



**Kentucky Public Health**  
Prevent. Promote. Protect.  
**ADMINISTRATIVE REFERENCE  
FOR LOCAL HEALTH DEPARTMENTS**

***Effective: Fiscal Year 2024***

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## FOREWORD

The Kentucky Department of Public Health (DPH) provides guidelines and procedural instruction that local health departments (LHDs) are to follow for their daily operations. This guidance is provided through the online publication of the Administrative Reference (AR). This edition of the DPH AR is updated to include all additions and changes that occurred from July 1, 2022 through June 30, 2023. **The effective dates of this AR publication are July 1, 2023 through June 30, 2024.**

### AUTHORITY FOR DPH ADMINISTRATIVE REFERENCE

The guidelines contained in this official document are minimum requirements for the operation of Kentucky's LHDs, established under the statutory authority of [KRS 194A.050](#) and [KRS 211.025](#) in accordance with [KRS 211.090](#), [KRS 211.170](#), [KRS 211.190](#) and [KRS 212.230](#). *These guidelines must be adhered to by all LHDs* and are related to [KRS 212.020](#), [KRS 212.210](#), [KRS 212.245](#), [KRS 212.640](#), [KRS 212.855](#), [KRS 212.860](#) and [KRS 212.880](#). Regulations regarding board of health requirements are outlined in [902 KAR 8:150](#) and LHD operations requirements are in [902 KAR 8:160](#).

Except as otherwise provided by law or regulation, any member of the public, patient, or LHD that is aggrieved by any guidelines included within this reference may request a waiver of such policy or procedure by submitting a signed and dated written request with appropriate and verifiable documentation of undue hardship to the Director of the [Administration and Financial Management Division](#) (AFM). In the event the AFM Director rejects/denies the waiver request, the affected party may appeal, in writing, to the DPH Commissioner for final review and consideration.

The Louisville Metro Health Department, Lexington-Fayette County Health Department, and Northern Kentucky Independent District Health Departments are governed by separate enabling statutes located under [KRS Chapter 212](#). These statutes are KRS 212.350 to KRS 212.639 and KRS 212.270 to KRS 212.794 and have their own agency-specific policies, particularly with regard to setting of patient fees, board of health governance, membership and appointments, and personnel policies. **Except as otherwise provided by law or regulation, the remainder of the topics and content contained within this AR shall apply to these health departments.**

## **MAINTENANCE OF THE ADMINISTRATIVE REFERENCE FOR LOCAL HEALTH DEPARTMENTS**

### **Keeping Reference Current**

*The DPH Administrative Reference for LHDs (AR) can be found on the Department's [LHD Forms, Documents and Administrative Reference webpage](#).*

- The AR guidance document shall be accessible to all employees, along with local policies, procedures and other reference materials and resources.
- The AR shall be maintained to include reference to all current state administrative guidelines.
- DPH and LHD employees shall have access to the above-referenced webpage and the opportunity to review the AR and any new or revised guidelines shall be conveniently available at all times to all appropriate staff.
- LHDs shall review and utilize the most current AR, located only on the DPH website, and provide training, at minimum, annually to include any new or revised guidelines set forth in this publication.
- Training should also be provided as a result of LHD internal control policy additions/changes, QA/QI assessments, DPH compliance reviews of an LHD site (e.g., review findings and LHD corrective action plans), and DPH onsite visit reports.
- The AR will be reviewed annually by the DPH AR Review Committee, consisting of state and local health department representatives, and coordinated by the Division of Administration and Financial Management (AFM).

### **Clarification of Guidelines**

Questions or issues regarding guidelines contained in the AR for LHDs should be forwarded in writing to the [AFM](#) Division Director and Assistant Director(s).

### **Other Services**

All LHDs must offer voter registration services and retain documentation of such in conformance with Public Law 103-31 ([National Voter Registration Act of 1993](#)).

# CHARTER

## DPH Administrative Reference for LHDs (AR)

**Sponsor:**  
Kentucky Department for Public Health (DPH)

**Contact:**  
Director, Administration and Financial  
Management Division

### Vision/Mission:

To provide operational and financial management guidance and direction to Kentucky local health departments (LHDs). The Administrative Reference (AR) provides guidelines as directed by federal and state statutes, regulations and policies.

### Importance:

The Department for Public Health (DPH) is responsible for the monitoring and oversight of all LHD operations and ensuring the guidelines established in this document are followed. DPH is dedicated to maintaining a strong partnership with LHDs to assure successful delivery of the "Public Health Foundational and Core Services" to the residents of Kentucky.

### Focus:

*The Administrative Reference for LHDs shall provide policies, procedures and guidelines to LHDs as established by state and federal laws and regulations as well as the DPH Commissioner's office and all DPH divisions.*

### Deliverable: Guidance document which:

- Contains complete, accurate and current program information
- Is readily accessible and easy to reference; and
- Is utilized by LHDs for agency operations and program management

### Measures:

- DPH programs provide guidance in accordance with current federal and KY statutes, regulations and DPH policies
- LHD services are delivered per regulations, policies and procedures
- *LHDs **that pass** Medical coding/documentation and financial compliance reviews, per DPH established standards and quality improvement initiatives, indicate LHDs are in compliance*
- LHD issues/concerns are monitored and technical assistance is provided
- User acceptance is evaluated

### Resources:

- 1) No budget is necessary
- 2) DPH Commissioner authorizes the annual fiscal year review with DPH division and program staff/section contacts and, when feasible, LHD representatives
- 3) The published Administrative Reference (AR) document is the approved DPH standards and guidelines that LHDs are to follow
- 4) Key stakeholders: Boards of Health, LHD directors and staff, DPH leadership and program staff, citizens of the Commonwealth
- 5) Between annual updates, the AR Interim Change process must be followed.

# **Contact Information**

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**[Kentucky DPH Divisions](#)**

**[Kentucky DPH Organizational Chart](#)**

**[Kentucky DPH Divisions and Programs Phone Directory](#)**

**The Kentucky Department for Public Health (DPH) consists of seven divisions:**

- [Division of Administration and Financial Management \(AFM\)](#)
- [Division of Epidemiology and Health Planning \(EHP\)](#)
- [Division of Laboratory Services \(DLS\)](#)
- [Division of Maternal and Child Health \(MCH\)](#)
- [Division of Prevention and Quality Improvement \(PQI\)](#)
- [Division of Public Health Protection and Safety \(PHPS\)](#)
- [Division of Women's Health \(WH\)](#)

A [DPH organizational chart](#) and a [phone/contact listing of DPH programs and employees](#) by divisions are on the [DPH website](#).

**DPH Nursing Office webpage**

**CSG Forms and Teaching Sheets** - CSG webpage

**NOTE:** The website-content of the above hyperlinked DPH organizational chart and program/employee contact listing *may change or need to be changed* given the fluidity of department-wide staffing updates. **Please call the DPH Commissioner's Office at (502) 564-3970 for organizational chart questions, program contact information or other assistance as needed.** URL hyperlinks for each DPH Division's webpage are provided below by clicking on the Division name.

**Department for Public Health (DPH) – Divisions & Programs Phone Directory**

**Commissioner’s Office ..... (502) 564-3970**

Chief Nursing Officer/Nursing Office ..... 564-3970  
Health Equity Branch .....564-3970

**Division of Administration and Financial Management ..... (502) 564-6663**

**Budget Branch:**

Local Health Budget Section ..... 564-6663  
State Budget Section ..... 564-6663  
Contracts and Payments Branch..... 564-6663  
Education and Workforce Development Branch ..... 564-6663  
Local Health Operations Branch..... 564-6663  
Local Health Personnel Branch ..... 564-6663

**Division of Epidemiology and Health Planning ..... (502) 564-3418**

Immunization Branch.....564-4478  
Infectious Disease Branch .....564-3261  
TB Prevention and Control Section.....564-4276  
STD/STI Prevention and Control Section.....564-4804  
Reportable Disease Section.....564-3261  
HAI/AR Prevention Program ..... 564-3261  
HIV/AIDS Section .....564-6539  
Vital Statistics Branch .....564-4212  
Registration and Amendment Section.....564-4212  
Certification Section.....564-4212  
Administrative and Quality Assurance Section .....564-4212

**Division of Laboratory Services ..... (502) 564-4446**

Business Operations Branch .....564-4446  
Procurement Section .....564-4446  
Customer Service Section .....564-4446  
Global Preparedness and Environmental Branch .....564-4446  
Environmental Chemistry Section.....564-4446  
Preparedness Section .....564-4446  
Microbiology Branch .....564-4446  
Virology Section.....564-4446  
Bacteriology Section.....564-4446  
Molecular and Clinical Chemistry Branch .....564-4446  
NBS and Metabolic Section .....564-4446  
Molecular and Biomedical Engineering Section .....564-4446

**Division of Maternal and Child Health ..... (502) 564-4830**

Child and Family Health Improvement Branch.....564-1366  
Adolescent Health Initiatives Program.....564-1376  
Newborn Screening Section.....564-1368  
Pediatric Section .....564-2146  
Perinatal Health.....564-1370  
Early Childhood Development Branch .....564-3756  
Early Childhood Promotion Section .....564-3756  
Early Intervention Section .....564-3756

Nutrition Services Branch .....	564-3827
WIC Program Management Section .....	564-3827
WIC Food Delivery/Data Section .....	564-3827
Clinical Nutrition Section .....	564-3827
WIC Vendor Management Section .....	564-3827
School Health Branch .....	564-4830
Program Support Branch.....	564-4830

**Division of Prevention and Quality Improvement ..... (502) 564-7212**

Chronic Disease Prevention Branch .....	564-7996
Health Promotion Section .....	564-9358
Health Care Access Branch .....	564-8966
Oral Health Branch .....	564-3204

**Division of Public Health Protection and Safety ..... (502) 564-7398**

Environmental Management Branch.....	564-4856
Facilities Environmental Section .....	564-4856
Community Environmental Section .....	564-4856
Food Safety Branch .....	564-7181
Retail Food Section .....	564-7181
Food Manufacturing Section .....	564-7181
Milk Safety Branch .....	564-3340
Milk Safety Technical Section.....	564-3340
Milk Safety Administrative Section .....	564-3340
Public Health Preparedness Branch .....	564-7243
Community Health Preparedness Section.....	564-7243
Healthcare System Preparedness Section .....	564-7243
Public Safety Branch .....	564-4537
Radiation Health Branch .....	564-3700
Radiation Producing Machines Section .....	564-3700
Radioactive Material Section .....	564-3700
Radiation/Environmental Monitoring Section.....	564-3700

**Division of Women’s Health ..... (502) 564-3236**

Breast and Cervical Cancer Screening Program .....	564-3236
Breast Cancer Research and Education Trust Fund .....	564-3236
Family Planning Program .....	564-3236
Ovarian Cancer Awareness.....	564-3236
Preconception Health Program .....	564-3236

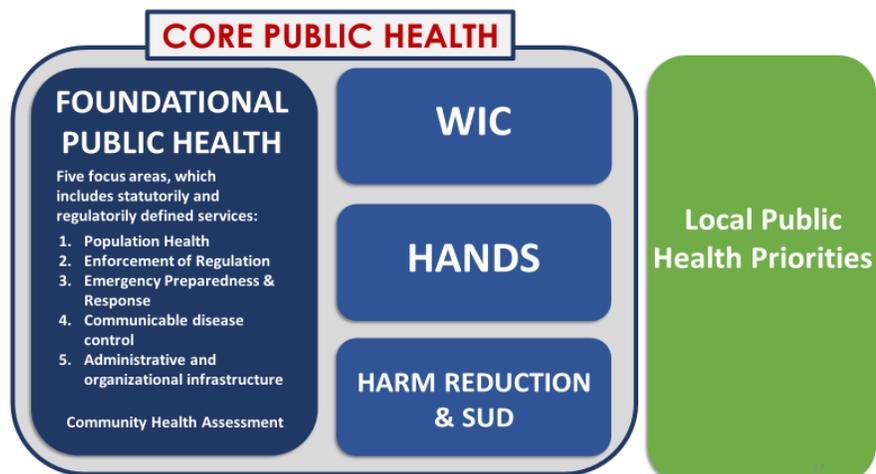
## Public Health Transformation

Public Health Transformation (PHT) officially launched in January 2019 and is intended to modernize Kentucky's public health system. PHT categorizes and prioritizes public health programs into **core** services which include mandated **foundational** programs to address population health, enforcement of regulations, emergency preparedness and response, communicable disease control and administrative and organizational infrastructure, as well as WIC, HANDS, and programs designed to address substance use disorders including harm reduction initiatives. The remaining public health programs are categorized **as local public health priorities** and considered optional for local health departments.

### Definitions for Core Services, Foundational Services, and Local Public Health Priorities

**Public Health Transformation** will result in the three categories of services provided at the local level defined as follows:

1. **Core Services** include all Foundational Services as well as the non-statutorily mandated services: WIC, HANDS, and approved interventions to address Substance Use Disorder/Harm Reduction. Non-statutorily mandated core public health services will be provided or assured by the LHD. These services may be provided by another entity; however, the LHD agrees it will remain responsible for ensuring these services are provided in the event the other entity no longer provides the service.
2. **Foundational Services** include statutorily mandated services as referenced in Kentucky Revised Statutes. Statutorily mandated foundational public health activities and service programs prevent and mitigate disease, protect people from injury and promote healthy lifestyles across all environments. Foundational public health programs include Population Health, Enforcement of KY Regulations, Emergency Preparedness and Response, Communicable Disease Control, and the Administrative/Organizational infrastructure to deliver associated services.
3. **Local Public Health Priorities** include services not included in Core or Foundational Services that are identified through a Community Needs Assessment. Local Public Health Priority programs may include but are not limited to family planning, cancer screening, diabetes, school health and well-child visits. A local health department will have the flexibility and authority to deliver these programs based on their community's need and in accordance with available federal, state and local taxing district funding limitations. Although local public health priorities are not mandated by DPH, the LHD is required to submit a local needs assessment along with their annual budget submission to DPH which includes the following criteria: data-driven need, adequate funding, evidence-based and/or promising practice interventions, performance metrics, and description of an exit strategy in the event the program is no longer a community need, the need is met by another provider or there is insufficient funding.



