optometry had a deep responsibility to the community and individual patient's visual needs. Ketchum was among the early pioneers of optometry, advocating the use of the retinoscope to determine refractive status of the eye. He is well known for his book, "Ketchum's Lessons on the Eye", published in 1920, that details not only the anatomy of the eye, but details on the medical practice of early optometry. Dr. Ketchum passed away in 1937, and the Marshall B. Ketchum, M.D. Memorial Library was established in his memory later that year. Dr. Ketchum was also awarded SCCO Centennial Honoree in 2004.

The Southern California College of Optometry is the third oldest optometric educational program in existence and the changes have been dramatic since its founding in 1904, one year after California passed a law regulating optometry. In 1911 the name was changed to the Los Angeles Medical School of Ophthalmology and Optometry at which time the school became incorporated. In 1948 the College was renamed the Los Angeles College of Optometry. The College's name was changed again to the Southern California College of Optometry in 1972. The College moved to a newly built campus in the City of Fullerton in Orange County, California in 1973, some 30 miles from its location in downtown Los Angeles.

In 2013, the institution adopted the name, Marshall B. Ketchum University, to honor Dr. Ketchum's legacy to developing Inter-Professional Education to encompass our expansion into

interdisciplinary health science educational training. Programs currently within the University include optometry, physician assistant, pharmacy and a graduate degree program in vision science. A College of Pharmacy was added in the fall of 2016. The University is accredited regionally by the Accrediting Commission for Senior Colleges and Universities of the Western Association of Schools and Colleges (WASC). Individual professional programs are also accredited by their national accrediting organization:

1.2 NON-DISCRIMINATION STATEMENT

MBKU is committed to providing an environment in which all individuals are treated with respect and professionalism. In accordance with applicable federal and state laws, it is University policy to prevent the unlawful discrimination against students, applicants for admission, employees, applicants for employment and patients requesting treatment on the basis of race, color, national origin, sex, disability, age or any other characteristic protected by applicable law. The University also prohibits sexual harassment and harassment on any of the above bases (refer to the Prohibited Discrimination, Unlawful Harassment & Sexual Misconduct Policy).

Inquiries regarding the University's equal opportunity policies should be directed to the Vice President for Student Affairs at StudentAffairs@Ketchum.edu for students and the Vice President for Human Resources at HumanResources@Ketchum.edu for employees.

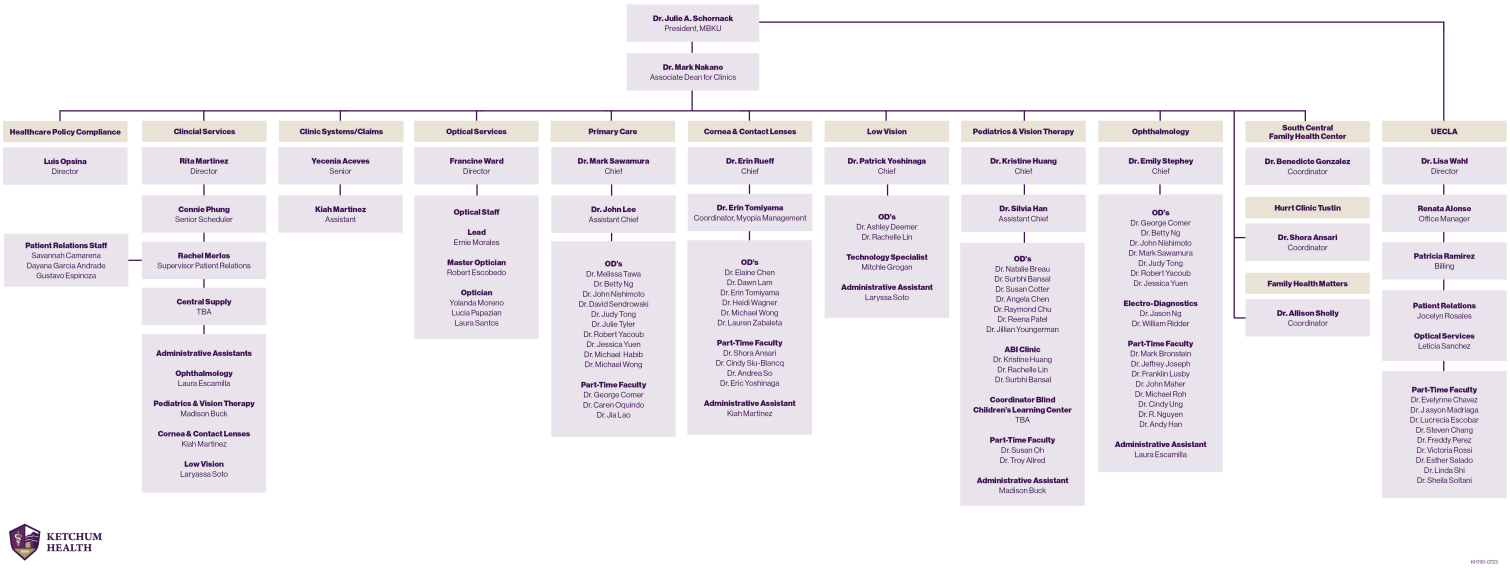
For further information on notice of non-discrimination, please contact the Office for Civil Rights at https://ocrcas.ed.gov/contact-ocr for the address and phone number of the office that serves his/her area, or call 1-800-421-3481.

1.3 UNIVERSITY EYE CENTER AT KETCHUM HEALTH

In April 2016, the University Center Eye at Ketchum Health was established at 5460 East La Palma Avenue in the city of Anaheim. The structure is the clinical education facility of Marshall B. Ketchum University, which is home to the Southern California College of Optometry's University Eye Center.

The facility is comprised of two floors of clinical space as well as office space for Advancement and Marketing, Accounting and Faculty Offices. Currently, the first floor is dedicated to optometric care and has 36 examination rooms and four (4) pre-testing rooms with the latest technology and diagnostic equipment. Soon (Summer 2018) the first floor will welcome a medical home, which will train our Physician Assistants and a dispensing pharmacy, which will train our Pharmacists. The services available on the first floor are: Primary Care, Cornea and Contact Lenses, Ocular Disease and Low Vision as well as all ancillary support staff such as patient relations, claims and other administrative services. The first floor is home to optical services with its state of the art optical dispensary and fabrication laboratory. The second floor of the facility is comprised of several services; Pediatrics and Vision Therapy, Ophthalmology, and Clinical Research.

1.3.1 Clinic Organizational Chart



1.3.2 Clinic Role Descriptions

President

The President is the Chief Executive Officer of the University and is appointed by the Board of Trustees. The authority and responsibility of the President relates to providing for effective functioning and implementation of fiscal policies, representing the University before various professional, legislative, educational, political, business, and community organizations, and the planning and implementing of long-term education and patient care goals of the University. The President is also responsible for providing strong leadership, which will establish high standards of ethical and professional conduct for the profession and all members of the University community.

Associate Dean of Clinics

The Associate Dean of Clinics is responsible for the leadership of the University Eye Center at Ketchum Health and has direct oversight of the affiliated clinics of SCCO at MBKU also known as the University Eye Center Clinical Enterprises in providing high quality comprehensive eye care services to the public and quality patient encounters for students. The Associate Dean of Clinics strives to evaluate and enhance the patient experience at the University Eye Centers and collaborates with the Assistant Director of Marketing and Communications in developing strategies that will maximize the visibility of all the clinical services. The Associate Dean of Clinics is responsible for negotiating appropriate contracts to maintain the clinic's fiscal viability and enhance the clinic's reputation as a center of excellence for exceptional eye and vision care services. The Associate Dean serves as the chair for the Clinic Council and Student Clinic Advisory Council.

Director of Clinical Services
The Director of Clinic Services reports to the Associate Dean of Clinics and is responsible for the development of external strategic program, vision and medical plans and all activities to enhance clinical relations, which includes development of a community network that will generate patient referrals, grants, and contracts. The Director is also responsible for management and leadership of employees providing patient care services and for educating faculty and staff on grant procedures and new project opportunities and assisting in designing and implementing continuing education programs for nurses, teachers, and other appropriate professionals as they relate to SCCO clinical services.

Director of Healthcare Policy Compliance
The Director of Healthcare Policy Compliance reports to the Associate Dean of Clinics and is responsible for ensuring that all policies and procedures of the Ketchum Health organization are being accurately maintained and organized; the employees of Ketchum Health are complying with the rules and regulations of regulatory agencies; that Ketchum Health policies and procedures are being followed and that behavior in the organization meets the University's Code of Ethics.

Clinic Systems Coordinator
The Clinic Systems Coordinator reports to the Associate Dean of Clinics and is responsible for the Electronic Health and Medical Records software for the Ketchum Health organization and affiliated clinics. The Clinic System Coordinator works directly with end users, IT Department personnel and software vendors in identifying best practices and assuring that the system is operating efficiently. Responsibilities include but not limited to software updates, identifying glitches or software errors, and finding resolution, work with all personnel on proper use of software features and assist with EHR onboarding.

Director of Optical Services
The Director of Optical Services reports to the Associate Dean of Clinics and is responsible for the optical department personnel, merchandise, service department fees, vendors, policies and procedures, and financial viability. The Director of Optical Services is to maintain all optical inventory, monitor optical laboratory efficiencies and finances, and the schedules of all opticians. Will coordinate and conduct quarterly orientation with student-interns within the service and ensure that opticians are up to date on ophthalmic education.

Chief of Service (Primary Care, contact Lens, Low Vision, Ophthalmology & Pediatrics / Vision Therapy)
The Chief of Service reports to the Associate Dean for Clinics and is responsible for the overall day-to-day functions of their respective Clinical Service (hereby referred to as Service). The Chief of Service is responsible for all aspects of Service operations including directly supervising and ensuring the development of Service Faculty Members and overseeing the clinic workflow for support staff. The Chief of Service will be responsible for providing leadership, management and faculty development including patient care services, employee relations, performance improvements and fiscal management. The Chief of Service plays a key role in achieving the KETCHUM HEALTHKH objective to effective growth.

Coordinator of Affiliated Clinic
The Coordinator of Affiliated Clinic reports to the Associate Dean of Clinics and is responsible for the day-to-day operations of the affiliated clinic including staffing, clinical education, patient care and financial viability. Coordinator of Affiliated Clinic is responsible for providing leadership, management and development of support staff, performance improvements, and fiscal management. The Coordinator of Affiliated Clinic plays a key role in achieving the KETCHUM HEALTHKH objective to effective growth

1.4 PURPOSE OF THE MANUAL

The Associate Dean of Clinics at Ketchum Health has compiled the University Eye Center Policies and Procedures Manual (the "Manual"). It is to be used by all Faculty, students, staff, volunteers, and the Interns at the clinical sites while delivering care on behalf of Ketchum Health.

The Manual provides all staff and students with guidelines, policies, procedures, and general information about Ketchum Health operations. All staff and students should become familiar and use this Manual as a primary resource. Please refer to it when you have inquiries about any part of the clinic operations.

As the health care environment continues to change, the need to preserve Ketchum Health highest standards of care is more important than ever. This Manual is an essential component of such a goal, and everyone is encouraged to understand and comply with its content.

Questions regarding any elements of the Manual or the operations of the clinic in general, should be addressed to the Associate Dean of Clinics or his/her respective supervisor. Additional resources may be found at Ketchum Health portal at my.ketchum.edu. All Ketchum Health employees, faculty, and interns will be informed and provided access to any changes or revisions to the Manual accordingly.

2.0 PRIVACY AND SECURITY

Executive Summary
As the University Eye Center enters its new era in patient care, a compliance program becomes paramount to the vision of performing with full transparency and accountability. Two purposes are served with the implementation of a compliance program:

- It is a way of communicating to employees, volunteers, patients, payers, government agencies and the public in general, that the institution is committed to compliance and strictly follows federal, state and local laws;
- It is the roadmap to create, implement and enforce policies and procedures that will allow us in turn to create awareness about regulatory mandates.

New laws and statutes are continuously enacted, making the compliance an evolving, ever-changing program. Among the topics that could be covered under any compliance program for a health care organization are patient privacy and security, claims reimbursement, coding and billing, marketing, conflict of interest, occupational safety, Anti-Kickback and Stark laws.

University Eye Center employees at all levels, as well as managing directors and board members of Marshall B. Ketchum University (MBKU), are responsible for following the law and perform in accordance with the ethics code.

As KETCHUM HEALTH acknowledge that excellence in clinical education and patient care are the priorities of its operations, a well-designed compliance program will allow the University to help protect patient privacy, reduce the chances that an audit will be conducted, minimize billing mistakes, speed up and optimize proper payment claims, and avoid conflicts of interest.

Finally, a compliance program sends a message to all the stakeholders recognizing that the University takes pride in operating at the highest legal and ethical standards.

Legal Framework

Compliance programs are designed to follow federal and state laws. The Office of Inspector General (OIG) of the U.S. Department of Health & Human Services has established compliance program guidance for recipients of federal financial assistance (Medicare- Medicaid), including individuals and small group practices. Although this is a voluntary program, Marshall B. Ketchum University will adopt the guidelines.

The OIG's compliance guidance for small practices was published in 2000 with the main purpose of preventing health care fraud, waste and abuse from providers billing for services for Medicare, Medicaid or any other Government related programs .The Patient Protection and Affordable Care Act of 2010 made mandatory for providers to adopt a compliance plan as a condition of Medicare enrollment.

The HIPAA act of 1996 and its subsequent amendments, including the Omnibus rule, regulated privacy and security of protected health information. KETCHUM HEALTH has a compliance program that addresses privacy and security separately.
Among other laws pertaining to compliance are the Anti-Kickback statutes, the Stark law, EMTALA, CLIA, OSHA, FERPA, DEFRA, ADA. For the purpose of the Compliance Program at the KETCHUM HEALTH, we will focus on the Confidentiality, Availability, and Integrity of protected health information, as regulated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its subsequent amendments.

2.1 HIPAA PRIVACY POLICIES & PROCEDURES

2.1.1 Terms & Abbreviations Used in this Manual

Act	The Act is the Health Insurance Portability & Accountability Act of 1996 and its updates, changes and revisions that are currently in effect.
Business Associate	An outside business or contractor or a subcontractor that assists KETCHUM HEALTH in certain activities or services that involve the use and/or disclosure of PHI.

Breach	Unauthorized acquisition, access, use, or disclosure of PHI that can compromise the Compliance and/or security of this information
Covered Entity	A person or organization that is required to comply with HIPAA regulations.
DHHS	Department of Health and Human Services.
Director	Director of Healthcare Policy Compliance
D-II	De-identified information.
Encryption	The use of technology to render or transform PHI unreadable.
HCP	Health Care Provider.
Health Care Operations	▪ Conducting quality assessment and improvement activities, contacting of HCPs and patients with information about treatment alternatives and related functions that do not include treatment. ▪ Reviewing the competence or qualifications of HCPs, evaluating practitioner and provider performance, conducting training programs (in areas of health care under supervision to practice or improve skills), training of non-health care professionals, accreditation, certification, licensing or credentialing activities. ▪ Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. ▪ Conducting or arranging for medical review, legal services, and auditing functions. ▪ Business planning and development, such as conducting cost-management and planning-related analyses. ▪ Business management and general administrative activities of the entity. ▪ Using PHI to conduct education and training sessions with interns and students within campus premises.
HIPAA	Health Insurance Portability & Accountability Act of 1996
HITECH	Health Information Technology for Economic and Clinical Act
Minor	An individual under the age of 18. Refer to Ca. Law for exceptions regarding especial considerations on the age of minors.
NPP	Notice Of Privacy Practices
Omnibus rule	HIPAA amendment to the HITECH act of 2009.
Payment	The activities undertaken by a health care provider to obtain or provide reimbursement for the provision of health care. The activities relate to the individual to whom health care is provided and include, but are not limited to: ▪ Determinations of eligibility or coverage of health benefit claims. ▪ Billing, claims management, collection activities, obtaining payment under a contract for reinsurance, and related health care data processing. ▪ Review of health care services with respect to medical necessity, appropriateness of care, or justification of charges.

	▪ Utilization review activities, including pre-certification and pre-authorization of services. ▪ Disclosure to consumer reporting agencies of any of the following PHI relating to collection of premiums or reimbursement: name and address, date of birth, social security number, payment history, account number, and name and address of the health care provider and /or health plan.
PHI	Protected health information.
PPO	Preferred provider organization.
Telehealth	The provision of healthcare remotely by means of telecommunications technology.
Director	See Section One of the manual.
TPO	Treatment, payment, or health care operations.
Treatment	▪ The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party. ▪ Consultation between health care providers relating to a patient. ▪ The referral of a patient, for health care, from one health care provider to another.

2.1.2 Protected Health Information

The Act protects any information that it is reasonable to believe could be used to identify an individual. This means information:

- That we created or received about the individual. This includes health information, as well as demographic information (address, phone number, SSN).
- That is collected using digital or electronic means, such as biometrics, retina imaging and facial recognition.
- About the individual's past, present, or future physical or mental health condition.
- About the treatment or services provided in the past, present or to be provided in the future.
- About past, present or future payments for provision of health care to the individual.
- Submitted electronically, such as insurance claims, insurance status inquiries, payments received, and remittance advice, etc.
- Stored on paper, CD, computer, mobile devices (thumb drives tablets, smart phones) microfilm, photographs, or any other permanent manner.
- Stored in the minds of KETCHUM HEALTH's faculty and staff.

2.1.3 Allowed Uses or Disclosures of PHI Without Patient Authorization

No authorization is required for certain uses or disclosures. However, in some cases, we must obtain proof or verification that the request is from an appropriate party. An identification badge, official credentials, official government letterhead stationery, etc., are all considered appropriate identification from individuals or parties unknown to KETCHUM HEALTH doctors or staff.

All uses and disclosures on the list below must comply with the “minimum necessary” standard.

The following is a list of allowed uses or disclosures of PHI, which *do not* require patient authorization:

- For treatment, payment or health care operations of KETCHUM HEALTH.
- For the treatment activities of the patient between HCP.
- For disclosures to any health care provider for the payment activities of that provider
- For disclosures to insurance payers when the PHI seek is not related to treatment for which patient has paid the full amount of rendered services in cash.
- To family members, friends or any other unofficial patient representative, after KETCHUM HEALTH staff has concluded, based on her/his professional judgment that the person asking for the records would have been allowed by the patient to obtain such records. This applies mostly to the release of spectacle and contact lens prescriptions and clinical summaries.
- To minors when they are authorized by law to obtain their own records without permission from their parents or legal guardians (Refers to Ca. State law).
- For disclosures to another covered entity for specific health care operations purposes of the other entity, provided both KETCHUM HEALTH and the other entity have had relationships with the patient. The disclosure must pertain to the relationship and be:
    - For the purpose of quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, case management and care coordination, conducting training programs, and accreditation, licensing, or credentialing activities. OR
    - For the purpose of health care fraud and abuse detection or compliance.
- For disclosures to another covered entity that participates in the same organized health care arrangement as KETCHUM HEALTH, for any health care operations activities of the organized health care arrangement.
- When required by a state or federal law.
- To public health authorities to protect the public health.
- To report abuse, neglect, or other domestic violence.
- To government agencies which oversee health activities or regulatory programs (e.g., Medicare, Medical, doctor licensing boards, or others that would investigate violations of health care laws or civil rights violations).
- In response to court or administrative orders or subpoenas.
- To law enforcement authorities in specific situations. There must be a valid reason to proceed with these releases and the asking authority must present a written request.
- To Medical Examiners, funeral directors, or vital records officers.
- To prevent imminent threat of harm to the health or safety of the patient or others, such as when the patient is in the emergency room and she/he cannot consent.
- For research purposes, when the PHI has been de-identified or constitutes a “limited data set.” Or when an Institutional Review Board or a Compliance board has granted permission according to the Act.

- Disclosures to correctional institutions and other law enforcement custodial situations.
- Disclosures for workers' compensation, which is not covered by HIPAA rule.
- To government officials for special purposes (protection of a high-ranking government official, national intelligence activities, military purposes, health of members of the Foreign Service).
- To business associates who have signed formal written agreements with KETCHUM HEALTH.

An incidental use and disclosure is permissible only to the extent that KETCHUM HEALTH has:

- Applied reasonable safeguards to protect PHI.
- Implemented the "minimum necessary" standard explained in the next section, where applicable.

Minimum Necessary

The use of PHI is limited to the minimum that is reasonably needed for accomplishing the intended purpose. This applies when we release PHI, request PHI, or otherwise use PHI within the office. For example, if an optical shop calls for a patient's spectacle prescription, it is appropriate to release the prescription. It is not appropriate to send a copy of the patient's chart, including exam notes. In most cases, we may not disclose, use or request an entire medical record. The only time the entire record is needed is when it is specifically justified as reasonably necessary to accomplish the task.
Before releasing PHI to anyone, you must:

- Verify the identity of the person requesting the information.
- Verify the authority of the person to have access to the PHI.
- Get any required documentation from the person requesting the PHI (e.g., an authorization form signed by the patient, a subpoena, or a legitimate court order).

If someone contacts you who requests more information than you think is necessary, please involve the Director (described below). He or she may need to discuss our concerns about the disclosure and negotiate an information exchange that meets the needs of both parties.
On the following two pages, you will find some routine and recurring situations when we disclose and request PHI and the guidelines for doing so. It is the responsibility of every doctor and every employee at KETCHUM HEALTH to strictly follow these guidelines. When in doubt about a specific release, always consult with the Director for guidance.

Please note that the "minimum necessary" standard does NOT apply to uses or disclosures:

- To other health care providers (HCPs) for treatment of the patient.
- To the patient him/herself.
- That are required for standardized HIPAA transactions.
- To the DHHS for enforcement purposes.
- That are required by law.

2.1.4 Guidelines for Releasing PHI

Outside Entity	Purpose	PHI to be Released
Health care providers outside KETCHUM HEALTH	Reports and referral letters for current/future treatment purposes.	Not limited to minimum necessary. PHI needed is determined by the asking provider
Subpoenas (including criminal, and workers compensation)	Requests for evidence in court proceedings	Not limited to minimum necessary. Could include financial and other related records
Marketing and Fundraising	External marketing, public relations campaigns.	Not allowed unless patient has signed a KETCHUM HEALTH Authorization Form, which specifically allows the release.
Opticians, optical stores, online retailers	Requests for Rxs.	Patient's name, Rx date, Rx, and expiration date written on Rx.
Primary Eyecare Network	Electronic Medicare billing service.	Patient's name, social security number, billing and services codes.
Third Party Insurance	Payment of patient claims.	All info required on billing form. This varies. Some only need info about materials supplied; others need ICD-10's, depending on patient's coverage. If patient paid cash for the service for which PHI is seek, patient could prohibit releasing it to insurance plans.
Patient Engagement Platforms	Patient recall and appointment reminders.	Patient's name and date of last eye exam.
Vision Services Provider Network	Provision/payment of materials for patient.	Spectacle/CL Rx, spectacle specifications, CL specifications. If patient needs non-covered materials, due to medical necessity, it is acceptable to provide medical information to support claim.

Collection Agency	Collection of overdue payments.	Patient's name, address, phone number, driver's license number, social security number, dates of payments received and methods, balance due. BAA needed.
Hospital or Surgical Center	Surgery scheduling.	Not limited to minimum necessary.
Department of Rehabilitation	Eligibility and allocation of services	Not limited to minimum necessary.

Non-routine disclosures (anything not described in the chart on the previous page) should be discussed with the Director prior to releasing PHI. He or she will determine if the PHI to be released is the minimum necessary to fulfill the request according to these guidelines:

1. Define the purpose of the disclosure.
2. Each type or portion of data to be disclosed must:
   a. Be relevant to the purpose.
   b. Not reveal information that is beyond the scope of the purpose.
   c. Be deemed relevant by the most recent examining doctor.

KETCHUM HEALTH may consider (if reasonable under the circumstances) a requested disclosure as the "minimum necessary" for the stated purpose when:

- Making disclosures to public officials, if the official signifies that the requested information is the minimum necessary for the stated purpose.
- The information is requested by another covered entity.
- The information is requested by a professional, who is a member of its workforce or is a business associate of KETCHUM HEALTH for the purpose of providing professional services to the KETCHUM HEALTH (if the professional signifies that the information requested is the minimum necessary for the stated purpose).
- A person requesting the information for research purposes has provided proper documentation following IRB guidelines.

<u>Guidelines for Requesting PHI</u>

When KETCHUM HEALTH requests PHI from other entities, the "minimum necessary" standard also applies. The following are the most common situations in which we would be requesting PHI. Please remember that in order to request PHI from a patient's previous eye doctor, KETCHUM HEALTH's office policy requires the patient to sign an authorization form.

Outside Entity	Purpose	PHI to be Requested
Health care providers outside KETCHUM HEALTH	Records for current/future treatment purposes.	Not limited to minimum necessary.
NVISION or refractive surgery centers	Refractive surgery reports.	Not limited to minimum necessary.
Medicare	Eligibility for services.	Previous date of service, new service dates.
Opticians, optical stores	Requests for previous Rxs filled.	Rx date, Rx, prescribing doctor, expiration date, and supply date, lens material and design, frame name.
State Welfare and Social Disability Determination Services	Eligibility for services.	Previous date of service, eligibility dates for new service. Minimum Necessary principle may not apply, depending on the service being provided
Vision Services Provider Network	Eligibility for services.	Previous date of service, eligibility dates for new service
Hospitals or doctor offices	Surgery or consultation reports.	Not limited to minimum necessary.

Reminder: We ***may not request the entire medical record***, unless it is specifically justified as the amount reasonably necessary to provide service to the patient.
For non-routine requests for PHI, the most recent examining doctor, using his/her best professional judgement, will determine the "minimum necessary" information needed for the stated purpose. Areas of concern or those requiring further clarification should be referred to Director.

2.1.5 Director of Healthcare Policy Compliance & Contact Person

The **Director** is responsible for developing, implementing and updating the HIPAA policies and procedures in this manual accordingly. This officer must monitor all activities related to PHI to be sure that the clinic and all its employees are in compliance with the most current HIPAA and state guidelines and regulations. The Director is the watchdog, who ensures that the workforce is acting within the letter of the law. The Director uses this Policies & Procedures Manual as a guideline, and suggests and coordinates with the Associate Dean of Clinics its revision and the inclusion of updates, when necessary.

The **Contact Person** is responsible for providing information to patients about how KETCHUM HEALTH protects the Compliance of PHI. The Contact Person also answers questions and receives and processes complaints from patients. The primary concern of the Contact Person is public relations.

The **Administrative Liaison** allows for the flow of information related to HIPAA standards within the organization and contributes to the general awareness process of the regulation among staff. The current Associate Dean of Clinics appoints the Director, the Contact Person and the administrative liaison.

- The current Director is Luis Ospina.
- The current Contact Person is Patient Relations Supervisor, Rachel Merlos
- The current administrative liaison is the Director of Clinic Operations, Michele Whitecavage.

EMPLOYEES ACCESS TO PHI

KETCHUM HEALTH has implemented a fully operational electronic medical records system and no hard copies or paper with PHI are stored or retained.

Access to medical records is granted based on the role of the individual, and there is a process in place to ensure that only the individual with legitimate business need to access the record can do it. The software has audit tracking capabilities, and the Director along with the Applications Support Manager monitor access patterns to PHI by individuals on a monthly basis.

Access to Computer-Based PHI is Limited as Follows (role based):

Full-time Faculty..... full access
Part-time Faculty and Consultant doctors ..... full access
All Team leaders (Clinic, Contact Lens & Admin) ..... full access
Patient relations staff .....access to all but “Exam” screens
Researchers .....restricted access
Dispensary staff ..... restricted access
Interns, students, work studies, volunteer’s .....restricted access
Device/equipment maintenance personnel ...…….restricted access

Work Stations Physical Security:
All employees at the KETCHUM HEALTH are trained and asked to closely monitor their work stations to prevent unauthorized access to the system. When leaving their workstations, staff must log off their computers and lock the door if leaving office.

When Faculty is working in consultation rooms open to the general public, no computers should be eft unattended, and they must log off the computers that are visible to all individuals.
<u>Use of Patient Forms</u>

HIPAA requires KH-KETCHUM HEALTH to utilize two different forms for patients: the Notice of Privacy Practices and the Release of PHI Form. These forms are to be used with any individual with whom we will have a *“**direct** treatment relationship.”*

Our relationship is considered ***indirect*** when we provide eye care based on orders from another HCP and that other HCP reports the diagnosis or results to the patient. Example of indirect treatment relationships:

- An outside HCP consults with a KETCHUM HEALTH doctor about a patient, but KETCHUM HEALTH never sees the patient.

Every time an individual becomes a patient of the KETCHUM HEALTH, a copy of our Notices of Privacy Practices (NPP) must be given to the patient and we must ensure that we obtain a signed acknowledgment from the patient.

Overview of Forms:

- The Notice of Privacy Practices informs patients of how we use and disclose their PHI. We are legally required to provide one to each patient who seeks our care and services. It also provides patients with information on requesting:
  - Additional restrictions on uses and disclosures of their PHI.
  - Confidential communications.
  - Copies of their records.
  - Changes to their records.
  - Copies of the Log of Disclosures of their PHI.

It is our legal duty to attempt to get a signed receipt from every patient, which states that they received the Notice. We must provide care and services, whether the patient agrees to sign the receipt or not. This could be achieved by electronic means enabled by a function in the EHR system.

- The law, in particular circumstances, requires the Patient Authorization Form for specific patients. In most cases, we must provide care and services, whether the patient agrees to sign the form or not. The Patient Authorization Form allows KETCHUM HEALTH to use or disclose PHI with the patient's permission in very well-defined and limited situations.

- For patient documentation purposes, KETCHUM HEALTH uses an intake form and medical Hx questionnaire. When setting up a new patient's chart, both forms must be incorporated into the electronic file to make them available to faculty and interns during the examination.

2.1.6 Notice of Privacy Practices

KETCHUM HEALTH's **Notice of Privacy Practices** is a written explanation of how we use and disclose our patients' PHI. Every patient must receive a copy of the Notice; it is unnecessary to give a Notice for every visit a patient makes. A copy of the notice must be:

- Given to each new patient and every returning patient who has not already been given the opportunity to sign one by patient relations staff at the time of check-in.

Exceptions:

- During emergency treatment situations. The Notice may be given when it is reasonably possible after the emergency situation is over.
- If the initial service is provided electronically, the website is set up so that the patient must acknowledge receipt of the Notice prior to service delivery.
- Posted in the office. We post a copy in the reception area and each of the inner patient holding areas.
- Posted on our website. The Director monitors the process.
- Available in the office for patients and non-patients to take a copy on request.

Once the patient has read the Notice, patient relations staff must ask him/her to sign and date the section of the intake form that relates to the NPP. Patient relations staff will complete the acknowledgement process by entering the appropriate information into the system. The patient may keep the Notice of Privacy Practices.

If the patient refuses to sign the receipt page, we must still provide services and treatment. Enter the date, his/her name, and the following statement on the patient's PHI History Sheet: *"Patient refused to sign receipt of Notice of Privacy Practices."*

If for any other reason, we are unable to get the patient's signed receipt, the attempt and the reason for failure must be documented in the EMR chart accordingly.

2.1.7 Patient Authorization Form

KETCHUM HEALTH is required to have the patient sign an Authorization Form for uses, disclosures or requests of PHI, unless the use, disclosure, or request is specifically permitted by the Act (see Definitions section*: Allowed Uses or Disclosures of PHI Without Any Authorization from the Patient*). We **may not** withhold treatment if a patient refuses to sign an authorization in most instances. Examples of situations requiring authorization are:

- If the patient is required to undergo a pre-employment visual examination and wants the results sent to the potential new employer.
- Release of PHI to third parties and agencies that are not covered entities.
- If we want to participate in marketing activity, which requires us to release PHI, with two exceptions discussed in *the Marketing Activities* section
- If a patient is trying to enroll in an insurance program and the underwriters require an exam to determine enrollment eligibility.
- If the patient is willing to participate in a research project that includes treatment.

There may be other situations, which require us to use the Authorization Form. the Director will help clarify if you have questions.

An Authorization Form is for a single use, not an open-ended document. Authorizations may be revoked, unless we have conditioned the treatment, payment, enrollment in a health plan, or eligibility for benefits on one of the authorizations (we may only condition treatment, etc. on a research-related authorization, not on any others).

An Authorization Form is not valid if it does not contain all of the required core elements. It is important to use plain, understandable language when filling in the core elements on the form. They are:

- A specific, meaningful description of the information to be used or disclosed.
- The identification of the persons (or class of persons) authorized to make the use or disclosure of the PHI.
- The identification of the persons (or class of persons) to whom the HCP is authorized to make the use or disclosure.
- A description of each purpose of the use or disclosure. If the patient requests an authorization for his/her own purposes, we may state “at the request of the individual.”
- An expiration date or event that relates to the purpose of the use or disclosure.
- The patient’s signature (or that of their personal representative) and date.
- If signed by a personal representative, a description of his/her authority to act for the patient.

An Authorization Form is defective, and thus invalid, if any of the following defects occur:

- The expiration date has passed or the expiration event has occurred and KETCHUM HEALTH is aware of the fact.
- Any of the required core elements are omitted or incomplete.
- The authorization has been revoked, and KETCHUM HEALTH is aware of the fact.
- The authorization violates the requirements for compounding or conditioning authorizations.
- KETCHUM HEALTH knows that information in the authorization is false.

It is responsibility of each individual (faculty, interns, opticians, and administrative assistants) to make sure that the authorization is presented for signature to the patient or her/his representative, prior to the release of PHI. Patient Relations Supervisor will work in conjunction with the Health

Information Coordinator to ensure that the authorization form is handed out accordingly to all patients when required.

Patients may revoke an authorization in writing at any time, with two exceptions:

- If KETCHUM HEALTH has already acted in accordance with the authorization.
- If the authorization was given as a condition of obtaining insurance coverage and another law gives the insurer the right to contest the claim or the policy itself.

Completed Authorization forms could be delivered in hard copy, by fax or electronically via email. The Director will ensure that the form is processed following KH internal protocols and he will document the release in the log accordingly.

Authorization forms are not posted on the KETCHUM HEALTH website.

Note about Requesting Previous Records:
It is the policy of KETCHUM HEALTH that any time we request previous records from a different physician's office, a patient must sign our Authorization Form***. Because PHI was generated by another provider***, KH wants the patient to give permission to the other provider to release the PHI. Even though the HHS expressly authorizes the exchange of PHI between providers without patient's authorization, other health care providers are more willing to release information when such authorizations are provided; it makes the process smoother and more clearly defined for everyone.

The Use of Personal Representatives

Some of our patients are unable to personally exercise their rights regarding PHI (e.g., children). Personal representatives are legally authorized to act on behalf of such patients. Our policies and procedures regarding the use of personal representatives are described below.

The following is a list of patients who will need a personal representative:

- Children under legal age, who by law, are not allowed to represent themselves. In California, a minor is an individual under the age of 18. The law has some exceptions.
- Persons who are mentally incompetent due to retardation, injury or illness.
- Individuals deemed wards of the court for custodian or legal purposes.
- Deceased persons.

The validity of an individual serving as a personal representative will be established as follows:

- Presentation of a valid photo ID for identity purposes.
- Presentation of a legal document, which describes the relationship of the individual with the patient. This could be in the form of a birth certificate, custody document, power of attorney, or court appointment.
- If the patient is not present due to incapacity or an emergency circumstance, the examining doctor may exercise professional judgement to determine whether the disclosure is in the best interests of the patient. Only that PHI which is directly relevant to the individual's involvement with the patient's health care will be released. We reserve the right to release PHI that is part of the electronic file and was not created or produced at KETCHUM HEALTH

A personal representative is to be treated the exact same way you would treat a patient with regard to the PHI of the individual they represent. They have all of the same rights under the Act. KETCHUM HEALTH will disclose to the personal representative only that PHI, which is necessary to the health care of the patient (minimum necessary).

KETCHUM HEALTH may disclose PHI about a minor child to a parent, if a state or other law permits or requires that disclosure. KETCHUM HEALTH may not disclose PHI about a minor to a parent, if a state or other law prohibits that disclosure. KETCHUM HEALTH may provide or deny access to a minor child's PHI by a parent as allowed or required by state or other law.

Sometimes parents are not the "personal representatives" of their children. Here are some of those instances:

- When state or other law does not require consent of a parent before a minor can obtain a particular health service, and the minor consents to the health care service, the parent is not the "personal representative" of the minor.
- When a court or the law authorizes someone other than the parent to make treatment decisions for a minor, the parent is not the "personal representative" of the minor.
- When a parent agrees to a confidential relationship between the minor and the physician, the parent does not have access to health information related to that conversation or relationship.
- A physician may choose not to treat a parent as the "personal representative" of a child when he/she reasonably believes in his/her professional judgment that:
    - The child has been or may be subjected to abuse or neglect, or
    - That treating the parent as the child's "personal representative" could endanger the child.

If there is a custody dispute between parents of a minor patient, Ketchum Health will treat both parents as legal representatives of the minor. PHI will be released to either requesting parent unless Ketchum Health is served with a court order prohibiting one of the parents from directing day-to-day care of the patient. In that case, the parent is not considered a legal representative under state law. It is not the Ketchum Health staff's responsibility to mediate between custody disputes or take sides regarding who gets the records when custody conflicts occur. Only Courts decide that.

2.1.8 Patient Request for Restriction on Disclosures

Every patient has the legal right to request restrictions on the release/use of PHI for purposes of treatment (except emergency treatment), payment or health care operations. KETCHUM HEALTH, however, is not required to agree to the limitation.

Patients are not allowed to request restrictions for the following reasons:

- In emergency circumstances.
- To a family member, other relative or close personal friend involved in the patient's care or payment related to the patient's care.
- To notify a family member or personal representative of the patient's location, general condition, or death.
- With the patient present.

- Made in the best interest of the patient, in emergency circumstances or when the patient is incapacitated
- For disaster relief purposes.
- When required by a state or federal law.
- To public health authorities to protect the public health.
- To report abuse, neglect or other domestic violence.
- To government agencies which oversee health activities or regulatory programs.
- In response to court or administrative orders or subpoenas.
- To law enforcement authorities in specific situations.
- To prevent imminent threat of harm to the health or safety of the patient or others.
- To Medical Examiners, funeral directors, or vital records officers.
- For research purposes.
- Disclosures to correctional institutions and other law enforcement custodial situations.
- Disclosures for workers' compensation.

Patients must submit a request in writing to the Director. This may be delivered in person, by mail, by a courier, by fax, or by e-mail. The Director and the Administrative Liaison then review the request.

A request will be accepted if it meets the following conditions:

- Withholding the restricted information would not be in opposition to state or federal laws (such as information about child abuse).
- KETCHUM HEALTH's legal counsel agrees to the restriction on legal grounds.
- The restriction causes no harm to the patient's medical condition, and it is otherwise authorized or required by law

If a request is accepted, the Director will:

- Make a note on the electronic medical record and check the "Restrictions" box.
- Scan the patient's letter and our acceptance letter to the electronic chart.
- Notify any applicable business associates.

The patient will receive the formal letter of acceptance or denial from the Director within two weeks of the receipt of the restriction request.

Whenever the PHI is released, the staff person involved is required to read the restriction letter before using or disclosing any information. If the staff person is unclear as to whether the use or disclosure would honor the intent of the letter, the Director should be consulted.

When the patient has paid cash in full for services rendered at the KETCHUM HEALTH, (s)he can ask for PHI strictly related to those particular services not to be released to her/his insurance plan. KETCHUM HEALTH staff will need to comply with this request, and only the exceptions of the law previously explained will apply.

The restricted PHI may be released to provide emergency treatment; however, we must request that the HCP, who receives the information, must not disclose it or use it in any other manner.

A restriction may be terminated by KETCHUM HEALTH if:

- The patient agrees to or requests the termination in writing (fax and e-mail are acceptable, too). In this case, the Director will document the date and the removal of the restriction on the patient's EMR chart. The termination letter from the patient will be scanned into patient's file

- The patient orally agrees to the termination. The Director will document the oral agreement and its date on the patient's chart.

- KETCHUM HEALTH informs the patient that we are terminating the agreement. However, it will only be effective for PHI that is created after notification of termination. The Director will document the date and the removal of the restriction on the patient's chart as follows: *"Restriction terminated by KETCHUM HEALTH only for PHI created after [date]"*. The termination letter to the patient will be scanned into patient's chart

- The Director notifies any applicable business associates.

Patients' Access to their Own PHI

A patient or personal representative has the right to inspect and obtain a copy of his/her own PHI for as long as the records are maintained by Ketchum Health. Some exceptions may apply. Ketchum Health will deny access for a specific reason occasionally.

Procedures:
The patient must submit a written request in person, by mail or electronically (e-mail) to the Director, which(s)he will document in the patient's chart. The Director will respond to the request within 48 hours and will arrange a date with the patient for the transfer/viewing of the PHI within 15 calendar days after receiving written request [Ca. Health & Safety Code § 123110(b)].

- We are allowed one 30-day extension to provide access, if we send written notice to the patient stating the reason for the delay and the date by which they will receive the requested information.
- The "minimum necessary" rule does not apply to requests made by patients or their representatives. We can ask what type of information is needed and release only the pertinent elements accordingly.
- A record of every PHI released must be documented in the patient's file. The Director will maintain a separate electronic log of disclosures, which will be available upon request.
- Printed records will be sent via US regular mail, faxed or emailed. If the patient wishes an expedited service for the printed records, (s)he will be advised of the cost prior to sending.

- PHI that is recorded via telemedicine encounters will be released following these protocols, and no exceptions apply, regardless of the platform used to conduct and record the encounter.

Format of PHI- Encryption

- If the patient requests the records to be released electronically (e-mail), KETCHUM HEALTH must encrypt the PHI before sending it, regardless the recipient.
- **Duty to Inform**. KETCHUM HEALTH may, at the request of the patient, send PHI electronically without encryption. The director will explain the patient the risks associated to that practice, and will ensure that patient understand and agrees with the unencrypted communication of PHI
- Records must be produced in the form and format requested by patient, if records are readily producible in such form or format; otherwise in hard copy or in such other form or format as agreed upon with patient.
- If approved, the Director will print the requested PHI from the patient's computer file and will charge a rate not to exceed $0.25 per page and in any case no more than $24.00. Fees are to be collected prior to delivery of PHI to patient. The Director, based on professional judgment, can waive the fees associated with the release.
- If the patient wishes to visually review the PHI on the computer screen, access will be allowed only in the presence of the Director at an approved location by management.
- The Director may provide a summary or explanation of the PHI requested, instead of the PHI itself, if the patient agrees to it and to the fees involved. This requires that the examining doctor(s) write and/or approve the summary created

There are a few circumstances, in which the patient will be denied access to PHI. Some denials may not be questioned; others may be reviewable, at the patient's request, by an uninvolved, licensed health care professional.

Non-Reviewable Reasons for Denial of Access:

- The PHI is psychotherapy notes.
- The information is compiled in reasonable anticipation of, or for use in a civil, criminal or administrative action or proceeding.
- KETCHUM HEALTH is acting under the direction of a correctional institution for that patient's PHI.
- The PHI is created or obtained in the course of research that includes treatment, as long as the research is in progress (provided the patient agreed to denial of access when consenting to participate in the research). Once the research is completed, the denial is suspended.
- The PHI is contained in records that are subject to the Compliance Act, 5 U.S.C. 552a.
- The PHI was obtained from someone other than an HCP under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of information.

If access is denied for one of the non-reviewable reasons detailed above, the Director will send a letter to the individual with a registered return receipt. The letter will explain that access is being denied and the reason for doing so. It will also explain that in these circumstances, the individual cannot appeal the decision. The Director will document the denial on the patient's chart and attach our denial letter to the sheet.

Reviewable Reasons for Denial of Access:

- A KETCHUM HEALTH doctor, using professional judgement, determines that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person.
- The PHI makes reference to another person (non-HCP) and an KETCHUM HEALTH doctor determines, using professional judgement, that access to the PHI would reasonably likely cause substantial harm to this other person.
- The request for access is made by the patient's personal representative and an KETCHUM HEALTH doctor determines, using professional judgement, that access by the personal representative to the PHI would reasonably likely cause substantial harm to the patient.

If access is denied for one of the reviewable reasons detailed above, the Director will send a letter to the individual with a registered return receipt. The letter will explain:

- That access is being denied and the reason for doing so.
- That in these circumstances, the individual has the right to appeal the decision.
- To request an appeal, that the patient must file a written letter with the Director.
- That the request must be submitted in writing (on paper or electronically) to the Director within 30 days. A request is no longer valid 31 days after the date of registered return receipt.

The Director will enter the date the letter is sent on the patient's PHI History Sheet and will attach the letter to it.

If KETCHUM HEALTH receives a letter of appeal, a review will be held. It is performed by a licensed health care professional, who is designated "Reviewing Official" by the most recent KETCHUM HEALTH examining doctor. The following guidelines will be followed:

- The Reviewing Official must not have participated in the original decision to deny access.
- The Reviewing Official must be a licensed HCP unacquainted personally or professionally with the patient.
- The Reviewing Official must be trained in optometry or ophthalmology.
- KETCHUM HEALTH will promptly refer the appeal to the Reviewing Official.
- The Reviewing Official must determine, within 30 days of receipt of the appeal, whether or not to deny the access, based on the standards outlined in this section.
- KETCHUM HEALTH, upon receipt of the Reviewing Official's decision will take whatever action is required to satisfy the ruling within two weeks.

- The Director will send a letter to the individual detailing the decision with a registered return receipt.
- The Director will document all proceedings on the patient's PHI history sheet and will attach all related documents.

In any communication with the patient regarding access to PHI, the patient will be informed that he or she may file a complaint, if it is believed that KETCHUM HEALTH is in violation of the regulations regarding access to PHI. See Part Nine of this manual for details.

2.1.9 Patients' Right to Correct Their PHI

If patients believe that their PHI is inaccurate or incomplete, they are legally entitled to have it corrected. If the University Care Center denies a correction, the patient has the right to disagree in writing, in which case KETCHUM HEALTH must attach the disagreement to the patient's file and include it whenever the PHI is released to others. KETCHUM HEALTH may also attach a written rebuttal to the patient's disagreement.

A patient may submit a written or electronic request for a PHI correction to the Director. The request must include the reason to support such a request.

A panel of three doctors: the most recent examining doctor, one other doctor from KETCHUM HEALTH, and another eye doctor from a non-associated practice in Orange County will review the patient's request for a correction. A correction will be allowed, if it meets the following criteria:

- It does not falsely represent the patient's medical condition, medical history, or treatment history.
- It serves to clarify or correct previously recorded PHI.
- It does not falsely represent the patient's billing history, payment history, or dates of service.
- It does not or will not adversely affect the patient's health or health care in the future.

A denial for correction is allowed if:

- The PHI was not created by KETCHUM HEALTH.
- Is not available for inspection (see Non-Reviewable Reasons for Denial of Access).
- The PHI is accurate and complete.

The Director will inform the patient of the panel's decision by mail with a registered return receipt within 60 days of the written/electronic request's arrival at KETCHUM HEALTH. The reason for the acceptance or denial will be included in the written decision. We are allowed one 30-day extension to consider a request for a correction, if we send to the patient written notice of the reason for the delay and the date by which the correction will be made.

If the correction is allowed, the Director will make the appropriate changes in the patient's file. Within 15 days of the ruling, any HCPs, business associates, or other entities named by the patient, who were sent the erroneous/incomplete information will be advised in writing of the correction(s) and a copy of such communication will be forwarded to the patient.

If another HCP informs KETCHUM HEALTH of an amendment to a patient's PHI, then the Director will make the appropriate amendments to the PHI in KETCHUM HEALTH's possession.

If the Correction Is Denied:

- The patient may request that KETCHUM HEALTH provide the patient's original request for change and the denial with any future disclosures of the subject PHI.
- Instructions for filing a Letter of Disagreement will be included with the denial letter to the patient. The disagreement must be submitted in writing (on paper or by e-mail) to the Director within 30 days. This Letter of Disagreement will accompany the patient's PHI for all uses and disclosures thereafter.
- In any communication with the patient regarding denial of changes to PHI, the patient will be informed that he or she may file a complaint, if it is believed that KETCHUM HEALTH is in violation of the regulations regarding changes to PHI. See Part Nine of this manual for details.

If the Patient Files a Letter of Disagreement:

- The examining KETCHUM HEALTH doctor may write a rebuttal.
- The Director must send a copy of the rebuttal to the patient.

Documentation:

The Director will document ***any and all*** proceedings in the patient's file regarding the request for corrections. Some examples are: the date the original request is received, our response to the request and its date, the patient's request to attach the original request should we deny a correction, date rebuttal letter is sent. Any and all of the following documents must be kept in the patient's chart:

- The original letter requesting a correction of the PHI.
- Any denial or acceptance letter from KETCHUM HEALTH.
- Patient's request to attach request letter to future disclosures, even though KETCHUM HEALTH denied a correction.
- The patient's Letter of Disagreement.
- KETCHUM HEALTH's rebuttal.

2.1.10 Accounting of Disclosures

Any time that KETCHUM HEALTH discloses PHI, an entry must be made in the patient "Log of Disclosures," with a few important exceptions. KETCHUM HEALTH need not to furnish an accounting of following disclosures:

- For treatment, payment, or health care operations, where the information is not in electronic form
- To the patient him or herself.
- For incidental uses or disclosures as defined in "Allowed Uses or Disclosures of PHI without Any Authorization from the Patient" in the Definitions section of this manual.
- For disclosures that the patient already signed an authorization for.
- To persons involved in the patient's care or a patient's personal representative, as long as the PHI disclosed is directly relevant to the individual's health care.

- To notify or assist in the notification of people involved in the patient's care about the patient's location, general condition or death.
- As a "limited data set" for research purposes.
- For national security or intelligence purposes.
- To correctional institutions or law enforcement officials.
- For disclosures that occurred prior to April 14, 2003.

The patient may ask KETCHUM HEALTH staff for accounting of disclosures of ePHI by any of our business associates; however, KETCHUM HEALTH may direct patient to business associates for a response.

The entry in the log for each disclosure must indicate the following:
- Date of disclosure.
- The name of the person/organization that received the PHI, along with the address, fax number, or e-mail address, if known
- A brief description of the PHI disclosed (for example: Rx, dates of service, etc.)
- A purpose of disclosure. Or in lieu of the statement, a copy of the written/electronic request for disclosure.

Patients are legally entitled to see their log listing each disclosure of their PHI during any portion of all of the previous six years. The log must also include disclosures to or by business associates of KETCHUM HEALTH. Events prior to the compliance date of April 14, 2003 do not have to be included.

KETCHUM HEALTH must temporarily suspend the patient's right to receive the disclosures made to a health oversight agency or law enforcement official, if the agency or official provides us with a written statement stating that an accounting to the patient would be reasonably likely to impede the agency's activities. The statement must also include a time period for which the suspension is required. If the agency or official's statement is made orally, KETCHUM HEALTH must:
- Document the statement and include the identity of the agency or official making the request on the patient's PHI History Sheet.
- Temporarily suspend the patient's right to a copy of the Log of Disclosures.
- Limit the temporary suspension to no longer than 30 days from the date of the oral statement, unless a written statement is submitted during that time.

Each patient is legally entitled to one free log per 12-month period. Any additional requests for logs within a 12-month period will be provided at a cost of $ 0.25 per photocopied page. The Director must inform the patient of the fee in advance and allow him/her an opportunity to withdraw or modify the request, in order to reduce or avoid the fee.

The patient may request the Log of Disclosures for any period of time less than six years from the date of their request. It must include disclosures to or by business associates of KETCHUM HEALTH. The Director will simply print the patient's personal Log of Disclosures for the requested

time period. If KETCHUM HEALTH has made multiple disclosures to the same entity for a single purpose for a specified period of time, we may instead report:

- The information for the first disclosure during the specific period of time.
- The frequency, schedule, or number of disclosures made during the specific period of time.
- The date of the final disclosure during the specified time.

The Director will supply the patient with the Log of Disclosures no later than 60 days after receiving the request. We are allowed one 30-day extension to supply the log, as long as we:

- Provide the patient with a written statement of the reasons for the delay.
- Supply a date by which the log will be provided.

The Director will document her name as the person responsible for processing the patient's request, the release date of the log to the patient, the contents of the log by entry dates, and any fees collected on the patient's PHI history sheet.

2.1.11 Complaints about Compliance Practices and Patient Grievances

Patients have the right to file complaints about KETCHUM HEALTH's PHI policies and procedures, i.e., they may complain if they believe that their right to privacy has been violated, or that KETCHUM HEALTH is not in compliance with the law. Complaints may be made directly to us or to the Office of Civil Rights in the Department of Health and Human Services, California chapter.

A patient will not be intimidated, coerced, threatened, discriminated against or have any other retaliatory action taken against them for:

- Filing a complaint either with KETCHUM HEALTH or the OCR.
- Testifying, assisting or participating in an investigation, compliance review, proceeding or hearing.
- Opposing any act or practice that is deemed unlawful by HIPAA, provided the patient has a good faith belief that the practice they oppose is unlawful and the manner of the opposition is reasonable and does not involve a disclosure of PHI.

Patients who have complaints should be referred to our Contact Person, who will assist. The complaint may be communicated in person, by phone, by written notification, by fax or by e-mail/electronic means to our Director.

Upon receipt of a complaint, a panel of the following individuals will investigate the complaint:

- Associate Dean of Clinics
- The Director.
- If patient care is involved, a faculty who did not participate in the care of the patient.

If the investigation confirms that a breach of a compliance related issue occurred, or that KETCHUM HEALTH acted unlawfully, appropriate corrective action must be taken. Patient will be informed about the actions taken to deal with the complaint and how KETCHUM HEALTH is

preparing to avoid future occurrences of similar incidents, if any. The Director will be responsible for ensuring that these actions are completed.

The investigation committee will also determine whether any harm occurred to the patient as a result of the breach. If harm did occur, KETCHUM HEALTH must affirmatively mitigate it. Realizing that "mitigate" means "lessen in intensity, make less severe" (in other words, we can't undo the harm or make it go away), the committee will define a reasonable course of action. This recommendation will be conveyed to all of the KETCHUM HEALTH doctors, who will make the final decision about the exact nature of the mitigation. The Director will be responsible for ensuring that the mitigation occurs as directed by the doctors.
A report of the investigation will be issued to the patient within 60 days of the written/electronic complaint's arrival at KETCHUM HEALTH. The report will be sent by mail with a registered return receipt. The report must contain the following:

- This statement: *"We appreciate his/her efforts to contact us. We want you to know that we will not discriminate or otherwise retaliate against you for having complained."*
- Details of the investigative action taken.
- If a breach of the law occurred, KETCHUM HEALTH's apologies, as well as details of the corrective action.
- If a breach of the law occurred, KETCHUM HEALTH's plan for mitigation, if deemed necessary by the investigation committee.

If the investigation is not completed within 60 days, the patient will be notified in writing of the delay and of the approximate date of completion.

If the investigation determines that the breach was caused by an individual staff member at KETCHUM HEALTH, due to a failure to comply with this Policies & Procedures Manual, the following will occur:

- The individual will be counseled and the incorrect behavior will be discussed, along with methods for ensuring that it will not occur again in the future.
- The individual will receive a formal warning that should the behavior be repeated, employment will be terminated.
- A three-month progress evaluation of the employee will be held.

The Director will maintain full documentation of the complaint received, the proceedings of the investigations, the report issued to the patient, and any corrective actions taken. The documents will be stored in the locked filing cabinet in the administrative office. A note will be added to the patient's chart referring to the admin file for further details.

The patient may file a complaint with the Secretary of DHHS, if he or she believes KETCHUM HEALTH is not complying with the requirements of the Act. The Director will supply the necessary information to the patient. The complaint must:

- Be filed in writing, either on paper or electronically.
- Name the HCP who is the subject of the complaint and describe the activities believed to be in violation of the regulations.

- Be filed within 180 days of the time when the patient knew the violation occurred.

Please refer to Ketchum Health “Breach Notification” policy for further information on how to handles breaches.

Patients can also file a formal complaint to administrative personnel for issues related to the quality of services or care received at Ketchum Health. There is a **Patient’s Grievance** policy in place, accompanied by a filing form. This form should be made available to any patient willing to file or initiate a grievance process.

Confidential Communication with Patients

Patients are legally entitled to receive their PHI from KETCHUM HEALTH in a confidential manner. We will attempt to deliver PHI using the method preferred by the patient. Commonly used methods are: private e-mail, regular mail, and occasionally fax machines. Sometimes patients will provide us with an address or location other than their homes.

The patient may identify the preferred method of communication when requesting PHI from the Director. We may not question the reason a patient is asking us to use a particular method. If the records are sent electronically (via email), it is the responsibility of the KETCHUM HEALTH to encrypt the PHI so it can’t’ be accessed only by unauthorized users. KETCHUM HEALTH has in place technology that allows for the encryption of PHI in transit. Only authorized personnel are trained in sending encrypted PHI to patients and third parties. Director has the responsibility of assigning and monitoring those roles.

The Director will decide if the patient’s request can be reasonably accommodated. If the Director determines that communication with the patient is not reasonably possible, (s)he will discuss alternate methods with the patient.

No fee will be charged to the patient, if the PHI is delivered by regular mail, e-mail, or fax. If any other manner of communication is used and KETCHUM HEALTH incurs costs to do so, those costs must be
reimbursed by the patient. The Director or the contact person must inform the patient in advance of the costs, and ensure payment prior to the communication.

The Director will document the preferred method of communication on the patient’s chart.

2.1.12 Compliance by Business Associates

Any of KETCHUM HEALTH’s business associates (individual or company), and any subcontractors they use or hire, that receive PHI from us, or create, maintain, handle, or transmits PHI on our behalf, are now considered covered entities and are required to comply with the Omnibus rule, too. They must safeguard PHI and assure us that they are doing so.
They must also assist us in providing patients with access to their health information and a history of disclosures. This is true for PHI used in the following ways:

- To perform health care functions and operations on behalf of KETCHUM HEALTH. Examples are billing services, claims processors, medical transcribers, computer services/ programmers, record storage companies, recall management services, etc.
- To provide administrative services on behalf of KETCHUM HEALTH. Examples are legal services, accounting and collection services, consultants, management services, etc.

Business associates, who either generate PHI for KETCHUM HEALTH or receive PHI from KETCHUM HEALTH, must remain HIPAA/HITECH compliant while performing on Ketchum Health's behalf. The PHI may be disclosed only to help KETCHUM HEALTH perform its care functions. The PHI is ***not*** for the independent use of the business associate. All such associates are required to sign a "Business Associate Agreement." These agreements are distributed, received, and maintained by the Director. Every year, the compliance team will conduct an inventory of all the business associates to determine the need to update our BA agreements.

If any employee of KETCHUM HEALTH becomes aware that a business associate may have used PHI inappropriately, the Director must be informed immediately. Director will notify Ketchum Health management officials and launch an investigation.

If it is discovered that a business associate inappropriately used or disclosed PHI, then corrective action must occur. Depending upon the severity of the infraction, management officials will determine what restorative actions should occur. The actions may include:

- Requiring the business associate to change its procedures.
- Requiring the business associate to notify the patients affected and to mitigate any harm to them.
- Requiring the business associate to submit proof of its corrective actions and mitigation.
- Termination of KETCHUM HEALTH's relationship with the associate.
- Notifying the U.S. DHHS, Office for Civil Rights about the problem, if it isn't possible to terminate the relationship. Please refer to the "Breach Notification" policy

The Director will maintain full documentation of the proceedings of the investigations, the report issued to the doctors, and any corrective actions taken in the Business Associate's file in the Administrative office.

The Associate Dean of Clinics and the Director of Healthcare Policy Compliance maintains an updated list of all Ketchum Health business associates

Use of De-identified Information

De-identified information (D-II) is PHI that has been edited, preventing from being used to de-identify a specific individual. This is not as easy as simply withholding a name or birth date.
D-II is not governed by HIPAA because it is no longer considered "individually identifiable." We are allowed to disclose freely. and use D-II. We may also release PHI to our business associates so that they may de-identify it. Although it is unlikely that KETCHUM HEALTH will ever need to

use D-II, we may do so, for example, if a PPO requires statistical information about the center, or if we decide to provide statistical information about patients for research purposes. D-II is most likely to be used for marketing, business planning, or research purposes.

There are two categories of PHI that may be used for research purposes: D-II and limited data sets, which are described below. It is unlikely that KETCHUM HEALTH will ever be involved in de-identifying PHI, re-identifying PHI, or creating limited data sets. In the event that it becomes necessary, the Director will review the current guidelines in the Act to ensure compliance before we proceed. At that time, the doctors and the Director will decide who will de-identify PHI, which method will be used, who will re-identify PHI, and/or who will create the limited data sets.

De-Identified Information

There are two methods for determining if health information is not individually identifiable (de-identified). PHI is de-identified, if:

(1) An expert (on methods for rendering information "not individually identifiable") hired by KETCHUM HEALTH deems information as D-II. This is allowable only if it is determined that the risk is very small that the information could be used alone or in combination with other reasonably available information by a recipient to identify an individual patient. This determination must be made using generally acceptable statistical and scientific principles. The method used and the results must be documented.

OR

(2) The following identifiers of the patient are removed:

- Name
- Address (geographical subdivisions smaller than a state). It is acceptable to use the initial three digits of a zip code.
- Dates, except year, relating to the patient (birth date, exam dates, etc.)
- Age if over 89 and all elements of dates indicative of such age
- Telephone numbers
- Fax numbers
- E-mail addresses
- Social security number
- Medical record numbers
- Health plan beneficiary numbers
- Account numbers
- License/certificate numbers
- Vehicle identifiers and serial numbers, including license plate numbers
- Device identifiers and serial numbers
- Web Universal Resource Locators (URLs)
- Internet Protocol (IP) address numbers
- Biometric identifiers, e.g., fingerprints and voice prints
- Full face photographs and any comparable images
- Any other unique identifying number, characteristic or code

And,
KETCHUM HEALTH does not have any actual knowledge that the information could be used alone or in combination with other information to identify the patient, who is a subject of the information.

Re-Identified Information:
The Director will be responsible for reviewing the current guidelines, if any D-II or limited data sets ever have to be re-identified.

Limited Data Sets:
In some cases, researchers require additional information that might be used to identify an individual. In this case, we create limited data sets by removing the following direct identifiers of the patient and of relatives, employers, or household members of the patient from the PHI:

- Name
- Address (other than city, state and zip code)
- Telephone and fax numbers
- E-mail address
- Social security number
- Medical record numbers, health plan beneficiary numbers, and other account numbers
- License/certificate numbers
- Vehicle identifiers and serial numbers
- Device identifiers and serial numbers
- URLs and IP addresses
- Biometric identifiers, including finger and voice prints
- Full face photographs and any comparable images

Once the above direct identifiers have been removed, the information is called a “limited data set.”

All limited data sets must comply with the minimum necessary standard as well as the other rules for disclosures. Before we can release limited data sets, we must enter into a Data Use Agreement with the recipient, which:

- Establishes the permitted uses and disclosures of the information by the recipient, consistent with the purposes of research, public health, or health care operations.
- Limits who can use or receive the data.
- Requires the recipient to agree not to re-identify the data or contact the individuals.
- Contains adequate assurances that the recipient use appropriate safeguards to prevent use or disclosure of the limited data set other than as permitted by HIPAA and the Data Use Agreement, or as required by law.

Ketchum Health does participate in research activities at this time. When participating in research, the Director, in conjunction with Ketchum Health’s IRB, will review current guidelines in the Act and will provide the information to the doctors. We may also need to retain legal counsel at that time.

2.1.13 Marketing and Fundraising Activities

Marketing

Marketing is described as:

- Communicating about a product/service that encourages the recipients of the communication to purchase or use the product/service.
- An arrangement between KETCHUM HEALTH and any other entity whereby KETCHUM HEALTH discloses PHI in exchange for direct or indirect remuneration. The PHI disclosed is for the other entity or its affiliate to communicate about its own products/services so as to encourage recipients to purchase or use that product/service.

In most cases, a valid Authorization Form from the patient is required before marketing activities using PHI can be directed to the patient.

The Omnibus rule does **not** consider communications about the following topics as "marketing":

- The participating providers and health plans in a network, the services offered by a provider, or the benefits covered by a health plan.
- The patient's treatment (e.g., recommendations of specific pharmaceuticals or referrals to other providers).
- Case management or care coordination for the patient, or directions or recommendations for alternative treatments, therapies, health care providers, or settings of care to that patient. (e.g., reminder notices for appointments, annual exams, or contact lens refills. As an example, informing a patient who is a smoker about an effective smoking-cessation program is not marketing, even if that program is offered by a clinic other than that of KETCHUM HEALTH.)
- Any other communication that describes health-related items or services offered by KETCHUM HEALTH, or treatment alternative.

The Act does NOT require KETCHUM HEALTH to seek a patient's authorization for the following two marketing communication circumstances:

- When it occurs face-to-face between KETCHUM HEALTH doctors or staff and the patient (e.g., when giving sample products during an office visit).
- When it involves a promotional gift of nominal value provided by KETCHUM HEALTH (e.g., KETCHUM HEALTH can provide lens cleaning cloths, eyeglass cases, bottles of lens cleaner, etc. with the practice name or a product manufacturer's name on it).

All other marketing activities require a signed Authorization Form **from the patient** ***to use or disclose PHI.*** The marketing authorization must include a statement about direct or indirect remuneration, if there is any.

Fundraising

All fundraising activities regarding PHI from patients at the UE Centers will be conducted in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its subsequent amendments, including the Omnibus rule of 2013

Procedures:

- All fundraising activities will be conducted and coordinated only by the Department of Development and its authorized staff.

- Every patient at the University Eye Centers is provided with a copy of the Notice of Privacy Practices (NPP), and they are given the opportunity to read it and ask questions about its provisions. Clear language about fundraising and marketing communications from KETCHUM HEALTH is incorporated in the notice, including the right of patients to opt out of receiving such exchanges without creating a burden on their part

  The following protected health information (PHI) may be used for fundraising purposes:
  - Demographic information, including name, address, date of birth, age and gender
  - Health insurance status, including type of insurance.
  - Department of service
  - Date of service
  - Treating physician
  - Treatment outcome
- Protected Health Information from KETCHUM HEALTHs patients obtained by the Development department should not be stored or recorded after the fundraising activity has concluded.

- If an outside organization is going to be contracted to conduct fundraising activities in any capacity, a business associate agreement must be signed, which will include the privacy and security provisions of the Omnibus rule.

Fundraising Opt Out Procedure

The KETCHUM HEALTHs must ensure that the individual being contacted is given the opportunity to request that there be no further fundraising communications from KETCHUM HEALTH, and that that request will have no adverse effect on her/his care or treatment as a result.

Written materials mailed to patients for the purpose of fundraising must include the following required opt out language:

"If you wish to be removed from future KETCHUM HEALTH fundraising communications, please contact the office of Advancement by telephone (714) 992.7832, or by email at advancement@ketchum.edu ."

Verbal communications/telephone solicitations must also advise patients of the right they have to opt out of fundraising communications.

A process will be created to make sure that individuals who have requested to be removed from future fundraising communications are honored on their request. The Director of Development will keep an updated log of all the opt-out requests available for review.

Before contacting patient for fundraising purposes, the Director of Development must verify that the individual they wish to contact have not opted out.

2.1.14 Retention of Documentation

As the KETCHUM HEALTH implemented the Electronic Medical Records (EMR) system, all PHI that is collected, produced *or received from patients, or third parties on behalf of patients, will be stored in each patient's file and will not be modified, edited, or otherwise deleted from the file it belongs to.*

KETCHUM HEALTH is required to document actions taken as described in this manual. The documentation will be included in the file and must be kept for at least six years from the date of the action, or from the last use of the relevant PHI, whichever is later. The following are examples of many (but not necessarily all) of the activities, documents, and communications that require documentation and retention:

- Uses and disclosures of PHI that require patient authorization.
- Business associate agreements.
- Notice of Privacy Practices.
- Restrictions on uses and disclosures of PHI for specific patients.
- Confidential communication requirements.
- Amendments to PHI.
- Logs of Disclosures of PHI.
- The policies and procedures described in this manual.

Documentation for specific patients is to be kept in their charts. This information should never be deleted. Seven years after the patient's last office visit, the patient's records may be purged except in the case of minors. Minor records must be kept until the age of majority plus seven years. Fifty years after the patient's death, the records may be deleted and/or destroyed entirely. The Director may delegate the archiving and deletion and/or destruction of records to a trained assistant.

Paper files in the administrative office (e.g., previous versions of the Policies & Procedures Manual, business associate agreements, complaints investigations and reports, documentation of associate breaches, etc.) must be held for at least six years. Personnel files must be held for a minimum of six years after termination. When it is appropriate to purge the files, all paper

documents must be shredded. The Director may delegate the purging and shredding to a trained assistant.

2.1.15 Changes to Policies and Procedures

Changes will be made to KETCHUM HEALTH's Privacy Policies & Procedures periodically. Sometimes the updates will be required because of changes in the law. These updates will affect the Privacy Policies & Procedures Manual, as well as some of the forms we distribute to patients. At other times the manual will need to be revised because of operational changes within the practice. *At no time are actual policies or procedures to be changed, prior to the effective date of the change.*

Because we have included a statement in our Notice of Privacy Practices that grants us the right to make changes in our Compliance practices, we may make the changes effective for all PHI that we created or received prior to the effective date of the revision.

When changes in the law occur, the Director will oversee the following activities to ensure that they are completed:

- Amend KETCHUM HEALTH's Notice of Privacy Practices, so new patients will have the most current information.
- Update any other forms that are affected (e.g., Authorization Form, PHI History Sheet, Business Associate Agreement, etc.)
- Amend this Compliance Policies & Procedures Manual, including re-dating any pages that are changed.
- Update any affected forms and information supplied on KETCHUM HEALTH's website.
- Post change Notice of Privacy Practices in the reception area, on the website, and have copies available for patients to take home.
- Provide information and training pertaining to the changes for all staff and doctors.

When we need to make procedural changes within the KETCHUM HEALTH, we are allowed to do so, as long as the changes are still in compliance with the current law. The Director will oversee the implementation of such changes and they may include:

- Revising this Compliance Policies & Procedures Manual.
- Posting the change in the reception area and on the website, as well as making copies available for patients to take home, if the change affects our patients. If the change is for internal procedures with no direct consequences for patients, then there is no need to post the change publicly.
- Providing information and training regarding the changed procedures to all staff and doctors.

When changes are made to this manual each faculty and employee, whose functions are affected by the change, must be re-trained. Updated pages for the manual will be provided to each faculty and employee.

2.2 HIPAA SECURITY POLICIES & PROCEDURES

The policies and procedures described in this manual have been developed for the purpose of compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the HITECH act of 2009, and the Omnibus Rule of 2013.

At Ketchum Health-University Eye Centers, all employees, students, interns, volunteers, and business associates function with the understanding that protection of our patients' health information is of the highest importance, especially when it could personally identify the individual. This manual describes the policies and procedures to be followed at all times, when the security of protected health information (PHI) is involved.

Statutory Framework:

The federal Health Insurance Portability and Accountability Act (HIPAA) requires Covered Entities (Health Care Providers) to comply with several provisions, including the security rule(45 CFR Parts 164.102, *et al*). This rule consists of three types of safeguards: Administrative, Physical and Technical. Each safeguard has a set of standards and implementation specifications that are being developed in this manual.

The security rule applies only to electronic protected health information (*e*PHI), unlike the privacy rule which applies to PHI in oral, hard copy, and electronic form. The rule covers PHI **in use** (creation, retrieval, revision, and deletion), **at rest** (database-servers), and **in motion** (transmission). As stipulated in the act, the security rule is technology "neutral" and it does not recommend any specific type of hardware or software solution. It only requires covered entities to take reasonable and appropriate measures to protect against reasonable, foreseeable threats to the organization.

It is the duty and responsibility of each person or entity associated with the University Eye Centers in any capacity to be familiar with the material in this manual and to comply with the requirements detailed within it.

2.2.1 Terms & Abbreviations Used in this Manual

Act	The Act is the Health Insurance Portability & Accountability Act of 1996 and its updates, changes and revisions that are currently in effect.
Business Associate	An outside business or contractor or a subcontractor that assists KETCHUM HEALTH in certain activities or services that involve the use and/or disclosure of PHI.
Breach	Unauthorized acquisition, access, use, or disclosure of PHI that can compromise the Compliance and/or security of this information

Confidential Information	A combination of any information that identifies and describes an individual, including her or her name in conjunction with SSN, PHI, and financial account information
Contingency Plan	Sets out a course of action that is maintained for emergency response, backup operations, and post-disaster recovery
Covered Entity	A person or organization that is required to comply with HIPAA regulations.
DHHS	US Department of Health and Human Services
D-II	De-identified information. Information that does not identify an individual
Disclosure	The release, transfer, provision of access, or divulging Individually Identifiable Protected Health Information (IIPHI) outside of the entity holding such information.
ePHI	Electronic Protected Health Information.
Encryption	The use of technology to render or transform PHI unreadable.
Health Care Operations	▪ Conducting quality assessment and improvement activities, contacting of Health Care Professionals (HCPs) and patients with information about treatment alternatives and related functions that do not include treatment. ▪ Reviewing the competence or qualifications of HCPs, evaluating practitioner and provider performance, conducting training programs (in areas of health care under supervision to practice or improve skills), training of non-health care professionals, accreditation, certification, licensing or credentialing activities. ▪ Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. ▪ Conducting or arranging for medical review, legal services, and auditing functions. ▪ Business planning and development, such as conducting cost-management and planning-related analyses. ▪ Business management and general administrative activities of the entity. ▪ Using PHI to conduct education and training sessions with interns and students within campus premises.
HIPAA	Health Insurance Portability & Accountability Act of 1996
HITECH	Health Information Technology for Economic and Clinical Act of 2009
IRB	Institutional Review Board

IT Security Incident	Any activity that harms or represents a serious threat to critical systems infrastructure, including computer, telephone and network-based resources.
NPP	Notice Of Privacy Practices
Omnibus rule	HIPAA amendment to the HITECH, 2013.
PHI	Protected health information.
PPO	Preferred provider organization.
Remote Access	Any access to a device on the data network through a non-controlled network
TPO	Treatment, payment, or health care operations.
KETCHUM HEALTH	University Eye Center
Workforce	Refers to employees, volunteers, trainees, volunteers, work studies contractors, and other persons under the direct control of the covered entity, whether or not paid by the covered entity, which have access to confidential information.

2.2.2 Administrative Safeguards

(45 CFR § 164.308)

Standards:

1. <u>Security Management Process</u>

A. Risk Analysis

Consistent with the provisions of the security rule, Ketchum Health IT personnel will conduct a risk assessment to identify, manage and mitigate potential threats and vulnerabilities of its business operations that could impact the confidentiality, integrity, and availability of patient's electronic PHI.

At the University Eye Center, there are individuals, systems and processes that have access to sensitive data. Improper handling of this information could expose PHI of our patients to internal or external threats.

<u>Scope of the assessment</u>

The assessment will include the following:

- Identifying individuals, systems and processes that have access to PHI:
  - Local and wide area networks
  - Main servers
  - Bandwidth connectivity and storage

- Determining the risks (potential and real), and situations that exist that may compromise PHI.
- Determining if there are processes or actions taking place that inappropriately exposes sensitive data.
- Assessing current security controls in the Clinic.
- Determining the levels of risk to our practice's electronic systems that contain *e*PHI:
  - All databases with ePHI
  - All computers that are connected to ePHI
  - BYODs including any mobile computing devices
  - All clinic-owned mobile computing devices or media
- Recommend security controls to mitigate such risk levels
- Document the risk assessment findings.

The risk assessment evaluates the confidentiality (protection from unauthorized disclosure); integrity (protection from improper modification); and availability (chart completion or loss of system or document access) of PHI.

Process Approach

The risk assessment should be conducted in accordance with the methodology described in the National Institute of Standards and Technology (NIST), special publication (SP) 800-30, and within the parameters outlined by the Health and Human Services Department Risk Assessment Tool application.

B. Risk Management

The KETCHUM HEALTH risk management plan consists of six processes that provide the foundation for the organization to protect the confidentiality, integrity and availability of ePHI. All electronic PHI created, received, maintained, or transmitted by personnel at KETCHUM HEALTH is subject to this policy. We understand that risk management is a critical element in our business operations and a key part of KETCHUM HEALTH security control program.

Steps of the Risk Management Plan:

I. **Categorize information Systems:** allows KETCHUM HEALTH to determine the criticality and sensitivity of the information systems and the information being processed, stored and transmitted. Servers, workstations, medical devices with networking capabilities, BYODs with access to network connectivity, software applications that support patient care, are examples of critical systems that must be categorized.

II. **Select Security Controls**: Allows for the selection of the appropriate security controls, tailored for the threats and vulnerabilities found after performing a baseline assessment. Authentication procedures for workstation access, encryption at rest (if feasible) /in transit, redundant data back-up procedures, software patches, USB port deactivation are examples of select security controls that must be considered.

III. **Implement Security Controls**: Allows for the physical implementation of security controls that have been determined to be reasonable and appropriate for the organization.

IV. **Assess Security Controls**: Allows for the evaluation of the effectiveness in the implementation of the security controls. By using assessment methods and procedures, we determine the extent to which the controls are implemented correctly and operating as intended with respect to protecting ePHI.

V. **Authorize Information System**: Allows for the acceptance of those identified risks that are deemed tolerable to the KETCHUM HEALTH.

VI. **Monitor Security State**: Allows for the continuous evaluation and monitoring of the implemented security controls to ensure that they remain operating effectively and as intended. Update of the security measures in response to environmental and operational changes that affect ePHI.

Impact Analysis

After evaluating the threat/vulnerability, the security team determines the level of severity or impact of the adverse event based on the following three categories:

1. High: The occurrence of the event will result in severe PHI breach and there is great likelihood of occurrence. Mitigation measures must be implemented immediately.

2. **Moderate:** The occurrence of the event may result in a violation of laws and internal procedures, and could eventually affect KETCHUM HEALTH's performance and reputation.

3. **Low:** The occurrence of the adverse event may result in the potential breach or misuse of PHI, and could minimally affect KETCHUM HEALTH business operations.

C. Sanction Policy

Any officer, employee, or agent of KETCHUM HEALTH who believes another officer, employee, student or agent of Southern California College of Optometry has breached the facility's Security Policy, or the policies and standards enacted to carry out the objectives of the Security Policy, or otherwise breached the integrity or confidentiality of patient or other sensitive information, should immediately report such breach to his or her superior or to the Director of Information Technology.

Any sanctions following the investigation of improper behavior related to the handling of ePHI will be discussed with the Associate Dean of Clinics in conjunction with HR. As noted in the organization's employee handbook, KETCHUM HEALTH has a progressive discipline policy under which sanctions become more severe for repeated infractions. This policy, however, does not mandate the use of a lesser sanction before KETCHUM HEALTH terminates an employee.

At the discretion of management, KETCHUM HEALTH may terminate an employee for the first breach of the security policy or individual policies if the seriousness of the offense warrants such action.

An employee could expect to lose his or her job for a willful or grossly negligent breach of confidentiality, willful or grossly negligent destruction of computer equipment or data, or knowingly or grossly negligent violation of HIPAA, its implementing regulations or any other federal or state law protecting the integrity and confidentiality of patient information.

For less serious breaches, management may impose a lesser sanction, such as a verbal or written warning, verbal or written reprimand, loss of access, suspension without pay, demotion, or other sanction.

Violation of the facility's security policy or individual policies and standards may constitute a criminal offense under HIPAA, other federal laws, such as the Federal Computer Fraud and Abuse Act of 1986, 18 U.S.C. § 1030, or state laws.

Any employee or agent who violates such a criminal law may expect that KETCHUM HEALTH will provide information concerning the violation to appropriate law enforcement personnel and will cooperate with any law enforcement investigation or prosecution.

Further, violations of the facility's security policy or individual policies and standards may violate professional ethics, and be grounds for professional discipline. Any individual subject to professional ethics guidelines and/or professional discipline should expect KETCHUM HEALTH to report such violations to appropriate licensure/accreditation agencies and to cooperate with any professional investigation or disciplinary proceedings.

D. Information System Activity Review

All employees at KETCHUM HEALTH understand that the use of software, hardware, equipment and any other system, including network and access to the web, is intended solely for the purpose of performing their job responsibilities.

There is no expectation of privacy while using any equipment or system that belongs to KETCHUM HEALTH, and management will implement a process to track and review all access activity by employees. The applications support manager will create and maintain a log-in report available for review by management.

The application report will be evaluated daily and will be kept on a separate electronic file by the Director of Healthcare Policy Compliance. Refer to the sanction policy for disciplinary action regarding employees' violations.

2. Assigned Security Responsibility

To ensure accountability on our security process when handling PHI, KETCHUM HEALTH has assigned the role of security officer to different individuals, based on their responsibilities.

The IT Manager will oversee all servers' activity, critical network infrastructure, and web access. The Applications Support Manager will oversee all EHR and practice management software applications that store and/or support PHI, including software patches and updates.

All policies and procedures regarding security issues will be created, updated and communicated by the Director of Information Technology. All IT security purchasing and investment projects will be conducted exclusively by the Director of information technology.

Employees, students, interns and volunteers at the KETCHUM HEALTH have been notified to communicate with the applications support manager in the event of a security problem.

3. Workforce Security

KETCHUM HEALTH shall implement workforce security procedures that require authorization and supervision in managing access to electronic protected health information. These procedures will include audit trail documentation for granting and termination of system access.

A. Authorization and Supervision: Each supervisor or department chief will request access to PHI by employees under her/his control area to the applications support manager. The goal is to establish a chain of command and a line of authority for accessing ePHI. Employees will be properly communicated about this procedure. No employee will request access to ePHI applications without asking their respective supervisor.

B. Workforce Clearance Procedure: Access to system infrastructure by employees is only granted on a role-based basis and limited to the scope of their job description. Workforce supervisors shall implement a formal process for screening and requesting access to ePHI system for their members. Consideration of required access to electronic confidential information should be included as part of workforce clearance for hiring, promotion, and transfer of employees into positions requiring such access.

C. Termination of Access: The process of denying/terminating workforce access to confidential information shall include procedures with authorization for informing application support manager to remove access privileges for specified systems. The process for removal of access shall include procedures that address changes in job duties, transfer of job position, promotions, and termination of workforce membership.

4. Information Access Management

A. Isolating health care clearinghouse function. No clearing house activities are performed by any individual or group of individuals within the organization; therefore, there are no clearinghouse functions that need to be isolated. KETCHUM HEALTH has contracted the services of an independent organization to perform clearinghouse functions on its behalf, and there is a signed business associate agreement in place which covers the Privacy and Security of PHI.

B. Access Authorization. This is the process of determining whether a prospective data user should be granted access to University Eye Center's patient databases. Access must be granted in accordance with this access and other related guidelines. No employee may access any confidential patient or other information that they do not have a need-to-know. Prospective data users will not get access unless they have a legitimate, job-related need, and such access will be only limited to the minimum necessary to perform their duties.

No employee may disclose PHI or other information unless properly authorized, according to the Confidentiality and Disclosure policies (see Privacy Manual).

C. Access Establishment and Modification. Is the process of granting access to an authorized data user, and who has been authorized access under KETCHUM HEALTH's access authorization policy. Department chiefs and supervisors will determine the personnel who need access to patient databases, and such access will be granted by the Applications Support Manager only on a role-based basis. To ensure proper patient care, the Director of IT will provide emergency override access for necessary personnel as determined by department chiefs. The same protocols apply when the employee is transferred to another department or her access needs to be modified.

The Applications Support Manager will suspend access when appropriate to respond to a breach of PHI in coordination with the Director of Healthcare Policy Compliance. Access shall be modified when notified to do so by the Department's chief or by respective supervisor. Access can also be terminated by the applications support manager when notified to do so by the Department chief, area supervisor, or Human Resources in accordance with the termination procedure.

5. Security Awareness and Training

A. Security Reminders. As part of our training practices, all employees, students, interns, volunteers and agents working on behalf of KETCHUM HEALTH will be periodically educated about PHI security issues. The Director of Information Technology is responsible for developing, presenting, and documenting training in the following subjects:

- Principles of security.
- Secure ePHI transmission.
- University Eye Center's policies and procedures regarding the security of health information.
- Procedures for reporting breaches of security and confidentiality of PHI.

This process will be achieved using different options, depending on the individuals selected to receive the training, and could involve email communications, online training using our blackboard platform (Moodle), in-person training, and/or printed

materials. The Director of information technology will send quarterly security reminders via email to all clinic personnel, including students and interns.

The training program is conducted at least once a year, and it is updated accordingly depending upon the enactment of new rules and regulations.

B. Protection from malicious software. The director of IT and his team are in charge of implementing and coordinating all the efforts to keep our critical systems and network infrastructure safe. We have currently installed all available software and hardware, including but not limited to Anti-virus, Firewalls, malware protection, aimed to protect our systems; the IT personnel is constantly upgrading and applying patches as they become available.

C. Log-in monitoring. Using the audit-trail capabilities of the software that handles PHI, the IT security team, led by the Applications Support Manager and Programmer will monitor all users' log-in attempt and will report discrepancies. The main goal is to identify users who access PHI without having the need to, and apply the corrective measures immediately.

D. Password management. Computer use is only possible when an individual logs-in and uses a personal password. Each individual is assigned a security level when hired, which allows role-based access to PHI. Passwords should be changed periodically based on threat exposures (e.g., every 30, 60, or 90 days) and staff will not post their passwords on sticky notes by their computers or desks. The password should be at least eight characters long, using a combination of letters, numbers and special characters. Avoid using date of births, phone numbers, or last names.

The Applications Support Manager will be the only individual with security rights to override other users' passwords, in case access is needed due to an emergency.

6. Security Incident Procedures

A. Response and Reporting. At Ketchum Health we recognize that ePHI may be available at multiple locations, devices, and applications. As we implement new procedures to safeguard PHI and any other sensitive patient information, we will make sure that security incidents are identified, investigated and corrected to the best of our technical capabilities. The incident report will have, at the minimum, the following elements:

1. Date, time, and location of the event (device, workstation, application)
2. Name of the individual who discovered the incident.
3. Evidence collected
4. Actions taken to minimize or mitigate potential damages or disruption to system's infrastructure.
5. Policy and procedural changes implemented to avoid recurrence.

When ePHI is breached and it affects more than 500 patients in a single incident, we will start the notification process, as required by federal and state law. Please refer to MBKU "Breach Notification" policy in this manual.

7. Contingency Plan

A. Data backup plan. The Director of Information Technology and his team are responsible for performing daily backups on University Eye Center's network, including all databases on which PHI resides or may reside, shared drives containing application data, general patient information, and other related critical data. All servers are backed up nightly at 23:00 hours.

The IT department will hold weekly backups for four weeks and monthly backups for one year. Each month a second copy of the backups are taken off site to a safe deposit box.

B. Emergency mode operation plan. Please refer to section **6.8** of the Manual (**Business Continuation Plan-Clinic Services**)

8. Business Associate Contracts and Other Arrangements

KETCHUM HEALTH conducts its business and operations in a manner consistent with the security rule, always preserving the integrity, confidentiality and availability of patients' information. Sometimes, in order to continue providing quality patient care, KETCHUM HEALTH may allow a business associate to create, receive, maintain, or transmit electronic protected health information on its behalf.

KETCHUM HEALTH will perform a periodic inventory to identify all business associates who have access to PHI in any manner while conducting business on its behalf, and will have agreements in place for any vendor, entity or third party that creates, receives, maintains, or transmits such information. The purpose of these agreements is to obtain satisfactory assurances, in accordance with the standard for business associate contracts or others arrangements of Organizational Requirements of the Security Rule, that the business associate will appropriately safeguard the information.