## Preventive Services Covered Under the Affordable Care Act

Source: [HHS.gov/HealthCare](https://www.hhs.gov/healthcare)

**Cost sharing** (including **copayments**, **co-insurance**, and **deductibles**) reduces the likelihood that *preventive services* will be used especially among women. Studies show that even moderate copays for preventive services such as mammograms or pap smears result in fewer women obtaining this care.

The **Affordable Care Act** (ACA) requires most health plans to cover recommended preventive services without cost-sharing for those patients with Medicaid, Medicare or private insurance. **Preventive services** provided at the LHD are covered without cost-sharing requirements include:

- **Covered Preventive Services for Adults**

- **Alcohol Misuse** screening and counseling
- **Blood Pressure** screening for all adults
- **Breast Cancer Screening** for age-appropriate persons
- **Cervical Cancer Screening** for age-appropriate persons
- **Cholesterol** screening for adults of certain ages or at higher risk
- **Colorectal Cancer** screening for adults over 45 years
- **Depression** screening for adults
- **Type 2 Diabetes** screening for adults with high blood pressure
- **Diet** counseling for adults at higher risk for chronic disease
- **Hepatitis B** screening for adults at high risk
- **Hepatitis C** screening for adults at high risk or one-screening for all adults
- **HIV** screening for all adults ages 15 to 65 years; older and younger if at higher risk
- **Immunization** Vaccines: Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza, MMR, Meningococcal, Pneumococcal, Tdap, Varicella
- **Lung cancer screening** for adults ages 50-80
- **Obesity** screening and counseling for all adults
- **Sexually Transmitted Infection (STI)** prevention counseling and screening for adults at higher risk
- **Tobacco Use** screening for all adults and cessation interventions for tobacco users

- **Covered Preventive Services for Women, Including Pregnant Women**

- **Anemia** screening on a routine basis for pregnant women.
- **Bacteriuria** urinary tract or other infection screening for pregnant women.
- **BRCA** counseling about genetic testing for women at higher risk for breast cancer.
- **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40.
- **Breast Cancer Chemoprevention** counseling for women at higher risk.
- **Breastfeeding** comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women.
- **Cervical Cancer** screening for sexually active women.
- **Contraception** and contraceptive counseling; FDA-approved contraceptive methods, and sterilization procedures (does not include abortifacient drugs).
- **Domestic and Interpersonal Violence** screening and counseling for all women
- **Folic Acid** supplements for women who may become pregnant.
- **Gestational Diabetes** screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
- **Hepatitis B** screening for pregnant women at their first prenatal visit.

- **HIV** screening and counseling for sexually active women
  - **HPV DNA testing** every three years for women with normal cytology results who are 30 or older.
  - **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk.
  - **STI** counseling and screening for sexually active women
  - **Tobacco Use** screening for all women, and expanded counseling for pregnant tobacco users.
  - **Well-woman Visits** to obtain recommended preventive services.
- **Covered Preventive Services for Children**
    - **Alcohol and Drug Use** assessments for adolescents
    - **Autism** screening for children at 18 and 24 months
    - **Behavioral** assessments for children of all ages
    - **Blood Pressure** screening for children
    - **Cervical Dysplasia** screening for sexually active females
    - **Depression** screening for adolescents
    - **Developmental** screening for children under age 3, and surveillance throughout childhood
    - **Dyslipidemia** screening for children at higher risk of lipid disorders
    - **Fluoride Chemoprevention** supplements for children without fluoride in their water source
    - **Height, Weight and Body Mass Index** measurements for children
    - **Hematocrit or Hemoglobin** screening for children
    - **Hepatitis B** screening for non-pregnant adolescents at high risk
    - **HIV** screening for adolescents starting at age 15 or younger if at higher risk.
    - **Immunization:** Tdap, Haemophilus influenza type b, Hepatitis A, Hepatitis B, Human Papillomavirus, Inactivated Poliovirus, Influenza, MMR, Meningococcal, Pneumococcal, Rotavirus, Varicella
    - **Lead** screening for children at risk of exposure
    - **Medical History** for all children throughout development
    - **Obesity** screening and counseling
    - **Oral Health** risk assessment for young children
    - **Sexually Transmitted Infection** prevention counseling and screening for adolescents
    - **Tobacco Use** screening for children and adolescents and cessation interventions for tobacco users
    - **Tuberculin** testing for children at higher risk of tuberculosis
    - **Vision** screening for all children

*For more information on these preventive services, please click the links below:*

HealthCare.Gov: *Health Benefits and Coverage* – [List of Covered Preventive Health Services](#)

[U.S. Preventive Services - TASK FORCE: A and B Recommendations](#) For information on Kentucky Medicaid Recipient Cost Sharing, review 907 KAR 1:604. Recipient cost-sharing.

# Abuse, Neglect, and Violence

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## SIGNS OF POSSIBLE ABUSE, NEGLECT, OR EXPLOITATION

**Note:** No list of indicators can be all-inclusive, nor does the presence of one of the indicators necessarily mean a person is being abused or neglected. The indicators are clues that can help you tune into the needs of the patient and her/his family. Additionally, although the following are categorized, many of the signs may indicate any of the types of abuse or multiple abuses. Kentucky is a mandatory reporting state for abuse/neglect [KRS Chapter 209](#)

<p><b>Sexual Assault</b></p> <ul style="list-style-type: none"> <li>• Distress at questions re: sexual history</li> <li>• Reluctance to undress / undergo pelvic exam</li> <li>• Sudden onset of sleep disorder</li> <li>• Anxiety or depression</li> <li>• Request for emergency contraception, pregnancy testing, or STI/HIV testing</li> <li>• Injuries to sexual parts of body</li> <li>• Difficulty walking or sitting</li> <li>• Swollen or red cervix, vulva, or perineum</li> <li>• Torn, stained, or bloody underclothes</li> <li>• Pain or itching in genital area</li> <li>• Stress related complaints (headache, back pain, gastrointestinal issues)</li> <li>• Bruising from being restrained (wrists, throat, etc.)</li> </ul>	<p><b>Child Abuse/Neglect</b></p> <ul style="list-style-type: none"> <li>• Utilize 10-4 Bruising Rule: Bruising to the torso, ear, or neck. Or, any bruising on an infant &lt;4 months of age. Burns – Patterned burns in clear shape of an object, cigarette, rope, iron, stocking-and-glove shape suggesting immersion burn.</li> <li>• Lacerations / Abrasions on lips, eye, any portion of an infant’s face, on gum tissues (forced feeding), on external genitalia</li> <li>• Missing or loosened teeth</li> <li>• Skeletal or head injuries (including missing hair)</li> <li>• Internal injuries (duodenal hematoma, jejuna hematoma, rupture of inferior vena cava, peritonitis (from hitting/kicking)</li> <li>• Pattern injuries (cord, paddle, etc.)</li> </ul>
<p><b>Domestic Violence</b></p> <ul style="list-style-type: none"> <li>• Injuries in various stages of healing</li> <li>• Bilateral, multiple, or patterned injuries</li> <li>• Physical findings inconsistent with history or statement of cause</li> <li>• Repeated visits for treatment of vague symptoms</li> <li>• Delay between injury and presentation</li> <li>• Chronic pain or depression</li> <li>• Partner reluctant to leave, uses demeaning language, or seems controlling, etc.</li> <li>• Pregnancy may trigger abuse to begin or worsen</li> <li>• Isolated or restricted contact with others</li> <li>• Unintended pregnancy (sabotage of birth control)</li> </ul>	<p><b>Vulnerable Adult Abuse/Neglect</b></p> <ul style="list-style-type: none"> <li>• Injury not been properly cared for or is inconsistent with explanation.</li> <li>• Pain from touching</li> <li>• Cuts, puncture wounds, burns, bruises, welts</li> <li>• Dehydration or malnutrition without illness related cause</li> <li>• Poor coloration, sunken eyes or cheeks</li> <li>• Inappropriate administration of meds or failure to seek medical attention</li> <li>• Soiled clothing or bed</li> <li>• Frequent use of hospital or healthcare/doctor shopping</li> <li>• Lack of necessities (food, utilities)</li> <li>• Forced isolation</li> <li>• Confused, disoriented</li> <li>• Lack of necessary aids, cane, walker, glasses, dentures or personal items</li> </ul>
<p><b>Human Trafficking</b></p> <ul style="list-style-type: none"> <li>• Makes references to frequent travel to other cities</li> <li>• Exhibits bruises or other physical trauma, withdrawn behavior, depression, or fear</li> <li>• Lacks control over her or his schedule or identification documents</li> <li>• Is hungry-malnourished or inappropriately dressed (based on weather conditions or surroundings)</li> <li>• Shows signs of drug addiction</li> </ul>	

- May not speak English, presents with “interpreter” who may make decisions for the patient
- Presents with STI or unwanted pregnancy
- Complains of not receiving payment by employer

**SCREENING AND IDENTIFICATION OF POSSIBLE VICTIMS**

**Universal Screening**

Physicians should routinely screen patients for abuse, neglect, and exploitation. This should be a non-threatening screening that asks patients about:

**FAMILY/MEDICAL HISTORY**

- History of Illness
- STIs
- HIV/AIDS
- Hx of broken bones or other injury
- Recent serious illnesses
- Other relevant conditions

**SOCIAL HISTORY**

- Family/relationship abuse
- Fear of harm
- Self or caregiver neglect
- Tobacco/alcohol use/abuse
- Illicit drug use
- Make-up of family unit
- Job conditions

Physicians should be prepared to provide and/or inform patients regarding the following services/requirements:

- |                                  |  |
|----------------------------------|--|
| Emotional support & reassurance  | Referrals to support services/specialty care   |
| Privacy and safety               | Mandatory reporting of CPS and APS Allegations |
| Comprehensive medical assessment | Access to medical records & treatment          |
| Expert medical testimony         | Collection and preservation of evidence        |
| Documentation of maltreatment    |  |

If risks are indicated or suspected, please conduct further evaluation and document findings.

<b>Sexual Violence Victimization Assessment (S-A-V-E) MODEL *</b>
<b><u>S</u>CREEN all patients for interpersonal violence</b>
<b><u>A</u>SK direct questions in a non-judgmental way</b>
<b><u>V</u>ALIDATE patient’s response</b>
<b><u>E</u>VALUATE, <u>E</u>DUcate and make referrals</b>

**DOCUMENTATION**

Appropriate documentation of subjective and objective findings; history and physical assessment; patient education and all mandatory reporting referrals shall be documented completely and filed in the patient’s medical record per record retention policies.

Screening for issues of abuse, neglect or exploitation:

- Should be a routine part of face to face visits with patients including annual/wellness exams, STI tests and treatment, injury visits, pregnancy test visits, etc.;
- Must take place in a private setting away from family or friends and must be confidential;
- Must be conducted in the patient’s primary language. Use a professional interpreter; **not** family members or friends;
- Must be direct and non-judgmental;

- Should be conducted by staff with some knowledge of the dynamics of interpersonal violence, safety issues, cultural competency, and safety planning; and
- Must include support and affirmation for the patient that discloses.

Physicians need to remember that often the abuser is someone deeply cared about by the patient/victim and should avoid all negative responses in front of the patient.

### **HIGH-RISK INDICATORS:**

- Threats (explicit or implied)
- History of violence
- Use or threat of weapons
- Stalking
- Increased substance use/abuse
- Any act of strangulation
- Killing or harming of family pets
- Escalation of threats or violence
- Serious injury or multiple injuries in various stages of healing
- Recent leaving of abuser (separation violence)
- Untreated mental health problems
- Head trauma (esp. in small children)
- Fantasies, talk of, or attempts at homicide or suicide
- Apparent sense of ownership and possessiveness of patient

Precautions may involve more than required reporting to the Department for Community Based Services. Make certain that the patient and other vulnerable family members (mother, child, disabled, etc.) are given appropriate safety planning assistance and referrals for emergency help. Law enforcement or security may need to be called for immediate protection in emergent situations.

### **SEXUAL VIOLENCE**

Anytime a person forces, coerces, or manipulates another person into unwanted or harmful sexual activity, sexual violence has been committed.

Consent is the critical issue. Consent has two parts: (1) an actual expression of agreement (2) by someone legally competent to give consent (i.e., not under age 16, intoxicated, or otherwise legally deemed incapable of consent). If the perpetrator is in a position of authority (ex. Clergy, teacher, coach, etc.) then the age of consent is 18. **Silence is not consent.** Sometimes victims are too scared, disoriented, or shocked to fight back or say no.

Sexual violence is perpetrated in many forms including:

- Non-physical aggression (stalking, verbal coercion, or harassment)
- Intimate contact without consent (such as child molestation, sex with an intoxicated person or groping)
- Assault/attacks such as forcible rape

### **Indicators:**

Physical evidence of sexual violence may often be absent or minimal. Therefore, healthcare providers must be aware of cognitive and emotional indicators to trigger appropriate follow up. Since there is no "typical" response to sexual violence, nor is there a prescribed time period for healing, indicators of sexual violence are varied and many. Examples that may present immediately following abuse and over the long term include:

- Possible injury, bruising, or chafing.
- Physical discomfort or soreness
- Nausea

- Loss of memory (due to shock or known/unknown substance use)
- Patient may seek care only for treatment of sexually transmitted infection or potential pregnancy
- Shock, anger, fear, confusion, etc.
- Distorted or confused thinking
- Self-medication (drug or alcohol use/abuse)
- Disordered eating
- Self-harming behavior
- Change in personal habits, personality, clothing choice, etc.
- Depression or depressive symptoms
- Significant decrease or increase in sexual behavior
- Somatic complaints: sleep disturbance, headache, nausea, etc.
- Relationship difficulties
- Overprotection of self or others, Hypervigilance
- Hyper startle response, nervousness, anxiety
- Appearance or return of symptoms during pregnancy
- Appearance or return of symptoms as patient's children reach age of patient's abuse/assault

Indicators may be immediate, ongoing, or sporadic. Life events, anniversary dates, anything, or nothing may trigger symptoms.

### **Referral and Resources:**

**Sexual Assault Medical-Forensic Exams (SAFE Exams)** are provided for victims seeking treatment after sexual assault or abuse. These exams are generally provided by hospitals or specialized sexual assault examination facilities. The Kentucky Sexual Assault Medical Protocol regarding procedures to be followed by medical staff before, during, and after examination of a victim of sexual assault is defined in [502 KAR 12:010](#). These exams may be performed by a doctor or a **Sexual Assault Nurse Examiner (SANE)**. While health departments are not required to provide SAFE examinations, it may be helpful for public health professionals to understand the basics of SAFE exams for referral and information purposes for patient education. Patients should be informed that the SAFE Exam includes both medical care and collection of forensic samples. Whenever possible, referral to a SANE nurse or physician.