All business associates who have access to KETCHUM HEALTH protected health information and conduct business on its behalf, will need to comply with the HIPAA security rule and are required to inform its covered entity of any breach of unsecured PHI that it discovers or experiences, and to assist the covered entity by providing requisite information that will facilitate the covered entity's fulfillment of breach notification requirements.

Please see Exhibit 21 for KETCHUM HEALTH standard business associate agreement.

2.2.3 Physical Safeguards
(45 CFR § 164.310)

Standards:

1. Facility Access Controls.

A. Contingency Operations. We believe that any effective contingency plan must start with preventive measures. In order to plan for potential environmental, human or technical threats to our network infrastructure and the facilities they reside in, a comprehensive plan is in place.

Our campus has four safety systems:

1. Fire safety;
2. Intrusion alarm;
3. CCTV;
4. Card access.

Each safety system is to be inspected annually by contracted service providers who will maintain, repair and replace physical campus security equipment to include the following:

- Fire sensors
- Fire sprinkler
- Fire alarm monitoring panel
- Motion sensors
- Door contact sensors
- Glass brake sensors
- Intrusion alarm monitoring panel
- Distress/panic alarm buttons
- Surveillance cameras
- Digital Video Recorder (DVR)
- Wiring of all systems
- Proxy cards
- Door card readers
- Monitoring computer system (card access)

In the event of a natural disaster or massive fire, evacuation procedures will be implemented, following the guidelines established by the Safety and Emergency Preparedness committee and local authorities. This committee will decide if continuing providing patient care under the current conditions will be suitable. Personnel assigned by the Director of Campus Safety and Security will conduct safety training, including fire drills, evacuation procedures, and disaster preparedness. They will be the first responders in charge of managing all emergencies and disasters on campus.

B. Facility Security Plan. MBKU-Ketchum Health campus facilities are open for students, staff, faculty and administration from 6 am to 1 am. It is the responsibility of the Campus Safety Officer to monitor the access to all campus locations. Only authorized personnel are

to use these facilities. Campus Safety will also make sure that the rules and regulations on the facilities are maintained.

There is a security plan enforced by the Director of Campus Safety and Security. Among his duties are:

- Interact positively with campus community members on a daily basis and assist members in identifying potential safety and/or criminal problems.
- Consistently patrol campus on foot as needed.
- Respond to, and manage all emergencies and disasters on campus.
- Observe safety hazards and promptly report them to appropriate persons, as well as responding to all security and fire alarms.
- Unlock/secure appropriate buildings/rooms and facilities as directed.
- When necessary, enforce University Policies, California Penal and Vehicle codes on university property.
- Proactively implement the department's community policing program.

Patrols.

In order to promote high visibility and interaction with our campus community, foot patrols will be conducted whenever possible. Patrols should be intermittent and sporadic as not to develop a pattern that can be tracked and/or anticipated.

During normal operations and given there are no extenuating circumstances there should be at least one Officer on foot patrol at any given time.

C. Access Control and Validation Procedures. Identification cards are issued to all employees and students for identification and security purposes and must be worn at all times while on campus. Campus Safety has the authority to verify the existence of the identification card at any time an employee, student or vendor/contractor is on campus. The card also functions as an access card that is programmed to allow entrance into certain buildings, offices and the parking structure as needed. If an employee or student does not have their card while on campus, access to certain areas can and will be denied. It is the responsibility of Campus Safety to ensure that access cards are not transferred. In the event a student or employee is found using another student or employee's access card, the card will be confiscated by the Campus Safety Department. A Ketchum Health-Campus Safety incident report will be completed.

D. Maintenance Records. All activity related to the facilities security and access plan, as well as the incident response, will be documented accordingly. The Director of Campus Safety and Security will ensure that activity logs are maintained and updated accurately.

2. Workstation Use.

Preventative Measures

It is the policy of KETCHUM HEALTH to ensure all members of its workforce have appropriate access to electronic PHI, and to prevent those workforce members who do not have access from obtaining access to PHI. Based on these premises, the following measures will be established:

- Implement, as appropriate, procedures for the authorization and/or supervision of workforce members who work with PHI or in locations where it might be accessed.
- Implement, as appropriate, procedures to determine that the access of a workforce member to PHI is appropriate.
- Implement, as appropriate, procedures for terminating access to PHI when the employment of a workforce ends, changes, or as required by determination made as specified in this security manual.
- All personnel using computers will familiarize themselves with and comply with the facility's disaster plans and take appropriate measures to protect computers and data from disasters.
- Each person using the facility's computers is responsible for the content of any data he or she inputs into the computer or transmits through or outside the facility's system. No person may hide their identity as the author of the entry or represent that someone else entered the data or sent the message. All personnel will familiarize themselves with and comply with the facility's e-mail policy.
- No employee may access any confidential patient or other information that they do not have a need-to-know. No employee may disclose patient or other confidential information unless properly authorized (see the Confidentiality Policy and the Disclosure Policy).
- Employees must not leave printers, scanners or copiers unattended when they are doing work that involves confidential patient or other sensitive information. This rule is especially important when two or more computers share a common printer or when the printer is located in an area where unauthorized personnel have access to the printer.
- Personnel using the computer system will not write down their password and locate it at or near the terminal, such as by putting their password on a yellow "stickie" on the screen, or a piece of tape under the keyboard.
- Each computer will be programmed to generate a screen saver when the computer receives no input for a specified period. Supervisors may specify an appropriate period to protect confidentiality while keeping the computer available for use in conjunction with the Health Information Department and the Applications Support Manager.
- Each user must log off the system if they leave the computer terminal for any period of time.
- As a general rule, PHI in printed form should not leave KETCHUM HEALTH premises unless it has been de-identified. Each department chief will make sure that staff, interns and students in his/her department are trained regarding this procedure.
- No personnel may download data from the facility's system without the express permission of the department head with notice to the Applications Support Manager.

- No personnel may upload any unauthorized software or data. The Director of Health Information Technology must approve any software or data that an employee wishes to upload/download. This rule is necessary to protect against computer viruses from being transmitted into the facility's system.

3. Workstation Security*

This Workstation Security policy is based on the following assumptions:

- Any computer/workstation in the facility can access confidential patient information if the user has the proper authorization.
- All computer screens may be viewed by individuals who do not have access to confidential information that may be displayed on the screen.
- Every computer workstation in the facility is vulnerable to environmental threats, such as fire, water damage, power surge, and the like.

In order to ensure the confidentiality, integrity and availability of PHI, KETCHUM HEALTH will implement the following security protocols:

- Personnel logging onto the system will ensure that no one observes the entry of their password.
- After five failed attempts to log on, the system will refuse to permit access and generate a notice to the system administrator.
- Personnel will not log onto the system using another's password nor permit another to logon with their password. Nor will personnel enter data under another person's password.
- All computer users will monitor the computer's operating environment and report potential threats to the computer and to the integrity and confidentiality of data contained in the computer system

*For all portable devices, including laptops, please refer to the remote access policy.

4. Device and Media Controls.

A. Disposal. This disposal-destruction policy is based on the following assumptions:

- Protected health information may reside in numerous locations and on different media.
- KH has a fiduciary duty to destroy such information in a way it preserves privacy and confidentiality.
- After electronic storage media have been erased, physical characteristics may still exist that would eventually allow data to be reconstructed, making the process more complex.
- Destroying data improperly may harm KETCHUM HEALTH collectively, its officers, employees, agents, students and patients.

The device and media disposal process will be handled by the IT department in conjunction with the System Applications Manager and his agents. Any device being decommissioned will be physically taken by the individual assigned by the Director of Information Technology, and stored properly at the Department's storage location.

Due to the complexities of the disposal process, this function is performed by a third party, which is responsible for picking up the media and devices, and securely transports and destroys it, following industry accepted standards. A certificate of destruction is issued after each job is completed.

B. Media-Reuse. By general rule, devices and media that completed their usability lifecycle are disposed accordingly. If a machine, hardware, or any other device is taken out of service and is reused, it will be reimaged prior to being redistributed for general use.

No storage media may be taken from KETCHUM HEALTH premises for reuse outside the clinic location, without taking all the steps necessary to ensure that PHI has been properly destroyed.

C. Accountability. In order to effectively control the movement of electronic systems, workstations, devices, and electronic media within the KETCHUM HEALTH, we will create and maintain and inventory. At clinic level, the Systems Applications Manager in conjunction with the assistant applications manager will keep an inventory of all the equipment, hardware and peripheral devices that are currently operating and that could store PHI.

The inventory will include, to the most extent possible, model and serial number, location of the device, individual's user name, and maintenance records. This individual will be responsible for updating the list as needed, and will document removal and/or additions to it.

The Director of IT will be responsible for creating and keeping updated an inventory of all the devices, hardware, and electronic media held by the entire organization. He will create a "report card" for each device, and will document the movement equipment.

An individual responsible for maintaining the log regarding upgrades, maintenance and repairs will be designated by the IT Director.

D. Data Backup and Storage. The Director of information technology and his team are responsible for performing backups on MBKU's network, including shared drives containing application data, PHI, financial data and critical system information.

- All servers must be backed up nightly.
- Weekly backups will be held for four weeks.
- Monthly backups will be held for one year.
- Each month, a second copy of the backups will be taken off site to a safe deposit box.

2.2.4 Technical Safeguards
(45 CFR § 164.310)

Standards:

1. Access Control.

A. Unique User Identification. This policy is based on the following assumptions:

- Data, media and computer assets are the physical property of MBKU, wherever located, although patients and others may have rights of access to the data.
- PHI is sensitive and confidential, and a loss or breach of confidentiality of such data may cause severe harm to the subject of the information, to MBKU, and to its officers, agents, and employees.
- We must ensure that access to PHI is limited to minimize the risk of breaches. Only individuals with a legitimate business need to access PHI, should have access to such information. Those with authorized access should have no more access than needed for the performance of their responsibilities.

Department chiefs will submit the name of staff needing access with the respective recommended level required to perform their duties. The System Applications Manager will ensure that prospective data users receive required training before access to the data applications is granted, including but not limited to password management, logging off protocols when leaving workstations, and closing unused applications that might contain PHI.

Access to databases that contain PHI is only granted on a role-based basis, and the Applications Support Manager will create and maintain a log with all the users, their level of access, and the modification of access, including termination of it, as needed.

B. Emergency Access Procedure. We recognize that there will be instances in which an emergency access to workstations and devices will be required by an individual(s) who is not the primary authorized user. Only the Director of Information Technology and his designees will have the ability to override the existing log-in credentials/passwords from current users in an emergency situation.

The emergency events will be only determined by the Associate Dean of Clinics (or the acting Clinic Director), and this individual or her designee will communicate with the Director of IT to activate the emergency access protocol in place. Each occurrence will be documented accordingly by the IT department.

C. Automatic Logoff. Computers and workstations in public areas which might hold PHI should have an automatic logoff feature that triggers after three minutes of inactivity. For offices and workstations located in less exposed areas, it is recommended that the timeout feature is set to work after 10 minutes of inactivity.

A security reminder will be sent on a quarterly basis to all MBKU staff, students and agents highlighting the importance of keeping a good security practices in place, including the need to lock their work stations when they plan to walk away.

2. **Audit Controls**.

Data users at the KETCHUM HEALTH have no expectation of privacy when accessing data, media, computers, or other devices that belong to the organization and that might contain

PHI, wherever located. It is understood that any official from KETCHUM HEALTH has the right to audit and monitor the use of these devices.

Patient management software comes with audit trail capabilities that allows for the tracking of users' activity. In addition to the built-in audit capabilities in the software, the IT department will develop and implement a mechanism to additionally track the users' access to PHI. The Director of Healthcare Policy Compliance in conjunction with the applications support manager will monitor the activity logs to identify potential misconduct, which could include the sharing of users' IDs, or users not logging off at the end of a work session.

3. **Integrity.**

A. Mechanism to authenticate electronic PHI. Data integrity is paramount to our business operations and it is also one of the three pillars of the security rule. We have a policy requiring providers to close and finalize patient files within three calendar days. The purpose of this procedure is to ensure, to the most extent possible, that PHI will not be altered, corrupted, or deleted, either unintentionally or maliciously by users.

This mechanism, in conjunction with the audit trail capabilities embedded in the software, and the stand alone program created by the IT department, will allow our security team to address any integrity issues that might arise from our business operations.

4. Person or entity authentication.

In order to verify that a person seeking access to electronic PHI is the one claimed, we will implement and monitor mechanisms that will enable our systems to authenticate who is accessing, reading, altering, or transmitting ePHI. Such procedures include:

- Required user name and password to access work stations and other hardware that might hold PHI.
- Audit trail capabilities embedded in the patient database software.
- Standalone application that tracks users' behavior.

Access to ePHI is granted only on a role based-basis; the department chiefs are responsible for determining who will need access to PHI and will communicate with the Applications Support Manager the name of those individuals to complete the process.

The Applications Support Manager will periodically monitor users' access to systems and applications, and will report any suspicious behavior to the Director of IT and the Associate Dean of Clinics, should corrective or disciplinary need to be initiated.

5. **Transmission Security**.

Integrity Controls-Encryption- Electronic Communications

The following policy describes the steps required from KETCHUM HEALTH workforce, agents and interns when communicating PHI electronically. This policy applies to workforce

authorized by KETCHUM HEALTH to access, create, store, respond, or transmit PHI via KETCHUM HEALTH e-mail system, internally and externally.

KETCHUM HEALTH will make all e-mail messages sent or received, related to the diagnosis or treatment of a patient, part of the patient's medical record, and will treat such e-mail messages with the same degree of confidentiality as afforded to other portions of the medical record. KETCHUM HEALTH will use reasonable means to protect the security and confidentiality of PHI transmitted electronically. Because of the risks outlined above, KETCHUM HEALTH cannot, however, guarantee the security and confidentiality of e-mail communications.

PROCEDURES:

To the most extent possible, all electronic communications and release of ePHI to patients, providers, health plans, state and federal agencies, school districts and to any other requesting third party will be performed by the Director of Healthcare Policy Compliance-

All other personnel who might need to release PHI will adhere to the following protocols:

- As a general rule, all PHI will be encrypted before being released electronically, unless the patient agrees to receive it unencrypted, and after being explained about the risks of such practice ("Duty to Inform"). KETCHUM HEALTH staff will document the patient's decision in the medical file.
- PHI will not be transmitted in the subject line of the email message.
- Email communication containing PHI of KETCHUM HEALTH patients will be transmitted through the MBKU email system using an MBKU email address and may not be transmitted using any other electronic method (other email system, IM, ICQ, FTP, etc).
- If a document that contains PHI is attached to the message, the sender must verify that only the proper information is attached and no unintended information is included.
- Users who communicate PHI via email will comply with all other KETCHUM HEALTH policies and procedures including, but not limited to, the Confidentiality of PHI Policy and the Minimum Necessary Policy.

A. Patients have the right to request their PHI and Legal Records to be disclosed electronically. KETCHUM HEALTH reserves the right to deny the request of release of PHI to the patient. If no other way of communication with the patient is available, KETCHUM HEALTH will discuss with the Director of Information Technology and the Associate Dean of Clinics the available alternatives for releasing PHI.

B. All requests for release of information via email must be specific and the intended recipient of PHI must be properly identified. Massive emails are not authorized to be sent from the KETCHUM HEALTH; it is the sole responsibility of the patient to safeguard his/her PHI after it has been released electronically. Since KETCHUM HEALTH or MBKU have no control of the uses or disclosures after the information has been released to the requesting party,

MBKU or KETCHUM HEALTH will not be held liable for unintended or malicious uses of PHI by third parties.

C. KETCHUM HEALTH will provide adequate training to email users regarding document security procedures, including password management and encryption methods. KETCHUM HEALTH has acquired software that handles the encryption process required by law, and each individual sending PHI to a requesting party via email must be knowledgeable with the software capabilities. When in doubt, the individual must communicate with the Director of Healthcare Policy Compliance to get the information released properly and timely.

To facilitate the exchange of ePHI, we will have Encryption capabilities implemented. This will be attained by using up-to-date commercial software that allows for the encryption of both the body of the email and the attachments.

2.2.5 Cyber Security at Ketchum Health

The mission of the Cyber Security Program is to support the clinic's plans for efficient growth by containing risks and threats through a combination of policies, controls, and user awareness training. The vision of the Cyber Security Program is to develop a collaborative approach to Cyber Security by instilling a continuous mindset of security into all aspects of the clinic's functions. The goal is to create a safe and secure technology infrastructure for both students and employees.

The success of the clinic depends on containing cyber risks, and a successful cyber risk management program depends on all members of the clinic. It is a collaborative engagement of processes, mindsets, and working together that will allow Ketchum Health to deliver effective healthcare and protect digital information.

The members of the clinics will need to comply with regulatory requirements from HIPAA (Health Insurance Portability and Accountability Act), PCI (Payment Card Industry) in addition to University wide cyber security policies. Departmental responsibilities include documenting compliant procedures, training clinic personnel on compliant procedures, and having checks and balances in place to ensure continuous enforcement.

Cyber Security Training

To ensure the members of the clinic are aware of the cyber threats and has a strong mindset to guard our patient's data, all new hires are required to complete a 30 minute online Cyber Security awareness course. In addition, all employees are required to complete an online Cyber Security awareness course annually. Coupled with the awareness training are assessments by way of social engineering tests via email that helps promote the practice of the cyber security training. The training process will also involve notifying the Associate Dean of Clinics and Dean of SCCO of any unsuccessful social engineer tests. For members of the clinic that have clicked

on 3 social engineering emails (internal test emails or external threats), further online training will be required.

Cyber Security Policies

The following list of Cyber Security Policies apply to all University Employees. All new hires are required to read and sign the MBKU Cyber Security Policies and Guidelines document within the first 2 weeks of starting. Managers are required to enforce the policies within their staff.

Acceptable Use Policy

With a lack of guidelines on properly assigning access or using computer systems, there is the possibility of individuals/vendors having too much access (i.e. access to our patient or personal information when not needed for their jobs) or the possibility of individuals/ vendors putting the University at risk of legal or reputational harm. This policy serves to provide guidance on how to use computer system and how to manage access to those systems.
All clinic members will need to follow an access approval process before access can be granted to any resource containing PHI.

Electronic Communication Policy

With the ability to transmit sensitive information or harmful payloads within emails or instant messages, this policy aims to provide safe usage guidelines on email or messaging systems.
All clinic members should ensure electronic communications are secure. Emails should be encrypted if it contains PHI. SMS texts conducted on personal devices should not contain PHI.

Internet Usage Policy

Without restricted access to the “Internet”, a user’s browsing activity may put the University’s network or reputation at risk. Such risks include visiting illegal sites or conducting illegal activity on the internet, unknowingly contracting malware via dangerous sites or productivity loss via personal browsing. This policy aims to provide guidance on proper usage of the Internet.
All clinic members should minimize personal usage of the internet at Ketchum Health. Any illegal or unethical internet activity is prohibited.

Password Policy

With passwords as the only layer of defense to applications and data, this policy aims to enforce the use and protection of appropriate, strong passwords that follows industry standard guidelines such as using password length requirements, complexity, and password expiration times.

All clinic members should change their passwords to any resource that contains PHI at least once a year.

Workstation Security Policy

This policy provides guidance on securing both physical and remote access to user workstations that handle sensitive information.
All clinic members should lock their workstation screen(s) when away from their computer for any prolonged period of time (i.e. more than 1 minute).

IT Incident Response Policy

The purpose of this policy is to provide a well-defined, organized approach for handling any "potential" threats/incidents to our computers or sensitive data. This policy provides guidelines on the different severity levels and types of incidents to be on the lookout for.
All clinic members should contact IT for any suspected or known cyber incidents such as clicking on a phishing email, losing their MBKU laptop, or suspected malware on their computer to name a few.

Vendor Risk Management Policy

The purpose of this policy is to manage the risks associated with third party vendors that provide critical services to MBKU. The policy ensures that MBKU properly reviews contractual requirements from third party vendors and properly manages third party vendor services to maintain MBKU's internal compliance and security requirements.
All clinic members should contact IT to conduct a vendor assessment for any potential new vendors.

3.0. AWARENESS AND TRAINING

3.1 HIPAA POLICIES AND PROCEDURES TRAINING

Awareness and training campaigns are essential components of Ketchum Health operations. All faculty, employees, interns, students, and volunteers at Ketchum Health receive training as mandated by law. HIPAA training is conducted at least once a year and is performed using different channels available and designed to achieve the maximum coverage, including video tutorials with certificates after completion.

As part of the onboarding process, new employees at the Ketchum Health are required to watch a video tutorial before engaging in any employment activity related to patient care. Once in clinic, new employees receive a document outlining the general mandates contained in this manual and are encouraged to read it entirely. Depending on their roles, new employees received customized training by the Director aimed to address specific risk topics in their respective areas. The training is conducted in person, and written materials are provided for further documentation.

After reading the training document and having the opportunity to discuss additional materials and ask questions, the employee must sign it. The Director will sign the document as well and will file it in the HIPAA training file. All new employees are explained that compliance with this training mandates is a condition of continued employment with Marshall B. Ketchum University.

When a current employee changes roles within the Ketchum Health, re-training in HIPAA privacy and security policies and procedures must occur, if the new role involves different uses of PHI.

When changes are made to this manual, each faculty and employee whose functions are affected by the change must be re-trained. Updated pages for the manual will be provided to each faculty and employee.

3.2 ROLE-BASED TRAINING

3.2.1 New Faculty, Residents, and Interns

New faculty with Clinic privileges, and interns starting their formal clinical experience at Ketchum Health must familiarize themselves with the basic rules and protocols intended to protect the confidentiality, availability, and integrity of patient information.

A. **Availability, Integrity and Confidentiality** of the medical record are essential components of the HIPAA rule.

i. *Availability.* Faculty must finalize charts within a three-day period after the patient has been seen. Only PHI from finalized charts is permitted to be released to patients or third parties.

ii. *Integrity***.** All data entered in the chart must be accurate and consistent; all charts must be reviewed and signed by the faculty provider and proof of this must be incorporated into the file for claim and billing purposes.

iii. *Confidentiality***.** Medical data should be protected from being seen or used by unauthorized individuals. Users will exercise caution while handling PHI on computers, papers, and verbally, having always in mind that confidentiality must be protected at all times

Make sure all additional exam documentation is properly scanned into patient's file (OCTs, VFs, Op reports, etc.), and review the chart to check for completeness before discarding the documents.
Please refrain from including in the chart personal comments or statements that have no direct association with the nature of the evaluation being performed or are not relevant to the exam outcome. Once the chart is finalized, it becomes a business and legal document as well.

B. **Workstation Use**. When leaving the exam room or any other workstation, users must close the medical record you are working on and lock the computer. This is to prevent unauthorized individuals to see and edit patient information, and to allow faculty to access the file in another station, if needed.

If you're granted remote access to PHI, you must adhere to the KETCHUM HEALTH remote access policy terms, and will be responsible for immediately notifying his/her service chief of any breach in the handling of such information.

C. Password Management. Passwords are intended for personal use and they are exclusively assigned to individual users to access the network. Passwords allow the system to authenticate the user, and are the basis for the electronic signature protocol in place. Under no circumstances they will be shared with any employee. Users are expected to change passwords frequently (please contact IT for guidelines on password management).

D. Authorizations and Release of PHI. As a general rule, authorization from patients is always required to release medical information to third parties, including referring doctors or PCPs. HIPAA requires that all PHI releases (except to patients themselves), be documented in the file for tracking purposes.

We can release PHI electronically via email with patients and third parties, including referring doctors, social agencies, and school districts. PHI release via email is permitted only if the information is encrypted. Please see the Director or IT assistant if you want to have any PHI encrypted before it is sent via email.

If you receive a written request for records from attorneys, patient/family advocates, or school district officials, please give all the paperwork to the Director for review and processing. To the most extent possible, please make a note in the chart every time you release PHI directly.

E. Minimum Necessary Standard. The patient file belongs to Ketchum Health, and we can limit the release of any PHI based on the HIPAA "minimum necessary" standard, unless otherwise required by law. This standard calls for the release or request of only the minimum information necessary to accomplish the intended purpose. The practice of requesting or releasing "all records" is not adequate, unless needed to provide care effectively.

If PHI is subpoenaed or required by any enforcing agency, please refer all requests to the Director to be handled properly. Under very specific circumstances, we can deny access to medical records to patients or other providers or agencies (refer to the Director for details).

F. Communications. If PHI should be shared or released, or if any patient or family member asks for PHI to be communicated in any manner, please refer to the staffing faculty or Director for guidance. Only authorized individuals can release patient's medical records, with few exceptions, such as spectacle and CL prescriptions given to patients at the end of the evaluation by interns. This also applies to verbal communications, including phone calls.

Please refrain from making statements about patient care in public areas such as halls and lobbies. Phone communications should be used as last resort when sharing PHI; Faculty will use professional judgment and they will determine when it is appropriate to use phone conversations to discuss or release PHI. If a verbal communication with a patient took place, it must be documented accordingly. Keep in mind that oral statements are part of the medical file as well.

Verbal case discussion with school officials, parents or minor's advocates should be limited and must be documented in the chart immediately. Residents will use their professional judgment, contract clauses (if any), and law guidelines, in determining the extent of PHI to be verbally discussed with third parties different than parents or school officials. Texting of PHI is not allowed due to technical limitations in our system.

G. **Compliance with Government Programs and Health Plans**. Faculty are expected to participate of government initiatives and incentive programs and adhere to the protocols and guidelines set by health plans regarding billing proceedings.

H. **Social Media**. The use of social media channels to communicate patient information or make comments about patient encounters is not allowed. Faculty and Interns must exercise professional judgment when posting information on their blogs that could potentially identify a patient or harm the reputation of the University. Please refer to his/her supervisor for social media guidelines.

I. **PHI Storage**. Under no circumstances PHI will be saved on personal thumb drives, CDs or any other digital media device. The use of cloud based applications (G-Drive, Dropbox) to save PHI is strictly prohibited. If sensitive patient data needs to be recorded in an external drive, please refer to the IT systems coordinator for assistance.

J. **Care of Minors.** When examining a minor, a responsible adult, at least 18 years of age (parent, personal representative, or any other responsible authorized person), must be present during the examination. If an adult is not present for some reason, please notify his/her supervisor regarding what protocol you must follow.. Never leave a minor unattended or wandering around while she/he is under his/her care. Please refer to the Ketchum Health Treatment of Minors policy for more guidance on this topic.

3.2.2 Administrative Assistants

It is important to understand that the medical file belongs to Ketchum Health, not to the patient. Following are the protocols to follow when release of protected health information is requested:

a. *By patients in person*

Always ask patient to fill the Release Form and hand out the release form to the Director for processing. Response is due between five (5) to eight (8) working days. By state law, we have 15 working days to complete the request. By general rule, we don't release

information the same day. Director will review the chart and make accommodations on a case-by-case basis.

b. *By family members*

We can always release spectacle or CL Rx to family members, friends and even co-workers. Beyond that, written permission is required by the patient. Director will review and grant extraordinary releases on a case-by-case basis.

c. *By third parties*

We need patient's authorization in writing. No exceptions.

d. *By payers*

By general rule, no written authorization is required (TPO). Allow claims staff to handle the request

e. *By enforcement personnel, court officials or public employees*

Pending a legal investigation. Always contact Associate Dean of Clinics and/or Director. Never release information based on a verbal statement of authority made by the individual asking for the record.

f. Phone Communications

Always exercise professional judgement. By general rule, no PHI is authorized to be released verbally or over the phone to anyone, including the patient. Only Optometrists or Interns can discuss case management or release PHI verbally to patients or their representatives.

Email Communications

To patients: By general rule, all PHI must be encrypted before sending it electronically. We can release medical records, including CL/Spectacle Rx and billing documents using non-encrypted email only when the patient approves it after she has been informed that there are risks of breaches while the unencrypted the data is in transit ("Duty to Inform"). A note must be made in the chart.

To third parties: PHI must always be encrypted, no exceptions.

Social Engineering

Defined as the practices or techniques used by scammers trying to obtain any type of information to hack the system and penetrate our network infrastructure. Phishing emails, callers claiming to be networks technicians asking for system passwords, thumb drives with malware left to be picked up by KH staff, are all examples of social engineering techniques.

Secret Shoppers

Government or auditing agencies posing as patients trying to measure the level of training, preparedness, and compliance in general, and to determine specifically how well we safeguard patient information.

Documentation

To the extent possible, every release of PHI, or any other communication which involves using or sharing PHI, should be documented in the patient's file. Documentation is the first and most effective line of defense against legal claims or litigation.

3.2.3 Patient Relations

Abbreviations and Terms

Breach: The unauthorized acquisition, access, use, or disclosure of protected health information, which compromises the security, or privacy of such information.

Encryption: the technique for transforming information in such a way it becomes unreadable, which is done through a computer software or computer application.

Identifier: Any piece of information that could be used to identify an individual:

- Individual's name
- SSN
- DOB
- Phone/fax numbers
- Zip Codes
- Medical record numbers
- Certificate/license numbers
- License plate/VIN numbers
- Health plan beneficiary numbers
- Full face photographic images
- Any account numbers.
- email addresses

PHI: Protected Health Information. Information created or received by a health care provider that relates to past, present or future physical or mental health condition, and that identifies the individual.

BA: Business Associate. A person or an entity who is not a member of a covered entity's workforce, that performs, on behalf of a covered entity, a function or activity involving the use or disclosure of PHI.

CE: Covered Entity. Any individual or entity, which is subject to HIPAA regulations

General Guidelines

Use discretion when verifying insurance information.

HIPAA Safeguard: When verifying insurance information, simply ask the patient for the "insurance card" without specifying the type of insurance plan or type. If the patient is at the clinic, provide her/him with a print-out of her insurance information for her to look over to confirm it is correct.

Do not repeat sensitive info with others present.

HIPAA Safeguard: When making appointments either over the phone or in person, checking patients in or out, or helping patients to complete intake forms, please refrain from repeating personal information over. Unless patient relations staff is stationed in their own cubicle or office, far from the ears of others, they should *not* read or repeat back personal information provided by patients.

Have the staff member taking down appointments ask the person who has called to repeat back the information that person has just given his/her staff member--rather than the other way around. That way the person calling for the appointment is saying her personal information out loud rather than the office saying it out loud with others waiting in the reception or check-out area.

Turn over sensitive documents and turn computer screen away.

HIPAA Safeguard: When handling print-outs of patient information (e.g. fee slips, intake forms, medical Hx, copy of insurance cards, etc.) don't leave the documents facing up unattended; all documents containing protected health care information must be placed facing down and away from public reach.

Keep all computer screens turned away from patients' view. Patient relations staff is not supposed to show PHI to patients or patient's representatives directly from computer screens.

Telephone conversations with patients - release of PHI over the phone, or in person

HIPAA Safeguard*:* Releasing protected health information or any other patient related data over the phone is not allowed, even if you're able to identify the caller. Discussing PHI over the phone with patients, family, friends or third parties (health plans, school districts, social agencies etc.) should be avoided at all times; we need to explain to the caller that patient relations staff are not doctors and, therefore, no details from the chart are allowed to be released verbally. Even when law enforcement personnel or insurance plans representatives call, we don't provide information over the phone. Please refer any request for release of PHI over the phone to his/her supervisor or Director for protocols observance.

Spectacle and contact lens prescriptions are allowed to be released to patients or family members who ask for them. Any other release regarding PHI must be consulted with his/her supervisor first.

Work station use and password management.

HIPAA Safeguard*:* If you're leaving his/her work station for extended time, you must lock his/her computer following the protocols established by his/her supervisor. Passwords are for personal use and they're not to be shared under any circumstances. Please don't write his/her password on sticky notes and place them near his/her workstation. Make sure you change his/her password frequently (please contact IT for guidelines on password management).

Care of minors.

HIPAA Safeguard*:* The University Eye Center has a very strict policy regarding the care of minors and this should be clearly explained to parents or guardians who want to leave their minors unattended during the examination. Under limited circumstances, the University Eye Center will allow minors of certain age to be seen without their parents or legal guardians being present. It is not the responsibility of patient relations staff to safeguard any unattended minor. Please refer to his/her supervisor for guidelines.

Release of patient's PHI to family members and friends.

HIPAA Safeguard*:* In general, release of PHI to third parties requires authorization from the patient or patient's representative. There are certain occasions in which we can release PHI to third parties without previous authorization from patient: spectacle and CL Rxs; certain records such as summary letters or case reports; treatment plans. Patient relations personnel must always refer to the Director or their Supervisor for additional guidelines on these types of releases.

Don't publicize diagnosis and treatment plan at check-out.

***HIPAA Safeguard*:** When creating follow-up appointments for specific conditions, please leave out the diagnosis while communicating the time and date to the patient.

Access to medical files and personal conversations about patients.

HIPAA Safeguard*:* Access to patient medical files by employees must be justified and only allowed when needed for business purposes, and to the extent required to perform the related treatment or health care operations.

Staff must refrain from engaging in personal conversations in public areas with other co-workers regarding patients seen at the KETCHUM HEALTH.

Sending PHI to patients via email.

HIPAA Safeguard*:* When a patient requests that PHI her electronically be communicated electronically, we must comply and proceed accordingly. However, this release process must follow strict security protocols (encryption) and only authorized personnel are allowed to do it. If a patient requests her/his medical records to be emailed, please refer to the Director.

Social Media.

HIPAA Safeguard: The use of social media channels to communicate patient information or make comments about patient encounters is not allowed, and employees must exercise professional judgment when posting information on their blogs that could potentially identify a patient or harm the reputation of the University. Please refer to his/her supervisor for social media guidelines.

Proper disposal of papers and documents containing PHI

HIPAA Safeguard*:* All papers containing PHI that are discarded, must be destroyed properly, using a shredding device or services of a certified document destruction company. If some papers need to be kept for future tasks, please coordinate with his/her supervisor about the best location to place them until they are used or required.

4.0 CLINIC OPERATIONS

4.1 GENERAL EMPLOYEE POLICIES AND PROCEDURES

4.1.1 Professional Standards and Dress Code

The University's professional atmosphere is maintained in part, by the image that employees present to patients, students, other employees and visitors. Employees are expected to dress neatly and in business attire that is consistent with the nature of the work performed and is appropriate for a professional health care environment. Acceptable clothing for employees includes suits, sport coats, or dress shirts and slacks, blouses and sweaters with skirts or dress slacks or dresses.

Casual sportswear, e.g. jeans, shorts, along with tight fitting leather, tight fitting knits and mini-length skirts or dresses, T-shirts, tank, halter or low-cut tops, and tennis shoes, casual sandals and flip flops are not considered appropriate and should not be worn to work. All clothing should be clean and without rips or holes. This list is an example of inappropriate dress and should not be considered a complete list. Employees who report to work inappropriately dressed may be asked to clock out and return back to work in acceptable attire. Department Directors may issue more specific guidelines beyond these.

Hair must be clean and demonstrate evidence of good grooming and styling. Beards and moustaches, when neat and groomed, are permissible. Jewelry should be conservative. Body piercing that goes beyond normal, conservative ear piercing, does not promote the health conscious image that the University wants to depict to its patients and therefore should be avoided. For the same reason, tattoos are to be covered by clothing.

Because of the presence of patients, employees working in the Clinic are held to a higher standard. Employees who are provided with a uniform should keep them in a neat and clean condition. Employees provided with uniforms must wear them at all times while on duty. Employees are required to return their uniforms in a timely manner upon termination of their employment. If there are any questions as to what constitutes proper attire within a given department, the supervisor or department head should be consulted in advance.

4.1.2 Clinic Appearance and Dress

All Employees must be presentable when reporting to work. Since you will be interacting with patients, the initial impression conveyed is extremely important. The clinical staff and faculty will set the example in applying these standards. If you do not dress appropriately, you may be asked to clock out and change his/her attire to meet the profession standards set forth.

The standards of dress for all employees entering the clinic shall be in effect in all clinics during any hour or day that clinics are open. These standards for the clinic apply during Clinical Seminars as well. The dress code applies to all KETCHUM HEALTH Students, Staff and Faculty.

The Associate Dean of Clinics ultimately determines if an individual's overall appearance is acceptable. If it is decided that the appearance or grooming is unduly distracting or inappropriate for the clinic, the individual may be sent home to change). Disciplinary actions may take place after the first warning.

The following are some examples of both appropriate and inappropriate attire. When in doubt if something is appropriate, it is best to contact the Associate Dean of Clinics prior to wearing it.

- Regular bathing is imperative to each person's appearance. Please present to clinic in a hygienic manner. Anyone found to have any offensive odors may be asked to leave clinic.
- Long hair should be tied back during exams to prevent it falling in his/her face and the face of his/her patients.
- Nail grooming which is profoundly unnatural or inappropriate to a health care environment is not allowed.
- Perfume and after-shave should be used sparingly
- Permanent or semi-permanent tattoos are to be covered and not visible when in the clinic.
- Blouses, shirts, and dresses should not be revealing in any way.
- Do not wear short or extremely tight-fitting skirts or dresses. Any skirt or slits in the skirt or dress nearing 3+ inches above the middle of the knee is to be avoided.
- Slacks or trousers must be clean, pressed and appropriate for a health care office. The following are inappropriate: shorts, skorts, stirrup or stretch pants, skinny or tight-fitting pants.
- Clothing, accessories and overall grooming should be conservative. Men are not to wear earrings while scheduled in the clinic. Earrings placed anywhere other than the ear lobes are not acceptable.
- Socks for men are to be worn at all times.
- Ties for men are optional while in the clinic
- Hosiery is to be worn with dresses and skirts that are above the knee.
- Footwear should complement his/her professional attire. Inappropriate shoes include sneakers (unless worn with scrubs), sandals, flip-flops, and slipper type shoes.
- Denim and leather clothing of any kind should be avoided because it is overly casual.
- Scrubs maybe worn by students, staff and faculty.

Note: Please refer to MBKU Employee Handbook for all other policies and procedures

4.2 UNIVERSITY EYE CENTER

4.2.1 The University Eye Center at Ketchum Health

The University Eye Center at Ketchum Health (UECKH) is the clinical training facility of the Southern California College of Optometry at Marshall B. Ketchum University. The goal of the center is to provide our patient with the highest quality vision care possible. Our providers are licensed doctors of optometry as well as student-interns and train with the latest techniques and

procedures in eye and vision care. The University Eye Center is proactive in providing and promoting preventive care for all of our patients. The University Eye Center at Ketchum Health has a number of specialty departments that can help patients from a few months old to 100 years old. The services offered at UECKH includes Primary Care, Ocular Disease, Low Vision Pediatric Care, Vision Therapy, Contact lenses, and Optical Services. Specialty Clinical Services offered are Dry Eye Clinic, Sports Vision and Myopia Control Clinic.

Comprehensive Examination

At The University Eye Center at KH, a comprehensive eye/vision examination takes approximately 90 minutes. An Intern is under the direct supervision of a licensed Optometrist during all phases of the exam. The comprehensive examination includes the following: Health History Review, Occupational or Educational requirements, Medication reconciliation, Examination of visual system (refraction, eye muscle teaming & focusing), Ocular Health evaluation (external and internal) this includes dilation to examine the retina, Retinal photography and peripheral vision testing.

Faculty

The Faculty at The University Eye Center includes some of the world's top authorities in Family Practice, Cornea and Contact Lens, Pediatrics, Vision Therapy, Low Vision, Ocular Disease and Special Testing (Electrophysiology). In addition to providing the highest quality of patient care, In addition to clinical care, several of our faculty members are actively involved with national research projects such as PEDIG, CITT, dry eye disease, macular degeneration and myopia control.

Payment for Services Overview

The University Eye Center accepts payment for services and materials by cash, check (with current state ID) Mastercard, AMEX, Visa, and Discover Credit cards. UECKH is a paneled provider for Vision Service Plan (VSP), Medical Eye Services (MES), Medi-Cal, Medicare, and a number of other vision and medical insurance programs. Please check with claims as this list is evolving.

Approach to Customer Service

The first steps to great customer service are easy to do, inexpensive, and generate an immediate positive image of the Clinic.

Step 1 is just simply a smile and a hello when someone walks in the door. Step 2 is just as easy and effective. Ask how you can help someone.

Following these key steps can translated into a great patient experience. People who have received good service also tend to become ambassadors for our clinic. When dealing with complaints, it is an opportunity to show our patient we are dedicated to our services. Six out of ten individuals would return to a business that handled their complaint satisfactorily. Some

research suggests that if we can remedy the complaint efficiently, the patient may increase the referrals.

Always remember to ask the patient(s), how was their visit and thank them for making University Eye Center their eye care provider.
Here are some of the other components of good customer service:

- Respond promptly
- Resolve issues quickly
- Listen
- Keep his/her promises
- Give more than expected
- Help even if it does not have an immediate return for you
- Make sure you and all his/her employees offer this assistance

Clinic Hours

- Monday (8 am to 5 pm)
- Tuesday (8 am to 5 pm)
- Wednesday (8 am to 6 pm)
- Thursday (8 am to 5 pm)
- Friday (8 am to 5 pm)
- Saturday (8 am to 5 pm)

Appointment Book colors

- Blue is for Primary Care.
- Gray is for Pediatrics
- Yellow is Contact Lens
- Pink is for Ocular Disease
- Turquoise is for Low Vision
- Purple is for Vision Therapy

4.2.2 Answering Phones Protocol

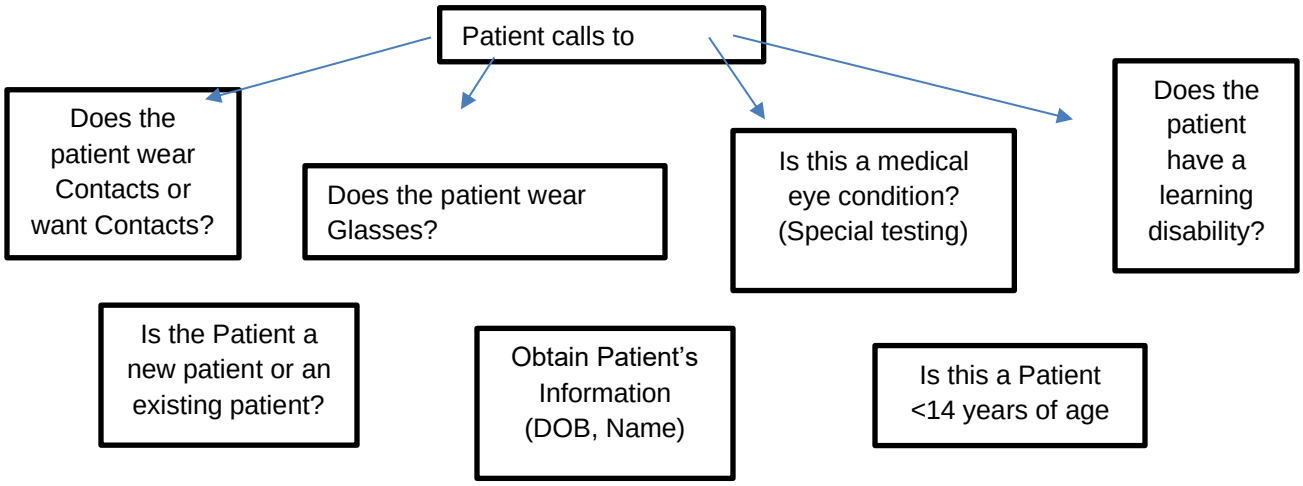
The purpose of this protocol is to establish a process in handling phone calls and determining the appropriate department the call must be directed to.

Procedure:

- Answer the call in a professional manner with a friendly tone and be sure to introduce yourself.
- Try to obtain as much information regarding the patient's reason for the visit to determine if you can help them schedule or must direct them to a specific department.

- Confirm contact information is accurate in the chart.
- Shoretel phones with Mitel system are used to find extensions and to listen to voicemails.

"Thank you for calling Ketchum Health, this is _____ speaking. How may I help you?



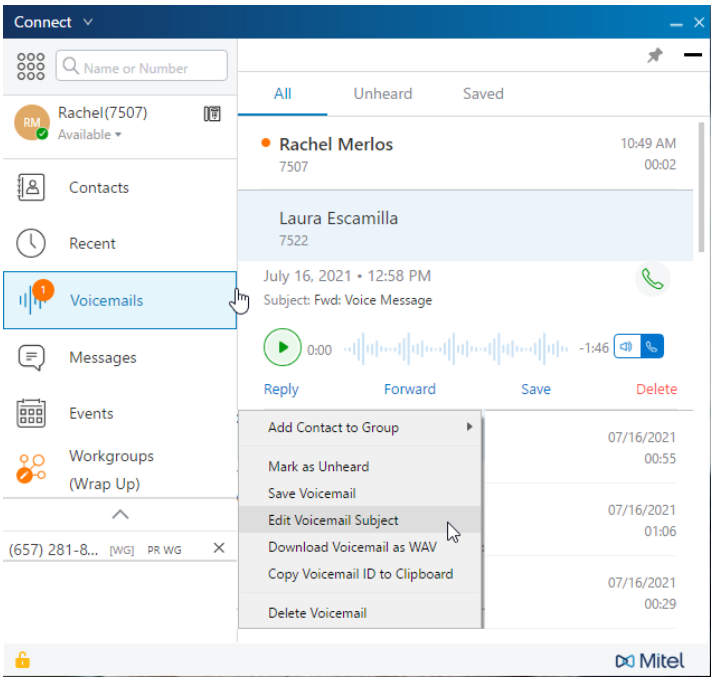
What is a Blind Transfer?
Transferring a call without consulting with the person on the receiving end.

How to use your phone

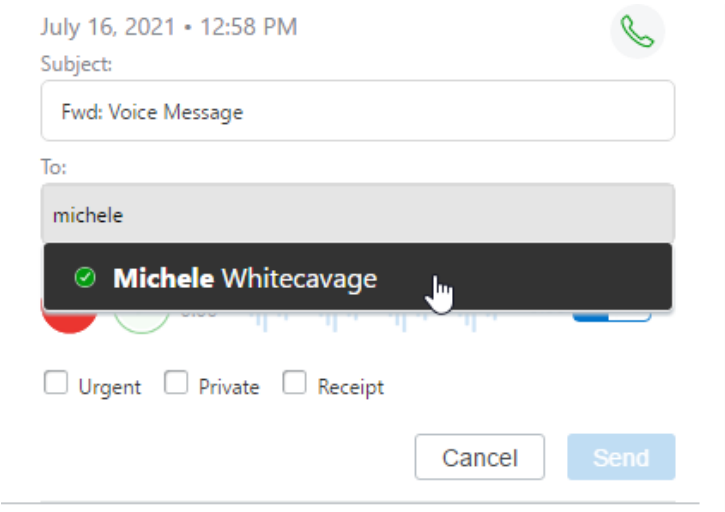
- To receive calls, you must log in/unwrap, depending on the phone.
- Transferring calls
  i. Make you are on the line that needs to be transferred (line with lit up green)
  ii. Press *transfer* + the *extension* and then *transfer* again**.**
  iii. When done with the day, make sure to log out/wrap up of your phone.

Listening to Voice Mails

a. The phone system we use is Mitel, located on your PC.
b. Double click on the Mitel icon.



c. The ● **bolded** names/numbers are the unheard voicemails.
d. To **forward** a voicemail to an extension, right click on the voicemail, select **Edit Voicemail Subject** from the popup menu and it will make the Forward option viewable.
e. Click on **Forward.**
f. Search for the person you need and press **send**.



g. After you have sent the voicemail to the correct person, you can click on **delete.**

4.2.3 Patient Charting Protocol

The purpose of this protocol is to establish a process when creating a patient's chart.

Procedure:

1. Log into EMR system.
2. Click on **Search** icon at the top left of the screen.
3. Enter the patient's date of birth and click **Search** to determine if patient has an existing chart.
4. If no chart found, create a new chart by clicking **Add** icon at the top left of the screen.
5. Click on **New Account**.
6. Complete *Edit Patient Demographics* screen and click Chart.
    a. Name
    b. DOB
    c. Address
    d. Phone Number
    e. Email Address
    f. Sex
    g. Guarantor Information
    h. SSN (last 4)
    i. Insurance information
7. If the patient has signed the Privacy Notice, choose dates it was signed/scanned in.

4.2.4 Scheduling an Appointment

Purpose:

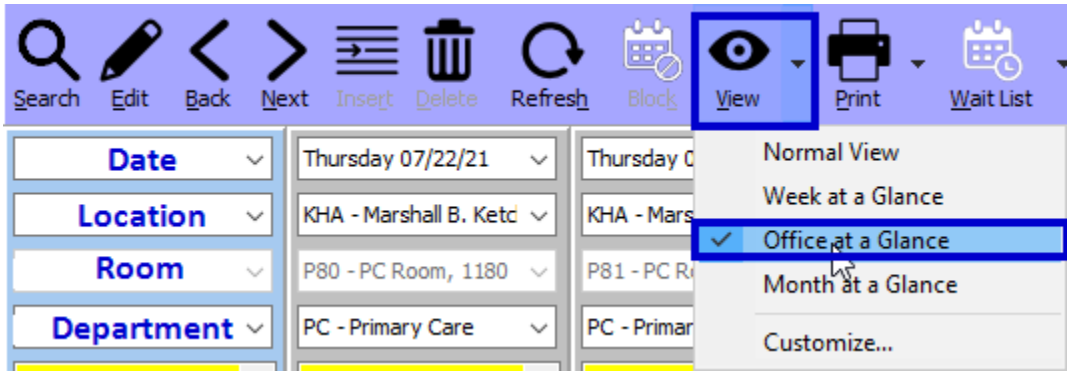
The purpose of this protocol is to establish a process in scheduling appointment(s) in Compulink.

Procedure:

1. Determine if the patient is a *New* or *Established by asking the patient if they are new or returning*.
    a. *New* or *Established*?
        i. If ***Established****,* review the chart history to determine if patient has been seen in a particular department.
        ii. If the Patient is ***New,*** search to confirm patient does not have a chart. If none, create a chart.
2. Determine what kind of appointment patient would like to set:
    a. Patient is having blurry vision and would like a comprehensive eye exam.
    b. Patient is experiencing pain, discomfort, or a problem that they would like the doctor to focus on.
3. Determine Patient's appointment preference, such as day and time.
4. Is the Patient interested in Glasses and/or Contacts Lens?
    a. If the Patient only wants glasses, schedule the appointment in **Primary Care**.
    b. If the Patients wants *both*, schedule the appointment in **Contact Lens Department**
5. Is the appointment emergent or associated with a medical eye condition?
    a. Glaucoma
    b. Cataracts
    c. Problem Focusing
    d. Red Eye
    e. Foreign Body
6. Ask the patient for their insurance information.
    a. If the appointment is just for an annual exam, this would be covered by Vision Insurances the clinic is contracted with.
    b. If the appointment is Medical, we accept the following PPO Medical Insurances:
        i. Blue Cross
        ii. BlueShield (PPO)
        iv. Cigna (PPO)
        v. Medicare (non HMO)
        vi. Health Net
        vii. Medi-Cal (straight)
        viii. Cal Optima (Direct, Community, Altamed, One Care, Prospect)
        ix. Medicare Advantage (Anthem, United Health, Aetna)
        x. Altamed
        xi. Prospect Medical

Adding a New Appointment

1. You must be on the chart of the patient for whom you are creating the appointment. If they are new, you must create the chart.
2. Click the **Appointment** icon at the top of the screen to access the Clinic Schedule.
3. Select the correct Date, Location, and Department.
4. Confirm you are using View setting: Office at a glance to view all rooms available.



5. Double-click on a desired appointment slot. In the primary care department, there are 3 time slot options for both AM & PM appointments:
    a. Annual exams can be placed into the first 2 time slots.
    b. The 3rd time slot is reserved for DFEs and Follow Ups.
6. Complete the fields as described in **Appendix A** seen below.
    a. Required fields will not allow you to continue to another window until complete:
        - Reason (Event type)
        - Plan
7. Select a **Reason** (Type of Appointment) from the dropdown menu.
8. In the Detail section, enter the copay for the exam, medical insurances information and any important appointment information. (SEE appointment cheat sheet)
9. Add insurances and authorization to the appointment. (See Attaching Insurance Verification Protocol)
10. Click **Save** to complete the creation of the appointment.
11. Scan insurance authorizations or eligibility under Scanned Documents (except VSP Authorizations)

Rescheduling an appointment:

1. Locate the appointment in the schedule.
2. Right click on the appointment.
3. **Click** on "**Cut**".
4. Find the new appointment slot.
5. **Right click** on the and click "**Paste**".

Appendix A

Field	Description
Date and Time	Select the date and time of the appointment or accept the default date and time.
Reason	Select an event from the drop-down list. This field is required.
Duration	The duration defaults to the value assigned to the event in Scheduling Administration. The application automatically recalculates the duration time when resources with override duration times are selected. You can manually override the duration unless an event chain is selected.
Service Location	If an appointment template with a location has been assigned to the slot selected, the location defaults from the template.
Comments	Enter notes regarding prices quoted to patient and any notes or appointment description that may be important for the doctor to know.
Status:	You can indicate the patient's appointment status by changing their status in the chart. If the patient confirmed, kept, canceled, or no showed their appointment it can be updated by selecting from the drop down menu.

Appointment Details

Procedure

Purpose: To make sure, when making an appointment, the correct details are listed in the correct manner.
Procedure:
Collect all information over the phone.

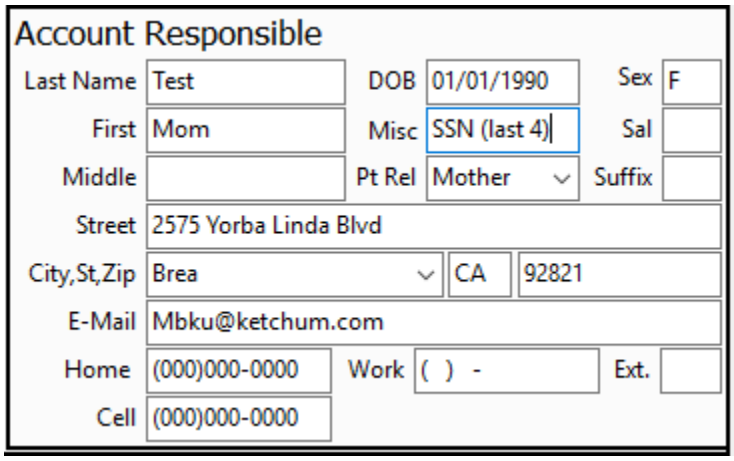
- NO *filler* addresses.
- Include Address, contact phone number, email address, first & last name and insurance information.

Attaching Insurances

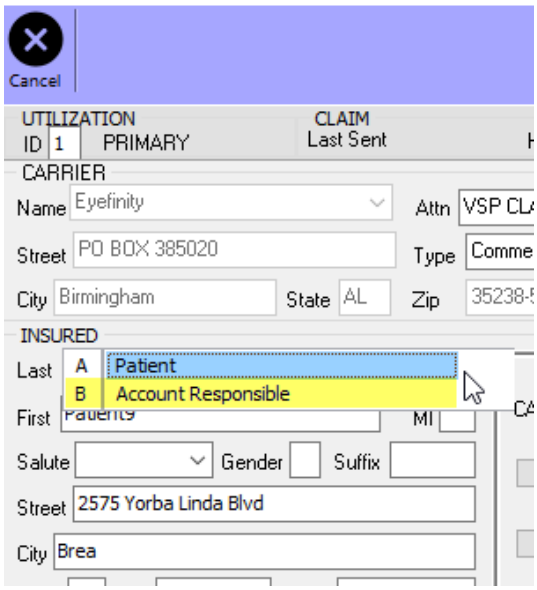
1. Confirm insurance holder's first & last name, DOB, insurance name and full member ID.
2. In the Insurance box hover over the 3 dots ⋮ and select Add.
3. Add/Edit In window will appear:
    a. ID: selects the placement of the insurance.

1	Primary	
2	Secondary	
3	Tertiary	
O	Optical	(Vision)
P	Pool	(Not in use)

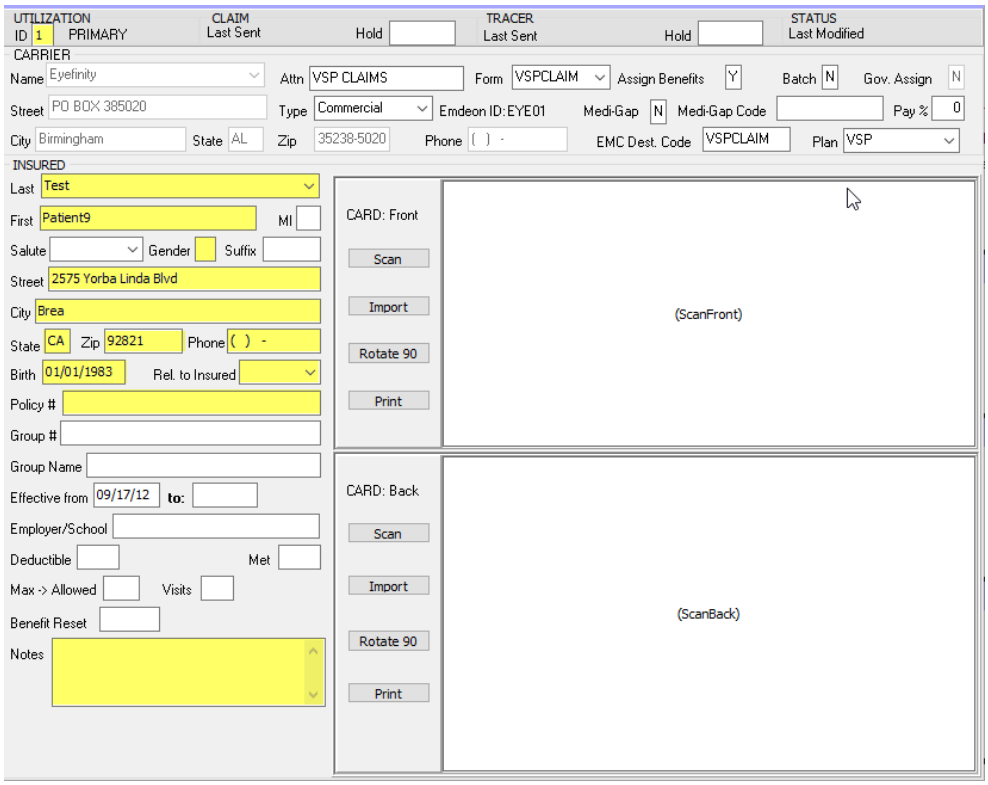
4. If no insurance has been added and the patient is underage, you will need to add an Account Responsible
    a. Open Patient Information window.
    b. Complete Account Responsible portion on the bottom right-hand corner.



5. Add appropriate insurance under the correct primary
    a. If the primary is the Account Responsible select Account Responsible under INSURED. This will auto populate the information you have already saved.

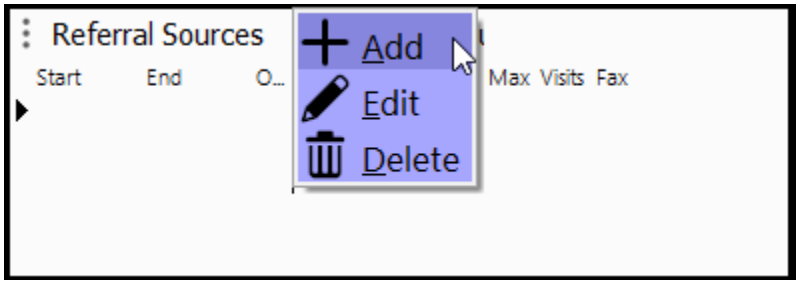


    b. If the primary is neither the patient nor the account responsible, still choose account responsible and manually override the INSURED information.
    c. Complete the following fields:

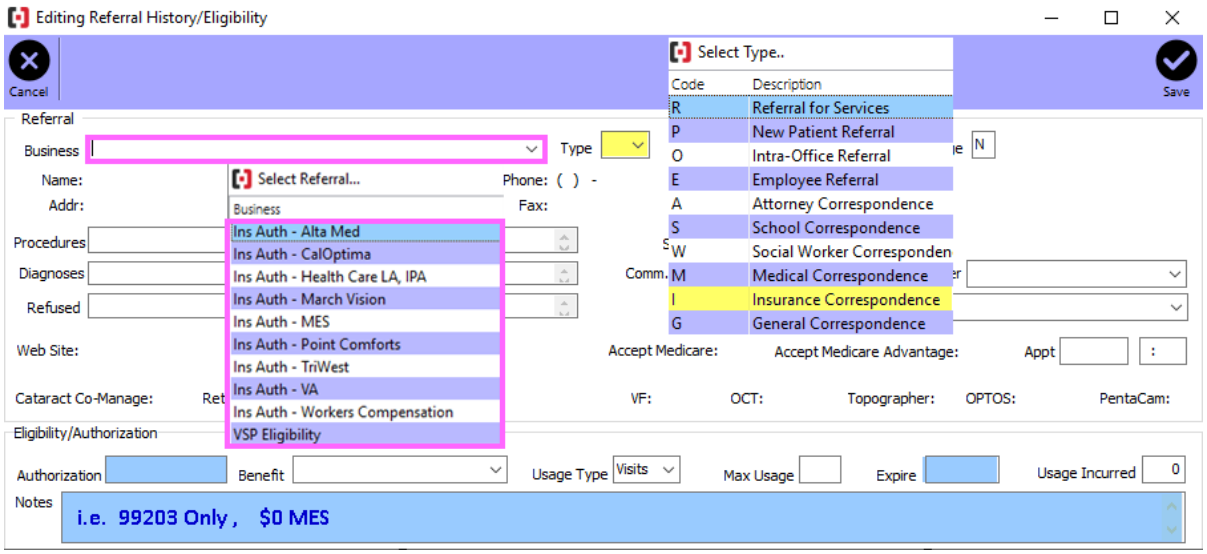


d. Click Save.

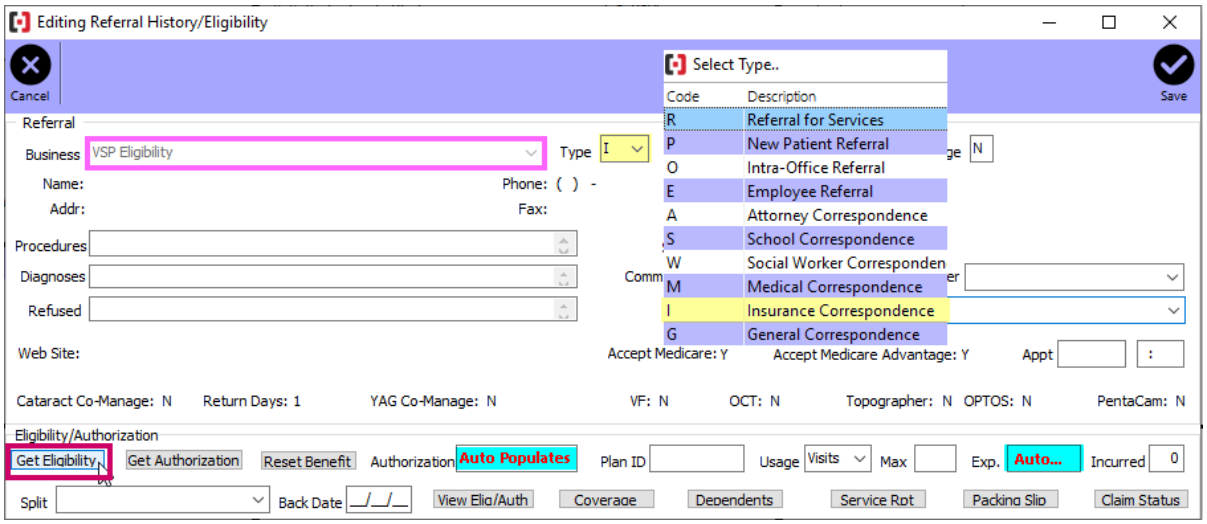
6. Attach Authorization number.
   a. Click Add in the Referral Sources window.



   b. Select insurance type from the **Business** drop down menu.
   c. Select Insurance Correspondence from **Type** drop down menu
   d. Non VSP Authorization, complete the following fields:



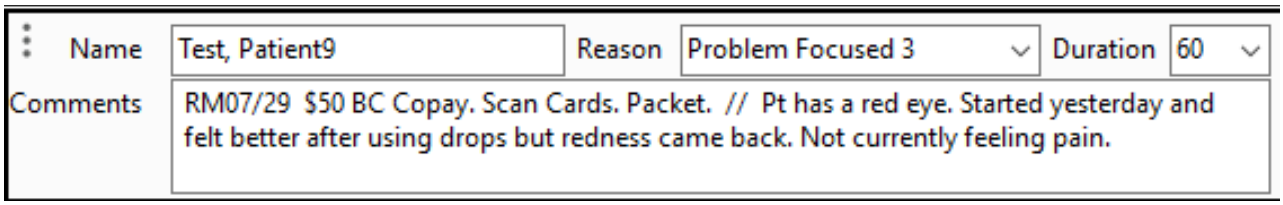
e. VSP Authorization, complete the following fields and click on Get Eligibility:



Comments:

1. When adding the details to the appointment, make sure you have verified all insurances before adding them. (i.e. vision & medical)
2. If the patient is coming in for a *vision exam*, you would put the copay first and then the name of the vision insurance. If the patient did not give you their medical insurance over the phone, make sure to add a note to SCAN CARDS ahead of all other notes so Patient Relations can catch it.
3. If the patient is coming in for a M*edical Visit; once verified, you* would put the copay first, followed by medical insurance name and notate if it's a PPO. If it is an insurance that we are not contracted with, you would quote the patient according to what type of appointment it may be. (i.e.: $35 Anthem PPO)
4. Include initials and date of insurance verification.
5. If the patient has *no insurance*, make sure the patient is quoted the correct amount and add a notation. (i.e.: Q: $159 Verify No insurance.)
6. Any other insurance the doctor may need to know should be started with "//". (i.e. // Glaucoma work-up, // Patient feeling pain in right eye, // Office visit + OCT)

Below is an example of how the Comment section should look when scheduling an appointment.



4.2.5 Patient Check-In Protocol

The purpose of this protocol is to establish an efficient check-in process.

Procedure:

1. At Triage: Greet patient and verify they are checking in for an appointment.
2. At Triage: Take temperature and complete covid screening.
3. At Triage: Mark patient as Arrived in compulink
4. At Triage: Direct patient to front Desk to check-in.
5. Greet patient
6. Request ID and insurance cards. Scan into chart.
7. Direct patient to scan QR code for online form or hand patient printed forms if requested.
8. Review and resolve issues noted on appointment comments (i.e. verify insurance at check in, collect balance at check-in, Must sign ABN)
9. Direct patient to have a seat while they complete forms.
10. Once forms are received, mark patient Ready for Pick-up to alert intern and doctor that patient is ready to be seen.
11. Enter all data as promptly as possible so that any prescriptions or exams reports printed in the back by the doctor has accurate patient information.
12. Scan all forms and shred.
13. Make sure to keep communication with patients and doctors if wait time is exceeding 5 minutes.
14. Patients should not be waiting more than 15 minutes. Alert Supervisor if patient is waiting too long.

4.2.6 Verifying Insurance Protocol

The purpose of this protocol is to establish a process in verifying and attaching insurances to appointments. Attaching insurance, allows the patient's exam and/or materials to be covered by their benefits.

Procedures:

Review:

1. Vison Plans Ketchum Health accepts:

    a. Eye-Med
    b. Eye-Med (through Humana, Aetna, Anthem BCBS, Anthem BC)

c. Envolve (through Healthnet/Medi-Cal)
d. Humana Comp Benefits
e. March Vision
f. Medical Eye Service (MES)
g. Medi-Cal
h. Medicare Advantage Plans (PPO) – If they have vision benefits
i. MetLife though VSP
j. Premier
k. Spectera
l. Vision Service Plan (VSP)
m. Cal-Optima Direct (if no separate vision plan)
n. Cal-Optima Community (if no separate vision plan)

2. Medical Plans Ketchum Health accepts:

o. **Accepted**
    i. Anthem Blue Cross PPO.
    ii. Cigna PPO
    iii. Blue Shield PPO
    iv. Medi-Care (non HMO)
    v. Medi-Care Advantage PPO (BC, Aetna, United Health Care)
    vi. Cal Optima
        - **Direct**
        - **Community** (Only *Established* patients)

p. **By Referral/Pre-authorization only**
    i. HealthNet (HMO included)
    ii. Cal Optima
        - Community (If *new* patient: needs referral/pre-auth)
        - Prospect
        - Altamed
    iii. Prospect Medical Group
    iv. TriWest VA
    v. AltaMed
    vi. Southern California United Food & Commercial Workers Union
    vii. QTC Medical Services
    viii. Crittenton Point Comforts

Pulling Authorizations/Checking Eligibility

Each insurance requires different fields to be filled in when searching for eligibility.

You may need the following from the *Primary* on the insurance.

- Last name, First name
- DOB

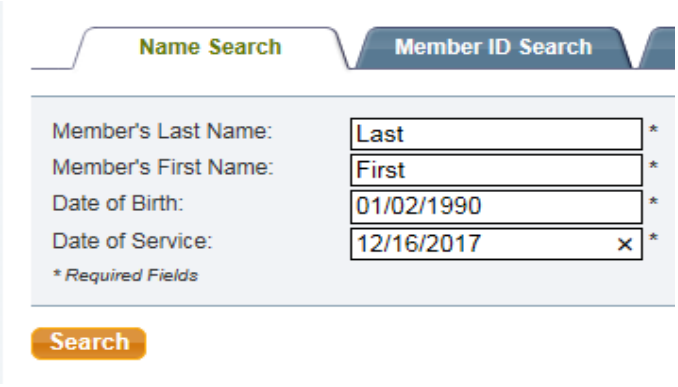
- Member ID number
- Last four digits of SSN

Eye-Med

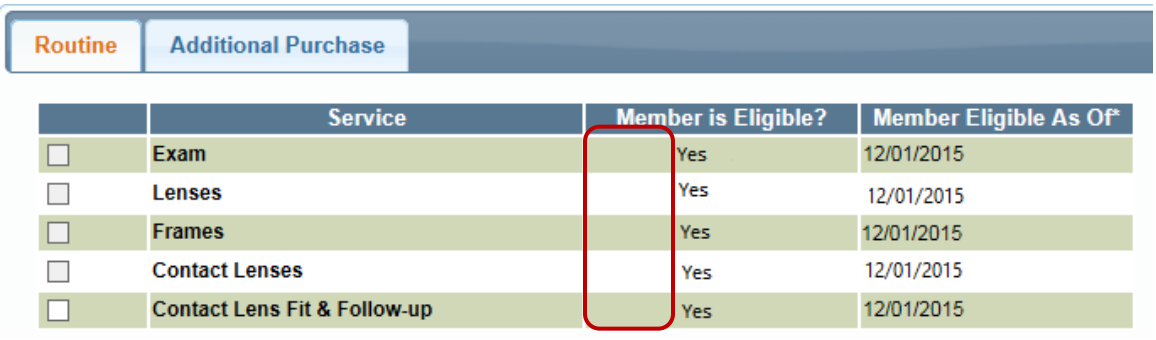
Requires:

a. Last Name, First Name
b. DOB
c. Date of Service
d. Member ID
e. Staffing Doctor

Note: With Eye-Med, ***Date of Service*** **is date patient** ***has appointment*****,** NOT the day you're verifying insurance.

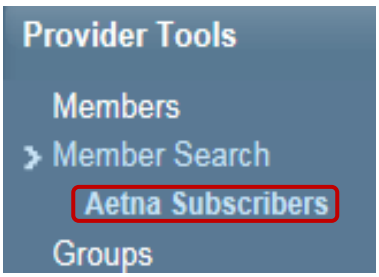


Eye-Med plans will not give authorization codes, like the example below:



In this case, verify that member is eligible for services and print out the eligibility with *member benefits*. Attach insurance and authorization number when available.

Eye-Med (Aetna)



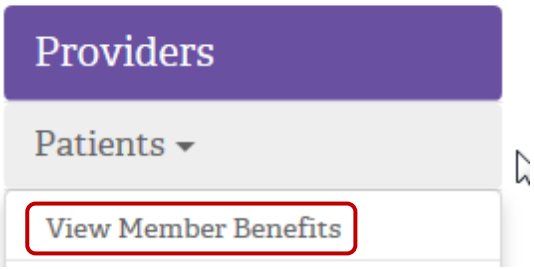
Envolve (through Healthnet/Medi-Cal)

Requires:

- Member ID
- Date of Service
- Physician

Once logged in:

Under *Patients,* choose *View Member Benefits*



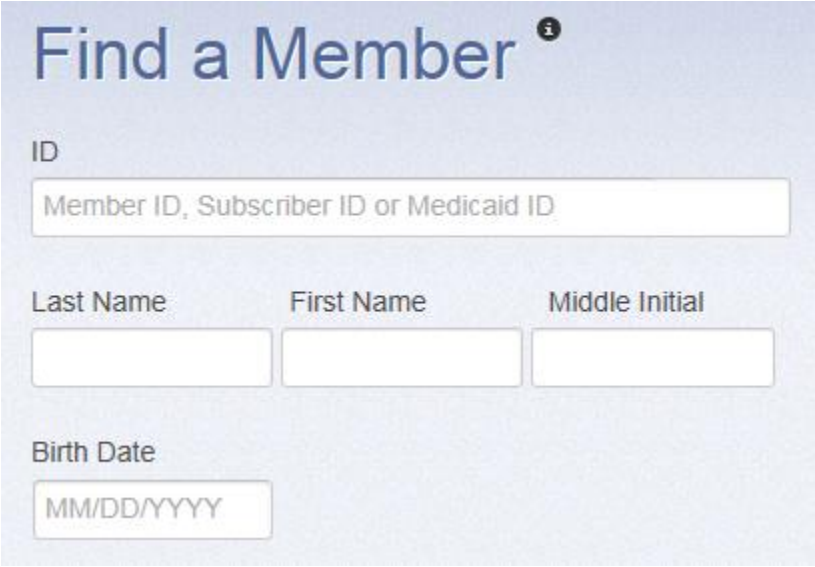
Fill in required fields:

Envolve Vision *does not* give an Authorization number, only allows you to verify eligibility. Verify patient is eligible for services, print eligibility, attach insurance, and scan.

March Vision

Requires:

- Member ID
- Last Name, First Name
- DOB



This insurance *does* give an authorization.

Review insurance for eligible benefits and pull authorization. Attach insurance and Authorization.

Medical Eye Service (MES)

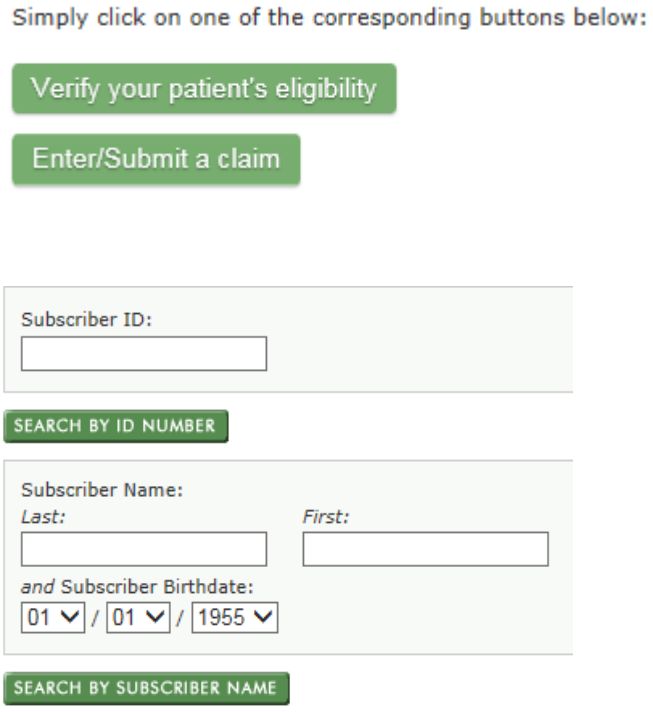
Requires:

- Member ID (Also happens to be Primary's *full* SSN)

Or

- Last Name, First Name
- DOB

Note: All information needed is for Primary on the insurance.



Always try both methods. If Member ID does not work, try searching by name and DOB. Sometimes ID numbers change or patients give shortened names instead of legal names. (i.e. Mike for Michael)

This insurance *does* provide authorization number. Verify eligibility of service needed for specific patient. Pull authorization, attach insurance and authorization to appointment, and scan.

Medi-Cal

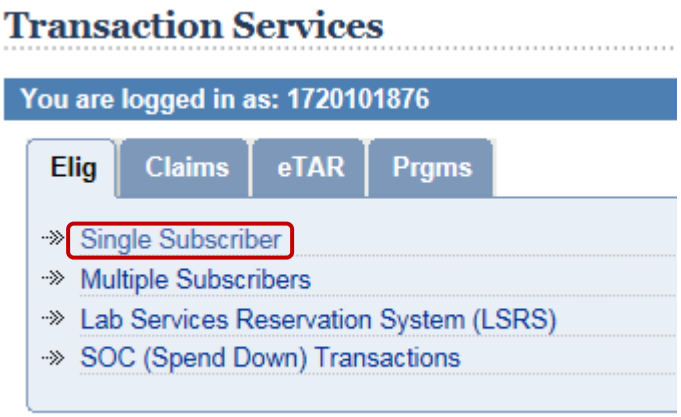
Requires:

- Full Member ID (There should be 5 digits after the letter)
- DOB
- Issue Date (Found on Medi-Cal Card)
- Service Date (Today's date)

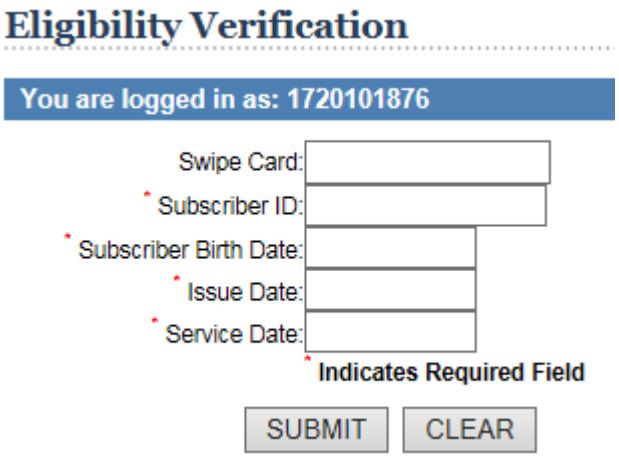
Note: When scheduling, let the patient know they need to bring their Medi-Cal ID or letter from Medi-Cal that shows card information with correct Issue Date. This is **required** to bill, if they do not have it they will have to reschedule for a different date when they are able to provide their card.

Once logged in:

Click on *Single Subscriber*



Fill required fields.



Medi-Cal *does not* give authorizations. Verify patient is eligible for benefits.

- Patients are covered for Exam and Glasses for every 2 years.
- If it has been more than a year but less than two years, they can be eligible for interim benefits. (SEE interim benefits protocol)

Attach insurance and scan.

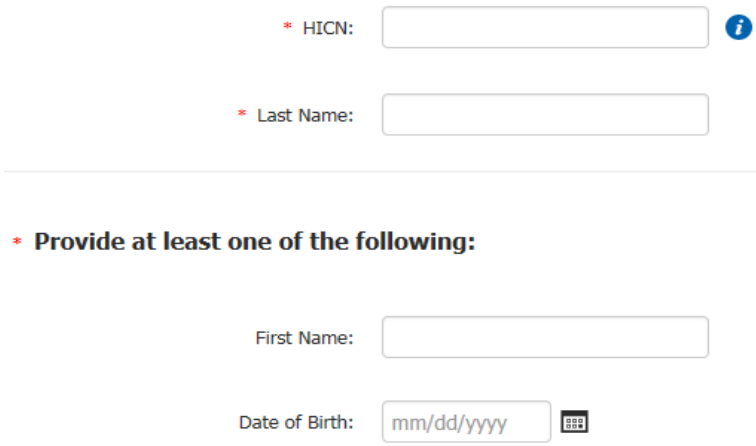
Medicare Advantage Plans (PPO) – If they have vision benefits

*Medicare Member ID is a 9 digit number including numbers and letters.
Requires:

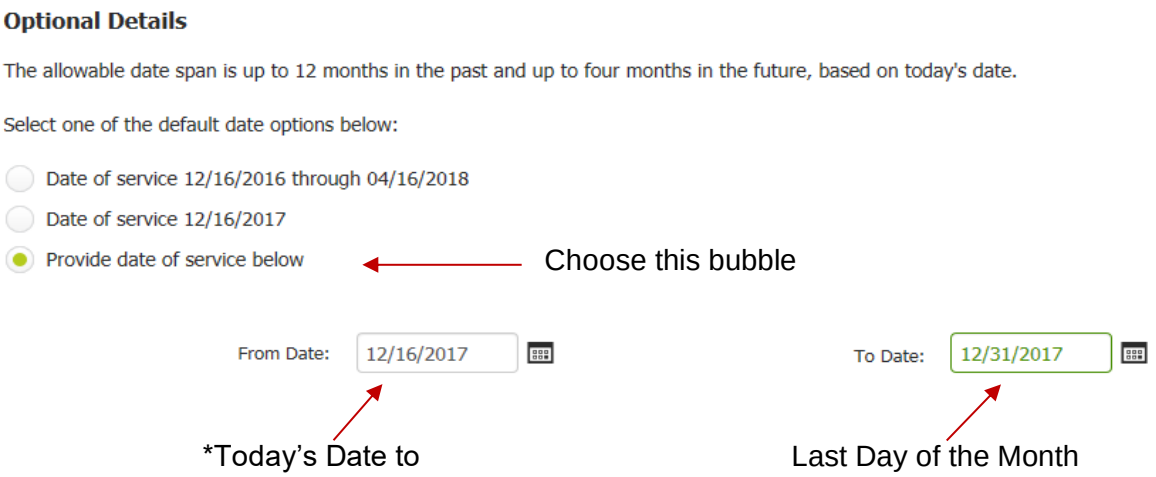
- Member ID (HICN)
- Last Name
- First Name

Or

- Member ID (HICN)
- Last Name
- DOB



In *Optional Details* change date of service range:



1. We pull for the rest of the month in case they come back for a follow
2. We re-verify if their follow up is scheduled for the next month.

    a. Medi-Care does not give authorizations. Verify Eligibility, attach insurance, and scan.

3. When pulling insurance, you are verifying that the insurance is active, not an HMO and whether Medicare is the primary payer or a secondary payer.

4. **For an eye exam**, if Medicare is the primary payer, (with a medical diagnosis) Medicare will cover 80% of the services. The secondary insurance will cover the rest leaving the patient balance with a $20 fee.

    - The **refraction is NOT** covered by Medicare & secondary payer.
    - Usually a curtesy senior discount, (20% off) is applied leaving the patient balance of $16.

Spectera

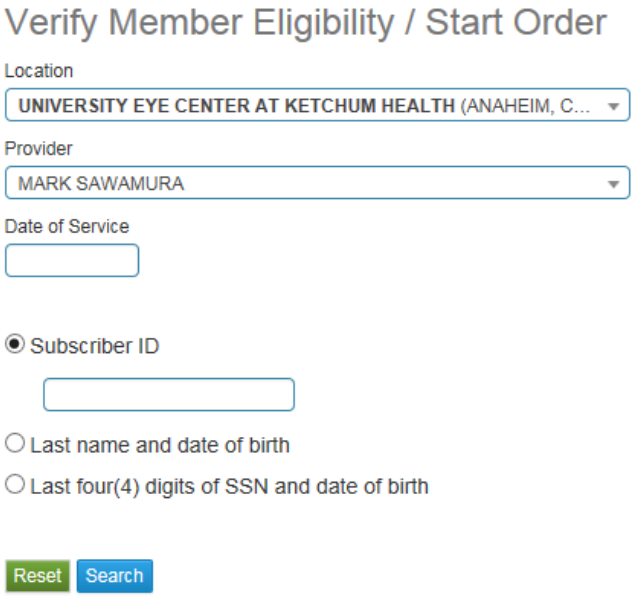
- Requires:
- Date of Service
- Subscriber ID

Or

- Last Name
- DOB

Or

- Last 4 of SSN
- DOB



Fill in Required Fields:

Spectera *does not* give authorizations. Insurance is verified and attached when scheduling appointment and **must be *re-verified* day of** to make sure benefits have not been used since appointment was scheduled.

- Have patient sign print-out of insurance eligibility when checking in. Scan signed eligibility.

- Let the patient know the reason for their signature:

"Your signature allows us to bill this insurance. States that you have not used it elsewhere and if used elsewhere, you are responsible for any balances your insurance did not cover."

Vision Service Plan (VSP)

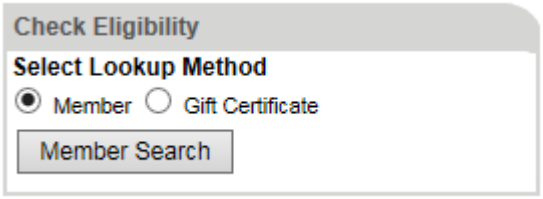
- Requires:
- Last Name, First Name
- Last 4 of SSN

Or

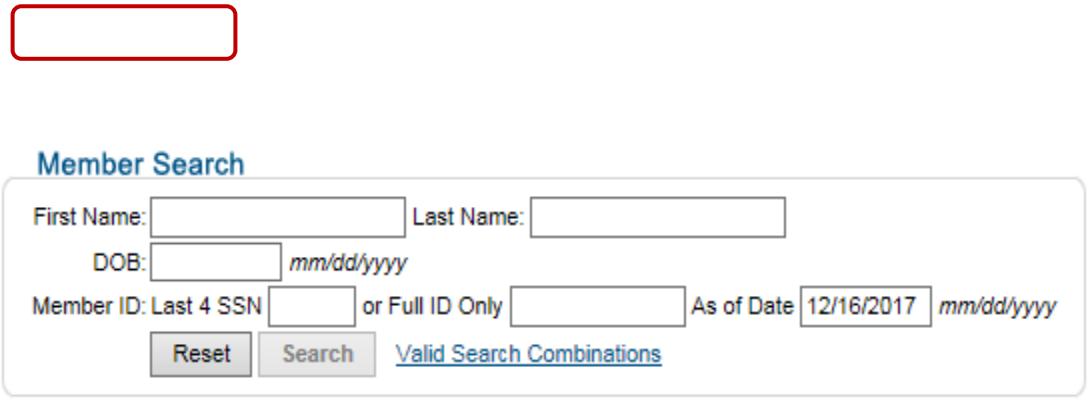
- Member ID Number

1. Click on ***eInsurance*** tab
2. Check Eligibility
3. Look Up Method: Member
4. Member search will come up

Click *Member Search*



Enter required fields:



Name and last 4 of SSN is usually enough information.

- Entering DOB will get you a more detailed search.

Some VSP plans are only searchable by a unique Member ID Number.

- If patient does not know their Member ID Number:

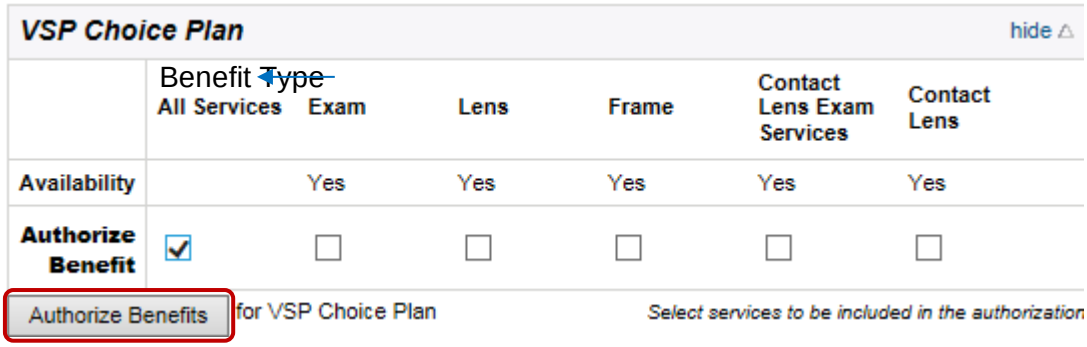
- Patient can call employer or insurance to find out.
- You can call VSP to verify eligibility and request Authorization over the phone.

VSP Medicaid plans are only searchable through their Medi-Cal number.

- **Only up to the letter**, last 5 digits are not entered.

(i.e. 12345678A99999)

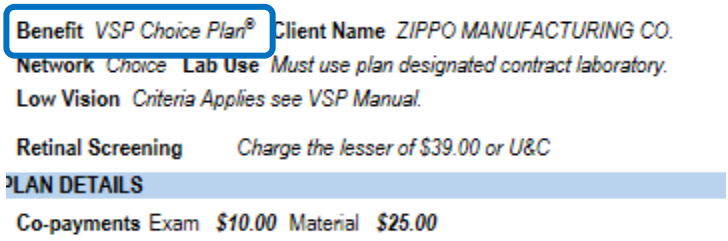
1. Verify patient's eligibility and pull benefits.
2. Select all that apply, or you can also choose to pull *All Services.*
3. **Click *Authorize Benefits***



- VSP ***does* give Authorizations** and has many *Benefit* types. When attaching insurance make sure you are attaching the correct type of VSP.

VSP Choice Plan, as shown above.

You are also able to search Benefit type on Authorization:



Attach insurance and Authorization. Scan.

Vision Insurances

a. VSP
b. Spectera
c. Eyemed
d. MES
e. March
f. Medical (Not HMO)

g. Medicare (Not HMO)
h. Med-cal
i. Caloptima
j. Anthem BC
k. Cigna
l. Blue Shield

Note: Certain insurances require extra steps even though we are providers (I.E Referrals)

4.2.7 Ketchum Health Forms Protocol

The purpose of this protocol is to establish a process in preparing the next day appointments and attaching the necessary forms.

Procedures:

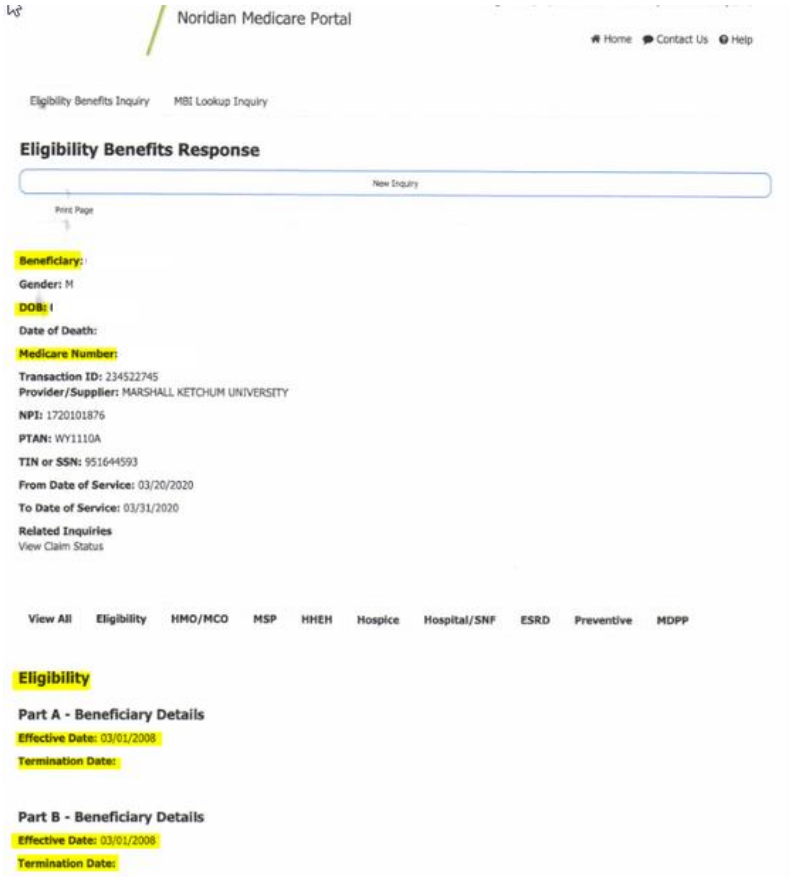
1. Once insurance for next day are verified print routing slips for all departments.
2. Determine if additional forms need to be completed by reviewing coments.
3. Attach forms needed to the routing slip. (i.e. ABN Form, Possible Interim Benefits, Sliding Fee Scale application.

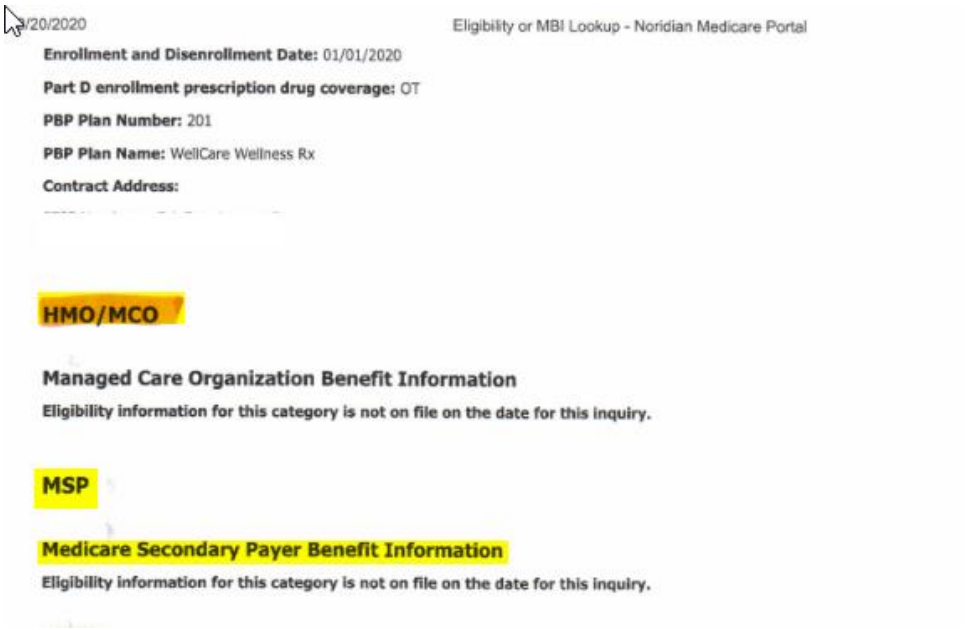
Verifying MEDICARE

Purpose: The purpose of this protocol is to establish a process in verifying and attaching Medicare to appointments. Attaching insurance, allows the patient's exam and/or materials to be covered by their benefits.
Medi-Care PPO
When verifying Medi-Care you are looking for:

- Is it active? Eligibility date to Term date.
- Is it an HMO? (not contracted w/ HMO plans)
- Looking for an MSP (Medi-Care Secondary Payer)
  - You want to make sure Medicare is the *primary payer.*

IMPORTANT: Only if there is a medical diagnosis, Medi-care will cover 80% of the eye exam services. With a secondary payer, it will cover the 20% that is left. Medicare & the secondary does not cover a refraction leaving the patient with a balance.
IMPORTANT: The only time Medi-Care will cover an annual exam is if the secondary payer is straight Medi-cal. (ie: Medi/Medi)
***The picture below represents an active Medi-Care Plan we take. The areas highlighted are what we are looking for when verifying.





Medi-Cal (secondary payer)
When verifying Medical you are looking for:

- Name matches the full member ID given (must have 5 #'s after the letter)
- Medi-Care Number is present under Medi-Care ID (circled in red)
- In Eligibility Message, you are looking for "*Must be billed to Medicare before billing Medi-Cal.*"

Pictured below is an example of a medical supplement to Medi-Care. The highlighted areas are what we are looking for as a supplement.

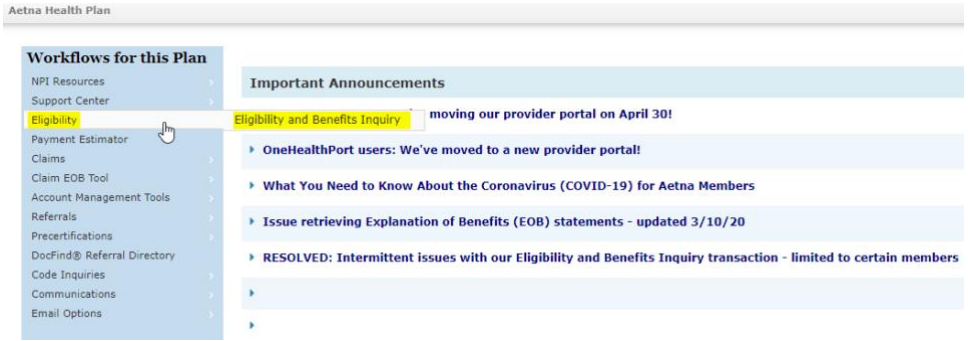
Name: M N		
Subscriber ID: 9 C		
Service Date: 03/24/2020	Subscriber Birth Date: 06/ /19	Issue Date: 03/24/2020
Primary Aid Code: 60	First Special Aid Code:	
Second Special Aid Code:	Third Special Aid Code:	
Subscriber County: 30 - Orange	Medicare ID: 1 2	
Primary Care Physician Phone #: 714	Service Type: R	
Trace Number (Eligibility Verification Confirmation (EVC) Number): 9 G		
Eligibility Message: SUBSCRIBER LAST NAME: MURGA . EVC #: 91711H0VGG. CNTY CODE: 30. PRMY AID CODE: 60. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. HEALTH PLAN MEMBER: CALOPTIMA. MEDICAL CALL (800)463-0935. HCP: CALOPTIMA DIRECT ADMINISTRATIVE CALL: (888)587-7277. PCP: CALL: (714)246-8500. PART A, B AND D MEDICARE COV W/MEDICARE ID #1EJ5GE8GH72 . MEDICARE PART A AND B COVERED SVCS MUST BE BILLED TO MEDICARE BEFORE BILLING MEDI-CAL.MEDICARE PART D COVERED DRUGS MUST BE BILLED TO THE PART D CARRIER BEFORE BILLING MEDI-CAL. CARRIER NAME: SILVERSCRIPT INSURANCE CO. COV: R.		

Aetna Medicare Adv

Steps on how to verify Medicare Advantage w/ Aetna:

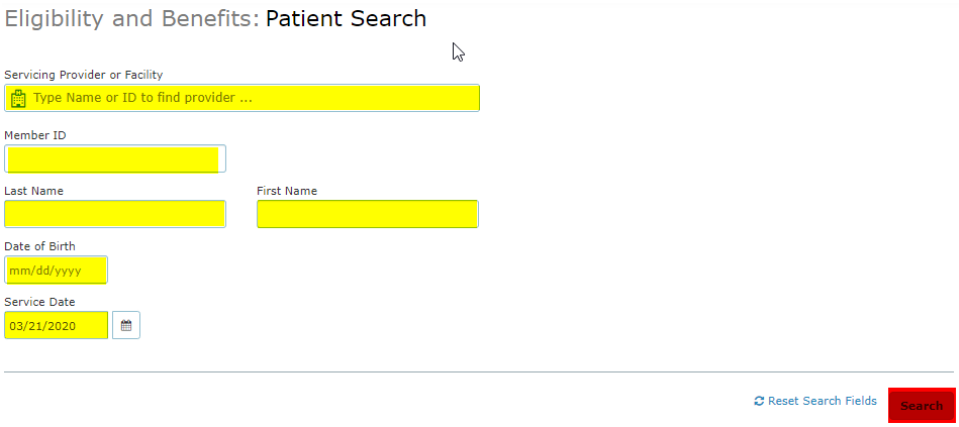
1. Sign into Navanet with the username and password given to you by your supervisor.
2. Hoover your cursor over *Workflow*.
3. Hoover over *My Health Plan.*
4. Under my health plan you will then click on *Aetna Health Plan.*

5. Workflows for this plan will come up.
6. Click on *Eligibility* and then click on "*Eligibility & Benefit Inquiry*."

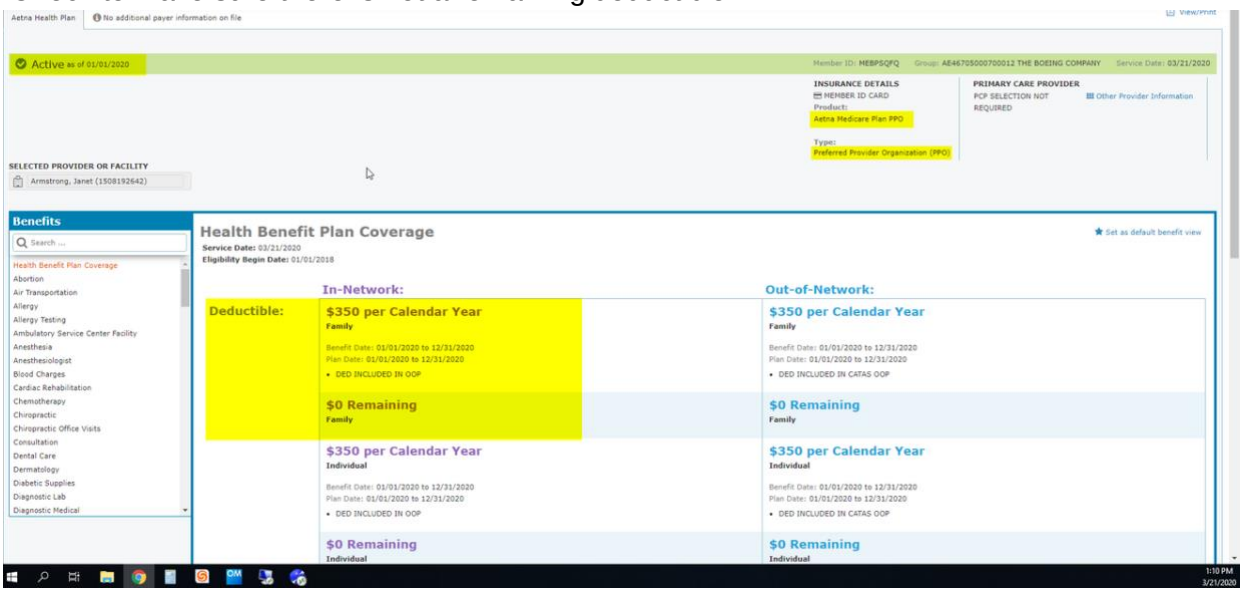


7. Eligibility and Benefits Patient search will pop up

8. Enter in all that is required:
- Full Member ID
- Last name/ First Name
- DOB
9. Click on search on the right bottom hand corner.



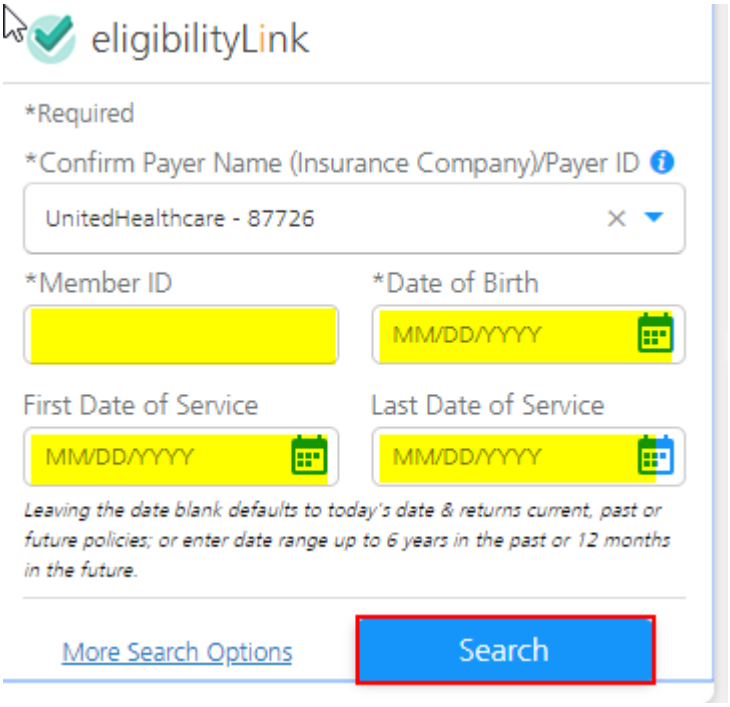
10. The patient's health benefit coverage will open
- Check to make sure the plan is a PPO (located on the top right corner)
- Check to make sure there is not a remaining deductible.



UHC Medicare Adv

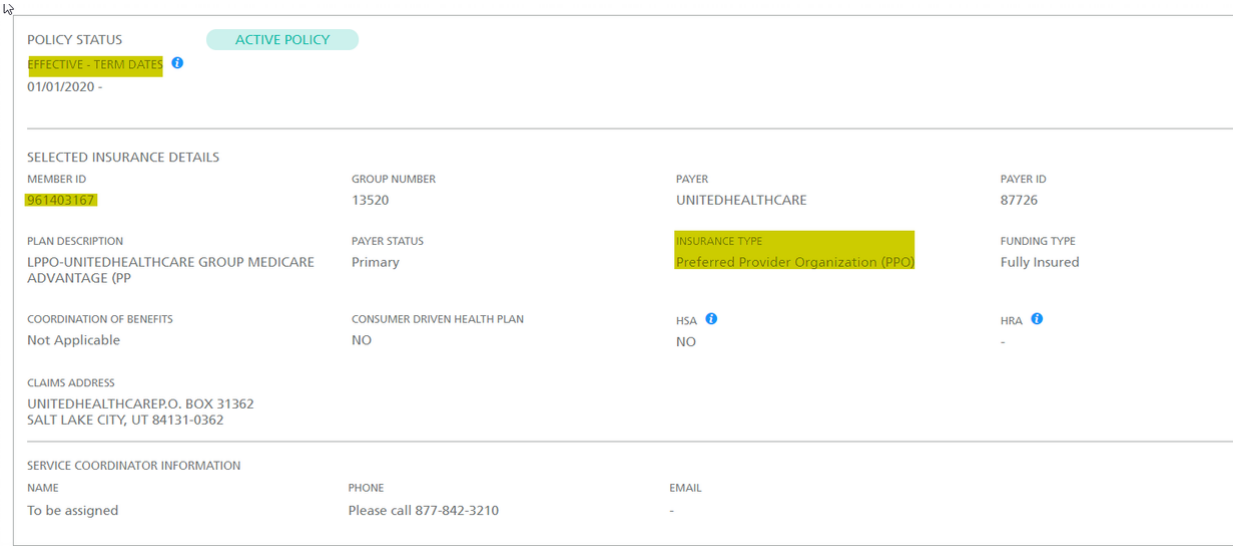
Steps on how to verify Medicare United Health. Care Advantage:

1. Login into Optum for UNC Advantage with the member ID & password given to you by your supervisor.
2. Once logged in, the eligibility link will pop up. Enter everything that applies.
- Member Id (usually UHC member ID)
- DOB
- Today's date to the last day of the month



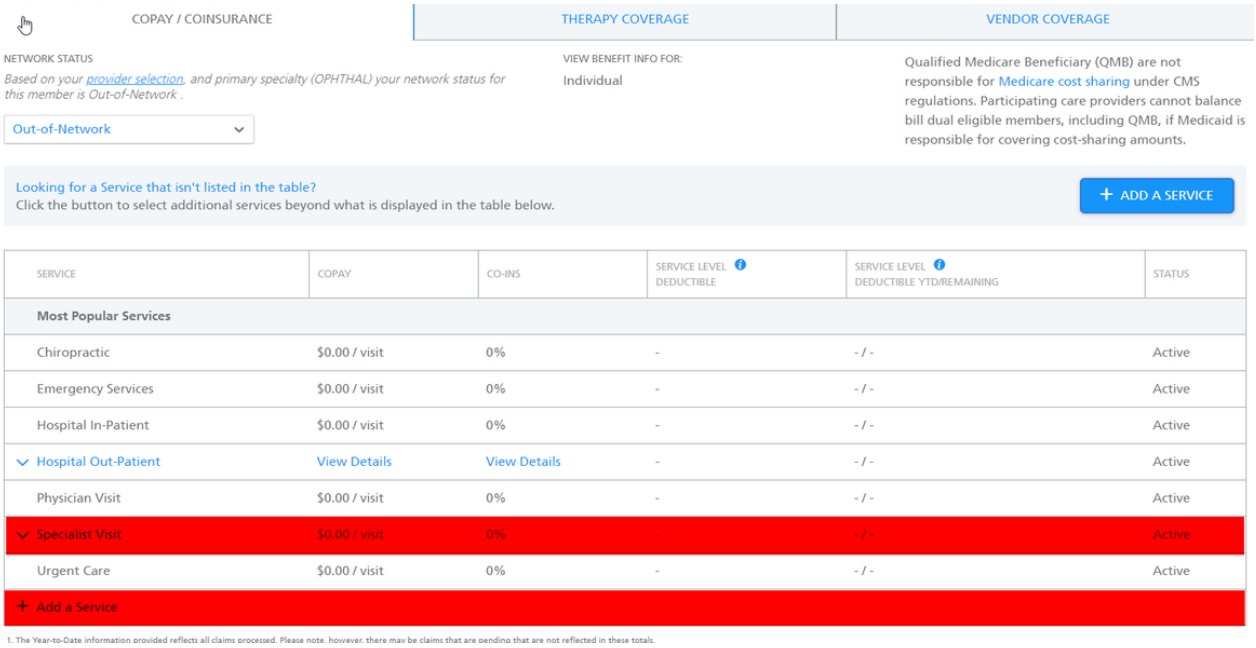
3. Click Search
4. Policy Status will come up. The highlighted portion is what you are looking for when verifying.

- Effective date to Term
- Member ID
- Insurance Type (PPO)

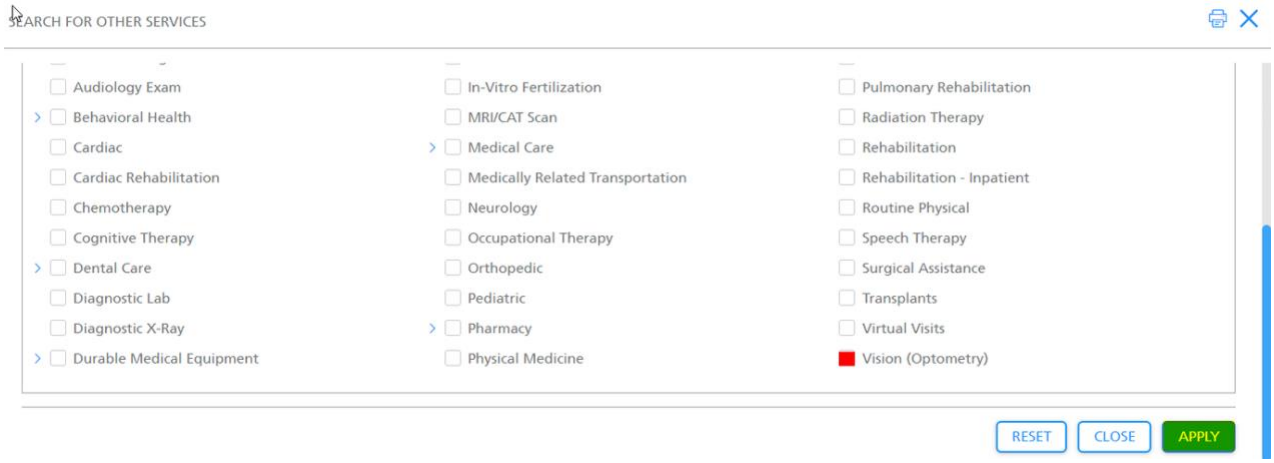


5. From this screen, you want to scroll down till you get to Most Popular Services, underneath the copay tab.
6. If the patient is being seen for a *medical visit*, you need to check the SPECIALST VISIT.
7. If the patient is being seen for an *Annual Exam*, you need to go to ADD SERVICE.

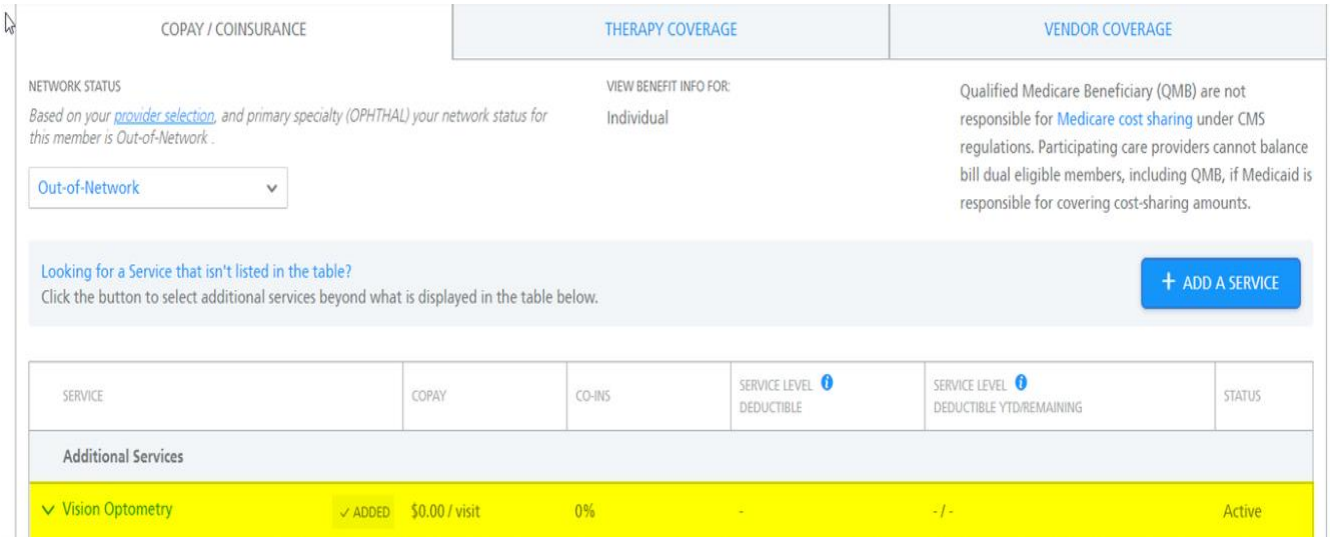
- This is where you will ADD the vision service to the plan. (You will always manually add the vision service.)



8. Once you click on ADD SERVICE, it will take you to SERACH FOR OTHER SERVICES.



9. Look for VISION and click the box to select it. (demonstrated in the above picture)
10. Click APPLY.
11. It will then take you to the COPAY Page.
12. Make sure in *additional services*, vision was added.
13. This is where it will tell us what the copay for the exam will be and if there is a deductible.



14. Make sure you print this page out, update and scan into the patient's chart.

4.2.8 Professional Courtesy Policy & Fee Adjustments Protocols (Patients)

The purpose of this policy is to provide guidelines for extending professional courtesy discounted or free-of-cost services to Ketchum Health physicians, employees, students, and their immediate family.

Scope
All MBKU clinics and affiliated facilities, including satellite health care centers.

Definitions
"**Professional Courtesy Discount**" is a discount extended to physicians, MBKU employees, students, interns, and their immediate family members (other than those who are Federal Health Care Program beneficiaries) *

"Immediate Family" is defined to include spouse, registered domestic partner and children (no age limit).

Policy
Ketchum Health may extend a professional courtesy discount (up to the total customary fee charged by the facility to regular patients), if the following conditions are met:

1. Ketchum Health adopts this professional courtesy policy which is approved by the Associate Dean of Clinics.

2. The discounts are consistently offered and applied to all individuals listed in the discount schedule, and in a manner that does not take into account directly or indirectly any group member's ability to refer to, or otherwise generate Federal health care program business for the physician directly or Ketchum Health.

3. The health care items and services provided are of a type routinely provided by the facility.

4. The discount recipient (or immediate family member) is not a Federal Health Care Program beneficiary (*e.g.,* Medicare, Medicaid, Tricare, Champus), or has a PPO insurance coverage for which a co-pay must be charged, unless KH makes a good faith determination of financial need.

5. The discount does not violate the federal anti-kickback statute or any federal or state law or regulation governing billing or claims submission.

6. Professional courtesy discounts and fee waivers can be extended to individuals outside the group listed on a case-by-case basis. Ketchum Health does not engage in routine discount practices, or waive co-payments as a general procedure in its business operations. Before granting the discount or waiving the fee, Ketchum Health reviews the request to determine the insurance status and financial need of the individual requesting it*.

   ***C.F.R. 42 U.S.C. 1320a-7a.**

PROCEDURES

1. Ketchum Health offers professional courtesy discounts on a voluntary basis, and it is not obligated to extend such discounts. Ketchum Health may discontinue this program at any time and without previous notice.

2. Professional courtesy discounts go into effect on the first day of hire. Medical care necessary due to workplace accident, injury, or exposure will be directed to MBKU's Worker's Compensation provider.

3. Routine services does not include vaccinations, ancillary laboratory tests or radiologic services, or costs incurred due to outside referral care.
   Note: Please be advised that you may be financially liable if we provide services outside of your insurance coverage.

4. General medical examinations will not be rendered to enrolled students in the Physician Assistant program. Optometric examinations will be provided to the general student population, regardless of the program in which they are enrolled.

5. Ketchum Health has a policy regarding the collection, access, use, release, and disposal of Protected Health Information (PHI). Given the sensitivity of many medical conditions and the information collected related to such conditions, it is up to the individual to determine whether or not to be seen onsite. Ketchum Health will exercise due diligence protecting the confidentiality, integrity and availability of PHI.

Discount Programs of Ketchum Health.
There are multitudes of discounts that patients can qualify for at Ketchum Health and they are:

<u>Insurance Discount Codes</u>

- VSP
  - VSP patient = 30% off the 2nd pair. (Same Day purchases)
  - VSP 20 percent discount

- VSP 30 percent discount- same day
- VSP CL 15 percent discount

- Eyemed
  - EyeMed 20 Percent Discount
  - EyeMed 30 Percent Discount
  - EyeMed 40 Percent Discount
  - EyeMed CL 10 Percent Discount
  - EyeMed CL 15 Percent Material Discount
  - EyeMed CL 15 Percent Services Discount

- Spectera
  - Spectera 20 percent discount
  - Spectera 30 percent discount
  - Spectera discount

- Medicare
  - 20% off all services that are not being billed to Medicare.

- Cash Payment Discounts
  - Patient who purchases premium products will get 25% discount. (Optical)
  - When you purchase a 2nd pair = 20 % off on Same Day materials (Optical)
  - Senior Discount (> 62 years)
    a. 20% off all serves.
  - Latino Health Access (LHA) patients
    a. 50% off medical visits, does not include comprehensive exams.
  - CL second pair glasses 20 % discounts
  - When the patient purchases contact lenses they get 20 % off glasses or Sunglasses (Plano)
  - College discount
    a. 20 % off on materials (excluding Contact Lens Materials) and 50% off on services

- Professional Courtesy
  - 2nd Year Waiver Free FP Exam
  - Military Discount 20 % on Services and Materials (Except Contacts)
  - My Life collection Package 15%

- Kinsbursky Employees
  - Kinsbursky Employee 30% Discount
  - Kinsbursky Employee Discount
  - Kinsbursky Family 30% Discount

- Employee and Student Discount
  - Fee waiver Cat 1
  - Fee waiver Cat 2
  - Fee waiver Cat 3
  - Fee waiver Cat 4

- Fee waiver Cat 5

Sliding Fee Scale, Grant, and Voucher Application Protocol

To establish an efficient process to qualify a patient for the Sliding Fee Scale program.

Based on income information presented by a patient. This will determine the amount of discount the patient may receive.

Procedures:

1. Patient completes Sliding Fee application.
    a. Patient's name must be noted
    b. Date of birth of patient
    c. Enter Gross Wages
    d. Enter Total house hold income
    e. Enter number of house hold legal depends
    f. Signature
2. Supervisor will review data against the "Sliding Fee Scale Income Guidelines."
3. Gross Income and the number of legal dependents will determine the amount of discount.
4. Levels of Discount
    a. 25 %
    b. 50%
    c. Grant 25%
    d. Grant 50%
    e. VSP Voucher
5. Upon approval, Supervisor signs application.
6. Enter an alert in the chart:
    a. Level of discount that the patient has been awarded.
    b. Amount of time that the SFS/Grant/Voucher will be good for.
    c. Expiration date on Alert

Note: The Sliding Fee Scale (SFS) only applies to services. Materials are purchased at retail cost.

7. At the time of checkout if SFS, adjust amount with SFS Adjustment or if Grant, update the guarantor to *Patient Grant Funds*

PATIENT CANCELLATION & NO SHOW POLICY

To recover loss of revenue due to a patient not notifying the Eye Care Center of an appointment cancellation 24 hours in advance.

Procedure

The Patient Relations supervisor will generate a monthly cancellation/no show report and will forward it to the Director of Clinic Operations who will conduct the following:

1. Review the report to determine the number of occurrences.
2. Any patient who has missed two or more appointments within a two (2) month period without 24 hour advance notice, will be mailed a letter with the notification that any further occurrence will result in a regular office visit fee ($50) being charged.

3. If the patient exhibits the same behavior after the initial letter, the Claims department will be directed to generate a bill/statement with the following code: “Patient Cancelled Fee”, SIM “CC04”. A certified return receipt letter will be generated and mailed by the Director of Clinic Operations to the patient with the explanation of the office visit fee, accompanied by the bill/ statement. The letter will also inform the patient that he/she will be unable to make future appointments until the fee is paid. The Patient Relations supervisor will place a “no appointments until bill is paid” alert in the patient’s file in Compulink.
4. After payment is received, the alert will be removed and the patient will be able to make appointments.

CareCredit

To describe the process by which the Eye Care Center will perform a CareCredit transaction.

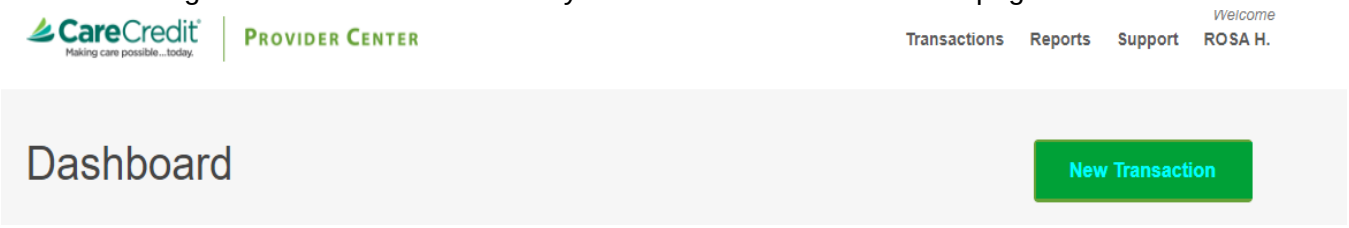
Definition:

CareCredit is a healthcare credit card offering a personal line of credit that can be used as a payment option for healthcare treatments and procedures not covered by insurance. Approval is based on the patient’s credit history and is solely determined by CareCredit.
Patients participating in the CareCredit program with the UEC will have a no interest payment plan provided their balance is paid in full within (as listed in Step 10) of purchase. CareCredit will charge interest to the patient’s account if the remaining balance is not paid within the period, other charges may apply.

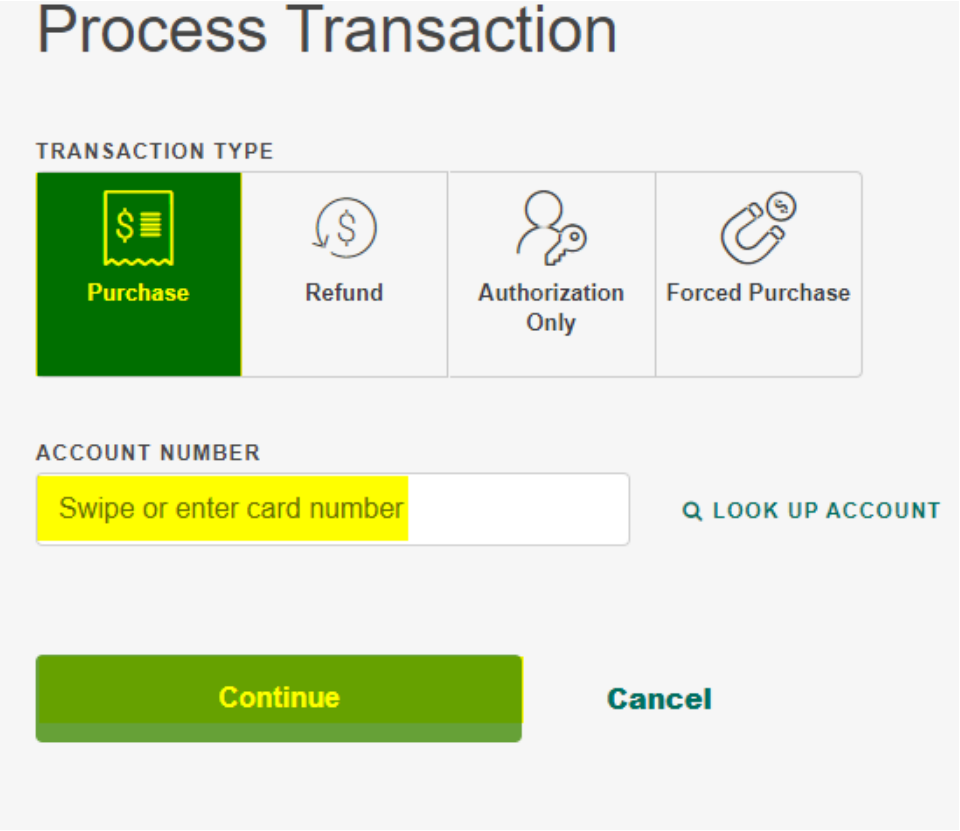
PROCEDURE:

1. Sign into Carecredit.com with the ID and Password that was provided to you by the Patient Relations Supervisor.
2. Collect CareCredit card and two forms of ID from patient
    a. State Issued ID or Driver’s License
    b. Debit Card/Credit Card/Other form of ID

    (Note: Forms of ID must have full name and an expiration date)
    c. The card member **must** be present at the time of purchase.
3. Clicking ***New Transaction*** will take you to the Process Transaction page



4. In *Transaction Type* drop down menu choose ***“Purchase.”***



5. For *Account Number* enter 16-digit CareCredit card number
6. Card Present: select *Yes*
7. Click *Continue*
8. Enter transaction amount
9. In *Program* drop down menu select:
    d. ***6 Months for purchase over $200***
    e. ***8 Months for purchases over $400***
    f. ***12 Months for purchases over $600***
10. Click *Submit*
11. If approved, Click *Print Receipt* and two receipts will be automatically printed
12. On the merchant copy, make sure you:
    a. Notate DL # & expiration date for both forms of ID
    b. Must sign off to confirm transaction
13. At the end of your shift, you must print “Credit Card Transaction” report.
    g. Click on Reports, which is located on the top right corner.
    h. Recent Transactions.
14. Report and Merchant copies are submitted with your closing Batch documents to claims.

Note: If the charge is declined, inform the patient to contact CareCredit directly at 866-893-7864

Refund

15. You must complete a “Refund Authorization Form” before refund can proceed.
16. Director of Clinical Operations must sign form.
    a. Must present documentation as to why the refund is being requested.

17. Once you have the form signed, then log into the CareCredit web site.
18. Click on “Transact”
19. Click on “Process Transaction”
20. In *Transaction Type* drop down menu choose *Refund.*
21. For *Account Number* enter 16-digit CareCredit card number
22. *Card Present:* select *Yes*
23. Click *Continue*
24. Enter transaction amount
25. Click *Submit*
26. If approved, Click *Print Receipt* and two receipts will be automatically printed
27. On the merchant copy, make sure you:
    a. Notate DL # & expiration date for both forms of ID
    b. Must sign off to confirm transaction
28. At the end of your shift, you must print “Credit Card Transaction” report.
    a. Click on *Reports*, which is located on the top right corner.
    b. Click on *Recent Transactions,* click *Print*.
29. Report and Merchant copies are submitted with your closing Batch documents to claims.
30. Email claims of the Refund completed through CareCredit so that they may apply refund in system.
31. Add note of refund to encounter visit.

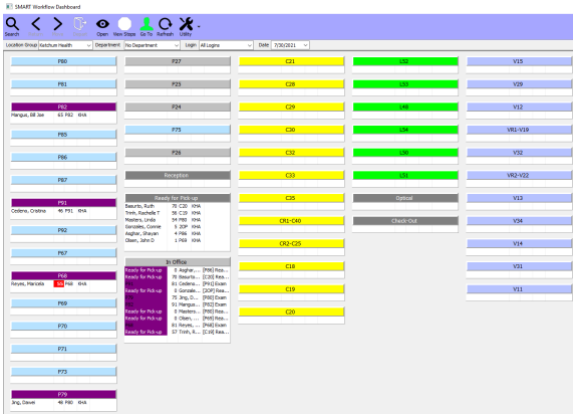
4.2.9 Check out Protocol

To establish an efficient process when checking out a patient upon completion of their appointment. In addition, demonstration of proper protocol when collecting payments for services rendered.

Procedure:

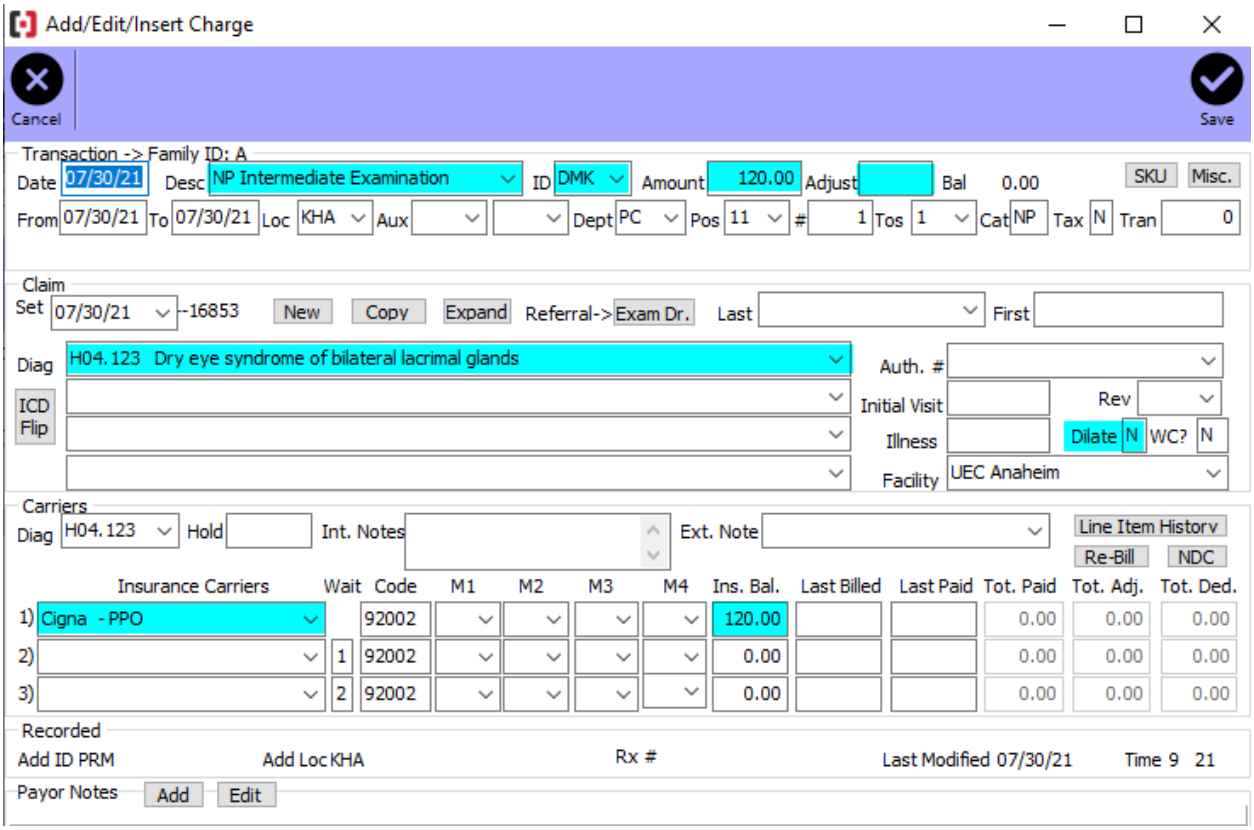
At the end of patient’s exam, the Intern will escort the patient to Checkout.

1. Select patient to check out from the tracking screen.

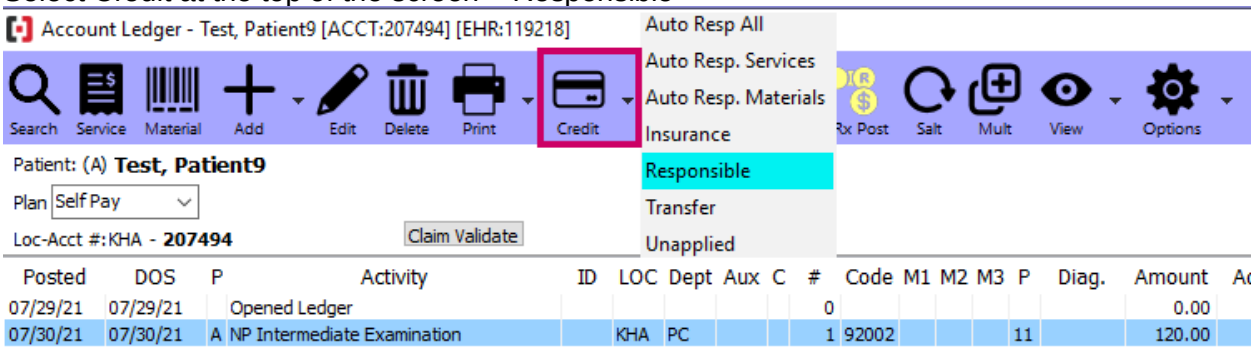


2. Review appointment comment to check what insurance was verified for visit.
3. Open up Insurance Authorization or Eligibility to confirm copay.
4. Set insurance being used as Primary and Pool all other insurances.
5. Click on Ledger at the top of the screen.
6. Click on EHR Post to review charges saved to ledger by the doctor.

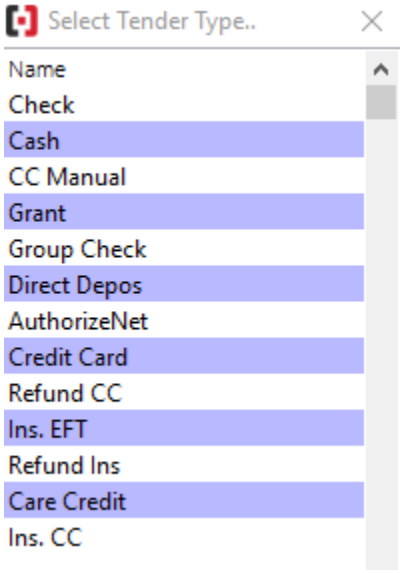
7. Review that charges match the type of visit set and insurance attached before posting charges.
8. Click on Post.
9. Charge windows will pop up one by one to allow for you to edit each one. Review that the following fields are correct:



10. At this time you can replace, add, or remove insurances for each charge.
11. Apply correct amounts towards insurance.
12. Click Save when finished.
13. On ledger window, add any adjustments needed and review that patient's balance is correct.
14. Let patient know amount and confirm payment method.
15. Select Credit at the top of the screen > Responsible



16. Enter the amount to be collected.
17. Select each line item you want to place money on. Each line item will have a pop up window where you will enter the amount that needs to be placed on that specific line item. Click Apply after each amount.
18. Click Yes to Confirm Completion of Line Item Distribution.
19. Select Tender Type.



20. Add a note under ID/CC
    a. Credit Cards: Enter card type and last 4 digits (Visa0808)
    b. Checks: Enter Check # (9601)
    c. Cash: No note required
21. Click Save.
22. Print receipt for patient.
23. Enter Recall.

4.2.10 Patient Relations-Handling Special Groups

Latino Health Access Appointments

To provide diabetic eye examinations to a cohort of patients that are part of a diabetes self-management course. Latino Health Access is a community based organization in Santa Ana, California. Patients from the community who are diabetic or pre-diabetic are recruited to participate in a 12 session educational program that focuses on improving awareness of the disease through exercise, focus groups and medical visits. SCCO and Latino Health Access have a long running partnership to provide eye examinations to their referred patient base.

Contact Person: Guillermo Alvarez, Program Coordinator, LHA

On-site Clinical Coordinator: Rachel Merlos

SCHEDULING:

Friday AM

Procedure:

1. Patients are scheduled by Patient Relations on pre-arranged dates. The maximum number of patients will be 16.
2. Patients are transported to the UECKH by LHA on the days of the examination. Patients may be brought in at the same time, or may come in two groups.They are accompanied by LHA volunteers who assist with translation and processing of paperwork.

3. Eye examinations are provided only in the Jarnagin Primary Care Center.
4. 5 interns are assigned by the PC Administrative Assistant for LHA patient care. One additional faculty is recruited to assist with staffing on LHA patient care days.
5. Interns use the LHA Examination. A complete eye examination with dilation is performed.
6. A LHA report is filled out by the faculty provider that outlines the pertinent clinical findings and the proposed management plan. This is returned to LHA via the volunteers.
7. Spectacle prescriptions are also dispensed, which may be filled at the UECKH optical service.
8. Patients who require additional medical or surgical care are offered services through UECKH Primary Care department, Ophthalmology Service or an outside practitioner based on the urgency of the condition.

Fees are set at a 50% fee reduction.

LHA Valueline Packages:

CPT Code	Service Item Description	Unit Price
LHA01	SV Frame and Lens CR-39	$69
LHA01A	SV Frame and Lens Poly	$79
LHA02	BF Frame and Lens CR39	$79
LHA02A	BF Frame and Lens Poly	$89
LHA03	PAL Frame and Lens CR39	$109
LHA03A	PAL Frame and Lens Poly	$125
Upgrades		
LHAU1	Crizal Alize	$90
LHAU2	Crizal Avance	$100
LHAU3	Transitions	$100
LHAU4	SV Hi-Index 1.67	$95
LHAU5	PAL HI-Index 1.67	$120
LHAU6	Polarize	$100

- Can upgrade for Transitions, AR coating, Hi-Index 1.67 with special pricing
- Charge **($5.00 per diopter per lens)** for over **+/- 4.00 Sph** to over **+/- 3.00 cyl RX**
- Use Valueline frames only
- LHA patients, friends and family of LHA patients, and LHA employees receives 25% discount if choose to go outside of the package.
    - Use “Latino Health Adjustment” code with 25% discount (found in discount drop down menu). LHA referrals are given discount cards. If patient does not have discount card at arrival, staff will still honor the discount.

VA-QTC (VETERANS) Appointments

To provide disability-related examinations for veterans of the United States armed forces. QTC is a third party company that coordinates the assignment of compensation examinations to providers and the collection of web based reports that are forwarded to the Veterans Administration Medical Affairs.

Contact Person: QTC Inc, Diamond Bar, CA

On-site Clinical Administrator: Rachel Merlos

Scheduling:

Jarnagin Center for Primary Eye Care

Monday thru Saturday.

Procedure:

1. Scheduling is done by Patient Relations Supervisor. QTC directly contacts Supervisor to set up appointments. DBQ paperwork is sent via US mail to Ketchum Health or the specified provider.

2. Faculty must be credentialed by QTC to examine patients. Periodic re-credentialing is required via web-based courses and examinations.

3. Examinations are focused on collecting information about service-related injuries and eye conditions. A complete eye examination is to be completed on the patients. No treatment is to be provided to the patients. No reports are given to the patients.

4. Patients may receive a check for travel, that is sent to MBKU and attached to a packet that is comprised of the billing page, the patient information and the patient's DBQ form. The patient is given the check upon check out.

5. Upon completion of the compensation evaluation, the provider must submit a web-based report on the secured QTC portal within a timely manner. Additional supporting documents are to be faxed directly to the assigned case worker at QTC in Diamond Bar, CA.

6. On occasion, there are Independent Medical Opinions (IMO) reports that must be also be filed. These are medical record reviews that may include all of the claimant's service medical service information, induction and separation documents, and private medical records. Reports are designed to review and assess if the claimed condition is caused by incident(s) during military service.

7. Some patients require Goldmann Visual Fields which will be performed on the Octopus perimeter. These patients are designated in the patient notes in our online department schedules for Primary Care. Visual fields are printed out and given to the Administrative Assistant to be faxed to QTC.

8. Upon completion of the web-based report, verification is sent to the provider. On occasion, there is a need for expedited review, and QTC will contact the Administrative Assistant to assist with this process.

No-show appointments will be compensated by QTC. These patients are identified and the intern or faculty will alert Supervisor so that we can bill for the missed visit. The veteran will need to be rescheduled.

Village of Hope

PURPOSE:
To ensure the Tustin (Village of Hope) patients are accurately documented in Compulink.

PROCEDURE:

The Tustin patient encounter information and petty cash box, containing $75, is provided to the Patient Relations department weekly by the doctor assigned to the location. Staff will enter information into EMR system as follows:

1. Refer to *Tustin excel spreadsheet* to confirm the number of patients seen and that all paperwork and money was received.
    a. If any paperwork is missing, that will cause the deposit to be inaccurate, email doctor and get a response before entering charges for that particular patient.
        i. If any changes are made, have the doctor update the spreadsheet to match actual data for future reference.
    b. If money is missing, include Patient Relations Supervisor in an email to the doctor.
        i. Supervisor will make note of short deposit and alert accounting.
2. Locate chart for *Established* patient or create a chart for a *New* patient utilizing *Intake Form* provided.
3. Create appointment charges on ledger with accurate information:
    a. Date of Service
    b. Doctor
    c. Student
    d. Location
    e. CPT and Diagnosis codes
4. Determine if patient is private pay or going through VOH.
5. For both private pay and VOH patients all but $40 will be adjusted for the full comprehensive exam.
6. Private pay will include money through Cash or Authorize.net receipt.
7. VOH patients will be billed to Village of Hope insurance.
8. Any glasses ordered will be given to Optical to process but money will be placed as unapplied until charges are posted.
9. Once glasses are processed, Optical will return glasses to Patient Relations to be marked in the system and placed in Bag for doctor to take.
10. In Petty-Cash Box leave only small bills.The cash box must always contain $75.
    a. If change is needed, a request can be placed with accounting.
11. Place all paperwork in designated file to keep for 3 months until everything is processed through accounting.

Second Year Exam Protocol

The purpose of this protocol is to establish a process in scheduling Second Year Students' first patient.

Procedure:

1. The Assistant Chief of Primary Care Service will notify Patient Relation's Supervisor and the Clinic Coordinator on what dates that the Second Year Students can schedule their appointments.
2. The Clinic Coordinator will enter a special clinic schedule into EMR System.
3. Create a secure OneDrive File where student can supply the Patient Relation's Supervisor the following information:
    a. Name of the patient

    b. Date of birth
    c. Phone number
    d. Date and time of the appointment.
    e. Name of Student
    f. Patient's Relation to Student
4. The Patient Relation's Supervisor will schedule the appointment in EMR System and add Fee Waiver alert in the event that patients want to use their fee waiver in optical or future visits.
5. A 2nd Year examination appointment duration is set for 120 minutes (2 Hours)
6. Once the appointment has been scheduled.
7. Student will be provided with fillable intake forms by Instructor of Record and will be responsible to email Patient Relation's Supervisor with PDF version of the completed forms.
8. Students will be paged overhead when their patients are ready to be taken back.
9. Students will pick up their patient and Routing Slip.
10. Student will turn the Routing Slip to checkout.
11. Charges are adjusted 100 percent by using "2nd Year Exam" adjustment code.

Department of Rehabilitation (S) Protocol

The purpose of this protocol is to establish a process in scheduling a Department of Rehabilitation (DOR) patient appointment(s).

Procedure:

1. DOR authorizations are directed to Low Vision AA if mailed and Claims Department, if emailed. Low Vision authorizations stay in low vision. All other authorizations are given to Rachel to distribute between departments.
2. Rachel Merlos will attach paperwork, that staffing doctor will complete on day of exam, to all authorizations and distributes them among various departments.
3. Once received, add patient to DOR Log to keep track of appointment and expiration date. (Authorizations expire after 90 days)
4. Scan DOR Authorization only, not full packet, as it is still blank.
5. Making the appointment:
    a. Call patient to schedule the appointment
    b. Get patients DOB (as authorization does not provide one)
    c. Verify their address and phone number
    d. Attach DOR insurance and Authorization
    e. Scan Authorization
    f. Ask if they require an interpreter
        I. If the answer is yes, then they have the option of requesting one through DOR or we can request one from DOR for them.
            a. If they will request include a note in appointment details (i.e. Patient will request Interpreter from DOR.)
            b. If we will request, call the DOR counselor on the authorization and request an interpreter by call or email. Make sure to receive confirmation that one will arrive. Include a note in appointment details (i.e. Interpreter confirmed by DOR)

        NOTE: If patient requested you book an interpreter for them it is your responsibility until you get confirmation.

6. DOR packet is placed in Pre-Authorization drawer until Next Day Insurance Verification.
7. See check in Protocol. Pt will complete intake forms and have their ID/DL scanned.
8. Doctor will complete DOR packet as it is needed to bill for exam as well as request a new authorization for glasses.
9. Check-out:
    a. Make sure packet is complete and scan.
    b. If patient required an interpreter and will need glasses, direct them to optical to choose glasses and take measurements, as an interpreter will not be provided if glasses authorization is approved. (We want to take advantage of having an interpreter for the patient.)
10. Return completed DOR Authorization to Claims for billing.
11. If patient needs additional services Low Vision AA or Director Clinical Services will request a new authorization for those services.

NOTE: Do not schedule patients for visits or process materials orders until you receive an authorization.

CRITTENTON

1. Crittenton nurse contacts Patient Relations Supervisor to schedule an appointment for patient.
2. Appointment is scheduled for patient in department needed.
    a. Crittenton office address and Nurse's phone number and extension is entered under patient demographics when creating chart.
    b. "Point Comfort Underwriters Insurance" and authorization is provided by nurse and attached to patient's chart.
3. Authorization is sent via fax.
4. Authorization is scanned into patient's chart.
5. Point Comforts insurance and Authorization is added.
6. Scan Authorization into system.
7. Crittenton representative arrives with patient. They provide a packet with patient information as well as a form that needs to be completed by doctor.
8. Scan Packet provided by Crittenton Representative at time of check-in.
9. See Check-In Protocol (patient will still need to complete required intake forms)
10. Staple Crittenton Form that needs to be completed by doctor to fee ticket so it is not lost.
11. At check out, scan form once completed by doctor and return to Crittenton representative.
12. See Check-Out Protocol to finish the visit.

Additional Information to know:

Insurance for Crittenton: Point Comfort Underwriters.
Additional Services can be requested through Patient Relations Supervisor.
Glasses orders are not set aside, they have a contract with another provider.

KIDS' VISION DAY

To establish a process in scheduling Kid's Vision Day appointment(s) in Compulink. The kids come from different school districts. The students either have Medi-Cal (VSP) or receives a Grant and/or both, which will be explain in detail in this protocol.

Procedure:

Prior to Event

1. Kids' Vision Days occur on most Thursdays and Fridays (refer to calendar) typically with 20 kids on Thursdays and 30 kids on Fridays.
2. University Eye Care Center and the respective school district must meet a timeline in order to prepare for the Kids' Vision Day:
    a. For SAUSD, KVFL & SCCO timeline on when items are due. (see Appendix A)
    b. For other school districts, the Student Roster is due to SCCO on the Monday of the week prior to the event.
    Note: If Student Rosters are late, inform Dr. Huang.
    c. Eligibility status needs to be finalized by Monday morning the week of the event.
3. The School District Contact will notify VT/Peds Administrated Assistant that the Student Roster on Google drive has been updated.
4. Ketchum Health will verify eligibility for each student that is on the roster by checking VSP Medicaid.
    a. When was the last eye exam?
        i. <9 months from last exam, the student is not eligible.
        ii. >9 months from last exam, the student is eligible. Note: If benefits are not available, follow "Interim Protocol."
    b. Is the insurance plan is an HMO, such as Kaiser? The student is not eligible for the program.
    c. What if the student is not covered by vision plan coverage? The student will receive a grant.
5. Print authorizations for all services that the patient is eligible for:
    a. Exams
    b. Lens
    c. Frames
6. Google Document that is associate with the specific school district is updated with the following information:
        i. Patient's eligibility (Yes or No)
        ii. Insurance information (Medicaid ID)
7. Inform the school contact by the Monday before the visit that the Student Roster has been updated and which students are not eligible for the visit.
    a. Request replacement students to fill the roster and verify eligibility on these additional students.
8. MBKU Drive to be updated by Dr. Kristine Huang
9. Print consent forms from Google Drive.
10. Build charts
    a. Guarantor

    b. Patient Demographics
        i. Address should be entered as their school district address (i.e.: AESD,SAUSD,FUSD)
        ii. Phone should be entered as “714-000-0000.”
        iii. Chart status should be noted as “Active – no mailing.”
    c. Emergency contact – none listed
    d. Privacy Notice needs to be updated with the date on the consent forms.
11. Scheduling appointments
    a. Appointment duration should be 60 min.
    b. Event type is “Peds Comp.”
    c. The youngest patients are scheduled in Pediatrics first.
    d. When entering authorizations under the appointment, note in “Description” field the type of authorizations. (i.e. “Lens only,” “Exam only, “All Services”).
    e. In the appointment “Details” note KV- “All services”, “Interim” or “Grant.”
    f. In Insurance Field note either “Grant” or “VSP”
12. Print the schedule and have Dr. Huang review prior to printing Fee Sheets.
13. Print Fee Sheets once approved
14. Preparing Packets
    a. Routing Slip (First Page)
        i. Highlight bottom section if faculty need to indicate whether patient is eligible for interim benefits (based on change in prescription)
    b. Fee Sheet (Second Page)
    c. Consent Forms (Third Page)
    d. Parent Report (School District Specific) (Four Page)

Day of and Post Event

1. Group packets by intern and service and lay out on counter with the top packet covered with a blank piece of paper (HIPAA compliance)
2. Check-In Students
    a. Dr. Huang will notify Front Desk Staff which students are absent.
    b. Follow check-in protocol
    c. Set the Guarantor to the specific school district that is being seen.
3. Check-Out Students
    a. Identify those students that qualified for “Interim Benefits.”
        i. Staffing Doctor will sign the bottom of the routing slip.
    b. Follow check-out protocol
    c. Check Compulink to make sure that all of the students are check out
4. Call VSP to have interim authorization released for all services
5. Scan all documents
    a. Patient Information
        i. Consents
        ii. Parent Letter
        iii. Routing Slip
    b. Fee Sheet = Fee Sheet
    c. Authorizations = Insurance Authorizations

Department of Rehabilitation

The purpose of this protocol is to establish a process in scheduling a Department of Rehabilitations (DOR) patient appointment(s).

Procedure:

1. DOR will send an authorization to the Billing Department.
2. Billing Department will forward the DOR packet to:
    a. Low Vision
    b. Patient Relations
3. DOR packet needs to be scan into Compulink.
4. DOR packet is placed in Pre-Authorization drawer.
5. Making the appointment:
    a. If the patient needs an interpreter, DOR will need call to schedule/reschedule the appointment, not the patient.
    b. If the patient does not require an interpreter, the patient can call in to schedule the appointment.
6. All paperwork needs to be collected by Check-Out.
7. DOR Packet is given to your Supervisor after the Patient has been checkout.
8. If the paperwork is not returned, notify your supervisor.
9. If a patient needs to come back for any reason, the doctor needs to note it in the form so it may be requested to DOR
10. The Billing Department will notify DOR Counselor.

Cal State University Protocol

To ensure the California State University Fullerton (CSUF) patients are accurately documented in Compulink.

Procedure:

The CSUF patient encounter information and petty cash box, containing $40, is provided to the Patient Relations department weekly by the doctor assigned to the location. Staff will enter information in Compulink as follows:

1. Refer to *CSUF excel spreadsheet* to confirm the number of patients seen and that all paperwork and money was received.
    a. If any paperwork is missing, that will cause the deposit to be inaccurate, email doctor and get a response before entering charges for that particular patient.
        i. If any changes are made, have the doctor update the spreadsheet to match actual data for future reference.
    b. If money is missing, include Patient Relations Supervisor in an email to the doctor.
        i. Supervisor will make note of short deposit and alert accounting.
2. Locate chart for *Established* patient or create a chart for a *New* patient utilizing *Intake Form* provided.
3. Create appointment charges on ledger with accurate information:
    a. Date of Service
    b. Doctor

    c. Student
    d. Location
    e. CPT and Diagnosis codes
4. $40 will be adjusted for the full comprehensive exam.
5. Any glasses ordered will be given to Optical to process but money will be placed as unapplied until charges are posted.
6. Once glasses are processed, Optical will return glasses to Patient Relations to be marked in the system and placed in Bag for doctor to take.
7. In Petty-Cash Box leave only small bills. The cash box must always contain $40.
    a. If change is needed, a request can be placed with accounting.
8. Place all paperwork in designated file to keep for 3 months until everything is processed through accounting. Apply payment made by patient and complete fields.
9. Fill in *Tracking*: Last 4 digits of card used, check number, or *if* cash: tracking # is **not** needed.

Special Testing

To establish a process in scheduling an appointment in Ocular Disease for Special Testing.

Procedure:

1. In the appointment book in EMR system, Special Testing appointments are booked in the aqua slots and are done on Tuesdays and Thursdays.
2. For external referrals, we need medical records for the patient before scheduling the appointment. (See Specialty Services Consultation/Referral Form)
3. Events with prefixes of “ST” are for Special Testing.

CHP Post Lasik Testing:

1. Check the insurance tab to verify that the insurance information is current or if you need to add a new insurance.
2. If cash paying give a quote.
3. For color vision test we can do multiple tests on the same day for one price.
4. Color vision tests are done in one hour, despite the number of tests and can be booked on the hour.
5. Color vision test are billable to our contracted insurances.
6. The “CHP Post Lasik test” event will be specifically requested by the patient and is billed to the CHP.
7. The patient will needs one appointment at 10:00am and the second appointment on the same day at 1:45pm.
8. The morning appointment can have a 60 minute block and the afternoon appointment only needs a 15 minute block.

Electrodiagnostic Testing:

- Book at either 10:00am or 12:00pm.
- If more than one Electrodiagnostic test is required please block off the entire 4 hour slot for the patient.

- Electrodiagnostic tests are also billable to our contracted insurances. See Special Testing Fees for pricing.

Note: In the details of the appointment document Specific test(s) requested and prices quoted.

Color Vision Tests:
Ishihara 24 plate edition
Dvorine 2nd edition
Farnsworth D-15
Farnsworth Lantern
Lanthany's Desaturated D-15
HRR 4th edition 24 plates
Farnsworth 100 Hue (Dr. Ridder)
Anomaloscope FUL (Dr. Ridder)

Electrodiagnostic Tests:
Electro-Oculography (EOG)
Visual Evoked Potential (VER/VEP)
Electro-Retinography (ERG)
Multifocal ERG
Full Field ERG

4.2.11 Patient Recall(s)

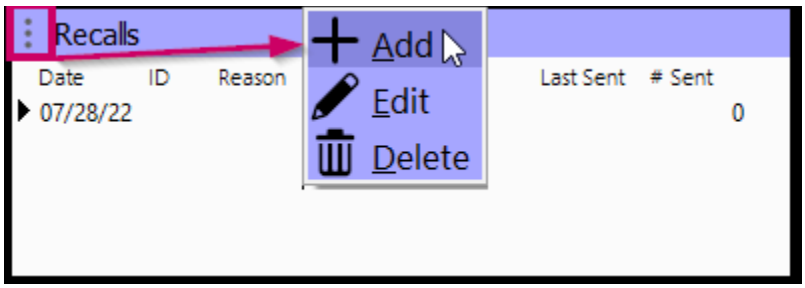
Purpose:

To establish a process to notify patient(s) of their Annual Exam or Follow-up Appointment.

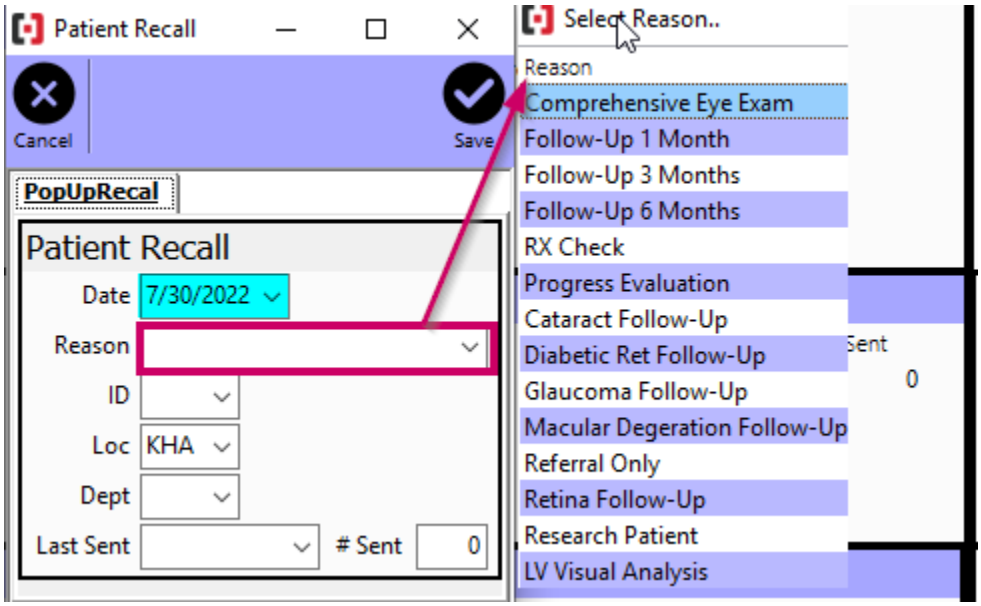
Procedure:

At check out or when scheduling patients, recalls are added for future events that patients are not yet ready to schedule or too far out for the EMR system to display.

1. In the Recalls box click on Add



2. In Patient Recall window fill the following information:



3. Click Save

4.2.12 Requesting an Interpreter

THINGS TO KNOW BEFORE SCHEDULING A PATIENT THAT NEEDS AN INTERPRETER:
Schedule at least 1 week out to allow enough time to book an interpreter.

- Extend the time of appt as communication will take a little longer.
- Appt must be made Tuesday through Friday when possible.
    - Goodwill has a strict 24 business-day- hr cancelation policy (I.e. An interpreter request scheduled on a Monday needs to be canceled the previous Friday otherwise the clinic will still be billed for 2 hours.
- Include an appointment note that you have requested an interpreter with Patient Relations Supervisor so an interpreter is not requested twice.

PROCEDURE:

1. Email Patient Relations Supervisor with the following appt information:
2. Patients Chart #
3. Patients Full Name
4. Date and time of Appt
5. Patient Relations Supervisor will do the following:

A. Request interpreter at deaf@goodwill.com with following message after confirming all details are correct.

i. “Hello,
ii. I would like to request an interpreter.
iii. Language: ASL
iv. Patient Name:
v. Date:
vi. Time:
vii. Location: 5460 E La Palma Ave., Anaheim, Ca 92807
viii. Kind Regards,
ix. Name”

B. Expect an email confirming they have received the request.
C. Update Appointment notes that you have requested an interpreter and are expecting confirmation.
D. Expect email with interpreter name and confirmation of booking. (this may take a few days)
E. Update Appointment Comments with interpreter name. “Interpreter Jane Smith confirmed”.
F. Add patient to Request-log. Request log is used to keep track of requests and invoices.
G. Once service has been received, expect emailed invoice from goodwill.
H. On invoice include pt chart #, Department service was used for, department GL code, and signature.
I. Scan Invoice into computer to keep a digital copy.
J. Inter office original to accounting.

5.0 PATIENT CARE MANAGEMENT

5.1 PATIENT RIGHTS AND RESPONSIBILITIES

Each patient at Ketchum Health will be treated fairly and compassionately. We have created the Patient Bill of Rights, which broadly lists rights and responsibilities of the patients we see at Ketchum Health.

Accordingly, every individual seen o treated at Ketchum Health has the right to:

- Be treated with courtesy and respect for his/her cultural, psychosocial, spiritual and personal values, beliefs and preferences, and receive impartial access to medical treatment or accommodation regardless of race, national origin, religion, gender, sexual orientation, gender identity, marital status, physical handicaps, or sources of payment;
- A prompt and reasonable response to questions and requests; receive information about his/her health status, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes, if applicable) in terms you can understand;
- Expect his/her protected medical information to be handled confidentially, following strict privacy and security protocols;
- Know who is providing medical services and who is responsible for his/her care;
- Know what patient support services are available, including access to interpreters, translators and resources for the disabled;
- Treatment for any emergency medical condition that will deteriorate from failure to provide treatment;
- Expect a reasonable continuity of care. Patients have the right to know, in advance, what appointment times and services are available and for what services;
- Refuse any treatment, except as otherwise provided by law, and to be fully informed of the probable consequences of his/her action;
- Know if medical treatment is for a clinical trial and to give his/her informed consent or refusal to participate in experimental research;
- Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care;
- Receive, upon request, information and counselling on the availability of known financial resources for his/her care;
- Know, upon request, in advance of treatment, whether the health care provider or facility accepts the Medicare assignment rate if the patient is eligible for Medicare;

- Receive, upon request, a copy of a reasonably clear and understandable itemized bill and to have the charges explained;
- File a complaint. If the patient wants to file a complaint, you may do so by calling 714-449-7401 or in writing to Ketchum Health, 5460 E. La Palma Ave., Anaheim, CA 92807.

PATIENT RESPONSIBILITIES AND CODE OF CONDUCT

Patients are responsible for:

- Providing accurate and complete information about present physical complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health;
- Reporting unexpected changes in his/her condition to his/her doctors, interns or Ketchum Health staff, when appropriate and possible;
- Asking questions if the patient does not understand his/her treatment or what is expected;
- Following the treatment plan recommended and agreed upon by the patient and the Ketchum Health staff doctors and interns;
- His/her actions. If the patient refuses treatment or do not follow the health care provider's instructions and the outcome for the recommended treatment or care is adverse due to these actions or lack of action;
- Keeping appointments and, when the patient is unable to do so for any reason, for notifying the Ketchum Health staff;
- Assuring that the financial obligations of his/her health care are fulfilled as promptly as possible;
- Providing accurate insurance and payment information to the Ketchum Health staff at the time of registration or service;
- Being considerate and respectful of the rights of other patients and Ketchum Health staff, and assist in the control of noise and the number of visitors accompanying him/her.
- Being respectful of the property of other persons. Not using abusive language, including profanity, angry shouting, negative comments, or jokes or slurs that demean or are hurtful to patients or staff.

5.2 PATIENT GRIEVANCE AND APPEALS POLICY

Purpose

To establish a process whereby patients or their authorized representatives may have their grievances and complaints filed, heard, and resolved in a prompt, reasonable, and consistent manner.

To develop a process which Ketchum Health may examine and correct any potential violation to patient rights, as it pertains to state or federal statutes and MBKU policies.

Definitions

A. Patient Complaint is defined as an informal expression of distress or dissatisfaction by a patient or the patient's representative, regarding the care or services rendered at Ketchum Health. Most complaints are resolved at the point of care and no further action is required..

B. Patient Grievance is defined as a formal verbal or written expression of dissatisfaction by a patient or the patient's representative when the complaint is not resolved at the point of care by staff. A grievance also involves instances of potential abuse, neglect, or harassment.

Policy

Ketchum Health is committed to providing excellence in patient care and promoting patient and family satisfaction.

Ketchum Health staff and faculty will handle all complaints and grievances following strict guidelines from state law and internal policies. All complaints and grievances will be investigated consistently and thoroughly to bring forth a satisfactory result to all parties.

Procedures and Responsibilities

A. Complaints

1. If a patient has a complaint pertaining to an intern's behavior or performance, the patient should be instructed to discuss their concern with the supervising faculty member.
Responsible Party: Faculty Supervisor

2. If the complaint relates to a patient relations staff's behavior or performance, the patient should be instructed to discuss their concern with the Director of Clinical Services. .
Responsible Party: Director of Clinical Services

3. If the complaint pertains to patient's privacy or confidentiality of protected health information, the Director of Healthcare Policy Compliance must be notified.
Responsible Party: Director of Healthcare Policy Compliance

B. Grievances

1. If the compliant cannot be resolved or is defined as a grievance, the supervisor or chief of service where the incident occurred shall complete a Patient Complaint/Grievance form and notify the Associate Dean of Clinics. If resolution is achieved, a response will be sent to the patient or patient's representative within five (5) working days.
Responsible Party: Associate Dean of Clinics

2. If resolution cannot be achieved to the patient's satisfaction,, the patient can appeal the decision to the Chief of Staff. The Chief of Staff will send the final resolution of the appeal to the grievant in written form, no longer than fifteen (15) working days after receipt of the form. This decision will be final.
Responsible Party: Chief of Staff

References:
California Patient Rights and Responsibilities Title 22

5.3 CARE OF MINORS

Purpose

To establish a process whereby care of minors is following state and federal laws, and best practices from industry regulators.

To establish protocols to obtain consent from the minors' personal representatives before they can be rendered care at any of our clinics, including research studies. To create a mechanism to report abuses or harassment to minors by any family member, personal representative, or Ketchum Health employee.

To create protocols to protect the privacy and confidentiality of minors' medical information, and the release of such information when required for continuity of care

Definitions

a. **Children vs. Minors:** Under California law, both terms are used to refer to individuals who are under 18 years of age, and cannot consent to treatment or procedures by themselves.

b. **Emancipated minor** include minors14 and older who have been emancipated by court order; minors who are married; minors who are on active duty with the armed forces of the United States**.** Emancipated minors can consent for their own medical care

c. **Self-sufficient minors** are defined by law as minors aged 15 and older who are living separate and apart from their parents and who are managing their financial affairs regardless of their source of income.

d. **Parent** means a child's biological or adoptive parent

e. **Guardian** means an individual who is authorized under applicable law to consent for a child to receive medical care.

f. **Consent** means giving permission to receive health services or giving permission to share patient information with others.

g. **Child Abuse** is any conduct defined as "child abuse" under the California Child Abuse and Neglect Reporting Act.

h. **Emergency** is a situation requiring immediate services for diagnosis of unforeseeable medical conditions, which if not treated, would lead to a severe disability or death.

Scope

Although most of this policy applies specifically to those working with or around a minor in clinic medical activities, all employees at Ketchum Health have certain reporting responsibilities.

Sexual abuse is widely perceived as the chief risk to minors, but it is not the only one. Minors can be physically injured, bullied, or given opportunities to cause trouble for themselves and others. To emphasize the importance of safety in campus activities involving minors – and by extension, to protect Ketchum Health – this policy addresses risks involving minors in a comprehensive manner.

Policy

Ketchum Health is committed to providing a safe and respectful environment for the care of minors. Our staff will treat minors with respect, regardless of their actions or behavior. No adult associated with the

clinic may use physical punishment to manage minor's conduct. **Physical or sexual abuse of minors will not be tolerated at Ketchum Health.**

Procedures

1. Consent for treatment.

A. Before a minor receives care, his or her legal representative must provide a formal informed consent. Such consent includes:
   a. Reason for the procedure;
   b. The risks, complications and expected benefits or effects of the procedure;
   c. Any alternatives to the treatment and any risks and benefits.

B. Consent is not required to treat minors under emergencies if the provider, based on her/his professional judgment, believes that the procedure should be undertaken immediately. Ketchum Health should not be liable for performing a procedure on a minor without consent under these circumstances.

2. Reporting abuses when suspected.

A. In California, health care practitioners are mandated to report any reasonable suspicion of child abuse. Ketchum Health will fully comply with the State of California's Child Abuse and Neglect Reporting Act (CANRA).

B. All personnel affiliated with Ketchum Health are encouraged to report suspected child abuse or neglect.

C. By law, mandated reporters are individuals required to make a child abuse report anytime if, in the scope of performing their professional duties, they discover facts that lead them to know or reasonably suspect a child is a victim of abuse. Mandated reporters will communicate with the Associate Dean of Clinics to process the incident accordingly. The Dean will decide if law enforcement needs to be involved. Mandated reporters could contact law enforcement directly if the suspect abuse is evident, and harm to the minor could increase by delaying such reporting.

D. Child abuse reporting is exempted from patient confidentiality regulations and Ketchum Health privacy bylaws.

3. Abandoned Minors, Dependents and Wards of the Court.

A. The court has the power to authorize medical treatment for abandoned minors, and for minors who are dependents or wards of the court (for example, kids in foster care or juvenile hall). Additionally, the court may order that other individuals be empowered to authorize such medical or treatment as may be necessary, if the parents are unable or unwilling to consent. In some circumstances, a court order is not necessary. For example, under certain circumstances, a police officer can consent to medically necessary care for a minor who is in "temporary custody.

B. Ketchum Health will evaluate the situation on a case-by-case basis to decide the best course of action, according to the legal mandates and internal bylaws

4. Unaccompanied Minors.

A. Unless expressly permitted by law, providers are not authorized to see minors without the presence of their parents or legal representative. If a parent or guardian cannot be present, the appointment will be rescheduled, unless the Associate Dean of Clinics authorizes the exam under extenuating circumstances. There will be at least two adults present during the examination.

B. Parents or guardians are not allowed to leave premises without the minor under their care. Ketchum Health will not supervise unaccompanied minors, and it will not be liable to parents or guardians who left the clinic premises without the minor. Ketchum Health will contact authorities immediately if a minor is left alone inside or around clinic premises for extended time. Parents and Guardians must be informed about his policy in advance.

5. Confidentiality and Release of Information

A. Protected health information about a minor is confidential, and is considered especially sensitive for purposes of its collection, use, sharing, and storing. Ketchum Health will apply all the safeguards available and required by law to protect the confidentiality and privacy of such information.

B. Unless required or authorized by law, minors' medical information will not be released to a third party without the express consent of the parent or legal representative. Ketchum Health will release minor's PHI to another provider for continuity of care purposes without express consent if the parent or guardian accepts the referral for treatment.

C. Mandated reporters are authorized to disclose sensitive information to fulfill a required report, or to alert competent law enforcement agencies. Ketchum Health will not be liable for such releases if they are done based on good faith and the professional judgment of the attending provider. Proper documentation must be in place.

6. Divorced Parents and Custody Proceedings

A. In the case of divorced parents, the right to consent rests with the parent who has legal custody. If the parents have joint legal custody usually either parent can consent to the treatment unless the court has required both parents to consent to the proposed care. Ketchum Health will only abide by the legal document presented at the time of the appointment.

B. If there is a custody proceeding between the parents of a minor who is undergoing care at Ketchum Health, both parents have access to the minors protected health information, unless otherwise presented with a court order or similar decree by the holding parent. Verbal statements about an ongoing custody dispute will not be binding for purposes of releasing or restricting the release of a minor's medical information.

7. Delegation of Authority to a Third Party

A. A parent or guardian who has the legal authority to consent to care for the minor has the right to delegate this authority to other third parties (aged 18 and older). For example, the parent may delegate authority to consent to medical care to the school, to a coach, to a step-parent, or to a care taker who is temporarily caring for the child while the parent is away or at work.

B. Ketchum Health has a dedicated form to be completed by the delegating parent or guardian. A copy of the written delegation of authority should be kept in the minor's medical record.

8. Special Programs involving Minors.

A. Ketchum Health has special arrangements with agencies or entities such as school districts or regional centers to provide vision services for the minors enrolled in their programs. A signed consent by the parent or guardian of the minor being examined is mandatory before starting the evaluation. The respective agency will be in charge of creating and obtaining such consent from parents or guardians. Ketchum Health administrative staff will process the form accordingly.

B. Due to the high volume of minors present at one time during these examinations, Ketchum Health does not provide a workforce to supervise them during their appointments. It is the responsibility of school officials to be present, accompany, and supervise the minors during the visit to our facilities.

9. Research involving minors

A. Special ethical and regulatory considerations apply when research involves children as subjects. Ketchum Health will work in conjunction with the Institutional Review Board (IRB) to apply the requirements and guidance found in federal regulations 45 CFR 46, Subpart D, "Additional Protections for Children Involved as Subjects in Research".

B. Customized consent from the parents or guardians of the minor subject of the research must be obtained before starting the program. The IRB could waive such parental permission if it determines that a research protocol is designed to study conditions in children for which parental permission is not a reasonable requirement to protect the minor subject.

10. Communication Protocols

A. If a minor, or the minor's parent or legal guardian (in the case of parent or legal guardian consent) cannot communicate with the Ketchum Health provider because of language or other communication barriers, arrangements must be made for an interpreter, "signer" or other help with communication before consent is obtained and before care is rendered.

B. Unless authorized expressly by the parent(s) or legal representative of the minor, Ketchum Health employees and Interns involved in the care of minors will not share or release their protected health information directly to the patient in any way or channel.
If any exemption to this rule should apply, the individual involved in the care of the minor must consult with the Associate Dean for Clinics and with the Director of Healthcare Policy Compliance for guidance before proceeding with the release of the minor's PHI

Responsibilities

Associate Dean of Clinics

- Takes administrative responsibility to this policy and interprets the policy for the Clinics.
- Accepts mandated reports for review when not filed to law enforcement directly by the mandated reporter

- Makes sure the policy is available to all staff at Ketchum Health and provides guidance on best practices regarding its applicability and enforceability.
- In conjunction with the Director of Healthcare Policy Compliance, proposes updates and revision of the policy as needed

Director of Health Care Policy Compliance

- Performs risk assessments to determine the level of risk exposure of Ketchum Health when treating minors.
- Revises internal reports of suspected child abuse or neglect, and follow up as appropriate
- Reviews and update procedures and forms regarding consent of treatment, the release of information, and special programs.
- Updates this policy as needed.

Campus Safety

- Notifies law enforcement when its involvement is warranted to deal with a child abuse incident, if physical or any other type of mitigation activity escalates.

5.4 PATIENT VIDEOS, PHOTOGRAPHS, AND AUDIO RECORDING

Purpose

Videos, photographs, and audio recordings of patients at the point of care can improve healthcare outcomes. At the same time, these recordings have the potential to violate patient privacy if not done correctly.

The purpose of this policy is to develop guidelines for Faculty with clinical privileges and research assignments to comply with federal and state laws while recording patients. The policy lays out specific protocols we must follow to prevent violations of patients' information privacy and confidentiality.

Definitions

a. **Recording-** For purpose of this policy, "recording" refers to photographing, filming, audio capture, or recording in any way.
b. **Authorization-** Refers to the permission that HIPAA requires for use or release of PHI, including recording. Under HIPAA, authorization must be in writing.
c. **Marketing-** The practice of recording patient encounters or testimonials to promote Ketchum Health services in the community and in the Media.

Scope

The policy applies to all Ketchum Health staff, faculty with clinic privileges, Faculty involved in clinical research activities, and Interns expressly authorized to record patient encounters. This policy covers all the affiliated clinics to Ketchum Health.

Policy

Photographing, filming, or recording in any way patient encounters is only permitted in the context of treating patients, and if the provider has determined that those recordings will add value in treating or diagnosing the patient.

In order to preserve the privacy and confidentiality of our patients, recordings may only be made for permitted purposes other than patient care, by authorized individuals. This includes testimonials, marketing campaigns and press releases.