### **Release of Information:**

The law requires an examination facility to contact the [Rape Crisis Center](#). However, the victim should have the choice of whether to report to law enforcement, except in cases of child abuse.

### **Payment:**

Basic SAFE Exam procedures are paid for by the state, but the patient may be billed for services that are not included in all exams, such as x-rays, surgery, and/or ambulance transportation.

### **Follow-up Care at Health Departments:**

Public Health personnel should also be aware that individuals are commonly referred to the Health Department for follow-up care, especially as related to testing for HIV and other sexually transmitted infections.

### **Additional Resources for Child Victims:**

Children’s Advocacy Centers have been developed throughout the Commonwealth to provide child-friendly setting for responding to sexual abuse of children. Referral to a Children’s Advocacy Center is typically made by DCBS or law enforcement personnel. Public Health professionals should be familiar with relevant local protocol related to referral.

**Rape Crisis Centers:** Provide multiple support services for victims including advocacy and counseling. To locate your regional center, click on the link provided or call the national 24 hour hotline which will direct all calls to the caller’s nearest center: 800-656-HOPE.

**Kentucky Association of Sexual Assault Programs (KASAP):** Statewide coalition of rape crisis centers provides training (including SANE certification training) and technical assistance. Call 502-226-2704.

**Office of Victims’ Advocacy:** Division of the Office of the Attorney General provides training, victim referrals, advocacy, and technical assistance regarding prosecution and the criminal justice system. Call 502-696-5312 or 800-372-2551.

**Crime Victims Compensation:** Administers the Sexual Assault Exam Program and Crime Victims Compensation Fund. Call 502-573-2290, 800-469-2120.

**UK Center for Research on Violence Against Women:** Advances scientific inquiry into the legal and clinical complexities presented by crimes against women. Call 859-257-2737.**Victim Identification and Notification Everyday:** Automatically calls registered numbers about the release or escape of particular offender(s) and services of Emergency Protective Orders in some jurisdictions. Call 800-511-1670.

**Kentucky Child/Adult Protective Services Reporting System:** Accepts reports regarding child and adult abuse 24 hours a day: Call 877-597-2331.

## **CHILD ABUSE: INDICATORS**

**Sexual Abuse:** Victims may demonstrate an array of the following behavioral and physical indicators. Please note that **not all** children will demonstrate observable changes in their behaviors and actions. Although some changes are negative, other changes in children may be viewed as positive. For example, some children may become more compliant. In utilizing the indicators below, please be mindful of sudden or drastic behavioral changes.

### **Behavioral**

- Regression of behavior
- Poor peer relationships
- Sudden behavior changes
- Sleeping and eating issues
- Fear of persons/places
- Run-away attempts
- Withdrawn behavior
- Aggressiveness
- Tells stories of sexual nature, reports sexual activity, acts out sexual behavior with dolls, toys or others
- Young children’s preoccupation with sex organs of self, parents or other children
- Reluctance to participate in recreational activity
- Prostitution
- Drug use

### **Physical**

- Difficulty walking and sitting
- Urinary tract infections
- Bed wetting or soiling once toilet training is completed
- Torn clothing
- Pain or itching in the genital area
- Bleeding, cracks or tears around orifices
- Psychosomatic complaints (stomach aches, headaches, etc.)
- Sexually transmitted diseases

- Stained or bloody underwear
- Gagging, vomiting
- Early pregnancy

**Physical Abuse:**

**Physical**

- Evidence of repeated injuries
- Fractures, joint injuries
- Pattern injuries (cord, paddle, etc.)
- Missing or loose teeth
- Bites or bruises
- Lacerations/abrasions on the lips, eye, any portion of child’s face, on gum tissues (forced feeding), on external genitalia
- Wounds in various stages of healing
- Unusual unexplained head injuries (including missing hair)
- Unusual burns (immersion, cigarette, rope, dry burns caused by irons or other appliances)
- Bruises on posterior side, clustered or in unusual patterns
- Internal injuries – jejuna hematoma, rupture of inferior vena cava, peritonitis (from hitting/kicking)

**Behavioral**

- Overly aggressive or destructive
- Unusually timid or fearful
- Afraid of physical contact or overly anxious to please adults
- Physical/language development problems

**Emotional Abuse:** rarely manifested in physical signs and is most often observed through behavioral indicators such as:

- Low self-esteem/self-worth
- Belittling oneself and verbal comments in general about oneself
- Lack of belief in thoughts and behaviors

**Neglect:**

- Abandonment
- Lack of supervision
- Constant fatigue
- Severe developmental lags
- Consistently hungry and dirty
- Beggars and steals food
- Lack of medical/dental care
- Lack of adequate nutrition
- Suffers persistent illnesses
- Lack of adequate clothing and hygiene
- Assumes adult responsibilities

**CHILD ABUSE: RESPONSE**

Every county in the Commonwealth of Kentucky has access to evaluation and care from a Child Advocacy Center that specializes in the evaluation and care of children who may be victims of child sexual abuse. Additionally, each Kentucky county has a local Department for Community Based Services (DCBS), Protection and Permanency office that is statutorily responsible for responding to allegations of child abuse/neglect.

**Child Advocacy Centers:**

Children’s Advocacy Centers (CACs) exist in each of the fifteen development districts and

provide a multidisciplinary team approach to the response, investigation, treatment, and prosecution of the crime of child sexual abuse. CACs are defined in KRS [620.020](#)(4) and are private, non-profit agencies governed by local boards of directors.

Based on the national best practices standards and accreditation of the National Children's Alliance, CACs in Kentucky were designed specifically to provide both critical services and a foundation for the important work of multidisciplinary teams in the Commonwealth. The [Kentucky Association of CACs](#) (KACAC), a chapter member of the National Children's Alliance, provides support and direction for the ongoing development of CACs to help ensure all are providing nationally recognized "best practices" services to the extent their local community resources will allow.

Medical examinations conducted at CACs are thoroughly documented in medical records that are maintained by the CAC and provided to MDT investigators and/or prosecutor in a timely manner.

CACs are identified as specialized children's services clinics within the Commonwealth and are the primary agency responsible for providing comprehensive child sexual abuse medical examinations to children when there are allegations and/or concerns of sexual abuse or molestation. Comprehensive child sexual abuse medical examinations provided at a CAC include at minimum:

- A medical history is taken from the child and a non-implicated parent, guardian or primary caretaker;
- A physical examination with detailed attention to the anogenital area;
- If clinically indicated, a colposcopic examination; and
- A mental health screening, provided on the same day and at the same location as the physical examination, to determine the impact of the alleged abuse on the mental health status of the child and the need for mental health services.

All comprehensive child sexual abuse medical examinations provided at CACs are provided by licensed physicians that have received specialized training in the medical examination of sexually abused children and have access to and have been trained on the use of a colposcope. CAC physicians must also participate in peer review and complete continuing education and training on the medical diagnosis and treatment of sexually abused children.

## **CHILD ABUSE: REFERRAL AND RESOURCES**

**Child Advocacy Centers** provide multiple services including specialized child sexual abuse medical examinations, forensic interviews, advocacy, and mental health services for victims of child abuse.

**[Kentucky Association of Children's Advocacy Centers](#)**: Association of CACs provides technical assistance and training. Call 1-877-597-2331.

**[Judi's Place for Kids](#)** Call Pikeville, KY: 606-437-7447 or Prestonsburg, KY: 606-886-8520

**[Prevent Child Abuse Kentucky \(PCAKy\)](#)** Call 800-CHILDREN

**[The Rape, Abuse, and Incest National Network \(RAINN\)](#)**: Operates the National 800-656-HOPE hotline, national statistics, resources, and links

**[Office of Victims' Advocacy](#)**: Division of the Office of the Attorney General provides training, victim referrals, advocacy, and technical assistance regarding prosecution and the

**Department for Community Based Services (DCBS) Local Office Search**

**Central Intake – Protection and Permanency**

**Hotline Number for all Counties 877-597-2331 (1-877-KYSAFE1)  
or 800-752-6200**

**Domestic Violence** is a pattern of coercive behaviors that may include repeated battering and injury, psychological abuse, sexual assault, progressive social isolation, deprivation, and intimidation. Someone who is or was involved in any intimate relationship with the victim, including dating, perpetrates these behaviors.

**DOMESTIC VIOLENCE: INDICATORS**

- Visible physical injuries: bruises, lacerations, burns, human bite marks, and fractures (especially of the eyes, nose, teeth, and jaw); injuries during pregnancy, miscarriage, or premature births; injuries that are inconsistent with explanation; multiple injuries in different stages of healing; unexplained delay in seeking medical treatment for injuries.
- Stress-related illnesses: headaches, backaches, chronic pain, gastrointestinal disorders, sleep disorders, eating disorders, fatigue, anxiety-related conditions (such as heart palpitations, hyperventilation, and panic attacks).
- Partner is unwilling to leave the woman alone during the examination.
- Partner completes the history forms or answers questions addressed to the patient.
- Changes in job performance: difficulty concentrating, repeating errors, slower work pace.
- Unusual or excessive number of phone calls from family members with strong reactions to these calls.
- Disruptive personal visits to the workplace from employee's present or former partner or spouse.
- Statements: "My husband won't let me...", "He got so mad that he put his fist right up to my nose...", etc.
- Health issues or hospitalization during pregnancy including pre-term birth.
- Marital and/or family problems.
- Depression
- Alcohol or other drug addictions
- Withdrawn
- Jumpy, irritable
- Absenteeism: lateness, leaving early.
- Lack of personal grooming. A total change from past habits.
- Overly dressed: turtlenecks, long sleeves in the summertime.
- Shows low self-esteem

## DOMESTIC VIOLENCE: Safety Planning

An immediate response to domestic violence should include safety planning with a patient.

When personal safety planning is viable, it must be undertaken with caution and an understanding by the client that leaving an abuser is the most dangerous time. Below are suggestions for what to share with a patient.

### Personal safety plan

#### WHAT DOES THE PATIENT NEED TO TAKE WHEN LEAVING?

Identification	Legal Papers	Other
Driver's License	Vehicle Registration	Prescription Medications
Birth Certificate	Vehicle Insurance	Car & House Keys
Children's Birth Certificates	Health Insurance Papers	Jewelry
Social Security Cards	Life Insurance Papers	Address Book
Government Assistance Benefit Cards/Identification (e.g. Welfare, Medicaid, Food Stamps, etc.)	PROTECTIVE ORDER: Patients should keep these at all times	Photos of you, children & abuser
Money and/or credit cards	Medical Records (you & children)	Change of clothes
Bank books (savings)	School Records	Children's toys
Checkbooks	Lease/Rental Agreement	Toiletries
Wallet	House Deed	Diapers and Diaper bag
	Divorce/Custody Papers	Baby wipes
	Marriage License	
	Passport	
	Work Permit/Green Card/VISA	

#### Why is a Safety Plan Necessary?

Once a violent act occurs in a relationship, the violence usually reoccurs. In fact, the violence tends to occur more frequently and will most likely increase in severity. This happens even though the abuser is likely to apologize and will promise to change. Therefore, it is extremely important that patients have a plan and think ahead about what should be done in case of an attack, or repeated attacks from the abuser upon his or herself and any children in the household.

Although some abusers do not give any indications or signals prior to an abusive incident, patients may be able to predict an attack by the abuser's behavior. For example, a certain look, a certain phrase that is said, certain times of the month or year, or when discussing various subjects that could provoke anger, are some things to look for. In many cases, victims of domestic violence contemplate leaving their abusers several times before finally taking action. There are some practical steps that can be used to help keep the patient and children safe.

### **Safety With a Protective Order**

When a patient or the patient's children have been threatened or assaulted the patient can request a protective order from the county District Court Clerk. This may be done 24 hours a day, 7 days a week. In most jurisdictions, after business hours, the patient will need to contact the Police Department to file a request. Among other things, the patient may request temporary custody, an order for no contact, and/or an order for the batterer to vacate the home. The patient should keep the protective order in hand at all times. The patient should give a copy of the order to the child's school and should call the police if the partner breaks the order. The patient should notify neighbors and co-workers to notify police if the offender is at a protection location, even if the victim is not. Protective orders list locations that offenders must stay away from regardless of the victim's presence. KRS 209A requires a brochure regarding how to obtain a protective order to be provided to any client experiencing domestic or dating violence.

### **Safety During an Explosive Incident**

If an argument seems unavoidable, the patient should try to have it in a room or area where there is access to an exit. The patient should stay away from the bathroom, kitchen, bedroom, or anywhere else where weapons might be available. Patients should practice how to get out of the home safely: identifying which doors, windows, elevators, or stairwells would be best. These safety measures should be practiced with children also. Patients should identify one or more neighbors to tell about the violence and ask that they call the police if they hear a disturbance coming from the home. Patients can devise a code word to use with children, family, friends, and neighbors when police are needed. Patients can decide and plan for where to go if there is a need to leave the home (even if the patient believes this will not occur). Patients will need to use internal judgment and might decide to give in to an abuser at a given moment to survive.

### **Safety In Patient's Own Home**

Patients should consider changing the locks as soon as possible. Additional locks and safety devices can secure windows. Patients should discuss a safety plan with any children in the home. Patients need to inform the children's school, daycare, etc. about who has permission to pick up the children. Patients can inform neighbors and landlord that the abusive partner no longer lives in the home and that they should call the police if they see him/her near the home. Patients may designate a "safe meeting place" with the children.

### **Safety when Preparing to Leave**

Patients should open a savings account and/or credit card in his or her own name to start to establish or increase independence. Getting a post office box or having an alternate safe address for mail to allow private receipt of checks and correspondence further builds independence. In 2013, the Kentucky Address Confidentiality Program was created. This program, administered by the Office of the Secretary of State, allows victims to register an address with that office and keep their address from being listed on any public records. Mail can be sent through the program and the victim's address cannot be released without a court order.

For more information or to see if a patient qualifies, visit the [Secretary of State website](#). Patients can leave money, an extra set of keys, copies of important documents, extra medicines, and clothes with a trusted someone or in a safe place in case there is a need to leave quickly. Safety plans should be reviewed often.