Procedures

a. Recordings of treatment sessions used for purposes of treatment or diagnosis will be considered part of the patient record and maintained and tracked within that record.
b. A written consent from the patient or patient's representative is required to proceed with the recording. A verbal authorization is not considered valid "consent' for purpose of this policy. The written authorization will be documented accordingly in the patient's file.
c. Only Institutionally owned and secured devices may be used for recordings otherwise allowed under University policy.
   Ketchum Health does not have a Bring Your Own Device–BYOD policy in place; therefore, the use of personally owned devices is not permitted to record patient encounters under any circumstances.
d. Whenever possible, applications associated with the EHR for use with photos, audio recordings, or video recordings, should transfer this media directly to the medical record so that it is not stored on the device**.** In no case the recording will be made and/or maintained in users' personal mobile device or in any other portable drive outside the control of the Chief of Service.
e. Each Service will be responsible for procuring and managing the devices used in the recordings. The chiefs of service-or their designee(s) will ensure that the devices are secured in accordance with University security standards for mobile devices, including encryption, limitations on the quantity of PHI that can be stored, timely and secure removal of PHI, and secure transfer of recordings to the medical record when feasible.
f. The Director of IT department, in conjunction with the chiefs of service will determine the best option to implement when the EHR software is not the ideal location to store the recordings. Such options may include a MBKU dedicated-server. The IT department will provide guidance on the type of recommended format for the recordings, encryption at rest, additional software to be deployed, and staff training.
   Storage used for all PHI must be reviewed for compliance with the HIPAA Security Rule.

Recordings by Patients or Family Members

California is an "all parties" jurisdiction; therefore, all individuals involved must accept a recording of any type. If a patient requests a family member or visitor to record the exam, the recording may take place provided the following conditions are met:

a. Staff may not be recorded without their **specific knowledge** and permission.
b. Recording is not to take place when staff is providing treatment, unless expressly authorized by the rendering supervisor.
c. Patients, family or visitors may not record any other patients without their specific knowledge and permission, or authorization where required.
d. Ketchum Health expressly reserves the right to suspend this privilege if in the judgment of clinic staff the care of any patient may be jeopardized and/or any time clinic operations may be impaired. In no case may recordings be obtained when doing so may interfere with the provision of care or otherwise create an unsafe environment. Faculty is authorized to notify

patients or visitors to stop recording when the activity is unsafe or interferes with patient care.

e. If recordings of patient encounters are allowed, Ketchum Health will not be responsible for breaches of patient information or any other security incident that occurs on patient's devices. It is the sole responsibility of the patient or family member to safeguard patient's sensitive information when personal devices are used.
f. Whether or not the request is related to a care issue, the staff member receiving the request should seek assistance through his/her manager or other appropriate resource to evaluate and develop an appropriate response to the request. Patients, family members and visitors involved in requests to record a patient should be informed of the rules applicable to this privilege.

Other Recordings

Recordings for other purposes, including education, quality improvement, documentation of abuse or neglect, insurance, general public release, or for other non-treatment purposes, will not be considered part of the medical record.

Recordings of patients taken for nonclinical purposes other than education and quality improvement (such as for promotion) should be coordinated through the Marketing and Communications department. MarCom staff will ensure that the appropriate authorizations are obtained from patients who will be recorded.

If recordings or images should be taken for the aforementioned purposes, only personnel authorized by the Associate Dean for Clinics will conduct such activities, using an encrypted Ketchum Health-approved recording device. Recordings should be moved to a secure network drive and deleted from the encrypted camera or device within two days of completing the recording.

To protect the privacy rights of our workforce members, all patients, visitors and staff members are prohibited from recording members of the workforce without their express permission while they are on the clinic premises or working off-site. Employees may photograph areas of Ketchum Health that are public spaces, and public events, but are prohibited from recording other areas of the clinic premises, equipment, or the clinic environment unless otherwise authorized under this policy.

5.5 ADA COMPLIANCE- DEAF OF HARD OF HEARING PATIENTS

Rules and Regulations

Background:

The American with Disabilities Act of 1990 (ADA) was enacted with the goal of allowing every individual with a disability to have equal access to services and places offered to people without disabilities, and to avoid discrimination against , based on their disabilities. The act has been subject to numerous revisions and amendments, being the *billing code 4410-13 revision of part III* (signed by the Attorney General on September 2010) the most recent .

ADA and Optometry

Title III section 36 makes specific references to the rights that individuals with disabilities have when seeking services, including those from health care providers. The following notes intend to explain those regulations pertaining the rights of deaf or hard of hearing patients, based on the text of the law, on opinions of representatives of the Department of Justice- ADA division, California Board of Optometry, private practitioners, and schools of optometry. These notes incorporate the latest regulations included in the September 2010 revision of the act (known as "*Title III: final rule amending 28 CFR part 36: Nondiscrimination on the Basis of Disability by Public Accommodation and in Commercial Facilities")*

a. **Place of Public Accommodation**. Means a facility operated by a private entity whose operations affect commerce and fall within at least one of the following categories: "Part 36.104 (6)…….professional office of a health care provider, hospital……"

b. **Qualified vs. Certified Interpreters.** Title III requires a doctor's office to provide auxiliary aids and services to patients who are deaf or hard of hearing. This may require the use of an interpreter. The revised rules defines a qualified interpreter in the following terms: **"**Qualified *interpreter means an interpreter who,* ***via a video remote interpreting (VRI) service or an on-site appearance****, is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary.* ***Qualified interpreters include, for example, sign language interpreters, oral transliterators*** *[sic]* ***and cued-language transliterators*** *[sic]*

   The law does not mention the word "certified" when referring to interpreters; only the "qualified" word is used and this is the key term to understand the scope of auxiliary service that a medical practice is required to offer. Providers are not obligated to make available certified sign language interpreters while caring for deaf patients; if the interpreter offered by the practice is capable of communicating effectively, then the requirement has been met.

   Providers can prove this fact by documenting previous encounters in which the same interpreter was able to communicate effectively and accurately with deaf patients. Requiring medical practitioners to provide "certified" or "especially trained" interpreters, could be construed as imposing an extraordinary burden in the operations of the facility, and this is specifically forbidden in the law. Proper documentation of all the steps taken to comply with the law is paramount, should any legal or malpractice dispute arises.

c. **Effective Communication.** Section 36.303, paragraph (c) of the title III makes clear reference to the concept of "effective communication", allowing the medical practitioner – not the disabled patient -to be the ultimate judge in deciding what means of auxiliary aids is considered appropriate to attain an effective communication. Such decision should be based on mutual discussion and agreement, and at no point should be imposed to the patient. Walk-in deaf patients should not expect to be seen with a qualified interpreter immediately; providers can re-schedule the encounter, unless it is an emergency; in such case, any method provided to obtain an effective communication is considered valid, even the use of minors as interpreters if they are family members, or the use of written/printed materials.

d. Undue Burden. Several factors must be considered when determining if providing an auxiliary aid constitute an undue burden for the provider. Cost of the action, financial resources of the practitioner, effect on expenses and resources, composition and structure of workforce and workflows at the facility, are some of the issues to be evaluated. According to the representative of the Justice Department -ADA division, if a provider makes available and pays for a qualified interpreter to a deaf patient, and the patient does not cancel the appointment or simply does not show up repeatedly, this is considered an undue burden and the provider might refuse to see the patient again.

AMERICAN WITH DISABILITIES ACT (ADA) – IMPLEMENTATION AND COMPLIANCE AT Ketchum Health

Key Elements to Review:

- Any building/office open to the public for business is subject to the ADA statute; no exceptions.
- California has some more stringent regulations.
- $4,000 is the minimum damages- plus attorney's fees-for each violation encountered. There is no cap as how much can be claimed by individuals.
- ADA regulates not only physical barriers for individuals with disabilities, but also speech, sight and hearing impairments.
- 90% of the complaints have to do with outside regulations: parking spaces, sign postings, etc.
- There are regulations for every single space and access process to the building, from parking (including signage) to path to travel; drinking fountains; from door pressure to door knobs; from loose mats to stripes' colors on parking spaces; from bathroom faucets to countertop's altitude.
- Review what is considered a "service animal", according to the California Law.
- Avoid the use of the "Handicapped" word. It's considered offensive.
- Review legislation (both state and federal and create policies and procedures accordingly.
- Need to meet with Greg and do a walkthrough (campus wise)
- Consider ordering a CASp review: Certified Access Specialist inspector.

5.6 DISRUPTIVE PATIENTS

Purpose:

To educate and protect staff members from patients who behave in a disruptive or threatening manner.

Introduction:

Our Clinic has a mission of providing comprehensive quality eye care in a caring setting. In order to achieve our mission, the administrators of our clinic strive to maintain a caring and safe clinical environment. Administration cannot completely control patient behavior. This policy addresses those rare instances when patients behave in an inappropriate way that disrupts a positive clinical setting.

PROCEDURES

For All Situations:

1. A quiet area needs to be used to speak to a disruptive person. Ideally a conference room or other common area can be used; if not, a counseling room, lane or administrative office may be used. Supervisors should plan in advance what room can be used for this purpose.
2. The manager involved should always consider his/her safety, and either leave the door open or have a second person (HR, Associate Dean for Clinics, Director of Operations or Safety Officer) present during interviews.
3. The manager should never position him/herself so the angry patient can block the door from the room.
4. If there are no security personnel at the location, calling 911 in a dangerous situation is the correct response to protect yourself, other staff members, and other patients.

Disruptive Patients

1. If a patient is being disruptive by raising his/her voice or using profanity, the staff member will speak in a calm voice and attempt to determine the cause of the patient's behavior.

    a. If a patient is on the telephone and behaving inappropriately, the staff member should attempt to determine the cause of the anger. The staff member can advise the patient that the call will be terminated if the patient continues to use inappropriate language. After warning the patient, the call should be terminated if the inappropriate patient behavior persists.

    b. If the patient is in the clinic, the staff member should call a manager or administrator to assist as soon as possible. The manager or administrator should escort the patient to a quiet area to discuss the problem, as long as the patient is not behaving in a threatening manner (see #4, below).

        i. If the patient does not become calm, the manager or administrator should ask the patient to leave the clinic for the day, and politely suggest they resolve the issues then next business day.

    c. If a patient mails a letter of complaint to the clinic, it should be forwarded to the Director of Healthcare Policy Compliance. The Associate Dean for Clinics will assume responsibility for follow up.

2. The manager or administrator will contact the patient the following day to attempt to resolve the issue. If on follow up call the patient is still behaving unreasonably, the manager or administrator will terminate the call after advising the patient that someone will contact him/her within the week. The manager or administrator will then contact the Associate Dean for Clinics. The Associate Dean for Clinics will pull the patient chart, interview all staff members involved in the incident, and assume control of the situation.
    a. If the patient has no history of unacceptable behavior and the incident was patient-induced (e.g. unprovoked patient insulting a staff member appearance, making unreasonable statements regarding staff members, etc.) the Associate Dean for Clinics will send a letter to the patient by regular mail. The letter will request the patient refrain from using inappropriate language while in the clinic.

If the patient behavior seems to have resulted from a practice policy, billing statement, or employee behavior, the Associate Dean for Clinics will call the patient and attempt to resolve the issue. If the patient is not immediately available by telephone, the Associate Dean for Clinics will send a letter to the patient with an apology and a proposed resolution, as appropriate.

b. If the patient continues to behave unreasonably after the manager, administrator or the Associate Dean for Clinics attempts to resolve the underlying issue(s), the Associate Dean for Clinics will discuss discharging the patient with all practice doctors involved in the patient's care.

3. In the unlikely event that a patient uses verbal or actual threats of physical harm, or is behaving in a completely irrational or unreasonable manner, the staff member must be careful to not be hurt.
    a. DO NOT approach the patient. Keep a safe distance. If in a confined area (e.g. exam lane), leave the room as soon as possible and contact a manager, administrator, or safety officer.
    b. Speak in a calm voice. DO NOT argue with the patient. Do not threaten the patient, or make any sudden movements.
    c. Signal to a coworker to call 911 immediately. If a coworker is not available, ask the patient permission to leave the area to "get a manager". Call 911 as soon as possible.
    d. If any weapons are ever displayed, stay calm and be sure an observer calls 911 immediately. Do not make sudden moves.

4. A Variance Report for any incident involving disruptive patient behavior must be completed and forwarded to the Risk Manager and Safety Officer as soon as possible.
    a. The Risk Manager will contact the practice malpractice insurance company for guidance when necessary.

CONCLUSION/OUTCOME:

A safe environment for all staff members and all patients of our practice, where mutual respect is recognized and supported by management, staff and patients.

Patient care is a contractual relationship between an individual and the physician, and any party can terminate such relationship unilaterally. Therefore, Ketchum Health officials, exercising professional judgement and due diligence, and following strict protocols in the law, can terminate care if the circumstances warrant such action. Please refer to exhibit 1 "Letter of Termination of Care" for guidance in this procedure.

5.7 NO SURPRISES ACT (NSA)

Summary

The No Surprises Act went into effect on Jan. 1, 2022, and it requires healthcare providers and health plans to comply with new regulations that will protect patients from unexpected medical bills.

The law outlines clear patient cost-sharing responsibilities, balance billing, Including several transparency and other related provisions. As a health care facility and a covered entity under the Act (Sec. 104), Ketchum Health must comply with its requirements by developing appropriate protocols.

Discussion

Although most of the regulation is aimed at healthcare plans and their obligations to adequately inform plan participants of their coverage and physician network access, healthcare providers were also included as they must notify patients of any gap in the coverage before providing services.

The main goal of the bill is to help prevent consumers from being blindsided by the cost of unanticipated or emergency healthcare services.

Regulatory Background

On Dec. 27, 2020, the No Surprises Act was signed into law as part of the Consolidated Appropriations Act of 2021 (H.R. 133; Division BB – Private Health Insurance and Public Health Provisions). The No Surprises Act addresses surprise medical billing at the federal level.
The final rule was published in November 2021 and most sections of the legislation go into effect on Jan. 1, 2022, and the Departments of Health and Human Services, Treasury, and Labor, are tasked with issuing regulations and guidance to implement a number of the provisions.

Scope of the Act

There are three main applicable categories of protections by the Act related to unexpected bills from providers:

- Unanticipated care from an out-of-network physician;
- Emergency care at an out-of-network health facility;
- Or emergency care from an out-of-network physician at an in-network facility;

Among other provisions, the No Surprises Act:

- Holds patients liable **only** for their in-network cost-sharing amount while allowing providers and insurers to negotiate reimbursement. Patients are only responsible for cost-sharing amounts that would be their responsibility if care had been provided in-network. Additionally, providers will be barred from holding patients liable for higher amounts. The patient's cost-sharing is based on the recognized amount.

- Allows providers and insurers to access an independent dispute resolution process if disputes arise around reimbursement. The legislation does not set a benchmark reimbursement amount.

- Requires both providers and health plans to assist patients in accessing health care cost information.

- Defines processes that improve the accuracy of provider directories.

Conclusions and Recommendations

As a covered entity under the new law, Ketchum Health must:

- Have a procedure in place to deliver provider directory information to health plans. This will require submitting regular updates to health plans to help insurers maintain up-to-date, accurate directories of their in-network doctors.

- Be prepared to submit information to the plan at any other time determined appropriate by the Secretary of the Health and Human Services Department.

- If the patient pays the bill, create a protocol to refund the cost difference when Ketchum Health has submitted a bill to the patient greater than the in-network cost sharing. The rule states that the refund must include interests.

- Provide a "good faith estimate" of all the billing and service codes for the care the patient is expected to receive to the health plan or to the patient if uninsured. The estimates must be submitted at least three days before providing the scheduled services and obtaining the patient consent.

- If a provider contract is terminated without cause, a "continuing patient" can continue to receive services from the newly excluded provider for either 90 days or the date when the services are no longer needed, whichever is earlier.

- Contact health care plan administrators to verify provider contract status regularly (at least once every 90 days). A log of these communications should be created and maintained for compliance purposes.

- Post a brief explanation of regulations related to balance billing on the Ketchum Health website and include contact information for the appropriate enforcement agency with which the patient can file a complaint.

- Train patient relations staff on the new rule, specifically on managing the consent required when patients are uninsured.

5.8 ELECTRONIC COMMUNICATION OF PROTECTED HEALTH INFORMATION

Definitions:

PHI – Protected Health Information. Information that could be used to identify an individual. It is data that Ketchum Health created or received about an individual, and it could be health or demographic information (address, phone number, social security, date of birth), pertaining to past, present or future treatment, and stored on paper, computer, CD, audiotape, microfilm, photographs, or any other permanent method.

Third Party – A third party is any federal/state/county agency or entity, outside providers, health plans, school districts, business associates, clearing houses, law firms, non-profit organizations, or any other entity or individual outside Ketchum Health.

Workforce – Employees, volunteers, trainees, work studies, social workers, agents, and other persons whose conduct, in the performance of work for the University Eye Center, is under the direct control of Ketchum Health.

Purpose:

The following protocols describe the steps to be followed by Ketchum Health staff, agents and interns when communicating PHI electronically.

This policy apply to the workforce authorized by Ketchum Health to read, create, store, respond, or transmit PHI via MBKU email system, internally and externally.

Procedures:

Communicating PHI via e-mail with patients

1. The KETCHUM HEALTH will implement the following safeguards when communicating PHI in or attached to an email:

i. All PHI must be encrypted before being released electronically. Ketchum Health uses a default Microsoft 365 software application which allows the encryption to take place following federal guidelines. Passwords and/or encryption keys may NOT be transmitted electronically if other encryption method is used different than MS-365.

ii. PHI will not be transmitted in the subject line of the email message or in the body of the message.

iii. Email communication containing PHI of Ketchum Health patients will be transmitted through the Ketchum email system using a Ketchum email address and may not be transmitted using any other electronic method or email system.

iv. If a document that contains PHI is attached to the message, the sender must verify that only the proper information is attached and no unintended information is included.

v.Users who communicate PHI via email will comply with all other MBKLU policies and procedures including, but not limited to, the Confidentiality of PHI Policy and the Minimum Necessary Policy.

2. Patients have the right to request their PHI and legal records to be disclosed electronically. A note must be included in the file documenting such request.

Duty-to-Inform Protocol

The University Eye Center personnel can release PHI to patients without encryption, only if the patient has been informed of the risks of transmitting such information unencrypted, and the patient makes an informed decision about it. A note documenting the patient's decision will be added to his/her file.

Electronic releases of PHI to other parties different than the patient must be completed following the encryption protocols, no exceptions allowed.

Ketchum Health reserves the right to deny the request of release of PHI to the patient. If no other way of communication with the patient is available, Ketchum Health will discuss with the Director of Information Technology and the Associate Dean of Clinics the possible alternatives for releasing PHI.

3. All requests for release of information via email must be specific and the intended recipient of PHI must be properly identified. Massive emails are not authorized to be sent from the Ketchum Health domain; it is the sole responsibility of the patient to safeguard his/her PHI after it has been released electronically. Since KH or MBKU have no control over the uses or disclosures after the information has been released to the requesting party, KH or MBKU will not be held liable for unintended or malicious uses of PHI by third parties.

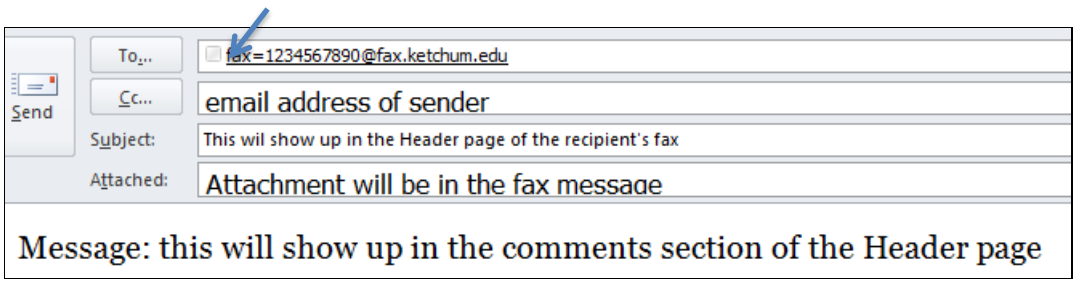
4. Ketchum Health will provide adequate training to email users regarding document security procedures, including password management and encryption methods. Every person sending PHI to a requesting party via email must be knowledgeable in the encryption/password procedures; if not sure about it, the individual must communicate with the Director of Healthcare Policy Compliance to get the information properly released.

5.9 E-FAXING PROTOCOLS

Anyone with a Ketchum email account is able to send faxes through Outlook. Following are the steps needed to send a fax using this email application:

- Documents are sent as attachments; therefore, if you have a hard copy, it must be scanned and saved in a place of your preference (Desktop is recommended for expediency).
- Make sure the document is saved in one of the following formats: PDF, TIF or TEXT. Documents in different formats are not supported by the system and cannot be faxed.
- Below is the actual formatting of the efax module. Make sure you follow these guidelines:

Fax number



- The number “1” is not needed before entering the area code. No spaces or dashes.
- It is recommended that the name of the sender is entered in the Cc section. This person will receive a copy of the eFax message, which will be used for documentation purposes.
- The attachment will be the actual fax message.
- The body of the message will appear in the comments section of the fax header page.

Sending a fax using one of the available Scan-To-Email copiers on campus

The same protocols as sending faxes via email apply, with the following additional steps:

- The document(s) to be sent must be placed in the copy machine facing up.
- Once the information is entered the screen, hit the send button and the email will be delivered.

- Make sure you pick up documents left in the tray (confidentiality) and exit the application by clicking the “home” key on  the screen

Directions are posted above each of the copiers. The format of the email address is Fax=###@Fax.Ketchum.edu (### is the fax number).
Example Email Address: Fax=7148799834@Fax.Ketchum.edu

6.0 PATIENT CARE SERVICES

6.1 CONTACT LENS

6.1.1 Appointments

Procedure:

When a patient, intern, staff, or doctor requests an appointment, staff will follow the steps below:

1. Follow the same “scheduling an appointment” steps noted in section 5.1
2. However, when checking Contact Lens available appointment slots, always adhere to the following**:**
    a. In the last appointment slot of the day, schedule follow up appointments only except for Monday, Friday, and Saturday where comprehensives are allowable.
    b. Do not schedule comprehensive exams back to back whenever possible
    c. When scheduling follow up appointments, schedule with the same intern or faculty who saw patient last if possible.
    d. Distribute appointments evenly throughout the half-day session among interns and also throughout the week.
    e. Give priority to third year interns.
    f. Enter specialty or insurance information in the appointment notes per patient relations protocol or staff doctor request (i.e. VSP MED NEC CO-PAY $25, Spectera, Ortho-K, 1-month post-op LASIK, etc.)
    g. Schedule appointments with interns who have low patient counts. Ask the contact lens chief or assistant chief for this list 5 weeks into the quarter.
    h. Most referral and specialty contact lens fits will be scheduled with the contact lens residents who will also help manage their own schedule.

When scheduling new contact lens patients, confirm if the patient wears a specialty contact lens (most patients know if they fall in this category). New specialty lens patients should be scheduled with the contact lens resident whenever possible unless the schedule is full or if the patient requests a specific doctor.

When scheduling contact lens patients, check to determine if the patient was previously examined by the contact lens resident doctor. If so, continue to schedule the patient with the contact lens resident (even if a new resident is currently scheduled).

The contact lens resident may schedule or manage their own contact lens follow-up appointments as appropriate.

6.1.2 Scheduling Contact Lens Assistants

Definition:

Contact Lens Assistants are 3rd or 4th year interns who are identified as "CL Assistant" on the COMPULINK schedule. Assistants are assigned to an exam room, but the second half of their schedules are blocked before the shift begins. Assistants aid other interns with patient care, aid in tasks in the contact lens service, and see patients when other intern schedules run behind and/or walk-in/emergency appointments are scheduled. Assistants can have one exam scheduled at the beginning of the shift (either at 8:30, 1:30, or 2:30), but no additional shifts should be added.

Procedures

1. Enhancers and assistants are scheduled in the same manner as appointments in COMPULINK.
2. Go to "Event" and select or "CL Assistant."
3. Assistants are scheduled on a rotating basis that is dependent on the varying schedule each quarter. For shifts that include Assistant schedules, a different intern will be scheduled until the schedule rotates back to the first intern to ensure that Assistant schedules are evenly distributed among each intern group.
4. The CL Chief will submit a schedule for the Assistant schedule several weeks before the quarter begins so the schedule can be updated to include the Assistant schedule (i.e. these students' schedules will be blocked on the days they are assigned as Assistants).

Summer Quarter Special Scheduling

- Week 1
    a. 60 minute orientation
    b. 90 minute patient care
    c. 90 minute charting and wrap up *manually schedule in COMPULINK as orientation
- Weeks 2 to 6
    a. 60 minute discussion
    b. 90 minute: patient 1
    c. 90 minute: patient 2

6.1.3 Medically Necessary Contact Lenses

Purpose:

To establish a process in collecting Contact Lens materials payments for Medically Necessary Contact Lenses.

Procedure:

1. Patient has eye exam
2. Doctor codes fee sheet, indicates at check out that exam and material fees will be billed as medically necessary (MNCLS). Doctor emails the billing department (Yecenia Aceves, yeceves@ketchum.edu) with patient account number and billing information for exam fees and materials to begin medically necessary billing process.

3. General Guidelines for Medically Necessary CL Eligibility Requirments:
    a. Anisometropia of 3D in meridian powers.
    b. High Ametropia exceeding –10D or +10D in meridian powers.
    c. Keratoconus when the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses.
        - **Mild/Moderate** – Initial fit of keratoconus patients should begin with lens designs, materials and modalities that are **not** classified as lenses for advanced/ectasia treatment.
        - **Advanced/Ectasia** – For cases in which prescription from the list of advanced/ectasia lenses is indicated to achieve comfort and/or vision correction not possible with other keratoconus contact lens applications. Please note that consistent use of keratoconus advanced/ectasia contact lenses where keratoconus mild/moderate lenses would achieve clinically appropriate outcomes will result in Quality Assurance audits and subsequent outcomes.
4. Vision improvement other than keratoconus for members whose vision can be corrected by two lines on the visual acuity chart when compared to the best corrected standard spectacle lenses.

6.1.4 Placing Contact Lens Orders

Procedure:

Check for newly created lab orders by faculty in Compulink Daily. New orders will be indicated in the "To Do" section of Compulink:

1. If an order has been created by no notes appear and it hasn't been signed off by a faculty doctor, contact the staff doctor via email and request finalization.
2. Ensure material fees have been entered correctly by clicking the "Fees" button on the top of the order screen. Ensure the appropriate number of lenses/boxes have been entered and that any shipping or pick-up fees/information has been posted to the ledger and/or documented.
3. Orders may be placed by telephone online, or by fax.
    a. For specialty contact lenses (GP, scleral, etc), the doctor may have already placed the order. If this occurred, a note will indicate who and when the order was placed from in the order notes.
    b. For specialty contact lenses (GP, scleral, etc), if the doctor did not place the order themselves, their notes should indicate what lens parameters they wish to order and from what lab. If more information is needed to place the order, contact the faculty doctor by email.
    c. For most soft contact lenses, orders can be place in a "batch" method at the end of the day from our current contact lens distributor (ABB).
    d. For all orders and laboratories, check One Drive "Resident's Guide" for the most updated list on laboratory and account information.
4. Update the order screen on Compulink to indicate the date the order was placed. Include any special notes that are applicable to each order.

Receiving and Checking-In Orders

1. Verify all items received by reconciling with the original order forms.
2. If an item is missing or incorrect, notify the appropriate laboratory.

3. Update Compulink with the date “received” and notify patient as necessary. See order notes to determine if patient will pick up lenses over the counter, or if a follow-up appointment is necessary in order to dispense the contact lenses.
4. Place the invoice in the invoice folder to be reconciled at month’s end.

6.1.5 Dispensing Contact Lens Materials

Procedure:

After the patient’s order is received from the distributor (ABB) or laboratory, the Administrative Assistant will conduct the following:

1. Review each order for dispensing instructions and verify if there is a remaining balance.
    a. Dispense without an appointment: follow steps 2-6 below
    b. Dispense with an appointment: Inform patient that it will be necessary to schedule an appointment prior to dispensing. If the patient is unwilling to make an appointment, contact the ordering doctor for their decision in this matter. If the doctor is not available, contact the staffing doctor(s).
2. If the patient had paid in full, dispense the contact lens materials and retain the order form.
3. If the patient has a remaining balance, escort him/her to the Cashier. After the patient has paid the balance, retain the order form from the Cashier and dispense the contact lens materials. Medi-Cal orders must be signed by patient as received. Please scan the signed order form into eDocuments.
4. Update the Compulink order screen to indicate the date the materials were dispensed.
5. If the order is for specialty lenses (GP, scleral, etc), scan the lab invoice to the patient’s documents as “CL Order” and label in notes with laboratory name and invoice number.
6. After dispensing, shred the order form.

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- Large Cabinets: soft and hard lenses (including trials) that may be dispensed without an appointment. These types of lenses can also be stored at the front desk.
- Smaller overhead cabinets: student educational lenses
- ABC bins: soft trials and hard lenses to be dispensed with an appointment

6.1.6 Mailing Contact Lens Materials

Procedure:

The patient may request to have materials or supplies mailed in lieu of picking them up. Examples included contact lenses, glasses, drug prescriptions, itemized receipts, or letters from the doctors.

1. Review the order form or reference COMPULINK to be sure the patient name, contact lens brand, base curve, diameter, power, and quantity are all correct.
2. Verify that the patient has paid for the item(s) in full.
3. Soft Lenses: Free shipping direct to patient’s address on annual supplies ordered from the distributor (ABB). If the order amount is less than an annual supply and the order is being placed directly from the distributor (i.e. order was not mailed to Ketchum Health first) and the patient would like the lenses shipped to their home, they will be charged a $12 shipping fee (choose this

fee when assigning material fees on the Compulink order form). Indicate in the ABB order where the lenses need to be shipped.

4. Specialty Lense (GP, Sceral, etc): Generally, lenses can be directly shipped to the patient with no extra charge if this is indicated when ordering directly from the laboratory. This information should be communicated to the laboratory at the time the order is placed (either by the faculty doctor or the administrative assistant). If any additional fee is charged by the laboratory, this entire fee will be charged to the patient.
5. 5. If any contact lenses (soft or specialty) are initially mailed the Ketchum Health and the patient requests that they be mailed to another address, the patient will be charged a $12.50 shipping fee. Once this fee is collected:
    a. Confirm shipping address with the patient.
    b. Write the patient's name and address on the mailing label and place it inside the package. The Mail room staff will box and package items to be mailed.
    c. If the item(s) need to be insured (check with the faculty doctor, generally items over $100 are insured), include a note for the mail room with the amount to be insured.
    d. Place the package in the outgoing crate in the clinic mail room.

6.1.7 Contact Lens Rule-Federal Trade Commission (FTC)

Summary

On June 17, 2020, the Federal Trade Commission (FTC) announced the passing of a final regulation modifying the agency's Contact Lens Rule. The amendment requires prescribers to obtain a confirmation from patients stating that they received the contact lens prescription. It allows flexibility in the way prescriptions and their mandated confirmation receipt are provided.

Despite targeted opposition by industry advocates, the agency decided to move forward with the final Rule by a 5-0 vote in favor of the amendment. Other changes were introduced that will affect online sellers' operations.

The changes will go into effect 60 days after publication in the Federal Register. No specific timeframe for such publication was announced; however, according to the agency's language, the "final notice will be published shortly."

This paper compiles the main elements of the Rule, and includes a protocol that the Contact Lens service may implement ahead of the enforcement date. Ketchum Health will act proactively to remain in compliance, regardless of legal challenges to the Rule, which are highly anticipated.

Legal Background

The Contact Lens Rule was enacted in 2004, and it imposes obligations on both eye-care prescribers and contact lens sellers. The prescriber must automatically provide the patient with a complete copy of the contact lens prescription after completion of a contact lens fitting, and also must verify or provide the prescription to authorized third parties. Amendments to the rule have been in the works for over four years.

New Prescriber Requirements-Changes to the Rule

Prescribers will be required to do **one of the following** to confirm that a patient received the prescription:

- Request that the patient acknowledge receipt of the contact lens prescription by signing a separate confirmation statement;
- Request that the patient sign a prescriber-retained copy of the prescription that contains a statement confirming the patient has received it;
- Request that the patient sign a prescriber-retained copy of the sales receipt for the examination that contains a statement confirming the patient received the prescription; or
- Provide the patient with a digital copy of the prescription, and retain evidence that it was sent, received, or made accessible, downloadable, and printable.

Prescribers must maintain proof that they satisfied the confirmation of prescription release requirement for at least three years. If a patient refuses to sign a confirmation, prescribers must note this and save it to the patient file to show compliance.

Procedures

Ketchum Health is well positioned to comply with the rule without making burdensome adjustments to patient care protocols.

By taking advantage of the EHR capabilities and the extent possible, we shall encourage patients to receive electronic copies of their prescriptions. As the rule adds a new definition of the term “provide to patient a copy”, faculty is allowed –with the patient’s verifiable consent- to provide the patient with a digital copy of the prescription instead of a paper copy.

When trying to obtain the patient’s consent, Faculty must inform the patient that the prescription will be delivered electronically via email. The permission will be documented in the patient’s medical file. If the patient declines or does not have an email account, we will provide a written copy of the prescription.

It is the responsibility of the attending provider or intern to obtain the require signed statement.

A sample of the confirmation statement:

“I (name of the patient), by way of my signature, acknowledge that I received a copy of my final Contact Lens prescription, which was made available in electronic format via email, or by printed copy handed out at Ketchum Health by the attending provider.”

Once we have the portal functional, current prescriptions will be uploaded for patients to download and print.

6.2 LOW VISION

6.2.1 Scheduling appointments

Purpose:

To establish a process to schedule Low Vision appointments.

Procedure:

1. When checking Low Vision available appointment slots, always adhere to the following:
   - Each Low Vision Evaluation or Continuing Appointment is allotted 1½ hours.
   - Patient history phone interviews are allotted 45 minutes.
   - Dispensing and progress check appointments are given a maximum of 45 minutes.
   - Type One technology evaluations are allotted 2 hours.
   - Prior to scheduling an appointment, the patient is asked the following questions:
     a. Is this your first appointment at Ketchum Health?
     b. If it is the patient's first appointment, ask "How did you hear about us"?
     c. If it is a referral, ask if the referring doctor will be sending any medical records. Enter the referring doctor in the field at the bottom of the scheduling screen in Compulink. Ask the patient for permission to contact the referring doctor to obtain previous records, then obtain the records and scan into the patient chart in Compulink ahead of the scheduled appointment.
     d. Follow the same "scheduling an appointment" steps noted in the section above
     e. Verify all insurance: VSP (if the patient has Low Vision benefits), Medi-Cal, Cal Optima (if through VSP), Department of Rehabilitation (if referred and we have authorization).
   - For new patients, the patient will be scheduled two appointments. The first will be a patient history phone interview with the doctor and student to review their health history, visual goals, medications, etc. The second will be their in-person visit for the vision exam and demonstration of low vision devices. Clinic times available for patient history phone interviews and in-person low vision evaluations will be pre-determined on a rotating schedule throughout each rotation. For established patients only the in-person visit will be scheduled.

6.2.2 Verifying Medi-Cal Insurance

Purpose:
To establish a process to schedule and verify eligibility for patients with Medi-Cal.

Procedure:
Before scheduling appointment*:*

1. Go to https://www.medi-cal.ca.gov/Eligibility/Login.asp to verify eligibility.
2. The patient's plan must be in the Orange County area; otherwise, it is an HMO plan.
3. If it is in the Orange County area, must read the information in the details box as it contains important information regarding eligibility.
4. Once confirmed it is not an HMO plan, proceed with scheduling the patient's appointment (see "Scheduling Appointment" section above).
5. All exam fees will be billed to Medi-Cal and no out-of-pocket charges are to be billed to the patient.

After the appointment:

1. Collect report, scan, and provide to the Claims Department for billing.
2. If materials are requested, the Claims Department will submit for a preauthorization request.

3. When approved, enter charges, and then order the materials (see “Processing Material Orders” section below).

Billing:

1. Collect the “Low Vision Dispensing form” and scan into Compulink.
2. Submit the report and invoices to the Claims Department.

6.2.3 Verifying VSP Insurance

PURPOSE:

To establish a process to schedule and verify eligibility for patients with Vision Service Plan (VSP) insurance.

PROCEDURE:

Before scheduling the appointment:

1. Must submit via fax a “LV VSP Pre-cert form”.
2. Scan all documents into scanned documents in Compulink that a Pre-cert was faxed.
3. VSP will notify the Claims Department of the status within 1-2 weeks.
4. Inform patient of the status.
5. Schedule the appointment for the patient (see “Scheduling Appointments” section above).

After the appointment:

1. Collect the report and the “Low Vision Order Form” from the faculty and complete another “LV VSP Pre-cert form” for devices.
2. Collect the wholesale invoices for each device requested.
3. Send the report along with the invoices to VSP for approval.
4. VSP will notify the Claims Department of the status within 1-2 weeks.
5. Call and inform the patient with the status of the request. If approved,
6 Order the devices (see “Processing Material Order” section below) and provide the patient with an estimated time of arrival of 14 business days.
7. Add charges in the Compulink with the approved authorization.
8. Scan all documents into Compulink and note that the Pre-cert was faxed.
9. Once all items arrive, call the patient to schedule a dispensing appointment.

Billing:

1. Collect the “Low Vision Dispensing form” and scan into Compulink.
2. Submit the report and invoices to the Claims Department.

Forms:

VSP Pre-Certification Form
VSP Low Vision Verification Form
Low Vision Order Form

6.2.4 Department of Rehabilitation (DOR) Referrals

PURPOSE:

To develop a process to schedule appointments for patients referred through the Department of Rehabilitation (DOR).

PROCEDURE:

Once approved, DOR will email the authorization to the AA for their client to obtain a Low Vision (LV) evaluation.

Patient Encounter

1. Call the patient to schedule an appointment.
2. Enter the appointment in Compulink (See the LV "Scheduling Appointments" procedure).

Patient Evaluation

After the evaluation is completed and the patient's record is finalized, the AA will send an electronic copy of the report to the patient's counselor. A copy of the report will be kept on file in the AA's office and the second copy will be forwarded to the Claims department. In addition, a copy will be scanned into the patient's file on Compulink. The documents will be compiled in the order below:

1. A signed and completed authorization
2. The original treatment plan
3. The original pre-fee determination
4. Copies of cost sheets for each recommended item

After the above information has been compiled, the AA will:

1. Scan all the documents in the patient's file.
2. Make a copy and keep all the documents on file in the office.
3. Place the following note in the patient's file in the appropriate Compulink screen: "DOR billed for low vision evaluation and request for devices mailed to the patient's counselor".
4. Request authorization by mail or fax to the DOR for the LV device(s).
5. Place the order in the "Hold" file until authorization is received.

Ordering LV Devices

1. After receiving the authorization, call to inform the patient and provide an estimated time of arrival, and pull the order from the "Hold" file.
2. Place order (see the LV Processing Material Orders Procedure below)
3. Enter the charges in Compulink.

Receiving Orders

1. Verify all devices received by reconciling with the order form (check Compulink if needed).
2. If the order is correct, contact the patient to schedule a dispensing appointment.
3. If the order is not correct, the AA will notify the vendor.

Preparing the Invoice for Billing

When preparing the invoice, always include the dispensing date and Ketchum Health's Tax ID#. The invoice is located in Microsoft Word in My Documents →Letters→DOR Invoices.

1. The AA will email the invoice to the counselor. In addition the documents below will be compiled and sent to the Claims Department for billing:
   a. A copy of the invoice
   b. A copy of the completed DOR purchase order
   c. A copy of the invoice for the devices (located in the white invoice binder)
   d. A copy of the pre-fee determination if applicable
2. Place the following note in the patient's file in Compulink: "DOR billed for LV devices".

3. Save the invoice as the patient's name.
4. Print the invoice on Ketchum Health letterhead.

After Dispensing

The patient signed "Low Vision Dispensing Form" will be kept on file for the DOR.

6.2.5 Processing Material Orders

PURPOSE:

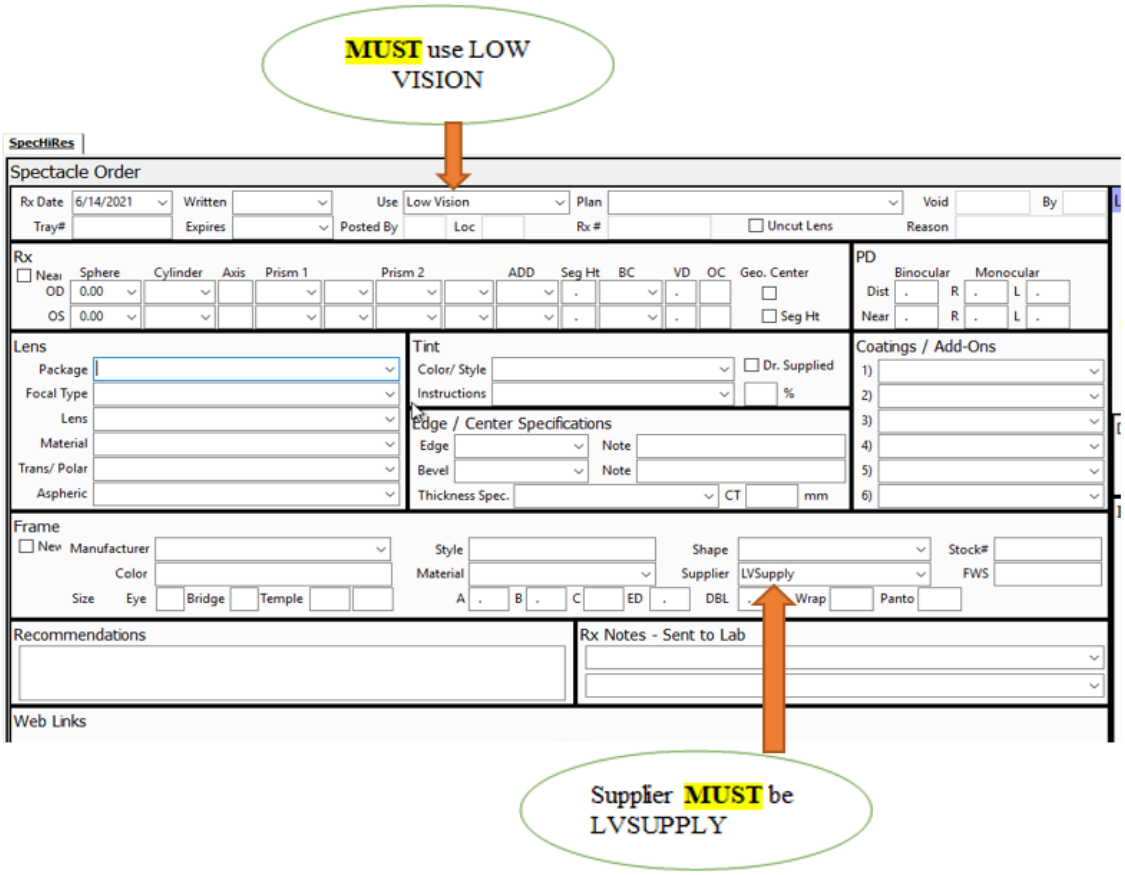
To establish a process to order low vision materials.

PROCEDURE:

Spectacles

At the end of the examination if glasses are to be ordered, the student intern will escort the patient either to the Administrative Assistant's (AA) office or to Optical to help select a frame. The procedure is as follows:

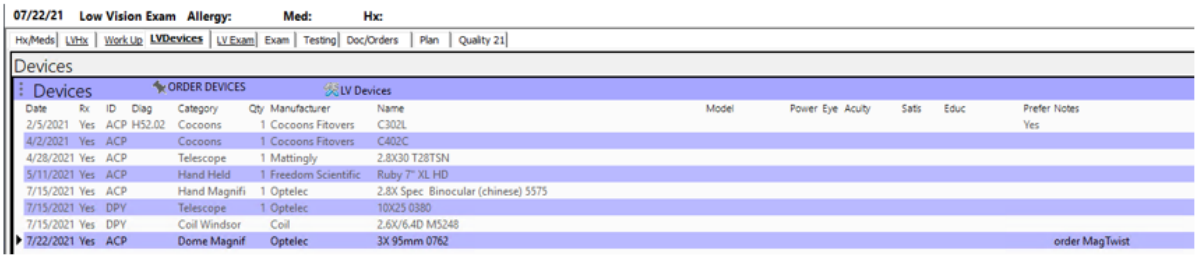
1. The appropriate measurements and specifications (PD, segment height, materials, coatings, etc.) will be determined by the intern.
2. If the frame is chosen in the AA's office the frame will be removed from the display rack and wrapped in the completed Low Vision Lab Order Form and given to the AA.
3. If the frame is chosen in Optical, the frame information will be sent to the AA to order the frame from Optical. No frames from Optical will leave the Optical area.
4. The student intern will complete the Low Vision Lab Order Form (Bartley Optical) as well as the general Low Vision Order Form and submit them to the AA.
5. For private paying patients, the charges for the glasses will be determined and posted on the fee slip before the patient checks out.
6. ALL spectacle orders must be entered in the SpecHiRes table. Include all pertinent information in the lens, tint, coating/add-ons, frame sections.



Low Vision Devices

At the conclusion of the examination, the intern and the faculty will discuss with the patient about the recommended devices that are available to assist the patient. With the patient's consent, the devices will be added in the LV Devices tab. For patients that will be purchasing the device on the same day, you MUST enter a quantity of 1 and select "yes" in the prescribed section (shown below). For all others, you do not need to enter a quantity, otherwise, it will be posted to the ledger. For patients pending insurance authorizations, you will still need to enter a quantity, but remove it in fee posting so that it is not posted to their ledger. The AA will post it once it is approved.

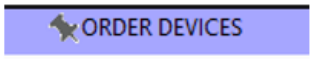
If there is a device that is not on the list, please email the Low Vision Administrative Assistant. The correct device recommended can be entered in the "Notes" section (shown above).



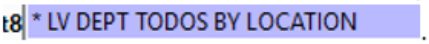
Ordering Spectacles:

When patient is ordering spectacles, the doctor will need to add the "LV V2610" in the LV devices tab with a 1 quantity. The AA will enter in the fees to be posted in the patient's ledger, or when it is approved by their insurance.

Ordering Devices

Click on 

and a task will be sent to the Low Vision administrative assistant.

All items in the LV devices tab, with a quantity of 1 and prescribed, will appear in the worklist query, 

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Private Paying Patients

1. For private paying patients the spectacles and devices will be ordered immediately upon payment for the items.

Note: The patient pays in full before leaving Ketchum Health. If the patient leaves without paying, the AA will call him/her and obtain a credit card payment if possible. A statement/receipt will be mailed to the patient. Payment in full is recommended at the time of the order however payment of at least 60% is required to order the item with the remaining balance to be paid in full at dispensing.

2. If the patient has chosen a frame from the AA's office, a new frame will be ordered and sent to the laboratory through the courier service which picks up in Optical. A copy of the spectacle information from the SpecHiRes table will be included with the frame. Notation of the order being sent to the lab will be recorded by the AA on the Low Vision Order Form.

3. If the patient has chosen a frame in Optical, the AA will order the frame from Optical. DO NOT remove the frame from Optical. Once the frame arrives, the AA will send it to the lab with the spectacle information from the SpecHiRes table. Notation of the order being sent to the lab will be recorded by the AA on the Low Vision Order Form.

4. Other low vision devices will be ordered by the AA directly from the appropriate vendor. Notation of the order will be recorded by the AA on the Low Vision Order Form.

Non-Private Pay Patients

1. Vision Service Plan (VSP) Patients

    a. The orders will be held until approved by VSP. The AA will contact the patient with the approval information and the co-payments required. Once the patient approves the co-payment amounts the AA will take payment by phone with the above requirements for ordering the devices. If paying by check, the AA will wait until the payment is received before ordering the devices. The AA will also post the co-payment amount on the Compulink encounter. Once the appropriate payment is received, the spectacles/devices will be ordered with the same protocol as above.

2. VSP Medicaid

    a. VSP Medicaid will cover a limited amount of devices. With the faculty approval, the devices/spectacles will be ordered using the above ordering protocol. Modifiers are necessary for add on items.

3. Medi-Cal

    a. Medi-Cal will cover a limited amount of devices for minors (< 21 years of age). A completed Treatment Authorization Request (TAR form) with the invoices for the items requested is required. If the authorization is approved by Medi-Cal then the devices/spectacles will be ordered using the above ordering protocol.

4. Department of Rehabilitation (DOR)

    a. The orders for spectacles/devices will be held until approval by DOR. Once approved, the AA will contact the patient with this information and order the devices/spectacle with the above ordering protocol.

5. Medicare

    a. Medicare does not cover low vision devices.

Receiving and Checking in Orders (performed by the AA)

1. Verify all items received by reconciling with the Low Vision Order Form.

2. For spectacles the student interns should verify that the prescription is correct.

3. If the orders are correct, place the invoice and the packing slip in the “Invoices to be Signed File”.

4. If the order received is not correct, place the item back in the original received box and call the vendor for a “Return Material Authorization” (RMA) number. Write the RMA number on the return label and document the date and the RMA number on the packing slip and invoice and send the item back to the vendor. Record this on the Low Vision Order Form.

5. If partial orders are received, document them as “received” on the Low Vision Order Form and file it in the “Orders on Hold” drawer in the AA’s office.

6. Once the devices are in, the patient will be contacted to pick up the devices, unless noted by the faculty a dispensing appointment is necessary.

7. On occasion with the faculty approval, items will be mailed to the patient. In this case a $20 shipping fee will have been previously charged and the item will be packaged and mailed through the mailroom.

8. On occasion with faculty approval, items will be shipped directly from the vendor to the patient. Full payment for the device is required before ordering. A tracking email and receipt will be mailed/e-mailed to the AA.

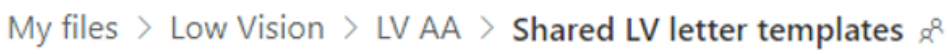
Processing Monthly Invoices

On an ongoing basis, invoices and packing slips are collected when materials and supplies are ordered and received. After organizing all paperwork by the vendors and verifying each balance due, the Administrative Assistant (AA) will take them to the Low Vision Chief of Service for review and signature approval.

After being verified and signed, the AA will deliver the invoices to the Accounting Department for payment processing.

Letter Writing

Letter writing if frequently required in the Low Vision Service. Letter templates are available in OneDrive



The protocol is as follows:

1. Letters requesting authorization for payment and material coverage are required for Vision Service Plan, Department of Rehabilitation, and Medi-Cal.
2. The letter will be drafted by the student intern and approved by the faculty on OneDrive. Once the letter is approved, the faculty will share the letter with the AA for printing, signature, and sending to the appropriate agency.
3. In addition referral thank you reports are sent to the referring providers. The protocol is the same as above.
4. For all letters, once they are signed, they will be scanned into Compulink in the patient's file.

6.2.6 Low Vision Clinic

The low vision clinic schedule will consist of either:

a. Direct in-person care:
   During these sessions, patients will be evaluated for a full low vision examination, including history review, discussion of visual goals, acuities and refraction, demonstration of low vision devices, ocular health assessment, adaptive technology evaluation, discussion of resources, and counseling and coordination of care. The case history, visual goals, and the devices that the patient may be interested in will have been determined previously through the patient history phone interviews (see below) for new patients as noted above in Section 6.2.1. Additionally, in-person care may consist of follow up visits and dispensing visits.

b. Patient history phone interviews and other clinical activities:
These sessions will consist of a variety of activities including student and faculty case discussion, review of special low vision topics, and patient history phone interviews. Patient history phone interviews will be conducted by the student(s) and faculty. All individuals on the call will be identified and information obtained will be documented on a low vision evaluation template on Compulink. Information will include: the complete medical, ocular and low vision history; previous eye care information, and referral information and documentation. An additional telephone interview to discuss adaptive technology options and other resources will be conducted by the adaptive technology specialist at a scheduled time that is convenient for the patient.

6.2.7 Genetic Testing

Scheduling appointments

Purpose:

To establish a process to schedule, determine eligibility, and manage workflow for patients receiving genetic testing for eye conditions.

Procedure:

Before scheduling appointment:

1. Confirm with staffing doctor patient eligibility for genetic testing.

    a. Faculty will determine:

        i. Eligibility for sponsored genetic testing programs.

        ii. Appropriate genetic test panel, testing lab, type of testing (i.e. diagnostic testing vs familial variant testing), and sample required (i.e. saliva, buccal swab)

        iii. Any additional clinical procedures needed to determine genetic testing eligibility and confirm diagnosis.

        iv. If sample collection needs to be coordinated with Ketchum Health Family Practice (i.e. blood sample, skin sample)

2. Provide patient with estimated cost of testing (lab fee + office visit + any additional clinical procedures).

    a. Cost of testing will vary depending on eligibility for sponsored programs (lab fee is fully covered), type of test selected, test panel selected, and any additional special testing circumstances.

During the appointment:

1. Informed Consent for genetic testing will be obtained.

2. Copy of Informed Consent and Test Requisition Form will be scanned to the patient's medical record and/or maintained on the patient's secure laboratory Portal.

After the appointment:

1. Schedule 1-2 month follow-up appointment to review results of testing with the patient.

6.2.8 Grading Interns

Procedure:

The faculty will enter grades in Meditrek as follows:

a. Log onto Meditrek
b. Under "Display Pending Evaluations" a list of the students to be graded will be visible. This is done twice, at the midpoint and the end of the rotation.
c. Click each student to be graded and enter the grade with comments under the sections of Technical Skills, Knowledge & Critical Thinking, and Interprofessional Attributes & Practice Building as well as Overall Summary Comments. This should be reviewed with the student individually and then submitted by clicking "Save Final".
d. Any students that are not performing adequately should be reported to the Senior Associate Dean for Professional Affairs and Clinical Education as soon as possible to allow for proper attention and counseling.

6.2.9 Grand Rounds

PURPOSE:

To provide 3rd year interns observation time in clinic as part of the CLS 774 Low Vision Rehabilitation course.

PROCEDURE:

The Administrative Assistant along with the Instructor of Record for CLS 774 and the Low Vision faculty will identify and recruit patients based on their visual acuity, condition, and treatment options. Scheduling for this event is not entered in Compulink. Typically, there are 4 patients per each of the 4 stations for a total of 16 patients. Patients who agree to be included in the Grand Rounds are compensated for their time.

Grand Rounds are held in the evenings after clinic hours.

6.2.10 Student Case Presentation Continuing Education Program

As part of the low vision clinical rotation experience, students will prepare a short (~ 7 minute) low vision case presentation discussing a patient encounter including a discussion of the disease or condition causing the visual impairment, case history and pertinent findings, low vision treatment options, and discussion and summary to be presented at an evening Advanced Procedure session. The purpose of this is to not only share their experiences with other students in the rotation, but also with other faculty and students as this will be an approved CE event. Students will follow all protocol to not disclose any patient identifiers in the presentation.

6.3 PRIMARY CARE & OCULAR DISEASE

6.3.1 Jarnagin Center for Primary Eye Care-Service Materials

To provide access to disposable items, diagnostic agents and instrumentation that is necessary for patient care in the Primary Care Service. These items require frequent replacement in individual rooms or storage cabinets. These are the guidelines for replacement.

PROCEDURE:

1. Rooms will be outfitted with the following items
    a. Proparacaine 1% or equivalent (1 bottle)
    b. Tropicamide 1% (1 bottle)
    c. Hydrogen Peroxide
    d. Alcohol wipes
    e. Sodium Fluorescein strips
    f. Fluress or equivalent
    g. Cotton-tipped applicators
    h. Saline solution
    i. Facial tissue
    j. Hand soap
2. Phenylephrine 2.5% and Cyclopentolate 1% will be made available by the faculty.
3. Single use latex free gloves are available in the module 2 closets
4. Limited back supply of the following items will be available in the module 2 closets
    a. Alcohol wipes
    b. Sodium Fluorescein strips
    c. Hydrogen peroxide
    d. Paper for FDT, HFA, and autorefractors
    e. Facial tissue
    f. Cotton-tipped applicators
    g. Saline solution
    h. Replacement instrument bulbs
5. Additional supplies are available in a locked Primary Care supply closet (1189). All Primary Care Faculty have access to this closet. When supplies are depleted in the downstairs central supply area, the faculty should contact the Chief of the service and/or Associate Dean of Clinics. Any items in low quantity that are required for the Saturday clinic need to be requested before Thursday afternoon.
    a. Gloves
    b. iCare probes
    c. Replacement DPAs (fluress, anesthetic, tropicamide, etc)
    d. Printer paper (consult office printers, instrument printers)
    e. Thank you cards, envelopes
    f. Printer cartridges
    g. Disposable eye patches
    h. First Aid kit
6. Glucometry testing supplies will be housed in two locations.

    a. Test supplies (glucometer, lancets, test strips, gloves, sharps container, etc) will be in a self contained box that will be housed in the locked 1189 closet.
    b. Hemoglobin a1c tests are kept in a refrigerator in the module 4 consult office
7. Artificial tears, Lid wipes, Neutraceuticals are available in unlocked storage closets in Module 2 and 3. These items will be periodically reviewed for expiration dates and replaced on an as needed basis.
8. TPAs are available to faculty only in locked storage in Module 3. Faculty must sign out for all samples on a sign out sheet.
9. Genetic tests for Macular Degeneration (Macula-Risk) are available in Module 3. These tests require a DNA sample via a cheek swab that is sent to Arctic Medical Laboratories. A credit card number is supplied by the patient and is sent along with the sample.The patient is billed $50 dollars by Arctic Medical Laboratories. Results are returned in 4-6 weeks to the investigating doctor
10. Paper towels and hand soap will be replaced by the janitorial staff.
11. Marco-Nidek Smart cards for the automated refracting systems will be provided by Ketchum Health. These have been placed in each room outfitted with the automated refracting lanes and are individually labeled. These cards will transfer data from the Nidek Autofractor/keratometer and Lensometer to the refraction system base unit. They are placed in the base of the refracting units when not in use.
12. Small instruments i.e. tonopen, iCare tonometer, exophthalmometer, RAM, pachymeter, etc., are in locked storage in Primary Care. Lenses such as 3-mirror, 90 D, 20 D lenses are also available to the faculty in locked storage.
13. Emergency supplies are available to on-call faculty and Ocular Disease faculty in the module 3 storage closet. This includes glucose tablets in the event of a patient suffering a hypoglycemic event. This closet will remain open.
14. Ammonia ampules are available in each consultation office. These are taped to the sides of the bookcase.
15. Passwords for all the instruments in the Primary Care service are available in each consultation office as well as the PC Clinic moodle page. This will be updated when passwords are updated or if instruments are acquired or relieved of duty.

6.3.2 Examination Room and Instrument Maintenance

PURPOSE:

To ensure that examination rooms and its associated instruments are in: appropriate appearance, working order, properly disinfected, and adequately supplied for each patient encountered. In addition to maximize the lifespans of all diagnostic instrumentation and avoid unnecessary repairs, each instrument needs to be powered off and covered at the end of the work day.

1. A daily check off list is posted in each examination room that outlines expected behaviors for each clinician prior to and after each examination.
2. These behaviors require students to evaluate the working status of the instruments, overall appearance of the room, and levels of disposable items at the start of each clinic session.
3. Disinfection of all surfaces including instruments, chairs, computers, desks, and keyboards will follow COVID-19 clinic protocols.

4. At the end of each half day session, interns must refill hydrogen peroxide and place the GAT probe in the vial. Refill of in-room supplies should occur on an as-needed basis but should be checked by interns at the beginning and end of each patient care session.
5. Any issues with plumbing, lighting, instruments or computer software or hardware will be identified and the service chief and/or associate dean of clinics will be notified. The service chief / associate dean of clinics will report these findings to the appropriate departments (IT support or Campus Operations).
6. Instruments in the primary care clinic are zoned to individual modules. The interns and clinical faculty are responsible for uncovering and turning on instruments as well as turning off and covering instruments at the end of the day.

6.3.3 Interruption of Normal Processes during Exam

PURPOSE:

To ensure patients continue to receive services in the event of an incident (power outage, server down, minor earthquake, etc.) occurring during the patient's exam. If an emergency or disaster occurs, the university's emergency preparedness plan will be implemented and will replace this procedure.

PROCEDURE:

If the Ketchum Health has an interruption that would affect normal processes while the patient is being examined, the staffing faculty will assess the situation, call Patient Relations to report the problem or to obtain information and will follow the steps below:

1. Instruct interns to open exam room doors and remain with the patient. Patients in pre-testing areas will return to exam rooms with interns.
2. Faculty will assign a runner to provide communication to interns.
3. Record all exam data gathered, prior to the incident.
4. Close Compulink to save the exam and to prevent potential loss of data.
5. If internet is still available, printable copies of exam forms and spectacle prescriptions are available on the PC Clinic moodle page.
6. In the case of internet disruption, paper exam forms (located in each consultation room) are available for the interns to record the entire exam.
7. Continue the exam (including dilation exam if applicable) if the patient agrees.
8. If the patient would like to reschedule the exam, or the intern/faculty is unable to complete the exam, the intern will complete the "Reschedule Form" (located in the consultation room) and give it to the service area Administrative Assistant. Note: If the exam occurs in Primary Care, the "Reschedule form" will be given to the Cashier at check-out.
9. At the end of the exam, the intern will:
   a) Escort the patient to Optical with the RX form (if applicable).
   b) Escort patient to check-out with the fee sheet, paper exam form and the Reschedule Form (if applicable) to be scanned by Patient Relations.
10. When power is restored, faculty will document in the patient's Compulink chart that power was out during the exam to explain the partial Compulink documentation and paper chart.

6.3.4 Types of examinations provided

1. Comprehensive eye examinations
2. Dilated fundus examinations
3. Spectacle recheck
4. Diabetic eye examinations
5. Problem focused examinations (acute care)
6. Problem focused examinations (chronic care)
    a. Glaucoma
    b. Macular degeneration
    c. Posterior segment conditions (PVD, lattice degeneration, nevus, etc)
    d. Retinal Vascular conditions such as diabetic retinopathy
    e. Other: cataract, anterior segment, uveitis
7. Interprofessional, integrated care
8. Ophthalmic Disability assessment

6.3.5 Scheduling appointments in Ocular Disease

1. Scheduling within Compulink
    a. Use the next appointment feature to describe the exact reason for the next appointed visit including:
        i. Time period of follow-up (1 mo, 3 mos, 6 mos, 12 mos)
        ii. Condition to be monitored
        iii. Testing to be conducted at the follow up so that a good faith estimate can be generated, if necessary.
2. Scheduling with the Administrative Assistant
    a. Schedule directly with the administrative assistant for follow up appointments within the next week.
    b. If the administrative assistant is not available (after hours), the faculty/intern will send a detailed communication about the nature and urgency of the follow-up visit.

6.3.6 Partners: Special Patient Groups

1. QTC (VA) Veterans Disability/Compensation evaluations
2. AltaMed Health Services
3. Latino Health Access Diabetic examinations
4. Kinsbursky Brothers.

FORMS:
Paper Exam Form
Reschedule Form

6.4 SPECIAL TESTING

6.4.1 Special Testing Appointments

PURPOSE

To establish a process in scheduling an appointment in Ocular Disease for Special Testing.

PROCEDURE

1. In the appointment book in Compulink, Special Testing appointments are booked in the aqua slots and are only done on Thursdays.
2. For external referrals, we need medical records for the patient before scheduling the appointment. (See Specialty Services Consultation/Referral Form).

3. Events with prefixes of “ST” are for Special Testing.

4. The administrative director for the Ophthalmology/Ocular Disease/Special Testing Service is Laura Escamilla. Please try to book all appointments through her when she is here, otherwise use the referral form and leave in her mailbox.

CHP POST LASIK TESTING

1. Check the insurance tab to verify that the insurance information is current or if you need to add a new insurance.
2. If cash paying give a quote.
3. For color vision test we can do multiple tests on the same day for one price.
4. Color vision tests are done in one hour, despite the number of tests and can be booked on the hour.
5. Color vision test are billable to our contracted insurances.
6. The “CHP Post Lasik test” event will be specifically requested by the patient and is billed to the CHP.
7. The patient will needs one appointment at 10:00am and the second appointment on the same day at 1:45pm.
8. The morning appointment can have a 60-minute block and the afternoon appointment only needs a 15-minute block.

ELECTRODIAGNOSTIC TESTING

- Book at either 10:00am or 12:00pm.
- If more than one Electrodiagnostic test is required please block off the entire 4 hour slot for the patient.
- Electrodiagnostic tests are also billable to our contracted insurances. See Special Testing Fees for pricing.

Note: In the details of the appointment document Specific test(s) requested and prices quoted.

6.5 PEDIATRICS AND VISION THERAPY

6.5.1 Scheduling Appointment

Pediatric Vision Service

Schedule children 15 years and under for “routine” care (i.e., comprehensive eye exams, dilation, cycloplegic refraction, red eye, and peds follow-up visits). (Children 16 years and older are scheduled in the Primary Care Service).

Vision Therapy

Schedule children and adults who require the following "specialty" care (binocular vision evaluation, visual information processing evaluation, strabismus and/or amblyopia evaluation, vision therapy).

SUB-SPECIALTY SERVICES

Schedule as follows:

- Special Populations - children with significant physical or developmental delays should be scheduled with the specified faculty or Peds/VT residents
- Pediatric Contact Lenses - contact lens evaluations for all young children (under 12 years) or any child 12-15 years who requests should be scheduled with the VT/Peds resident
- Sports Vision – screenings, evaluations, and therapy should be scheduled with the specified faculty
- Myopia Control Clinic - schedule with specified faculty and location
- Acquired Brain Injury Clinic - schedule with specified faculty and Peds/VT residents
- Reading Clinic - refer to specified faculty (Dr. Borsting) via VT administrative assistant

PROCEDURE

- The Peds/VT administrative assistants will schedule appointments for the Pediatric Vision Service. If the Peds/VT administrative assistants are not available, Patient Relations can help schedule these appointment as well (with the exception of Children's Vision Days, which are coordinated by the Children's Vision Day coordinator).
- The Peds/VT administrative assistants will schedule all appointments for Vision Therapy and the Sub-Specialty Services.

6.5.2 Boys and Girls Clubs of Garden Grove Vision Clinic

- Ketchum Health Network 4th- year interns are assigned to work with Dr. Allegra Burgher or Dr. Jillian Youngerman at the external KETCHUM HEALTH location, Boys and Girls Clubs of Garden Grove Vision Clinic to provide comprehensive eye examinations, follow-up care, medical evaluations, and optical services to patients ages 18 and under.
- Staff at Garden Grove (BGC staff) are responsible for scheduling patient appointments and for verifying eligibility and covered benefits for each patient.

1. An inventory of Modern Optical and minimal selected frames is kept at this location.
2. The designated administrative assistant at KETCHUM HEALTHKH will prepare the daily Garden Grove bag with glasses ready for dispensing for each scheduled day of clinic at the Garden Grove location. An intern will be responsible for bringing the bag to the Garden Grove clinic each day.
3. Garden Grove interns will be responsible for setting up and/or breaking down the clinic space for patient care each clinic shift.
4. When the patient arrives for his/her scheduled appointment, BGC staff will verify insurance information, collect the co-payment as applicable, and check in the patients.
5. The BGC staff is responsible for collecting signatures for and scanning into the electronic medical record: HIPAA waivers, financial policy forms, and any related patient forms.

6. Garden Grove interns will prepare a bag at the end of each clinic day containing optical order forms, selected pre-adjusted frames, and money collected. An intern will be responsible for bringing the bag back to Ketchum Health the following day.
7. After receiving the Garden Grove bag, Patient Relations at KETCHUM HEALTHKH will update the patient's file in Compulink as needed and complete all necessary billing through insurance. Any money received for copayments/office visits will be processed as usual after its receipt on the patients' ledgers are confirmed. All responsibilities will be completed within one day of the services rendered.
8. The Optical department at KETCHUM HEALTHKH will receive spectacle orders and will process and bill the orders through Compulink within one day of the services rendered.
9. The Optical department will place any spectacles ready for verification in the designated Garden Grove box at KETCHUM HEALTHKH for pick-up by the administrative assistant (see above #2).
10. Glasses orders will be verified by interns at Garden Grove and returned to the Optical Department if the orders do not pass inspection.
11. BGC Staff will dispense frames from the Boys and Girls Clubs office regardless of Vision Clinic hours. BGC staff will document internally and on Compulink that the frames were dispensed.

6.5.3 Children's Vision Days

Children from various school districts are transported by bus to the University Eye Center at Ketchum Health in groups of 20 for comprehensive eye exams.

1. The Children's Vision Coordinator is responsible for communicating with the school districts to maintain the Children's Vision calendar.
2. A school district representative is responsible for collecting signed consent forms and entering information for potential attendees on a spreadsheet to be shared with the Pediatrics Administrative Assistant.
3. The Pediatrics Administrative Assistant is responsible for…

   PRIOR TO THE EVENT
   - Verifying eligibility and covered benefits or assignment of available grant funds
   - Informing the school district representative on which children are eligible for the field trip
   - Creating charts which include attaching signed consent forms
   - Assembling day of event packets which include routing slips, parent forms and any necessary forms

   DAY OF THE EVENT
   - Setting up
   - Greeting the group upon arrovial and escorting them to the designated staging area, where patients will be greeted by the assigned interns
   - Providing the school district representative and the Children's Vision Coordinator a copy of the parent reports and spectacle prescriptions for all patients seen
   - Distributing dilation glasses to the patients and escorting the group out of Ketchum Health when the bus arrives.
   - Organizing and processing all paperwork and attaching them to the chart. This includes providing a copy of the spectacle prescriptions to optical, scanning forms inot the chart, and updating the interim benefit status.

4. The Optical department will process all optical orders and notify the Children's Vision Coordinator when orders arrive

The Children's Vision Coordinator will schedule dates for dispensing with the school district representative.

Printing and Mailing Correspondence

Upon request from faculty, correspondence regarding the patient's examination, diagnosis and treatment plan is mailed to the patient and/or referring doctor. Once the faculty notifies the Peds/VT Administrative Assistant that a letter is finalized, process the request as follows:

1. Access the letter from the 'Letters' folder on OneDrive.
2. Print the letter and have the faculty sign if no electronic signature is included.
3. Scan the letter into the patient's EHR under 'Doc/Orders' in Compulink.
4. Mail the letter to the addressee and to all copied parties.

Fee Reduction Options

Several fee reduction options for vision therapy are available:

- Sliding Fee Scale: Patients need to apply through patient relations.
- Prepayment Option: Prepay 5 visits and receive a 20% savings.
- Professional Courtesy Fee Waiver: For relatives and friends of interns and employees, or other health care professionals as outlined in current clinic policy.
- Grants or Other Chief Waivers: Various grants may be available from time to time or special allowances made for those with financial need and should be discussed with the chief prior to the patient's visit.

6.5.4 Vision Therapy Grant

Procedure

1. In the appointment, VT Admin will document the following:
    a. "Grant" will be noted in the insurance field.
    b. Patient's liability will be noted in the details section

Use payment code "VT Grant PMT 03179."

6.6 OPTICAL SERVICES

6.6.1 Processing Optical Orders

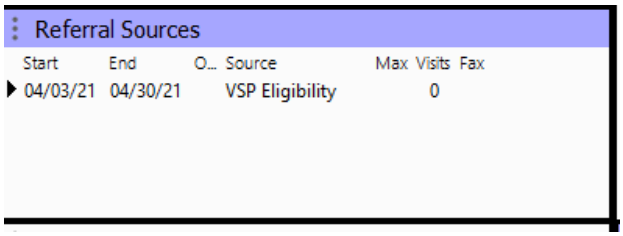
Purpose:

To fill patients' prescriptions.

Procedure:

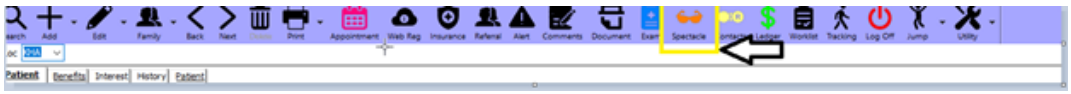
1. Sign into Compulink.

2. Find patients chart by account number, name or date of birth.
3. If patient has insurance, it will be scanned under "**scanned documents**". If patient has VSP-the authorization will be attached under **referral sources**. See example:



4. Print insurance authorization for eligibility. (Make sure patient is eligible for Lenses and/or Frame).
5. Help patient with frame selection.
6. Click on the **spectacle icon** on the tool bar to start order.
7. Click on **"Add"** then **"Exam Data"** to add the prescription. (Please make sure RX is current).
8. Mark what the usage will be. *(Reading only, Distance only, Fulltime, etc).*
9. Click on **"Plan"** and add the insurance plan or discount that will be used for the order.
10. Take all measurements needed and add it to order.
11. Fill in lens and frame information.
12. Add any notes under **"Order Notes Internal Only"**
13. Add **Lab** Information.
14. Once you're done filling the order, Click **"Save"**. *(All measurements are required in order save order.)*
15. Click on **"Fees"** to pull up fees. Make any corrections needed to patient's copays or add discounts.
    - **For VSP**: If there is any corrections being made to a VSP order use the discount function only. Do NOT use the allowance function.
16. Add the Provider ID, your Aux ID, and under department click OPT.
    - Provider ID: Exam Provider or Dr. Nakano for any outside RX
    - Aux: Whoever is signed in
17. Click **"Post"** to post charges and add diagnosis codes in ledger.
18. Collect balance
19. Print out spectacle order.

1.



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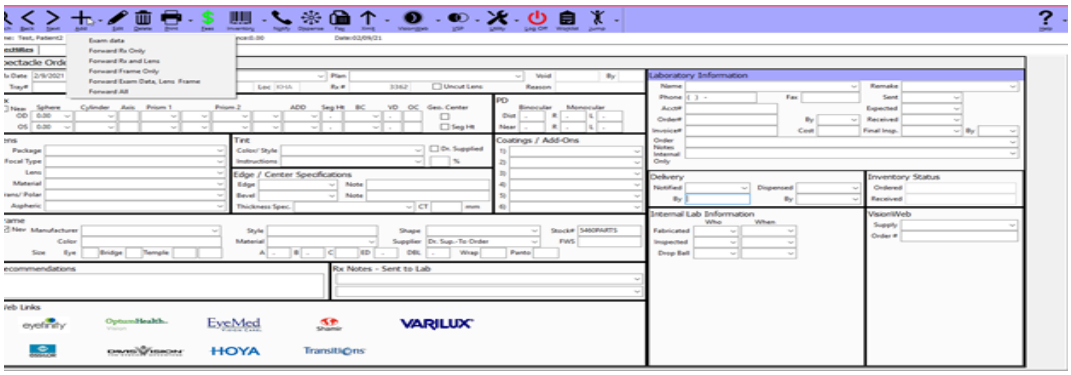

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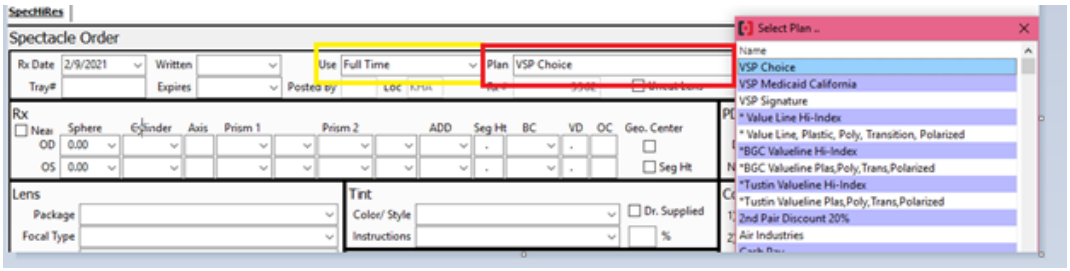
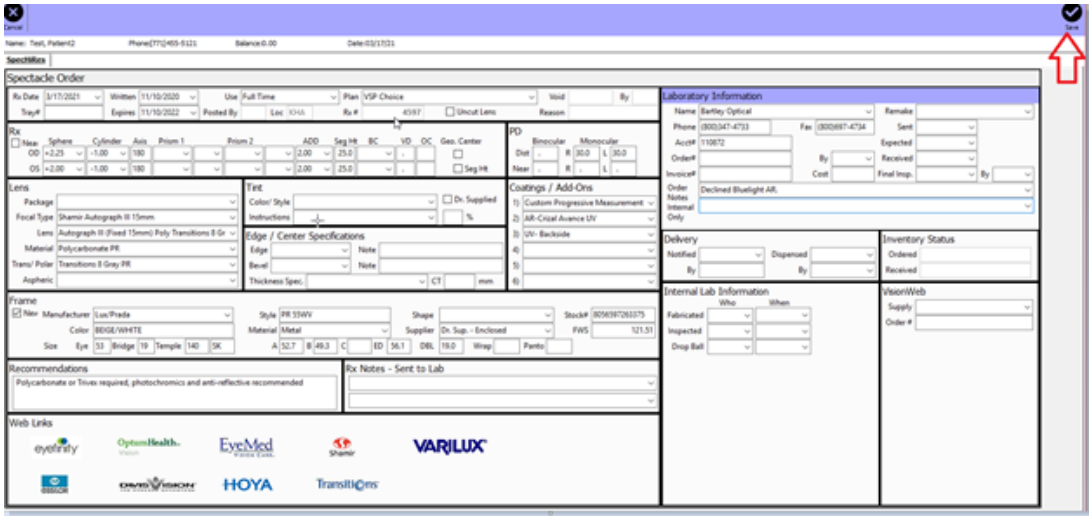
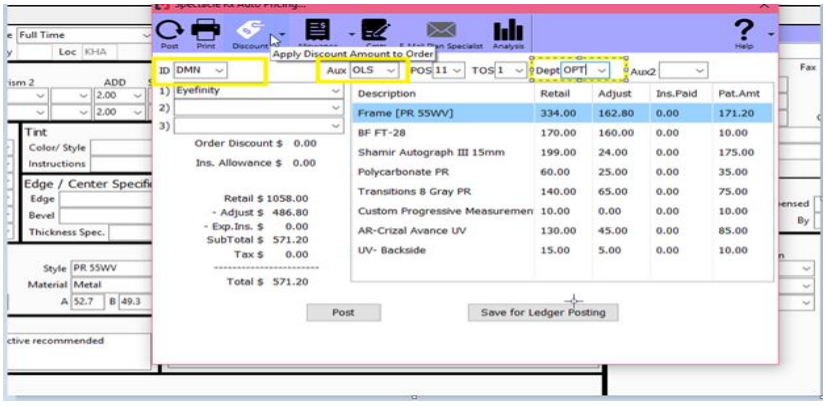

SpecHiRes
Spectacle Order
Rx Date 2/9/2021
Written
Use Full Time
Plan VSP Choice
Tray#
Expires
Posted By
Rx
Sphere
Cylinder
Axis
Prism 1
Prism 2
ADD
Seg Ht
BC
VD
OC
Geo. Center
OD 0.00
OS 0.00
Seg Ht
Lens
Package
Focal Type
Tint
Color/ Style
Instructions
Dr. Supplied
Select Plan ..
Name
VSP Choice
VSP Medicaid California
VSP Signature
* Value Line Hi-Index
* Value Line, Plastic, Poly, Transition, Polarized
*BGC Valueline Hi-Index
*BGC Valueline Plas,Poly,Trans,Polarized
*Tustin Valueline Hi-Index
*Tustin Valueline Plas,Poly,Trans,Polarized
2nd Pair Discount 20%
Air Industries

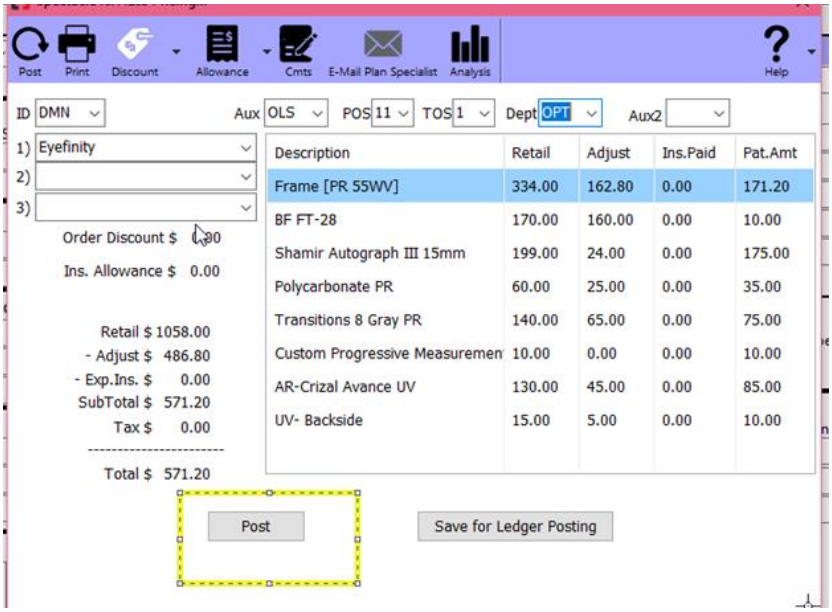
4.


Spectacle Order
Laboratory Information
Lens
Tint
Coatings / Add-Ons
Edge / Center Specifications
Frame
Recommendations
Rx Notes - Sent to Lab
Delivery
Inventory Status
Internal Lab Information
VisionWeb
Web Links
VARILUX
HOYA

5.


Apply Discount Amount to Order
ID DMN
Aux OLS
POS 11
TOS 1
Dept OPT
Aux2
1) Eyefinity
Description
Retail
Adjust
Ins.Paid
Pat.Amt
Frame [PR 55WV] 334.00 162.80 0.00 171.20
BF FT-28 170.00 160.00 0.00 10.00
Shamir Autograph III 15mm 199.00 24.00 0.00 175.00
Polycarbonate PR 60.00 25.00 0.00 35.00
Transitions 8 Gray PR 140.00 65.00 0.00 75.00
Custom Progressive Measuremen 10.00 0.00 0.00 10.00
AR-Crizal Avance UV 130.00 45.00 0.00 85.00
UV- Backside 15.00 5.00 0.00 10.00
Order Discount $ 0.00
Ins. Allowance $ 0.00
Retail $ 1058.00
- Adjust $ 486.80
- Exp.Ins. $ 0.00
SubTotal $ 571.20
Tax $ 0.00
Total $ 571.20
Post
Save for Ledger Posting

6.



6.6.2 Processing Optical Redo's

Purpose

To process optical redo orders.

Process

1. Use the SCCO soft program to open original order.
2. Highlight original order and click on "Redo Rx."
3. Select original "Encounter Date." The "Order Date" should be the same day as Redo date.
4. Enter information and change what needs to be redone. (For example, enter a new prescription if there has been an RX Change.)
5. Include notes for reason for optical redo such as AR Warranty, DR Redo, Lab Redo, etc. and original order invoice number.
6. Have Optician authorize order.

Retrieve packing slip and send to corresponding lab.

6.6.3 Dispensing Glasses

Purpose

To establish a process to properly dispense glasses to patients.

Procedure

1. Login to Compulink-ask for their last name, first name or date of birth. Click on their chart.

2. Click on spectacle Icon. Open spectacle order and locate the tray number (cubby number) the order was assigned to.
3. Go to the optical workroom and retrieve the glasses from the assigned cubby.
4. Make sure glasses are clean and adjust glasses if necessary. Make sure you give the patient the corresponding designer case.
5. If patient got AR coating give them a lens spray. All patients should receive a KH lens cloth.
6. Place all items in KH bag and hand to patient.
7. Have the patient try on the glasses, make sure they fit properly-adjust them if needed. Make sure patient is happy with the vision.
8. Check paperwork if patient has a balance. If there is a balance take them to Patient Relations to pay the balance.
9. In Compulink, "dispense glasses" and click "save".
10. Place spectacle order form in the red basket located in the optical workroom.

6.6.4 Ordering Frames

Purpose

Ordering frames per patient's request, possibly different size, color or a frame that is not available in the Optical Department.

Procedure

1. Login to manufacturer's website.
2. Place order. Get reference number
3. Log into ***Frame Book*** and add in reference number with patient's name account number, and frame information.

Ordering Frames to View

Purpose

To establish a process for a patient to view a frame before the order is processed.

Procedure

1. Frames can be ordered to view if it is not available in our Optical Department.
2. There is a $25.00 fee. The patient can order up to-two frames which can be from two different manufactures.
3. If the patient doesn't want the frame there is no refund. The $25.00 stays as a credit and will go towards their optical order or future purchases.
4. The frame is entered in Compulink and is then ordered.
5. When frame comes in-patient is notified to come in to view the frame.

6.6.5 Receiving Rx Orders from Labs

Purpose

Receiving completed prescription glasses for patients from various labs.

Procedure

1. Remove lab invoice from the order.
2. Match lab invoice with correct Compulink's RX number located on order form.
3. Wrap optical job with Compulink paperwork.
4. Have interns neutralize jobs.
5. Sign in to Compulink.
6. Search patients file number on top left corner.
7. Assign a cubby number. Write the cubby number on top right corner of the order form.
8. Type in the cubby number in Compulink (under the "tray #" tab).
9. After cubby has been assigned, click on "Notify" to notify the patient that their glassed are ready.
10. Place the neutralized glasses along with the original order form in the assigned cubby.

6.6.6 Receiving and Pricing Frames

Purpose

To receive and price new frames that come into inventory.

Procedure

1. Count frames received, make sure the total count matches what was ordered.
2. Match frames with frames listed on the invoice.
3. Price frames with the following mark up.
   a) All ophthalmic and sunglass frames are marked 2.75 from wholesale price.
4. The total number of frames received from each manufacturer will be logged into the appropriate vendor form.
5. The total number of frames will also be logged into a spread sheet, to keep track of all frames received in optical.
6. Frame invoices will be filed away.
7. Add the frames to the Compulink inventory library.
8. Scan, then Print UPC code price tag.
9. Place tag on magnetic price tag and put frames on designated vendor space in dispensary.

6.6.7 Ordering Supplies

Purpose

To establish a process to replenish deleted supplies and order new items as needed.

Procedure

The Optical Department will order supplies as follows.

1. Use the Staples.com website to order most office supplies. The login and password are needed to order the supplies.
2. To order branded supplies use the assigned Vendor to place the order.

3. If the optical director is unable to order supplies-fill out the MRF form with vendor information, supplies needed, cost, and GL number.
    - When form is completed, you need a signature from the Optical Director and Dean of Clinic.
    - Make a copy of the MRF form and send the original to the purchasing department for the order to be place

6.6.8 Mailing Orders to Patients

Purpose

To develop a process to accommodate the patient's request to have their glasses mailed to them.

Procedure

The patient may request to have glasses mailed in lieu of picking them up.

1. The patient will be charged a $20.00 shipping fee.
    - Patient can pay for shipping fee at the time of placing optical order or can pay fee over the phone when notified that the glasses are ready.
2. Verify that patient has paid for the glasses in full before mailing them out.
3. Log into Compulink and search for the patient and verify patients mailing address.
    - Mailing address cannot be a PO Box address. If patient has PO Box address on file, request a home address.
4. Go to ledger, under **"Service"** drop down-add shipping fee.
5. Clean, adjust and put glasses in a case with cleaning cloth.
    - If patient has anti-reflective coating, give patient a lens spray.
6. Put glasses in a box and place mailing label on it.
7. Make note on Compulink that "*Glasses mailed to patient"* and include the date.
8. Dispense glasses in Compulink.
9. Enter mailing information into the Excel spread sheet labeled Optical mail out log.
10. Place package in designated mail out section for the mail room to pick up.