**Remember: Leaving an abuser is the most dangerous time for the victim!**

### **Safety On the Job and In Public**

The patient should decide whether to inform anyone in the workplace. Informing office or building security and providing a photo of the abuser can increase safety. Patients may also arrange to have a coworker or voicemail screen calls. A safety plan should include the workplace and leaving the workplace.

### **DOMESTIC VIOLENCE: REFERRALS/RESOURCES:**

#### **[KRS Chapter 209](#)**

**[Kentucky Domestic Violence Association \(KDVA\)](#)**: This statewide coalition of domestic violence programs provides information, training, and technical assistance. Call 502-209-KDVA (5382).

**[Domestic Violence Shelters](#)**: In addition to providing a safe, secure environment for victims/survivors and their children, programs now also offer a variety of support services to residents and non-residents including Legal/Court advocacy, Case management, Safety planning, Support groups, Individual counseling, Housing assistance, Job search and Children's groups. To locate your regional center, click on the KDVA link or call 800-799-SAFE (7233) to be connected to the nearest shelter.

**[Kentucky Child/Adult Protective Services Reporting System](#)**: To report child abuse and vulnerable adult abuse, 24 hours a day: 1-877-597-2331.

**[UK Center for Research on Violence Against Women](#)**: Advances scientific inquiry into the legal and clinical complexities presented by crimes against women. Call 859-257-2737.

**[Office of Victims' Advocacy](#)**: This division of the Office of the Attorney General provides training, victim referrals, advocacy, and technical assistance regarding prosecution and the criminal justice system. 502-696-5312 or 800-372-2551.

### **VULNERABLE ADULT ABUSE: INDICATORS**

In addition to the possible indicators listed below, a patient's report that someone is mistreating them should be included. Just like we should listen to children when they report they are being harmed, a vulnerable adult's report of mistreatment should not be dismissed on the basis of dementia or some other cognitive impairment.

#### **Indicators of Neglect:**

- Soiled clothing
- Soiled bedding
- Poor hygiene
- Dry skin
- Weight loss
- Urine odors
- Inappropriate food
- Lack of food or water
- Left alone or locked up for extended periods of time
- Sunken area under the eyes and around the cheekbones
- Lack of necessary aids (cane, walker, glasses, dentures)

#### **Indicators of Exploitation:**

- Unusual activity in the bank account
- Attempts to isolate from support system

- Missing property
- Level of care inconsistent with resources
- Sudden affection or attention to the elder
- Negative reaction to personal touch

### **Indicators of Physical Abuse:**

- Bruises
- Scratches
- Skin tears
- Cigarette burns
- Fractures
- Dislocations
- Poisoning
- Pain upon touching
- Untreated wounds
- Hematomas
- Strangulation marks
- Scalp injuries
- Detached retina

### **Safety Planning for Vulnerable Adult Maltreatment**

*The information in the following Safety Plan is, in most part, based on the work of Anne Ganley and Susan Schechter, "Domestic Violence: A National Curriculum for Child Protective Service." Family Violence Prevention Fund, 1996. Competent adults, unlike children, have the right to refuse to participate in this or any aspect of social services.*

### **Guidelines for Safety Planning**

1. Safety Planning is two-fold:
  - a. Strategy for getting a patient physically away from the maltreatment; and/or,
  - b. Planning for a patient to remain safely in the situation.
2. Safety Planning is based on principles of empowerment to assist in the development and implementation of the safety plan(s).
3. The Safety Plan:
  - a. Increases the patient's ability to protect self, particularly when a crisis exists and the potential for harm is high.
  - b. Helps to continually assess the degree of danger.
  - c. Confronts minimization and denial of the presence and extent of maltreatment.
  - d. Enhances safety by maximizing support system and resources; and,
  - e. Specifies a plan of action.
4. Safety planning is essential during any contact with a patient, whether it is by telephone or face-to-face. A safety plan is for the patient, to be carried out by the patient, and developed by the patient for themselves and others.
5. A safety plan can be brief or comprehensive.
6. It is essential that the safety plan be person-centered, specific, practical, detailed, and developed and implemented by the elderly with appropriate support.
7. The safety plan is, in part, based on the participation of community partners, significant family members, and friends. The process may be difficult.
8. It is recommended that the patient and significant others practice the safety plan so that each develops automatic responses if a crisis occurs.

### **Elements of Safety Planning:**

1. Listen to the patient recount the events of maltreatment. Acknowledge and reinforce the patient's attempts to protect self and others.
2. Help the patient identify behaviors exhibited by the offender that may place the patient at risk of harm. When are you the most vulnerable, such as time of day, week, or month?

3. Educate the patient on the different types of maltreatment. Help identify the types of maltreatment the patient is experiencing or has experienced. Explain that it may be necessary for the patient to seek help to get out of the situation.
4. Explain to the patient that anticipated high-risk times can be reduced by having family members, friends, and other support system members visit during those times or periods of time, or by participating in community activities and agency programs, such as senior center, adult day, church, and so forth.
5. Identify areas of the house where maltreatment occurs most often, and develop strategies for avoiding these areas.
6. Consider a variety of options that may provide safety. For example, have a friend or family member present in the home when an "outside" presence is there to prevent maltreatment, use of safe houses.
7. Educate the patient to recognize and use community resources such as emergency shelter, elder shelter, transportation, police intervention, and legal action.
8. Check for practicality, for example, the neighbor's home should not be considered a "safe home" if the neighbor is gone most of the time.

### **Safety Planning with Maltreated Vulnerable Adults**

Sample questions for discussing safety:

1. What do you think you need to be safe?
2. What particular concerns do you have about your or other household members' safety?
3. How have you protected yourself in the past?
4. Do you have a support system?
5. Who in your support system will help you with what you want to do?
6. Are you willing to accept assistance from "outside" your current support system, i.e. community agencies?

**If the patient is not currently living in the situation that resulted in maltreatment, evaluate the following options:**

1. Change the locks on the doors and windows.
2. Install a better security system, i.e., window bars, locks, better lighting, and smoke detectors.
3. Find a lawyer, including Legal Aid Services, knowledgeable about vulnerable adult maltreatment and related issues, and ask about other options for protection.
4. In rural areas, the patient may want to cover the mailbox with bright colored paper so the Police and/or emergency medical service may more easily locate the home. A beacon light may also be considered.
5. Educate the patient about getting an order of protection, and help the patient get one, if desired.
6. Tell a trusted neighbor that the offender no longer resides in the home and ask the neighbor to inform the patient when or if the offender returns to the area.

**If the patient is leaving the situation, review the following:**

1. How and when is it safer to leave? Is there transportation? Money? A place to go? Special arrangements needed?
2. Is the new place where the patient will be staying safe?
3. What community, medical, legal, faith-based resources, and services are needed for the patient to feel safe? Provide information. Assist with telephone calls, if appropriate. Encourage the use of community resources.

4. Is the patient comfortable calling the police if needed?
5. Who will be told about the patient leaving?
6. Who needs to be contacted about the patient leaving?
7. Who is the patient's support network? Does the patient trust them for protection or assistance needed?
8. What options may be used so the offender does not locate or have access to the patient?
9. Is traveling safe?
10. Is a protective order a viable option?
11. Is the patient able to live alone and meet their own needs? If not, what services are needed? Will the patient be able to live alone with supportive services?
12. Tell the patient that if the decision is to leave the situation, the patient should have the following available:
  - Health insurance cards (i.e., Medicare)
  - Social Security card
  - Medication(s) and prescriptions
  - Assistive devices
  - Clothing and comfort items
  - Marriage license, driver's license, car title
  - Bank account number(s), credit, savings, passbook(s), keys to safe deposit box
  - Mortgage papers, lease rental agreements, house deed
  - Legal documents, such as Power of Attorney (POA), Durable Power of Attorney (DPOA), curatorship, conservatorship, and so forth
  - Phone numbers and addresses for family, friends, and community agencies (i.e. faith community, medical professionals)
  - Arrangements for animal care

**If the patient is remaining with the offender, review the following:**

1. What works best to keep the patient safe in an emergency?
2. Who is available to call during a crisis?
3. Will the patient call the police or other protective services if maltreatment occurs again? Is there a telephone in the house? Is there a telephone accessible?
4. If the patient wants to leave temporarily, what is available? Help the patient think through the options. Provide information.
5. Is a protective order a viable option?
6. Is there a way out of the house?
7. Identify danger areas and/or items in the house.
8. Are resources available in the community to serve the maltreated vulnerable adult? Are the resources accessible?
9. Does the patient have accessible emergency funds?
10. What is the patient's physical, mental, cognitive, and emotional status?

For a **Safety Planning Resource List**, review the AR documents on the [LHD Forms, Documents and Administrative Reference webpage](#).

**HUMAN TRAFFICKING: INDICATORS**

**Physical Health**

- Untreated STDs/STIs, HIV/AIDS, pelvic pain, rectal/urinary trauma
- Pregnancy; unwanted, little/no prenatal care, related complications from lack of care in delivery or termination of pregnancy, infertility
- Malnutrition; dehydration, poor personal hygiene, dental problems
- Bruises, scars, broken bones, other signs of physical abuse (esp. hidden areas)

- Infections caused by unsanitary medical “treatment” poorly administered.
- Chronic back, hearing, vision, or respiratory problems
- Undetected critical/life-threatening diseases (cancer, diabetes mellitus, heart disease, infectious diseases)
- Drug/alcohol abuse, eating disorders, etc.

### Mental Health

- Depression
- Anxiety
- Panic attacks
- Disorientation
- Trauma, PTSD
- Suicidal ideation/tendencies
- Self-mutilation
- Phobias
- Flat affect

### HUMAN TRAFFICKING: REFERRALS AND RESOURCES

#### If you suspect your patient is a victim of human trafficking:

- **Attend to acute medical needs FIRST.**
- Determine if interpretive services are necessary.
- Do NOT use the patient’s friend/relative/etc. for translation.
- It is best to use a hospital translator because live translators are able to document the discussion in the patient’s chart.
- Based on what you already know about your patient, review and utilize the Human Trafficking Screening Tool. It may only be necessary to ask a few questions from the screening tool to determine if your patient is a victim of human trafficking.
- If you are unsure of your next best action, call the National Human Trafficking Hotline at (888) 373-7888. The call center will listen to your scenario and can provide guidance as to your next best action. They will also ask if you would like to ‘report’ this case of human trafficking and you can provide as much information as your patient will allow, so that they may continue the ‘reporting’ process and document the case.  
**Remember: An adult patient (18 or older) has the right to decline assistance.**
- If the patient is a **minor**, it is MANDATORY to report the case to Child Protective Services, call: 877-597-2331.
- If the patient is a **foreign national**, you may also wish to contact an immigration attorney:

- |   |              |
|---|--------------|
| • Legal Aid of the Bluegrass Covington Office | 859-431-8200 |
| • Legal Aid of the Bluegrass Morehead Office  | 606-784-8921 |
| • Maxwell Street Legal Clinic                 | 859-233-3840 |
| • Catholic Charities of Louisville            | 502-636-9263 |

#### Screen for other immediate needs:

- Medical, Mental Health, Food, Clothing, Shelter

*Please read this page carefully before screening anyone for human trafficking.*

In the link provided are [screening questions](#) social service organizations can ask in order to determine if an individual is potentially a victim of human trafficking. As with domestic violence/sexual assault victims, if you think a person is a victim of trafficking, it is best to NOT begin by asking directly if the person has been beaten or held against his/her will. Instead, you should start at the edges of his/her experience. If possible, please enlist the help of a staff member who speaks the person’s language and understands the person’s culture, keeping in mind that any questioning should be done privately and confidentially. You should

screen interpreters to ensure they do not know the victim or the traffickers and do not otherwise have a conflict of interest.

Before you ask the person any sensitive questions, it is important to get the person alone if they came to you accompanied by someone who could be a trafficker posing as a spouse, other family member or employer. However, when requesting time alone, you should do so in a manner that does not raise suspicions.

If you think you have come in contact with a victim of human trafficking, you may call the National Human Trafficking Hotline at 1.888.373.7888. This hotline will help you determine if you have encountered victims of human trafficking, will identify local resources available in your community to help victims, and will help you coordinate with local social service organizations to help protect and serve victims so they can begin the process of restoring their lives.

For more information on human trafficking visit the [Office on Trafficking in Persons website](#).

In the Kentucky area, the following agencies are working directly with Kentucky Rescue and Restore Victims of Human Trafficking. These individuals/agencies may be contacted directly with any questions or concerns regarding human trafficking or to report any cases of trafficking you have knowledge of personally:

- [Bakhita Empowerment Initiative of](#) Louisville, Louisville, KY 40208: 502637-9786
- [Women's Crisis Center](#), Covington, KY 41011: (800) 928-3335 or (859) 491-3335
- [Ampersand, Sexual Violence Resource Center of the Bluegrass](#) (formerly, Bluegrass Rape Crisis Center), Lexington, KY 40588 (859) 253-2511
- [Kentucky Association of Sexual Assault Programs](#) (KASAP), Frankfort, KY (800) 656-4673
- Nationally: [The National Human Trafficking Hotline](#) (1-888-373-7888) is an anonymous reporting tool that operates 24 hours a day, 7 days a week.

## REPORTING REQUIREMENTS

Consistent with state law, you must report known or suspected abuse, neglect, and/or exploitation of children and certain adults, as described below. Persons reporting in good faith are immune from criminal and civil liability. Failure to comply with reporting laws could result in criminal penalties and/or possible civil liability.

**NOTE: HIPAA allows medical providers to make reports of child and adult abuse when required by state law. HIPAA also requires that the health care provider notify the victim that a report has been made. Patient authorization for the report is not required. LHDs should contact their attorney on inquiries related to HIPAA, Privacy and Confidentiality laws.**

Kentucky's mandatory abuse reporting laws require that abuse, neglect, and exploitation be reported when the victim is a child (under 18), or adult as defined in KRS 209.020. For additional information, review [KRS 600.020\(1\)](#), [KRS 620.030](#), [KRS 209](#). The purpose for [reporting](#) known or suspected adult or child abuse, neglect, and exploitation is as follows:

- Identify victims;
- Provide services aimed at preventing & remedying maltreatment (if indicated); and

- Document incidents of maltreatment

**WHO IS MANDATED TO REPORT?** In Kentucky, **all people**, including a physician and nurse are mandated to [report abuse](#).