6.6.9 Frame Inventory

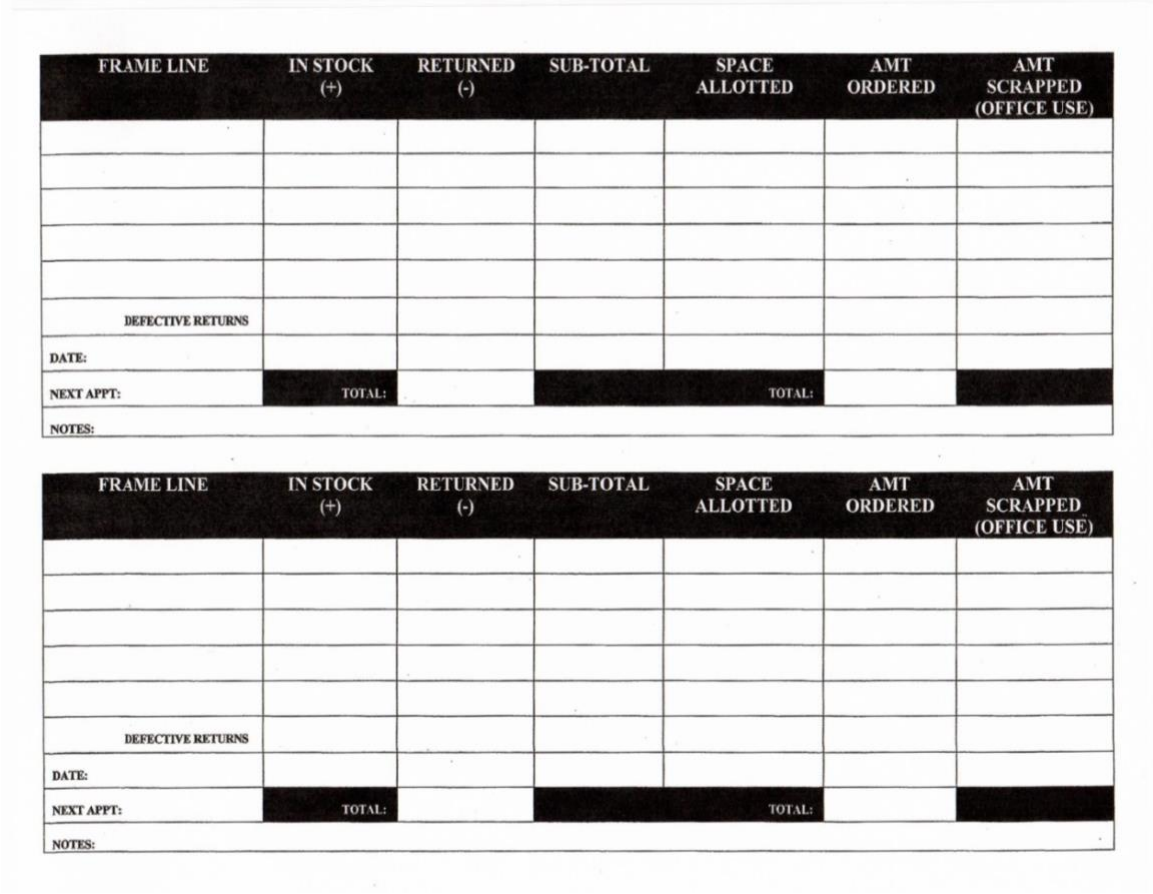
Purpose

To develop a process for accountability of frames in inventory with each manufacturer to oversee their stock levels, losses and sales.

Procedure

1. Log into Compulink-under "inventory frame sales" pull a report that gives you the number of frames sold from that manufacture.
2. The Optical Director/Optician will work with the vendor and remove all frames form the frame board.
3. Each vendor has a file folder which shows the allotted number of frames that a specific vendor can display in Optical. The report must match the frames sold off the board.

4. Forms are filled out for frames sold, discontinued, defected, and frames not sold beyond one year.
5. Vendors will provide return authorization numbers for all discontinued, and defected frames.
6. All returned frames will be taken out of Compulink's frame inventory.
7. Returning frames with matching cases will be packed and returned along with return authorization forms.
8. Frames returned to the manufacturer are entered in an excel spread sheet with return date, number of frames returned, and authorization numbers.
9. The vendor will replace new frames to be displayed in optical to match their allotted number.
10. Replaced frames will be counted and entered into an excel spread sheet.
11. Vendors will set up appointments every 2 to 3 months to check their inventory..



FRAME LINE	IN STOCK (+)	RETURNED (-)	SUB-TOTAL	SPACE ALLOTTED	AMT ORDERED	AMT SCRAPPED (OFFICE USE)
DEFECTIVE RETURNS						
DATE:						
NEXT APPT:	TOTAL:			TOTAL:		
NOTES:						

FRAME LINE	IN STOCK (+)	RETURNED (-)	SUB-TOTAL	SPACE ALLOTTED	AMT ORDERED	AMT SCRAPPED (OFFICE USE)
DEFECTIVE RETURNS						
DATE:						
NEXT APPT:	TOTAL:			TOTAL:		
NOTES:						

6.6.10 Vision Insurance

Purpose

To obtain proper authorizations and benefits summary to provide the correct copays for patient's services and materials

Procedure

1. Follow the same insurance verification procedure listed in Clinic Manual.
2. When verifying Optical materials coverage always adhere to the following:

a) Make sure the services you are requesting are available. If there is a date next to that service, it means they are not eligible until that date.
b) You can always offer a courtesy insurance discount of 20% if patient is not eligible for a frame or lenses. This discount will be applicable if the patient has VSP, Eyemed, Spectera or Davis Vision.
c) Always verify that all products you are offering to the patients are available/covered under the insurance plan/lab.
d) For Eyemed, Davis Vision, and Spectera insurance always reference back to the formulary sheet to see what category each product is under and collect that proper copay.

VSP Medicaid/Medi-cal Plans Only

1. All Medicaid plans are eligible for exam and glasses every 2 years.
2. If glasses are broken or lost, the patient/guardian must sign a MCL replacement form explaining why they need the replacement.
3. Verify the patient's benefits-if they have VSP Medicaid you must call VSP to get interim benefits for repair/replacement since they are only allowed one pair every 2 years.
4. If you use the interim benefits, patient is only allowed 4 replacements.
5. If patient has any other Medi-cal plan other than VSP Medicaid, replacement procedure is different.
    a) Envolve Vision will allow one replacement within the 2-year period if glasses are lost or broken. You must verify the patient's benefits are still active and if so have patient/guardian fill out MCL replacement form. Submit a claim and add the proper replacement modifier (RE).
    b) If patient has straight Medi-Cal or March vision, they are not allowed any replacements..

6.6.11 Processing Lenses in A-lab

Purpose

To develop a process of making glasses in house at most cost-effective price.

Procedure

The lab technician will be responsible to process and track the progress of glasses done in A-lab, from beginning to end.

1. Create a monthly spreadsheet to track the number of jobs done and the cost of each job, new or redo.
2. Lab report spreadsheets are submitted to the Accounting Department on a monthly basis.
3. Create a work ticket for each job to process on Mr. Blue Edger through ESSIBOX software.
4. Work ticket is accessible and printable in the event of a redo in the same frame. Specs on work ticket are also modifiable.
5. Lab technician is responsible for ordering lenses and sending back lenses for credit on lens warranties when possible.

6. Lab technician is responsible for coordinating maintenance on Mr. Blue Edger on a yearly basis.
7. Lab technician is responsible for final inspection of all glasses processed in A-lab. Glasses are verified and pre-cased.
8. In the final step of processing glasses, the lab technician forwards the glasses to an Optician to receive and will assign a cubby for each pair of glasses.

6.6.12 Processing Monthly Statements

Purpose

To establish a method of processing statements and invoices by first week of each month.

Procedure

1. All invoices are collected and separated by date and each manufacture.
2. When the invoice is located on the statement the invoice number is highlighted. If there are any invoices missing the manufacture is called and the invoice is emailed.
3. If product is ordered from another department, it is noted on the invoice and statement.
4. Each department has a total amount due with their GL number written on the statement.
5. After organizing all paperwork, the balance due is verified and circled.
6. Once the statement is complete it needs a signature from the Optical Director and Dean of Clinic.
7. The statement is sent to the Accounting Department for payment.

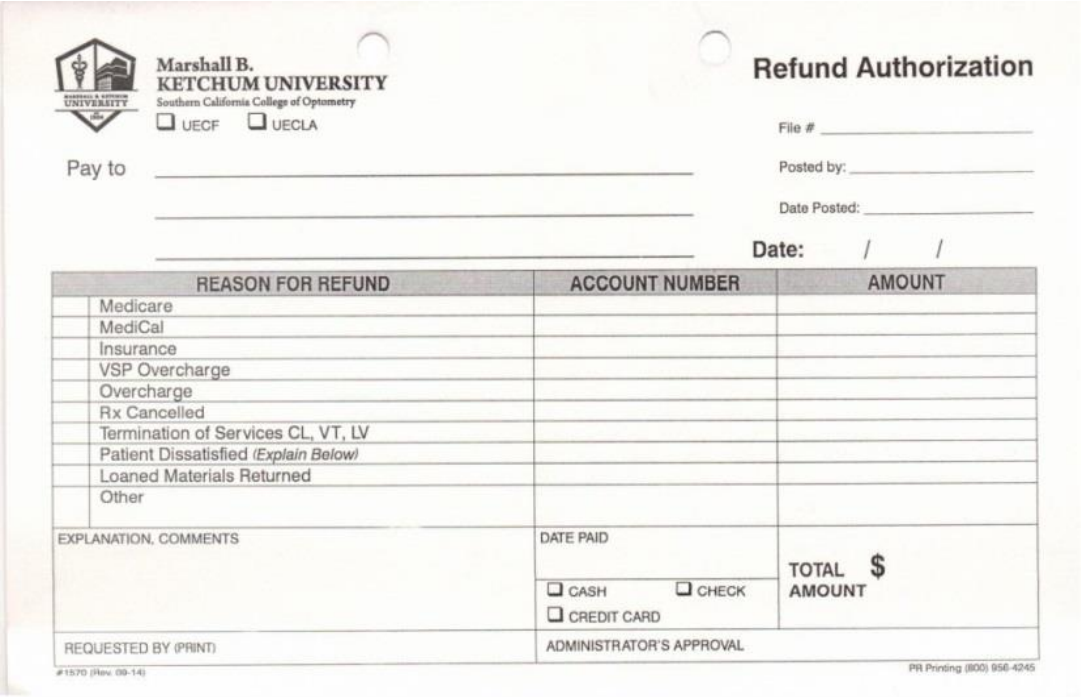
6.6.13 Processing Refunds

Purpose

To establish protocol to process patient refund.

Procedure

1. Calculate the total amount to be refunded and completely fill out the refund authorization form.
2. If optical order is cancelled after charges have been posted. Open spectacle order, go to ***"Utility"*** then click ***"Void"***. This will void optical order. This will create a negative amount in ledger that will need to be refunded to the patient.
3. Using Compulink, confirm the patient's account number, address and guarantor information.
4. Enter a note under patient's account under **"comments"** that explains that a refund for the specific material has occurred and reason.
5. A note in the Spectacle order needs to be entered regarding the date of processing refund, amount and reason.
6. The refund form is signed by the Optical Director and Dean of Clinic.
7. Take the completed authorization form to the Claims Department and the patient is contacted regarding the refund.



Marshall B.
KETCHUM UNIVERSITY
Southern California College of Optometry
☐ UECF ☐ UECLA

Refund Authorization

File # _____
Posted by: _____
Date Posted: _____
Date: / /

Pay to _____
_____
_____

	REASON FOR REFUND	ACCOUNT NUMBER	AMOUNT
	Medicare		
	MediCal		
	Insurance		
	VSP Overcharge		
	Overcharge		
	Rx Cancelled		
	Termination of Services CL, VT, LV		
	Patient Dissatisfied *(Explain Below)*		
	Loaned Materials Returned		
	Other		
EXPLANATION, COMMENTS		DATE PAID ☐ CASH ☐ CHECK ☐ CREDIT CARD	TOTAL AMOUNT $
REQUESTED BY (PRINT)		ADMINISTRATOR'S APPROVAL	

#1570 (Rev. 09-14) PR Printing (800) 956-4245

6.6.14 Children Vision Day

Purpose

To process spectacle orders for Children's Vision Day program.

Procedure

Order Entry

1. Determine if patient is using VSP Medicaid, VSP Voucher, or an Essilor Grant.
2. Use Compulink to input frame, lenses, and measurement information. Patient's Rx my not be available until later that day.
3. Once exam has been finalized, the doctor in charge of the Children's Vision Day program will email optical with the list of patients that need glasses.
4. A copy of the patient's Rx will be brought to optical, which will be inputted into Compulink and posted.
5. Record order date in the Children's Vision Day spreadsheet.

Submitting Orders to Lab

1. Determine if patient is using VSP Medicaid, VSP voucher, or an Essilor Grant for exam and/or glasses.
2. If glasses are to be made through VSP Medicaid:
    a. Use the PIA website to place the spectacle order.
    b. Use the Eyefinity website to bill for exam and/or frame and lenses.
    c. Use the Compulink to record the authorization number, and what was billed.
    d. When orders arrive from lab, record the receiving date in Children's Vision Day spreadsheet.
3. If glasses are to be made through an Essilor Grant:

a. Use the VisionWeb website to place spectacle orders.
b. In Compulink, record the date of when the order was sent out and order number.
c. When orders arrive from lab, record receiving date in the Children's Vision Day spreadsheet.

4. If glasses are to be made through a VSP Voucher:
    a. Fill out VSP voucher with patient's information. SS information will be substituted with the gift certificate number on the voucher form.
    b. Use Eyefinity to pull an authorization for services.
    c. Using Eyefinity also bill and submit order for exam and/or frame and lenses.
    d. Use Compulink to add the authorization number.
    e. In the Compulink spectacle order record the date of when the order was sent out and include the order number.
    f. When orders arrive from lab, record receiving date in the Children's Vision Day spreadsheet.

<u>Dispensing orders</u>

1. When all orders have been received for each school, notify the doctor in charge of the Kid's Day Program.
2. Doctor will pick up orders from Optical Department and take them to each school for dispense.
3. Optical fee slips are returned to Optical Department and scan under "***scanned documents***" in Compulink.

6.6.15 Discounts on Glasses

Purpose

To provide discount to seniors, students, military, MBKU employees and their friends and families, MBKU students and their friends and families, patients purchasing multiple pairs, contact lens patients, Latino Health Association patient, and patients with no vision insurance.

Procedure

1. All seniors 62 years and older will receive 20% discount on frame and lenses.
2. All college students with valid student ID will receive 20% discount on frame and lenses.
3. All military personnel with valid military ID will receive 20% discount on frame and lenses.
4. For all MBKU employees/ students and their friends and families please see attached fee waiver courtesy policy.
5. All patients purchasing additional pairs will receive 20% discount on frame and lenses.
6. All VSP signature patients having exam the same day will receive 30% off additional pairs.
7. All contact lens patients will receive 20% off frame and lenses.
8. All patients purchasing premium lens product will receive 15% discount on frame and lenses.
9. All LHA patients, employees, and their friends and family will receive 25% discount on frame and lenses.
10. Discounted package (Value-Line) for single vision, bifocal, trifocal and progressive-will include selected frame and lenses. Lens enhancements will be an additional cost. ***See reference below:***

VALUE LINE PACKAGE

CPT Code	Service Item Description	Unit Price
VL102A	SV Frame and Lens **POLY**	**$120**
VL103A	BF Frame and Lens **POLY**	**$170**
VL104	TF Frame and Lens **CR39**	$175
VL105A	PAL Frame and Lens **POLY**	**$270**

- Can upgrade for Transitions, AR coating, Hi-Index material
- Use only Black Tray Frames (Modern frames only)

PROFESSIONAL COURTESY FEE DISCOUNT RATES

	Category	Diagnostic Services	Dispensing Materials	Contact Lenses	In Office OMD Surgical Services	Therapeutic Laser Service Only
1	• Faculty (full & part-time, Adjunct & Emeriti) MBKU employees, residents, & their **immediate family***. • **Golden retirees**& their immediate family*†** • Members of the MBKU Board of Trustees, Trustee Emeriti & their **immediate family***†	100%	At Cost	Cost + 20%	Cost + 20%	100%
2	• MBKU Students & their **immediate family*** • Externship Preceptors	100%	40%	Cost + 30%	Cost + 30%	50%
3	• Siblings, including brothers and sisters-in law† • Mother/father in-law† • Daughter/son-in law† • Grandchildren† Of MBKU employees, residents, and students'	100%	30%	Cost + 30%	Cost + 30%	50%
4	• **Friends & Family of MBKU Faculty, Employees, residents, and students** • Licensed health care professionals and students enrolled in a professional health care degree program† • MBKU alumni & their **immediate family***†	25%	25%	25%	25%	25%

***Immediate family includes spouse, registered domestic partner, parents, grandparents and children (no age limit).**
**** Golden Retirees- See Human Resources to ensure qualification for discount**
† Not applicable to Family Medicine exams

- **If you are an employee or student at MBKU, simply show your I.D. badge and you will receive the fee reduction.**
- If you would like a fee reduction for a family member or a friend, you need to provide the person's first and last name, their relationship to you, your first and last name (include year of graduation, school or dept). Approval must be obtained 48 hrs *prior to the rendering of services and/or ordering of materials. Fee reductions will not be honored after the service is rendered or materials are ordered*.
- Fee reductions may not be used in conjunction with any type of insurance or Value Line items.
- Contact the Patient Relations Supervisor at UECKH when requesting a fee waiver at extension 7507.
- Only one fee reduction waiver is needed per calendar year (Jan-Dec.)
- Injectables, durable medical equipment, lab studies and other consumable items will be charged at cost plus XX%. All costs will be discussed prior to treatment and billing.
- **No discounts will be applied to low vision devices.**

February 2021, Revised Policy/MN/JS

6.6.16 Warranties on Frames and Lenses

Purpose

To develop a process of getting proper credit on frame and lens warranties.

Procedure

1. All frames have a one-time, one-year manufacturer's replacement for any manufacturer's defect.
2. Frames deemed to be outside normal wear and tear or that have been glued shall void manufacturer's warranty.
3. Only Silhouette and Sospiri frame have a one-time 2-year warranty.
4. Only complete frames returned are eligible for warranty. Any incomplete frames returned shall void manufacturer's warranty.
5. All lens materials (Polycarbonate, Trivex and High Index), other than plastic (CR 39) have a one-time replacement within a year.
6. Any lens material with category A anti-reflective coating, has a one-time replacement within a year.
7. Any lens with a category C anti-reflective coating, have a one-time, two-year replacement.
8. Any lens with a category D anti-reflective coating, have a two-time, two-year replacement.

6.6.17 Financial Policy - Spectacle Lenses and Frames

1. A 60% deposit is required to process all orders. You have 24 hours to cancel the order and get your full deposit refunded.
2. If order is billed and/or processed by the lab there is no cancelation or refund.
3. Materials and cash deposits will be transferred to the State if not claimed during the period stipulated in the law. We will make reasonable attempts to contact the patient and notify them about their order

6.6.18 Spectacle and Contact Lens Prescription Release Procedures

Purpose

To allow the release of copies of spectacle and contact lens prescriptions to patients and third parties without the wet signature of providers.

Procedure

All original spectacle and contact lens prescriptions are generated electronically from the EMR system, and are printed and signed by the attending provider at the point of care; all prescriptions are given to patients at the end of the examination, when applicable.

If a patient or a third party requests a copy of an existing prescription after the examination is completed, authorized University Eye Center personnel will access the patient's EMR file, and will print the requested prescription. No wet/handwritten signature of the provider will be required to complete the release.

The individual who releases the Rx must document it in the file accordingly, and following the Contact Lens final rule amendment protocols, if applicable.

Electronics Signatures

All providers at Ketchum Health have their digital signatures recorded on file, and we have the ability of authenticating and validating the issuer of any prescription upon request. Only providers who have designated access rights to the EMR system will be able to authenticate and validate their signature through their registered credentials.

Legal Background

The University Eye Center at Ketchum Health strictly adheres to regulations contained in the California Business and Professions Code § 2541.1 and 2541.2, California Code of Regulations § 1565, and Civil Code § 1633. All the elements required by the state law for a spectacle or contact lens prescription to be valid are met; including the amendments to the Contact Lens Rule by the FTC. Ketchum Health has its own policies regarding the use of electronic signatures according to federal regulations.

6.6.19 Unclaimed Property Policy

Purpose

There are specific statutes regarding the disposition of unclaimed property to the state of California by businesses if not claimed by the patient after a period of time. As Ketchum Health receives deposits for materials and special orders, this policy is intended to provide guidelines to help us stay compliant with state law when handling such deposits.

Legal Background

California has an Unclaimed Property Law in place. Code of Civil Procedure, Title 10, Chapter 7 § 1500 et al., requires businesses to annually report and deliver property to the State Controller's Office if there has been no activity or contact with the owner for a period of time specified in the law—generally three (3) years. For purpose of the law, contact is lost when the owner forgets that the account exists, or moves and becomes impossible for businesses to reach them.

Scope

This policy applies to all deposits in cash made by patients toward the final purchase of spectacle lenses, contact lenses, or frames (in excess of $50.00). It also applies to materials left by patients of value equal or above $50.00.
The manager of the optical department has discretion in establishing additional reasonable conditions to manage such deposits and related orders, in strict accordance with the law.

Policy

General

1. When cash deposits are made to cover the initial costs of lenses, frames, or special orders, Ketchum Health has a fiduciary responsibility to keep those deposits and materials available to the owners for a period of THREE (3) years. The period is calculated from the time the transaction was initiated by the patient by voluntary extending the deposits or handing out the materials to optical personnel.

2. Ketchum Health will collect, at the time of the transaction, all contact information from the patient, including, but not limited to, mailing address, email address, and phone number(s). Patients should be told in advance that this information will be used to notify them about the status of the order, and eventually, that unclaimed deposits or materials will be escheated to the State if not claimed within the three-year period.

Procedures

1. Ketchum Health is required to make reasonable efforts to contact the owner(s) of the unclaimed property, which may include sending a notice to the owner's last address on file and notifying him/her that the account will be transferred to the state.

   The Director of the optical department will develop a protocol to determine how frequently the patient should be contacted to satisfy the "reasonable effort" standard. In any case, the notice shall be sent not less than 6 or more than 12 months before the time when the owner's deposit or material held by Ketchum Health becomes reportable to the Controller in accordance with the law.

   The face of the notice shall contain a heading at the top that reads as follows:

   "***THE STATE OF CALIFORNIA REQUIRES US TO NOTIFY YOU THAT YOUR UNCLAIMED PROPERTY MAY BE TRANSFERRED TO THE STATE IF YOU DO NOT CONTACT US".*** The notice will contain a detailed account of the deposit held, the time when such deposit will escheat to the state, and contact information for the patient to communicate with Ketchum Health.

2. Ketchum Health might deduct from cash deposits, all costs incurred processing orders, re-stocking fees (if applicable), and additional labor and related costs, before sending the deposit to the state for final disposition. Ketchum Health must present to the patient its financial policy explaining the terms of the present clause, and Clinic staff will document patient's acknowledgment of receipt of the policy. Ketchum Health will not, under any circumstances, escheat, appropriate, or otherwise unilaterally dispose cash deposits or materials without the lapse of the three-year period, and without following the protocols established in this policy.

3. Once the THREE (3) –year period has elapsed without the deposit or material being claimed by the patient, the Director of the optical service will send the deposit and related documentation to the accounting department for processing and final transfer to the state. Proper documentation must be filed in patient's file.

4. The optical department staff will keep records for a period of five (5) years after sending the unclaimed property and related documentation to the accounting department.

6.7 CENTRAL SUPPLY

PURPOSE:

- Main goal is to assist in increasing clinic efficiency
- Start of the day procedures:
    - Turning on all instruments (Decreases intern and faculty wait time)
- Equipment Inventory: Collect all returned equipment from the previous day
- Monitor and track equipment, consumables (tissues, pharmaceutical drops, etc.)

6.7.1 Diagnostic Instruments & Supplies (Start of Day 6)

PURPOSE:

To ensure equipment is ready for use and exam rooms are well stocked.

PROCEDURE:

At the start of the day, the Central Supply Clerk (CSC) will do the following:

- Turn on the diagnostic instruments in the Peds Pretesting Room (2233) as it takes time to calibrate.
    - Turn on the Daytona OPTOS using the switch on the back of the scanner. Wipe down the Daytona mirror once a day or as needed.
    - Turn on the auto-refractor.
- Periodically inspect each exam room and pre-testing room for needed replenishments of disposable supplies and to replace DPAs that have expired.

REFERENCES:

Daytona Instructions Posted on the Wall behind the Daytona Monitor

6.7.2 Equipment Loan Requests

PURPOSE:

To establish a process to respond to equipment loan requests.

PROCEDURE:

The University Eye Center (KETCHUM HEALTH) permits students/interns/faculty and patients to check out equipment. The following describes the process for internal and home use:

Equipment Loan Request for Internal Use

- The requester must complete the **'Equipment Request'** **lilac** slip in detail including the item name (e.g., red/green bar reader, Clown tranaglyph, ±1.00, -4.00 lens blank, large GTVT) and inventory number/letter, if applicable.
- All equipment must be returned the same day by close of business. Items will be inventoried (see section 6.7.3).
- Additional 'Equipment Request' slips can be requested from the Print Shop.

Equipment Loan Request for Home Use (**Vision Therapy patients only**)

- Patients must sign the VT Agreement Form and pay a $50 non-refundable equipment fee in order for equipment to be loaned. Faculty and residents will code 92499 'VT Equipment' on Compulink when saving charges to post (CSC will verify).
    - Family members of MBKU students, faculty and staff: This equipment fee also applies, however, these individuals are eligible to receive a 20% discount when purchasing VT materials.
    - MBKU students, faculty and staff: This equipment fee is waived. All equipment must be returned to Central Supply prior to the student graduating or leaving the program.
    - Create a file card for this patient and enter the patient's information on the 'Home Loan Spreadsheet' (see below).
- The requester must complete the **salmon** 'Home Loan Equipment Request' slip in detail including the item name and inventory number/letter, if applicable (e.g., ±1.00, #B20).
- Do not loan equipment for home use if there are fewer than 4 in inventory for clinic use, unless authorized by faculty.
- The CSC will keep an accurate record of loaned equipment that includes the patient's name, chart number, item name, inventory number, requester's name and returned equipment date.
    - In the small gray cabinet underneath the desk are file cards for patients in VT and their **salmon** 'Home Loan Equipment Request' slips.
    - The 'Home Loan Spreadsheet' on the desktop is used to track home loan equipment. Indicate when an item is checked out and when an item is returned
- Additional 'Home Loan Equipment Request' slips can be requested from the Print Shop.

FORMS:

Equipment Request Slip (lilac)
Home Loan Equipment Slip (salmon color)
Vision Therapy Agreement
File Card

6.7.3 Equipment Inventory

PURPOSE:

To establish a process to ensure all equipment is accounted for and ready for patient care.

PROCEDURE:

At the start of each shift, the Central Supply Clerk (CSC) will conduct the following:

Equipment Used In-Office

- Check in equipment placed in the equipment drop off bins.
- Ensure all items in kits have been returned (contents are listed on the bag/folder).
- Refer to the *'*Equipment Request*'* **lilac** slips from the day before and check off each item returned. Make sure the information on the slip matches the name and inventory number on the equipment.
- Disinfect the equipment (when possible) and return the equipment to the corresponding cabinets (each cabinet has a list of contents).
- When items are missing or not returned in a timely manner, contact the person who checked out the item.
- If the item is not listed on a lilac sheet, it may be home VT equipment that was returned to the wrong bin (see below).

Home VT Equipment

- Check in equipment placed in the Home VT equipment drop off bin.
- In the small gray cabinet underneath the desk are file cards for patients in VT and their **salmon** 'Home Loan Equipment Request' slips.
- If the patient's MRN is not given with the equipment, refer to the appointment list from the day before to see which patients were here that may have returned their equipment and cross check this with the file cards in the gray cabinet.
- Note the date of return on the **salmon** 'Home Loan Equipment Request' slip. Make sure the information on the slip matches the name and inventory number on the equipment.
- Please also enter the date of return on the "Home Loan Spreadsheet" on the desktop.
- Disinfect the equipment (when possible) and return the equipment to the corresponding cabinets (each cabinet has a list of contents).
- When items are checked out for longer than a month, contact the person who checked out the item for a status update.
- If VT services are postponed for 30 days or more, equipment must be returned, unless approved by faculty.

6.7.4 Resale Items

PURPOSE:

To establish a process to ensure resale items are in stock and are charged.

PROCEDURE:

- If equipment is sold, the CSC will check to see if the patient has been charged for the item/s sold by Patients Relations check out staff.
- In most cases the CSC will enter the charge on the patient's fee sheet before he/she leaves.

- Additionally, the CSC will keep an accurate record that includes the patient's name, chart number, sold by and the item name on the re-sale sheet (hot pink). This information is placed on the re-sale cabinet for future equipment replacement. Faculty are required to fill out the re-sale sheet when CSC has left for the day or is away from the office.

FORMS:

Re-Sale Sheet

6.7.5 Vision Therapy Kit

Purpose:

To ensure patients are given their VT starter kit.

consistency of the contents in the VT kit and This protocol is a guideline for the assembly of Vision Therapy Kits (VKT). This is to ensure that all VTK are similar in content.

- The patient or guardian will be charged a $50 equipment use fee that is non-refundable. Please circle code **VT51 on the fee sheet**. Fill out a file card with the patient's name and place it in a filing drawer. There should be a spreadsheet called "Home Loan List", which lists the patients name, equipment dispensed for home therapy as well as when returned.

The VT kits and bags are theirs to keep.

VT Kit:

Using a 6" x 9" bag, include the following equipment:

1. 3-dot card (1)
2. Opaque life saver card (1)
3. ABC pencils (2)
4. Adult Pirate Patch (1)
5. Brock String (1)
6. Opaque Eccentric Circles (2) A-B & B-A
7. Clear Eccentric Circles (2) A-B & B-A
8. Fastener to hold the eccentric circle
9. Pocket folder (1)
10. KH Purple bag

6.7.6 Replacing and Replenishing

Purpose:

To establish a process to ensure that supplies are readily available for patient care.

Procedure:

Inspect all VT/Peds exam rooms for the following:

- Replace all expired diagnostic pharmaceutical agents
- Replenish Alcohol Prep Pads
- Replenish Cotton-tipped Applicators
- Replenish Fluorescein Strips
- Replenish Multi-Purpose Solution
- Replenish Hydrogen Peroxide

Inspect and replenish downstairs central supply located in room #1117 with the following items:

- Tissue Boxes
- Diagnostic Pharmaceutical Agents
- Laser Paper 24lb
- Fluorescein Sodium Drops (5 mL)
- Autorefractor Paper
- Visual Field Paper (9")
- FDT Paper
- 61XL Black Ink Cartridge
- 61XL Tri-color Ink Cartridge
- Inspect all five (5) Disinfecting stations for replenishing of:
- Hand Sanitizer (1 bottle)
- Facial Masks (1 box)
- Tissue Boxes (2 boxes)

Inspect the student lounge printer as well as printers in VT/Peds. Use 20lb paper.
Inspect the employee breakroom for diminished coffee supplies.

6.7.7 Replenishing Supplies for Patient Care

PURPOSE:

Is to establish a process to replenish supplies in the downstairs Central Supply.

PROCEDURE:

The Central Supply Clerk will inspect downstairs Central Supply room (#1117) where most patient care supplies are being stored for the use of Primary Care, Ocular Disease, Low Vision, and Contact Lens departments.

Supplies Generally Stored in Central Supply Room #1117:

<u>Printing Paper for the following Diagnostic Instruments:</u>

- HRT, Optovue, Matrix, and Topography
- **61XL Black and 61XL Tri-color Ink Cartridges for:**
  HRT, Optovue, Matrix, and Topography instrument

Diagnostic Products:

- Tropicamide 1% 15 mL
- Altafluor Fluorescein Drops 5 mL
- Cyclopentolate HC1 1% 15 mL
- Proparacaine HCI 0.5% 15 mL
- Pro-Glo Fluorescein Strips 300/box
- Lissamine Green Strips 100/box
- Schirmer Tear Flow Strips 100/box

Pharmaceuticals:

- Multi Purpose Solution 4 fl. oz

Miscellaneous Supplies:

- PH Paper
- Hydrogen Peroxide 16 fl. oz
- Isopropyl Alcohol 70%
- Cotton-tipped Applicators

6.7.8 Ordering Supplies

PURPOSE:

To establish a process to replenish depleted supplies.

PROCEDURE:

The Central Supply Clerk will order supplies as follows:

Office & Coffee Supplies

- To order from Staples's online; you must first be set-up by the Accounting Supervisor. Once set-up, go to www.staplesbusinessadvantage and log-in.
- On the log-in screen, you will need to type in MBKU's staples account number which is **1819585**. In the User ID box, enter the service department's general ledger account number shown below, however, when ordering for **Primary Care/Ocular Disease**, you will need to enter your MBKU e-mail address instead of the GL account number which you will then select before you submit the order
  for approval.

- Be sure to select the **correct GL account number** from the drop down box before you submit your order. The order will be sent to your approver once you click the ***"submit"*** box. The approver will then submit it to the Accounting Supervisor who then sends it to Staples. Accounting will also make changes if necessary to lower the cost. You will need to fill out a Material Request Form, aka MRF when ordering from other vendors.
- For assistance, contact the Accounting supervisor if you are unable to find what you are looking for.

Diagnostic Pharmaceutical Agents & Medical Disposable Supplies

- Fill out a ***"Material Requisition Form"*** **aka MRF** which can be obtained through "**My.Ketchum.edu" portal.**
- Type in **"Campus Store"** on the Supplier/Payee line.
- If ordering for more than one service department on the same MRF, make sure to enter the correct GL account number that needs to be charged for each item/s.
- Once the MRF is completed, have it signed by the chief of the department that you are requesting the merchandise for or you may scan the MRF and send it via e-mail for a signature of approval or interoffice the request.
- Once the order is received, sign and date both packing slips. Keep one for your records and the other goes to the Accounting Secretary Clerk. If a packing slip has not been included in the box/package, notify the Accounting Supervisor and the Accounting Secretary Clerk via e-mail.

Reconciling Orders Received

- Verify all items listed on the MRF have been received. If an item is missing, or you received the incorrect item, send an e-mail to the Accounting Supervisor or dial X7542.
- Write in the date received and sign the packing slip. Take a copy for your records and provide the Accounting Secretary Clerk with the original slip **ASAP**. This will assist the Accounting department in expediting payment.

GL Account Numbers

- BCLC: 15320-7280 (Blind Children's Learning Center)
- Clinic Expenses: 15200-7280 (Ketchum Health)
- Coffee Supplies: 58150-7280
- Contact Lens: 15280-7280
- CSUF: 15310-7280 (Cal State University Fullerton)
- Garden Grove: 15380-7280 (Boys and Girls Club aka Garden Grove)
- Ocular Disease: 15290-7280
- Pediatrics: 15250-7280
- Primary Care: 15220-7280
- Tustin: 15550-7280 (Hurtt Clinic)
- KETCHUM HEALTHLA: 15400-7280 (University Eye Center Los Angeles)
- Vision Therapy: 15260-7280

FORMS:

Material Requisition Form (MRF)

6.7.9 Commonly Used Vendors

PURPOSE:

To establish a list of vendors to contact when needing equipment or supplies.

PROCEDURE:

Keep a copy of all orders for reference purposes.

Symbol Digit Modalities Test Forms

- Item Number: 4698-AS

Psychological Assessment Resources, Inc. (aka PAR)
16204 N. Florida Ave.
Lutz, FL 33549
(800) 331-8378
(800) 727-9329 Fax
www.parinc.com

CHILDREN'S COLOR TRAILS 1 & 2 TEST FORMS:

- Item Number: PQ5060ST

Psychological Assessment Resources, Inc. (aka PAR)
16204 N. Florida Ave.
Lutz, FL 33549
(800) 331-8378
(800) 727-9329 Fax
www.parinc.com

BEERY VMI 6TH EDITION & MOTOR COORDINATION FORMS:

- Item Number for VMI: 46240
- Item Number for Motor Coordination: 46250

Pearson Assessments
P.O. Box 1416
Minneapolis, MN 55440
Supplier Account Number: 952038
(800) 627-7271
(800) 232-1223 Fax
www.pearsonassessments.com

TOWRE FORMS

- Item Number: 0158700619

Pearson Assessments
P.O. Box 1416
Minneapolis, MN 55440
Supplier Account Number: 952038
(800) 627-7271
(800) 232-1223 Fax
www.pearsonassessments.com

MOST VISION THERAPY & PEDIATRIC EQUIPMENT PLUS HOME THERAPY SOFTWARE:

Bernell Vision Training Products, Inc.
4016 N. Home Street

Mishawaka, IN 46545
Supplier Account Number: 45803
(800)348-2225
Fax (574)259-2102 or 2103
www.bernell.com

Diagnostic Pharmaceutical Agents & Various Disposable Items:
Campus Store at Fullerton Campus
Auxiliary Services Manager
(714) 449-7424
E-mail Printshop@ketchum.edu for 20lb and 24lb printing paper and when need bulk jobs done.

Staples Business Advantage (After You Get Set-up by the Accounting Supervisor):

- Auto-Refractor Printing Paper

FDT & Humphrey Visual Field Printing Paper:

- Item Number: 266002-11-1-300 Thermal Paper - Package of 5
- Item Number: 266010-0024-433 Thermal Paper – Package of 12

Carl Zeiss
5160 Hacienda Drive
Dublin, CA 94568
Supplier Account: 7252000
(877) 486-7473
(925) 557-4298 Fax
www.meditec.zeiss .com

6.8 BUSINESS CONTINUATION PLAN- CLINIC SERVICES

This plan does not replace Marshall B. Ketchum's (MBKU) emergency preparedness plan. In the event of an emergency or disaster, the emergency preparedness plan will be implemented.

This Business Continuation Plan sets out the process by which the University Eye Center at Ketchum Health (UEC-KH) will respond to, manage, and recover from an incident, such as server down, power outage, no telephone service, department area interruption, etc. It has been developed to a) provide guidance on how to proceed in the event of an incident that may have short term or long term effect on services; b) mitigate the impact on UEC-KH's ability to carry out its functions; c) provide a communication/reporting process; and d) ensure services continue to be provided to our patients in an organized manner. Appropriate planning can reduce the impact on patients, student learning and the level of operational disruption.

Definitions

- **Emergency Preparedness Plan**- MBKU's plan to prepare for, react and recover from any event of magnitude that causes or has the potential to cause injury or death to staff, faculty, students and which may cause extensive damage to property. It also includes an evacuation plan.

- **Business Continuation Plan**- UEC-KH's plan to respond to a specific systems failure(s) or disruption of operations due to an incident that would not warrant implementing the emergency preparedness plan.

This plan also includes contact information to reach key individuals during evening hours, weekends and in urgent situations.

In any situation where there is a possible interruption in services due to circumstances beyond our control, we should determine the following:

1. Are staff and patients safe?
2. Is our building safe?
3. Can we continue to provide services to our patients?
4. Can we communicate to our patients?
5. Can we check-in and check-out patients?
6. Do we have adequate staffing to provide services?

Contact Information

Urgent Support Team

Name	Title	Department	Telephone #
KH Security			**7490**
Greg Smith	Director	Campus Operations	949-436-0329
Jesus Barrera	Director	Safety and Security	909-551-1036
Samuel Young	Director	Information Technology	310-883-4805
Rita Martinez	Clinic System Coordinator	Clinic	562-552-1423

UEC-KH Contact Information

Name	Title	Department	Telephone #
Dr. Julie Schornack	Sr. VP & Chief Staff	MBKU Operations	818-681-6877
Dr. Mark Nakano	Assoc. Dean	Clinics	310-739-2337
Dr. John Nishimoto	Associate Dean	Clinical Education	714-788-3570
Francine Ward	Director	Optical Services	714-745-6235
Rachel Merlos	Supervisor	Patient Relations	714-271-9486
Diana Dicdican	Coordinator	Clinical Education	562-228-3913
Connie Phung	Coordinator	Clinics	909-210-5809
Dr. Judy Tong	Assistant Dean	Residencies	714-343-9044
Dr. Dave Sendrowski	Chief	Ocular Disease	949-584-8677
Dr. Erin Rueff	Chief	Contact Lens	510-541-6422
Dr. Kristine Huang	Chief	Vision Therapy	626-224-8666
Dr. Mark Sawamura	Chief	Primary Care	714-473-6869
Dr. Patrick Yoshinaga	Chief	Low Vision	562-756-4491

6.8.1 Department Area Disruption

Purpose

To ensure patients continue to receive services in the event of a service area interruption. If an emergency or disaster occurs, the university's emergency preparedness plan will be implemented and will replace this procedure.

Procedure

If the University Eye Center at Ketchum Health (UEC-KH) has a service area interruption due to fire, earthquake, roof problems, etc., the following steps will be taken:

Accommodating Patients in another Service Area

1. The number of appointment slots will be reduced to accommodate patients using exam rooms in other service areas.
2. Patients will be contacted by phone, if it becomes necessary to reschedule their appointment.
3. Patients receiving urgent care or follow-up care will take priority over routine exams.
4. Exam rooms will be reserved and stocked with supplies (if appropriate) to accommodate patients from the affected service area.

Multiple Service Area(s) Disruption/External Relocation Required

1. Notification to patients regarding appointment cancellation, rescheduling and temporary location will occur by telephone, eblast, and through U.S. Mail. A general statement may also be posted on UECKH's website.
2. Patients requiring immediate follow-up may be referred to local Optometrists and Ophthalmologists.

6.8.2 Communication with Patients when Telephone Service is Down

Purpose

To develop a mechanism to communicate with patients when the University's telephone service is down for an extended period of time.

Procedure

UEC-KH's practice management system Compulink) currently holds over 10,000 patient email addresses and a little over 39,000 cell numbers. In special circumstances when mass communication to patients must be made, an eblast will be sent, using DemandForce, the appointment reminder software system. In the event there is a need to cancel scheduled patient appointments for the next day, or two, an email and text message will be sent.

Additional methods of communication may include using UECKH's website and/or U.S. Mail.

6.8.3 Interruption of Normal Processes During Exam

Purpose

To ensure patients continue to receive services in the event of an incident (power outage, server down, minor earthquake, etc.) occurring during the patient's exam. **If an emergency or disaster occurs, the university's emergency preparedness plan will be implemented and will replace this procedure.**

Procedure

If the University Eye Center at Ketchum Health has an interruption that would affect normal processes while the patient is being examined, the staffing faculty will assess the situation, call Patient Relations to report the problem or to obtain information and will follow the steps below:

1. Instruct interns to open exam room doors and remain with the patient. Patients in pre-testing areas will return to exam rooms with interns.
2. Faculty will assign a runner to provide communication to interns.
3. Record all exam data gathered, prior to the incident.
4. Close Compulink to save the exam and to prevent potential loss of data.
5. Distribute paper exam form (located in each consultation room) for the intern to record the entire exam.
6. Continue the exam (including dilation when applicable) if the patient agrees.
7. If the patient would like to reschedule the exam, or the intern/faculty is unable to complete the exam under the presenting circumstances, the intern will complete the "Reschedule Form" (located in the consultation room) and give it to the service area Administrative Assistant. **Note:** If the exam occurs in Primary Care, the "Reschedule form" will be given to the Cashier at check-out.
8. At the end of the exam, the intern will:
    a) Escort the patient to Optical with the RX form (if applicable).
    b) Escort patient to check-out with the fee sheet, paper exam form and the Reschedule Form (if applicable) to be scanned by Patient Relations.
9. When power is restored, faculty will document in the patient's Compulink chart that power was out during the exam to explain the partial Compulink documentation and paper chart.

FORMS

Paper Exam Form
Reschedule Form

6.8.4 Lack of Personnel-Extended Illness

Purpose

To maintain essential operations and services in the event that faculty/staff/interns are absent for an extended time due to illness. **This procedure does not replace the University's Emergency Preparedness Plan.**

Procedure

It is essential that emergency contact information for faculty staff and interns remain current at all times. In the event of 1/3 of this classification of personnel being absent due to a major illness or a **pandemic situation**, it may become necessary to change the clinic's hours of operations and create alternate appointment and work schedules.

Faculty Absent

The Chief of Service will request assistance from other faculty members within the service, followed by other service areas to cover absent faculty. If no faculty/doctors are available from other services, the Chief of Service will contact part-time and on-call doctors in an effort to cover the service. If no faculty/doctors are available, appointment slots will be reduced or closed and patients will be notified.

Support Staff Absent

The Director of Clinical Services will deploy cross trained support staff to temporarily work in the area of employees absent for an extended period of time. Deployed support staff will assume the duties and responsibilities of the position(s) being replaced until the employee returns, or until instructed to return to their regular work assignment. If no support staff is available, Human Resources will be notified to contact retired staff and/or temporary employment agencies. Associate Dean of Clinics will make the decision to create alternate work schedules and temporarily change the Eye Center's hours of operations if it becomes necessary.

Interns Absent

The Chief of Service will instruct the clinic coordinator, working in conjunction with the Associate Dean of Clinical Education to contact students who are on call to work in the service. If no students are available, it may become necessary to cancel appointments and notify patients.

6.8.5 Contact Lens Ordering – Business Continuation Plan

Purpose

To ensure patients can order contact lenses during a power outage or when the server is down.

Procedure

If the patient would like to order contact lenses and the University Eye Center is experiencing a power outage, or the server is down, the following will occur:

Patient is Present and Was Examined

1. The intern, using the Contact Lens Materials List, will write the quantity of lenses to be ordered in the column with the appropriate vendor.
2. The staffing faculty, using the paper chart will obtain the prescription (RX), complete the Contact Lens Order Form, and will give it to the Contact Lens Inventory Assistant to place the order.
3. The intern will escort the patient to check-out with the materials list and fee sheet. Check-out will collect the appropriate fees for the lenses from the patient.
4. The Contact Lens Inventory Assistant will call the vendor to place the order.

5. After power is restored, the Inventory Assistant will enter the contact lens order information into Compulink.

Patient is Requesting a Refill Order on the Phone

The Contact Lens Inventory Assistant will inform the patient of the following:

1. We are experiencing a power outage and are unable to access his/her medical record.
2. Can take the order request over the phone and will place the order after the power is restored.
3. Can take the credit card information over the phone for payment of lenses.

Patient Requesting Order Status on The Phone

The Contact lens Inventory Assistant will inform the patient of the following:

1. We are experiencing a power outage/server down and are unable to access his/her order.
2. After power is restored, the status of the order will be checked and he/she will receive a call.

FORMS

Contact Lens Materials List
Contact Lens Order Form

6.8.6 Optical Ordering of Frames and Lens – Business Continuation Plan

Purpose

To ensure patients are able to order frames and lenses during a power outage, server down or no telephone service.

Procedure

Patient Is Present and Was Examined

1. After the exam is completed, the intern will escort the patient to the Optical department with the Patient's RX form.
2. The Optician will assist the patient on frame selection as usual (if lighting is ideal) and will use the Optical Order form.
3. After patient makes a selection the Optician will:
    a) Call the patient's insurance provider (if applicable) to determine material benefits and obtain authorization.
    b) In the event, telephones are not working, inform the patient you will call them after speaking to the insurance provider and will require a 50% deposit at that time.
    c) If the patient is paying by cash, escort him/her to cashier (50% deposit required).
4. If able to place order, patient will be escorted to check out for manual payment processing.
5. After power/server is restored, enter order information in Compulink.

Walk-in Patients

1. The optician will inform the patient that we are experiencing a power outage; however they can assist with frame selection (if lighting is ideal).
2. The Optician will follow steps 2 -5 above for customers with an outside RX.

3. UECKH patients will be informed we are unable to access their RX at this time; however they can make a frame selection. Follow steps 2-5 above.

Patient Requesting Order Status on the Phone

Inform the patient of the following:

4. We are experiencing a power outage/server down and are unable to access his/her order.
5. After power is restored, the status of the order will be checked and he/she will receive a call.

FORMS

RX Form
Optical Order Forms

6.8.7 Patient Relations Check-in/Check-out – Business Continuation

Purpose

To provide the Patient Relations (PR) staff with a protocol that outlines a business continuation plan in the event of one or all system(s) failures occurs. The procedure will cover the processes to follow when the server is down, affecting Compulink and the internet. In addition, it provides the contact information for the Director of Campus Operations in the event there is loss of telephone service, or a power outage.

Procedure

Daily Procedure

To prepare for the next day's patients, PR staff will print fee sheets and verify insurances for each appointment (**walk-in patients will not be accepted, with the exception of patients needing immediate medical attention**). Staff will also generate a report listing the next day's schedule of patients by time and will do the following:

1. Print next day fee sheets approximately 2 hours prior to close of business.
2. Determine what paperwork (if any) each patient will need to complete and attach to the patient's fee sheet.
3. Print the report titled "?" located in the "Patient Relations" memorized reports list.
4. After the report has printed, place it with the next day fee sheets and staff schedule in the black inbox near the copy machine.

Backup Procedure

1. Call IT and notify them of the situation.
    a. During regular business hours call:
        i. Sam Young at ext. 7481
    b. After hours or weekends call:
        I. Sam Young
            1. Cell: 310-883-4805

Check-in

1. Staff will each have a manual check-in log to write patient names as they check in.
2. Staff will then use the printed list of patients (Apt List Contingency Plan) to check them in by highlighting each name.

Check-out

1. Service charges need to be calculated and documented on the fee sheet.
    a. All payments are to be collected at the time of service.
        i. Cash and Check payments will be processed as usual.
        ii. Credit card payments will be processed using a manual credit card slip, and will be entered and processed in the credit card terminal once the machines are functioning.
        iii. Manual credit card receipts will be given to the patient at the time of checkout. If the patient requests an itemized receipt, one shall be printed and mailed out once the system is back online.

Compulink

Patient intake, financial policy, and health history forms will be kept in a folder in PR. When the system comes back online, the exam documents will be entered and scanned.

Internet Connection

In the event we are unable to verify insurances for the next day's appointments, the following process will be implemented:

a. A staff member will be assigned to come in early to verify that day's insurances.
b. For same day outage, all authorizations will need to be obtained over the phone.

Phone Outage

Contact IT Department and Campus Operation:

a. Sam Young at ext. 7481 or 310-883-4805 (Cell)
b. Greg Smith at ext. 7456 or 949-436-0329 (Cell)

Power Outage

Contact Campus Operation:

a. Greg Smith at ext. 7456 or 949-436-0329 (Cell)

Patient Communication

In the event the power outage/server down has a long-term effect, or after receiving instruction from the Associate Dean of Clinics, the PR staff will call scheduled Primary Care patients to cancel and reschedule their appointment. The Administrative Assistants for the remaining service areas will contact their scheduled patients.

6.9 TELEMEDICINE

Executive Summary

As the COVID-19 emergency has challenged physicians and healthcare professionals to continue providing care without physical contact with patients, Telemedicine has emerged as the most viable solution. Ketchum Health plans to incorporate virtual care via Telemedicine technology through a dedicated software. This paper summarizes the basics of Telemedicine and lays out best practices with the minimum requirements we must observe to comply with federal and state laws.

I. Credentialing

Optometrist must be licensed in the state to conduct telemedicine encounters in California. Optometrists need not to reside in California, if they have a valid, current California Optometry license.

Optometrist who treat or prescribe through electronic video conferencing technologies are practicing optometry and must possess appropriate licensure in the jurisdiction where patients receive care. There are no legal prohibitions to using technology in the practice of optometry as long as the practice is done by a California licensed Optometrist, and complies with state and federal and privacy laws.

Pursuant to the Emergency Proclamation of March 2020, medical facilities in California can use out-of-state physicians to conduct telemedicine encounters without having the state license, if the protocols established by the Emergency Medical Services Authority are followed. Ketchum Health will adhere to those protocols when required.

II. Establishing the Physician-Patient Relationship

To start providing Telemedicine services, Optometrist must establish a professional relationship with the patient. This relationship is clearly established when the doctor agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an encounter in person between the physician (or other appropriately supervised health care practitioner) and patient.

An appropriate doctor-patient relationship has not been established when the physician's identity may be unknown to the patient. Where applicable, a patient must be able to select an identified doctor for telemedicine services and not be assigned to a doctor at random.

III. Informed Consent

Patient consent is required before rendering care. The consent could be obtained in writing or verbally and must be documented in the patient file accordingly, regardless of the format. The provider offering telemedicine services at the originating site must advise the patient about:

a) The proposed use of telemedicine;
b) Potential risks, including data lost during the encounter;
c) Types of transmissions permitted using telemedicine;
d) Consequences and benefits;
e) Obtain the patient’s or the patient’s legal representative’s consent.

Ketchum Health requires, to the extent possible, the use of a written form unless there are technical or physical challenges preventing doctor from offering such option.

IV. Types of Services

According to CMS, authorized Telemedicine encounters are

a) Telehealth visits
b) Virtual Check-in
c) E-visits

V. Standard of Care

The standard of care for licensees is the same whether the person is seen at a healthcare facility, through telehealth, or through another method authorized by law.

Optometrist who provide Telemedicine care, will adhere to the same standards of care established by the California Board of Optometry and Ketchum Health related protocols for in-person visits.

VI. Referrals and Continuity of Care

Patients should be able to seek follow-up care or information from the doctor who conducts an encounter using telemedicine technologies. Patients also should seek a referral for specialty services outside Ketchum Heath, and the rendering provider should have a protocol in place to share patient information with other providers.

VII. Medical Record and Encounter Documentation

Doctor must document all telemedicine services, including copies of all patient-related electronic communications, evaluation and consultation, diagnosis, treatment plan, prescriptions, and test results (when applicable). The physical location of both patients and providers must be documented, and everyone involved in the clinical encounter, including those who may be off-camera. Additional documentation needs are determined by the service or procedure performed.

VIII. Privacy and Security of Patient Records & Exchange of Information

Although waivers have been put in place by the HHS Secretary regarding the use of public-facing applications and platforms, and the potential for privacy breaches, Telemedicine encounters will be governed by the same standards of privacy and confidentiality afforded to face-to-face visits. Therefore, the HIPAA Privacy and Security rules apply, and California confidentiality of patient information and retention laws.

IX. Billing

Optimal telemedicine billing practices are paramount to the sustainability of the program. Billing for services must comply with State and federal laws and following any third-party payer's requirements. Ketchum Health will adhere to CMS and Private payers' billing guidelines

X. Training

Ketchum Health requires all providers to become familiar with the workflows and functionality of the telemedicine platform adopted. Providers will be educated on best practices, which includes: clinical documentation, encounter workflows, coding and billing, and patient engagement tools. Providers will have the opportunity to access training materials before engaging in telemedicine encounters. A team of telemedicine champions will be created with the goal of guiding the training process for all providers.

References.

Meyer BC, Friedman LS, Payne K, et al. Medical undistancing through telemedicine: a model enabling rapid telemedicine deployment in an academic health center during the COVID-19 pandemic. Telemed J E Health. 2021;27(6):625-634. doi:10.1089/tmj.2020.0327

Ca. Business and Professions Code § 2290.5 (a)(6). **Definition of Telemedicine**

California AB 133 California. **Temporary extension of the emergency declaration until the end of December 2022**

CMS https://www.cms.gov/files/zip/list-telehealth-services-calendar-year-2022.zip-0 **- List of Telehealth Services Calendar Year 2022**.

6.10 GENETIC TESTING

Topic Presented

Is genetic information (genetic testing) considered protected health information under HIPAA?
How do we collect, store, share, and discard genetic information from patients at Ketchum Health?

Discussion

As scientific and technological advances have allowed genetic testing to become almost prevalent in healthcare, the resulting amount of data generated, analyzed, shared, and stored increased dramatically. The biggest challenge continues to be ensuring that this subset of patient data remains secure and private.

Regulatory Background

When HIPAA was enacted in 1996, the topic of genetics was not included in the statute as part of the set of 16 individual identifiers. It was only until the enactment of the Omnibus rule in 2013 that the concept of protected health information (PHI) was expanded to include genetic testing information.
In May of 2008, Congress passed the Genetic Information Nondiscrimination Act (GINA), and it became the legal standard for the collection, use, and disclosure, of genetic information. Although only focused on genetic information, GINA served as a further step in evolving health information privacy laws.

It is worth noting that each law has different objectives. While HIPAA is mainly concerned with the privacy and confidentiality of patient information, GINA is essentially an anti-discrimination law that has nothing to do with privacy.

Legal Framework

Section 45 C.F.R § 160.103 -The Omnibus Rule of 2021, includes genetic information as another subset of protected health information (PHI), and specifically defines such data in the following terms:

Genetic information means:

i. *The individual's genetic tests;*
ii. *The generic tests of family members of the individual;*
iii. *The manifestation of a disease or disorder in family members of such individual; or*
iv. *Any request for, or receipt of, genetic services, or participation in clinical research, which includes genetic services, by the individual or any family member of the individual.*

It is essential to mention that the HIPAA rule only applies to Covered Entities as defined by the statute. Private enterprises that provide commercial genetic sequencing analysis are not regulated by HIPAA, opening a gap in privacy that Congress has failed to close.

At state level, California has enacted several laws in the last decade aimed at protecting the privacy and confidentiality of genetic data, and discrimination based on genetic profiles of individuals. Among the prominent ones are:

- **SB1442** of 2016 -Employment and health insurance nondiscrimination;
- **AB 825** of 2021 -Privacy breaches-It adds genetic data to the scope of personal information under the law;
- **Cal. Civil Code § 51** –CalGINA amendment, Nondiscrimination;
- **Cal. Health and Safety Code § 124975** – Confidentiality of genetic testing results in research-informed consent.

There are multiple case-law decisions; however, they are not consistent, and I will not discuss them in this memo.

Legal and Practical Analysis

With the inclusion of genetic testing data as protected health information (PHI) in the Privacy Rule, the law officially granted to this subset of information the same protections offered to other patient identifiers. This is critical for healthcare providers as it offers guidance on how to collect and store this data, and also it standardizes the sharing process across the continuum of care.

It is worth clarifying that the inclusion of genetic data as PHI did not create a unique "class" of protected information, e.g., psychotherapy notes, or HIV-positive results. The omnibus rule merely expanded the category to accommodate the growing trend of genome analysis. Subsequently, covered entities are not required by law to apply special safeguards to protect genetic testing.

One significant challenge in this area is the de-identification of genetic testing. Because of the nature of such data, de-identifying it is almost unfeasible, leaving a gap that health information managers must address on a case-by-case basis when required.

Conclusions and Recommendations

As a Covered Entity, Ketchum Health has the legal duty to protect patient information. Genetic testing is part of such information, and it must be safeguarded under the same standards applied to other patient data.

Knowing the sensitivity of genetic data and its inclusion in the electronic health record, Ketchum Health should implement the following measures to ensure that proper protocols and best practices are observed:

- **Informed Consent**. Patients must be educated that their genetic profile will be part of their electronic record once received by Ketchum Health. They need to know about the risks associated with the release of PHI that potentially includes genetic data. Once released to a third party, agency, or another physician, Ketchum Health has no control over the information.
- **Forms.** We must update both the "authorization to release PHI" and the Notice of Privacy Practices to include genetic testing data as part of protected health information.

- **Data segregation.** Ketchum Health is not required by law to segregate genetic data. Due to technical limitations from the EHR software, this is not feasible currently either. Additionally, offering data segmentation poses logistical and operational challenges related to the management of such information.
- **Family Members.** Family members of patients with genetic disorders will be notified with express consent from the subject patient only.

7.0 FINANCIALS

7.1 CLAIMS

7.1.1 Accounts Receivable

PURPOSE:

To locate any accounts with an outstanding balance either from patient or insurance company.

PROCEDURE:

On a monthly basis, run the following reports Accounts Receivable and Ins. Receivables by Payor.

1. Go to reports (Patient open balance)

a. Financial
b. Account Management
c. Accounts Receivable
d. Select location (KHA, BGC, ULA) begin report
e. Export file and save to desktop
f. Go through each account starting from 180 and over
g. Contact patient to try and collect balance over phone
h. Enter note in ledger under open balance charge

2. Go to reports (Insurance open balances)

a. Financial
b. Account Management
c. Insurance Receivable by Payor
d. Select location (KHA, BGC, ULA)
e. Select payor
f. Export file and save to desktop
g. Go through each account starting from 180 and over
h. Contact payor to check claim status an make any corrections if needed or resubmit claim
I. Enter note in ledger under open balance charge.

7.1.2 California Highway Patrol Billing

Purpose:

To ensure the California Highway Patrol (CHP) is accurately billed for Visual Acuity examinations.

Procedure:

Daily staff will login Compulink go to Worklist and run “Insurance Unbilled Charges” go to CHP insurance double click and a list of patients will show up it must be billed as an invoice as follows:

1. The invoice will be the patients account number and month/year of service
2. Click on Print, then Report and select LIP Receipt Options
3. Enter the start and end of the month you want to bill
4. Export and save document as Microsoft word- RTF to desktop
5. Once saved, access the file, and update information as follows
    a. Change ‘Statement’ to ‘Invoice’ on top left corner
    b. Change “account” to “Invoice” and add month and year to complete the invoice #
    c. Change Receipt Balance to Invoice Balance
    d. Change patient name and address to CHP information
6. Print the invoice for each patient.
7. **The doctor will write the results of the exam on the Visual Acuity Form, provided by CHP. Mail the invoice to CHP with a copy of the Visual Acuity Form to the attention of the Cadet Hiring Unit. Note: CHP will not issue payment for the exam if the Visual Acuity Form is not attached.**
8. When submitting payment to the MBKU, CHP will include the patient’s invoice number. This will notify staff where to post the payment.

Forms:

Visual Acuity Form

7.1.3 Billing Medical Payers for Services

Purpose

To establish a process to submit billing to any medical payers the clinic is contracted under.
Payers:

- Medicare
- Anthem Blue Cross PPO
- BlueShield of California PPO
- HealthNet PPO
- Cigna PPO
- CalOptima
- Point Comforts
- Prospect Medical Group
- AltaMed
- Medi-Cal

Procedure

1. On the home screen of Compulink, click on Report- Financial- Acct Management- Pre Billing Claims Review
2. Enter the parameters of the claims you are going to be reviewing and submitting
3. Once report is generated, review and scrub each claim
    a. All claims should be billed with a medical diagnosis
        i. Except- if the referral is noted for eye exam only- refractive is needed
            1. Point Comforts
    b. Appropriate modifiers if needed
        i. CalOptima and Medicare requires modifiers for some services
4. Once all claims are ready to be submitted to Change healthcare, go to Compulink home screen
5. Click on Function then select Insurance Activities- Billing
    a. Enter the parameters for the location you are billing for:
        i. Location- Anaheim
        ii. ID- *
        iii. Form- CMS1500
        iv. EMC- NEICANSI
        v. Plan- *
        vi. Paper only and Claim min $ leave as is
        vii. Threshold- enter up to the date you want to submit clean claims

Once all claims have been submitted to Change healthcare, Compulink claims function will complete

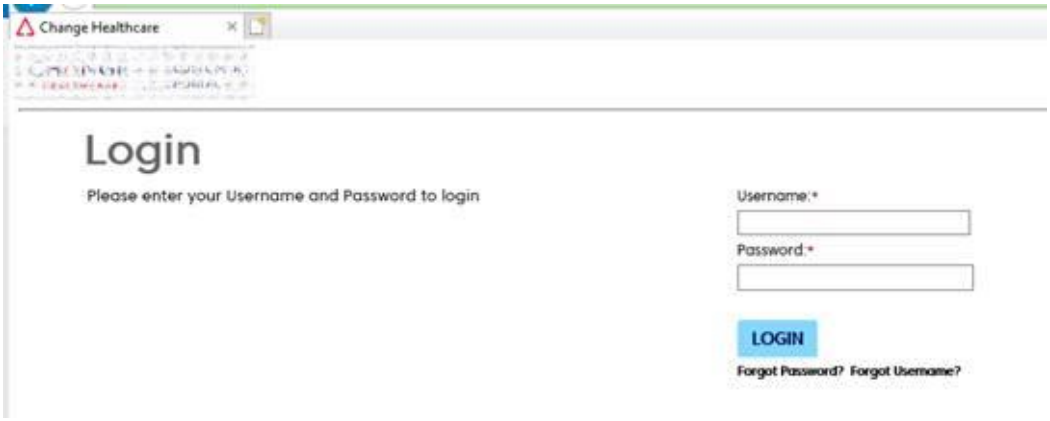
7.1.4 Change Healthcare Clearinghouse Portal

Purpose

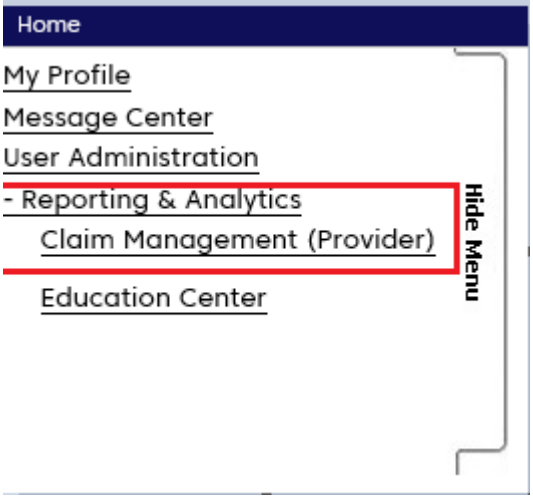
To ensure all medical claims have been accepted for claim submission.

Procedure

1. Go to the Change Healthcare portal https://access.emdeon.com/CIHS/
2. Log in using your approved credentials



3. Click on *+Reporting & Analytics- Claim Management*



4. Review *File Summary Status* for all Accepted or Rejected file status

File Summary Status

FILE RECEIVED DATE	FILE ID	FILE STATUS
05/04/2022	EP2MI5N01HV2T49	Accepted
05/10/2022	EP2E72701JUD0P9	Accepted
05/10/2022	EP8HABU01JVZ8X9	Accepted
05/10/2022	EP2EBM801JWLN89	Accepted
05/10/2022	EP2EABX01JW74W9	Accepted

   a. Any rejected files need to be reworked in Compulink and submitted to Change Healthcare using the Billing Function within Compulink.
      i. Worked Rejected claims need to be changed from “unworked” to “worked” under the Claims Queue.

7.1.5 Processing PEDIG Vouchers

Purpose

To develop a process of billing the “JAEB Center for Health Research” when the patient participates in the Pediatric Eye Disease Investigator Group (PEDIG) research study.

Procedure

Participates in research studies conducted by the PEDIG. Patients who enroll in one of the Amblyopia Treatment Studies are given vouchers to obtain a free pair of glasses from the Optical department’s Value Line.

Staff will process this type of billing as follows:

1. Login Compulink, go to Worklist Run “Insurance Unbilled Charges”
2. Select JAEB Research list of patients will come up
3. Optical will enter charges as “Usual and Customary” under “Spectacles”

4. We will provide spectacles and lenses from Valueline. **Note: Lenses should be polycarbonate with scratch coating. Add-ons and upgrades are not permitted.**
5. JAEB must be billed on an Invoice created on a Word Document it must include:
    a. Date of service
    b. Patient ID provided by JAEB
    c. Description exp: “Spectacle with Corrective Lenses”
    d. Price it should never be more than the approved amount $150
6. Email invoice to **pedig@jaeb.org**

FORMS:
Invoice

7.1.6 VSP Billing

Purpose
To establish a process to submit billing to the VSP.

Procedure
Claims are submitted daily to VSP through Compulink interface. Except for LV and MNCTL claims those are to be submitted via VSP portal.

1. Click on Worklist and select ‘Claims to be billed by EMC and Location’
    a. Enter KHA
    b. Enter VSPCLAIM
2. Select each patient that shows up on the list
3. Check that only services being billed have “Eyefinity” attached
    a. Proper diagnosis needs to be attached
    b. Staffing Dr is linked
    c. Authorization attached
4. Click Claim Validate
5. Click Print, Ins. Claim
    a. Double click on charges being billed
    b.Click enter
6. Once claim is successfully submitted open exam charge and enter note of services billed.

7.1.7 Vision Insurance Billing

Purpose
To establish a process to submit billing to the vision plans Ex: EyeMed, Envolve, Spectera, March Vision, MES.

Procedure
Claims are submitted daily to insurances through portal for exam, glasses and CTL.

1. Click on Worklist and select ‘Insurance Unbilled Charges’
2. Select Insurance that you are billing at the time
    a. Patient list will pop up

b. Select first patient on list

3. Check that only services being billed have proper insurance attached
    a. Proper diagnosis needs to be attached
    b. Staffing Dr is linked
    c. Authorization if provided by insurance attached
4. Click Claim Validate
5. Go to insurance portal and submit insurance through there
6. Open exam charge on ledger and enter a note of charges billed and enter billed date under “Last Billed”.

7.1.8 School District Contract Billing

Purpose

To establish a process to bill school districts for vision therapy services.

Procedure

When a student is referred to the University Eye Center for vision therapy services, the school district will issue an authorization that includes the number of authorized visits and the agreed upon payment amount. On a monthly basis, staff will print invoices from Compulink and submit them to each School District. Invoices will be processed as follows:

1. Click on Worklist and select Insurance Unbilled Charges
    a. All school districts will be listed under ‘SD’
2. Each patient needs to be billed with its own invoice to the school district
3. Ensure billing is accurate by reviewing the contracted billed charges and school district.
4. Each invoice is assigned by the patient’s account number and month of service
    a. Ex. 2525250521
        i. Patient account 252525
        ii. Service date- May 2021

How to create Invoice

5. Click on Print, then Report and select LIP_Receipt_Options
6. Enter the start and end of the month you want to bill
7. Export and save document as Microsoft word- editable RTF on your desktop
8. Once saved, access the file, and update the following information
    a. Update ‘Statement’ to ‘Invoice’ on top left corner
    b. Update the School district name and address
    c. Change account # to Invoice #
    d. Zero out the amounts under Responsible Balance and Previous Balance and only show the amount due under Amount Expected and Account Balance
    e. Print the invoice for each patient. **Note: school districts will only issue payment if there is an invoice number and <u>not</u> a statement.**
9. All patient invoices can be mailed or emailed together

FORMS

Invoice.

7.1.9 Department of Rehabilitation Billing

Purpose
To establish a process to submit billing to the Department of Rehabilitation (DOR).

Procedure
Unbilled DOR claims can be pulled up under worklist "Insurance Unbilled Charges"
The DOR will mail/fax an "Authorization and Invoice for Medical Services" when referring their client for services. Upon receipt, staff will follow the process below:

Primary Care Appointment

1. Copy the authorization form and attach the Instructions. Place a copy in the Claims department file and forward the original to Patient Relations or Low Vision.
2. When billing the DOR, attach the original authorization, the Report of Optometric Examination, the V Codes and the Pricing form. **Note: The DOR must have the V Codes and pricing to authorize services.**
3. Email the above documents to Osginvice.ca.gov and CC the counselor **Note: If the documents are not mailed timely, authorization may be delayed for the recommended glasses.**

Authorization for Glasses

1. Upon receipt, copy and forward the authorization to the Optical department. Maintain the original for billing.
2. Optical Informs patient he/she can make a selection and place their order.
3. When the patient arrives, the Optician will pull the authorization from the Optical department's file folder. The patient will only receive what is authorized on the Rehabilitation Authorization Form. **Note: The DOR pays basic Medi-Cal rates and will not pay for upgrades.**
4. When the patient receives the glasses, he/she will sign the Verification of Delivery form.
5. When billing the DOR, create an invoice with charges, attach a copy of the lab invoice and the signed Verification of Delivery form to the original authorization. Verify the appropriate material amounts have been completed on the form. **Note: Do not submit billing until the glasses have been dispensed and the patient has signed the Verification of Delivery form**.
6. Once billing is submitted enter a note under changer in patient ledger and make sure that all services billed have a "Last Billed" date entered.

Low Vision Services

1. Low Vision authorizations are given to Connie Phung/Low Vision admin
2. The authorization is emailed to the patient's counselor. If the doctor is requesting a low vision device, a Pre-Determination Recommended form is completed and attached with the billing information.
3. When the purchase order is received for the Low Vision device (s), give the original to the Low Vision department for billing and maintain a copy for the Claims department file. Materials are ordered and dispensed by the Low Vision department staff.

4. Adjust charges in Compulink from the usual and customary fees to the DOR's authorized amount. Email the paperwork to the patient's counselor.

Payment Follow-Up

If after reviewing monthly statements it is determined MBKU has not received payment, staff will contact the DOR regarding payment status.

FORMS:

Authorization and Invoice for Medical Services
Intern Instructions
Report of Optometric Examination
V Codes and Pricing
Verification of Delivery
Pre-determination Recommended

7.1.10 Daily Financial Reconciliation

Purpose

To establish a process to reconcile cash and credit card purchases.

Procedure

On a daily basis, the accounting representative will conduct the following:

- Remove the deposit bag from the safe located in the patient relations supervisor's office.
- Retrieve the Compulink and OminiFlex financial reports and those from the external clinics (Tustin, GG, CSUF).
- Count all money and match the amount to the appropriate report. If there is an input error, notify the patient relations/claims representative to correct it.

7.1.11 Patient Statements

Purpose

To communicate with the patient the outstanding balance they owe the clinic.

Procedure

At the beginning of each day, staff will login to Compulink and print statements for services rendered to patients as follows:

1. Click on Worklist and select 'Patient Statements Due by Location'
    a. Enter KHA
2. Select each patient with a balance and research if it is a true amount the patient owes.
3. Open the first line item with a balance and enter your statement note:
    a. Statement Mailed (1-5 months)
    b. Past Due (6-12 months)

    c. Why the patient has a balance and how much the balance is
    d. You can also enter a note why a statement will not be mailed
4. Click on Print and select Statement

FORMS:

Claims Envelope
Claims Return mail Envelope.

7.1.12 Refund Policy

Purpose
Healthcare payments are complex, making it difficult to determine the exact amount a patient will owe, leading to overpayments. In addition, patients can withdraw their Optical, Low Vision, or Contact Lens order (approved by the Chief of Department) and request a refund.

Refund Process
A staff member will need to fill out a refund slip, documenting each area:

- Patient name
- Home address
- Account number
- Date of refund
- Reason and comments for refund
- Date paid
- Amount of Refund

Once the refund slip is complete, the staff member must get it approved and signed by Michele Whitecavage or Dr. Mark Nakano. For all Optical orders, the Optical Director's signature is needed.

A note is entered under "Comments" in Compulink with an explanation for the refund request.

Timeline for Refunds- Patients

- Check refunds will be processed and mailed within two (2) business weeks from the posted date
- Credit card refunds within 45 days from the original transaction date will be refunded back within 2-3 days

Timeline for Refunds- Claims Department

- The Claims Department should process all refund requests within a week from delivery

Type of Refunds

Check Refund

- Original payments made in Cash, Check, Money Orders, FSA/HSA- over a year, and Credit Cards- over 45 days

Credit Card Refund

- Original Credit Card payment date within 45 days, FSA and HSA within the current year

7.1.13 Stop Payments of Checks

Purpose
To establish a process to follow when a patient stops payment on a check for services/materials provided.

Procedure

1. Go to the patient's ledger in Compulink
2. Click on Credit and select Responsible and enter the amount of the check as a negative. Apply the negative payment to each line item that was paid. This will reverse the payment.
3. Go to “Services” and enter a new charge under ‘NSF’ (not sufficient funds) in the amount of $35.00.
4. The patient ledger will now show the balance from the original payment and a new charge of $35.00
5. Enter an alert showing there is an outstanding balance to be collected with the balance, collection fee, and total due.
6. Inform the patient he/she is responsible for payment of the original check amount as well as a $35.00 returned check fee. In addition, make the patient aware that the entire amount must be paid by cash or with credit card within 48 hours.
7. Mail the patient a statement if patient cannot make a payment over the phone.
8. If payment is not received within 48 hours, patient cannot schedule any upcoming appointments and the account will be reviewed for collections.

8.0 STUDENTS

8.1 General Student Policies and Procedures

8.1.1 Student Clinic Absences

This serves as the policy for time off from intern assignments within the University Eye Center at Ketchum Health. This policy discusses the various time-off classifications, the nature of the make-up and the protocol for notification of absences from intern assignments.

PROTOCOL FOR UNPLANNED/UNFORESEEN ABSENCES

For any unplanned/unforeseen circumstances (e.g. illness, automobile accident, death in family), the intern must personally contact the Clinic Coordinator, Ms. Connie Phung at (714) 463-7520 or Patient Relations as soon as possible, preferably no later than 7:45 AM each day of the absence so that appropriate arrangements in patient re-scheduling can be made.

A completed time off form must be submitted to the Clinical Education office within three days of the intern returning to clinic; otherwise the absence may be considered unexcused.

TYPES OF ABSENCES

Excused Absences – The following are considered excused absences. The intern must report the absence as soon as the occurrence becomes evident and it MUST NOT be later than the beginning of patient care. Documentation should be provided upon request. As a healthcare facility we encourage anyone who is ill to stay home and to seek necessary medical care as indicated. Interns may be sent home if they appear to be a health hazard to others.

All make up time equals time missed. We are required to document a minimum number of hours in the clinic as a requirement for graduation.

Urgencies/emergencies:
Personal illness or injury
Auto accident
Medical emergency involving the intern, domestic partner or an immediate family member.
Death of a family member
Non emergent situations with preapproval of time off. Activities which cannot be scheduled around the clinic assignments such as:
Doctor's appointments
Weddings

a. Attendance at the AOSA, AOA, AAO National Meetings
b. Graduation of immediate family member and significant other
c. Religious holidays as approved by the Office of Student Affairs

Unexcused Absences – Absences when the intern appears to be negligent in attending their clinic assignment.
Late for clinic or leaving early without permission.
Arriving late– MAKE UP = HALF DAY. If the intern misses an appointment slot – MAKE UP = ONE DAY
Multiple tardiness can result in disciplinary action
No show to clinic, no notification - An intern who is a no show for a clinic assignment is considered to be Unprofessional Behavior and a Breach of the Student Code of Conduct, which may result in disciplinary action.
Make-up time will be at the discretion of the Associate Dean of Clinics or Associate Dean of Clinical Education.

PERSONAL & PROFESSIONAL TIME OFF POLICY

A. Four (4) Days Total or Eight (8) Clinic Shifts will be granted to each student. The Personal/Professional Time Off can be used for:

Personal:

- Doctor's Appointments
- Weddings
- Family Matters, etc.

Professional:

- NBEO
- Interviews (Residency & Job)
- Professional Meetings

- Licensing Examinations, etc.

B. Black-out Periods

These are dates where personal or professional time off may not be granted:

a. First Week of the rotation
b. Two days before or after break/vacation
c. 2 days before and after Part I and/or Part II NBEO
d. Dates other than the above where time off may adversely affect patient care and clinic operations.
e. One Day before a test.

C. Personal & Professional Time Off

1. Fourth Year Interns at the University Eye Center at Ketchum Health
    a. The Four (4) Days are allocated as follows: (See Section III Item A)
        I. Two (2) Personal
        II. Two (2) Professional
    b. Only during the Quarter which they are at KETCHUM HEALTH at KH
    c. Any additional days missed will require a one to one make-up.
    d. Please follow the proper protocol for requesting time off from clinic
2. Third Year Interns during the Academic Year (July 1 – June 30)
    a. Two (2) personal days or four (4) shifts per quarter.
        I. Total of eight (8) personal days.
    b. Any additional days missed will require a one to one make-up.
    c. Please follow the proper protocol for requesting time off from clinic

PROTOCOL FOR REQUESTING TIME OFF FROM CLINIC ASSIGNMENT

A. A completed time off form must be submitted to the Office of Clinical Education. **This action including approval must occur no less than two weeks prior to the planned absence, otherwise the request will be denied.** Days are awarded on a first come, first served basis.
B. **The Associate Dean of Clinics or Associate Dean of Clinical Education reserves the right to refuse any request that adversely affects patient care and clinic operations (e.g. multiple intern requests for a specific date/time).**
C. Make-up time must be scheduled within the service missed and should be completed by the end of the rotation or quarter in which the absence occurred. Failure to do so will result in a grade of incomplete.
D. At the time of the make-up assignment, the assigned faculty or optical staff should sign in the area under “Signature of make-up supervisor”.
E. The form must then be returned to the Clinic Coordinator to be logged by the end of the quarter.
F. **Scheduled make-up dates will be at the discretion of the Associate Dean of Clinics, which can include assignments during the holiday recess (Thanksgiving, Christmas, and spring break as well as Commencement week).**

LEAVE OF ABSENCE POLICY

Students who need to request a leave of absence for a period of time should consult with the Dean of Optometry, the Vice President of Student Affairs, as well as with friends, faculty, advisors, and other informal counselors. Please refer to the MBKU Student Handbook for details.

CLINIC CONDUCT

Clinical service is a privilege. As a clinician, you represent not only yourself but this college and the profession you have chosen to devote your future to. To the patient, you are Optometry and you are the University Eye Center. For this reason, you will be expected and should be proud to maintain the highest standard of conduct within your capability. The following guidelines are therefore minimal and designed for those few in every class who need such direction.

8.1.2 Appearance and Dress

The clinician must be presentable. Since you must convince patients that their visual welfare is in competent hands, the initial impression conveyed is extremely important. The clinical faculty will set the example in applying these standards. If clinicians do not come up to these standards, they will be dismissed (unexcused absences) from clinical assignments until they are able to meet them.

All students on clinical service or otherwise in the clinical facilities of SCCO will, unless otherwise instructed, wear a short professional smock or jacket with the MBKU emblem sewn neatly on the upper left pocket. All students will dress in a manner suitable for patient care.

The standards of dress for all students entering the clinic shall be in effect in all clinics during any hour or day that clinics are open. Enrolled students whether a clinician, patient or visitor are expected to be in full compliance at all times. These standards for the clinic apply during Clinical Seminars as well. The dress code applies to all KETCHUM HEALTH Students, Staff and Faculty.

The Associate Dean of Clinics, the Senior Associate Dean of Professional Affairs, Chiefs of Service, and/or Clinical Faculty Members ultimately determines if an individual's overall appearance is acceptable. If it is decided that the appearance or grooming is unduly distracting or inappropriate for the clinic, the individual may be sent home to change (unexcused absence). Disciplinary actions may take place after the first warning.

The following are some examples of both appropriate and inappropriate attire. When in doubt if something is appropriate, it is best to contact the Associate Dean of Clinics, Senior Associate Dean of Professional Affairs and/or the Chief of Service prior to wearing it.

- Ties for men are to be worn at all times in the clinic.
- Blouses, shirts and dresses should not be revealing in any way.
- Do not wear short or extremely tight fitting skirts or dresses. Any skirt or slits in the skirt or dress nearing 3+ inches above the middle of the knee is to be avoided.
- Slacks or trousers must be clean, pressed and appropriate for a health care office. The following are inappropriate: shorts, skorts, stirrup or stretch pants, skinny or tight fitting pants.
- Clothing, accessories and overall grooming should be conservative. Men are not to wear earrings while scheduled in the clinic. Earrings placed anywhere other than the ear lobes are not acceptable.
- Socks for men are to be worn at all times.
- Hosiery is to be worn with dresses and skirts that are above the knee.
- Footwear should complement your professional attire. Inappropriate shoes include sneakers (unless worn with scrubs), sandals, flip-flops and slipper type shoes.

- Denim and leather clothing of any kind should be avoided because it is overly casual.
- Long hair should be tied back during exams to prevent it falling in your face and the face of your patients.
- Nail grooming which is profoundly unnatural or inappropriate to a health care environment is not allowed.
- Perfume and after-shave should be avoided (or used very sparingly).
- Permanent or semi-permanent tattoos are to be covered and not visible when in the clinic.

MONITORING OF THE PROFESSIONAL STANDARDS OF DRESS

Monitoring of the professional standards of dress is considered the responsibility of every student as well as the faculty members, support staff and administrators. The dress code is expected to be maintained by everyone connected with the College.

Infractions of the dress code should be brought to the attention of the supervisor or supervising faculty of the person who is in violation. Repeated violations are to be reported to the Director of Clinic Operations, the Associate Dean for Clinical Education or the Associate Dean of Clinics (in Clinic matters) or to the Vice President of Student Affairs. Disciplinary actions, including removal from patient care, may take place after the first warning.

DRESS CODE FOR VISION THERAPY

Pediatrics & Vision Therapy- white clinic jackets may be removed when working with young children. To be authorized by the supervising faculty.

1. Nametags

   a. Nametags are to be worn by all clinicians, faculty and staff and visible to patients and faculty. Clinicians should make sure patients know their names for future reference.

2. Personal Hygiene

   a. Lack of personal cleanliness is intolerable in any practitioner of a health profession. The clinical faculty and staff, and hopefully, your classmates will feel free to inform you of any shortcomings in this regard. Inattention to personal hygiene will result in dismissal (unexcused absence) from clinical assignments.

   b. Clinicians are expected to wash their hands before beginning any patient examination and to exercise extreme attention in assuring cleanliness of all instruments or materials making contact with their patients.

3. Behavior

   a. Excessive noise, vulgarity or crudity of language is inappropriate. Undue familiarity with patients, faculty or staff is not desirable. Care should be given so that all patients are treated with respect and concern is demonstrated for problems and needs. **Never call a patient by their first name unless specifically requested to do so.** Clinical faculty are always to be addressed as "Doctor". Clinical non-professional staff are to be addressed as "Miss", "Mrs." or "Mr." as appropriate.

b. Clinicians are not to lounge or congregate for discussions in aisles or hallways.

c. No clinician is permitted behind the reception desk or in restricted areas unless specifically directed to do so by the clinical faculty or Patient Relations personnel.

d. Smoking is prohibited in all campus areas.

e. Beverages and food are not to be brought into or consumed in clinical facilities except as specified at a specific clinical education site.

f. Students in the pre-clinic, laboratory classes and being seen as patients will observe the same rules of appearance, hygiene, and manner as clinicians whenever they are in a patient care area.

8.1.3 Student Responsibilities

The primary responsibility of a student in the University Eye Center is patient care. This care will be provided in accordance with the policies and procedures in this Manual. However, due to patient "no-shows", light patient loads, etc., a student may find themselves without patients from time to time. During these times, to provide some practice management education to broaden the student's experiences, the supervising faculty or Chief of Service may assign other tasks. Students should not leave the clinical area to which they are assigned so they are available for patient care duties if the need arises. They may receive permission from the supervising faculty to leave the clinical area temporarily.

To fulfill quarterly assignments, a student will be expected to:

1. Attend all scheduled patient examination sessions and discussions on time.

2. Attend scheduled Optical Service sessions on time.

3. Verify Rx's and perform any other duties as instructed by the Optical Service Supervisor or their designee.

4. No Shows: If the patient is later than the 30-minute limit or does not come in, this may be considered a no show. If you have a no-show or a cancellation, report to the instructor for an alternate assignment. **Do not leave the clinic.** Students are assigned to a specific clinic service (i.e. Primary Care, Vision Therapy) for an entire four (4) hour (or 3 hours in the Third Year Contact Lens Service) and **MUST** be immediately available to provide patient care, attend discussions, demonstrations, etc. Failure to do so will be considered an unexcused absence and may result in clinical suspension and/or referral for disciplinary action.

5. Trading regularly scheduled clinic times, enhancing assignments or patients is prohibited. Students are expected to meet their clinical responsibilities at the designated times. This may

be waived in special circumstances by obtaining written permission from Vice-president of Clinical Affairs and the Chief of Service.

6. Clinical faculty consists of both full and part time instructors. Every attempt will be made to arrange the assignment of instructors so that each student will have a maximum exposure to as many instructors as possible. By necessity, some repetition is inevitable.