### **WHAT MUST BE REPORTED?**

- Any abuse or neglect of a **child** (person under the age of 18)
- Any abuse or neglect of a **vulnerable adult** (age 18 and older), who because of mental or physical dysfunction, is unable to manage her/his own resources or carry out the activity of daily living or protect self from neglect or hazards without assistance from others. *This includes abuse of elders and adults with disabilities who may be dependent upon others for daily care in one or more areas (i.e., financial management, necessities, etc.)*
- Any abuse or neglect (regardless of age of victim) inflicted by a spouse or other intimate partner, including dating violence, **when the victim requests it to be reported**. Domestic/intimate partner violence should not be reported if the patient does not request it (review [KRS 209A](#)).

**TO WHAT AGENCY IS THE REPORT MADE?** [Reports](#) of child or vulnerable adult abuse/neglect should be made to the statewide hotline at 877-597-2331. During business hours (M-F 8am-4:30pm), reports can also be submitted through the online reporting system: [CHFS Online Reporting](#). Reports can also be made to local or state law enforcement.

### **Fear of Criminal Prosecution or Deportation:**

Many victims are afraid to report that they have been abused, assaulted, or trafficked because they are undocumented and afraid of deportation or because in the case of sex trafficked victims, they fear arrest for prostitution. There are options to help victims report without the fear of deportation or prosecution. Although no one but a prosecutor can promise these protections, they should be explained to the patient as a way to encourage reporting and thus ensure their safety. The following are some of the options available:

**U-Visas:** Federal Visas that allow undocumented victims of domestic violence, sexual assault and other specific crimes obtain legal status to remain in the country if they cooperate with the prosecution of the offender. The prosecutor or law enforcement can work with the reporting victim to apply for and receive a U-Visa.

**T-Visas:** Federal Visas that allow undocumented victims of human trafficking to obtain legal status to remain in the country if they cooperate with the prosecution of the offender. The prosecutor or law enforcement can work with the reporting victim to apply for and receive a T-Visa.

**Safe Harbor:** [Human Trafficking Victims' Rights Act](#) provides safe harbor for victims of domestic and foreign human trafficking so that they cannot be prosecuted for crimes committed at the insistence of the trafficker. The most common charges faced would be prostitution or status offenses. This legislation encourages victims to protect themselves and report without fear of incarceration. Review the [Human Trafficking Victims' Rights Act \(2013\)](#); [KRS Chapter 529, 529.160](#); [KRS 630.125](#).

## COMMUNITY RESOURCES

The roles of agencies involved in vulnerable adult maltreatment are described in the following section.

**Department for Community Based Services (DCBS):** provides an array of services from financial assistance to protection. DCBS is mandated by statute to investigate [reports](#) of suspected adult abuse, neglect, and exploitation in the community and in long-term care facilities if the allegations reported meet acceptance criteria. DCBS staff provides adult protective services and supportive services to help vulnerable adults remain safe in their homes or alternate care facilities. Adult Protective Services are voluntary unless court ordered. Examples of services that may be accessed through adult protection are social work counseling and coordination of services.

In addition to Adult Protective Services, General Adult Services are provided to adults and elders who request services. This includes elders who are 65 years and older (but who are not mentally or physically dysfunctional) who are being abused, neglected, or exploited by a caretaker, family member, or household member. General Adult Services include referrals to community partners to help the adult remain at home and meet their own needs or an alleged victim of domestic violence who is requesting services. All General Adult Services are voluntary services.

Adult protective services are voluntary. This means the adult may accept or refuse services offered by DCBS, except in life-threatening situations where the adult lacks the capacity to consent and refuses to consent to services, in a state of abuse or neglect, and when an emergency exists. In these cases, a DCBS representative may petition the court for an order for involuntary adult emergency protective services.

**Department for Aging and Independent Living (DAIL):** The Kentucky [Department for Aging and Independent Living](#) (DAIL) oversees the administration of statewide programs and services on behalf of Kentucky's elders and individuals with disabilities. Its mission is to preserve individual dignity, self-respect and independence of Kentucky's elders and individuals with disabilities through leadership, education, and delivery of programs and services.

In partnership with Kentucky's 15 Area Agencies on Aging and Independent Living, Community Mental Health Centers, Center for Independent Living and other community partners, DAIL provides leadership and addresses issues and circumstances that stand in the way of elders and individuals with disabilities achieving the best possible quality of life. Programs administered by DAIL include guardianship, homemaker services, meals on wheels and court-ordered services. Homemaker services may help the elder adult remain in his or her home longer by helping with budgeting, activities of daily living, applications for other agency services and follow-up appointments with those agencies, and information and referral services.

**Area Agency on Aging and Independent Living (AAAIL):** is designated as the lead for aging issues, concerns, services, and programs within the Area Development District. The AAAIL administers programs that are authorized by the Older Americans Act and Kentucky Area Development Districts, Area Agencies on Aging and Independent Living. Priority for programs is given to persons 60 and over, but persons in other age groups may be served as well.

Funds for programs for seniors are provided by the U. S. Department for Health and Human Services, U.S. Department of Labor, and Kentucky General Fund monies. Programs and services provided through contracts with the AAAILs include:

- Title III – Supportive services, nutrition in congregate settings or home delivered meals, senior centers, in-home services.
- Title V – Senior Community Service Employment Programs.
- Title VII – Vulnerable Elder Rights Protection and the Long-Term Care Ombudsman Program;
- General Fund – Home Care, Adult Day Care Program, and Personal Care Attendant Program.

AAAILs work with community agencies when appropriate to address the needs of the elderly. AAAILs, working together with community partners, may help the patient obtain services such as medical assistance, food stamps, housing, legal assistance, and Medicaid.

In vulnerable adult abuse issues, AAAILs contact the Kentucky Cabinet for Health and Family Services' Department for Community Based Services to report suspected elder abuse situations. While there are many cases of abuse perpetrated against the elderly, statistics indicate that a significant number of cases are self-neglect. This type of case may require interventions such as making the home safer (cleanup, barrier removal, home maintenance or repair), providing basic human necessities (personal care, assistive devices, nutrition), addressing medical needs, or removing the elder from the abusive setting in an emergency. When an elder can remain at home through the use of community-based resources, the AAAILs may work with community partners to coordinate service delivery.

AAAILs conduct follow-up reports, when appropriate to identify potential service needs and develop a plan of service for addressing those needs. The AAAIL will work with other community-based agencies or organizations to achieve this goal.

### **Community Mental Health Centers**

[Community Mental Health Centers](#) are the regional planning bodies for mental health and mental retardation services within the 14 regions throughout the state. The Community Mental Health Center Board and programs are established in accordance with [KRS 210.370](#) – [KRS 210.460](#). Of the many duties of the Community Mental Health and Mental Retardation Board, two of them are to 1) "act as administrative authority of community mental health and mental retardation programs" and 2) provide "oversight and be responsible for the management of the community mental health and mental retardation programs." By law, Community Mental Health and Mental Retardation programs can provide inpatient services, outpatient services, partial hospitalization or psychosocial rehabilitation services, emergency services, consultation and education services, and mental retardation services. Services can be provided to all age groups.

### **Spouse Abuse Centers**

Kentucky has private and state-funded spouse abuse centers. A state-funded spouse abuse center is in each of the 15 Area Development Districts. A center provides services to victims, adult and child, of domestic violence. Among the services provided are shelter, counseling, advocacy, and support groups, and children programs.

### **Rape Crisis Centers**

There are 13 rape crisis centers providing services to all Kentuckians. Local rape crisis centers may offer any of the following services and can also provide referrals to other resources.

1. Victim assistance, such as a 24-hour rape crisis line, counseling for survivors, support to help family and friends of the rape victim, support groups for survivors.
2. Public awareness, such as rape awareness and risk reduction, sexual harassment in the workplace, legal and medical aspects of sexual victimization.
3. Consultation, such as consultation for area professionals working with survivors of rape and sexual abuse, and in-service training.

In addition to the above-described agencies, communities have many resources available to them, such as law enforcement, the faith community, and medical and health care resources.

**Emergency, temporary shelter for elder abuse victims of maltreatment:**

S.A.R.A.H. located in Northern Kentucky at 606-738-4270.

**Name and contact information for AAAILs:**

[Kentucky Area Agencies on Aging and Independent Living](#) (AAAIL)

**Name and contact information for CMHCs and Psychiatric Hospitals/Facilities:**

[Community Mental Health Centers](#) (CMHCs); and

[Adult State-Operated or State-Contracted Psychiatric Hospitals](#)

**[CMHC and Psychiatric Hospital Listing by County and 24-Hour Crisis Hotline](#)**

**[Kentucky State Police Posts](#)** (*locations and phone numbers*)

**Other Hot Line/Crisis Telephone Numbers by Agency:**

Alzheimer’s Association	800-272-3900
Child and Adult Abuse	877-597-2331
Department for Public Health	502-564-2154
Consumer Protection	800-727-4272
Attorney General	800-372-2960
Pathways Mental Health	800-562-8909
<a href="#">DiaWEB™ Reporting</a> )	800-718-0377
DCS, Inc. (SSA Appeals)	800-601-1874
FIVCO Long Term Care Ombudsman	877-295-4137
General Telephone Company	800-483-6697
Guardianship	800-372-2973
KY Relay Voice Service	800-648-6057 or 800-325-0778
KY Relay TDD Service	800-648-6056
KY State Police Emergency	800-222-5555
Legal Aid	800-274-5863 or 800-245-4137
KMA Fraud	800-627-4720

Durable Medical Equipment	800-895-6465
Migrant Family Helpline	800-234-8848
State Ombudsman	800-372-2973
Poison Control	800-772-5725
Safe Return Registration	800-572-8566
Social Security Administration	800-772-1213
Samaritan Hospital Intake	800-776-2673
Veteran's Administration	800-292-4562
Victim Information Notification Everyday (VINE)	800-816-0491
Long Term Care Ombudsman	800-372-2991
Legal Helpline for Older Kentuckians	800-200-3633
Elder Care Locator	800-677-1116

## **Reporting Laws**

### **CHILD ABUSE/NEGLECT**

[KRS 600.020: Definitions for KRS Chapters 600 to 645 \(\*excerpts only\*\)](#)

[KRS 620.030: Duty to report dependency, neglect, or abuse \(\*child abuse\*\)](#)

### **VULNERABLE ADULT ABUSE**

[KRS 209.020: Definitions for chapter \(\*excerpts only\*\)](#)

[KRS 209.030: Administrative regulations -- Reports of adult abuse, neglect, or exploitation -  
- Cabinet actions -- Status and disposition reports.](#)

### **SPOUSE ABUSE**

[KRS 209A.020: Definitions for chapter \(\*excerpts only\*\)](#)

[KRS 209A.030 Administrative regulations -- Reports of abuse or neglect -- Cabinet actions -  
- Penalty for failure to report abuse or neglect. \(DOMESTIC VIOLENCE\)](#)

[209A.130 Educational materials to be provided suspected victim of domestic violence and  
abuse or dating violence and abuse -- Availability of online materials.](#)

Review the [References](#) page for this AR Section

# Accreditation, Quality Improvement, Performance Management and Customer Satisfaction

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## **ACCREDITATION, QUALITY IMPROVEMENT, PERFORMANCE MANAGEMENT AND CUSTOMER SATISFACTION**

KDPH strives for a culture of performance management and quality improvement across the state. Standards set by the [Public Health Accreditation Board \(PHAB\)](#) are used as the driving force to comply with what is nationally recognized as best practices for a department of health. KDPH achieved national initial accreditation status in March 2022. Kentucky LHDs are encouraged to follow the same PHAB standards, regardless of intent to apply for accreditation, to improve performance and ultimately health status.

### **ACCREDITATION**

[PHAB](#) is the nationally recognized organization responsible for accrediting departments of health. Achieving accreditation means that the health department has met national standards for capacity and performance. Accreditation is voluntary, and any LHD seeking to become accredited must make this decision in consultation with their board of health, carefully weighing the requirement for staff time, application fees and other resources. PHAB requires completion of a Readiness Assessment that allows the department to assess their ability to complete this process.

Prior to application, it is recommended that the department complete a Community Health Assessment (CHA), Community Health Improvement Plan (CHIP), and an agency Strategic Plan. The Office of Performance Improvement and Accreditation (OPIA) created a CHA toolkit that walks through the steps for conducting a CHA and contains many resources to aid in the CHA process. The KDPH Chief of Staff sent an electronic version of the CHA toolkit to the KY Local Health Department Directors. To learn more about what is necessary to achieve national accreditation status and to access useful tools and materials, visit the [Accreditation Resources webpage](#).

[Pathways Recognition](#) is a new program released by PHAB in 2022 designed to support performance improvement efforts, strengthen infrastructure, facilitate public health system transformation and accreditation readiness for health departments not yet ready to apply for initial accreditation. Pathways assesses health departments on the Foundational Capabilities measures in the PHAB initial accreditation Version 2022 Standards and Measures. There are 34 measures assessed in Pathways Recognition and they are divided into two tracks: Services and Partnerships and Health Department Systems. Health departments can apply for one or both tracks, in any order.

### **QUALITY IMPROVEMENT**

A culture of quality improvement (QI) is essential to any department seeking to meet best practices and improve overall performance. PHAB standards require departments to maintain a QI plan, committee, multiple projects and staff trainings.

KDPH embraces the Plan, Do, Study, Act (PDSA) model. To learn more about this and other available tools used to achieve quality improvement, visit the [Accreditation Resources webpage](#).

The Continual Quality Improvement Utilizing a Health Equity Lens training series ([ID# 5290](#), available via the TRAIN Learning Management System) contains multi-level training, each course designed to build on one other, to provide individuals the opportunity to learn about continuous quality improvement and how to incorporate health equity into operations and QI initiatives. It was designed for public health professionals employed at the state health department, local health department and/or academia.

## **PERFORMANCE MANAGEMENT**

Performance management is the practice of actively using performance data to improve the public's health. This practice involves strategic use of performance measures and standards to establish performance targets and goals, to assess the success in meeting performance goals, and to improve the quality of public health practice.

A Performance Management System uses performance information on a regular basis as part of a continually repeated cycle of performance monitoring, analysis, and improvement, in which measured results are fed back into decision making to improve future performance.