7. Students may use the clinical facility to examine additional patients (those not regularly scheduled as part of the clinical assignment) if the proper procedure is followed:
   a. It is the student's responsibility to appoint the patient appropriately, register the patient in advance, and to arrange for a room assignment with the reception desk and staffing doctor.
   b. The student must arrange, prior to the examination, for a clinical instructor to consult. **No patient is to be given optometric care in the clinic without consultation with a licensed faculty member.**

8.1.4 Professional Misconduct

A proven violation of the policies, procedures and protocols of either the Southern California College of Optometry or its University Eye Center constitutes professional misconduct. Professional misconduct may include (but is not limited to) dishonesty involving clinic patient records such as alteration or fabrication, forgery of signatures, providing patient care without consulting with a licensed faculty member, excessive unexcused absences, or use of the clinic for financial gains, i.e., practicing Optometry without a license and/or receiving a fee for services rendered or materials ordered. Patient endangerment or abandonment represents professional misconduct. Any form of professional misconduct is strictly prohibited, and is grounds for dismissal from the College of Optometry. Please refer to the MBKU Student Handbook.

8.1.5 Exam Room Protocols

At the beginning of the clinic session, students should go through the equipment and determine if any equipment is missing or not in working order. It should be reported to the supervising faculty before patient care begins for that session. If no equipment problem is reported to the supervising faculty, it will be assumed that all equipment was present and functional at the time the clinic session started.

Students are to complete the following tasks at the beginning of their clinic session:

1. Check all electrical equipment for operational readiness
2. Check ophthalmic instrument stand for elevation and depression.
3. Check ophthalmic chair for elevation, depression and rotation.
4. Check acuity chart for function, calibration and focus.
5. Check keratometer for calibration.
6. Check phoropter cross cylinders and prisms for alignment.
7. Make sure a near point rod is available.

8. Neatly fold and place all dust covers and all cases in drawers. (Do not drop dust covers; leave rolling carts or cases on the floor.)
9. Clean all equipment and surfaces to ensure optimal hygiene (i.e. tonometer's, all chin rests, forehead rests, phoropter bank, etc.)

Students are to complete the following tasks at the end of their clinic session:

1. Return phoropter sphere and cylinder lens banks to plano and replace dust covers.
2. Turn off all electrical equipment and lights (unless otherwise specified for a particular instrument.)
3. Lower stand and chair to lowest position, lock chair, and turn all switches off.
4. Lift or remove the near point rod and place in a drawer or on a service cabinet.
5. Replace dust covers on every piece of equipment.
6. Return any check-out equipment to Central Supply.

If a student fails to adhere to the rules and regulations set down in this exam room protocol, it is the responsibility of the supervising faculty or student to report these violations to the Associate Dean of Clinics.

EXAMINATION ROOM CLEANING

Each clinic examination room is spot cleaned every evening. However, from time to time special cleaning needs arise or specific areas may be overlooked. If special cleaning needs in the clinic appear an "KETCHUM HEALTH Cleaning Request" should be filled out to target areas for cleaning. The "KETCHUM HEALTH Cleaning Report" forms are available in the forms section of the portal. After completely filling out this form it should be dated and submitted to the Associate Dean of Clinics or Central Supply for further action.

8.2 EQUIPMENT MANAGEMENT

8.2.1 Equipment and Technology Protocols

Equipment is to be used only for College related activities and is required to be checked out. Any use of equipment outside of the Center requires prior approval of the Associate Dean of Clinics. It is anticipated that all equipment will be returned at the end of the day's clinical activity. Supplementary equipment not located in the exam room can be found in Central Supply.

1. Equipment checked out to a student for clinic use remains the responsibility of the student until it is returned.
2. Equipment checked out to a faculty member remains the responsibility of that faculty member until it is returned.
3. The person who is checking out the equipment should inspect it thoroughly before it leaves Central Supply to make sure that it is functioning properly. If the equipment is not functioning properly, it should be reported immediately; not when the equipment is returned.
4. Students will be charged the full cost of lost equipment.

5. Clinic supplies are for use in the clinic only and may not be used for labs. Supplies to be used for course work or labs should be requested with other supplies from the Vice-president's office.

Faculty responsibilities for equipment:

At the close of each clinical session, the supervising faculty or their designee is to survey all rooms used by the students in his/her section. The faculty is to feedback to the students, and report if any students fail to observe guidelines for care of equipment and facilities.

EQUIPMENT DONT'S

1. DO NOT force a knob or switch or instrument arm which appears to be stuck. Ophthalmic equipment is made to operate smoothly.
2. DO NOT move equipment from room to room. If your room is not functional, report the problem and then move to another room. This is absolutely essential in maintaining equipment inventory.
3. DO NOT leave instruments on when they are not in use.
4. DO NOT leave any room at the end of the day without replacing dust covers.
5. DO NOT leave any room until it is clean enough that you would not mind bringing your own patient into the room.
6. DO NOT bring bike bags, back packs or purses into an examination room. Use your locker.

EQUIPMENT DO'S

1. DO exercise extreme care in providing your patients with a hygienically safe clinical experience.
2. DO carefully calibrate all instruments before use preferably prior to patient contact.
3. DO replace bulbs, paper towels, tissues and make minor adjustments yourself prior to the time the patient enters the room.
4. DO inspect your room thoroughly before and after each patient.
5. DO report to your faculty any inoperable or missing equipment and supplies, complete and submit the appropriate repair form (See CM 2.12)
6. DO make sure all locks and threads are properly disengaged before changing any instrument's position.
7. DO exercise gentle care and concern for equipment.
8. DO remember how frustrating it is to set up in a room which has been left unclean and in disrepair by the clinician before you. Act accordingly by leaving your room clean and by reporting all malfunctioning equipment immediately.
9. DO lock your examination chair. In light of the potential for injury and legal liability, it is essential that all examination chairs be maintained in a locked position. If you need to rotate the chair, immediately re-lock the chair after you have turned it.
10. DO log off and lock your computer when leaving the room.

Administrative Responsibility

Periodic inspections of each room are scheduled to make calibrations and alignments and replace consumable supplies. Upon receiving an equipment repair form, the Associate Dean of Clinics will have

campus operations trouble-shoot the problem as soon as possible. Items which cannot be repaired on campus may be sent for factory repair.

8.2.2 Out-of-Center Use of Equipment

General Policy Statement

1. Under **NO** circumstances is equipment belonging to the College to be taken from the College facilities for personal use by students, faculty or practitioners without approval by the Associate Dean of Clinics. Non-faculty practitioners requesting use of equipment for special projects, research, etc. will be turned down.

2. Use of equipment needed for specific, on-campus, time-specified teaching, research, or demonstration purposes may be taken by authorized College personnel. However, no equipment is to be taken from any clinical facility until written approval is received from the Associate Dean of Clinics. This is necessary to maintain inventory control and to insure that equipment is available for its primary use in patient care.

3. Equipment to be purchased by patients: patients wishing to purchase specialty supplies may do so through the Bookstore or Central Supply. Supplies may be purchased only in conjunction with diagnostic, fitting, or therapy in progress in a clinical program of the College.

8.2.3 Equipment Maintenance and Repair

Center equipment receives heavy usage during the course of the week. Occasionally, there will be equipment breakdowns. On those occasions when the clinician discovers equipment malfunctioning, an Equipment Repair Form should be obtained, completed, and turned in at the Associate Dean of Clinics Office. These forms are available on the portal. Please try to be as specific as possible about the problem.

Repair requests should be filled out promptly. It is everyone's responsibility to report malfunctioning clinic equipment when it is discovered; please do not assume that someone else has filled out a report on that piece of equipment.

Prevention of equipment failure is always more efficient than trying to compensate for equipment out of service. Treating each piece of equipment as if it was our own can prevent most equipment failures.

A large number of needed repairs could be prevented by handling equipment gently and never forcing movement when there is resistance to it. One of the most important aspects of preventive maintenance is the covering of equipment when not in use. The last student clinician to use equipment in a given day is required to cover it with dust covers. If dust covers are missing, then this fact should be reported through the use of an equipment repair form as above described.

8.2.4 Instrument and Equipment Data Management

Purpose

The purpose of this policy is to create a process to identify all the instruments and equipment that are used at the Ketchum Health, and how they are managed in order to account for the protected health information they store. This process will allow the Privacy and Security team to establish a better way to control the movement, servicing, removal and final disposal of instruments and equipment that contain PHI. A policy regarding the use and maintenance of equipment is necessary to ensure the integrity, confidentiality and availability of patient's Protected Health Information.

Scope

This policy applies to all faculty, full or part time, residents, interns and any other authorized employees who have access to instruments or equipment that store patient information. Service Chiefs, Associate Dean of Clinics, and IT Director have discretion in establishing additional reasonable and appropriate procedures to enforce this policy. Any amendment or additional revision of this policy must be communicated to the Director of Healthcare Policy Compliance for documentation purposes.

Policy

Instrument and Equipment Inventory

Every instrument or equipment set in campus premises and used in patient care must be identified and its working physical location documented. An inventory list with all instruments and equipment should be updated at least twice a year by the Applications Support Team.

New Equipment

The Chief of Service will coordinate with the Applications Support Manager when new equipment is going to be installed at the KETCHUM HEALTH or at any other location on campus if it is to be used in patient care. This individual will ensure that proper training is provided to all potential users and that patient information associated with the equipment will be protected from breaches and improper use and/or disclosures. The purpose of this is to ensure that patient care will not be affected and that proper procedures are setup prior to the equipment being available to the general population.

At this time the Applications Support Manager will ensure that the system has appropriate authentication methods setup as to prevent unauthorized access and appropriate backup processes identified.

Equipment Maintenance and Repair Process

In-House maintenance. Unless an emergency occurs, physical maintenance to instruments or equipment on site must be scheduled in advance and the Associate Dean of Clinics will be notified of such procedures.

Access to Clinic premises by maintenance personnel will be allowed only when there is a scheduled visit in place and the chief of service or the faculty responsible for the equipment has requested or authorized such maintenance activity.

Maintenance personnel must register at the Patient Relations desk before starting any activity in the clinic, and technicians will be escorted to the equipment. Once the maintenance job has been completed, the technician will notify the Applications Support Manager to provide clearance. KETCHUM HEALTH patient relations staff can, at any time, deny access of maintenance personnel if they believe that proper protocols were not followed, and such decision will be notified to the Associate Dean of Clinics.

Remote Maintenance

If remote access to conduct a repair or regular maintenance is requested, service technician will be required to contact the Applications Support Manager before such access is granted. The same log-in procedures established for physical maintenance at the clinic will be followed while doing remote maintenance.

For accountability purposes, every technician will provide a summary of the repair, maintenance or upgrade performed, and it will be properly documented by Applications Support Manager.

No data that includes PHI shall be transferred, copied or printed during remote maintenance to any location off KETCHUM HEALTH premises. This also includes any other individuals at the off-site location having visual access to PHI unless covered under the Business Associate Agreement.

Equipment Back-up and Removal

To ensure data integrity and to prevent data from being lost or deleted, a back-up process must be implemented. Every month, at a designated date, the Applications Support Manager will oversee back-up activities on all instruments that store patient information. The external drive used for this purpose will be kept by the Applications Support Manager.

Before removing any equipment or instrument from the KETCHUM HEALTH, faculty responsible for it must ensure that all protected health information has been backed-up and removed from the hard drive. No equipment or instrument will leave Clinic premises without getting clearance from the Applications Support Manager and/or Associate Dean of Clinics.

Personnel removing equipment from KETCHUM HEALTH will contact the Applications Support Manager to schedule a date to perform the removal. The same protocols established to provide maintenance will be applied when removal of equipment is conducted.

Business Associate Agreements

The purpose of these agreements is to incorporate privacy and security clauses aimed to safeguard the health information of our patients, and to prevent breaches from happening. The Associate Dean of Clinics and the Director of Healthcare Policy Compliance will coordinate with the chiefs of service responsible for the equipment, the creation and enforcement of business associate agreements with vendors and manufacturers of equipment and instruments used at KETCHUM HEALTH.

8.2.5 Credit Card Terminals-Point of Sale (PCI DSS

Physical Security Protocols

Introduction

Ketchum Health handles sensitive, non-public information, including but not limited to payment data from patients. Ketchum Health is committed to protecting the privacy and security of such data in a manner consistent with law requirements and industry standards.

These protocols are intended to address the physical safeguards required to protect critical systems that store, process, or transmit cardholders' data.

Legal Framework

Although payment data from patients is part of a broad set of identifiers included in federal and state laws subject to privacy protection, The Payment Card Industry Data Security Standard (PCI DSS) is the generally accepted statute that directly applies to entities handling cardholder data.

The PCI compliance framework is comprised of 12 requirements. These protocols will focus on requirement 9, "Restrict physical access to cardholder data," which contains ten sub-requirements. In addition, Ketchum Health's existing protocols, policies, and guidelines related to the privacy and security of patient information are still in force when applicable.

Credit Card Terminals Inventory and Location

There are 10 points of sales terminals at Ketchum Health. They are located as follows:

- Five (5) in the patient relations area (check-in/checkout)
- Three (3) in the optical dispensary
- One (1) in claims
- One (1) in Island 2

Operating Procedures

- **Physical Access to Ketchum Health Premises**

  Hours of Operations-Building open to Faculty, employees, and students at 6:00 am, Mondays to Saturdays only. On Sundays, the building is open to Faculty and employees from 1:00 pm to 6:00 pm. Interns, patients, or third parties are not allowed in the optical dispensary area outside business hours or hours. Interns must be supervised by a staff member while in optical.

  Main Entrance Doors- They are set to auto, two-way, and full open mode at 7:00. Authorized personnel open patient relations and optical dispensary upon request. Only Ketchum Health safety personnel grant access to the patient relations office (room 106) when requested by unauthorized individuals.

  Closing Procedures- When optical services close, the main double doors are set to one-way with the key. The building is open until midnight except for Wednesday and Thursday. Wednesday &Thursday closing is 1:00 am. Patient relations staff announce the building closing 10-15 minutes before to ensure no patients or third parties are present.
  Safety personnel walks the interior of the building to check and ensure that everyone has left. In addition, the front lobby doors are set to close with key.
  Patient relations waiting room doors are closed after janitors finish cleaning the optical dispensary and lobby areas. Safety officer (s) leaves the building, and the alarm is activated.

Access Badges Management- Except for patients and their family members or accompanying individuals, all other persons entering Ketchum Health premises must check in with campus safety to get clearance and obtain a badge. This is to account for every individual entering Ketchum Health facilities.

Surveillance Cameras and Closed-Circuit Television (CCTV)
In addition to door card readers and monitoring computers system, Ketchum Health has a 24-hour camera surveillance system covering the premises, inside and outside. The cameras are located as follows:

- Three (3) at the patient relations-reception
- Five (5) at the optical dispensary

The system runs 24 hours, and the recording data is kept by default for six (months). The information is available upon request to the director of Campus Safety, and it is deleted automatically after six months.

Point of Sale Terminal Access and Physical Security
Only authorized personnel at the designated locations and during business hours use POS terminals. All devices are stored in a locked cabinet underneath the desk where they are located. Supervisors or their designees are responsible for granting access to the cabinets by providing the respective keys. Terminals are not to be removed from their designated location unless approved by the respective area supervisor and in conjunction with the Information Technology department.

Unless needed to complete a credit card payment transaction, the terminals remain locked at their respective station.

At the end of the business day, all terminals used that are outside their designated security boxes will be placed inside. Optical dispensary personnel will ensure that this protocol is followed and that no terminals are left outside of their designated lockboxes.

Personnel Training
All individuals responsible for handling credit cards and payer data must complete a role-based training before processing transactions at the POS terminals. The training should cover at the minimum the threats to credit card security, and users must become familiar with the type of sensitive information that needs to be protected and must know the best practices that help keep this data protected.

Physical Inspection of Terminals
It is the responsibility of the personnel assigned to handling card transactions to inspect the status of the POS terminals at the beginning and end of their assigned shift. They will also monitor the devices during business hours to check for their security status and to verify that they have not been tampered with. Any suspected action must be notified immediately to their supervisor or IT department.

Business Continuity Plan
Supervisors in conjunction with the Information Technology department will develop a contingency plan to ensure proper continuity of operations should a breach of information occurs. Such plan will have the following minimum elements;

- Contact individual (s) to notify any known or suspected breach;
- Location where the suspected breach occurred and approximate date and time of the incident.
- Device ID if available.
- Description of the compromised data, if available

Ketchum Health or the Information Technology department may have a business continuity plan in place, and this should cover patients' data comprehensively, including credit card information. Please refer to the Director of IT or the Associate Dean for Clinics for directions.

Data Retention

To the extent possible, credit card data and related transactions should not be saved or physically produced unless otherwise required by law or auditing protocols. If paper trail or reports of credit card transactions containing sensitive information are required, the supervisor will collect and store the documents in a secure manner. Following PCI guidelines, documentation containing credit card data should not be kept longer than six (60) months, unless a litigation hold is in place requiring extended time.

8.3 CELL PHONE POLICY

PERSONAL PHONE CALLS

Student Personal Calls

All personal phone calls should be made outside the clinic. Calls from KETCHUM HEALTH phones are to be used for patient contacts or related KETCHUM HEALTH business only, i.e., confirmation of appointments, phone follow-ups, to advise patients that their glasses are ready, to call no-shows, etc. The college switchboard will not dial numbers for students for any reason.

Student Calls to Patients for KETCHUM HEALTH Business

Students who find it necessary to contact KETCHUM HEALTH patients can make the call directly to the patient on the phones that are found in the module staffing offices through-out the clinic. Care should be taken in phone calls to patients to exercise principles of privacy and confidentiality in all communications.

Outside Calls to Students at KETCHUM HEALTH

Personal phone calls to students working at KETCHUM HEALTH are prohibited. In the case of an emergency, the name and number of the caller will be taken. The student will be paged and advised to return the call.

Cell Phones and Pagers

Cell phone and beeper technologies afford convenient communications access for all users. While this has significant benefits from a business and personal standpoint, the equipment presents problems within the confines of a learning environment and patient care facility. While recognizing the importance for doctors to use these technologies to be accessible to patients, the personal use by students and faculty is disruptive to others and compromises quality health care delivery to our patients.

To preserve the integrity and decorum of the academic and patient care programs, the following guidelines are in effect at the University Eye Center and affiliated clinical teaching programs.

1. No audio signals from cell phones or beepers will be permitted as these disrupt patient care and clinical education.
2. No cell phones may be used by students in a clinical facility; faculty should use their offices when making such calls.
3. No texting or e-mailing during patient care.

8.4 SOCIAL MEDIA POLICY

At the Southern California College of Optometry (SCCO), we understand that social media can be a fun and rewarding way to share your life and opinions with family, friends and co-workers around the world. However, use of social media also presents certain risks and carries with it certain responsibilities. Please refer to the MBKU Student Handbook to reference the current social media policy.

For more information

If you have questions or need further guidance, please contact the Office of Student Affairs (students) or Human Resources (employees).

9.0. HEALTH AND SAFETY

9.1 INFECTION PREVENTION AND CONTROL-REVIEW OF KEY ELEMENTS

As Ketchum Health consolidates its inter-professional ecosystem of patient care, a creation and implementation of an infection prevention and control policy becomes necessary for compliance and accreditation purposes. Below the key elements of such policy are described.

Purpose

The main objective of an Infection Control policy is to provide information and guidelines to Ketchum Health employees about regulations and current accepted best practices in the prevention and control of healthcare-associated infections (HAI). Staff must become aware of, and use routine infection control precautions, and should be aware of the immunizations for adults that help to prevent he transmission of infections among co-workers, students, volunteers and patients.

Regulatory Framework

Several federal and state agencies are in charge of enforcing the statutes related to the topic. Among the federal agencies are CMS (conditions of participation); Occupational Health and Safety Administration (OSHA); State agencies include Cal-OSHA and California Department of Public Health. There are also non-regulatory agencies and accreditation bodies at both federal and state level such as the CDC, The Joint Commission, NIAHO, IHI.

California has also passed several bills related to Infection Prevention and Control, among them Senate Bills 739, 1058, 158, and 1311.

Timely public reporting and disclosures of infectious incidents is required by state law as a mean to assess quality of healthcare

Scope

The policy should be designed to cover both Family Medicine and the Eye Centers (Anaheim and LA). It also needs to state who is covered and under what circumstances; not all employees at Ketchum Health are in contact or proximate to patients, therefore, their compliance with the policy is attenuated or not needed at all.

Elements

Five elements have been identified as critical in the developing an IPCP, as follows:

- Healthcare Associated Infections (HAIs)
- Bloodborne pathogens
- Standard precautions
- Personal protective equipment gear (PPE)
- Immunizations

The CDC defines healthcare associated infections (HAIs) as infections patients can get while receiving medical treatment in a healthcare facility.

Blood borne pathogens are microorganisms such as bacteria and viruses that are carried in the blood, and can cause disease in humans (Hepatitis B and HIV are specifically addressed by OSHA).

Standard precautions include a prevention strategy in which all blood and potentially infectious materials are treated as if they are infectious. That includes treating blood or any other body fluid as if it is infected and certain work practices should always be utilized any time exposure may occur.

OSHA defines personal protective equipment (PPE) as specialized clothing or equipment worn by an individual when potential exposure to blood, body fluids, excretions, secretions (except sweat or tears), mucus membranes, or non-intact skin, is anticipated. PPE includes gloves, masks/respirators, gowns, and goggles, face shields, among others.

Following industry best practice and regulatory statutes, any individual at Ketchum Health who is providing care to patients, or who may be in contact or proximate to a patient, must be immunized against Hepatitis B, Flu (Influenza), MMR (measles, mumps, rubella, varicella, Tdap (Tetanus, Diphtheria, Pertussis), and Meningococcal (if routinely exposed to N. Meningitis.

Implementation and Enforcement

Once the subjects of the policy and their level of responsibility at KH is determined, we must coordinate with chiefs of service and clinic directors the best way to implement the policy.

Humans Resources must be included, especially at the onboarding process, to ensure that all new employees understand the policy and comply with the immunization requirements. They also need to be involved in the enforcement process should we need to discipline or terminate an employee for lack of compliance with the policy.

9.2 STERILIZING INSTRUMENTS

PURPOSE:

To establish a process of sterilizing instruments used by the any service area.

PROCEDURE:

The Central Supply Clerk will adhere to the following steps:

- Using **only** purified water**,** ensure the water level in the reservoir of the autoclave is at the line indicated.
- Scrub the instrument(s) with soap and water and dry thoroughly
- Place the instrument(s) in the cassette tray.
- If the instrument(s) is not being sterilized in a pouch, press the button that shows a pair of scissors without a pouch.
- If the instrument(s) is being sterilized in a pouch, press the button that shows a pair of scissors in a pouch.
- If the instrument(s) is needed urgently, remove it from the autoclave before it goes into the "drying" mode.
- **The sterilizer tray is very hot; therefore remove the instrument(s) after it has cooled to avoid getting burned.**
- Place the instrument in the sterilization pouch (only one instrument per pouch) and write down the sterilization date.
- Return the sterilized instrument(s) to the Chief of Ocular Disease.
- Clean the residue bottle bimonthly or sooner if needed.
- If you run into technical problems with the autoclave and/or it is time for a yearly maintenance workup; you must contact Dr. Sendrowski, Chief of Ophthalmology first for his guidance.

REFERENCES:
Instructions are above the Autoclave

9.3 EXAMINATION ROOM: DAILY CHECK OFF LIST

BEGINNING OF THE SESSION:

- Gross inspection of the room:
    - Remove unnecessary items (clipboards, open art tear drops, magazines)
- Instruments are operable
- Replaceable items are stocked (alcohol pads, FL strips, etc)
- Diagnostic eye drops are stocked (tropicamide, proparacaine, AltaFluor)
    - Check expiration dates
- Disinfect the chair and instruments
- Replace Hydrogen peroxide and soak your GAT probe

END OF SESSION:

- Gross inspection of the room
    - Remove unnecessary items
    - Make sure you have your GAT probe and lenses
- Turn off all instruments
- Turn off the computer
- Cover all instruments
- Ensure that each room has two stools and a chair
- Turn off the lights
- Report any problems to the appropriate parties

Module: Turn off all pretest equipment at the end of the day

- Modules 1 and 2: Pretest room 1178
- Module 3: Zeiss equipment and Pretest room: 1166
- Module 4: Room 1145 (OCT/VF) and Octopus

Room Issues: Lighting, plumbing, etc: Contact the Associate Dean for Clinics.
Equipment: Your assigned module faculty. If not resolved, contact the Chiefs of Service or the Associate Dean for Clinics.

9.4 EMERGENCY OPERATIONS PLAN

INTRODUCTION

PURPOSE & GOAL

The main goal of the Marshall B. Ketchum University (MBKU) Emergency Operations Plan is the preservation of life, protection of property, and the continuity of campus operations. Other objectives include but are not limited to:

- Delegation of responsibility to emergency personnel.

Coordination of emergency operations with external agencies such as the City of Anaheim Emergency Management Team, the Orange County Sheriff's Department, the Anaheim Police Department, the Anaheim Fire Department and other applicable agencies and organizations.

The information and procedures listed in this manual apply to all aspects of the MBKU community including students, faculty, staff, physical structures, and other properties owned and operated by MBKU.

9.4.1 Definition of a Major Emergency

Major Emergency/Disaster: any event or emergency that interrupts or halts the operations of the University or clinics. In some cases, mass casualties and severe property damage may be sustained. A coordinated effort of all campus-wide resources may be required to effectively control the situation.

TYPES OF MAJOR EMERGENCIES

The following represent a list of major emergencies. Recommended procedures are listed in this manual.

- Earthquake
- Armed suspects/Active shooter
- Bomb threats
- Fire
- Medical emergency
- Suicide
- Power outage
- Hazardous material leak or spill
- Flood or aircraft crash on campus

ASSUMPTIONS

The following general assumptions may exist in the event of a major emergency on campus:

- An emergency or a disaster may occur at any time of the day or night, weekend, or holiday, with little or no warning.
- The succession of events during a major emergency is unpredictable. Therefore, published operational plans will serve only as a guide. Field modifications may be necessary to meet specific requirements.
- A major emergency or disaster may affect residents in the surrounding geographical location of MBKU. Therefore, external emergency services may not be immediately available to the University.

9.4.2 General Responsibilities

President and the Presidents Executive Council (PEC)

The University President acts as the highest level of authority for MBKU. The University President or his/her designee is responsible for the following:

- Approve funding to keep MBKU in a constant state of readiness to respond to major emergencies.
- Gather information from the Emergency Response Team during a major emergency.
- Declare a state of emergency on campus and all properties owned and operated by MBKU. This may include the cancellation of classes or suspension of business operations.
- Be prepared to visit with persons affected by an emergency affecting campus.
- Maintain communication with the Board of Trustees during an emergency.
- Approve immediate disbursement of funds to manage any major emergencies on campus as well as other properties owned and operated by MBKU.
- When appropriate, declare an end to a state of campus emergency.
- Be prepared to make other executive decisions.

If the President is not available, his/her designee shall be one of the following individuals from the President's Executive Council.

- Senior Vice President for Administration
- Vice President for Administration and Finance & CFO
- Vice President for Clinical Affairs
- Vice President for University Advancement

- Vice President Student Affairs
- Vice President for Human Resources

Direction and Coordination

The Chief of Campus Safety or his\her designee shall direct and coordinate all emergency operations including but not limited to:

- Act as the Chief of Emergency Operations in the Emergency Operations Center
- Coordination of all on-campus emergency functions
- Coordination of the MBKU Emergency Response Team
- Liaison with external agencies

Zone Coordinators

Each Zone Coordinator is responsible for a particular zone or area within the building and is responsible for the following:

- Emergency Preparedness: Campus Safety will pre-determine evacuation assembly areas. The evacuation points shall be used for evacuation purpose.
- Emergency Procedures: Inform the occupants of the building of the emergency and initiate emergency procedures as outlined in this manual.
    - If an evacuation is necessary, building occupants will follow the evacuation guidelines and report to their designated assembly area outside the building. Zone Coordinators will assist with the building evacuation and should conduct a head count at the assembly area.
    - Zone Coordinators shall be observant and report any and all injuries, building damage, fires, gas leaks, etc., to the Emergency Operations Center via radio, cell phone, or through a runner.

SERT Team Leaders

- Emergency Preparedness: Knowledge about the location of all emergency exits in their building. Be prepared to implement evacuation orders, take notes of any injuries, damage to buildings, or other pertinent information. The Zone Coordinator should review and be well versed on the University's emergency and evacuation procedures.

IMPORTANT: Remember to inform all students to follow the building evacuation guidelines during any emergency.

9.4.3 Recommended Procedures

This section entails a list of recommended procedures for some types of emergencies. These procedures may be followed in sequence unless conditions dictate otherwise.

EARTHQUAKE

- In the event of an earthquake:
  - **DROP** – Drop down on the floor.
  - **COVER –** under a sturdy desk, table or other furniture. If that is not possible, or in a hallway, seek cover against an interior wall. Protect your head and neck with your arms.
  - Avoid danger spots near windows, hanging objects, mirror or tall furniture.
  - **HOLD ON** – If you take cover under a sturdy piece of furniture, HOLD ON to it and be prepared to move with it. Hold the position until the ground stops shaking and it is safe to move.
  - Do not enter or exit any building during the shaking; there may be danger from falling debris. Do not use elevators.

If you are Outdoors during an Earthquake

- Find a spot away from buildings, trees, streetlights and power lines.
- Drop to the ground and stay there until the shaking stops.
- Do not return to your building until authorized to do so.

If you are in a Vehicle during the Earthquake

- Stop in the safest place away from underpasses/overpasses, bridges, etc.
- Stay in the vehicle until the shaking stops.
- BE PREPARED TO REPEAT THESE STEPS IN THE EVENT OF AN AFTERSHOCK.
- ONCE THE SHAKING HAS STOPPED:
  - Determine if evacuation is required.
    -If evacuation is required:
  - Remain calm.
  - Exit the building carefully, in an orderly manner.
  - As you evacuate the building, assist others, if possible.
  - Beware of danger as you exit the building.
  - Take mental note of any injured/trapped individuals or groups.
  - Upon evacuating, ensure that you are at a **safe distance**, at least (200-300 feet) from the building.
  - When you are outside, stay away from buildings, trees, light poles, power poles and await instructions.
  -

Once You Have Evacuated

Call extension 7509 or direct dial 714.463.7509 from a mobile phone for emergency assistance. If you are unable to get through to either of those numbers, dial 714.992.7892 and report your emergency to a 24-hour Campus Safety Officer.

ARMED SUSPECTS/ACTIVE SHOOTER

If you suspect an individual of carrying a weapon on the facility grounds, call 911 or contact Campus Safety at extension 714.463.7509 from a mobile phone.

- An active shooter is an armed individual who has used deadly force and continues to do so with unrestricted access. The incident may be over quickly and can occur anytime and anywhere. It can involve single shooters, multiple shooters, close encounters, distant encounters, random victims, and mobile confrontations.
- Unfortunately, college campuses are not immune from an active shooter incident.
- A survival mindset can provide a strong foundation upon which you can base decisions and your course of action. It enables you to act quickly and effectively. It is comprised of three components: awareness, preparation, and rehearsal.
    - **Awareness**
        - Gain a basic understanding of the situation.
        - Become attuned to your environment.
    - **Preparation**
        - Look at your environment through the lens of survival.
        - "What if" questions are critical in developing effective response strategies.
        - Survivors prepare themselves both mentally and emotionally to do whatever it takes to survive.
    - **Rehearsal**
        - Mentally or physically practice of your plan will reduce response time and build confidence.

PREPARED VS. UNPREPARED	
Prepared	Unprepared
Startle and fear	Startle and fear
Feel anxious	Panic
Recall what they have learned	Fall into disbelief
Prepare to act as rehearsed	Lost in denial
Commit to action	Descend into helplessness

Active Shooter Course of Action

- **Get Out**
    - Move quickly; don't wait for others to validate your decision.
    - Leave your belongings behind.
    - Survival changes increase if you're not where the shooter is or go to where he can't see you.
- **Call out**
    - Inform authorities.

    - Call 911 or Campus Safety at extension 7509 or direct dial 714.463.7509 from a mobile phone. Tell them your name, your location, shooter's name (if known), description, direction of travel, and type of weapons.
- **Hide Out**
    - If getting out will put you at risk, hide out.
    - The hiding place should be well hidden and well protected.
    - Avoid places that might trap you or restrict movement.
- **Keep Out**
    - Find a room that can be locked with objects to hide behind.
    - Blockade the door with heavy furniture.
    - Turn out lights; become totally silent.
    - Turn off noise-producing devices.
    - Call 911 or Campus Safety at extension 7509 or direct dial 714.463.7509 from a mobile phone (if you can do so without alerting the shooter).
- **Spread Out**
    - If there are two or more of you, DO NOT huddle together.
    - Quietly develop a plan of action in the event the shooter enters the room.
    - Remain calm. It keeps others focused on survival.
- **Take Out**
    - Assume the shooters intentions are lethal.
    - The shooter may succeed in killing all those with whom he comes in contact UNLESS you stop him.
    - Develop a survival mindset that you have "what it takes" to survive when your life is on the line.
    - You must be prepared to do whatever it takes to neutralize the threat.
    - Throw things, yell, and use improvised weapons.
    - If there are two or more of you, plan to overcome the shooter.

BOMB THREAT

Bomb threats on campus shall be handled by the Department of Campus Safety, the Orange County Sheriff's Department, and other applicable Emergency Response Team members. The decision to evacuate any MBKU-owned property will be made at the time of the incident.

Procedures for Handling a Bomb Threat Caller

If an individual receives a bomb threat call, he/she should immediately record the time and date the call was received and terminated. The person receiving the telephone call should attempt to gather some of the information listed below.

- Determine if the caller is a male or female?
- Ask the caller where the bomb is planted?
- Ask the caller when the bomb is going to explode?
- Ask the caller where he/she is calling from?
- If received via social media alert Campus Safety Immediately.

As soon as possible, call 911 or Campus Safety at extension 7509 or direct dial 714.463.7509 via a mobile phone.

Procedure If/When a Suspicious Package is Found

- **DO NOT TOUCH OR MOVE THE OBJECT!**
- Immediately leave the area and call Campus Safety or 911
- Advise others in the area to do the same.

FIRE

General Fire Safety Precautions

- If you suspect someone is trapped inside a building during a fire, notify the fire fighters on scene or Campus Safety personnel. Do not reenter a burning building.
- If you are trapped in a fire, attempt to leave the building. Cover your nose and mouth with a cloth or T-shirt. If it is not possible to exit through a door, find another exit such as a window. If possible, place wet towels or clothing in the cracks around the door. Jumping from a window is only to be considered when you are in immediate danger.
- If you exit through a door, stay low to the floor but do so with cautions. Use a wet towel or blanket to protect yourself from flames and smoke.
- Many fires are of electrical origin. Check for frayed cords, broken plugs, and avoid using too many appliances in one circuit.
- Be familiar with emergency exits inside your building as well as the location of fire extinguishers.
- Move away from the building to your pre-determined evacuation assembly area.
- A campus Emergency Command Center may be set up near the emergency site. Keep clear of the Command Center unless you have official business there.
- Do not return to an evacuated building unless told to do so by a university official.

Fire extinguishers are located throughout campus in many strategic locations. Learn to identify the extinguishers and find out where they are in your area. In the event of a **small fire that would not put your safety at risk,** utilize the fire extinguisher if you can do so. If you decide to use a fire extinguisher, follow the instructions listed below on how to operate a fire extinguisher.

Learn How to P.A.S.S.

PULL – the pin or ring or release the lock latch.

AIM – the extinguisher nozzle at the base of the fire.

SQUEEZE – or press the handle.

SWEEP – from side to side slowly at the base of the fire until it goes out.

VIOLENT OR CRIMINAL BEHAVIOR/CRIMINAL THREAT

Everyone is asked to assist in making the Marshall B. Ketchum University campus a safe place by being alert to suspicious situations and by reporting them as outlined below.

Do not take any unnecessary chances.

If you are a victim or observe a criminal threat or any on-campus criminal activity such as battery, assault, robbery, theft, aggressive or inappropriate sexual behavior, etc., call the Marshall B. Ketchum University Campus Safety Department:

Ketchum Health Safety Office: 714.463.7509

From outside line: Main Campus 714.992.7892

Be prepared to supply Public Safety with:

- Your name.
- Nature of the incident.
- Campus location of the incident.
- Description of person(s) involved.
- Description of property involved.
- Assist Campus Safety Officers when they arrive by describing characteristics of possible suspect(s) such as height, weight, hair color, physical appearance, and similar other detail. Identify other potential witnesses who may be interviewed by Campus Safety Officers and ask them to share similarly descriptive information.

Campus Safety Officers will conduct the required campus search and will evacuate areas as necessary and will enlist the support of local law enforcement, as may be required/necessary. If evacuation is ordered, assist anyone who needs help in exiting the building. Follow the instructions of Campus Safety and law enforcement officials.

Report to your departmental office the presence of anyone who appears to be loitering, soliciting, or otherwise on campus without an apparent legitimate reason. These people may be kindly asked to leave the campus if they do not offer evidence of proper permission or a proper reason for being on campus. Campus Safety (ext. 7509) is to be called if such persons offer any resistance or refuse to leave when asked.

MEDICAL EMERGENCY

If a serious injury or illness occurs, remain calm and proceed as follows:

- Call Campus Safety at extension 714.463.7509 from a cell phone or call 911 directly. Relay the following:
    - Your name.
    - Location of the victim.
    - Indicate whether the victim is conscious and breathing.
    - Describe the nature and severity of the medical problem.
    - Provide an estimated age and gender of the victim.
    - Look for emergency medical ID and give all information to the dispatcher.
    - If trained to administer first aid/CPR, do so.

NOTE: All Campus Safety Officers are trained on how to administer first aid, CPR and AED.

SUICIDE

Students, faculty, and staff must take all statements or notes about suicidal thoughts seriously. If a person threatens to commit suicide on campus and has the means or a lethal weapon available, the following steps should be taken:

- Remain calm and immediately alert Campus Safety at Extension7509 or 714.463.7509 from a mobile phone.
- Provide as much information as possible to the Campus Safety Office (location, your name, name of suicidal person, a call-back phone number, and intended weapon/drug).
- Make a mental note of everything the suicidal person says and does.
- Do not minimize or challenge the person's threat; take it seriously.
- Never promise confidentiality; instead, promise help and privacy.
- Retreat if your safety is at risk.
- If possible, attempt to keep the personal calm until Campus Safety and/or the police arrive.

POWER OUTAGE

- Power outages are a common occurrence, especially during the summer months.
- Dial 714.463.7509 from a cell phone to notify Campus Safety.
- If you are in a lab or classroom, secure all experiments or equipment that might present a danger or be damaged while electrical power is off, or when power is restored.
- Remain where you are unless told to evacuate.
- Raise window blinds to let in outside light.
- If evacuation of the building is ordered, seek out and assist any persons with disabilities.
- Emergency lighting in stairwells and throughout the common areas and most suites will activate.

HAZARDOUS LEAK OR SPILL

- Take steps to protect all chemical containers and gas cylinders in the event of a violent shake from an earthquake.
- Any serious chemical spill should be reported to Facilities Services and Campus Safety immediately.
- Depending on the severity of the spill, be prepared to evacuate the building.
- Stay upwind and upstream of the spill.
- In the event of a large off campus spill, evacuation of the campus may be necessary. Be prepared to cooperate with traffic control officials.
- All laboratory personnel should be prepared to assist in assessment of spills within their area following a major earthquake.

FLOOD/WATER EMERGENCY

Criteria:

Generally, a flood emergency exists if floodwater is uncontrolled and flowing beyond the area where the source of water is normally contained or controlled.

Forecasting

MBKU Campus Operations and Campus Safety shall work in conjunction to forecast a major flooding. Resources and systems that may be used to forecast a major flooding includes but not limited to the following:

- Information obtained from the daily situation report Campus Safety staff receives from the Area E division of the California Emergency Management Agency (CALEMA).
- Information obtained from Camus Safety's weather alert radio that was obtained from the National Oceanic Atmospheric Administration (NOAA).
- Information obtained from the National Weather Service.

Reporting Incidents of Sudden Flooding

Calls concerning or potential flooding may be received by the University's Campus Safety Communications Division via extension 7509 from any campus extension, 714.463.7509 from a cell phone, or from a "blue-light" emergency phone/call box. Callers will be asked to identify themselves and to provide the exact location of the flooding. The safety of the caller will be of utmost importance throughout the call.

Upon a Major Flood Forecast

- Campus Safety shall immediately activate all applicable members of the MBKU Emergency Response Team.
- Campus Safety shall work in conjunction with Student Affairs and the Human Resources Department to notify students, faculty, and staff on all vital information pertaining to the flooding. The systems that may be used to notify students and staff include the University's mass notification system and the University's mass email system.
- Campus Safety may request additional resources from external agencies such as the City of Anaheim Emergency Management Team, the Orange County Sheriff's Department, the Anaheim Fire Department and Anaheim Police Department. Any or all special conditions will be relayed at the time of the request.
- Campus Safety shall consult with Campus Operations to restrict access to the affected area, evacuate student and staff to higher ground, establish a perimeter, and take other necessary steps.
- If injuries occur as a result of any pre-storm, actual storm, and post-storm, the SEPMO Team and Campus Safety shall conduct triage and provide basic first aid/CPR.
- In the event of a prolonged storm and normal operations is affected, Campus Safety and other applicable SEPMO members shall plan to manage the situation accordingly, Food and Water rations.

EXPLOSION, AIRCRAFT CRASH OR SIMILAR INCIDENT

A violent accident such as an explosion or aircraft crash on campus could endanger lives or render a building or area unsafe. In such an event:

- Immediately take cover under a table, desk or other object that provides protection against glass or debris.
- After the immediate effects of the incident have subsided, call the Marshall B. Ketchum University Campus Safety Department:
    - From MBKU phone: extension 7892
    - From outside line: 714.992.7892
    - Ketchum Health Safety Office: 714.463.7509
    - Give your name and describe the location and nature of the emergency.

- If necessary or directed to do so by a Campus Safety Officer or university staff, activate the building alarm system.
- Notify your supervisor, and then evacuate the immediately affected area.
- Be aware of structural damage.
- Stay away from glass doors and windows
- Do not touch or move any suspicious object.
- Help others, especially the injured and persons, who are disabled, evacuate the building.
- Once outside, move to the designated evacuation zone for your building. If this area is deemed unsafe, your SEPMO Team Leader or Campus Safety Officer will designate an alternate site. Keep the walkways clear for emergency vehicles.
- To the best of your ability, and without re-entering the building, help your SEPMO Team Leader, Campus Safety Officer or other university staff determines that everyone has evacuated safely.
- An Emergency Command Post will be set up near the emergency site or at the designated university Emergency Operations Center (EOC). Keep clear of the command post unless you have important information to report.
- DO NOT RETURN TO A BUILDING UNTIL TOLD TO DO SO BY A MARSHALL B. KETCHUM UNIVERSITY CAMPUS SAFETY OFFICER OR OTHER UNIVERSITY OFFICIAL.

CIVIL DISTURBANCE

The University supports the free exchange of ideas by members of the community when done in an orderly fashion in accordance with our policies. Most campus demonstrations are peaceful. In these circumstances, everyone should attempt to carry on business as usual. Avoid provoking or obstructing the participants.

If at any time you believe there is an immediate threat to your safety or the safety of others, call the Marshall B. Ketchum Campus Safety:

  - Ketchum Health Safety Office: 714.463.7509
  - From outside line: Main Campus 714.992.7892

Upon observing a civil disturbance on campus that appears to be unsafe for the community, call the Safety Office extension 7509 or from an outside line/cell phone at 714.463.7509. To avoid causing further disturbances, be discrete and use a private office when making the call if possible. Campus Safety and/or a university administrator will assess the situation and take appropriate action.

If safety is a concern:

- Alert all employees in the area to the situation.
- If directed by Campus Safety, cease operations, lock all doors and secure all files, documents and equipment. If evacuation is indicated, Campus Safety will assist you.
- If a class or lecture is disrupted, the participants should be requested to leave. If they refuse, call Campus Safety at extension 7509 and your immediate supervisor.

9.4.4 Emergency Operations & Resources

EMERGENCY OPERATIONS CENTER (EOC)

When a major emergency occurs or is imminent, it shall be the responsibility of Campus Safety to coordinate all aspects of setting up an Emergency Operations Center. The EOC may be established in Building “A” Lecture Hall 1, 2 & 3/Building “F” Student Lounge or in an area/building designated by Campus Safety. The ECO staff shall consist of applicable members of the MBKU Emergency Response Team and at least one uniformed Campus Safety Officer.

A staging area for responding external agencies shall be established in conjunction with the agencies or other assisting organizations.

Incident Commander Responsibilities

The overall Incident Commander shall be the Chief of Campus Safety or his\her designee. The responsibilities of the overall Incident Commander include the following:

- Responsible for the overall direction and coordination of the University emergency response.
- Responsible for the overall direction and coordination of the University Emergency Response Team.
- Determines the type and magnitude of the emergency and establishes the appropriate EOC.
- Notify and assemble the SEPMO Team to manage the situation.
- Initiate contact with the President of the University and/or other PEC members.
- Coordinate communication with external agencies.
- At the conclusion of the emergency, prepare and submit an after-action report to the President of the University.

EOC Resources Include but are not limited to

- Emergency Operations Manual
- Barricades & barrier tape
- Portable public address system
- First aid kit
- Latex gloves & face masks
- Automatic external defibrillator
- Laptop
- Campus telephone directory and local telephone directory
- Campus maps
- Digital camera
- Emergency key sets
- Breaching tools
- SEPMO resources

Other Resources

- One centralized storage container & two strategically established areas that serve as storage:
    - Emergency supplies
    - 3-day food and water supply
    - Health Center and search and rescue supplies

EMERGENCY RESPONSE TEAM

The SEPMO Team is composed of MBKU employees from departments that may play crucial roles during major emergencies on campus. The departments that are represented and their general areas of responsibility include the following:

- Campus Operations
- Communications / Multi-Media
- Department of Campus Safety
- Finance

- Human Resources
- Information Technology
- Student Affairs
- University Eye Center – Ketchum Health

Campus Operations

The Director of Campus Operations or his/her designee shall represent the Facilities Services on the SEPMO Team.

Emergency Preparedness

- The purpose of this team is to provide for the maintenance and operation of campus property, buildings, structures, and equipment. It will also provide the restoration of utility services to the campus following a disaster.
- Staff an emergency crew and maintain a roster of all current employees.
- Maintain (via advance contract, communication, or other appropriate means) a current resource of special assistance personnel such as earth-moving contractors, electrical and plumbing contractors, etc., to provide material and labor assistance.
- Provide and maintain a current inventory of personnel, apparatus and auxiliary equipment needed for their services.
- Prepare a practical plan of Critical Response Actions for all applicable major emergencies listed in this manual.
- Provide written instructions of the emergency plan for use by the Chief of Campus Safety/Incident Commander.
- Conduct periodic emergency preparedness training for department staff.
- Complete and return training documentation forms to Campus Safety as requested.

Emergency Procedures

- Implement a practical plan of Critical Response Actions for all applicable major emergencies listed in this manual.
- Organize, mobilize, and operate equipment necessary to perform needed functions.
- Provide labor, equipment and necessary supervision to aid other services.
- If necessary, conduct evacuation procedures in cooperation and coordination with building coordinator.
- Carry out other responsibilities as may be assigned to this team.

Skilled workers are always available from Campus Operations during normal working hours and on short notice at other times. They can provide the following emergency services:

- UTILITIES: Repairs to water, gas, electric and sewage systems.
- STRUCTURES: Repairs to structures and mechanical equipment therein, including heating and cooling systems.
- EQUIPMENT: Portable pumps, generators, floodlights, welders, air compressors, tractors, backhoes, forklifts, etc.

Communications/Multi-Media

The Director of Communications and Director of Multi-Media and/or a designee shall represent the Communications or Multi-Media Department on the SEPMO Team.

Emergency Preparedness

- Have a pre-established plan on possible methods to communicate with students, faculty, staff, and parents.
- Maintain a plan on how to deal with external media organizations.
- Prepare a practical plan of Critical Response Actions for all applicable major emergencies listed in this manual.
- Conduct periodic emergency preparedness training for Multi-Media department staff.

- Complete and return training documentation forms to Campus Safety as requested.

Emergency Procedures

- Work in conjunction with the IT Department to establish a method to communicate with the MBKU community.
- Acts as the primary handling all external media-related requests.
- Serve as the primary department handling all matters regarding public relations.
- Prepare statements for release to news media concerning the university disaster operation.
- Maintain a complete diary of events during the disaster operation, including photographs, slides, and/or videotapes, etc.
- Carry out other responsibilities as assigned.

Department of Campus Safety

The Chief of Campus Safety, his/her designee or the highest-ranking field personnel on-duty shall be the Incident Commander. The Emergency Operations Manager shall assist the Chief of Campus Safety as applicable.

Emergency Preparedness

- Be prepared to staff an emergency crew comprised of campus safety personnel.
- Prepare a practical plan of Critical Response Actions for all applicable major emergencies listed in this manual.
- Provide written instructions of the emergency plan for use by team members.
- Conduct periodic emergency preparedness training for Campus Safety and/or the University community as applicable.
- Establish a plan to keep the Campus Safety Department in a state of constant readiness.
- Work in conjunction with the City of Anaheim Emergency Management Team as well as other local, state, and federal agencies.

Emergency Procedures

- Take immediate and appropriate action to protect life, property and to safeguard records.
- Implementation of the pre-established campus Safety's emergency response guide for dispatchers and officers.
- Notify the MBKU community and university administrators of major emergencies, as applicable. This may involve the university notification system, university email system, university website, and other methods deemed necessary by the Chief of Campus Safety or his\her designee.
- Monitor campus emergency warning and evacuation systems.
- Conduct evacuations in cooperation and coordination with building coordinators.
- Provide traffic control, access control, perimeter and internal security patrols and fire prevention services as needed.
- Provide and equip an alternate site for the EOC.
- Maintain communication with all members of the ERT/SEPMO Team.
- Work in conjunction with the City of Anaheim Emergency Management Team as well as other local, state, and federal agencies.

Finance

The Senior Director of Finance Management or other designee shall represent the Finance Department on the Emergency Response Team.

Emergency Preparedness

- Prepare a practical plan of Critical Response Actions for all applicable major emergencies listed in this manual.
- Work in conjunction with Risk Management and other applicable ERT members to develop a business continuity plan.
- Conduct periodic emergency preparedness training for Finance Department staff.
- Complete and return training documentation to Campus Safety as requested.

Emergency Procedures

- Upon request, prepare to fund emergency-related needs that emerge.
- Disbursement of emergency funds.
- Track all expenses related to the emergency.
- Preserve financial records.

Human Resources

The Vice President of Human Resources or their designee shall represent the Human Resources Department on the Emergency Response Team.

Emergency Preparedness

- Prepare a practical plan of Critical Response Actions for all applicable major emergencies listed in this manual.
- Coordinate and develop a group of volunteers that can assist members of the Emergency Response Team.
- Conduct periodic emergency preparedness training for Human Resources staff.
- Compete and return training-related documentation forms to Campus Safety as requested.
- Prepare a practical plan of emergency action.
- Develop a business continuity plan in conjunction with the Finance Department.
- Prepare a practical plan of Critical Response Actions for all applicable major emergencies listed in this manual.

Emergency Procedures

- Assist with the evacuation of faculty and staff members.
- Coordinate a group of volunteers that can assist the Emergency Response Team.
- Maintain roster, pay records, etc., of all workers during the emergency incident.
- Perform other duties as may be assigned to this team.
- Work in conjunction with the Emergency Response Team Members on all risk-related matters that emerge during a major emergency.
- Be prepared to contact the MBKU insurance company and present claims associated with the major emergency.
- Manage all claims against the University via appropriate documentation, photographs, and videos.

Information Technology

The Director of IT Operations and Infrastructure Technician shall represent the information Technology Department on the Emergency Response Team.

Emergency Preparedness

- The purpose of the IT Department's ERT involvement is to ensure the security and safety of institutional data. IT personnel shall also ensure that reasonable levels of IT-related operations are in a functional mode.

- Staff an emergency crew and maintain a current roster.
- Prepare a practical plan of Critical Response Actions for all applicable major emergencies listed in this manual.
- Conduct periodic emergency preparedness training for the IT Department staff.
- Ensure that the IT Department has a pre-established contract with external vendors that may assist IT to bring its operations back to normal.
- Complete and return training documentation forms to Campus Safety as requested.

Emergency Procedures

- Ensure that the MBKU website is operational.
- Ensure that a reasonable level of internal telephonic communication is established.
- Ensure that there is a method to send electronic or telecommunication messages to the MBKU community.
- Remove live wire telephone service from any phones or buildings are required.
- Activate stand-by voice and data communications equipment.
- Verify business-critical, institutional data is backed-up to an off-site location.
- Carry out other responsibilities as may be assigned.

Student Affairs

The Vice President for Student Affairs and/or his/her designee shall represent the Student Affairs Office on the Emergency Response Team.

Emergency Preparedness

- Ensure all resident students are properly advised about emergency procedures.
- Work in conjunction with other departments across campus to plan for a unified response in the event of a major emergency.
- Prepare a practical plan of Critical Response Actions for all applicable major emergencies listed in this manual.

Emergency Procedures

- Assist Residence students, as necessary.
- Be prepared to conduct a head count.
- Work in unison with Campus Safety, Campus Operations, Media Relations, off-site Counseling Center, and others as deemed necessary.

9.5 SAFETY OPERATING PROCEDURES

MBKU Facilities:
Ketchum Health – (714) 463-7509
5460 E. La Palma Ave., Anaheim CA. 92807

Fullerton Campus – (714) 992-7892
2575 Yorba Linda Blvd., Fullerton, CA. 92831

KETCHUM HEALTHLA – Ext. 3108 or clinic line (323) 234-9137
3916 S. Broadway, Los Angeles, CA. 90037

South Campus
2501 E. Chapman Ave #130, Fullerton, CA. 92831

Chief Cooper: Ext. 7858 CP (626) 437-1020
Sgt. Barrera: Ext. 7485 CP (909) 551-1036
Sgt. Escobedo: CP (951) 205-1970
Department's Email: campussafety@ketchum.edu

Keys: The main set of keys are located in the top left drawer of the Campus Safety Office. In the wall mounted lock box there are a set of back up keys, janitorial keys and extra drawer keys.

Opening Procedures:
Remote Access can be granted from Fullerton Campus for card reader doors.
Building opens to Faculty, employees and students at 0600 hours Mon – Sat only. On Sundays the building is open to faculty and employees from 1000 to 1800 hours. Optical students are not allowed in the Optical area prior to Optical hours and unsupervised by a staff member.
0600 – 0700 Hours
Open Patient waiting room glass double doors.
Courtyard / Atrium Door: The **atrium is not for patients or the public and should be kept locked during business hours.** To unlock door and use Allen wrench to lock down door push bar in the open position. The atrium is for staff, faculty, students and special events. **.**
Staff Lounge Patio Door (2nd Floor): Unlock at beginning of the shift and lock when closing the building.
Main Entrance Doors: At 0700 hours set doors to **Auto, Two way and Full Open.**
Leave a radio on Patient Relations desk.
Open room 1106 (Patient Relations Office) upon request by personnel.

Closing Procedures:
During evening / hours of darkness have a presence outside when individual females walk to their vehicles.

Closing Procedures Continued:
When Optical Services closes (check schedule) set the main double doors to **One-Way** with the key**.**
The building is open until midnight except for Wednesday and Thursday. Wednesday & Thursday closing is 0100 hours.
PA Announcement: 10-15 minutes prior to end of watch make an announcement of building closing. 2222#.
Prior to locking up walk the interior of the building to visually check that everyone has left.
Lock the Staff Lounge Patio door.
Set front lobby doors to **Closed** with key.
Recover radio if left in Patient Relations and place in charger.
Close Patient waiting double glass doors after janitorial cleans Optical / waiting area.
Check exterior doors before setting alarm.
Leave Campus Safety keys in top drawer
Set alarm and exit.
Alarm Panel Locations:
Campus Safety Office / South Door entrance / Administration (S/E) stairwell door.
Stanley Security Monitoring Center – 887-476-4968

Daily Operations:

Ketchum Health Binders / Access Badges

Visitor Badges – Identification that they have checked in with Campus Safety. They do not grant access

Vendor Badges – Badged 1 and 2 to be issued for contractors, delivery personnel that will delivery within the building (i.e. Staples) and vending services.

KH Access Badges - 1 – 4: Loaner badges to be used by faculty, staff and students for the day. Badges must be returned by the end of their work day. To insure that the badges are returned ask the person checking out the badge to leave their car keys.

Janitorial Badges – Badges 1, 3 and 4. To be issued to each janitorial services member (1 for day shift / 2-3 at swings shift) along with the janitorial keys.

Precision Security Badge – 1

All badges should be turned in at the end of the day for each respective user

An email should be sent to the person who checked out the badge when not returned.

For each category of badges listed (except Precision Security) there is a binder to log in and out the issuance of the badges. Log in and out each time a badge is used.

Account for all badges at the opening and closing of the facility.

Parking Permits / Citations:

Parking permits, citations, warning flyers are in secured drawer *(SK).

Log in vehicle information and location in log book.

** No parking in the red fire lane**

Radios:

There are three Motorola radios (KH-1 / KH-2 / KH-3) in the Campus Safety Office. When working alone leave a radio with Patient Relations. **Ketchum Health channels is #3.** When not in use please place the radios in their charging stations and the power if off

Intercom System:

When the intercom bell rings press talk to communicate with the subject, press the key symbol to allow entry and press the off button to end the call.

To call an intercom station from the Campus Safety Office push the arrow down button to select the door location. Double click center button and wait for the ring. Talk and unlocking a door functions are the same.

Voicemail pass code is 7509 for Campus Safety phone.

Inmate / Special Patient Escort:

Cone off parking stall #232 the night before the visit for the transport vehicle to park in. **Exam room #1125 / 1140. Review Special Patient procedures for further detail.**

Fire Alarm System:

Fire alarm panel located in Room #1162 (south side of building)

Fire annunciator located in front lobby. Key located in Campus Safety Office lock box.

Fire Riser located in room #1184. **Auxiliary drain** in #1111.

Fire Alarm Test Mode Contact: West Coast Fire and Integration (888)-884-5222

Ask for Testing department and request to have alarm placed on test. Password is **MYOPIA.** Second contact Stacie Townley (714) 957-5750, Cell (714) 348-5174

First Aid / AED:
AED, oxygen tanks, adult and infant resuscitator mask / bags in Campus Safety Office.
Additional Emergency Supplies and disaster equipment located the cage storage room #1195-B

Miscellaneous Rooms and Equipment:

Electrical Rooms: 1196 (back up lights), 1162, 1102, 2106, 2244, 2209, 1188 and 2109.
Fuse Box: 2126 and Future PA 1203 circuit box.
Server Rooms: 1165, 1116, 2224 and 2240 (PA equipment)
Elevator Equipment Room: 1101 and 1197
Elevator Emergency Phone: Amtech Dispatch (714) 939-6516 or (714) 584-1993 ****Emergency Dispatch** 844 258-1522**
Miscellaneous Rooms and Equipment Cont'd:
Roof Access: 2241
Wheel Chairs: Located in rooms 1205 and 1164
*2184 (S) / *2195 (S)
After Hours Emergency Kit: Located across from 1166 in hallway wall cabinet.
Vending Machine: For refunds refer to Patient Relations.
Non-Smoking Campus: No smoking on any part of the property and parking lot. Direct to public sidewalk or off property.
Orange County Animal Control: Business hours 0800-1700 hrs. / (714) 935-6848
After hours # (714) 935-7158.
Courier Lock Box: The box is located in the Campus Safety Office and is to be used upon request. If the box is to picked up during the hours an officer is on-duty keep the box in the Campus Safety Office. If the pick-up will occur after hours (closed) place the box on the south exterior door 1195. Secure the box and remove the key. Place the key in the Campus Safety Office's lock box.
Room 1156 black cabinet requires keys. Key holders are PC Chiefs of OD/PC Service and the administrative assistant

Subpoena Service: Medical records / HIPAA compliance refer to Director of Healthcare Policy Compliance Ext. 7534
IT Support After Hours: Call Director of Information Technology (310) 883-4805

10.0 INFORMATION TECHNOLOGY

10.1 ACCESS CONTROLS

Purpose
To establish a process whereby designated individuals grant and administer privileged user accounts following role-based access needs. Access Controls are designed to protect the confidentiality, integrity, and availability of Marshall B. Ketchum University networks, systems, and applications.
To track and monitor privileged role assignments, and to minimize or avoid unauthorized use of resources.

Definitions
a. "**Access Control"** is the process that limits and controls access to resources of a network system, including computers, cloud applications, and virtual platforms.

b. "**Users"** are employees, students, volunteers, contractors, consultants, and any other authorized third party or agent accessing Ketchum Health systems and applications.

c. "Privileged account" is a system or application that have advanced permissions, as compared to regular user accounts permissions. Examples include administrative and super user accounts.

d. "Access Privileges" are system permissions associated with a specific account, including permission to access or change data, create or adjust settings, or process transactions.

e. "Administrator Account" is a user account with privileges that have advanced permissions on an IT system that are necessary for the administration of this system. An administrator account can create new users, change account permissions, modify security settings such as password settings, and modify system logs.

f. "Non-disclosure Agreement" is a contract between Ketchum Health and an individual stating the terms on how the sensitive, non-public information is handled and protected by the individual when the person is exposed to such information.

g. "Business Application Owner" is an individual or group with the responsibility of defining the expected business needs, works with the Information Technology department in aligning application functions to business workflows, reviews and approves functional changes and access changes to the application.

Scope

The scope of this policy applies to all Information Technology (IT) resources that store or process non-public records. All users, contractors, vendors, volunteers, or any other agent acting or performing on behalf of Marshall B. Ketchum University are responsible for adhering to this policy.

This policy also applies to all Marshall B. Ketchum University non-public information may be accessed for educational purposes.

Policy

Protecting access to IT systems and applications is critical to maintaining the integrity data and preventing unauthorized access to such resources.

Access to systems must be restricted to only authorized users or processes, based on the principle of strict need to know and least privilege.

Procedures for Information Technology

- **Role-based access**. Information Technology will provide employees, students, contractors, volunteers, and third parties with on-site access to systems and information that are only necessary to carry out their assigned responsibilities.
- **Least privilege**. Users or resources will be provided with the minimum privileges necessary to fulfill their roles and responsibilities.
- **Privileged Access.** Enhanced access rights (such as administrator rights) shall only be provided to users based on business requirements, job functions, responsibilities, or need-to-know AND must follow the rule of segregated duties. The Director of Information Technology must approve all Privileged Access changes.
- **Passwords and Authentication.** All systems shall require a layer of authentication before granting user access to system information or functionality. Users of systems must provide verification of his/her identity when requesting password resets or authentication changes.
- **Termination**. Access rights will be immediately disabled or removed when the user is terminated or ceases to have a legitimate reason to access. Extended access post-termination requires approval from the Business Application Owner.

Procedures for Clinic Faculty and Staff

I. **Granting access.** The **Business Application Owner** authorizes access to systems and the information they contain. IT shall implement access changes only upon approval from the Business Application Owner. New employees will be instructed to communicate with their supervisors regarding their level of access granted to perform. Promoted or otherwise transferred employees will be assigned new access by their respective supervisors.

II. **Documentation.** Requests for users' accounts and access privileges must be documented formally by submitting an email request to ITsupport@ketchum.edu, and the log shall be retained following MBKU record retention policies.

III. **Audit Review-Audit Trail.** To the extent possible, the Director of Healthcare Policy Compliance will compile a daily report on users' access to patient databases, showing the user's name and ID, system accessed, date, time, and medical record number. The Director will be granted with audit trail capabilities to track and review individual access to patient files.

IV. **Access Review.** Business Application Owners, in conjunction with the Director of IT and the Director of Healthcare Policy Compliance, will review accounts semi-annually (December and June) to determine accuracy of the level of access granted, potential excessive privileges, or dormant accounts. Examples of accounts with excessive privileges include:
   - **a.** An active account with access rights for which the user's role and responsibilities do not require access.
   - **b.** An active account assigned to volunteers, work-study, external contractors, vendors, or employees that no longer work for the institution.
   - **c.** System administrative rights or permissions (including permissions to change the security settings or performance settings of a system) granted to a user who is not an administrator.

V. **Remote Access.** Remote access requires approval from the Business Application Owner, and completion of the Telecommuting Policy. No uncontrolled external access shall be permitted to any network device or networked system.

VI. **Related Policies.** Other supporting policies and procedures have been developed to reinforce this Access Policy. All staff, students, and third parties authorized to access network or computing facilities are required to familiarize themselves with these supporting documents, and to adhere to them in the working environment.

10.2 REMOTE ACCESS POLICY

10.2.1 Remote Access of ePHI-Guidelines for Faculty and Staff

Purpose

The purpose of this policy is to define the standards for Faculty, residents, and other remote users when accessing ePHI through KETCHUM HEALTH IT systems. These standards will minimize potential exposure to the College from damages resulting from the accidental or intentional use or disclosure of ePHI to unauthorized parties. A policy for the proper use of the remote access of ePHI is necessary to maintain the accuracy, security, and confidentiality of individually identifiable health information and other sensitive data.

Scope

This policy applies to all full or part time faculty, residents, and any other authorized employee who uses KETCHUM HEALTH system for remote access of *e*PHI, and governs all electronic access, communications, and

storage using the KETCHUM HEALTH system. Service chiefs have discretion in establishing additional reasonable and appropriate conditions of remote use by Residents under their supervision; however, it must be consistent with this policy and must be provided to the director of information technology for review.

Policy

General

1. KETCHUM HEALTH can benefit from access to and use of the ePHI remotely. The resources, services, and interconnectivity available provide significant resources to improve the efficiency of patient care at the University Eye Center.
2. Improper use of the remote access function puts KETCHUM HEALTH- University Eye Center and its employees and patients at risk.
3. Faculty and other authorized users must ensure that ePHI and other sensitive information is not viewable by those not authorized to see it, even close family members, colleagues, and personal friends.
4. Personal laptops, hand held or mobile devices, memory keys, smart cards, CD/DVDs and the like, must be encrypted and password protected.
5. Remote users must have a proper medical or business purpose for any access and use of the *e*PHI, and Faculty should use and have access only to data of patients that they have responsibility for as acting providers.
6. If a breach or accidental or unauthorized disclosure of PHI occurs, it must immediately be reported to Director of Healthcare Policy Compliance, IT Director and Chief of Service. Data users will report security problems, breach of confidentiality, and any violations of this or other KETCHUM HEALTH policies following state and federal rules and regulations.

Data users have no expectation of privacy when KETCHUM HEALTH's system is used to access ePHI remotely. At any time and without prior notice, KETCHUM HEALTH reserves the right to audit remote access practices, and unilaterally can suspend, restrict or even terminates access if appropriate**.**

Procedures

1. Passwords and log-in IDs are personal and confidential; Faculty and authorized users will not share or discuss them with anyone. Faculty may not use any other user's password or somebody else's identification to access the system
2. If printing of PHI is granted, do not dispose of sensitive material in your personal trash unless you process it through a crosscut shredder. You can make arrangements to bring all sensitive printed documents to the University Eye Center and use the on-site shredding bin services.
3. Faculty is responsible for safeguarding ePHI. Do not leave sensitive information on the screen, or printed documents unattended in your home if other family members or friends are present. Do not leave ePHI or other sensitive data unattended in a public place if you must step away.
4. To the most extent possible, avoid using public hot spots for internet access when working with ePHI.
5. Faculty may not transfer ePHI or KETCHUM HEALTH's business information electronically without prior approval by the director of information systems. Before transmitting ePHI, Faculty will comply with University Eye Center's Electronic Communications policy to ensure legal authority for the disclosure exists.
6. Users may not establish or use new or existing internet connections to create new communications channels without the prior approval of the director of information systems.

Enforcement

Any employee found to have violated this policy may be subject to escalating disciplinary action that ultimately could result in termination of employment.

10.2.2 Remote Access of PHI -Guidelines for Students

Purpose

You have been granted remote access to sensitive patient information, and we expect you will exercise diligence and care when accessing/using such information in the available devices. The confidentiality, integrity, and availability of patient information and other sensitive data must be safeguarded at all times.

General Guidelines

1. Improper access/use of the remote access function puts MBKU, University Eye Center-KH and its employees and patients at risk.
2. Students must ensure that PHI and other sensitive information is not viewable by those not authorized to see it.
3. Passwords and log-in IDs are personal and confidential. Students will not share or discuss them with anyone. Students cannot use other student's password or somebody else's identification to access the system
4. The same principles related to access of patient information at Ketchum Health are applied to remote use/access. Students must have a proper medical or business reason (role-based) for any access and use of the *e*PHI. Printing or saving PHI to cloud apps or thumb drives is not permitted.
5. The remote access is for educational purposes only, and students will not share or release PHI in any way from a remote location. If needed, the release process will be conducted following the established protocols at the University Eye Center-KH and only by authorized personnel.
6. Students are responsible for safeguarding PHI while accessing it. Do not leave ePHI or other sensitive data unattended for public view if you must step away.
7. Students may not transfer ePHI or MBKU's business information electronically without prior approval by the director of information systems.
8. Users may not establish or use new or existing internet connections to create new communications channels without the prior approval of the director of information systems.
9. Data users have no expectation of privacy when MBKU's system is used to access ePHI remotely. At any time and without prior notice, MBKU reserves the right to audit remote access practices, and unilaterally can suspend, restrict or even terminates access if appropriate.
10. If a breach or accidental or unauthorized disclosure of PHI occurs, it must immediately be reported to Director of Healthcare Policy Compliance, IT Director and/or Chief of Service.

Students who are found to be in violation of these guidelines, will be subject to disciplinary action (s), following University sanction policies.

11.0 LEGAL COMPLIANCE

11.1 COMPLIANCE PROGRAM

11.1.1 Executive Summary

As the University Eye Center at Ketchum Health enters its new era in patient care, a compliance program becomes paramount to the vision of performing with full transparency and accountability. Two purposes are served with the implementation of a compliance program:

- It is a way of communicating to employees, volunteers, patients, payers, government agencies and the public in general, that the institution is committed to compliance and strictly follows federal, state and local laws;
- The roadmap to create, implement and enforce policies and procedures will allow us in turn to create awareness about regulatory mandates.

New laws and statutes are continuously enacted, making the compliance an evolving subject. Among the topics that could be covered under any compliance program for a health care organization are patient privacy and security, claims reimbursement, coding and billing, marketing, conflict of interest, occupational safety, Anti-Kickback and Stark laws. University Eye Center employees at all levels, as well as managing directors and board members of Marshall B. Ketchum University (MBKU), are responsible for following the law and perform in accordance with the ethics code.

As KETCHUM HEALTH acknowledge that excellence in clinical education and patient care are the priorities of its operations, a well-designed compliance program will allow the Ketchum Health to help protect patient privacy, reduce the chances that an audit will be conducted, minimize billing mistakes, speed up and optimize proper payment claims and avoid conflicts of interest.

Finally, a compliance program sends a message to all the stakeholders recognizing that the organization takes pride in operating at the highest legal and ethical standards.

Legal Framework

Compliance programs are designed to follow federal laws. The Office of Inspector General (OIG) of the U.S. Department of Health & Human Services has established compliance program guidance for recipients of federal financial assistance (Medicare- Medicaid), including individuals and small group practices. Although this is a voluntary program, Ketchum Health will adopt the guidelines.

The OIG's compliance guidance for small practices was published in 2000 with the main purpose of preventing health care fraud, waste and abuse from providers billing for services for Medicare, Medicaid or any other Government related programs .The Patient Protection and Affordable Care Act of 2010 made mandatory for providers to adopt a compliance plan as a condition of Medicare enrollment.

The HIPAA act of 1996 and its subsequent amendments, including the Omnibus rule, regulated privacy and security of protected health information. KETCHUM HEALTH has a compliance program that addresses privacy and security separately.

Among other laws pertaining to compliance are the Anti-Kickback statutes, the Stark law, EMTALA, CLIA, OSHA, FERPA, DEFRA, ADA. For the purpose of the Compliance Program at the KETCHUM HEALTH, we will focus on

the OIG guidelines and its voluntary plan for individuals and small providers. The remaining regulations will be addressed in separate policies.

11.1.2 Compliance Program Overview

OIG recommends the implementation of a program with seven elements. Ketchum Health is committed to voluntarily comply with OIG guidelines and has implemented the following elements into its program:

1. Risk assessment and mitigation plan
2. Policies and procedures creation and implementation
3. Identification of a Director of Healthcare Policy Compliance
4. Role based education and training of staff about regulations and standards
5. Monitoring and auditing
6. Procedures to effectively communicate or disseminate information
7. Disciplinary enforcement of policies and standard procedures.

1. Risk assessment and mitigation plan

A process is in place to identify areas of risk that could potentially impact Ketchum Health performance. It also allows for the identification and prioritization of institutional vulnerabilities and to put preventive measures in place as appropriate. The assessment includes, but is not limited to, privacy and security of PHI, electronic communications, clinical documentation, referral response, claims submission, physical access to our facilities, care of minors and equipment maintenance, among other subjects.

The risk assessment is performed every year in accordance with the methodology described in the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-30 Revision 1 “Guide for Conducting Risk Assessments”. The mitigation plan is followed throughout the year, implementing remediation responses as needed. The Director of Clinic Operations, the Systems Coordinator and the Director of Healthcare Policy Compliance work in conjunction with the chiefs of services and administrative assistants to make sure risk issues are identified and addressed.

2. Policies and Procedures Creation and Implementation

An integral element of Ketchum Health institutional performance, policies and procedures are created for every service or department in the organization. Central supply, claims, clinic operations, clinical services by specialty, health information, patient relations, computer systems are among the areas covered by our policies and procedures.

As new regulations are enacted, KETCHUM HEALTH policies and procedures are continuously reviewed and updated. A collective process is used to implement the latest changes in policies, gathering information from key stakeholders in each area.

For the privacy and security of protected health information, a dedicated manual containing all the HIPAA policies and procedures has been created and is also updated as needed.

3. **Identification of a Director of Healthcare Policy Compliance**

A Director of Healthcare Policy Compliance has been designated with the following suggested duties:

- Maintain an inventory of how we use and disclose all protected health information (PHI).

- Work with Clinic management to ensure compliance documents are drafted, reviewed, and approved, including the Notice of Privacy Practices (and relevant updates), acknowledgment forms, authorizations, consents, and other forms as required.
- Develop, coordinate, and participate in training programs that focus on the components of the compliance program, and seek to ensure that training materials are appropriate.
- Provide an avenue for the reporting, investigation and correction of possible compliance issues.
- Guide the research about applicable standards and laws.
- In conjunction with the Associate Dean of Clinics, act as facilitator or mediator when legal/ethical issues or questions arise.
- Create a process to manage PHI and to retain medical records and clinic's business activities properly.
- Maintain an inventory of all business associate agreements.
- Provide timely reports on assessments of the areas of risk for Ketchum Health.
- Keep up to date on the latest privacy, security and compliance developments and federal and state laws and regulations.

4. Role based education and training of staff about regulations and standards

A key component of the compliance program is the ability for all the employees of getting role- based education and training. KETCHUM HEALTH has implemented an education program aimed at providing specific training to those employees who are in critical areas such as claims, privacy and security and information systems.

Training is provided in several ways:

- Webinars with CE credits
- One-day seminars at designated locations
- Conventions and annual meetings
- Users-group meetings
- In house training

In addition to role-based education, Ketchum Health employees are encouraged to becoming members of professional associations. Claims staff is part of the AAPC (American Academy of Professional Coders); The Director of Healthcare Policy Compliance is member of AAPC, HIMSS, OCEG, and HCCA.

Every new employee is given a comprehensive training on compliance issues before she/he is assigned to duties and their respective supervisor is responsible for updates as needed. A clear message is set as compliance being a condition of continued employment.

5. Monitoring and auditing

Several auditing activities are implemented at Ketchum Health to make sure processes are working in full compliance. Following is the list of such auditing activities by service:

Claims:

- Codes are audited regardless the payer (government or private plans), for accuracy in the refraction/ medical element of the examination. When discrepancies are found, claims staff will make the correction and send the bill accordingly.
- A thorough review of the CMS-1500 form is performed to check for the correct use of modifiers, accurate linking of diagnosis code with the reason for visit.

- Exams using CPT codes that require interpretation and report are randomly audited. The results are communicated to clinic management for quality review with faculty. This audit is also performed regardless the payer. Before billing for an exam that requires I & R, claims staff communicate with faculty to make sure the report is completed and the claim is fully documented.
- Monthly reports are produced regarding timely chart completion by faculty and Medicare encounters.

Patient Care

- General reports are produced (monthly or quarterly) on referrals rate, medication prescribing patterns; no-shows and cancellations rate; recalls and pre-appointments; grants and fee reduction programs.

Credentialing

- A dedicated employee is in charge of the entire credentialing process for renewal of privileges for existing faculty, and the accreditation of the new hires.

Clinical Documentation

- Random medical records auditing is performed monthly to review the quality of clinical documentation entered by faculty and processes performed by interns. A subsequent report is produced and shared with management if inconsistencies are found.

6. Procedures to effectively communicate or disseminate information

Policies, procedures and general guidelines are shared throughout the entire organization using several channels. The most common method of communication used is email; faculty hold a bi-weekly council in which policies and procedures, as well as plans of action for each service, are discussed. A weekly meeting is also held for administrative assistants and staff in general. Every quarter the entire campus conduct a development day in which specific training is provided in different areas, including compliance.

7. Disciplinary enforcement of policies and standard procedures

Ketchum Health takes every compliance issue seriously and disciplinary action is enforced once an incident is identified. In those cases where the action appears to be intentional or criminal in nature, the disciplinary measures will be more severe.

Disciplinary actions taken may include, but are not limited to, the following;

- Verbal warning
- Written warning
- Written reprimand
- Suspension
- Termination
- Restitution

Decisions about the reports of noncompliance to external agencies should be made when appropriate and in consultation with legal counsel. All significant reports, research/investigation results and actions taken will be reported to senior management and the President. Every decision on employee disciplinary action will be reviewed by KETCHUM HEALTH management in conjunction with the VP of HR.

11.1.3 Provider Credentialing

Provider credentialing is the process of establishing that medical providers have proper qualifications to perform their job. This requires contacting a range of organizations, to verify that the providers have the correct licenses and certificates. In addition, the credentialing organization makes sure there are no past reported issues that suggest the providers are incapable of competently treating patients. As a University clinic, MBKU has a list of clinic requirements that are required for all faculty within the University Eye Center. These include CPR certification, DOJ fingerprinting for Pediatrics/VT doctors, yearly TB test, HIPPA training and Abuse/Abduction training.

The primary phases of provider credentialing are as follows:

Gather Information: After the background check is complete, HR will provide credentialing team with an email providing the faculty name and start date. Once received, the new hire will be sent an email including an application for clinical privilege, credentialing questions and an attestation for credentialing on behalf of the faculty.

Credentialing software: After the paperwork is signed and returned, the new hire will receive a welcome email with the link to the “QGenda” software. The “QGenda” software allows the faculty access to update their information and upload required documents through a secure website. The new faculty will then upload the required documents. These documents include; OD license, DEA license, CPR card, TB test results, Fingerprinting (if applicable), Driver’s license, medical diploma, Abuse training certificate, Behavioral training certificate, Professional CV, Professional references. The new hire will also verify that all required demographic information is complete.

Verify the Information: The information is verified and the faculty will be contacted for any missing information. The “QGenda” program runs a query for any sanctions matching the provided information. The query runs each month through Sam.gov (SAM) (https://sam.gov/search) and Office of Inspector General (OIG) (https://exclusions.oig.hhs.gov/SearchResults.aspx).

Start Individual Credentialing: Individual packets of information and licenses are submitted to the insurance plans/Panels. We credential new hires with the following plans.

- Medicare
- VSP
- Spectera
- Prospect Medical (Closed panel)
- Premier
- Medical Eye Services
- March Vision
- HealthNet
- EyeMed vision
- Envolve
- Davis Vision
- Cigna
- CalOptima (OC docs only)
- Blue Shield of California
- AltaMed

- Anthem Blue Cross

Monthly verification: Each month all insurance require demographic and clinic verification. This is done through a few different ways but always requires the faculty information to be verified and most require a faxed or online attestation.

11.2 INSTRUCTIONS FOR RESPONDING TO SUBPOENAS

Introduction

Subpoenas are legal documents that need to be processed following strict guidelines. The purpose of this document is to provide general instructions in handling subpoenas related to litigation involving Ketchum Health patients and Faculty, including Worker's Comp cases. This document should be used in conjunction with any other existing University procedure(s) on the subject.

Any questions regarding the correctness of subpoenas, or the disclosure of documents requested therein must be directed to the desk of the Director of Healthcare Policy Compliance.

Definitions

A. Subpoena
In general, a subpoena is a legal document requiring a specific individual to appear and testify in court as a witness

B. Subpoena Duces Tecum
It orders the individual subpoenaed to produce documents or any other records available under her/his control at a specified time and place. It may also require the person to accompany the documents and testify as a witness.

C. Deposition Subpoena
It requires a non-party to provide copies of business records and to appear before a subpoenaing party.

D. Worker's Compensation.
These follow the same general rules applicable to civil subpoenas, except that billing records are generally no being sought, and HIPAA rules do not apply

Issuance and Service of Subpoenas

An officer of the court or an attorney of record in the case issues subpoenas, and they are served on a named individual, department, or office. Generally, subpoenas are served upon the custodian of the sought records, or upon the individual person named in the document.

Procedure for Acceptance and Response

Subpoenas not related to patients or faculty at Ketchum Health must be directed to the respective department, as follows:

a. Employees, former employees, applicants. They must be referred to Human Resources
b. Current students or alumni. They must be referred to Student Affairs
c. Directors or administrators. They must be referred to the VP of Financial Affairs

d. General records pursuant to FOIA suit. They must be referred to VP of Financial Affairs.
e. If the President or any VP is named, they must be directed to the Vice President of Financial Affairs.

Subpoenas allocate a reasonable amount of time before the production of records is expected. This will allow the opposing party or the individual whose records are being sought to review and accept/oppose the production of documents.

Subpoenas cannot be served by mail, electronic mail or fax. They must be served in person whenever feasible. Subpoenas served by mail or fax are not acceptable

To be valid, subpoenas will be accompanied by affidavits, as follows:

a. Description of the exact records to be produced
b. The date when the documents are expected
c. A copy of proof of service to the individual whose records are being sought, served at least ten days before the date specified.

We will attempt to contact the patient to notify the individual to whom the records pertain that they have been subpoenaed unless law prohibits such notification.

Objections from Consumer to Produce Records

The patient or her/his legal representative may oppose the production of records, if he has been properly notified. Objections to Ketchum Health furnishing the records must be filed with the court prior to when the documents are to be produced. This is called “motion to quash”.

Witness Deposition and Fees

If any employee is required to appear as a witness, or to personally accompany the documents requested in a subpoena Duces Tecum, the employee is entitled to all normal allowable daily fees plus mileage actually traveled, both ways, at the prevailing rate, and any additional costs incurred. Please coordinate with Human Resources and your supervisor regarding this provision.

11.3 DATA RETENTION PROTOCOLS

Purpose

Ketchum Health collects, handles, stores, and shares data from multiple sources, and use different methods to process such data. As a healthcare organization, we are bound by various obligations with regard to the data we manage, including federal and state laws, industry standards, or contracts with third parties.

As a result, data may need to be archived beyond its active use. Furthermore, when a retention period for a particular type of data is over, KH is obligated to destroy that data in a secure manner.

This policy addresses how long certain categories of data we must retain, and when and how we can destroy it.

Definitions

- “**Anonymization”** is the process of turning data into a form that does not identify individuals.

- **“Archiving”** is the process of moving data that is no longer actively used to a separate storage device for long-term retention. Archive data consists of older data that is still important to the organization and may be needed for future reference.
- **“Data”** is Record and Document.
- **“Designated Record Set”** is a group of records that include Protected Health Information (PHI), billing records, enrollment, claims adjudication, case management.
- **“Destruction”** is defined as physical or technical destruction sufficient to render the information contained the document irretrievable by ordinary commercially available means.
- **“Document”** as used in this Policy, is any medium which holds information used to support an organizational operation.
- **“Personal Data”** is any information related to an identified or identifiable natural person.
- **“Protected Health Information”** is any information that could be used to identify an individual, and that relates to the past, present, or future provision of healthcare, or payment of health care.
- **“Record”** is defined as the maintenance of documents in a production or live environment which can be accessed by an authorized user in the ordinary course of business.
- **“Retention”** is defined as the maintenance of documents in a production or live environment that can be accessed by an authorized user in the ordinary course of business.

Scope

This Policy applies to all Ketchum Health employees, agents, affiliates, students, volunteers, contractors, vendors, consultants, advisors, or service providers that might collect, process, or have access to KH Protected Health information (PHI)

This policy covers all patient data processed or in Ketchum Health custody or control, in whatever medium such PHI is contained in.

Each Chief of Service, Office Director, or Unit Supervisor, is responsible for the data it creates, collects, uses, shares, stores, and/or destroys. Any action related to the permanent destruction, deletion, or modification of the Ketchum Health patient data must be notified to the Director of Healthcare Policy Compliance for approval.

Data Inventories

For purpose of this policy, the following is considered data, and therefore should be covered accordingly:

- Patient records, including images form devices
- Billing and claims transactions
- Electronic messages and texts related to patient care
- Legal documents such as subpoenas, court orders and injunctions, Worker’s comp

A medical record shall be maintained for every individual who is evaluated or treated at Ketchum Health, and it can include digital images, photographs, films,

Procedures

The retention period of any record or document, regardless of format, shall be an active use period of ten (10) years (Ca. Welfare and Institutions Code) unless an exception has been obtained permitting a longer or shorter active use.

Records of minors must be retained for 10 years after the patient reaches the age of majority.

When communicating with a patient via email, text, or a phone call, the message or the call content must be merged into patient's file if it contains medical related language, e.g., treatment plan, comments on diagnosis and follow up actions, medications dosage, and the like.

Due to space constrains, some data (e.g., images) will be stored in a separate backup media, if necessary. The data will still be available to users after some protocols are followed, including a timely request to the Information Technology department. All archived data, which is stored on backup media, must be encrypted at rest.

Paper records shall be archived in secured storage onsite, clearly labeled in archived boxes or shelves, and stating the date to be destroyed.

No destruction or deletion of medical records will take place without getting the prior approval of the Chief of Service, the Director of Healthcare Policy Compliance, or the Associate Dean of Clinics.

Litigation Holds and Emergency Procedures

Ketchum Health may be involved in unpredicted events such as litigation, board proceedings, PHI breaches, or disaster recovery incidents. As a result, access to data may need to be restricted or prohibited altogether.

Once a hold has been placed on a file, data will only be accessed, copied, used, shared, or reviewed by a designated member of KH workforce, following strict confidentiality and integrity protocols set by Clinic Management.

Enforcement and Reporting

Breaches of this policy may have serious legal and reputation consequences and could cause material damage to MBKU. Breaches can potentially lead to disciplinary action that could include summary dismissal and to legal sanctions, including criminal penalties.

All employees are expected to promptly and fully report any breaches of this Policy. A report may be made to the Chief of Services, the Associated Dean of Clinics, or the Director of Healthcare Policy Compliance.

11.4 ANTI-KICKBACK STATUTE AND STARK LAW POLICIES

Purpose

Ketchum Health is required to comply with federal and state laws intended to help prevent instances of fraud, waste, abuse and other unethical actions related to its operations.

The purpose of this policy is to develop a set of protocols for faculty with clinical privileges, associated administrative staff, and contractors, to comply with federal Anti-kickback and Stark laws.

The policy provides a comprehensive information about the aforementioned statues and other related regulations, and it explains how Ketchum Health will implement appropriate guidelines to regulate potential referral activities.

Definitions

a. **Kick-Back** - Compensation or remuneration of any kind, offered or received, knowingly and willingly intended to induce the purchase, lease, order of any item or service that is reimbursed under a Federal Health Care program.

b. **Remuneration -** anything of value given, directly or indirectly, overtly or covertly, in cash or in kind, to an individual an includes, but is not limited to:

   - cash;
   - free goods;
   - free services;
   - payment for items, services, or data at above fair market value

c. **Referral Source** - Any physician, physician family member, or any non-physician who may be capable of making referrals to Ketchum Health.

d. **Reportable Event** - An isolated event or a series of occurrences that involves a substantial overpayments; a matter that a reasonable person would consider a probable violation of criminal, civil, or administrative laws applicable to any Federal health care program for which penalties or exclusion may be authorized; the employment of or contracting with a covered person who is an ineligible individual.

e. **Immediate Family Member** - Immediate Family Member means husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

f. **Safe Harbor -** Regulations issued by the Office of Inspector General (OIG) containing provisions which describe various payment and business practices that the OIG has deemed acceptable.

Scope

The policy applies to all Ketchum Health employees, contractors (subcontractors), patients, families, students, and volunteers , and any other individual who is acting as an agent on behalf of Ketchum Health.

Policy

Ketchum Health is committed to conducting its patient care activities and related business operations in compliance with the Anti-Kickback statute, Stark laws, and applicable state regulations. To that end, Ketchum Health does not pay, provide, or accept remuneration, including any payment of any type, for referrals of patients.

Ketchum Health employees and its agents shall report suspected violations of these statutes and related policies and procedures

Procedures

I. All Ketchum Health employees, providers, interns, volunteers and associated staff members and, where appropriate, others who provide services to or on behalf of Ketchum Health, shall become familiar with

the requirements of the Anti-Kickback Statute and the Stark Law through training and through the attached overview of the laws **(see exhibit A).**

II. The Associate Dean of Clinics, in conjunction with the Director of Healthcare Policy Compliance will review all the agreements between faculty (including part-time), to check for areas of potential violations or conflict with the statutes.

III. The Associate Dean of Clinics or his designee shall approve agreements between Ketchum Health and any other entity that involves the referral or transfer of any patient to or by a Ketchum Health affiliate. These agreements:

a. Shall be in writing

b. Shall be signed by all parties

c. Shall specify all obligations of the parties

d. Shall specify the fee or payment, which shall be set at fair market value for the items or services provided

e. Shall not involve the referral or transfer of any patient to or by Ketchum Health or its affiliates to induce the other party to refer or obtain referrals of patients from Ketchum Health

IV. Routine waiving of fees or co-pays due by participants of federal funded healthcare programs is prohibited. Ketchum Health will exercise due diligence when applying those waivers, following pre-established criteria approved by the Associate Dean of Clinics (Please refer to the **Professional Courtesy policy**)

V. Before engaging in any activity, including but not limited to, marketing and promotion of new services or products, continuing education sessions, and the offering of certification courses, the Associate Dean of Clinics and the Director of Healthcare Compliance must be consulted to review potential areas of conflict that could trigger a violation of the statutes.

- Failure to comply with this Policy may result in disciplinary action, up to and including termination of employment, for Employees; or termination of the contractual arrangement, for Contractors.

Responsibilities

Associate Dean for Clinics
Director of Healthcare Policy Compliance
Dean for Professional Affairs and Clinical Education

Revision and Amendments

Origination**:** **03/2021**
Effective:
Last approved:
Owner: Associate Dean for Clinics

References:

42 U.S.C. § 1320a-7b(b), 42 CFR § 1001.952
42 U.S.C. § 1320a-7a(a)(7) 42 U.S.C. § 1395nn;
42 CFR § 411.350 et seq.

11.5 BREACH NOTIFICATION OF PROTECTED HEALTH INFORMATION

PURPOSE:

To provide guidelines to communicate breaches when unauthorized access, acquisition, use and/or disclosure of the organization's unsecured patient protected health information occurs.

POLICY:

The KETCHUM HEALTH is committed to the privacy and security of the information it collects from patients. To protect identifiable information, we have secured the latest technology available and have implemented procedures to ensure its confidentiality and integrity. KETCHUM HEALTH Breach notification will be carried out in compliance with the American Recovery and Reinvestment Act (ARRA)/Health Information Technology for Economic and Clinical Health Act (HITECH) as well as California Senate Bill SB 24 (2011).

DEFINITIONS:

Access: The ability or the means necessary to read, modify, or communicate data/information or otherwise use any system resource.

Breach: The disclosure of PHI that compromises the confidentiality, privacy and integrity of information. The breach may directly or indirectly compromise the individual financially, affect his/her reputation or create personal harm.

Business Associate: A person or company (other than a KETCHUM HEALTH employee) that performs or assists in the performance of a function or activity involving the use or disclosure of identifiable health information.

Disclosure: The release, transfer, provision of access, or divulging Individually Identifiable Health Information (IIHI) outside of the entity holding such information.

Individually Identifiable Health Information (IIHI): Refers to health and demographic information collected from an individual that is created or received by a health care provider, health plan, employer, or health care clearinghouse. 1) It relates to the past, present or future physical or mental condition of an individual, 2) The past, present of future payment for the provision of health care to an individual, and 3) Identifies the individual or there is a reasonable basis to believe the information can be used to identify him/her.

PHI: Any form of Individually Identifiable Information that is transmitted electronically, maintained in electronic media; or transmitted or maintained in any other form or medium.

Unsecured Protected Health Information: Information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of technology or methodology specified by the Health and Human Services Secretary.

Workforce: Refers to employees, residents, volunteers, work studies, trainees, and other persons whose conduct, in the performance of work, is under the direct control of the KETCHUM HEALTH, whether or not they are paid by it.

PROCEDURE:

The following describes the processes that will occur in the event information is disclosed in a way that could pose significant and quantifiable harm to patients:

Discovery of Breach: A breach is "discovered" as of the first day it is known to the organization, or by exercising reasonable diligence, would have been known to the organization. Any breach that occurs, whether from KETCHUM HEALTH workforce, or from a Business Associate, must be reported to KETCHUM HEALTH officials at the time the breach occurs.

Risk Assessment and Breach Investigation: Once a breach is discovered or reported, the Director of Healthcare Policy Compliance will conduct an investigation to determine the nature of the breach. The investigation will be coordinated with the Vice President and Dean of Clinical Affairs, the Director of Clinic Operations, Human Resources (if applicable) and the KETCHUM HEALTH Systems Coordinator. If determined that improper access, use or release of PHI needs to be communicated to affected parties, the Director of Clinic Operations will coordinate the notification process.

Timeliness of Notification: Upon determination that breach notification is required, the notice shall be made within 60 calendar days after the discovery of the breach by KETCHUM HEALTH, or the Business Associate involved. It is the responsibility of the organization (KETCHUM HEALTH or the organization of the Business Associate) to demonstrate that all notifications were made as required, including evidence demonstrating the necessity of the delay, if needed.

Content of the Notice

The notice shall be written in plain language and must contain the following:

- A brief description of what occurred, including the date of the breach (if known) and the date of the discovery.
- A description of the type(s) of unsecured PHI involved the breach (i.e., full name, social security number, full address, date of birth, insurance policy numbers, and bank account numbers.
- Recommendation(s) about the steps the individual should take for protection from potential harm resulting from the breach.
- A detailed description of the action(s) that KETCHUM HEALTH is taking to avoid, mitigate or alleviate the potential harm to the individual(s) involved.
- Details for the individual (s) affected by the breach on how to contact KETCHUM HEALTH officials to learn additional information, including a telephone number, email address, website or postal address.

Types of Notifications

- Notice to individuals- written notification by first-class mail to the last known address or by electronic notice (via email) on file. If it is determined that the breach could potentially cause imminent harm, or the unsecured information could be used for malicious purposes, notification may be provided by telephone or by other means as appropriate, in addition to the above methods.
- Notice to media- If the breach affects more than 500 individuals, a press release shall be provided to prominent media outlets serving California and the local region.

- Notice to Secretary of Health and Human Services (HHS) - If the breach affects more than 500 individuals, the Secretary of HHS will be notified in compliance with instructions from their website at www.hhs.gov. If the breach affects less than 500 individuals, KETCHUM HEALTH will maintain a log and will submit it annually to HHS (logged breaches occurring during the preceding calendar year will be submitted no later than 60 days after the end of the calendar year). The log will be maintained by the KETCHUM HEALTH Director of Healthcare Policy Compliance. Instructions for submitting the log are provided at www.hhs.gov.
- Notice to California Attorney General: For breaches affecting more than 500 individuals, KETCHUM HEALTH will in addition to notifying HHS, will notify the office of the California Attorney General.
- Business Associate- Will notify KETCHUM HEALTH no later than 60 calendar days after a breach is discovered. Business Associates are responsible for breaches caused by all contractors, subcontractors, subordinates, volunteers and other personnel under its supervision. The notice to KETCHUM HEALTH shall include the identification of each individual affected. After receiving notification of the breach, KETCHUM HEALTH will notify the individuals, following the "Notice to Individuals" protocol outlined in this policy.
- Workforce Training – KETCHUM HEALTH will provide training to it's workforce on this policy and procedure.

REFERENCES:

- 45 CFR, 160 and 164- HIPAA Privacy and Security Rules
- ARRA Title XIII, Section 13402 HITECH: Breach Notification Rule
- SB 24 (2011): California Breach Notification Rule
- SB 570 (2015) California Notice of Data Breach Rule
- Health & Safety Code § 1280.15
- Health & Human Services- www.hhs.gov

11.6 INFORMATION BLOCKING RULE

Statement of Policy

Under provisions of the 21st Century Cures Act, Section 4004, Ketchum Health is required to establish policies and procedures to provide patients and their healthcare providers secure and unrestricted access to their health information

Ketchum Health will comply with the statute by ensuring that protected health information (PHI) from our patients is managed and released according to the Rule's requirements.

Definition & Legal Framework

Information blocking is defined by the Cures act (45 CFR 171.103) a practice that:

a. Except as required by law or covered by and exception, is likely to interfere with access, exchange, or use of electronic health information.

b. If conducted by a health care provider, such provider knows that the practice is unreasonable and is likely to interfere with access, exchange, or use of electronic health information.

Scope

Information blocking regulation applies to three types of "actors":

1. Health care providers (Ketchum Health)
2. Health IT developers (COMPULINK)
3. Health information networks (HINs) & health information exchanges (HIEs).

Each actor is uniquely and individually accountable for his or her own information-blocking conduct.

The act also empowers patients with their rights to access their records in the format they desire, including mobile apps, at no cost to them.

Electronic health information (EHI) means electronic protected health information (ePHI) to the extent that the ePHI would be included in a designated records set as these terms are defined for HIPAA. To determine whether the information is EHI, we should consider the following conditions:

- The information is individually identifiable health information, that is transmitted by electronic media, or maintained in electronic media, and
- The information would be included in medical and billing records of a provider about individuals, or records used to make decisions about individuals.

The Office of National Coordinator (ONC) requires all physicians to make available their ***office notes, lab results, and other diagnostic reports*** to patients as soon as the physician's office receives the request.

What is not EHI:

- Psychotherapy notes as defined in 45 CFR 164.501
- Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding
- Individually identifiable health information in education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g
- Individually identifiable health information in records described at 20 U.S.C. 1232g(a)(4)(B)(iv)
- Individually identifiable health information in employment records held by a covered entity in its role as employer
- Individually identifiable health information regarding a person who has been deceased for more than 50 years
- De-identified protected health information as defined under 45 CFR 164.514

Information Blocking Exceptions

The norm is to avoid actions or omissions ("practices") that are likely to interfere with information sharing.

The exceptions offer assurance that reasonable and necessary "practices" covered by an exception will not be considered information blocking.

Five (5) exceptions allow not fulfilling requests to access, exchange, or use EHI, as follows:

1. **Preventing harm exception**: a covered component engages in practices that are reasonable and necessary to prevent harm to a patient or another person, provided certain conditions are met (45 CFR § 171.201).
2. **Privacy exception**: a covered component does not fulfill a request to access, exchange, or use EHI in order to protect an individual's privacy, provided certain conditions are met (45 CFR § 171.202).
3. **Security exception**: a covered component interferes with the access, exchange, or use of EHI in order to protect the security of EHI, provided certain conditions are met (45 CFR § 171.203).
4. **Infeasibility exception**: a covered component does not fulfill a request to access, exchange, or use EHI

due to the infeasibility of the request, provided certain conditions are met (45 CFR § 171.204).

5. **Health IT performance exception**: a covered component takes reasonable and necessary measures to make health IT temporarily unavailable or to degrade the health IT's performance for the benefit of the overall performance of the health IT, provided certain conditions are met (45 CFR § 171.205).

Three (3) exceptions involve procedures for fulfilling requests to access, exchange, or use EHI, as follows:

1. **Content and manner exception:** a covered component fulfills a request to access, exchange, or use EHI in any manner requested or in an alternative manner, provided certain conditions are met, using (i) certified health IT specified by the requestor; (ii) content and transport standards specified by the requestor and published by the federal government or a standards-developing organization accredited by the American National Standards Institute; or (iii) an alternative machine-readable format, including the means to interpret the EHI, agreed upon with the requestor (45 CFR §171.301).

2. **Fees exception**: a covered component charges fees, including fees that result in a reasonable profit margin, for accessing, exchanging, or using EHI, provided certain conditions are met (45 CFR §171.302).

3. **Licensing exception**: a covered component licenses interoperability elements for EHI to be accessed, exchanged, or used, provided certain conditions are met (45 CFR §171.303).

Enforcement Power

The act identifies the HHS Office of Inspector General (OIG) as the government office to investigate claims of information blocking and provides referral processes to facilitate coordination with the HHS Office for Civil Rights (OCR). It Prescribes penalties for information blocking, and charges the Office of National Coordinator (ONC) with implementing a complaint process for reporting information blocking, and provides confidentiality protections for complaints.

Ketchum Health Release of Information (ROI) Best Practices

- **Who is the owner of the medical file?**
  The medical file belongs to Ketchum Health, and we have limited rights regarding our ability to grant or deny access to patient information.
- **What is the "minimum necessary" standard?**
  This standard requires Ketchum Health to limit the release of protected health information to the minimum necessary to accomplish the intended purpose. Unless specifically asked by the patient or providers, we are not required to share the entire patient's file. HHS is reviewing this standard in the latest rule change proposal.
- **Data in multiple legacy systems–Archived files**
  Scanned documents migration from legacy systems (i.e., eDocs) is complete, and all scanned documents are available in Compulink. The Ketchum Health Information Technology department (IT) allows limited access to legacy systems (Eyefinity/NextGen) for document retrieval purposes. Please refer to the Director of Healthcare Policy Compliance for additional assistance if needed.
- **Encryption in transit**
  Sharing patient information electronically is permitted if it is done via encrypted message. Only patients can authorize us to send their information without encryption in transit. Other releases of PHI must be encrypted at all times.

- **Texting PHI**
  Sending information via text is not supported, as Ketchum Health does not have the technical tools to link text messages to patients' files. Please refrain from texting sensitive information via text.
- **Handling of subpoenas and third-party requests**
  All subpoenas must be given to the Director of Healthcare Policy Compliance for proper handling. Ketchum Health has a Subpoena management policy, and we must ensure proper protocols are followed when responding to these legal requests.
- **Timeline to respond to requests for Medical Records**
  Ketchum Health adheres to California statutes, which require two (2) business weeks to respond once the provider receives the request. State law is more stringent than HIPAA.

12.0 QUALITY ASSURANCE PROGRAMS

12.1 CLINICAL DOCUMENTATION IMPROVEMENT-CDI PROGRAM

Purpose

a. To ensure excellence in patient care through a methodical, accurate documentation of the medical chart.
b. To improve our billing practices, and to achieve full coding compliance.

Authority and Responsibility

c. A compliance committee (the "Committee") will be created with the responsibility of overseeing the charting process to ensure a continuous evaluation of the clinical documentation practices.
d. The Director of Healthcare Policy Compliance (the "Director") will have oversight of the Committee and its members.
e. The Committee will consist of one faculty from each service and the Director.
f. The Committee will meet at least once a month and will report its activity and findings to the Associate Dean of Clinics, who in turn will publish the results and make the material available to appropriate parties for follow up and remediation.

Scope

g. Charts will be reviewed and audited, following strict privacy and security protocols.
h. The following elements will be evaluated:
    i. Clinical documentation-Chief complaint, diagnosis, ROS, PPFS
    ii. Interpretation and reports
    iii. Accurate coding and billing-Numbering fee sheets
    iv. Accurate diagnosis
    v. Medication-allergies and drug interactions
    vi. Identification of risk factors and coordination of care (MIPS)
    vii. Patient education, e.g., AREDs
    viii. Chart completion
    ix. Translation/interpretation services for Limited English Proficiency (LEP) patients

Methodology and Criteria

i. Chart completion is expected within three (3) business days. Remote access to patient databases has been granted to all faculty to facilitate chart review when not in clinic.
j. The appointed Committee faculty will randomly select an exam and its corresponding fee sheet. The audit will check for the presence and accuracy of the main elements needed to attain the level of billing presented to claims.
k. The committee will check for consistency on the production of Interpretation and Reports when required after a test is performed. A list of CPT codes requiring I & R will be timely provided.
l. A general review of documentation practices will be conducted, including but not limited to, providing patients with appropriate educational materials; timely communication with PCP when patients are referred to KH; accuracy, appropriateness, and relevance of stated documented facts in the evaluation; availability of translators and interpreters when needed.

12.2 MEDICAL CHARTING PROTOCOLS

Goals:

- Identify methods to increase provider specificity of Clinical Documentation capturing all the elements required
- Develop methodology to engage providers by creating a meaningful educational program
- Emphasize the importance of collaborative communication for all stakeholders
- Define measurable success factors & monitoring the impact of improved Clinical Documentation
- Designate a team of CDI specialist(s) in charge of randomly reviewing charts to check for CD accuracy. It could be the start of the more comprehensive “peer-review” program
- Determine the needs in terms of real time education and training for faculty to adjust to the new specificity requirements from the ICD-10

Benefits:

- High quality of patient care
- Improved provider and clinic profiles
- Doctors have a vested interest in collected data is as accurate as possible
- **Improved reimbursement** due to more ICD-10 selection (also to meet the specificity requirements)

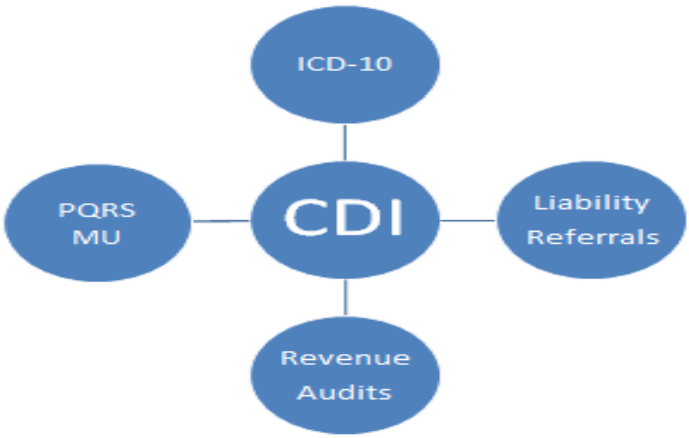
Provider Liaison/Champion(s) will:

- Engage all faculty involved in patient care
- Assign a provider or group of providers in charge of reviewing and grading records accordingly.

Key Elements:

- Medical necessity and chief complaint always documented
- Cloned Documentation (“copy and paste”) must be, if not eliminated completely, reduced significantly. This would require re-engineering templates; adjusting EHR settings; educating interns and providers; creating a formal policy addressing the issue
- Accurately coding for new vs. established to avoid over and/or underpayments

- Interpretation and report always completed and incorporated in the chart



Executive Summary

The medical record validates all the procedures and care provided to patients, and ultimately serves as a foundation to support our claim submissions. It also shields us from potential liability issues that may arise in the course of our business.

The medical record should contain information that properly documents precisely what services were provided to match the diagnosis and the procedures used for billing purposes. Documentation in the medical record should be self-explanatory, and it should stand on its own without the need of the doctor to explain it or "defend" it. As stated by the CMS Evaluation and Management documentation protocols: "If it isn't documented, it hasn't been done".

Guidelines

1. Each page in the record contains the patient's name or ID number. EMR software allows this to be done by default.

2. The medical record is complete and legible, including time and date of all entries and signature of individual making entry, including his or her title.

Chart completion is expected to happen within three business days. Full time Faculty has been granted remote access to EMR software to allow them to work while not at the Clinic; part time faculty are expected to complete charts the same day of the visit, if they are scheduled to see patient just for that day.

Every element of the chart must have the name of the faculty who is in charge of the exam. Name of the faculty must be entered at the end of the Reason for Visit/ Chief Complaint, History Present Illness, Patient History, Review of Systems, Impression/Assessment and Plan.

Charts must have the signature of the provider in charge of the examination; if the name of the intern is entered at the end of each element, a parallel signature from the rendering physician must be entered as well. The only responsible party for the exam is the staffing doctor and the billing validates this fact.

3. The documentation of each patient visit includes**:**

- Presenting problem/chief complaint/reason for the visit

  The Chief Complaint is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter.

  This is the most important element of the chart. Chief Complaint is recommended to be recorded in the patient's own words and must be clearly stated. The reason for visit suggests what test(s) will be needed (if any) and the possible CPT codes to use for the encounter.

  Avoid using the following statements while documenting the reason for visit:

  "Patient here for comp. exam"

  "Eye Health Check"

  "Annual Exam"

  Reason for visit could also be "doctor driven"- tests ordered at completion of last visit. It is important to be accurate in the RFV/CC documentation because it also determines if the best way to treat the condition is medical or refractive.

- Any relevant medical/ocular/visual history

  Always interview the patient and customize the Hx to explain and justify the reason for visit/chief complaint. "Unable to respond", "patient unresponsive or uncooperative" are accepted statements to be incorporated in the file. If an interpreter is needed, please make sure that patient and faculty agree on the chosen individual. If a family member is designated as the interpreter, the following statement must be included in the Hx form:

  "Interpretation provided by family member, **at patient's request**".

  The ROS and /or PFSH may be recorded by the intern or on a form completed by the patient. While documenting the PESH, please refrain from including statements that are not relevant to the case or are outside the scope of the practice itself.

  A ROS and/or a PFSH obtained during a previous encounter do not need to be re-recorded if there is evidence that the faculty reviewed and updated the previous information. If no updates are needed in the chart, faculty could note it by adding a simple statement such as "there has been no change in the information".

- Ocular examination findings
- Previous diagnostic test results

  Every ancillary test ordered must be interpreted and a report must be created and included in the file separately. The report on the test results cannot be part of the EMR template and a separate report must be filed.

- Medication usage/medication allergies

  Documentation on allergies, drug/drug interaction and medication side effects must be consistent when multiple visits are recorded. Avoid the copy/paste function to prevent inconsistencies in the chart.

- Assessment
- Clinical impression or diagnosis

  Medicare (and subsequently, most private payers) only goes by the principle of reasonable and necessary services. Faculty can order any test(s) or apply any diagnosis they might think is appropriate; however, payers will only reimburse for services that they consider "reasonable and necessary".

- Treatment/plan of care

  It is very important to document all recommendations given to patient regarding compliance with medication intake and treatment plan. This has two immediate effects: assuring that patient's non-compliance might be one possible cause of any lack of improving or worsening of patient's condition; and to shield the provider from potential malpractice issues that could arise in the course of the treatment.

- Date and legible identity of the observer

4. The rationale for ordering diagnostic and other ancillary services must be documented or easily inferred by a medically trained independent reviewer, including another OD in a peer review process (if such a process exists).

5. Evidence that the patient is not placed at an inappropriate risk by a diagnostic or therapeutic procedure.

6. The medical record documentation must support the ICD-10 and CPT codes submitted for claims reimbursement. The level of specificity in the documentation must accurately support the diagnosis code related to the claim being submitted.

7. Health risk factors are identified. Progress notes must document any changes in response to treatment, and any revisions in diagnosis.

8. Recommendations made to the patient are extremely important, including any patient educational information and appropriate follow up in terms of weeks, months, or as needed.

12.3 INTERPRETATION AND REPORT PROTOCOLS

Legal Background

It's been assumed that an I & R required a separate, handwritten document created by rendering providers to comply with billing procedures.

After careful analysis of existing government guidelines, and CMS conditions of participation-billing manual, and articles from billing experts, we have concluded that there is not consistent regulation to support any specific way to present the I & R as proof of the test performed, much less a direct indication about the need for the report to be "separate and handwritten".

The Medicare Carriers Manual (15023) specifies that and Interpretation & Report should "address the findings, relevant clinical issues, and comparative data (when available). There must be a **written** report that becomes part of the patient's medical record".

Discussion

To make the I & R process more transparent and expedient, we are eliminating the requirement for it to be separate and handwritten. To that effect, we are using the tools provided by EMR Exam Writer instead. Three goals will be achieved:

- Completion of the report in a timely manner, with less steps for faculty to follow;
- Ability to support the billing process more consistently; and
- Improving compliance rates, which in turn will help us to pass auditing proceedings when they occur.

Claims for tests requiring an interpretation and report will be sent "as is", meaning the required proof will be obtained from the EMR exam template, should an auditor request additional support for the payment. Claims staff **will not** communicate with faculty to obtain reports needed to support billing processes, and faculty will be solely responsible to ensure that the accompanying report is produced once the test is completed.

The paper forms and the subsequent scanning are effectively eliminated with the new process. A completion tracking tool will be developed to monitor faculty's compliance with the report.

Procedures

Following are the steps to complete the Interpretation and Report using the existing Exam Writer tools:

1. **Procedure Steps to complete Interpretation and Report in Compulink:**
    I. Click the heading tab "Special Testing"
    II. Click box all the additional testing performed during the exam with the correct CPT code listed next to the description of the test. Multiple tests could be chosen at this point and after all selections have been made, click the process button at the bottom of the pop up window.
        i. For example if I performed a macula OCT. I would click the box under the heading "Posterior Segment" next to the wording "Retina – 92134".
    III. A new pop up window will appear with the test name at the top. You will now click the upper left hand box labeled "Interpretation & Report" first before clicking any additional boxes to describe your test. Afterwards, you have the ability to either complete the results with click boxes or free text. And then press the "Process" button at the bottom of the window and then the next test will appear. After you complete the last test, all the data will now appear in the "Special Testing" section. Edits can be made after completion by clicking on any of the test heading titles.
        i. The necessary components needed for an interpretation report are:
            1. Reason for the test (Clinical finding to support why you are testing with a previous order for the test)
            2. Reliability of test
            3. Interpretation of results of the test
            4. Comparative data to previous test results (if applicable)
            5. Clinical management adjusted based on findings from the test
            6. An assessment or diagnosis (if possible)
            7. Signature of the doctor (see below)
    IV. For the signature of the doctor, please complete the following steps:
        i. Click the "Notes" box at the very top in between "Finalize" and "Exam/Draw".
        ii. Click the "Special Testing" box

iii. A blank small pop up window will appear. Please type in “Interpretation and Report completed”. Please leave the check in the box “Date Stamp this note.
iv. Then click “Save/Exit” at the bottom. This will automatically add the note at the bottom of the “Special Testing” section with your statement, a time stamp and your electronic signature to the section.

2. **Extended Ophthalmoscopy** will be completed using tools from ExamDraw. The report does not need to be in color. Make sure the drawing captures all elements required for this test, including appropriate labeling.

3. **Signature.** Electronic signature can be used to sign the report. Faculty has the ability to authenticate any entry in the exam by using her/his log-in credentials to access the electronic medical file. This type of authentication is valid and accepted by Medicare following CFR § 482.25(ii). Please include the “Attestation Statement” that is used to sign the medical record.

4. **Completion deadline**. When a test is performed, the subsequent I &R is expected to be completed within three business days.

12.4 DATA-ENTRY POLICY AND PROCEDURES

Data Integrity

As we establish our new inter-professional education and healthcare ecosystem at KETCHUM HEALTH, with integrated, multifunctional programs and applications, it is necessary to make sure that the data we collect translates to meaningful and useful information when entered into our databases.

The guidelines below provide standards for establishing measures for the collection, entry, access, and use of data that is maintained electronically on Ketchum Health databases. These guidelines should define the responsibilities of users who input and access that data.

We all have a fiduciary responsibility to preserve the integrity of the information collected and stored in our systems. All individuals handling and entering data must adhere to the policies and procedures of this policy.

Duplicate Records

To the extent possible, we must avoid the creation of duplicate files. **Search first, BEFORE** creating a new record or changing an existing record for an individual. Conduct a name search using different elements (DOB, first/middle/last names, address, phone numbers, email address) to make sure the person has not already been entered into databases. Eliminating/merging duplicate files is a very time consuming activity; thorough searching is necessary to prevent creating duplicate records.

Quality Control

Supervisors and the Director of Healthcare Policy Compliance will conduct random audits to determine the accuracy of the data entered into KH databases, and will provide timely feedback to those users who have not followed the guidelines.

Naming Conventions

We all use files to store data related to our daily workflow. Organizing files and folders using standard naming conventions must be priority when saving data to any location. These conventions could include things like the

date of creation, author's name, project name, name of a section or a sub-section of the project, the version of the file, etc. Avoid using acronyms when naming files or folders.

Examples:
123456LOspina_RecordsRelease_08252018
VSP Authorization

Types of Data

Person Data: Relates to any demographic information that identifies an individual.
Non-Person data: Data that pertain to organization or companies and is established and used by various departments.

Procedures

- **General**:
  - When information is unknown, avoid entering mockup data into the system to create the file. If the system does not allow creating a new file without completing specific fields, you must set an alert and follow up on collecting the right information to be entered in the system once known.
  - Patient databases are case sensitive, and all character data is to be entered using mixed case (standard combination of upper- and lower-case letters), as provided by persons. Never use ALL CAPS to enter a names or addresses.
  - Use only Compulink to change demographic information on all patient databases. Do not use Compulink or Compulink to enter new patient data, or to modify existing data.
  - Do not use special characters when creating files, such as # * %, < > , as this might cause problems with queries and report generation.
  - Users are responsible for understanding all data elements that are used. If unsure about the format of the data, or the meaning of the data element, the user should consult his/her supervisor for guidance.
  - Users must protect all Ketchum Health data files from unauthorized use, disclosure, alteration, or destruction. Users are responsible for the security, privacy and control of data within their control.

- **Creating/Entering Names-Demographic Data**
  - Enter the entire middle name when provided by the individual for identification purposes. Enter the legal spelling and format of the last name as supplied by the person.
  - Appropriate punctuation must be used consistently, even when not provided by the individual, including commas, periods, dashes, colons, semi-colons, apostrophes, and quotation marks.
    Example: OConnor, O,leary
    Enter: O'Connor, O'Leary
  - Use only names in the first or last names fields. Do not use titles, prefixes, and suffixes (e.g., **Example**: Dr., Mrs., MD., Jr., III. These go in their separate and appropriate fields, if available.
  - When entering names beginning with a prefix, spell the name as the person does. If that spelling is unclear (as with poor handwriting), capitalize the second part of the name and do not type a space between the two parts of the name:
    Example: Mac, Mc
    Enter: MacDonald or McDonald
  - Enter single character first names with no period.
    Example: P Wallace

- Use hyphens to separate double last names as supplied by the person. Hyphenated last names are to be entered with no spaces between the hyphens.
  Example: Mohammed Al-Khasi
  However, if there are two last names that are not hyphenated, the first name provided would be entered as first name, the second would entered as middle name, and the third/fourth will be entered as last name.
  Example: Huang You Quinton Lee
  Enter: Huang, You, Quinton Lee
- Spaces are permitted if the legal spelling and format of the name includes spaces.
  Example: Mary Ann, Joe Daniel.
- Enter the legal name as it appears on a government issued document (SSN/TIN)
- When entering a date of birth, we follow this format: 00/00/0000
  Example: 08/12/1947 or 10/05/1970
- When entering phone numbers, if a format is not already embedded in the system, we follow this format: **111-000-1234**.
- Insurance information. The name of the insurance company will be always entered with the first letters of the names capitalized, followed by lowercase characters. Enter the data as it appears in the insurance card, or as is provided by the patient, including all alphanumeric and special characters.
  Example: Anthem Blue Cross XLD75482154-4NA.

❖ **Creating, Changing and Inactivating Addresses**

Most of the software applications we use are "intuitive" in nature, allowing data to be properly documented if entered in a disparate format. Sometimes, however, users enter addresses with values or characters that the systems do not recognize, creating a duplicate or redundant file. Following are some general guidelines to follow while creating or changing addresses.

- Always use the "billing address" in NG field to enter main addresses of patients. Use only the "secondary" address field when provided by the individual, and never instead of the "billing" field.
- When changing an address for which history is not maintained, remove (or overwrite) the prior record and follow the instructions for setting up a new address.
- Character data is to be entered using mixed case (standard combination of upper and lower case letters). Never use ALL CAPS when entering address data.
- If only a PO Box was provided, enter it in the same format used by the USPS. Capitalize the "PO" without periods, followed by a space and the letter "B" capitalized. If and address includes both a PO Box and a street address, enter the PO Box on the line below the street address without punctuation.
- Be consistent in the way you spell abbreviated street designators without punctuation.
  Example: Ave (Avenue); Blvd (Boulevard)**;** Ctr (Center); Cir (Circle); Dr (Drive) Hwy (Highway)
- Compass directional words may be abbreviated if they are not the street name. Do not use punctuation.
  Example: 102 N South St; 5460 E La Palma Ave
- If unit types are known and needed, use always the same designators without punctuation.
  Example: Apt (Apartment); Bldg (Building); Ste (Suite) Dept (Department)

❖ **Creating/Entering Vendors, Non-Person Names**

- Non-Person names of Corporation Names, including insurance payers, should appear exactly as shown on the IRS form, vendor's invoice, or letterhead. If initials are used, they must be entered in upper case.
  Example: IBM, US Insurance

- Where abbreviations of non-person or corporation names are necessary due to the length of the name, abbreviate with standard USPS abbreviations. These can be found at http://pe.usps.gov/cpim/ftp/pubs/Pub28/pub28.pdf.
  Example: HIPAA would be entered as Health Insurance Portability and Accountability Act
- A company with initials should not have a space between the initials. Do not use periods or commas.
  Example: BS of CA
- Use the ampersand sign (&) instead of the word “and” when appropriate.
  Example: AT&T
- Use "The" if the vendor name starts with it.
  Example: The Insurance Group
- Do not capitalize “a”, “an”, “the”, “of”, “for”, “to”, “etc.”, when used in the vendor name.
  Example: Business Insurance Co. of Anaheim.

EXHIBITS

EXHIBIT 1 LETTER OF TERMINATION OF CARE

Date
Re: Letter of Termination of Care
Medical File #
DOB:

Dear (Patient):
After careful consideration, we feel it would be in your best medical interest to seek the services of another optometrist. The University Eye Center will no longer be able to be your eye care provider, and we have decided to discontinue as your optometrist effective immediately, for the following reason(s): ***(Indicating the specific reason(s) for termination is optional, although if it involves medical treatment, or repetitive aggressive behavior, you may wish to do so.)***

I urge you to make arrangements for the services of another ophthalmologist/optometrist to maintain the continuity of your care. If you need a referral, you might contact your vision insurance provider, check your local telephone directory, or contact the California Optometric Association at (916) 329-9450. Our office will transfer a copy of your records to your new physician if you so desire.

If you should have a medical eye emergency before you have been able to secure the services of another Doctor, we will be able to provide emergency care for 30 days from the date you receive this letter. All usual and customary fees will apply.

I appreciate your understanding and assure you we will do all we can to facilitate a smooth transition in your care.
Sincerely,

Dr. _____
Signed by the Chief of Service and/or Associate Dean of Clinics.

EXHIBIT 2 REFERRAL FORM

SPECIALTY SERVICES

CONSULTATION / REFERRAL FORM

University Eye Center at Fullerton | 2575 Yorba Linda Boulevard, Fullerton, CA 92831

UNIVERSITY EYE CENTER *at Fullerton*

Please fax this form, ALONG WITH ANY PATIENT RECORDS, to the service below.

Please check types of specialty services needed:	Service Phone #	Service Fax #
☐ **Dry Eye:** Dry Eye Institute	714.449.7420	714.992.7833
☐ **Contact Lenses:** Stein Family Cornea & Contact Lens Center	714.449.7420	714.992.7833
☐ **Low Vision:** Mary Ann Keverline Walls Low Vision Rehabilitation Center	714.992.7890	714.992.7863
☐ **Ocular Disease:** Ocular Disease / Ophthalmology / Electrodiagnostic Service	714.449.7415	714.992.7848
☐ **Ocular Prosthetics:** Stein Family Cornea & Contact Lens Center	714.449.7420	714.992.7833
☐ **Pediatrics:** Pediatric Vision Care	714.992.7870	714.992.7856
☐ **Research:** Center for Vision Research	714.449.7490	714.992.7864
☐ **Vision Therapy:** Studt Center for Vision Therapy	714.449.7430	714.992.7846

Sent by:

Doctor's Name: _____ Doctor's NPI # ***(required)***: _____

Office Address: _____

City: _____ State: _____ Zip: _____

Office Phone #: _____ Fax #: _____

Email: _____ ☐ *I prefer electronic correspondence*

Introducing:

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Contact Phone #: _____

I am sending the above patient to the Eye Care Center for the following reasons:

☐ Consultation / 2nd Opinion Only (pt to be returned to original doctor) ☐ Special Testing Only

☐ Transfer of Care (referral) ☐ Treatment/Therapy (further information may be needed upon request)

Other/Comments/Special Requests/Tests Requested: _____

_____

_____

Would you like us to contact the patient for an appointment? ☐ Yes ☐ No

Please fax this form, ALONG WITH ANY PATIENT RECORDS, to the service above.

Signed _____

01/05/15 md

EXHIBIT 3 BACK-UP FORM FOR SPECTACLE RX

Ketchum Health

5460 E. La Palma Avenue

Anaheim, CA 92807

Phone (714) 463-7500 FAX: (714) 992-7811

Final Spectacle Rx

Patient: Click here to enter text. Exam Date: Click here to enter a date.

Sphere	Cylinder	Axis	H Prism	V Prism	Add	Intermed	PD

Lens Type: Choose an item. Wear Time: Choose an item.

Material: Choose an item. Lens Treatments: Click here to enter text.

Notes: Click here to enter text. Expiration Date: Click here to enter a date.

Provider Signature: _____

Provider: Choose an item. License No: Click here to enter text.

EXHIBIT 4 INTER-SERVICE REFERRAL FORM

INTERSERVICE REFERRALS

Date: Click here to enter text.

Patient Name: Click here to enter text. **Patient File No:** Click here to enter text.

SERVICE (To Be Referred): Choose an item. **Date of Birth:** Click here to enter text.

Referring Doctor: Choose an item.

Reason for referral: Click here to enter text.

Tests requested: Click here to enter text.

Day or time requested: Click here to enter text.

Faculty requested: Click here to enter text.

Urgency: Choose an item.

Insurance: Unknown ☐ Known ☐ Type: Click here to enter text.

Policy No: Click here to enter text.

Check list

☐ Business card of Administrative assistant given to the patient

☐ Referral information/brochure given to the patient

EXHIBIT 5 LOW VISION DEVICE DISPENSING FORM

KETCHUM HEALTH
University Eye Center

Low Vision Device Dispensing Form

Dispense Appointment Date: _____

Glasses Analyzed ☐ Yes

Patient Name: _____

MR#: _____

	Item(s) Dispensed
1	
2	
3	
4	
5	
6	

I acknowledge that I have received the above devices.

Patient Signature: _____

Date: _____

Return to Connie Phung after dispense.

KH1092-0919

EXHIBIT 6 LOW VISION ORDER FORM

Low Vision Order Form

KETCHUM HEALTH
University Eye Center

Date: _____

Patient Name: _____ MR#: _____ Phone Number: _____

Clinician Name: _____ Faculty: Yoshinaga / Lin / Shakhri

Payment Method: Self-Pay / DOR / VSP

Office Use Only	Glasses	
Price	Type	SVN / SVD / Bifocal / PALs / Computer / Sunglasses / Plano
Date ordered	Frames Name	Eye Size / /
Sent to lab	Lens Material	Color
Received	AR Coating	PD /
Tint sample included ☐	Add-ons	Seg Ht /
	Notes	

Office Use Only	Glasses	
Price	Type	SVN / SVD / Bifocal / PALs / Computer / Sunglasses / Plano
Date ordered	Frames Name	Eye Size / /
Sent to lab	Lens Material	Color
Received	AR Coating	PD /
Tint sample included ☐	Add-ons	Seg Ht /
	Notes	

Office Use Only	Telescopes	
Price	Manufacturer	
Date ordered	Description	
Order #	Item #	
Received	Notes	

Office Use Only	Magnifiers	
Price	Manufacturer	
Date ordered	Description	
Order #	Item #	
Received	Notes	

Office Use Only	Other	
Price	Manufacturer	
Date ordered	Description	
Order #	Item #	
Received	Notes	

☐ No dispensing appointment necessary
☐ Shipping Fee *($15.00)*
Shipping Address:

Shipping *optional*	
Total	
Balance Due	

Flow Chart *Office Use Only*		
	Submitted to Ins.	Auth Received/Notified
	Follow up tests	
	Additional Notes	

KH1091-0819

EXHIBIT 7 LOW VISION REFERRAL FORM

KETCHUM HEALTH
University Eye Center

General Referral / Consultation Form

☐ **University Eye Center at Ketchum Health Anaheim**
5460 E. La Palma Ave. | Anaheim, CA 92807
P 714.463.7500 | F 714.992.7811 | ketchumhealth.org

☐ **University Eye Center at Ketchum Health Los Angeles**
3916 S. Broadway | Los Angeles, CA 90037
P 323.234.9137 | F 323.235.6203 | ketchumhealth.org

Patient Name: _____ **DOB:** _____

Address: _____

Phone Number: _____

To assist in caring for your patients, please provide current clinical notes or patient record. This will allow us to avoid repeating services.

Diagnosis / Reason for Referral: _____

_____

Pertinent Clinical Findings: _____

_____

Did you perform a comprehensive eye examination?

☐ Yes ☐ No Date of last eye exam: _____ Date of last dilation: _____

Please choose the appropriate evaluation, program, and / or testing required from the list below:

☐ Binocular Vision Evaluation: Vision Therapy / Strabismus / Amblyopia	☐ Pachymetry	☐ Dry Eye
☐ Corneal Topography	☐ Specialty Contact Lens Fitting	☐ Electrodiagnostics
☐ Low Vision Evaluation	☐ Threshold Visual Fields	☐ Myopia Control
☐ OCT (Anterior / Posterior Segment)	☐ Other (please list): _____	☐ Prosthetic Fit
		☐ Sports Vision Evaluation

May we contact the patient for an appointment? ☐ Yes ☐ No

Patient referred for: ☐ Consultation ☐ Special testing ☐ Transfer of care ☐ Evaluation and Treatment

Referring Physician: _____

Address: _____

Email: _____

Phone Number: _____ **Fax:** _____

Please email this form with any pertinent patient records to refer@ketchum.edu

Thank you for your referral. We look forward to working with you!

EXHIBIT 8 **LOW VISION VSP PRE-CERT FORM**

VSP Vision Care

LOW VISION VERIFICATION

Use this form to request low vision evaluation and aids. Refer to the Plans and Coverages section in the VSP® Manual on VSPOnline for requirements and limitations.

Doctor NPI 17201018765 1644593

Doctor Name Marshall B. Ketchum University

Address 5460 E. La Palma Ave.

City, State, Zip Anaheim, CA 92807

Phone (714) 463-7526

Fax (714) 992-7863

Office Staff Contact Name Connie Phung

Date of Service

Member ID (or last four of SSN)

Authorization Number

Patient Name

Patient Date of Birth

Member Name Same as above

Member Date of Birth Same as above

Member Address

REQUEST IS FOR ❑ Low Vision Evaluation – U&C fee for proposed evaluation $ ❑ Low Vision Aids

PATIENT'S DIAGNOSES

Indicate the patient's low vision diagnosis.

DIAGNOSIS CODE 1. H54. 2. H54. 3. H54.

4. 5. 6.

BEST CORRECTED VISUAL ACUITY

RIGHT: Dist / Near / LEFT: Dist / Near /

COMPLETE THIS SECTION FOR LOW VISION AIDS PROPOSED

(Catalog price sheets or invoices required for each aid to support the wholesale cost listed.)

Low Vision Aid	Model #	Mon/ Bin	Visual Acuity	Patient Use of Aid	Wholesale Cost	Doctor's U&C
		M B				
		M B				
		M B				
		M B				
		M B				
		M B				

Please fax this form to **916.851.4733** or mail to VSP, PO Box 385020, Birmingham, AL 35238-5020.

IMPORTANT: Forms received with missing or incomplete information won't be processed.

EXHIBIT 9 LOW VISION D.O.R. INVOICE

Marshall B.
KETCHUM UNIVERSITY

Walls Low Vision Center
Patrick D. Yoshinaga,
O.D., M.P.H., FAAO,
Dipl.
Chief Assistant
Professor
714.463.7585
FAX 714.992.7863
pyoshinaga@ketchum.e

Connie Phung
Administrative Assistant
714.463.7526
FAX 714.992.7863
cphung@ketchum.edu

INVOICE

Service date:

Invoice date:

Department of Rehabilitation
BFS 4th Floor
721 Capitol Mall
Sacramento, CA 95814

Counselor's Name:
RE:
File No:

To Whom It May Concern:

Low Vision Services:

Total:

Signed: Patrick Yoshinaga/
Patrick Yoshinaga, O.D., FAAO
Chief, Low Vision Rehabilitation Service

Tax ID #: 95-1644593
PDY: RH

EXHIBIT 10 LOW VISION D.O.R. 359 FORM

STATE OF CALIFORNIA
MEDICAL DEVICE RECOMMENDATION
DR 359 (Rev. 08/14)

DEPARTMENT OF REHABILITATION

Page 1 of 2

Provider Name: Marshall B. Ketchum University	Consumer / Patient Name:
Provider Address: 5460 E. La Palma Ave. Anaheim, CA 92807	Counselor Name, Division (☐ VRED or ■ BFS), Mailing Address:
Provider Phone Number: 714-463-7526	Counselor Phone Number:
Provider Email: cphung@ketchum.edu	Date:

Instructions to Provider:

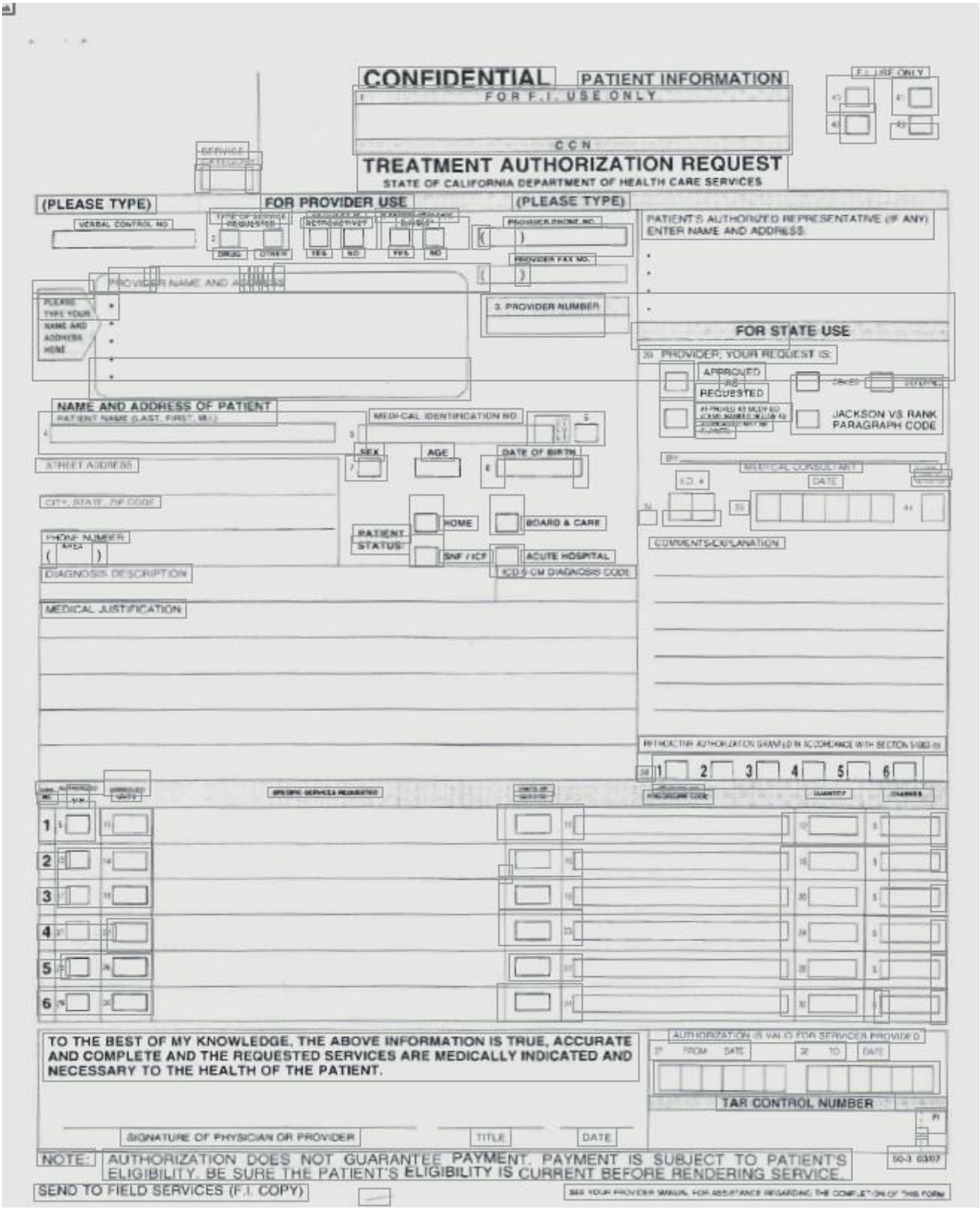
Completion of this form is mandatory. In order to provide medical equipment, attachments, and custom features for your patient, please fill out this form in detail, including the medical necessity of each aspect of the medical device/service prescribed for your patient. Failure to fill out this form completely could result in the consumer/patient not receiving all necessary medical devices or services promptly. This form is not a substitute for a completed narrative report. Use additional sheets if necessary. (Maintenance Authorized by California Code of Regulations, Title 9, section 7140.5.)

Procedure Code	Description of Recommended Device	Wholesale Cost	Tax[1]	Shipping and handling[2]	Rate to DOR
Total					

Justification/Special Circumstances:

[1] List an estimate for taxes calculated by multiplying the listed wholesale cost by the provider's local tax percentage; the actual tax will be reimbursed based on the wholesale cost sheet submitted with the invoice.
[2] List an estimate for shipping and handling, the actual shipping and handling will be reimbursed based on the wholesale cost sheet submitted with the invoice.

EXHIBIT 11 LOW VISION TREATMENT AUTHORIZATION REQUEST-CTLS



CONFIDENTIAL PATIENT INFORMATION
FOR F.I. USE ONLY
CCN
TREATMENT AUTHORIZATION REQUEST
STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
(PLEASE TYPE) FOR PROVIDER USE (PLEASE TYPE)
VERBAL CONTROL NO.
PROVIDER PHONE NO.
PROVIDER FAX NO.
PROVIDER NAME AND ADDRESS
PLEASE TYPE YOUR NAME AND ADDRESS HERE
3. PROVIDER NUMBER
PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS
FOR STATE USE
20. PROVIDER, YOUR REQUEST IS:
APPROVED AS REQUESTED
DENIED
DEFERRED
JACKSON VS RANK PARAGRAPH CODE
NAME AND ADDRESS OF PATIENT
PATIENT NAME (LAST, FIRST, MI.)
MEDICAL IDENTIFICATION NO.
SEX
AGE
DATE OF BIRTH
STREET ADDRESS
CITY, STATE, ZIP CODE
PHONE NUMBER
PATIENT STATUS:
HOME
BOARD & CARE
SNF / ICF
ACUTE HOSPITAL
ICD-9-CM DIAGNOSIS CODE
DIAGNOSIS DESCRIPTION
MEDICAL JUSTIFICATION
MEDICAL CONSULTANT
DATE
COMMENTS/EXPLANATION
RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (b)
1 2 3 4 5 6
SPECIFIC SERVICES REQUESTED
PROCEDURE CODE
QUANTITY
CHARGES
TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.
AUTHORIZATION IS VALID FOR SERVICES PROVIDED
FROM DATE
TO DATE
TAR CONTROL NUMBER
SIGNATURE OF PHYSICIAN OR PROVIDER
TITLE
DATE
NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.
SEND TO FIELD SERVICES (F.I. COPY)
SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM

EXHIBIT 12 LOW VISION D.O.R. INVOICE TEMPLATE

DEPARTMENT of REHABILITATION
Employment, Independence & Equality
Requesting DISTRICT or BRANCH Address

Edmund G. Brown, Jr., Governor
State of California

DATE: Wednesday, July 28, 2021

PRE-DETERMINATION VISION REQUEST

TO: Dr. Harter
C/O Medical Services

FROM: Connie Phung
PH # (714) 463-7526

I am requesting your approval for the following: Please see below.

Counselor: _____
NAME: _____

VENDOR: SCCO Low Vision
PHONE # (714) 463-7526

The following visual aids, with the approval of the counselor in the district office and upon dispensing, can be billed and will be reimbursed at the following level:

	DESCRIPTION	VCode	BILLED	Wholesale	DOR ALLOWANCE
1					
2					
3					
4					
5					

*NOTE these aids are unlisted and subject to fee adjustment by the Statewide Vision Consultant.

The above determination will be honored by the Dept of Rehab with the following stiplations:

1 This document (Vision Consultant Review) must be attached to final billing.
2 The district counselor approves the above-mentioned aid(s).
3 The rendered aid(s) are as per the request.
4 A final report with lab invoices is attached to the billing

Sincerely,

Todd J. Harter, O.D.
Statewide Optometric Consultant

EXHIBIT 13 OPHTHALMOLOGY CONSULTATION-SPECIAL TEST/ CHRONIC CARE SERVICE

Referral Criteria for Primary Angle Closure Suspect*

1. History of intermittent eye pain, headaches, blurry vision in association with a gonioscopic narrow angle.

   ☐ Yes ☐ No

2. History of PDR, RVO, OIS, previous Laser Tx (anterior segment).

   ☐ Yes ☐ No

3. Gonioscopic classification: Table I (Please use table below for referral purposes)

Table 1. Classification of various types of angle closure

	Iridotrabecular contact (≥ 180°)	Elevated IOP	PAS	Glaucomatous optic neuropathy
PACS	Present	Absent	Absent	Absent
PAC	Present	At least 1 present		Absent
PACG	Present	At least 1 present		Present

ICP, intraocular pressure; PAC, primary angle closure; PACG, primary angle closure glaucoma; PACS, primary angle closure suspect; PAS, peripheral anterior synechiae

EXHIBIT 14 FLUORESCEIN ANGIOGRAM (FANG) INFORMED CONSENT-ENGLISH

Name_____ Date_____

The purpose of this special test is to give your doctor valuable information regarding your eyes. This test allows us to study the layers of tissue, the blood vessel circulation and any abnormalities that may be present.

To begin the fluorescein dye study, your eyes must be dilated with eye drops. These drops may cause increased light sensitivity and slight blurring of your vision.

Essentially the test consists of first taking several photographs of your retinas. The next step is an injection of a small amount of dye into a vein and more photographs are taken over a 10 to 20 minute period, depending on the information needed. There are no X-rays used in any of these photographs. The dye used contains no Iodine, is water-soluble, and mixes very well with the blood. Severe side reactions from the eye are very rare. Minor changes resulting from the dye might include slight discoloration of the urine and skin. Your skin and urine may take on a yellow cast. The discoloration is perfectly normal and should disappear within thirty-six hours.
There are no special precautions that need to be taken prior to this test, but we suggest that it be done while you have a fairly empty but not completely empty stomach. This will help avoid the chance of temporary nausea that might occur. Do not alter your current medication schedule. After testing is over, you may resume your normal activity, meal and medication schedule. Sunglasses may be worn if light sensitivity causes discomfort.

I hereby authorize Dr. _____and/or such assistants that may be designated by him/her to perform a Fluorescein Angiogram upon myself. I understand the above read procedure is necessary to diagnose my condition.
(*Female patients only)* I also declare that I am not pregnant nor have reason to believe I may be pregnant.

_____ _____

Signature of Patient
(Parent/Guardian or Legal Representative)

Signature of Witness

EXHIBIT 15 FLUORESCEIN ANGIOGRAM (FANG) INFORMED CONSENT – SPANISH

Nombre _____ **Fecha** _____

El presente examen especializado tiene como propósito suministrarle a su Doctor, información acerca de sus ojos. Este examen nos permite estudiar las capas de tejido, así como también la circulación de los vasos sanguíneos, y cualquier otra anormalidad que pueda existir.
Para realizar este examen, sus ojos deben ser dilatados con gotas. Dichas gotas pueden causarle un aumento de sensibilidad a la luz, y una ligera sensación de visión borrosa.
Inicialmente, se tomarán varias fotografías de sus retinas. Posteriormente, se le inyectará un medio de contraste (tinte) en una vena y se le tomarán más fotografías por un periodo de 10 a 20 minutos, dependiendo de la información requerida. Estas fotografías no involucran el uso de Rayos X. El medio de contraste no contiene Yodo, es soluble en agua y se mezcla sin complicaciones con la sangre.

Efectos secundarios en los ojos son poco comunes. Cambios menores a consecuencia del medio de contraste pueden consistir en una ligera decoloración de la orina y la piel, los cuales pueden tornarse amarillos. Esta decoloración es normal y debe desaparecer dentro de las siguientes treinta y seis horas.
No existen precauciones adicionales para llevar a cabo el examen; le sugerimos que coma algo ligero antes del examen. Esto le ayudara a evitar la sensación de nausea que se pueda presentar. Siga tomando sus medicinas normalmente. Después de que hayamos terminado con el examen, puede
continuar con sus actividades normalmente. Puede usar gafas oscuras si presenta sensibilidad a la luz.

Yo autorizo al Dr._____ y a su(s) asistente(s) para que lleven a cabo el Angiograma de Florescencia. Entiendo que el procedimiento explicado arriba es necesario para diagnosticar mi condición médica.

(**Solo pacientes femeninos**) Declaro que no estoy embarazada y que no tengo razones para creer que lo estaré.

_____ _____

Firma del Paciente Testigo
(Padre/Guardian o Representante Legal)

EXHIBIT 16 OPHTHALMOLOGY CONSULTATION FORM

Name: _____

File#:_____

M / F DOB:_____Age:_____Date:_____

Race: □ W □ B □ His □ Asian

Referring Dr._____
_____
_____

OPHTHALMOLOGY CONSULTATION SERVICE

CC / HPI: _____

_____

_____

ROS

Y N		Y N		Y N		Y N	
☐ ☐	Weight Loss, Fever	☐ ☐	Asthma	☐ ☐	Stroke	☐ ☐	Diabetes Mellitus
☐ ☐	Diplopia	☐ ☐	COPD	☐ ☐	Seizures	☐ ☐	Thyroid disease

**Reviewed / No change since visit on: ___/___/_____ Initials:_____

PMHx: _____ POHx: _____

_____ _____

_____ _____

Key Elements of CC/HPI/PMHx/POHx verified on: ___/___/____ by (initials): _____

Allergies: NKDA / NKA or: _____

Systemic Medications			Ocular Medications			
Name	Dosage	Frequency	Name	Dosage	Eye	Last Admin

SHx: Y N

☐ ☐ Illicit Drugs _____ ☐ ☐ Occupational Exposure _____

☐ ☐ Alcohol _____ ☐ ☐ _____

☐ ☐ Tobacco _____ ☐ ☐ _____

FMHx:

Y N		Y N		Y N		Y N	
☐ ☐	Diabetes	☐ ☐	Asthma	☐ ☐	Stroke	☐ ☐	_____
☐ ☐	Hypertension	☐ ☐	COPD	☐ ☐	Seizures	☐ ☐	_____
☐ ☐	Cardiovascular disease	☐ ☐	Kidney Disease	☐ ☐	Multiple Sclerosis	☐ ☐	_____

☐ ☐ Sinusitis ☐ ☐ Kidney Stones ☐ ☐ Sickle cell disease ☐ ☐ _____

☐ ☐ Thyroid disease ☐ ☐ Cancer ☐ ☐ Bleeding Disorders ☐ ☐ _____

Neuro/Psych: ☐ Oriented to time/place/person ☐ Normal Mood & Affect

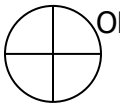
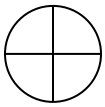
Objective:

V_A (sc or cc) @ D < (SN / FB)

V_A (sc or cc) @ N < (RS / Text)

HabSRx:_____ Add:_____Type: FT Tri PAL

_____

CVF: OS  OD  PE__ R__ RL ____ A ____ APD _____

EOMS: FROM or H Δ H

Alignment: ortho or _____ Method:_____

SLE

OD **OS**

Cl _____ Adnexa _____ Cl

Cl _____ Lids / Lashes_____ Cl

Cl _____ Conj _____ Cl

W/Q _____ Sclera _____ W/Q

CL **or** see diagram Cornea see diagram **or** Cl

D/Q _____ A/C _____ D/Q

Fl/Cl _____ Iris _____ Fl/Cl

CL **or** see diagram Lens see diagram **or** Cl

IOP: OD _____ @ _____ GAT ☐ NCT ☐ TONO ☐

OS _____

BP: RAS / LAS: _____ mmHg

Time:

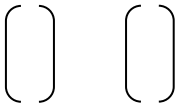
Informed Consent DPAs ☐

Ed S/E DPAs ☐

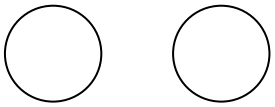
Dilation: $T_{1\%}$ $P_{2.5\%}$ $C_{1\%}$

OD

OS Time:_____



OD Lens OS

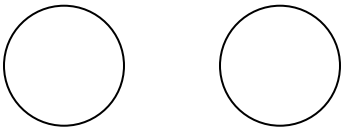


OD Cornea OS

3 or 4 MR

*Anterior Segment Evaluated/Verified on:___/___/___ by: (Initials)_____

Posterior Pole: Undilated or Dilated □ 90D □ 78D □ 20D □ Optos



OD ONH OS

OD **OS**

Cl _____ Vitreous _____ Cl

Dist Optic Disk _____Dist

_____H/____V C/D ____H/____V

Pink/Fl Rim Pink/Fl

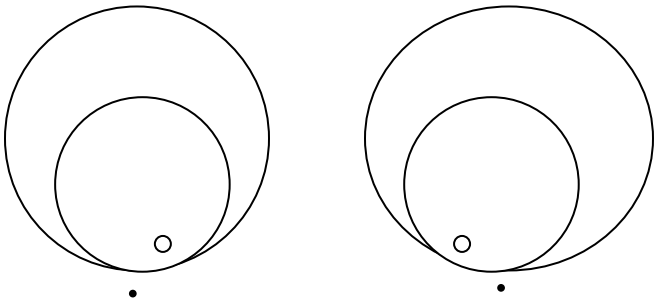
Pink/Fl _____ Macula Pink/Fl

+ or ϕ FR + or ϕ

0.7 0.6 0.5 ____ A/V ____ 0.5 0.6 0.7

+ or ϕ SVP + or ϕ

_____ Periphery_____



OD Fundus OS

Posterior Segment

Evaluated/Verified on:___/___/___ by: (Initials)

Assessment: Plan:

Education:

☐ Importance of F/U ☐ Instructions & S/E Eye Meds

☐ Symptoms of RD ☐ R & B Tx Plan Discussed Fully

☐ Amsler Grid Application ☐ W/C Comp., Lid Scrubs

☐ Vitamins ☐ Artificial Tears

☐ RTC Sx R/S/V/P ☐ Business Card Given w/ 24-hr Contact #

Next Appointment

Date:_____

Time:_____

Location:_____

Intern:_____Physician:(Signed & Printed)_____

Faculty:(Signed & Printed)_____

EXHIBIT 17 LASER TREATMENT /SURGICAL PROCEDURES INFORMED CONSENT – ENGLISH

Patient Name_____Date_____

1. I hereby authorize Dr. _____ and whomever he/she may designate as his/her assistants to perform the following procedure(s):_____ and if any unforeseen condition arises in the course of the procedure calling in his/her judgment for procedures in addition to or different from those now contemplated. I further request and authorize him/her to do whatever he/she deems medically advisable.
2. The following have been fully explained to me: the nature of my condition, the purpose of the procedure, possible alternative methods of treatment, the risks and complications, the probability that the purposed treatment will be successful and the prospect of recovery of no treatment is received. No guarantee or assurance has been made to me as to the results that may be expected.
3. I have had an opportunity to discuss the procedure with the doctor or doctors involved and I have been given an opportunity to ask questions and my questions have been answered.
4. I consent to the taking and publication of any photographs in the course of this procedure for the purpose of advancing medical education.
5. For the purpose of advancing medical education, I also consent to the admittance of observers to the treatment room.
6. I have read and understand this form.

Signature of patient_____
(Parent/Guardian or Legal Representative)

Signature of Witness_____

EXHIBIT 18 LASER TREATMENT /SURGICAL PROCEDURES INFORMED CONSENT - SPANISH

Nombre del Paciente_____ Fecha_____

1. Yo autorizo expresamente al Dr. _____ y a quien el/ella designe como su(s) asistentes, para llevar a cabo los siguiente procedimientos quirúrgicos:_____; de igual manera lo(a) autorizo para practicar otros procedimientos en uso de su criterio profesional, en caso de que algún evento inesperado surja durante la cirugía. Yo autorizo al Dr. a realizar cualquier procedimiento que considere médicamente aconsejable.
2. Me han explicado a satisfacción los siguientes puntos: la naturaleza de mi condición medica, el propósito de la cirugía, métodos alternativos de tratamiento, riesgos y complicaciones que se puedan presenter, la posibilidades de éxito después de la cirugía o las consecuencias de no recibir el tratamiento. El grupo medico no garantiza un resultado especifico después del procedimiento.
3. He tenido la oportunidad de discutir el procedimiento con el grupo medico y he podido formular preguntas acerca del mismo, las cuales han sido respondidas a satisfacción.

4. Autorizo para que las fotografÍas tomadas en el curso de la cirugia sean publicadas con fines educativos.
5. Autorizo a terceras personas (observadores) para que presencien el procedimiento quirúrgico con fines educativos.
6. He leÍdo y entiendo satisfactoriamente este documento.

Firma del Paciente_____

(Padre/Guardian o Representante Legal)
Testigo_____

EXHIBIT 19 LASER OPERATIVE REPORT

Patient Name _____ Date _____

DIAGNOSIS:
- ☐ Proliferative Diabetic Retinopathy
- ☐ Clinically Significant Diabetic Retinopathy
- ☐ Subretinal Neovascularization
- ☐ Macular Degeneration
- ☐ Branch Retinal Vein Occlusion
- ☐ Central Retinal Vein Occlusion
- ☐ Other: _____

PROCEDURE: YAG RIGHT LEFT EYE
LASER PHOTOCOAGULATION RIGHT LEFT EYE
☐ Argon Green ☐ Krypton

ANESTHESIA: ☐ Topical ☐ Retrobulbar

SPOT SIZE (mc): _____ **POWER (mw):** _____
DURATION: _____ **# OF LESIONS:** _____
COMPLICATIONS: _____

REMARKS: _____

*Attending Physician*_____

EXHIBIT 20 DIAGNOSTIC SURVEY-OCULAR DISEASE

This is a **confidential** survey. Please respond to all questions by circling the proper answer.

Patient Name: _____
Address: _____

Telephone #: (_____) _____

Referring Physician: _____
Physician's Address: _____

Physician's Telephone #: (_____) _____

FAMILY HISTORY

These questions refer to your grandparents, parents, aunts, uncles, brothers and sisters, children or grandchildren.

Has anyone in **your family** had:

Cancer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Allergies	☐ Yes	☐ No
Arthritis or rheumatism	☐ Yes	☐ No
Syphilis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Sickle cell disease or trait	☐ Yes	☐ No
Lyme disease	☐ Yes	☐ No
Gout	☐ Yes	☐ No

Has anyone in **your family** had medical problems of the:

Eyes	☐ Yes	☐ No
Skin	☐ Yes	☐ No
Kidneys	☐ Yes	☐ No
Lungs	☐ Yes	☐ No
Stomach or bowel	☐ Yes	☐ No
Nervous system or brain	☐ Yes	☐ No

SOCIAL HISTORY

Age (Years): _____ Current job: _____

Have you lived outside the U.S.A.?	☐ Yes	☐ No
If yes, where? _____		
Have you every owned a dog?	☐ Yes	☐ No
Have you ever owned a cat?	☐ Yes	☐ No
Have you ever eaten raw meat or uncooked sausage?	☐ Yes	☐ No
Have you ever drank unpasteurized milk?	☐ Yes	☐ No
Have you ever been exposed to sick animals?	☐ Yes	☐ No
Do you drink untreated stream, well or lake water?	☐ Yes	☐ No
Do you smoke cigarettes?	☐ Yes	☐ No
Have you ever used intravenous drugs?	☐ Yes	☐ No
Have you ever had a bisexual or homosexual relationship?	☐ Yes	☐ No
Have you ever taken birth control pills?	☐ Yes	☐ No

PERSONAL MEDICAL HISTORY

Are you allergic to any medications? ☐ Yes ☐ No

If yes, which medications _____

Please list the **medications** that you are currently taking, including non-prescription drugs such as aspirin, Advil, antihistamines, etc.

_____

_____

PAST MEDICAL HISTORY

Please list all **eye** operations you have had (including laser surgery), and the dates of the surgeries.

_____

_____

Have **you** ever been told that you have the following conditions?

Anemia (low blood counts)	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Pleurisy	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Herpes (cold sores)	☐ Yes	☐ No
Chicken Pox	☐ Yes	☐ No
Shingles (Zoster)	☐ Yes	☐ No
German Measles (Rubella)	☐ Yes	☐ No
Measles (Rubeola)	☐ Yes	☐ No
Mumps	☐ Yes	☐ No
Chlamydia or Trachoma	☐ Yes	☐ No
Syphilis	☐ Yes	☐ No
Gonorrhea	☐ Yes	☐ No
Any other sexually transmitted disease	☐ Yes	☐ No
Tuberculosis (TB)	☐ Yes	☐ No
Leprosy	☐ Yes	☐ No
Leptospirosis	☐ Yes	☐ No
Lyme Disease	☐ Yes	☐ No
Histoplasmosis	☐ Yes	☐ No
Candida or Moniliasis	☐ Yes	☐ No
Coccidiomycosis	☐ Yes	☐ No
Sporotrichosis	☐ Yes	☐ No
Toxoplasmosis	☐ Yes	☐ No
Toxocariasis	☐ Yes	☐ No
Cysticercosis	☐ Yes	☐ No
Trichinosis	☐ Yes	☐ No

Whipple's Disease	☐ Yes	☐ No
AIDS	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No
Allergies	☐ Yes	☐ No
Vasculitis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Rheumatoid Arthritis	☐ Yes	☐ No
Lupus (Systemic Lupus Erythematosus)	☐ Yes	☐ No
Scleroderma	☐ Yes	☐ No

Have **you** ever had any of the following illnesses?

Reiter's Syndrome	☐ Yes	☐ No
Colitis	☐ Yes	☐ No
Crohn's Disease	☐ Yes	☐ No
Ulcerative Colitis	☐ Yes	☐ No
Behcet's Disease	☐ Yes	☐ No
Sarcoidosis	☐ Yes	☐ No
Ankylosing Spondylitis	☐ Yes	☐ No
Erythema Nodosa	☐ Yes	☐ No
Temporal Arteritis	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No
Serpiginous Choroidopathy	☐ Yes	☐ No
Fuchs' Heterochoromic Ididocyclitis	☐ Yes	☐ No
Vogt-Koyanagi-Harada Syndrome	☐ Yes	☐ No

Have **you** ever had any of the following symptoms?

GENERAL HEALTH

Chills	☐ Yes	☐ No
Fevers (persistent or recurrent)	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Fatigue (tire easily)	☐ Yes	☐ No
Poor appetite	☐ Yes	☐ No
Unexplained weight loss	☐ Yes	☐ No
Do you feel sick?	☐ Yes	☐ No

HEAD

Frequent or severe headaches	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
Numbness or tingling in your body	☐ Yes	☐ No
Paralysis in parts of your body	☐ Yes	☐ No
Seizures or convulsions	☐ Yes	☐ No

EARS

Hard of hearing or deafness	☐ Yes	☐ No
Ringing or noises in your ears	☐ Yes	☐ No
Frequent or severe ear infections	☐ Yes	☐ No
Painful or swollen ear lobes	☐ Yes	☐ No

NOSE AND THROAT

Sores in your nose or mouth	☐ Yes	☐ No
Severe or recurrent nosebleeds	☐ Yes	☐ No
Frequent sneezing	☐ Yes	☐ No
Sinus trouble	☐ Yes	☐ No
Persistent hoarseness	☐ Yes	☐ No
Tooth or gum infections	☐ Yes	☐ No

SKIN

Rashes	☐ Yes	☐ No
Skin sores	☐ Yes	☐ No
Sunburn easily (photosensitivity)	☐ Yes	☐ No
White patches of skin or hair	☐ Yes	☐ No
Loss of hair	☐ Yes	☐ No
Tick or insect bites	☐ Yes	☐ No
Painfully cold fingers	☐ Yes	☐ No
Severe itching	☐ Yes	☐ No

RESPIRATORY

Severe or frequent colds	☐ Yes	☐ No
Constant coughing	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No
Recent flu or viral infection	☐ Yes	☐ No
Wheezing or asthma attacks	☐ Yes	☐ No
Difficulty breathing	☐ Yes	☐ No

Have **you** ever had any one of the following symptoms:

CARDIOVASCULAR

Chest pain	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Swelling of your legs	☐ Yes	☐ No

BLOOD

Frequent or easy bruising	☐ Yes	☐ No
Frequent or easy bleeding	☐ Yes	☐ No
Have you received blood transfusions	☐ Yes	☐ No

GASTROINTESTINAL

Trouble swallowing	☐ Yes	☐ No

Diarrhea	☐ Yes	☐ No
Bloody stools	☐ Yes	☐ No
Stomach ulcers	☐ Yes	☐ No
Jaundice or yellow skin	☐ Yes	☐ No

BONES AND JOINTS

Stiff joints	☐ Yes	☐ No
Painful or swollen joints	☐ Yes	☐ No
Stiff lower back	☐ Yes	☐ No
Back pain while sleeping or awakening	☐ Yes	☐ No
Muscle aches	☐ Yes	☐ No

GENITOURINARY

Kidney problems	☐ Yes	☐ No
Bladder trouble	☐ Yes	☐ No
Blood in your urine	☐ Yes	☐ No
Urinary discharge	☐ Yes	☐ No
Genital sores or ulcers	☐ Yes	☐ No
Prostatitis	☐ Yes	☐ No
Testicular pain	☐ Yes	☐ No

Are you pregnant?	☐ Yes	☐ No
Do you plan to be pregnant in the future?	☐ Yes	☐ No

EXHIBIT 21 PATIENT COMPLIANCE-GLAUCOMA

You have an unusual disease called primary open-angle glaucoma. While we have attempted to explain glaucoma, it is a very complex disease. You don't feel anything and you can still see straight ahead. So why are we treating you with these expensive medications that sometimes burn when you put them in? We are treating you because glaucoma is an especially dangerous disease. You don't feel it, you don't see it slowly eating away your vision but it is the number one cause of blindness in blacks and the number five cause of blindness in whites. Even with the treatment that we have chosen, the disease may not be well controlled and we may have to change therapy. That is why we see you on a regular basis.

We have also taught you how to put in the medications, but this is a reminder.

Medication_____ Cap Color_____Use_____Times/Day
Medication_____Cap Color_____ Use _____Times/Day
Medication_____Use_____

For Drops:

- If you can't feel the drop when you put it in, you may want to refrigerate it 5 minutes before instillation.
- If you can't "hit" your eye, pull your lower lid out to create a pouch while you are looking up. Squeeze one drop into the pouch and repeat the process on the other eye.

- After both drops are “in the pouch” look down and gently pinch the area between your eyes and your nose for 1 minute. This will prevent the drops from washing out too fast.

For Ointments:

Most instructions indicate that you must squeeze a line of the ointment into a pouch in the lower lid. This only results in missing the lid and using too much ointment.

- Instead, first wash your hands.
- Squeeze out about 1/4 inch of ointment onto your index finger opposite the eye in which you want the ointment.
- With your other hand create a pouch in your lower lid while looking up.
- Place the ointment into the pouch.
- Repeat in the other eye.
- You won’t be able to see very well so take a nap or go to sleep for the night. **You are scheduled to return in _____ months.** Call me if you have a problem before then. Don’t forget – we want you to continue to see your children, grandchildren, great grandchildren and the beauty in our world.

EXHIBIT 22 ABN-OFFICE VISITS

(A) Notifier: Eye Care Center, 2575 Yorba Linda Blvd, Fullerton CA 92831, 714.449.4401
(B) Patient Name: **(C) Identification Number:**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Med-Cal doesn’t pay for ***(D)*** **office visit** below, you may have to pay.

Medi-Cal does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medi-Cal may not pay for the ***(D)*** _____ below.

(D)	***(E)*** **Reason Medi-Cal May Not Pay:**	***(F)*** **Estimated Cost:**
Office visit (CPT 99211)	Medi-Cal does not pay for this test for your condition.	No more than $50

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the ***(D)*** office visit listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) **OPTIONS:** **Check only one box. We cannot choose a box for you.**

❑ **OPTION 1.** I want the ***(D)*** **office visit** listed above. You may ask to be paid now, but I also want Medi-Cal billed for an official decision on payment, which is sent to me on a Medi-Cal Summary Notice (MSN). I understand that if Medi-Cal doesn’t pay, I am responsible for payment, but **I can appeal to Medi-Cal** by following the directions on the MSN. If Medi-Cal does pay, you will refund any payments I made to you, less co-pays or deductibles.

❑ **OPTION 2.** I want the ***(D)*** **office visit** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medi-Cal is not billed.**

❑ **OPTION 3.** I don’t want the ***(D)*** **office visit** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medi-Cal would pay.**

(H) **Additional Information:**

This notice gives our opinion, not an official Medi-Cal decision. If you have other questions on this notice or Medi-Cal billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

(I) **Signature:**	***(J)*** **Date: 04/12/2017**

Form CMS-R-131 (03/08) Form Approved OMB No. 0938-0566

EXHIBIT 23 RE-SCHEDULE FORM FOR DISCONTINUED EXAM

Return this form to Patient Relations and inform patient someone will call them to reschedule their appointment.
Date: _____
Intern's Name /Class Year: _____
Service Area Name: _____
Patient's Name: _____
Medical Record #: _____
Patient's Telephone #: _____
Patient's Alternate Phone #: _____
Best Time To Reach Patient: _____
Preferred Day And Time To Continue Exam:

EXHIBIT 24 MEDICARE BILLING-AUDIT & QUALITY ASSURANCE

Intern Name _____ Date_____

Patient Record # _____ Exam Date _____

Clinician Reviewed _____ Faculty Reviewed _____

Type of Visit: ☐PC Comp ☐ CL Comp ☐ Peds Comp ☐ Other_____

History	Yes	NI	No	NA	Comments
Clinician name completed?	☐	☐	☐	☐	
Is the Chief complaint identified with associated HPI?	☐	☐	☐	☐	
Were all elements of the ocular and medical history properly documented?	☐	☐	☐	☐	
Medications and Allergies documented?	☐	☐	☐	☐	

Examination	Yes	NI	No	NA	Comments
Were monocular VA's taken (DVA and NVA)?	☐	☐	☐	☐	
Were pupils, stereo, EOMs, screening VF performed?	☐	☐	☐	☐	
Was a binocular vision test performed? Ranges when necessary?	☐	☐	☐	☐	
Was an accommodative test performed?	☐	☐	☐	☐	
Refraction with VA's or cyclo/damp retinoscopy performed?	☐	☐	☐	☐	
IOPs recorded?	☐	☐	☐	☐	
Biomicroscopy (External/adnexa, cornea, lens, ant chamber and angles)?	☐	☐	☐	☐	
Ophthalmoscopy (C/D, macula, retina, vascular, vitreous) documented?	☐	☐	☐	☐	
DPA's recorded or otherwise documented reason for not dilating?	☐	☐	☐	☐	
Contact lens Fit assessment and OR complete?	☐	☐	☐	☐	
Assessment/Plan	Yes	NI	No	NA	Comments
Was CC addressed in assessment?	☐	☐	☐	☐	
Assessment list complete (systemic issues addressed, all complaints addressed)?	☐	☐	☐	☐	
Decreased BVA addressed?	☐	☐	☐	☐	
Administrative	Yes	NI	No	NA	Comments
All assessments have a plan with clearly stated course of action?	☐	☐	☐	☐	

Was follow up care completed (appointment, referral, letter)?	☐	☐	☐	☐	
Fee sheet completed with primary diagnosis identified and correlates with chief complaint?	☐	☐	☐	☐	
VSP boxes checked?	☐	☐	☐	☐	
Medicare faculty notes completed?	☐	☐	☐	☐	
Interpretation reports completed?	☐	☐	☐	☐	
MU and PQRS components completed?	☐	☐	☐	☐	

Please describe any overall comments you may have regarding the chart. (Would you do anything differently? What documentation was outstanding versus could have been improved? Did you learn anything that will affect your future patient care?)

Patient Grievance Form

GENERAL INFORMATION

Complaint received by: _____

Date & Time of Complaint: _____

How complaint was initially made or delivered:

□ e-mail □ in person □ phone □ in writing □ via another person: e.g., KH Employee

Name of person **making the complaint**? _____

Relationship to the Patient? □ Self □ Other; if other, please state relationship: _____

Patient Name_____

Address and Phone number(s). _____

ABOUT THE COMPLAINT Service or Department involved_____

Staff involved [include name / job title]_____

SUMMARY OF PROBLEM OR REASON FOR COMPLAINT

_____

_____

_____

_____

_____

_____

_____

_____

FOR OFFICE USE ONLY

COMPLAINT TYPE

□Access to Care □ Quality of Care □ Facilities □ Personal Interaction with staff □ Other

Route to: _____

Follow up with Department Manager _____ Date _____

Follow up by: □ email □ Phone□ Letter □ In-Person

Describe action(s) taken by the authorized individual to resolve issue:

_____

_____

_____

_____

_____

Was issue resolved? □ Yes No

□ Complaint addressed. Not resolved to patient satisfaction

If not, state the reason(s) why:

_____

_____

_____

Final follow-up/action taken:

_____

Date: _____ Signed by: _____ Date_____

Title: _____

EXHIBIT 26 CONSENT TO TREAT MINOR PATIENT

CONSENT TO TREAT MINOR PATIENT

California Law requires the express consent of a parent or legal guardian for healthcare of individuals under eighteen (18) years of age who are not emancipated. If your dependent is a minor please complete and sign the form below before care is rendered.

Patient Information

Last Name _____ First Name_____ DOB_____

Address _____ City _____State_____ Zip_____

Parent/Legal Guardian Information

Name _____ Phone(s) _____

Address _____City _____ State _____ Zip_____

AUTHORIZATION

- I, the above named Parent or Legal Guardian, certify that the patient named above is currently a minor for which I am legally responsible.
- I authorize Ketchum Health to provide medical care to my legal dependent, including but not limited to, diagnostic examinations, diagnostic pharmaceutical medications (dilation, cyclopedia, etc), and any other medical treatment required.
- I understand that my dependent's medical records will be produced, used and/or disclosed following strict HIPAA privacy and security protocols, and that release of medical information from my dependent's appointment to third parties not permitted by law will require my express authorization.
- I understand that I am required to be present during the course of the appointment, and that I cannot leave Ketchum Health premises during this time.
- I do have the right to designate another adult to accompany my dependent minor, if I cannot be present. I understand that an authorization may be needed for this purpose.

By my signature, I acknowledge that I have read and understand this Consent, and that any questions I have prior to signing can be answered by calling Ketchum Health at (714) 463-7500

_____ _____ _____

Parent/Legal Guardian Name Parent/Legal Guardian Signature Date

---

Relationship to Patient

EXHIBIT 27 RISK ASSESSMENTS 2020 & 2021

Executive Summary

With the occurrence of the COVID-19 pandemic in 2020, Ketchum Health operations have been and continue to be significantly impacted, forcing the institution to adjust rapidly and decisively. Dealing with the crisis and its aftermath continues to be challenging, and it is reshaping priorities at MBKU. The "new normal" will inevitably bring changes to our business model, including how we educate our students, how we treat our patients, and how staff will work.

This Risk Assessment will depart from the usual format used in previous reports. The assessment will concentrate on the impending risks, threats, and vulnerabilities found to be the most pressing during the hybrid-working environment. It will also review the procedures and strategies needed to mitigate or cope with those events' potential occurrence.

The Assessment is not intended to amend previous versions. Its purpose, scope, and approach have been adjusted to reflect the current environment in which Ketchum Health is currently operating and will continue to operate for the near future.

Scope

The Risk Assessment report is intended to cover elements beyond the confidentiality, integrity, and availability of patient information. It evaluates several components of Ketchum Health businesses and its operational preparedness. Identifiably personal, non-public information is also considered in the analysis, as systems and users have the capabilities of storing an assortment of data, not only limited to patient information. Recommended privacy and security safeguards from this assessment will allow management to make decisions about protocols on security and privacy-related initiatives.

Process Approach

The risk assessment identifies and reviews some inherent risks in eight domains that can potentially affect Ketchum Health operations in multiple ways. The document will present critical and plausible risks as well as mitigating strategies and recommendations based on best practices embraced by industry leaders.
The assessment identified threats and vulnerabilities in the following domains:

1. Technology
2. Clinical & Patient Safety
3. Strategic
4. Financial
5. Human Capital
6. Legal and Regulatory
7. Operations
8. Hazard

Assessment Steps

The assessment was conducted as follows:

- **Review and identification** of threats and potential vulnerabilities in the remote ecosystem. This phase included interviews with system users; workflow analysis of business units; to the extent possible, inventory of hardware and peripheral devices given to users.
- **Customized Questionnaire**. A service-designed survey was submitted for review and response to all members of Ketchum Health Clinic Council.
- **Mitigation response**. After evaluating each threat/vulnerability, different options were considered to include the most effective response to avoid, minimize or neutralize the impact of the risk event.

Risk Assessment

<u>Risk Domains</u>

1. **Technology**.

Risks:

- Cybersecurity attacks due to an unexpected increase in telecommuting.
- Increased use of virtual private networks for telework also intensifies the chances of more vulnerabilities being found and targeted by malicious cyber actors.
- Exploiting the pandemic frenzy, hackers may increase phishing emails targeting teleworkers to steal their usernames and passwords.