KDPH recommends all departments adopt a performance management system to assist in performance monitoring and improvement efforts. There are many different platform options that departments can use. An ideal performance management system will allow a department to set goals and objectives, assign leaders to each activity, provide reminders when an action is required, monitor progress, compile performance reports and assist in many other tasks that are essential for successful performance management. Though it is not required to purchase a performance management system, there are "plug-and-play" systems available which can be helpful for a department that does not have an established culture of performance management.

To learn more about performance management tools, visit the [Accreditation Resources webpage](#).

## **CUSTOMER SATISFACTION**

KDPH recommends that customer/patient satisfaction surveys be completed annually, and internal control policies should be in place and reviewed semi-annually to specify the procedures for these surveys. Most of the federally funded programs also require patient satisfaction surveys to be completed. Departments are encouraged to initiate efforts to improve satisfaction within their agency and with other stakeholders.

Questions in the survey should focus on three areas about your agency:

- Quality of service being delivered
- Accessibility of service being delivered
- Treatment of patients (e.g., were they treated with courtesy and respect, will they refer others, will they return)

Samples of Patient Satisfaction Surveys, in English and Spanish can be found on the [LHD Information webpage](#).

KDPH also recommends a department develop a systemic process for collecting customer feedback and using that feedback to inform QI and performance management work.

# Boards of Health AND Agency Functions

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## Local Board of Health (BOH) Requirements

In accordance with [902 KAR 8:150](#), a governing board functions shall include:

- Interviewing and hiring a qualified agency director in accordance with 902 KAR 8:140;
- Effectively communicating approved board policies and priorities to the agency director;
- Assuring LHD services meet the needs of local citizenry to protect and promote public health;
- Establishing agency priorities and objectives based on service delivery, a [community health assessment](#), [compliance reviews](#) and the resources of the agency and updating them as needed;
- Review and approve policies and procedures governing the operations of a local health department;
- Assuring acceptable financial controls and program evaluation measures are ongoing and facilitate effective and efficient agency services and operations;
- Reviewing information and data provided by agency director to assess the effectiveness of the agency (e.g., [DPH compliance review findings](#), [financial summary and local community health assessment/surveys](#)); and
- Evaluating the performance of the agency director on an annual basis making sure to consider the information and data evidence obtained as outlined above.
- Authorize by vote all Public Health Director salary increments..

A non-governing board shall meet the requirements of [902 KAR 8:150](#) Section 3(2). A nongoverning board shall:

- (a) Maintain a membership on the county public health taxing district board;
- (b) Prepare the annual public health tax resolution;
- (c) Maintain trusteeship of the county public health tax;
- (d) Provide for maintenance and upkeep of the agency building;
- (e) Determine the appropriate use of the facility by community groups and other agencies; and
- (f) Provide the district board with information regarding specific public health needs and concerns of the city-county or county board.

The policies and procedures developed by a governing board shall be in compliance with [KRS 212.230](#)(1)(b) through (d). Internal board regulations and ordinances must be approved by the board and the cabinet prior to implementation. New BOH policies shall be available online and/or placed in a health policy manual no later than thirty (30) days after approval by the board and the cabinet, if applicable. All local ordinances acted upon by a board shall be in compliance with [KRS 67.076 and 67.077](#).

## Employment of Counsel

In all matters related to the enforcement of health and medical laws, HIPAA requirements, and in the performance of the board, representation shall be in accordance with [KRS 212.270](#). County, city-county and district boards formed by [KRS 212.020](#), [KRS 212.640](#), and [KRS 212.855](#) shall employ counsel as needed to act as legal advisor for the board.

## LHD Director's Responsibility to Board

The agency director is responsible for accurately and timely presenting the policies, regulations and guidelines of the Department for Public Health (DPH) to the board for their information and action and to keep the board informed of the activities and effectiveness of the health department.

The agency director is responsible for executing the policies and plans adopted by the board and for regularly reporting on their progress. **Regular reports are to include:**

- Program/Service Report
- [Financial Summary Report](#)
- [LHD Compliance Review Findings and Corrective Action Plan Report\(s\)](#)
- Personnel Action Summary Report
- Local Community Health Assessment/Surveys Report

In the absence of a local health officer, the Secretary of the Cabinet for Health and Family Services or the Secretary's duly appointed representative shall serve as health officer for the county concerned. [KRS 212.170](#), [KRS 212.240](#)

## LOCAL BOH APPOINTMENTS/MEMBERSHIPS AND GOVERNING OF AGENCY FUNCTIONS

### Board Members and Conflicts Of Interest

Board of health members must comply with [902 KAR 8:150, Section 7](#) and [KRS 45A.340](#), Conflicts of interest of public officers and employees.  
COPY PASTE REG section 7

### Nominations

Nominations for BOH members shall be in accordance with [KRS 212.020](#) .

[Advertising for new board of health nominations may begin in September. Online nomination submission must be made by November 1.](#) Email AFM's BOH inbox [LHDBoardofHealth@ky.gov](mailto:LHDBoardofHealth@ky.gov) with questions.

### Appointments/Membership

The Secretary of the Cabinet for Health and Family Services (CHFS) appoints members to 118 of the 120 county or city-county boards of health based on [KRS 212.020](#) and [KRS 212.640](#). Fayette and Jefferson County board members are appointed by the mayor and fiscal court respectively.

- Membership is for 2 years and there is no restriction on the number of terms a member may serve, and includes the county judge executive or designee, the mayor, city manager or designee of the city-county containing a city containing a population equal to or greater than 15,000 and a fiscal court appointee.
- **Each member's term has an end date, and they must be re-nominated for new term every two years.**
- **If a current BOH member fails to be re-nominated, they may lose their term.**

- Physicians, dentists, pharmacists and fiscal court appointees are appointed in even-numbered years; nurses, engineers, optometrists, veterinarians and laypersons are appointed in odd-numbered years.
- If one or more of the professionals do not reside in the county or are unwilling to serve, the Secretary of the Cabinet may appoint a resident layperson in lieu of the vacancy.
- Members of the BOH receive no compensation for their services.
- The Secretary of the Cabinet shall remove any member, other than the county judge/executive or fiscal court appointee, who fails to attend three (3) consecutive scheduled meetings and may remove board members according to [KRS 65.007](#). The fiscal court may remove its appointee in like fashion.
- The composition of a district BOH must be in accordance with [KRS 212.855](#).

### **Professional Members**

A person eligible for membership as a professional member shall be qualified and must maintain a current license in Kentucky in their respective profession.

### **Board Chairperson**

The board shall elect a chairperson from its membership on an annual basis and that chairperson may serve more than (1) consecutive term. The BOH Chairman must be reported to AFM on or before April 1. [Local Health Personnel Branch - Cabinet for Health and Family Services \(ky.gov\)](#)

### **Secretary of Board**

Officers shall be elected or appointed members of the board except that the agency director may serve as secretary to the board. An agency director of a district agency may serve as secretary to the district board and as secretary to the non-governing board within the district; or the agency director may designate an employee to serve as secretary of a city-county or county board. When agency staff is serving as secretary, the secretary has no voting powers.

### **Persons Not Eligible for Membership**

- An employee of an agency shall **not** serve as a member of the board.
- A person shall **not** serve on a board and receive in excess of \$2,000 per year in contract payments, unless approved in writing by the Cabinet.
- A personal service contract shall not be entered into with a local board of health member, unless authorized in writing by the Department for Public Health, and except for medical or professional services under \$10,000.
- State officials, members of the General Assembly, superintendents of school districts, and members of local boards of education are **not** eligible for appointment to local boards of health. Such positions are considered incompatible under [KRS 61.080](#).

## **MEETINGS OF BOARDS OF HEALTH**

### **Quorum**

- A quorum must be present in order to conduct business and approve actions. A quorum is seven voting board of health members. This number does not change with vacant positions on the board of health.
- A telephone poll vote is **not** permitted on any issue considered by the board.
- In order to attain a quorum, a public agency may conduct any meeting, other than a closed session, through video teleconference (meeting shall comply with the requirements of KRS 61.820 or 61.823 as appropriate).

**The context below must adhere to KRS Chapter 61, specifically 61.805 through KRS 61.850:**

**Proxy**

A member of a board must **not** be represented by a proxy at a board meeting, except for the designated officials of a county; or city of the second class.

**Meeting Schedule**

Meetings of a board and its committees must comply with the Kentucky Open Meetings Law.

- Meetings of a board must be regularly held at specific times and places convenient to the public.
- The board must provide a schedule of regular meetings, which must be made available to the public, in advance of the meeting, and published on the LHD website and in a local newspaper of general circulation.
- Board meetings must be held in locations accessible to individuals with disabilities.
- A qualified interpreter for the deaf and hard of hearing must be made available upon request to the board chairperson or agency director at least ninety-six (96) hours prior to the scheduled meeting.

**Executive Committee**

A board may establish an executive committee for the execution of specific tasks.

- The executive committee is subordinate to the board.
- Matters delegated to the executive committee must be specified in the Minutes.
- Executive committee must report its actions at the next regular board meeting.
- An action of an executive committee must be confirmed by the board and reflected in the board Minutes.

**Frequency of Meetings**

- Governing county boards and district boards of health **shall** hold a regular meeting at an minimum, quarterly, and other special or regular meetings as necessary.
- Non-governing county or city-county boards (those within a district) shall hold a regular meeting at minimum once every twelve months.

**Special Called Meetings**

The following procedures shall apply when a board of health wishes to conduct a special called meeting:

- Only the chairperson or a majority of the board members may call a special meeting.
- The board of health shall provide written notice of the special meeting that shall state the date, time and location of the meeting.
- Discussion shall be limited to only those items on the agenda.
- Written notice shall be delivered by email, mail, or in person to every board member, as well as to any media organization that has filed a written request to receive notice of special meetings. The notice shall be delivered at least 24 hours prior to the meeting, or if not possible because of an emergency, the board shall make a reasonable effort to notify board members and the media. Notice of the special called meeting shall be posted in the lobby or reception area of the LHD.
- At the beginning of the special called meeting, the chairperson shall briefly describe the emergency circumstances precluding 24-hour, (when applicable), notice and these comments shall be reflected in the minutes.

**Executive/Closed Session Meetings**

Boards of health may conduct closed meetings for any of the following reasons:

- To deliberate on the future acquisition or sale of real property, but only when publicity would be likely to affect the value of a specific piece of property to be acquired for public use or sold by a public agency;
- To discuss proposed or pending litigation against or on behalf of the LHD or board;
- To discuss issues or concerns which might lead to the appointment, discipline, or dismissal of an individual employee or board member without restricting that individual's right to a public hearing if requested; and
- To discuss a specific proposal with a representative(s) of a business entity if open discussions would potentially put the interests of the business at risk.

The following procedures shall apply when a board of health conducts an executive or closed session meeting:

- Notice of the executive or closed session shall be given in the regular open meeting; the general nature of the business to be discussed and the reason(s) for the closed session shall be indicated.
- A closed session shall be held only after a motion is made and carried by a majority vote in open session.
- No final action shall be taken during a closed session.
- No matter shall be discussed in closed session other than those publicly announced prior to convening the closed session.

Minutes of a closed meeting are not required to summarize or record the discussion, or any statements made by a board member.

Any decisions made in the closed session must be voted on in open session., When board members return to open session, a summary of the decision is announced and voted on by the board.

**Review the Opinion of the Office of the Kentucky Attorney General, entitled: [Protecting Your Right to Know: The Kentucky Open Records and Open Meetings Act](#) – Published August 2019 .**

## **MINUTES OF BOARD MEETINGS**

Minutes of Board Meetings must comply with the following: [902 KAR 8:150](#), Section 6. All meeting minutes must be submitted to the LHD Local Budget Analyst in DPH Administration & Financial Management within 2 weeks.

## **TRAINING FOR BOARD MEMBERS**

A new member appointed to the board must receive training from the agency director or other appropriate agency representative. The training must occur prior to the new member's first board meeting.

The training must include discussion and written materials on the following topics:

- Statutory responsibilities and functions of the cabinet, agency, and the board;
- Board laws, regulations, and local ordinances; and
- Board members' responsibilities and functions.
- Agency service sites and the services provided at these sites;
- Agency staff by discipline or profession;

- Thorough review of agency clinic (medical) and environmental services, current DPH compliance review findings, budget and annual report;
- Board Minutes for the last calendar year; and
- A tour of the agency's main facility, and if feasible, a tour of all satellite or remote sites.

### **Taxing District**

Where applicable, a taxing district function is created in accordance with [KRS 212.720](#) for all county boards of health (independent county-governing boards) and counties within districts (non-governing boards).

If a county has a public health tax, the tax resolution form [CH-61](#) or [CH-62](#) is used by the local BOH in establishing their public health tax rate. Form [CH-61](#) is completed by Fiscal Court Taxing Counties and Form [CH-62](#) is completed by Ballot Taxing Counties.

If a county does not have a public health tax, the fiscal court makes an appropriation to the health department using Form [CH-31](#). This function is not applicable to district boards of health.

These forms may also be accessed on the [LHD Information webpage](#). For additional questions or assistance, please contact the AFM Budget Branch, [Local Health Budget Section](#) at (502) 564-6663, Option 2.

The minimum acceptable level of local support shall be determined annually by the Commissioner of the DPH per [902 KAR 8:170](#) Section 3 (2).

The taxing district funds are to be used for the maintenance and operations of LHD. Operations include initiatives designed to improve the public health status of their citizens. Additionally the funds are for LHD capital improvements for the purchase or construction of new or additional facilities.

# **Kentucky Women’s Cancer Screening Program (KWCSPP) Breast and Cervical Cancer Screening**

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## [The Kentucky Women’s Cancer Screening Program \(KWCSPP\)](#)

**LAWS AND REGULATIONS** - The Breast and Cervical Cancer Mortality Prevention Act of 1990 (Public Law 101-354) established the Centers for Disease Control and Prevention’s (CDC’s) National Breast and Cervical Cancer Early Detection Program (NBCCEDP). The program provides grant awards to states for breast and cervical cancer screening and diagnostic services to uninsured women, including those who have low incomes or are members of racial and ethnic minority groups. The program operates in all 50 states, the District of Columbia, 6 U.S. territories, and 13 tribes or tribal organizations. Additionally, in 1990, legislation (KRS 214.554) established the [Kentucky Women’s Cancer Screening Program \(KWCSPP\)](#) in the Department for Public Health (DPH), in the Division of Women’s Health. The KWCSPP, the state branch of the NBCCEDP, is 100% funded by the CDC and provides breast and cervical cancer screenings, diagnostic follow-up services and case management.

For KWCSPP clinical guidance, review the [CSG – Cancer Screening/Follow-Up](#)

### Also housed in the Division of Women’s Health **KWCSPP ELIGIBILITY**

- Women 21 years of age or older
- Household income at or below 250% of the federal poverty level
- Uninsured (no Medicare, no Medicaid and no private health insurance)

### **CLINICAL SERVICES**

For complete KWCSPP clinical guidance: see [CSG – Cancer Screening/Follow-Up](#)

The KWCSPP received KDPH/AFM approval to eliminate the sliding fee scale for ALL KWCSPP-eligibles. LHDs do not have to calculate sliding fee scales and/or collect copays for *any* KWCSPP screening or diagnostic services because they are **FREE for ALL KWCSPP eligibles**. This new policy not only removes a financial barrier for KWCSPP-eligible women but also lifts a financial burden from KWCSPP-participating LHDs.

The KWCSPP provides statewide oversight of services rendered through participating LHDs and/or LHD’s contracted providers. LHDs and contracted providers shall ensure each KWCSPP-eligible woman receives a complete cycle of care in regards to breast and/or cervical cancer screening, including:

1. Screening
2. Diagnostics and follow-up
3. Timely referrals to contracted service providers
4. Nurse Case management/patient navigation
5. Access/Enrollment to cancer treatment, if applicable, through Medicaid’s Breast and Cervical Cancer Treatment Program (BCCTP)

For BCCTP guidance, Review: [CSG—Cancer Screening/Follow-Up](#)

Follow-up Referrals for Mobile Mammography Units:

KWCSPP eligible woman may receive their screening mammogram within a mobile mammography unit. If a LHD chooses to host a mobile mammography event in their community, it is a recommendation for LHDs and LHD nurse case managers to create partnerships with mobile mammography vendors in order to coordinate completion of the

WH-58 form and provide follow-up/case management for clients in the event of an abnormal screening result.

### **CLINICAL SERVICE PROVIDER CONTRACTS REQUIRED**

LHDs must contract only with licensed facilities and/or providers that ensures a patient's cycle of care is complete, and must include:

- Gynecological providers
- Oncology surgeons
- Anesthesiology providers
- Imaging facilities offering Mammography, MRI, Ultrasounds, X-rays, etc..
- Radiology providers
- Cytology/pathology providers/facilities

### **REIMBURSEMENT AND CODING**

**LHD contracts** with clinical service providers must include the most current version of the [KWCSF Approved CPT Codes and Reimbursement Rates](#) sheet and include ONLY the CPT codes/services that will be reimbursed by your LHD to that specific provider. The KWCSF reimburses LHDs at 100% of the Medicare Part B rate, therefore services are FREE to eligibles, and patients should not be billed or provide co-pays. This policy applies to the LHD's contracted providers as well. Any reimbursement rate amount, negotiated by the LHD and contracted provider, greater than the approved KWCSF rate will be the responsibility of the LHD.

KWCSF will pay for all the program approved CPT codes reported under the 813 cost center up to the LHD's allocation. LHDs must enter these procedure codes into the [LHD Network System\(s\)](#). Please contact the Local Health Operations (LHO) Branch for medical coding questions at (502) 564-6663. Contact Custom Data Processing for technical system-related problems related to the [LHD Network System\(s\)](#) at 866-237-4814.

### **QUALITY ASSURANCE (QA) AND QUALITY IMPROVEMENT (QI)**

QA: QA will be evaluated through the completion and submission of the WH-58, the program's Minimum Data Elements (MDEs) data collection form. The data elements are designed to measure quality performance. If a clinic fails to submit completed WH-58s, or if a specific need for QI is noted, the KWCSF will provide assistance.

QI: When a need for QI is identified, a CAP (Corrective Action Plan) form may be sent to the particular clinic to complete and return to the KWCSF's QI Nurse Consultant and/or a site visit may be scheduled. These steps will only be taken with individual clinics on an as-needed basis. Other than completing the WH-58 on all KWCSF-eligible women, there will be no *routine* steps that LHD clinics will be asked to take for QA/QI.

**MINIMUM DATA ELEMENTS (MDES)** are a set of standardized data variables required to be collected on women screened utilizing KWCSF federal funds. LHDs complete the [WH-58](#) to comply with the MDE requirement.

The purpose of collecting MDE data is to:

- Assure high quality services for women screened by the KWCSF

- Timely reimbursements for participating LHDs
- Evaluate and manage the KWCSF efficiently and effectively
- Prepare reports for stakeholders
- Secure future funding from NBCCEDP grant

Based on this data, the KWCSF develops key reports to share with stakeholders. LHDs are contacted for any outstanding and pending records or to address any inconsistencies in the MDE data. This information is provided to assist the LHD nurses and support staff responsible for completing and entering the [Patient Encounter Form](#) (PEF), and the [KWCSF Data Collection Form \(WH-58\)](#). The CDC required data (MDEs) is submitted to the KWCSF Data Manager who compiles a data report and sends to CDC for determination of federal funding awards as well as program quality assurance.

### **WH-58 Data Collection Process**

After a patient arrives, the support staff will collect and enter patient demographic information in the patient registration screen(s) within the CDP web-based system. KWCSF eligibility is calculated automatically by the system, not by staff. The LHD Network System(s), e.g., Patient Services Reporting System (PSRS), will determine the KWCSF eligibility requirements for women during the registration process.

If the patient is deemed eligible, the system generates a label (C) to be placed on the WH-58 and sends a status line message to place [WH-58 form](#) in the chart. The nurse will then complete the Cancer Screening screen within the CDP system. For your convenience, this screen has been designed to mirror the hard copy WH-58 data collection form.

### **WH-58 Follow-Up Audit Reports**

Audit reports are used to apply a proactive quality assurance process at the LHD level to identify records with incomplete screens and to supply the missing data. The Nurse Case Manager will use the audit reports as an additional tool to assure the LHD's follow-up on patients who have abnormal breast and cervical cancer screening results. The following audit reports must be run and reviewed every month. For report details, review the MDE Manual, Version 2.0.

323 (Cervical Screening Report)

676 (Breast Screening and Diagnostic Report)

1709 (BC Screen Missing Data Report)

1706 (Breast Final Diagnostic Pending Report)

1707 (Cervical Final Diagnostic Pending Report)

2646 (Cervical Lost to Follow-up or Refused)

2647 (Breast Lost to Follow-up or Refused)

2649 (Duplicate MDE Records Report) 2653 (Cancer Reimbursement Report)

2654 (Duplicate Cancer CPT Codes)

Along with KWCSF, in the Division of Women's Health, is the **Breast Cancer Research and Education Trust Fund (BCTF)**, created in June 2005, in accordance with KRS 211.580. The purpose of the Trust Fund program is to distribute funds to support breast cancer research, education, treatment, screening, and awareness in Kentucky. The Trust Fund consists of funds collected from the state income tax check off, the sale of the "Driving for a Cure" license plates, and any other proceeds from grants, contributions, appropriations, or other funds made available for the purposes of the Trust Fund. Trust Fund moneys are allocated through a competitive grant process to provide funding to not-for-profit entities, educational institutions, and governmental agencies in Kentucky (e.g., Local Health Departments). Preference for funding is given to entities whose programs will serve medically underserved populations. Trust Fund grant availability is advertised through a board-approved notification plan.

### **KWCSF WEBPAGE**

The KWCSF webpage has been updated and designed with LHDs and other providers in mind. For participating provider access (interactive map), important forms, Breast Cancer Trust Fund application, announcements and directions; bookmark our site today: [\*\*KWCSF WEBSITE\*\*](#)

# Consent for Services

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A **general consent** is required for each person prior to clinical/personal health service provision. The general consent is obtained as part of the registration process. The signed consent is valid for one year from date signed. (Access the [LHD Forms, Documents and Administrative Reference webpage](#) to view the [CH-5 or CH-5B – REGISTRATION, INCOME DETERMINATION, AUTHORIZATIONS, CERTIFICATIONS and CONSENTS forms](#). A general consent statement will be reviewed and signed by the patient, parent or legal representative (*legal guardian, legal custodian, an adult with Power of Attorney rights, or another adult with legal authority according to applicable laws*). Assuring an appropriate person signs the consent is very important. This section is not all-inclusive to every situation the LHD may encounter.

The consent contained on the [CH-5 or CH-5B](#) covers all general medical services. Services that require more in-depth explanation (**informed consent**) will require an additional signature after the patient, parent or legal representative has been given adequate information to make an informed decision about the service or treatment to be rendered. Guidelines for who may give consent are contained on the following pages.

When providing health services, it is essential that the health professional ensure to the extent possible that the patient, parent or legal representative fully understands the treatment and services being provided.

With any procedure or treatment of a patient, there are certain risks that are present. It is the duty of the medical professionals to be aware of the risks and inform the patient of the procedure to be performed, acceptable alternative procedures or treatments and substantial risks and hazards inherent in the proposed treatments or procedures, which are recognized among other health care providers who perform similar treatments or procedures.

Informed Consent **MUST** be completed and signature obtained by the medical staff person providing the service. This consent must be signed and dated by the patient, parent or legal representative.

“Informed consent” comprises seven (7) basic elements. To help remember these elements, think of the word “**BRAIDED**”:

- **B**enefits of the drug, procedure, service.
- **R**isks of the drug, procedure, service.
- **A**lternatives to the drug, procedure, service.
- **I**nquiries about the drugs, procedures, services are the patient’s, parent or legal representative’s right and responsibility.
- **D**ecision to refuse the drug, procedure, and service without penalty is the patient’s, parent or legal representative’s right.\*
- **E**xplanation of the drug, procedure, service is owed the patient, parent or legal representative.
- **D**ocumentation that the health professional has covered each of the previous six points, usually by use of a consent form or statement.

Certain procedures or services require **specific consent forms**. Forms are located on the [LHD Forms, Documents and Administrative Reference, Family Planning](#), and the [Nursing Office](#) webpages:

- Federally required [Consent for Sterilization](#) ([OMB 0937-0166](#))

- *Consent for Removal of the Contraceptive Implant* ([FP4](#))
- *Consent for Insertion of the Contraceptive Implant* ([FP3](#))
- *Consent for Intrauterine Device (IUD) Insertion/Removal* ([ACH280](#))
- *Informed Consent for Vaccines* ([IMM-1](#))

A patient's decision to **refuse a procedure** (such as hemoglobin or hematocrit) may cause the person to be ineligible for a service that requires the procedure to determine eligibility (see specific service guidelines). Review the [Clinical Service Guide](#) for additional information.

The [CH-5WIC](#) may be used in certain applicable situations. Please refer to the [WIC and Nutrition Manual](#), Policy 211, Rights and Responsibilities.

### **GUIDELINES FOR CONSENT ARE AS FOLLOWS:**

The patient is a minor (under 18 years of age - according to [KRS 2.015](#)) and is living with her/his parent(s), legal guardian, or under the custody or control of the Cabinet for Health and Family Services (CHFS). In these cases, either the parent, legal representative, or a CHFS social worker may legally give consent, as applicable.

Exceptions to parental or legal representative consent for minors (patients under 18 years of age) to receive services are:

- Patient is under 18 years of age and has contracted a lawful marriage (and therefore emancipated) and may give consent for services, provided associated risks are fully comprehensible to him/her ([KRS 214.185](#)).
- Patient is under 18 years of age, unmarried and has borne or fathered a child. The patient may give consent for services for her/his child and herself/himself without the consent of the patient's parent or legal representative ([KRS 214.185](#)).
- Patient is under 18 years of age and seeks diagnosis and/or treatment for sexually transmitted disease, pregnancy, alcohol and/or drug abuse or addiction. The LHD may treat the minor for sexually transmitted disease, contraception, pregnancy or childbirth upon consent of the minor and without the consent or notification of the patient's parent or legal representative. Treatment shall not include inducing of an abortion or the performance of a sterilization operation ([KRS 214.185](#)).
- **Patient is a minor and victim of a sexual offense.** He/she, even though a minor, may consent to examination by a physician and such consent is not subject to disaffirmance because of minority. Consent of the patient's parent or legal representative is not required for such an examination ([KRS 216B.400](#)).

The patient is 18 years of age or older who is mentally disabled. If a patient has been adjudged by a court to be mentally disabled, then the court appointed guardian has legal authority to give consent. ([KRS 387.660](#))

**A child may enter the foster care system** by either:

- being removed from the home and placed in the "care and custody" of CHFS, **or**

- being placed in the “care and custody” of a relative/other adult or agency

“Care and Custody” would be defined as any necessary medical, education or other prevailing needs will be the responsibility of the person(s) or agency granted custody by the court.

A child’s removal from the home would be determined through Kentucky District or Family Court. If legal custody is temporarily assigned to one other than the parent, then all release of record decisions and treatment decisions are made by the entity or person with legal custody. LHD should contact their attorney for questions about legal custody.

### **Placed with CHFS**

For a child removed from the home and placed in the care and custody of CHFS, LHDs should contact the local Department for Community Based Services (DCBS) Social Services Worker (SSW) or supervisor if a child needs medical services. The SSW or supervisor will determine the type of custody designation the child has been assigned. **The LHD should obtain a signed copy of the DPP-106A (CHFS Authorization for Health Care) to validate the type of custody designation the child has been assigned.**

If the child has entered care but has not been committed (i.e., “**temporary or emergency**” **custody order**) the SSW or their supervisor should assure CHFS has been authorized, by the judge or birth parent, to consent to any needed medical/treatment services for the child. The SSW will need to communicate with the judge or parent to assure proper consent has been attained, if applicable.

Once the child is **committed** to CHFS, the SSW may authorize or sign the consent for medical services treatment. LHDs may allow a SSW or supervisor to sign consent for medical/treatment services prior to services being rendered, but no more than thirty (30) days prior to the service.

KY DCBS revised their policy allowing for CHFS foster parents to sign consent for the foster child to receive services **with the exception of any NON-ROUTINE service/procedure** needed. “A DCBS staff person is required to sign a consent form for all NON-ROUTINE services/procedures.” The revised KY DCBS policy **DOES NOT** apply to those CHFS foster children in **Emergency** or **Temporary** custody. A Foster Parent cannot sign consent for children in Emergency/Temporary custody. An LHD should contact their attorney for questions concerning emergency or temporary custody.