- If availability of connection to VPNs is limited, critical business operations may suffer, including information technology security personnel's ability to perform cybersecurity tasks.
- Data governance challenges. Users not saving sensitive data at all or saving it on personal devices.
- Lack or weak network infrastructure to support remote operations, including increasing online learning needs (bandwidth, gateways, cloud operations).
- Bring Your Own Device- Increased use of personal devices lacking security protections, such as encryption by design or antivirus software.
- Frequent, unchecked use or downloading of free, commercial platforms to conduct meetings and to store and share sensitive, non-public information.
- Payments for services and products pose a high risk of contagion since there is an exchange of currency or debit/credit cards.

Recommendations:

a. Following Cal. Civ. Code § 1798.81.5 mandates, Ketchum Health must implement and maintain reasonable security procedures and practices appropriate to the nature of the information. Although "reasonable security procedures" are not defined in the law, we must customize our response accordingly.
b. Updating VPNs, network infrastructure devices, and devices being used to work in remote environments with the latest software patches and security configurations.
c. Implementing multi-factor authentication-MFA on all VPN connections to increase security. If MFA is not implemented, then require remote workers to use strong passwords.
d. Providing a list of measures to improve or enhance home security (g., secure router and unique user identification that are not shared with others in the household, changing the default password of the internet service provider).
e. Reiterating the importance of the "clean desk" policy, even when working from home.
f. Raising employee awareness to the increased risk of cyber-attacks including, specifically, phishing scams.
g. Issuing company devices, where possible, and avoiding the use of personal devices for remote work. Those users who have assigned work to complete at home should be provided laptops or other devices to perform their work. The Associate Dean of Clinics should evaluate these scenarios in conjunction with the Chiefs of Service to determine who needs such remote infrastructure, and it will approved on a role-based basis.
h. Distributing information security tools virtually (g., antivirus and antimalware software) and ensuring updates occur in a controlled manner.
i. Assessing risks of information storage and disposal, which will be most prevalent if paper files are being brought home or if the information is being stored locally or on portable devices.
j. Requiring employees to use only encrypted communications (g., no personal email even when the VPN is down).
k. Requiring authentication before receiving calls from helpdesks or otherwise to avoid pretexting/phishing.
l. Ensuring incident response plans are up to date (g., virtual workspace contact information for cyber incident response team members and backup contacts) and ensuring IT security personnel are prepared to ramp up the following remote access cybersecurity tasks: log review, attack detection, and incident response and recovery.
m. Research for viable contactless payment solutions and procure them if financially feasible. Point-of-sale terminals using RFID technology are the most used solution currently. We could also become Apple Pay,

Android Pay, and Google Wallet merchants. We should encourage patients to avoid paying cash for their services or items purchased and continuously explore alternatives to implement contactless payments at checkout stations.

n. Plan for the potential need to invest in Ethernet cables and ports in case Wi-Fi bandwidth is overwhelmed by a return to campus that still includes widespread online learning.
o. Accelerate digital transformation to serve new patients, students, and employee needs. This crisis saw rapid growth in the adoption of technological solutions. Successfully maintaining these solutions will require more employee training in the use of new tools that can raise their performance, as well as training in cybersecurity best practices.
p. Implement a digital signature solution, which will eliminate the need for wet signatures. The Director of Information Technology has launched this initiative already and adoption rate will be reviewed at the end of the first semester of 2021. (DocuSign)
q. Improve data-driven decision-making solutions and develop a clean data initiative. Time is ripe for developing and implementing a Ketchum Health digital strategy.
r. Rethink the portfolio of IT projects and technology spending. A revision of the budget is vital to address immediate network infrastructure needs.
s. Increase training campaigns for all MBKU employees to include cybersecurity and cloud technology. Several cybersecurity training campaigns were launched at the beginning of the pandemic with a satisfactory completion rate. At the start of December 2020, a new mandatory cybersecurity session was introduced to all Ketchum Health employees with a completion deadline of January 10, 2021.
t. The Director of Information Technology, in conjunction with the Director of Healthcare Policy Compliance and the Associate Dean of Clinics, should consider creating a “COVID-19 Resource Center” to document the new, but likely temporary, notices, policies, and procedures. We will collectively evaluate which efforts can be applicably scaled consistent with the severity of the current situation and then appropriately adjust those protocols when things return to a “normal” state.

2. Operational

Risks:

- Increase in COVID-19 cases at Ketchum Health locations. One of the most significant risks MBKU faces is the continuation of high COVID-19 infections in the area, which will force state or local authorities to issue/maintain a shelter-in-place order.
- Lack of standard/general set of protocols and proper enforcement.
- Unchecked maintenance crews.
- Mail/package delivery. Allowing deliveries of any kind without clear protocols on logistics increases the risks of infection.

Mitigation Responses

- Create a Business Continuity Plan (BCP). The most crucial element of our re-engagement strategy, the BCP is the roadmap that defines our ability to adapt quickly and learn on-the-go. The BCP is a written statement that must:
    - Have defined short and middle term goals;
    - Have a governance structure (representative committee from all business units of the organization and enforcing authority);
    - Develop a business impact analysis;

    - Design a robust communication strategy and documentation practices;
    - Be continuously revised and updated.
- Maintenance crews must operate under a modified schedule (after business hours) unless they handle an emergency.
- Mail and package delivery should receive special considerations to account for safety practices, including cleaning packages and delivery personnel wearing masks/gloves
- We need to continually evaluate the incidence and trends for COVID-19 in Orange County and Los Angeles to update our protocols accordingly. Ketchum Health should always review whether OC/LA remains a COVID-19 a high-risk incidence area, and should be prepared to cease non-essential procedures if there is an unmanageable surge.
- Evaluate processes to determine efficiencies in the new normal and how employees' productivity was positively or negatively impacted.

3. Clinical/Patient Safety

Risks:

- Patient Expectations. Patients having different/conflicting expectations regarding the level of care we will provide when scheduling for their appointments.
- Lack of consistency in the message and the delivery with patients regarding our new safety protocols.
- Patients claiming a disability, which will prevent them from wearing masks and a refusal to grant them an exemption violates the title II of the ADA.
- Allowing different points of access to clinic premises.
- Personal interactions between patients and receptionists at check in and check out.
- Optical dispensary. Potential for frames and items to be contaminated after customers or patients try on or touch them.

Recommendations:

a. Create special hours of operation for patients who are higher at-risk. Follow patient prioritizing rules recommended by the CA Dept. of Public Health.
b. Within the facility, administrative and engineering controls should be established to facilitate social distancing, such as minimizing time in waiting areas, spacing chairs at least 6 feet apart, and maintaining low patient volumes.
c. Consider opening KH clinics seven days a week for the next two months to make up for clinical experience and lost revenue.
d. Ketchum Health clinics must have protocols/policies in place to deal with the following:
    - Patients reluctant to adhere to public health measures, e.g., wearing face masks or complying about sanitizing practices;
    - Draft a protocol addressing the "legitimate safety requirement" to refuse to grant an exemption for patients claiming an ADA disability.
    - Patients with known respiratory/pulmonary or other high at-risk medical conditions who cannot wear masks;
    - Patients claiming allergies produced by the materials of the masks/gloves, or claiming a disability covered under ADA.

- Patients bringing several family members to the appointment, making social distancing impossible to maintain.
- Patients who need interpreters, including sign language.
- Patients with special needs or minors, who must be accompanied by a responsible adult.

e. Remote check-in must be implemented to all patients to the extent possible. All paperwork must be made available to patients prior to the encounter. This will reduce the need for prolonged interactions and physical contact with papers, clipboards, and pens.
f. To the extent possible, Optical dispensing by appointment only. Develop a frame cleaning protocol to disinfect the optical dispensary regularly.
g. Without exception, only one point of entry to clinic premises will be allowed. If resources permit, other points of access will be arranged with the same safety protocols in place.
h. We need to be prepared to provide masks or any other protective gear to patients who show up without it. **This is critical to prevent negligence claims from patients.**
i. Develop a contingency plan allowing Faculty and clinicians to refuse to see patients if they are not wearing masks or other types of safety protections required.
j. Conversation between patients and doctors during the examination should be limited to the extent possible. Patients should be informed in advance about this expectation.
k. Create a contactless payment process to avoid the exchange of cash or credit/debit card handling.

4. Strategic

Risks:

- Interrupted supply chains (including PPE provisions), or delayed, or canceled deliveries.
- Reputation. All it takes is only one case of infection to create an adverse chain-reaction in the community.
- Lack of marketing and sales plans post COVID-19.
- Insufficient community outreach.
- Lack of business responsibility message.
- Inconsistent communication strategy and delivery methods to the MBKU community at large.
- Leaving key stakeholders from Ketchum Health management team out of the COVID-19 decision-making mitigation plans.

Recommendations

a. Develop a pool of new vendors or suppliers to plan for disruptions in our current supply chain environment.
b. Implement an effective communication strategy with defined channels and a designated voice.
c. Create strategic alliances with healthcare providers to coordinate care and refer potentially infected individuals for testing or treatment
d. Revamp our online store to offer more products and services as customers will stay disengaged from retailers. It would be an excellent opportunity to capture patients and generate safe revenue without exposing our employees.
e. Include key individuals from the Ketchum Health management team in the COVID-19 response team. They are well positioned to address the most critical risks at the clinics.

5. Financial

Risks

- Direct impact on revenue, cost, and resources on Ketchum Health operations. These include budget revisions and adjustments, new operational expenses (such as procurement and supply of PPE), insurance coverage, and risk transfer strategies.
- Students asking for reimbursement of tuition or other features.
- Lack of capital-liquidity challenges, affecting growth.
- Lack of adequate insurance coverage to transfer risks from COVID-19 unexpected events.
- Collections process of unpaid bills for patient care services.

Recommendations

a. Reviewing cyber-insurance to determine what is covered. Policies should be broad enough to cover incidents that may occur while employees are working from home.
b. Seek for grant and funding opportunities available. Telemedicine is a clear example in which millions of dollars have become available to qualified recipients.
c. Conduct a stress test to challenge the financial health of the organization moving forward under unknown circumstances.
d. Revise budgets and capital allocations to allow for post-crisis adjustments (e.g., the supply of protective gear).
e. Consider instructing the billing department to suspend collections efforts against patients with unpaid balances, if they are happening during the crisis.
f. Developing potential scenarios and conduct periodic situational assessments to determine the best strategies to respond systematically to the “new normal”.

6. Human Capital

Risks

a. Safe Environment and applicability of the **General Duty Clause** 5(a)(1) requires employers to provide their employees with a workplace free from recognized hazards likely to cause death or serious physical harm.
b. Infection outbreak management at Ketchum Health. Lack of an Infectious Disease Preparedness and Response Plan (“IDPRP”)
c. Harassment and Discrimination due to COVID-19 suspected cases.
d. Whistleblower issues related to OSHA workplace safety.
e. Increased absenteeism.
f. Employees privacy considerations.

Recommendations

a. To satisfy the requirement of the General Duty Clause, employers must undertake a hazard identification analysis to identify the steps that should be taken in order to reduce the risk of worker exposure to COVID-19. Every hazard analysis contains three basic elements: (1) identification of workers at high risk; (2) identification of potential sources of exposure; and (3) identification of appropriate control

measures. Once the hazard identification analysis is complete, employers are encouraged to use this information to develop an Infectious Disease Preparedness and Response Plan ("IDPRP"). The IDPRP is MBKU's best defense against OSHA liability claims files by employees.

b. Human Resources must be mindful of implementing and enforcing non-discrimination, non-harassment policies. HR needs to ensure also that the place is entirely safe for employees to return.
c. Deactivate time clock. Hourly employees must log in/off from their computers when feasible
d. Constant employee monitoring. Staff should be routinely screened for symptoms of COVID -19. If an employee is sick and sent home, supervisors should be instructed not to reveal the confidential medical information, which includes the identity of the infected employee.
e. Embracing Telework, selectively. Evaluate the impact of teleworking in productivity. Establish a measuring criteria/process to evaluate employee's productivity, engagement, accountability, and work ethic.
f. Enforce the need for social distancing; staggered work shifts, downsizing operations if needed, delivering services remotely, and other exposure reducing measures.
g. Restrict employee travel.
h. Employees training and education. As more work is performed remotely, employees must be trained accordingly, covering topics such as cloud applications, new software platforms, cybersecurity best practices, and collaborative virtual work environments.

7. Legal and Regulatory

Risks:

- Potential commercial, employment, and patient claims and litigation.
- Lack of understanding of different jurisdictions in Ketchum Health operations-Anaheim and LA
- Increase of reporting obligations to state and federal agencies.
- Applicability of *Force Majeure* and Impossibility clauses–or the lack of them in service or other agreements.
- Unpredictable and evolving regulatory ecosystem. Uncertainty on new laws being enacted or changed as the pandemic unfolds.

Recommendations

a. Special considerations must be given to different jurisdictions where we operate: UECLA operates under Los Angeles County, which has enacted specific rules covering several topics such as family/sick leave for employees, classification of essential operations, safety gear, among others. Ketchum Health Anaheim is under OC.
b. Review our contracts and general agreements to prepare for potential, unexpected breaches. Review force majeure/impossibility clauses in existing agreements, and section 269 of the restatement (second) of contracts.
c. Conform to industry standards for health and safety, including recommendations from California Optometric Association (COA) and California State Board of Optometry (SBO).
d. Work with the credentialing department to review and apply the latest Board rulings. Those include guidelines regarding online, live courses as a means to attain CE credits. (see bulletin posted 4/29/20 by SBO). For Faculty with active licenses that expire between March 31, 2020, and June 30, 2020, CE requirements are temporarily waived for purposes of license renewal. Any waived renewal requirements must be met within six months of this order unless further extended. These ruling also apply to waive

physician assistants' supervision requirements (Governor's Executive Order N-39-20-Waiver issued 4/14/20)

e. Revise daily press releases from County public agencies for the latest ruling and recommendations for the return-to-work environment.
f. Stay current on laws and regulations as they are updated daily, and draft policies accordingly.

8. Hazard

Risks

- Gaps in cleaning and disinfectant protocols.
- Vendors and maintenance crew management. Lack of control by MBKU over the safety practices observed by these individuals.
- Disposal of potentially contaminated PPE or other items

Recommendations

a. Consider any exposure reducing measures, including a HAZMAT disposal protocol.
b. Appoint a dedicated cleaning crew with a set route and schedule and documented protocols.
c. Implement controls to minimize the risks of potential infections from vendors and third parties.
d. Compliance with the latest Cal-OSHA recommendations, including the new reporting protocols.

Risk Assessment 2021

Executive Summary

2021 marked the first year of the post-go-live implementation of the new electronic health record software at Ketchum Health.

The selection of COMPULINK as the electronic health record of choice was conducted following a meticulous vetting process that assessed multiple commercial options available in the market.

Special consideration was given to the potential impact in our operations and the ability to improve efficiencies at all clinic settings, including associated sites.

As this software implementation changed from one system platform to another, the risks evaluated were concentrated on data integrity, data availability, and the continuity of clinic operations without compromising patient care.

A. Purpose.
To identify threats and vulnerabilities of Protected Health Information (PHI)/Personal Identifiable Information (PII) and the systems in which it resides. To assess individuals' performance, technology, and processes that may affect Ketchum Health operations.

B. Scope
The Risk Assessment evaluates the **confidentiality** (protection from unauthorized disclosure of system and data information), **integrity** (protection from improper modification of information), and **availability** (chart

completion or loss of system or document access) of PHI. Recommended privacy safeguards from this assessment will allow management to make decisions about protocols on privacy related initiatives.

C. Process Approach

The risk assessment was conducted in accordance with the methodology described in the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-30. A partial assessment of the potential financial impact of data loss or costs associated with any PHI breach was included.

The risk assessment focus on threats and vulnerabilities that may arise with the implementation and subsequent use of the software. Six domains were identified as critical:

- Data migration
- Legacy systems
- Staff training
- Continuity of care
- Business associate agreements
- Regulatory environment

D. Assessment Steps

The process was performed in three phases:

1. **Threat/vulnerabilities inventory and identification**. Interviews with key stakeholders and workflow analysis were conducted to determine which activities, by omission or commission, could trigger an adverse event.

2. **Customized Questionnaire**. A questionnaire with targeted areas was submitted for review and response to the software vendor to determine its level of readiness and responsiveness regarding the privacy of PHI.

3. **Mitigation response**. After evaluating each threat or vulnerability, we considered different options to avoid, minimize, or neutralize the impact of the risk event.

E. Impact Analysis

The final step was to determine the level of impact of the adverse event and its consequences for Ketchum Health operations. Three categories were considered:

- **High**: the occurrence of the event will result in a severe PHI breach, and there is a great likelihood of occurrence. Mitigation measures must be implemented immediately.
- **Moderate**: the occurrence of the event may result in a violation of laws and internal policies and could eventually affect Ketchum Health's performance and reputation.
- **Low**: the occurrence of the adverse event may result in the potential breach or misuse of PHI and could minimally affect business operations.

The matrix above was used in the legacy systems domain assessment only. For the other domains, a description of potential adverse occurrences and mitigation actions were used to assess the risk.

Risk Assessment Domains

A. Data Migration

With over 120.000 individual patient files, Ketchum Health required the migration of practice management and clinical data into the new electronic health records system selected.

- **Risks.** There are several risks regarding this process:
  - Data integrity: potential for getting corrupted information, including mixing up data from different accounts/patients.
  - Data availability: potential for users not being able to retrieve the information when needed from the location of choice.
  - Data loss: potential for permanently losing the data.
- **Approach**. The migration required the retrieval, mapping, and subsequent linking of data located in multiple databases, including "home-grown" applications. Documents were stored in different formats, such as Word, JPG, DICOM, Excel, CSV, rtf. The goal was to preserve the format of the document from the legacy system to the extent feasible.
- **Mitigation.** The following steps are being implemented to mitigate data risks:
  - Designation of a data-reviewing team in charge of identifying missing data, locating such data where it resides, and retrieving and linking the patient information into the new EHR system.
  - To ensure proper access to missing or misplaced data, maintaining the legacy systems active for a determined period, and only available to individuals of the above team. By restricting access to these systems, Ketchum Health minimizes the chance of security incidents, including but not limited to data breaches.
  - To assign a dedicated computer station and driver that will host the Eyefinity legacy system. This driver will be segregated from the main network, preventing security incidents. Only designated individuals will have physical and login access to this station.

More analysis on this issue comes in the next risk domain.

B. Legacy Systems- Information Technology Risks

Risk Description
System: Nextgen
Application: Nextgen version 5.8.128
Operating System: Windows Server 2012
Database: Microsoft SQL Server 2012

Nextgen is currently a legacy system that functioned as the practice management system for Ketchum Health and UECLA. It was used by the patient relations and billing departments. The system became legacy status when Compulink was brought online in November 2020. However, the system is currently available because of the need by Ketchum Health and UECLA personnel to view balances owed. There are ~5200 patients with balances owed.

The technical support contract with Nextgen ended on September 9, 2021. With the end of support, software updates have also ceased and MBKU is no longer applying software updates for potential security flaws, making the system vulnerable to hackers. The lack of software updates also makes the system non-compliant to HIPAA standards.

The risk is an unauthorized breach of the single Nextgen server and the financial cost to deal with such a breach of our patient records.

The below are estimates of the financial cost if the system data was breached by an unauthorized entity.

The clinic has set a sunset date of May 2022 to turn off the system.

The system contains ~120,000 patient records. A single system breach would require the following costs:

- Forensics $10000+
- Free credit monitoring to the 120,000 patients with assumed cost of $10/person = $1.2 million
- Possible Civil judgements and legal fees
- HIPAA fines $50,000-$100,000

The average breach cost is $3.86 million dollars in IBM's 2020 report of data breaches

Risks Threats & Vulnerabilities

The threats include both external malicious actors and unknowing/disgruntled internal employees. As a healthcare institution and in the education sector, we are high-value targets to for-profit or casual hackers. The system is not publicly accessible, but social engineering attacks have reduced the effectiveness of network defenses at the perimeter making internal systems almost as vulnerable as external public facing systems.

The system is vulnerable because all software has bugs in the code, including security bugs that a malicious actor can exploit to gain access to the system & data. Software that is no longer supported by the manufacturer is vulnerable to exploits because it lacks the software updates that remediates known security bugs.

Risk Impact

	IMPACT LEVEL	DESCRIPTION
	MINOR	Minor business disruption and minor (<$10K) financial loss
	MODERATE	Moderate business disruption and moderate (< $100K) financial loss
X	SEVERE	Severe business disruption and Significant (>$100K) financial Loss

Risk Probability

	PROBABILITY LEVEL	DESCRIPTION
	HIGHLY UNLIKELY	Rare chance of an occurrence
	UNLIKELY	Not likely to occur under normal circumstances
X	POSSIBLE	May occur at some point under normal circumstances
X	LIKELY	Expected to occur at some point in time

	HIGHLY LIKELY	Expected to occur regularly under normal circumstances

Risk Severity Matrix

IMPACT x PROBABILITY	NOT SIGNIFICANT	MINOR	MODERATE	MAJOR	SEVERE
HIGHLY UNLIKELY	LOW	LOW	LOW / MED	MEDIUM	MEDIUM
UNLIKELY	LOW	LOW / MED	LOW / MED	MEDIUM	MED / HIGH
POSSIBLE	LOW	LOW / MED	MEDIUM	MED / HIGH	MED / HIGH
LIKELY	LOW	LOW / MED	MEDIUM	MED / HIGH	HIGH
HIGHLY LIKELY	LOW / MED	MEDIUM	MED / HIGH	HIGH	HIGH

Risk Severity Level

SEVERITY LEVEL

	LOW
	LOW / MED
	MEDIUM
X	MED / HIGH
X	HIGH

Mitigation Actions

ACTION	DECISION	WHO	STATUS
Renew Nextgen support for next 8 months @ $1800/mo. Total cost = $14,400			

Disable all accounts on Nextgen (all SCCO faculty and staff) except for Patient Relations, Rita, Yecenia, Luis, Mark Nakano	Yes	IT	IT requests information on when we can disable all accounts excepts those provided
Disable all remote access to Nextgen	Yes	IT	Will disable the week of 9/23

Risk Description

System: ExamWriter

Application: Examwriter version 12.0.3

Operating System: Windows Server 2003 R2

Database: Microsoft SQL Server Express

Examwriter is currently a legacy system that functioned as the Electronic Medical Records system for Ketchum Health and UECLA. Each site had its own dedicated server. It was used by the SCCO faculty and staff to create/update patient charts and store e-documents. The system became legacy status when Compulink was brought online in November 2020. The system is currently available because of the need by Ketchum Health and UECLA personnel to view historical patient charts.

The version of ExamWriter (12.0.3) is no longer supported by the manufacturer (Eyefinity) for several years (2019 or before). Microsoft also no longer supports the version of the operating system (Windows Server 2003) since 2015. The lack of software updates also makes the system non-compliant to HIPAA standards.

The risk is an unauthorized breach of the ExamWriter server(s) and the financial cost to deal with such a breach of our patient records.

The clinic has proposed a sunset date for mid-2023, with the requirement that the data be readily available indefinitely.

The below are estimates of the financial cost if the system data was breached by an unauthorized entity.

The system contains ~120,000 patient records. A single system breach would require the following costs:

- Forensics $10000+

- Free credit monitoring to the 120,000 patients with assumed cost of $10/person = $1.2 million
- Possible Civil judgements and legal fees
- HIPAA fines $50,000-$100,000

The average breach cost is $3.86 million dollars in IBM's 2020 report of data breaches

Threats and Vulnerabilities

The threats include both external malicious actors and unknowing/disgruntled internal employees. As a healthcare institution and in the education sector, we are high-value targets to for-profit or casual hackers. The system is not publicly accessible, but social engineering attacks have reduced the effectiveness of network defenses at the perimeter making internal systems almost as vulnerable as external public facing systems.

The system is vulnerable because all software has bugs in the code, including security bugs that a malicious actor can exploit to gain access to the system & data. Software that is no longer supported by the manufacturer is vulnerable to exploits because it lacks the software updates that remediates known security bugs.

RISK IMPACT

	IMPACT LEVEL	DESCRIPTION
	MINOR	Minor business disruption and minor (<$10K) financial loss
	MODERATE	Moderate business disruption and moderate (< $100K) financial loss
X	SEVERE	Severe business disruption and Significant (>$100K) financial Loss

RISK PROBABILITY

	PROBABILITY LEVEL	DESCRIPTION
	HIGHLY UNLIKELY	Rare chance of an occurrence
	UNLIKELY	Not likely to occur under normal circumstances
X	POSSIBLE	May occur at some point under normal circumstances
X	LIKELY	Expected to occur at some point in time
	HIGHLY LIKELY	Expected to occur regularly under normal circumstances

RISK SEVERITY MATRIX

IMPACT x PROBABILITY	NOT SIGNIFICANT	MINOR	MODERATE	MAJOR	SEVERE
HIGHLY UNLIKELY	LOW	LOW	LOW / MED	MEDIUM	MEDIUM
UNLIKELY	LOW	LOW / MED	LOW / MED	MEDIUM	MED / HIGH
POSSIBLE	LOW	LOW / MED	MEDIUM	MED / HIGH	MED / HIGH
LIKELY	LOW	LOW / MED	MEDIUM	MED / HIGH	HIGH
HIGHLY LIKELY	LOW / MED	MEDIUM	MED / HIGH	HIGH	HIGH

RISK SEVERITY LEVEL

	SEVERITY LEVEL
	LOW
	LOW / MED

	MEDIUM
X	MED / HIGH
X	HIGH

MITIGATION ACTIONS

ACTION	DECISION	WHO	STATUS
Renewing support is not an option. Upgrading the system to a level that can be supported by the manufacturer is equivalent to setting up a new EMR system. One option is to transport all the data to a current secure version of Microsoft Server, but sunset the application (Examwriter).			
Disable all accounts on Examwriter (all SCCO faculty and staff) except for Patient Relations, Rita, Yecenia, Luis, Mark Nakano	Yes	IT	IT requests information on when we can disable all accounts excepts those provided
Disable all remote access to Examwriter	Yes	IT	IT will disable the week of 9/23

C. Workforce Training

System users' timely and effective access to practice management and clinical data is essential to Ketchum Health operations. With the change of health records software, staff needs to become familiar with the system's new features to perform effectively.

- **Risks.** The risks identified by the conversion team are comprised of four major areas:
    - Lack of familiarity by users with the general utilities of the software.
    - Inability to locate the suitable functionalities to record and retrieve patient data from the system.
    - Lack of knowledge on documentation best practices offered by the software, including but not limited to summary reports and letters, and Continuity of Care documents (CCD).
    - Exam templates conversion and creation.
- **Approach.** In anticipation of the training challenges, the conversion team set a go-live date with the goal of allowing all users enough time to become familiar with the software's applications. The team was tasked with identifying champions from the workforce, learning the basics of the system, and serving as liaisons between the software company and their co-workers in their respective services.
- **Mitigation.** The following steps are being implemented to mitigate training-related risks:
    - Engaging Compulink in a legal agreement to facilitate and provide appropriate education to all software users before, during, and after the go-live day. Such agreement included onsite and Webex training provided by the software specialists, in an amount determined by the Team.
    - Securing unlimited access by users to the software-training module called "Compulink University." This utility offers customized education on selected topics

related to the system's performance, and it is updated by the company as needed. The eLearning module is included in the monthly fee, and it is available 24/7.

- Creating a training-dedicated room at Ketchum Health, with as many as 12 stations available with the EHR software uploaded. This training set is being used to:
  - Provide onboarding to all new hires with clinic assignments and educate them on the new system features.
  - Provide additional training and support to existing users when required.
  - Provide targeted training to groups quarterly. This will address software updates and new features that require education on specific areas of our operations.

D. Continuity of Care

The ability of optometrists to continue providing patient care without interruption after the system migration is vital to Ketchum Health operations. The new system must offer the needed tools to ensure patient care is not impacted after the implementation go-live date and its subsequent updates.

- **Risks**. The following risks related to continuity of care were identified:
  - Patient care disruption due to system updates management.
  - Available user licenses.
  - Ability to maintain a consisting practice management flow, including but not limited to patient scheduling and recalls, check-in and check-out, referrals, insurance eligibility, and coding and billing.
  - Ability for providers to access to data in real time and retrieval of pertinent historical data, including images.
  - Ability to document exam findings properly and producing data for referring patients.
  - Template development and refinement of the existing ones is essential to ensure software integration with the legacy system patient flow
- **Mitigation.** The following steps are being implemented to mitigate continuity of care-related risks:
  - System updates are handled with anticipation as the Systems Director notifies users of upcoming updates to prevent patient care disruptions. Compulink and Ketchum Health IT departments manage every software upgrade. Updates are always scheduled and performed after hours when access to the software is not needed for patient care. Generally, the upgrades take place over the weekends or in the early hours of weekdays.
  - Ketchum Health officials executed a customized agreement addressing the availability of licenses to all users when needed. This allows access to the software by providers without compromising patient care due to the lack of available system licenses. The new software allows different users to perform tasks while accessing the system simultaneously, with no limits.
  - Templates and workflows could be customized depending on the needs of the service. The implementation team decided that templates and workflows should remain standard and integrated to the extent possible. Only the system

administrator can modify or create new templates after carefully reviewing patient care workflows and expected outcomes to avoid template proliferation.

Equipment integration and image conversion remain issues to solve in the new software. Although this creates an availability risk for PHI, most images are still retrievable through the legacy system. Ketchum Health IT personnel work with Compulink and a third party to resolve this issue.

E. Business Associate Agreements

The Office of Civil Rights of the HHS requires ensuring that third parties and vendors outside the Ketchum Health ecosystem have an executed business agreement to safeguard protected health information.

- **Mitigation.** An inventory of existing and new vendors with access to Ketchum Health patient databases is conducted yearly. In 2021, two new vendors were identified as having access to patient information to perform their operations on Ketchum Health's behalf. The business agreement developed by our general council was submitted to the vendors, and the executed copy is available upon request.

There were no material changes to existing agreements with current parties; therefore, no amendments to previous contracts were necessary.

F. Regulatory Environment

With the Secretary's new upgrades in health law and privacy regulations, Ketchum Health must ensure that the new software complies with the latest provisions.

- **Risks.** Two areas were reviewed for compliance purposes:
  - The 21st Century Cures Act and the Information Blocking rule.
  - Revisions to the HIPAA privacy rule.

- **Approach.** The Information Blocking final rule eliminates intentional barriers to electronic health information (EHI) exchange. This rule was designed to give patients greater control over their health data and make it easier to share patient records between organizations and patients.
  The Rule affects anyone accessing EHI, including Ketchum health providers, health IT developers, and exchange networks. The rule went into effect on April 2021.
- **Mitigation.** The information blocking rule is expanding the ability for patients to gain access to their records timely. In that regard, Compulink is committed to upholding Federal regulation concerning the 21st Century Cures Act and the Information Blocking rule, as follows:
  - Compulink advantage v12.4 and subsequent updated versions are compliant with the rules.
  - Providers can send patients Continuity of Care Documents to the Advantage Patient Portal when there is a request for electronic health information (EHI).

- Providers are encouraged to use the Patient Portal (www.mysecurehealthdata.com) for all Patient Communications.
- Providers may continue to deliver a printed Patient Care Summary as long as the request for information is for a printed document.
- The Clinic manual has been updated to incorporate the changes in the privacy rule, specifically on policies related to the Minimum Necessary standards and the time to respond to requests for protected health information (PHI).
- Adequate training is provided to all personnel communicating or releasing PHI to patients and third parties.

EXHIBIT 28 BUSINESS ASSOCIATE AGREEMENT SAMPLE

This Business Associate Agreement ("BAA") is entered into by and between **Marshall B. Ketchum University-Ketchum Health ("KETCHUM HEALTH"),** hereinafter referred as **"Covered Entity"** and _____ hereinafter referred as "**Business Associate**" , and is effective as of _____(the "BAA Effective Date") . KETCHUM HEALTH and _____ may be individually referred to as a "Party" and collectively as the "Parties" in this BAA.

RECITALS

A. KETCHUM HEALTH intends to disclose certain sensitive information to Business Associate

pursuant to the terms of a separate service agreement ("Service Agreement"), some of which may constitute Protected Health Information ("PHI")

B. KETCHUM HEALTH and Business Associate intend to protect the privacy and security of PHI disclosed pursuant to the terms of the Service Agreement in compliance with (i) the Health Insurance Portability and Accountability Act of 1996 ("HIPAA'); (ii) Subtitle D of the Health Information Technology for Economic and Clinical Act ("HITECH"); (iii) the Omnibus final rule, effective September 2013.

C. The purpose of this agreement is to set forth the terms and conditions under which "protected health information" (PHI), as defined by "HIPAA" and regulations enacted thereunder, created, maintained or received by Business Associate and their subcontractors on behalf of Covered Entity, may be used or disclosed.

AGREEMENT

In consideration of the mutual promises below and the creation, use, or disclosure of Protected Health Information pursuant to this BAA, the Parties agree as follows:

1. Definitions.

a. “Breach” shall have the same meaning given to such term in 45 C.F.R. § 164.402.

b. “Business Associate Subcontractor" shall have the same meaning given to such term in 45 C.F.R. § 160.103.

c. “Electronic Protected Health Information” shall have the same meaning given to such term under the Privacy Rule and the Security Rule in 45 C.F.R.§ 160.103, as applied to the information that Business Associate creates, receives, maintains or transmits from or on behalf of Covered Entity.
d. “Encryption” shall have the same meaning as the term “Encryption” in 45 C.F.R. § 164.304.
e. “Electronic Media” shall have the same meaning given to such term under 45 C.F.R. § 160.103.
f. “Individual” shall have the same meaning given to such term in 45 C.F.R § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R § 164.502(g).
g. “Limited Data Set” shall have the same meaning given to such term in 45 C.F.R. § 164.514(e).
h. “Protected Health Information” shall have the same meaning given to such term in 45 C.F.R. § 160.103.
i. “Security Incident” shall have the same meaning given to such term in 45 C.F.R § 164.304
j. “Security Rule” shall mean the Security Standards at 45 C.F.R Part 160 and part 164, subparts A and C.
k. “Unsecured PHI” shall have the same meaning given to such term in 45 C.F.R § 164.402, and guidance promulgated thereunder.

Terms used, but not otherwise defined, in this agreement shall have the same meaning that those terms have under “HIPAA” (Public Law 104-191) and “HITECH” (Public Law 111-5).

2. Obligations and Activities of Business Associate

2.1 Permitted Uses and Disclosures of PHI

a. Business Associate may use or disclose PHI to perform functions, activities or services for, or on behalf of, Covered Entity as specified in the Service Agreement. Business Associate shall not disclose protected health information to any member of its workforce unless Business Associate has advised such person (employee) of Business Associate the privacy and security obligations and policies under this Agreement, including the consequences for violation of such obligations. Business Associate shall take appropriate disciplinary action against any member of its workforce who uses or discloses protected health information in violations of this Agreement and applicable law.

b. Business Associate may only use and disclose protected health information created or received by Business Associate on behalf of Covered Entity if necessary for the

proper management and administration of Business Associate or to carry out legal responsibilities, provided that any disclosure is:

i. Required by law, or

ii. Business Associate obtains reasonable assurances from the person to whom the protected health information is disclosed that (i) the protected health information will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person; and (ii) Business Associate will be notified of any instances of which the person is aware in which the confidentiality of the information is breached.

c. Subcontractors. Business Associate shall ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of Business Associate agree to the same restrictions, conditions, and requirements that apply to Business Associate with respect to such information as required by 45 CFR §164.502(e)(1)(ii) and (2) and 164.308(b)(2)(i)-(iii). Business Associate may fulfill this requirement by having the subcontractors execute an agreement that incorporates the terms of this Agreement. Business Associate shall not disclose protected health information created or received by Business Associate on behalf of Covered Entity to a person, including any agent or subcontractor of Business Associate until such person agrees in writing to be bound by the provisions of the Agreement and applicable State or Federal law.

2.2 Appropriate Safeguards

a. Privacy and Security of PHI. Business Associate will continue to create, implement, maintain, communicate and use appropriate administrative, technical, and physical safeguards to protect the privacy and security of the PHI, including its availability, integrity and confidentiality. The safeguards will reasonable protect PHI from any intentional or unintentional use or disclosure in violation of the e HIPAA Privacy and Security Rules and this BAA.

b. Reporting of Improper Use or Disclosure, Security Incident or Breach. Business Associate shall, following the discovery of any breach of unsecured PHI, or the occurrence of any security incident affecting the use or disclosure of PHI, notify the covered entity of such breach or incident, without unreasonable delay, and in any event no more than thirty (30) calendar days following discovery. A breach shall be treated as discovered by Business Associate as of the first day on which such a breach is known to Business Associate. Such notification will contain the elements required in 45 C.F.R. § 164.410.

c. Minimum Necessary Standard and Creation of Limited Data Set. Business Associate shall utilize a Limited Data Set if practicable, otherwise, only request, collect, use and disclose the minimum amount of PHI necessary to conduct its business, and in any case, in accordance with Covered Entity's minimum necessary policies and procedures as disclosed by Covered Entity to Business Associates.

d. Documentation of Disclosures. Business Associate agrees to maintain a record of all disclosures of PHI as would be required for Covered Entity to respond to a request by

an individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528, as applicable Such record shall include (i) date of the disclosure, (ii) the name and, if known, the address of the recipient of the PHI, (iii) a brief description of the PHI disclosed, and (iv) the purpose of the disclosure.

e. Accounting of Disclosures. Business Associate agrees to document all activity related to disclosures of PHI received from Covered Entity and will, upon request and to the extent permitted by law make it available to Covered Entity within ten (10) business, should it respond to a request by an individual for an accounting of disclosures.

f. Governmental Access to Records. Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity, available to the Secretary of the United States Department of Health and Human Services, for purposes of determining the Covered Entity's compliance with HIPAA Privacy and Security Rules.

g. Amendment of PHI. Business Associate agrees to amend, pursuant to a request by Covered Entity, protected health information maintained and created or received by Business Associate, on behalf of the Covered Entity. Business Associate further agrees to complete such amendment within thirty (30) days of a written request by Covered Entity, and to make such amendment as directed by Covered Entity.

3. Obligations and Activities of Covered Entity.

a. Notice of Privacy Practices**.** Covered Entity shall provide Business associate, at the request of Business Associate, with its Notice of Privacy Practices, produced in accordance with 45 C.F.R. § 164.520.

b. Notifications of Restrictions and Changes. Covered Entity shall notify Business Associate any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R § 164.522, to the effect that such restriction may affect Business Associate's use or disclosure of PHI.

4. Term and Termination

a. Term. This agreement shall be effective as of the date executed by the parties and shall continue until terminated as provided below.

b. Termination. Covered Entity may immediately terminate this Agreement and related agreements if Covered Entity determines that Business Associate has breached a material term of this Agreement. Alternatively, Covered Entity may choose to (i) provide Business Associate with ten (10) days written notice of the existence of an alleged material breach; and (ii) afford Business Associate an opportunity to cure said alleged material breach to the satisfaction of Covered Entity within (10) days. Business Associate's failure to cure shall be grounds for immediate termination of this

agreement. Covered Entity's remedies under this Agreement are cumulative, and the exercise of any remedy shall not preclude the exercise of any other.

c. Effect of termination. Upon termination of this agreement for any reason, Business Associate shall return or destroy all PHI created or received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, and shall retain no copies of the PHI.

If infeasible for Business Associate to return or destroy the PHI upon termination of the Service Agreement or this BAA, Business Associate shall extend the protections of this Agreement to such information, and limit further uses and disclosures to those permitted to Business Associates to continue its proper management and administration, or to carry out its legal responsibilities.

5. Survival. The respective obligations of Business Associate under this BAA shall survive the termination, expiration, or cancellation of this Agreement and the Service Agreement.

6. Amendment. This agreement may be amended or modified only by a written document executed by the authorized representatives of both Parties. Nothing in this BAA shall confer any right, remedy, or obligation upon any third party.

7. Governing Law. This BAA shall be construed to comply with re requirements of the HIPAA rules, and any inconsistency or ambiguity in this agreement shall be interpreted to permit compliance with the mandatory provision of the Privacy and Security Rules and the HITECH Act.

8. Indemnification. Business Associate shall, to the fullest extent permitted by law, protect, defend, indemnify and hold harmless Covered Entity and its officers, employees, trustees, and agents ("Indemnitees") from and against any and all losses, costs, claims, penalties, fines, demands, liabilities, legal actions, judgments, and expenses of every kind (including reasonable attorney's fees, including at trial and on appeal) asserted or imposed against any Indemnitees arising out of the acts or omissions of Business Associate or any of Business Associate's employees, directors, or agents or subcontractors related to the performance or nonperformance of this Agreement.

9. In the event of an inconsistency between the provisions of this BAA and a mandatory term of the HIPAA Requirements (as these terms may be expressly amended from time to time by the DHHS or as a result of interpretations by DHHS, a court or another regulatory agency with authority over the Parties), the interpretation of DHHS, such court or regulatory agency shall prevail. In the event of a conflict among the interpretations of these entities, the conflict shall be resolved in accordance with rules of precedence.

10. Where provisions of this BAA are different from those mandated by the HIPAA Requirements, but are nonetheless permitted by the HIPAA Requirements, the provisions of this BAA shall control.

11. Except as expressly provided in the HIPAA Requirements or this BAA, this BAA does not create any rights in third parties.

MBKU—KETCHUM HEALTH	**BUSINESS ASSOCIATE**
By:_____	By: _____
Name:_____	Name: _____
Title:_____	Title: _____

EXHIBIT 29 REMOTE ACCESS CONFIDENTIALITY AGREEMENT

This Agreement is made between _____, hereafter referred to as "Faculty" or "Resident", and the Marshall B. Ketchum University-Ketchum Health, hereafter referred to as "College", on the _____ day of _____ , _____.

Confidential Information

For the purpose of this agreement, College *e*PHI (Protected Health Information) refers to any information about health status, provision of health care, or payment for health care that can be linked to a specific individual and can be used to identify such individual, created and maintained by the College database.

Nondisclosure Agreement

As remote access of electronic protected health information (*e*PHI) becomes available to all Faculty and residents at the College, the use of confidential and proprietary patient data is granted to you as a privilege, on the basis of privacy and confidentiality. Accordingly, to protect the College's PHI that will be accessed in such way, you agree to do as follows:

A. Exercise all reasonable and practicable safeguards to maintain the privacy and security of the protected health information which access is granted, following the University remote access policy and associated protocols.
B. Faculty and resident will refrain from using the remote access function to open and review ePHI except as required to carry out their job responsibilities. Such information seen in the course of professional duties will be kept confidential during and after the term of employment.
C. The main purpose of the remote access function is to allow faculty and resident to expedite the completion of patient charts. Faculty or Resident will not share, release or disclose PHI in any way from any remote location. The release process will be performed following the established protocols at the University.
D. Faculty and resident will communicate immediately to University officials any known, intentional or unintentional, disclosure of ePHI to a third party.
E. MBKU reserves the right to initiate disciplinary action for violation of this agreement, up to and including termination of employment. Criminal action may be brought against Faculty or Resident by University officials if the nature of the violation constitutes a breach of the law which exposes the University to a higher liability.

I understand that by signing below I agree to the terms and conditions of this agreement.

Faculty/Resident Name Faculty/Resident Signature Date

EXHIBIT 30 PATIENT CONSENT TO PHOTOGRAPH/VIDEO/INTERVIEW-AUTHORIZATION

Patient Name:	**Birth Date:** **Medical Record Number:**
Person(s) or Class of Persons Authorized to Use/Disclose the Information:	**Persons Authorized to Receive the Information:**

Patient consents to be:

☐ Photographed ☐ Filmed ☐ Videotaped ☐ Interviewed ☐ Other:

Purpose of Use/Disclosure:

☐ Publication in newspaper(s), magazine(s) or other publications, online or print distribution

☐ Broadcast by radio or television

☐ MBKU | Ketchum Health marketing and public relations materials/publications

☐ By Ketchum Health -University Eye Center to document the progress of my care

☐Other

Description of Protected Health Information to be Used or Disclosed:

☐ All Patient Identifying Information; or ☐ Age/Date of Birth ☐ City of Residence ☐ Nature of Medical Condition/Illness	☐ Other: Name, photo, condition and treatment related to story.	☐ Not applicable

By way of my signature, I relieve and hereby agree to hold Marshall B. Ketchum University Communications and/or Ketchum Health University Eye Centers free and harmless from any and all liability arising out of the use and/or release of information; interview; photograph/videotape/film; and subsequent publication or broadcast. I understand

that the interview(s) or photo session(s) are being carried out upon my consent and authorization and so assume full responsibility.

I understand that:

1. I may refuse to sign the authorization and that it is strictly voluntary.
2. I will not be compensated for the uses described above.
3. If I do not sign this form, my health care and the payment for my health care will not be affected.
4. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
5. If the requester or receiver is not a health plan or health care provider, the released information may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. MBKU or Ketchum Health have no control of the materials after they have been published, and they will not be responsible for third-party uses of the information.
6. I understand that I may see/obtain a copy of the information described on this form, if I ask for it.
7. I get a copy of this form after I sign it.

This authorization will expire on the following: (check and complete only one box)
□ Date: _____ □ When the University no longer has need for the image/video

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative or Employee/Volunteer/Physician:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

EXHIBIT 31 AUTORIZACIÓN PARA VIDEO-FOTO-ENTREVISTA

Nombre del Paciente: **Fecha de Nacimiento:**	
Personas Autorizadas para Usar/Divulgar la Información Confidencial	**Personas Autorizadas para Recibir la Información Confidencial** □ **MBKU Comunicaciones & Mercadeo** □ **MBKU Servicios Multimedia** □ **MBKU/Ketchum Health**

Autorizo para ser : □ Fotografiado □ Filmado □ Entrevistado □ Otros :		
Propósito de la Divulgación de la Información: □ Publicación en periódicos, revistas, u otras publicaciones de distribución impresa o virtual □ Transmisión por radio o televisión □ Publicaciones en materiales o productos de comunicaciones de la oficina de relaciones públicas de MBKU | Ketchum Health □Otras		
Descripción de la Información para Divulgarse:		
□ Cualquier información que identifique al paciente; o □ Edad y fecha de nacimiento □ Lugar de residencia □ Descripción de la enfermedad o condición medica	□ Otros: Nombre, foto, condición médica y tratamiento relacionado con la historia.	

Por medio de mi firma, declaro expresamente que acepto mantener al Departamento de Comunicaciones de la Universidad Marshall B. Ketchum y/o al Centro Universitario de los Ojos- Ketchum Health libres de cualquier responsabilidad derivada del uso y / o la divulgación de mi información médica confidencial; entrevista; fotografía / video / película; y su posterior publicación o difusión por cualquier medio impreso o virtual. Entiendo que las entrevistas o sesiones de fotos se llevan a cabo con mi consentimiento, por lo cual asumo toda la responsabilidad.

Entiendo que:

1. Puedo negarme a firmar la autorización y que mi consentimiento es estrictamente voluntario.
2. No seré compensado económicamente por los usos descritos anteriormente.
3. Si no firmo este formulario, mi atención médica y el pago de mi atención médica no se verán afectados.
4. Puedo revocar esta autorización en cualquier momento por escrito; si lo hago, no tendrá ningún efecto en ninguna acción tomada antes de recibir la revocación.
5. Si el solicitante o quien recibe la información no es un plan de salud o proveedor de atención médica, dicha información divulgada puede ser revelada nuevamente por el receptor y no estará protegida por las regulaciones federales de privacidad (HIPAA). MBKU o Ketchum Health no tienen control de los materiales después de su publicación, y no serán responsables por el uso de la información por parte de terceros.
6. Entiendo que puedo ver/obtener una copia de la información descrita en este formulario, si la solicito.
7. Recibo una copia de este formulario después de firmarlo.

Expiración de la Autorización	
☐ Fecha: _____	☐ Cuando la Universidad no requiera o use las imagines o video(s)

He leído lo anterior y autorizo el uso y/o divulgación de mi información medica confidencial descrita.

Firma del Paciente-Representante Legal	**Fecha:**
Nombre del Paciente o Representante Legal:	**Relación con el Paciente:**

EXHIBIT 32 NOTICE OF DATA BREACH
(CA SB 570, 2015)

Mark Nakano, O.D.
Associate Dean of Clinics
5460 E. La Palma Ave.
Anaheim, CA 92807

What Happened?

We, at the Marshall B. Ketchum University-University Eye Centers take the privacy and security of your personal information as one of the most critical elements of our operations. We exercise extreme care and due diligence at protecting your data from unauthorized disclosures or breaches of any kind. Unfortunately, due to circumstances that are beyond our control, we were subject of a (describe the incident here) that might have compromised or exposed your personal information.

Based on our preliminary investigation, we have determined that on or around (date of discovery of the breach) our network infrastructure was intruded /a theft of portable device occurred-explain.) Upon detection of the incident, MBKU took steps to contain the attack/intrusion and further secure our network.

What Information Was Involved?

The investigation is ongoing, and to date, there is no conclusive evidence that Protected Health Information or any other sensitive information was compromised; however, we cannot decisively dismiss that possibility, and for that reason we are taking precautionary measures by informing you about the incident. The types of information stored in the network/stolen device include:

names, date of births, phone numbers, Medicare and/or health ID card plan numbers, medical diagnosis and test results, and medications.

What We Are Doing

As required by law, we have notified local and federal authorities, and we're proactively working with the FBI to determine the extent of this incident. The investigation is ongoing and we are putting all of our resources available to mitigate negative consequences to your identity and to help to protect yourself.

As a result, we've made arrangements with (describe the type of credit monitoring services contracted) which will oversee the credit monitoring process for the period of . These services are provided to you at no cost, and you will have to enroll in the program by registering here: .In addition, we have established a hot line to help you with any questions you might have regarding the status of this event.

We value your personal information and we will do anything in our power to mitigate the potential negative effects of this incident on your identity.

What You Can Do

Once you have enrolled in the credit monitoring program, you can also take advantage of your right to the free fraud alert services offered by the three major credit bureaus. Keep in mind that by placing fraud alerts, you'll have an additional protection to your credit history.

You can always contact us during business hours to inquire for additional details regarding the incident, unless otherwise forbidden by law enforcement due to the ongoing investigation.

Other Important Information

For More Information

As we keep committed to our patients and their wellbeing, we have made available a Toll-Free Hotline. Please call us at _____Monday through Friday from 8am to 5pm. You can also visit our website at www.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Clinic Record Information

Each time you visit a health care provider, the provider makes a record of your visit. Typically, this record contains your health history, current symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment. This information, often referred to as your medical record, serves as the following:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care that you received.
- Means by which you or a third-party payer can verify that you actually received the services billed for.
- Tool in medicine education and research.
- Source of information for public health officials charged with improving the health of the regions they serve.
- Tool to assess the appropriateness and quality of care that you received.
- Tool to improve the quality of health care and achieve better patient outcomes.

Understanding what is in your health records and how your health information is used helps you to:

- Ensure its accuracy and completeness.
- Understand who, what, where, why, and how others may access your health information.
- Make informed decisions about authorizing disclosure to others.
- Better understand the health information rights detailed below.

Your Rights under the Federal Privacy Standard

Although your health records are the physical property of the health care provider who completed it, you have the following rights with regard to the information contained therein:

- Request restriction on uses and disclosures of your health information for treatment, payment, and health care operations. “Health care operations” consist of activities that are necessary to carry out the operations of the provider, such as quality assurance and peer review. The right to request restriction does not extend to uses or disclosures permitted or required under the following sections of the federal privacy regulations: § 164.502(a)(2)(i) (disclosures to you), 164.510(a) (for facility disclosures, but note that you have the right to object to such uses), or 164.512 (uses and disclosures not requiring consent or an authorization). The latter uses and disclosures include, for example, those required by law, such as mandatory communicable disease reporting. In those cases, you do not have a right to request restriction. The consent to use and disclose your individually identifiable health information provides the

ability to request restriction. We do not, however, have to agree to the restriction. If we do, we will adhere to it unless you request otherwise, or we give you advance notice. You may also ask us to communicate with you by alternate means, and if the method of communication is reasonable, we must grant the alternate communication request. You may request restriction or alternate communications on the consent form for treatment, payment, and health care operations.

- Obtain a copy of this Notice of Privacy Practices. Although we have posted a copy in prominent locations throughout the facility and on our website, you have a right to a hard copy upon request.
- Inspect and copy your health information upon request. Again, this right is not absolute. In certain situations, such as if access would cause harm, we can deny access. You do not have a right of access to the following:
    - Psychotherapy notes. Such notes consist of those notes that are recorded in any medium by a health care provider who is a mental health professional documenting or analyzing a conversation during a private, group, joint, or family counseling session and that are separated from the rest of your medical record.
    - Information compiled in a reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings.
    - Protected health information ("PHI") that is subject to the Clinical Laboratory Improvement Amendments of 1988 ("CLIA"), 42 U.S.C. § 263a, to the extent that giving you access would be prohibited by law.
    - Information that was obtained from someone other than a health care provider under a promise of confidentiality and the requested access would be reasonably likely to reveal the source of the information.

    In other situations, we may deny you access, but if we do, we must provide you a review of our decision denying access. These "reviewable" grounds for denial include the following:

    - A licensed healthcare professional, such as your attending physician, has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety or yourself or another person.
    - PHI refers to another person (other than a health care provider) and a licensed health care provider has determined, in the exercise of professional judgment, that the access is reasonably likely to cause substantial harm to such other person.
    - Your personal representative makes the request and a licensed health care professional has determined, in the exercise of professional judgment, that giving access to such personal representative is reasonably likely to cause substantial harm to you or another person.

    For these reviewable grounds, another licensed professional must review the decision of the provider denying access within 60 days. If we deny you access, we will explain why and what your rights are, including how to seek review. If we grant access, we will tell you what, if anything, you have to do to get access. We reserve the right to charge a reasonable, cost-based fee for making copies.

- Request amendment/correction of your health information. We do not have to grant the request if the following conditions exist:

- We did not create the record. If, as in the case of a consultation report from another provider, we did not create the record, we cannot know whether it is accurate or not. Thus, in such cases, you must seek amendment/correction from the party creating the record. If the party amends or corrects the record, we will put the corrected record into our records.
- The records are not available to you as discussed immediately above.
- The record is accurate and complete.

If we deny your request for amendment/correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we grant the request, we will make the correction and distribute the correction to those who need it and those whom you identify to us that you want to receive the correct information.

- Obtain an accounting of non-routine uses and disclosure, those other than for treatment, payment, and health care operations. We do not need to provide an accounting for the following disclosures:
  - To you for disclosures of protected health information to you.
  - For the facility directory or to persons involved in your care or for other notification purposes as provided in § 164.510 of the federal privacy regulations (uses and disclosures requiring an opportunity for the individual to agree or to object, including notification to family members, personal representatives, or other persons responsible for your care, of your location, general condition, or death).
  - For national security or intelligence purposes under § 164.512(k)(2) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
  - To correctional institutions or law enforcement officials under § 164.512(k)(5) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
  - That occurred before April 14, 2003.

  We must provide the accounting within 60 days. The accounting must include the following information:

  - Date of each disclosure.
  - Name and address of the organization or person who received the protected health information.
  - Brief description of the information disclosed.
  - Brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure or, in lieu of such statement, a copy of your written authorization or a copy of the written request for disclosure.

  The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.

- Revoke your consent or authorization to use or disclose health information except to the extent that we have taken action in reliance on the consent or authorization.

- Request your PHI be provided in electronic format, or be transferred to you electronically, via email. We will try to accommodate such requests to the best of our abilities. If we cannot, we will inform you accordingly.
- Request a specific way of communication when releasing your PHI, e.g. fax, mail, email etc.
- Be notified immediately once a breach of PHI occurs, or is detected by any Clinic representative, and inform you what measures we are talking to mitigate the harm, if any.
- Restrict certain disclosures of PHI to a health plan if you pay out of pocket in full for the healthcare item or service, and the PHI requested is directly related to that item or service.

Our Responsibilities under the Federal Privacy Standard

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law. In addition to informing you your rights, the federal privacy standard requires us to take the following measures:

- Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.
- Provide you this Notice as to our legal duties and privacy practices with respect to individually identifiable health information that we collect and maintain about you.
- Abide by the terms of this Notice.
- Train our personnel concerning privacy and confidentiality.
- Implement a sanction policy to discipline those who breach privacy/ confidentiality or our policies with regard thereto.
- Mitigate (lessen the harm of) any breach of privacy/confidentiality.

Examples of Disclosures for Treatment, Payment, and Health Operations

- We will use your health information for treatment.
- Example: A physician or another member of your health care team will record information in your record to diagnose your condition and determine the best course of treatment for you. The primary caregiver will give treatment orders and document what he or she expects other members of the health care team to do to treat you. Those other members will then document the actions they took and their observations. In that way, the primary caregiver will know how you are responding to treatment.
- We will also provide your physician, other health care professionals, or subsequent health care provider copies of your records to assist them in treating you once we are no longer treating you.
- We will use your health information for payment.
- Example: We may send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatment received, and supplies used.
- We will use your health information for healthcare operations.
- Example: Members of the staff, students or members of the quality assurance team may use information in your health record to assess the care and outcomes in your cases and the competence of the caregivers. We will use this information in an effort to improve the quality and effectiveness of the health care and services that we provide.

- Business associates: We provide some services through contracts with business associates.
- Examples include certain diagnostic tests, a copy service to make copies of medical records, and the like. When we use these services, we may disclose your health information to the business associates so that they can perform the function(s) that we have contracted with them to do and bill you or your third-party payer for services provided. To protect your health information, however, we require the business associates and their subcontractors to appropriately safeguard your information by following strict privacy and security protocols, as mandated by law.
- Notification: We may use or disclose information to notify or assist in notifying a family member, a personal representative, or another person responsible for your care, your location, and general condition.
- Communication with family: Unless you object, health professionals, using their best judgment, may disclose to a family member, another relative, a close friend, or any other person that you identify health information relevant to that person's involvement in your care or payment related to your care.
- Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.
- Marketing/continuity of care: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You have the right to request not to receive subsequent marketing materials and opt out from getting marketing communications.
- Fundraising: We may contact you as a part of a fundraising effort and may look for some demographic information for fundraising purposes. You have the right to request not to receive subsequent fundraising materials and opt out from getting fundraising communications.
- Food and Drug Administration ("FDA"): We may disclose to the FDA health information relative to adverse effects/events with respect to food, drugs, supplements, product or product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
- Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relation to workers compensation or other similar programs established by law.
- Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- Correctional institution: If you are an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.
- Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
- Health oversight agencies and public health authorities: If a member of our work force or a business associate believes in good faith that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public, they may disclose your health information to health oversight agencies and/or public health authorities, such as the department of health.

- The Federal Department of Health and Human Services ("DHHS"): Under the privacy standards, we must disclose your health information to DHHS as necessary to determine our compliance with those standards.
- Educational presentations: We may use information collected in an examination for the purpose of educating our students and practitioners. Adherence to established protocols to ensure the privacy and confidentiality of your health care information will be applied.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION THAT WE MAINTAIN.

This Notice of Privacy Practices applies to the following entities:

- Clinics at Ketchum Health-Anaheim

How to Get More Information or to Report a Problem

Additional Information or complaints about how the Clinic(s) has handled your health care information should be directed to the Director of Healthcare Policy Compliance, by calling his office at 714.463.7534.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights, 200 Independence Avenue, S.W., Room 590F HHH Building, Washington, DC 20201

EXHIBIT 34 NOTICE OF PRIVACY PRACTICES-SPANISH

AVISO SOBRE PRACTICAS DE PRIVACIDAD

ESTE DOCUMENTO DESCRIBE COMO LA INFORMACIÓN RELACIONADA CON SU ARCHIVO MEDICO PUEDE SER USADA O DIVULGADA, Y COMO USTED PUEDE TENER ACCESO A DICHA INFORMACIÓN. POR FAVOR LEA ESTE DOCUMENTO CUIDADOSAMENTE.

Explicación sobre la información contenida en su archivo médico.

Cada vez que usted visita su proveedor de salud, dicho proveedor elabora un registro de su visita. Generalmente, este registro (archivo) contiene su historia médica, síntomas actuales, resultados de exámenes diagnósticos, tratamientos sugeridos y recomendaciones para cuidado en el futuro. Esta información, también conocida como archivo médico, tiene los siguientes propósitos:

- Servir de base para planear su atención médica.
- Permitir la comunicación entre profesionales de la salud que pueda contribuir al cuidado de su salud.
- Es un documento legal que describe el tipo de atención médica que usted recibe.

- Facilitar la verificación de servicios suministrados cuando otra entidad lo requiera, o para su propio beneficio.
- Servir de herramienta educativa y de investigación.
- Servir de fuente de información para funcionarios de la salud, encargados de mejorar las condiciones médicas de la región donde dichos funcionarios trabajan.
- Facilitar la evaluación de la calidad del servicio que usted ha recibido.
- Servir de medio para mejorar la atención a los pacientes.

Explicación acerca del contenido de su archivo médico.

El uso de la información de su archivo puede ayudarle a:

- Asegurar que dicha información este correcta y completa.
- Saber quién, qué, cómo, cuándo, dónde y cuáles otras entidades o personas tendrán acceso a dicho archivo.
- Decidir correctamente acerca de cómo entregar información a otras personas o entidades.
- Saber sus derechos sobre información de la salud, los cuales se detallan a continuación.

Sus Derechos contenidos en la Ley Federal de Privacidad.

Aunque el archivo médico es propiedad de la entidad que lo creó, usted tiene los siguientes derechos en cuanto a su contenido y al uso del mismo:

- Solicitar la restricción en el uso y divulgación de su archivo médico, para efectos de tratamiento, pagos y actividades médicas relacionadas. Dichas actividades consisten en todos aquellos actos necesarios llevados a cabo por los proveedores de salud para cumplir con sus operaciones, tales como control de calidad y evaluación del personal médico. El derecho a solicitar restricciones en el manejo de su archivo no se aplica al uso o divulgación permitidos o requeridos por la Ley Federal de Privacidad, de la siguiente manera: 164.502(a)(2)(i) (entrega del archivo a usted mismo), 164.510(a) (listados telefónicos del mismo centro de salud; sin embargo, usted tiene el derecho a oponerse a dichos usos), o 164.512 (uso del archivo cuando no se requiere consentimiento del paciente). El uso del archivo bajo estas leyes federales incluye, por ejemplo, el reporte de enfermedades contagiosas. En estos casos, usted no tiene el derecho de solicitar restricciones en el manejo del archivo. El consentimiento para usar y divulgar su información médica le permite a usted solicitar restricciones en dicho manejo. La Clínica no está obligada a cumplir con dicha solicitud de restricción. Si la Clínica acepta la solicitud, nosotros acataremos dicha restricción a no ser que usted disponga lo contrario; nosotros le avisaremos anticipadamente cualquier determinación en contrario. Usted puede solicitar también un medio alternativo para comunicarnos con usted; si la Clínica acepta dicho medio, nosotros acataremos su solicitud. Usted puede pedir restricciones o medios alternos de comunicación al momento de recibir esta forma.
- Obtener una copia de este documento. Aunque dicha forma está exhibida en la recepción y se encuentra publicada en nuestra página de Internet, usted tiene el derecho de solicitar una copia por escrito.

- Revisar y solicitar copia de su archivo. De nuevo, este no es un derecho absoluto. En ciertas ocasiones este derecho puede ser negado: por ejemplo, cuando el acceso a su archivo puede causar algún daño. En los siguientes casos, usted no puede acceder al archivo:
    - Notas de Terapia Psicológica. Dichas notas consisten en apuntes que son registrados o grabados en cualquier medio, por parte de un especialista en salud mental, y tienen como finalidad documentar o analizar conversaciones sostenidas durante terapias individuales o de grupo, o sesiones de ayuda familiar, y son separadas del resto de su archivo médico.
    - Cuando se ha recogido información anticipadamente la cual va a ser usada en procesos judiciales o administrativos
    - Información Médica Protegida ("PHI") regulada por el Acuerdo para Mejoramiento de Practicas de Laboratorio ("CLIA", por sus siglas en Inglés), 42 U.S.C. 263ª, cuando el acceso a dicha información esté prohibido por la ley.
    - Cuando la información fue obtenida de otra fuente diferente al proveedor de salud, bajo un acuerdo de confidencialidad, y la divulgación del archivo médico podría revelar la identidad de dicha fuente.

  Pueden presentarse otras situaciones en las que le neguemos el acceso al archivo; en dicho caso, le explicaremos las razones para dicha negativa, que podrían incluir los siguientes hechos:

    - Un profesional de la salud, tal como el Doctor que lo atiende, en uso de sus facultades profesionales, considera que el acceso al archivo médico puede poner en riesgo la vida o la salud física suya, o de cualquier otra persona.
    - La información médica contenida en el archivo hace referencia a alguna persona diferente al proveedor de salud, y el Doctor, en uso de sus facultades profesionales, considera que el acceso al archivo podría causarle daño a dicha persona

  Otro Doctor deberá revisar las razones para negar el acceso al archivo, dentro de los siguientes 60 días. Si la Clínica niega el acceso a su archivo, le explicaremos las razones, y cuáles son sus derechos, incluyendo la petición para ser revisar la decisión.

  Si la Clínica permite el acceso al archivo, le explicaremos qué debe hacer. La Clínica de Medicina Familiar se reserva el derecho de cobrar una suma de dinero razonable por copias y manejo administrativo.

- Solicitar que el archivo sea agregado y/o corregido. La Clínica puede negar dicha solicitud, si las siguientes condiciones se presentan:
    - El archivo no fue creado en la Clínica, y por lo tanto no podemos certificar la veracidad de la información. Tal es el caso cuando LA CLÍNICA obtiene un reporte de consulta creado por otro proveedor de salud. Sin embargo, usted podrá solicitar que el record sea corregido por dicho proveedor. Si el archivo es enmendado, la Clínica incluirá dicha información dentro de su record médico.
    - El archivo no está disponible, según lo expuesto en el punto anterior.
    - El record se encuentra completo y la información esta correcta.

En caso de que la Clínica niegue la solicitud de enmienda o corrección, le explicaremos las razones, y la forma en que usted podrá incluir en su archivo una declaración con su desacuerdo. La Clínica se reserva el derecho de agregar dicha declaración a su record. Si la Clínica acepta la solicitud de enmienda, nosotros corregiremos el archivo y lo haremos llegar a todas las partes que lo necesiten o a las personas indicadas por usted.

- Cuando su archivo ha sido usado para efectos diferentes al tratamiento médico, pagos o actividades relacionas con su salud, usted podrá obtener un registro de dichas actividades y usos. La Clínica no está obligada a entregar copia de este registro en los siguientes casos:
  - Cuando la entrega de su información se ha realizado a usted mismo(a)
  - Al director de la Clínica o a las personas encargadas de su atención médica, o de acuerdo a lo dispuesto por la Ley Federal de Privacidad en 164.510 (uso o divulgación del archivo cuando se requiere que al paciente se le brinde la oportunidad de objetar o aprobar dichos usos, incluyendo la notificación a familiares, representantes personales, o cualquier otra persona encargada de su atención médica, o cuidados generales, incluyendo su fallecimiento.
  - Para efectos de seguridad nacional, de acuerdo a la Ley Federal de Privacidad 164.512(k)(2) (divulgación del archivo sin autorización u oportunidad para objetar)
  - A establecimientos carcelarios o a funcionarios de ley de acuerdo a la Ley Federal De Privacidad 164.512(k)(5) (divulgación del archivo sin autorización u oportunidad para objetar).
  - Uso o divulgación de información ocurrida antes del 14 de abril del 2003

La Clínica debe entregar el reporte dentro de 60 días. Dicho reporte debe incluir:

- Fecha de la entrega
- Nombre de la entidad o persona quien recibe la información confidencial
- Breve descripción de la información entregada
- Una declaración breve en la que se explique la razón para entregar su información confidencial, o copia escrita de su autorización para entregar información confidencial.

La información de los primeros 12 meses no tiene costo. La clínica se reserva el derecho de cobrar una suma razonable por información entregada después del primer año.

- Usted podrá revocar la autorización o consentimiento para el uso o la divulgación de su archivo medical, excepto en los casos en los cuales alguna actividad fue desarrolla antes de dicha revocación.
- Solicitar que su PHI le sea entregada en formato electrónico, o le sea transferida a usted electrónicamente vía email.
- Escoger el medio de comunicación más conveniente para usted cuando requiera su historial médico, e.g. fax, correo ordinario, etc.
- Ser notificado inmediatamente después de que alguna información de su archivo medico haya sido divulgada a terceras personas no autorizadas para recibirla. En dicho caso, le informaremos cuáles medidas se están tomando para corregir el incidente.

- Restringir la entrega de algún elemento de su historial médico a su plan de seguros, cuando la información requerida se relacione con un servicio o producto pagado en efectivo.

Responsabilidades de la Clínica bajo la Ley Federal de Privacidad

Además de informarlo a usted acerca de sus derechos, la Ley Federal de Privacidad nos exige que tomemos las siguientes medidas:

- Mantener la privacidad de su archivo médico, implementando medidas de seguridad físicas, técnicas y administrativas.
- Entregarle a usted este documento, el cual contiene información sobre nuestros deberes legales acerca del manejo de su archivo médico y de toda la información médica que obtengamos de usted.
- Acatar los términos de este documento.
- Instruir a nuestros empleados en todo lo relacionado con asuntos de privacidad y confidencialidad.
- Implementar políticas disciplinarias encargadas de corregir y sancionar al personal que incumpla las disposiciones de este documento.
- Corregir en lo posible cualquier violación a la privacidad de su archivo.

La Clínica no entregará información de su archivo sin su consentimiento, excepto en los casos mencionados en este documento, o cuando lo requiera la Ley.

Ejemplos de Divulgación del Archivo para Tratamiento, Pagos y Actividades Medicas Relacionadas.

- ***La Clínica usara la información médica para su tratamiento***.
  Ejemplo: Cualquier miembro del equipo medico encargado de atenderlo, va a registrar toda la información en su archivo médico, con el fin de suministrar un diagnóstico y determinar el mejor tratamiento a seguir. El Doctor proveerá las órdenes relacionadas con su tratamiento, y registrará todas las indicaciones dadas al equipo médico acerca de cómo usted debe ser atendido. Dicho equipo médico registrara igualmente todas las acciones tomadas y sus observaciones. De esta manera, el Doctor sabrá cómo usted está respondiendo al tratamiento.

  Cuando nosotros hayamos terminado con su tratamiento médico, la Clínica también entregará copia del archivo médico a su Doctor primario, o a cualquier otro profesional de la salud, para asistirlos en su atención.

- ***La Clínica usará la información médica para efectos de pago.***
  Ejemplo: La Clínica podrá enviarle un cobro a usted o a su compañía aseguradora. Dicho cobro podrá incluir información confidencial que lo identifique, tratamiento recibido, diagnósticos, o suministros proveídos.

- Empleados, estudiantes, o miembros del equipo de servicio al cliente podrán usar la información de su archivo médico para evaluar el tratamiento brindado y los resultados

obtenidos en su caso, así como también la idoneidad de los Doctores. La Clínica usará su información en un esfuerzo por mejorar la calidad de nuestros servicios.

- ***Socios de Negocios:*** La Clínica provee servicios a través de contratos con terceros. Ejemplos incluyen exámenes diagnósticos, o servicios de copiado, y similares. Cuando la Clínica contrata estos servicios, es posible que su información médica sea divulgada o usada para llevar a cabo el servicio contratado; igualmente, podremos enviarle un cobro por dichos servicios. La Clínica exige que nuestros socios de negocios protejan adecuadamente su información confidencial.
- ***Notificación:*** La Clínica usará su información para avisarle a su familia, a su representante personal o a cualquier otra persona responsable por su cuidado, acerca de su ubicación y de su estado de salud.
- ***Comunicación con la familia:*** Nuestros doctores podrán, en uso de sus facultades profesionales, divulgar su información médica a miembros de su familia, amigos personales, o a cualquier otra persona siempre y cuando la participación de dichas personas sea relevante para llevar a cabo su tratamiento o para efectos de pago.
- ***Estudios de Investigación:*** La Clínica podrá divulgar información confidencial a los investigadores siempre y cuando el estudio en curso haya sido aprobado por la Junta Institucional de Revisión, y se hayan establecido procedimientos adecuados para proteger su información confidencial.
- ***Mercadeo/ Continuidad en la atención médica:*** La Clínica podrá contactarlo(a) a usted para recordarle visitas de control, o para ofrecerle tratamientos alternativos, o cualquier otro plan de salud que pudiera beneficiarlo. Usted puede solicitar no ser contactado para estos propósitos
- ***Recolección de Fondos:*** Nosotros podremos contactarle como parte de nuestros esfuerzos para la obtención de recursos económicos. Usted puede solicitar no ser contactado para estos propósitos.
- ***Administración Federal de Drogas y Alimentos ("FDA"):*** La Clínica podrá entregar a la FDA información relacionada con efectos secundarios adversos causados por alimentos, drogas, suplementos, producto(s) defectuosos, o información relacionada con seguimiento a productos que permitan su reemplazo o decomiso de dichos productos.
- ***Compensación al trabajador:*** Nosotros podremos entregar información relacionada con la Compensación al Trabajador hasta el límite permitido por la ley para dichos efectos, o para programas similares.
- ***Salud Pública:*** De acuerdo a la ley, la Clínica podrá entregar su información confidencial a entidades públicas encargadas de velar por el control y prevención de enfermedades, accidentes y discapacidades.
- ***Instituciones Carcelarias:*** Si usted está detenido, nosotros podremos entregar su información médica a la institución carcelaria para efectos del cuidado de su salud y la seguridad de cualquier otra persona alrededor.
- ***Cumplimiento de la Ley:*** Podremos entregarles información confidencial a miembros de la fuerza pública cuando así lo requiera la ley, o cuando se solicite a través de decisión judicial.
- ***Supervisión por parte de Entidades de Control y Agencias Públicas de Salud:*** Si alguno de nuestros empleados, o asociado de negocios considera de buena fe que la Clínica se ha involucrado en alguna conducta ilegal, o de alguna manera ha violado los

estándares profesionales y está poniendo en riesgo a uno o más pacientes, empleados o al público en general, nosotros podremos entregar su información confidencial a entidades públicas de control, tales como el Departamento de Salud.

- ***Departamento Federal de Salud y Servicios Humanos ("DHHS"):*** Bajo los estándares de privacidad, nosotros tendremos la obligación de divulgar su información confidencial al DHHS hasta el punto necesario para determinar nuestro cumplimiento con dichas normas de privacidad.
- ***Educación:*** La Clínica podrá usar la información médica obtenida en el curso de su examen para efectos educativos. Nosotros haremos cumplir todos los procedimientos con el fin de que la privacidad de su información confidencial sea respetada.

LA CLINICA SE RESERVA EL DERECHO DE CAMBIAR SUS PROCEDIMIENTOS, Y DE AGREGAR NUEVAS DISPOSICIONES RELACIONADAS CON EL MANEJO DE LA INFORMACION MEDICA CONFIDENCIAL QUE POSEE. EN CASO DE CAMBIAR NUESTRAS POLITICAS DE MANEJO DE INFORMACION, LA CLINICA LE ENVIARA POR CORREO UNA COPIA DE LOS NUEVOS PROCEDIMIENTOS.

Cómo Obtener Información Adicional o Reportar un Problema

Cualquier reclamo acerca de sus derechos sobre el manejo de la información confidencial, diríjase al Director de Políticas de Salud, llamando al 714.463.7534

Si por cualquier motivo usted no se encuentra satisfecho con el manejo dado a su reclamo, usted puede formular una queja directamente a:

DHHS, Oficina de Derechos Civiles
200 Independence Avenue, SW
Room 5009F HHH Building
Washington, DC 20201

EXHIBIT 35 CONFIDENTIALITY NON-DISCLOSURE AGREEMENT – PERSONAL VISIT

I, the undersigned, acknowledge that during the course of my visit at Ketchum Health, (hereby referred to as "facility"), I may receive or have access to Sensitive Confidential Information of the facility, including protected health information (PHI) that is prohibited from disclosure to others. Such information can be acquired by any means and in any form, written, spoken, or electronic.

An express consent from the patient must be obtained before allowing third party individuals to be present during the exam. Signing this form does not guarantee access to protected health information if the patient refuses to allow individuals other than faculty or interns to be present during the evaluation.

I agree not to share, disclose or discuss Confidential, Protected Health Information with anyone who does not have a legitimate interest in such information. I will maintain and protect

the privacy of the facility's employees, medical staff and patients in my business use and disclosure of Confidential Information, and I will not misuse or be careless with such information.

I acknowledge that I have reviewed this document entirely. I understand that compliance with the principles, policies and procedures expressed above is a condition of my participation and continued presence at the facility.

_____ _____ _____

Name *Signature* *Date*

EXHIBIT 36 APPLICATION FOR DISCOUNTED SERVICES-PROOF OF INCOME REQUIRED*

I hereby request consideration for professional services to be discounted based on my household income. I voluntarily give the below requested information for the purpose of determining my eligibility for these services.

Parent/Guardian name(s) _____

Patient's name(s) _____

DOB _____ SS# _____

Address _____

City _____ State _____ Zip _____

Phone Numbers: Home _____ Work_____ Cell_____

Employer _____

Employer's Address _____

Do you have health insurance such as Medicare, Medi-Cal, Kaiser, Blue Cross? ☐ Yes ☐ No
Do you belong to a vision care plan such as Medi-Cal or VSP (Vision Service Plan)? ☐ Yes ☐ No
Are you entitled to Medi-Cal/ CalOptima benefits? ☐ Yes ☐ No

Attach Proof of Household Income * 3 months most recent pay stubs OR W2/1099forms. W2/1099 forms will ONLY be accepted through June 30th of each calendar year.
List total household income. Household income refers to income from any source of all members living in the same residence.

Gross wages or salary before taxes $_____ Per _____

Public Assistance (cash aid, food stamps) $_____ Per _____

Other income $_____ Per _____

Total monthly income $_____

Total number of legal dependents _____

I hereby certify that the information on this form is true and correct. I further authorize the **University Eye Center at Fullerton** to check with any person, business, credit reporting agency, or government organization, whether named above or not, for the purpose of verifying the information provided.

I understand and agree that if it is later determined that the information I have provided on the form has been misrepresented or is not factual, the amount of the reduction of professional fees obtained by this request will, at the discretion of the **University Eye Center at Fullerton**, be added to my account and that sum is due and payable on the date the determination is made.

_____ _____

Signature of Requestor Date

****DISCOUNTS ARE ONLY VALID FOR 6 MONTHS FROM APPROVAL DATE.****

EXHIBIT 37 TELEMEDICINE CONSENT

TELEMEDICINE PATIENT CONSENT FORM

California law defines telemedicine as a method to deliver healthcare services using information and communication technologies to facilitate the diagnosis, consultation, treatment, and care management while the patient and provider(s) are at two different locations.

The purpose of this form is to obtain your consent to participate and engage in a telemedicine consultation as part of your care.

By signing this form, I understand and acknowledge the following:

1. The laws that protect the confidentiality of my medical information also apply to Telehealth. As such, I understand that the information disclosed by me during the course of the consultation is generally confidential.

2. There are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my providers, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

3. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

4. I understand that telemedicine may involve electronic communications of my personal medical information to third parties as part of the continuity of my care, if required.

5. I understand that I may benefit from Telehealth, but my providers cannot, and will not, guarantee a specific result based on these encounters.

In rare cases, security protocols could fail, causing a breach of privacy of protected health information.

I hereby authorize Ketchum Health to use Telehealth in the course or my diagnosis and treatment.

Patient Name: _____ Date_____

Patient Signature: _____

EXHIBIT 38 NSA-GOOD FAITH ESTIMATE

Good Faith Estimate for Services and/or Materials

Name: **Date:** **Acct #:**
Date of Birth:

Patient Last Name	Patient First Name and Middle Name	Patient ID Number	Date of Birth
		Total Cost Estimate of Services and Products	

Questions about this notice and estimate? Call (714)463-7500

Understanding your options

You can also get the items or services described in this notice from providers who are in-network with your health plan. Please call or visit the website of your insurance provider for a list of in-network providers.

More information about your rights and protections

Contact the U.S. Centers for Medicare & Medicaid Services (CMS) at 1-800-MEDICARE (1-800-633-4227) or visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

I understand that I give up my federal consumer protections and agree to pay for out-of-network care. With my signature, I agree to receive the items or services from **Ketchum Health and its Providers**
With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I am giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services or have to pay out-of-network cost-sharing under my health plan
- I was given a written notice on or before the date of service explaining that my provider or facility is not in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I received this notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I understand this estimate is subject to change
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You **do not** have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

Patient's Signature	Date	Guardian or Authorized representative's Signature	
Print Name of Patient		Print Guardian/authorized representative's Signature	

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The amount below is only an estimate. It is not an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This estimate is subject to change. The estimated costs are valid for 12 months from the date of the Good Faith Estimate. This means that **the final cost of services may be different than this estimate**.

Date of Service	Service Code	Description	Estimated Amount to be Billed

EXHIBIT 39 NSA-GOOD FAITH ESTIMATE SPANISH

Estimación de buena fe para servicios y/o materiales

Apellido	Nombre Completo	Identificacion	Fecha de Nacimiento

Estimación del Costo Total de Servicios y Productos	

¿Tiene preguntas sobre este aviso y presupuesto? Call

(714) 463-7500 **¿Cuáles son sus opciones?**

Usted puede obtener los artículos o servicios descritos en este aviso de proveedores que están dentro de la red de su plan de salud. Llame o visite el sitio web de su proveedor de seguros para obtener una lista de proveedores dentro de su plan**.**

Más información sobre sus derechos y protecciones

Comuníquese con los Centros de Servicios de Medicare y Medicaid (CMS) de EE. UU. al 1-800-MEDICARE (1800-633-4227) o visite https://www.cms.gov/nosurprises para obtener más información sobre sus derechos según la ley federal.

Renuncio a mis protecciones de ley al consumidor y acepto pagar la atención fuera de la red.
Con mi firma, acepto recibir los artículos o servicios de **Ketchum Health y sus proveedores de Salud** Con mi firma, reconozco que doy mi consentimiento voluntario y que no estoy siendo obligado ni presionado.

También entiendo que:

· Renuncio a algunas protecciones de facturación al consumidor según la ley federal

· Es posible que reciba una factura de cobro por los cargos completos de estos artículos o servicios, o que tenga que pagar un costo compartido adicional fuera de la red según mi plan de salud. Recibí un aviso por escrito en la fecha del servicio (o antes), en el que se explica que mi proveedor o centro no está en la red de mi plan de salud, el costo estimado de los servicios y lo que podría deber si acepto ser tratado por este proveedor o centro de salud. Recibí este aviso en papel o por correo electrónico, de acuerdo a mi elección.

· Entiendo total y completamente que algunos o todos los montos que pago pueden no contar para el deducible o el límite de gastos de bolsillo de mi plan de salud.

· Entiendo que este estimado está sujeto a cambios dependiendo del producto o servicio obtenido · Puedo terminar este acuerdo notificando al proveedor o centro de salud por escrito antes de recibir los servicios.

IMPORTANTE: No es necesario que firme esta forma. Si no lo hace, es posible que este proveedor o centro no lo atienda. Puede optar por recibir atención de un proveedor o centro dentro de la red de cubrimiento de su plan de salud.

Firma del Paciente Firma del Representante Legal/Guardián

Nombre del Paciente Nombre del Representante Legal/Guardián

Fecha

Esta estimación de buena fe muestra los costos razonables por artículos o servicios que usted debería pagar por concepto de dicha atención médica o artículo. La estimación se basa en información conocida en el momento de crear el presupuesto. **La cantidad a continuación es solo una estimación**. No es una oferta o contrato de servicios. Esta estimación muestra los costos totales **estimados** de los artículos o servicios enumerados. No incluye ninguna información sobre lo que puede cubrir su plan de salud. **Esta estimación está sujeta a cambios.** Los costos estimados son válidos por 12 meses a partir de la fecha del Estimado de buena fe. Esto significa que el costo final de los servicios puede ser diferente a esta estimación.

Fecha del Servicio	Codigo	Descripcion	Valor Aproximado para Cobrar
		Estimación del Costo Total de Servicios y Productos	

EXHIBIT 40 DILATION FAQS

Dilation FAQs

How does dilation works?

Dilating your pupil lets more light into your eye — just like opening a door lets light into a dark room**.** Dilation helps your eye doctor check for many common eye problems, including diabetic retinopathy, glaucoma, age-related macular degeneration (AMD), and retinal detachment. Your eye doctor will check for vision problems that make it hard to see clearly, like being nearsighted or farsighted.

What is a dilated eye exam?

Your doctor will put some eye drops to dilate (widen) your pupil and check for eye diseases. It takes anywhere from 15 minutes to half an hour for your eyes to completely dilate. Dilation allow your eye doctor to check your eyes from front to back.

How long will it take for my pupils to return to their normal size?

You can expect to wait two to four hours before they return to their pre-dilated state. Everyone is different and metabolizes the medication differently.

Will I be able to drive afterward?

Since dilation turns focusing into struggle, we do not recommend you drive while your eyes are dilated. Please find a friend or a family member to take you to your eye appointment.

Will I be able to work after?

Like with driving, you will have trouble focusing and seeing after eye dilation. You may also experience eye strain. So, try to schedule your appointment for the end of the day. Alternatively, if you can, plan to take the rest of the day off!

Are there any side effects or risks from dilation?

Dilation does not hurt. It is only temporary, and there are no lasting side effects. In fact, our eyes naturally dilate on their own throughout the day as they adjust to changing light, stimulation, and even our changing emotions. Having them medically dilated simply helps your eye doctor re-create what your body does on its own.

EXHIBIT 41 DILATION FAQS (SPANISH)

Dilatación de la Pupila-Preguntas Frecuentes

¿**Cómo funciona la dilatación?**
Dilatar la pupila permite que entre más luz en el ojo. La dilatación ayuda al Doctor a detectar muchos problemas oculares comunes, como la retinopatía diabética, el glaucoma, la degeneración macular relacionada con la edad (AMD), y el desprendimiento de retina. Su Doctor revisará si hay problemas de la vista que dificulten una visión clara, como la miopía o la hipermetropía.

¿En qué consiste un examen de los ojos con dilatación?
Su médico le colocará unas gotas en los ojos para dilatar (ampliar) su pupila y detectar enfermedades de la visión. Los ojos tardan entre 15 minutos y media hora en dilatarse por completo. La dilatación le permite al Doctor revisar sus ojos desde el frente hasta la parte de atrás.

¿Cuánto tiempo tardarán mis pupilas en volver a su tamaño normal?
Podrían tardar entre dos a cuatro horas antes de que vuelvan a su estado anterior a la dilatación. Todos somos diferentes y metabolizamos el medicamento de manera desigual.

¿Podré conducir después del examen?

Dado que la dilatación dificulta el enfoque de la vista, no recomendamos que conduzca con los ojos dilatados. Busque a un amigo o familiar para que lo lleve a su cita.

¿Podré trabajar después del examen?

Al igual que conducir un vehículo, tendrá problemas para enfocar y podría sentir fatiga visual después de la dilatación. Por lo tanto, trate de programar su cita para el final del día. Alternativamente, si puede, planee tomarse el resto del día libre.

¿Existen efectos secundarios o riesgos derivados de la dilatación?

La dilatación no duele. Es solo temporal y no hay efectos secundarios duraderos. De hecho, nuestros ojos se dilatan naturalmente por sí solos a lo largo del día a medida que se adaptan a los cambios de luz, la estimulación externa, e incluso a nuestras emociones cambiantes. Tenerlos médicamente dilatados simplemente ayuda a su Doctor a recrear lo que su cuerpo hace por sí solo.

KETCHUM HEALTH

University Eye Center