### **Placed with Relative/Other Adult or Other Agency (not CHFS)**

A child may be removed from the home and placed by the Court in the care and custody of a relative/other adult or agency (agency other than CHFS). The custody order would need to be reviewed to determine the type of order and time frames for which the order is effective. The person/agency listed on the Court Order should be allowed to sign for needed health services during the time period they are designated custody by the court. An LHD should contact their attorney for questions concerning this type of custody order.

Children removed from the home for dependency, negligence or abuse, are processed through District or Family Courts. The proceedings are documented on appropriate [KY Administrative Office of the Courts \(AOC\) numbered legal forms \(Example: AOC-DNA-1, AOC-DNA-2.1, AOC-DNA-12\)](#). [KY Family Court Rules of Procedure and Practice](#) (FCRPP) are found online.

[KRS 405.024](#) includes (*but is not limited to*) the following:

- A “caregiver” means an adult person with whom a minor resides, including a grandparent, stepparent, step-grandparent, aunt, uncle, or any other **adult relative** of the minor;
- “**Health care treatment**” is **defined** as any necessary medical and dental examination, diagnostic procedure, and treatment, including but not limited to hospitalization, developmental screening, mental health screening and treatment, preventive care, immunizations recommended by the federal Centers for Disease Control and Prevention’s (CDC) Advisory Committee on Immunization Practices, well-child care, blood testing, and occupational, physical, and speech therapies; however, “Health care treatment” **Does not mean** any procedure to terminate a pregnancy, pregnancy determination testing, HIV or AIDS testing, controlled substance testing, or any other testing for which a separate court order or informed consent is required under other applicable law.
- The caregiver shall create an affidavit establishing the caregiver’s ability to authorize health care treatment for a minor. The duly executed affidavit shall include **all information** listed in [KRS 405.024](#);
- The affidavit shall be valid for one (1) year and may be renewed annually thereafter unless it is revoked;
- The decision of a caregiver to authorize or refuse health care treatment for a minor shall be superseded by a decision of a parent, de facto custodian, guardian, or legal custodian of the minor.

**Minors are sometimes involved in a child custody issue between parents.** In the cases of shared custody through divorce decree and the parents cannot agree on consent for services, the LHD should try to attain information from the divorce decree stipulating which parent has responsibility for obtaining routine medical care for the minor child. In situations where there is no “child custody order” in place at the time and parents cannot agree on consent for service, authorization only needs to be executed by one (1) parent. However, be aware of your agency decision and your agency should not become involved in a domestic dispute and do not violate HIPAA laws. If in doubt, the LHD should contact their local legal counsel for advice and guidance.

**Minors who are probated or committed to Kentucky Department of Juvenile Justice (DJJ)** are assigned and supervised by a Juvenile Service Worker (JSW). While in committed care of DJJ, the assigned JSW or supervisor may sign consent for needed medical/treatment services. For probated youths, the parents shall sign for all medical services.

When intensive treatment is necessary, youth may be committed to the DJJ. Committed youth are not always removed from the home. Per state law, commitment will generally end at the age of eighteen (18) but can continue until the age of twenty-one (21) in certain circumstances.

The Kentucky Department of Juvenile Justice contracts with several agencies through-out the state for out-of-home placement services. When a youth is determined to need an out of-home placement, other than a DJJ facility, consideration is given to place the youth in the

nearest alternative program that best meets the youth's needs. This helps the youth stay connected to his or her family with visits and counseling, as well as transition/aftercare services back to the youth's home, school, and community.

The [Kentucky Department of Juvenile Justice](#) (DJJ) operates or contracts with various Day Treatment Centers, Group Homes, Residential programs, Independent Living programs, foster homes (both traditional and therapeutic), psychiatric treatment centers, and community agencies to provide a continuum of services for youth committed or probated to the Department.

## **LEGAL GUARDIANSHIP**

- A legal guardian is a person appointed by District Court to manage the affairs of a minor (a person under eighteen years old) or an incompetent adult, or anyone else who does not have the ability ("legal capacity") to manage their own affairs.
- A Conservator, appointed in the same way, is someone who manages only the financial affairs of such a person who is called the "Ward".
- [KRS Chapter 387](#) contains laws covering guardianship and conservatorship. [KRS 387.065](#) covers powers, duties, and responsibilities of guardians; such as: "(3)(b) Consent to medical or other professional care, treatment or advice for the ward,".
- Guardians should present the appropriate court documents indicating their appointment of guardianship prior to services rendered.
- Information about a public guardianship program can be found on the [CHFS Division of Guardianship](#) webpage.

## **USE OF "POWER OF ATTORNEY"**

- Parents/legal guardians may voluntarily complete a "[Standard Power of Attorney for Medical/School-Making Decisions](#) (AOC-796)" on a minor child. This completed and notarized Power of Attorney allows the designated person to consent for most medical services for the minor child, with the exceptions of HIV/AIDS testing, controlled substance testing, or any other testing for which a separate court order or informed consent is required or applicable under law. Consent for immunizations is allowed under this type of Power of Attorney.
- Other "Medical Power of Attorney" for healthcare should contained specific instructions and designate a healthcare proxy to make healthcare decisions when the principal party is unable to make them himself/herself. These documents are required to be notarized. It is recommended that specific information be included that describes each type of medical service the parent or legal guardian allows the designated proxy to provide consent for the minor on their behalf.
- "Power of Attorney" to be revoked, rescinded, or terminated should be in writing and include the name of the Grantor, Attorney-in-Fact, and the date. These documents should be duly notarized.
- Historically, Kentucky has a large number of children who are being reared by relatives who do not have legal guardianship but are the primary caregivers of the child. These relatives should, if possible obtain a notarized legal statement (preferably an [AOC-796](#)

Power of Attorney) from the patient's parent or legal guardian allowing them the ability to consent to medical care for these children. Refer to "Use of Power of Attorney" above for information required as part of a statement and any exceptions. Efforts should be made to assist these families and children seeking service.

- A helpful resource is a handbook for grandparents and other caregivers provided by the Kentucky Cabinet for Health and Family Services entitled "[\*\*\*HELP – A Handbook for Kentucky Grandparents and Other Relative Caregivers\*\*\*](#)" is available online.
- Kentucky Revised Statutes relating to Power of Attorney is [KRS 27A.095](#).

## **"GENERAL CONSENT" WHEN PARENT/LEGAL REPRESENTATIVE CANNOT BE PRESENT AT VISIT**

When an appointment is made for a child and the parent or legal representative is unable to accompany the child, the following should be followed:

The LHD should mail to the parent or legal representative prior to the appointment, but no more than 30 days prior to the appointment:

- The appropriate Patient Registration and Income Determination form ([CH-5B](#)), and advising date form must be returned;
- The LHD HIPAA Notice of Privacy Practices and the Receipt for the Notice of Privacy Practices, if this is patient's first medical service provided by LHD

At the scheduled appointment or prior (but no more than 30 days) the following documents should be returned to the LHD:

- The [CH-5B](#), **completed and signed** by the parent or legal representative prior to the appointment, should accompany the child at the visit or should be returned to the LHD prior to the scheduled appointment
- A daytime phone number where the parent or legal representative can be reached
- If applicable, the Receipt of the Notice of Privacy Practices

If someone with legal authority does not present at the visit with the child, general consent may be obtained by telephone:

- The LHD provider should place a telephone call to the parent or legal representative and explain thoroughly the instructions for collecting the demographics, income, and any other pertinent information required for **general consent for service**.
- Information collected may either be documented on a [CH-5B](#) or input into the system to generate registration labels placed on [CH-5](#).
- Identify the [reason for visit](#).
- The parent or legal representative should state understanding and give verbal consent.
- Another LHD employee should listen to the phone conversation to confirm the parent or legal representative's verbal consent. The person presenting with the child should also witness the conversation.
- All information should be documented in the medical record.
- Document on the medical record ([CH-5](#) or [CH5B](#)) that verbal consent obtained, the name of the parent or legal representative who provided the general consent, who witnessed the verbal consent and sign and date. If a second LHD employee, if available witnessed, they will need to sign and date the entry to confirm the verbal consent.
- The LHD should follow up to arrange for a convenient time for the parent or legal representative to sign the [CH-5](#) or [CH-5B](#). Or the LHD may mail, fax or email the [CH-5](#) or [CH-5B](#) to the parent or legal representative for signature. If the [CH-5](#) or [CH-5B](#) is mailed then a copy of the document shall be kept until the signed copy is returned.

Persons or agencies having legal custody, legal guardianship, or power of attorney may provide consent. REMINDER: Foster parents, resource parents or pre-adoptive parents **cannot** sign for non-routine health care for children in their care pursuant to the DCBS form, [DPP-106A](#).

**“INFORMED CONSENTS” FOR IMMUNIZATIONS WHEN PARENT/LEGAL REPRESENTATIVE CANNOT BE PRESENT AT VISIT (*a General Consent should also be completed if applicable*)**

The Kentucky Immunization Branch recommends the following when an appointment is made for a child and the parent or legal representative is unable to accompany the child, the directions below should be followed:

- If written consent is received **by mail**, the LHD should **mail** to the parent or legal representative prior to, but no more than 30 days:
  - Appropriate vaccine information materials ([VIS forms](#))
  - The LHD vaccine consent form
  - A statement which includes the LHD telephone number and information on how calls are taken
- The parent should be encouraged to call for further information/questions. The LHD should encourage the parent or legal representative to provide a phone number where they may be reached on the day the immunizations are to be given in case questions or concerns arise.
- The **signed consent form** with the parent’s emergency phone number **must** be returned to the LHD.
- The parent or legal representative should keep the vaccine information materials for future reference.
- If verbal consent is received **by telephone**:
  - The LHD provider should place a telephone call to the parent, explain the proposed procedure thoroughly and provide **informed consent**.
  - The LHD provider should explain the service to be performed, the risks, side effects, benefits, alternatives and comfort measures for the procedure.
  - The parent or legal representative should state understanding and give verbal consent.
  - Another LHD employee or a school administrator or administrator’s designee must listen to the phone conversation to confirm the parent or legal representative’s oral consent. This information must all be documented in the medical record.
  - The complete legal name of the second witness to the oral consent must be documented in the medical record.

- The LHD should follow up with asking the parent or legal representative to sign the consent form.

Persons or agencies having legal custody, legal guardianship or power of attorney may provide consent for immunizations. **CHFS/foster parents, resource parents or pre-adoptive parents are only permitted to sign for ROUTINE health care procedures/services pursuant to form, DPP-106A** developed by the Department for Community Based Services (DCBS), Division of Protection and Permanency (DPP). After reviewing [the DPP-106A form](#), any questions related to routine versus non-routine shall be made to the county's local DCBS, Protection and Permanency office or by calling the state's DCBS, DPP, Adoption Branch at (800) 232-5437. Legal inquiries would be directed to the LHD's local legal counsel for advice and guidance.

## Public Health Competencies Crosswalk

[Crosswalk of the Competencies for Public Health Professionals](#) as prepared by the Council on Linkages Between Academia and Public Health Practice.

### KENTUCKY PUBLIC HEALTH NURSING COMPETENCIES NARRATIVE

The Quad Council Coalition (QCC) of Public Health Nursing Organizations was founded in 1988 to address priorities for public health nursing education and practice. The QCC was originally comprised of:

- The Association of Community Health Nurse Educators (ACHNE)
- The Association of State and Territorial Directors of Nursing (ASTDN)
- The American Public Health Association - Public Health Nursing Section (APHA)
- The American Nurses Association's Congress on Nursing Practice and Economics (ANA)

In 2000, prompted in part by work on educating the public health workforce being done under the leadership of the Centers for Disease Control (CDC), the QCC began work on drafting a set of national public health nursing competencies.

The approach utilized by the QCC was to start with the Council on Linkages between Academia and Public Health Practice (CoL) ["Competencies for Public Health Professionals"](#) and to determine their application to the levels of public health nursing practice: the staff nurse/generalist role, the manager/specialist/consultant role and the senior management/executive level role. It was the QCC's intent to examine these CoL competencies for their fit with public health nursing and to continue to identify and refine unique competencies for public health nursing. By selecting the CoL competencies as the framework, the QCC felt that the competencies could provide a guide for agencies that employ public health nurses and academic settings to facilitate education, orientation, training and lifelong learning using an interdisciplinary model where appropriate.

The CoL established in 1992 is a collaborative of 22 national organizations focused on improving public health education and training, practice, and research. The Core Competencies for Public Health Professionals (Core Competencies) are a consensus set of skills for the broad practice of public health, as defined by the [10 Essential Public Health Services](#). Developed by the CoL, the original version of the Core Competencies was released in 2001. The CoL unanimously adopted revisions to the Core Competencies in May 2010 and again in June 2014. The CoL's Core Competencies are regularly reviewed and revised by the Council on Linkages' [Core Competencies Workgroup](#) to ensure these competencies continue to reflect the skills needed for protecting the nation's health.

In part because the CoL revised its "Core Competencies for Public Health Professionals" in 2010, the QCC undertook revision of the ["Core Competencies for Public Health Nursing \(CCPHN\)"](#). The CCPHN document was kept consistent with the "Definition of Public Health Nursing" adopted by the APHA's Public Health Nursing Section in 1996 and the Scope and Standards of Public Health Nursing.

In undertaking the revision process, a crosswalk matrix was developed to strengthen the CCPHN and align them with the “Core Competencies for Public Health Professionals”. The following assumptions guided the Quad Council’s work:

- The QCC adopted the CoL definition of core competency: “The individual skills desirable for the delivery of Essential Public Health Services. ”
- Public Health Nursing (PHN) is defined as the practice of promoting and protecting the health of populations, using knowledge from nursing, social, and public health sciences. PHNs engage in population-focused practice but can and do often apply the CoL concepts at the individual and family level.

The QCC adopted the CoL structure for competencies: eight recognized domains spanned by three tiers of practice. The CCPHN assumes that PHNs practice at the intersection of population-focused nursing care and public health practice. Proceeding from this assumption, the CoL document was used to determine how PHNs should demonstrate core competencies for public health professionals at all three levels: the basic or generalist level (Tier 1); the specialist or mid-level (Tier 2); and at the executive and/or multi-systems level (Tier 3).

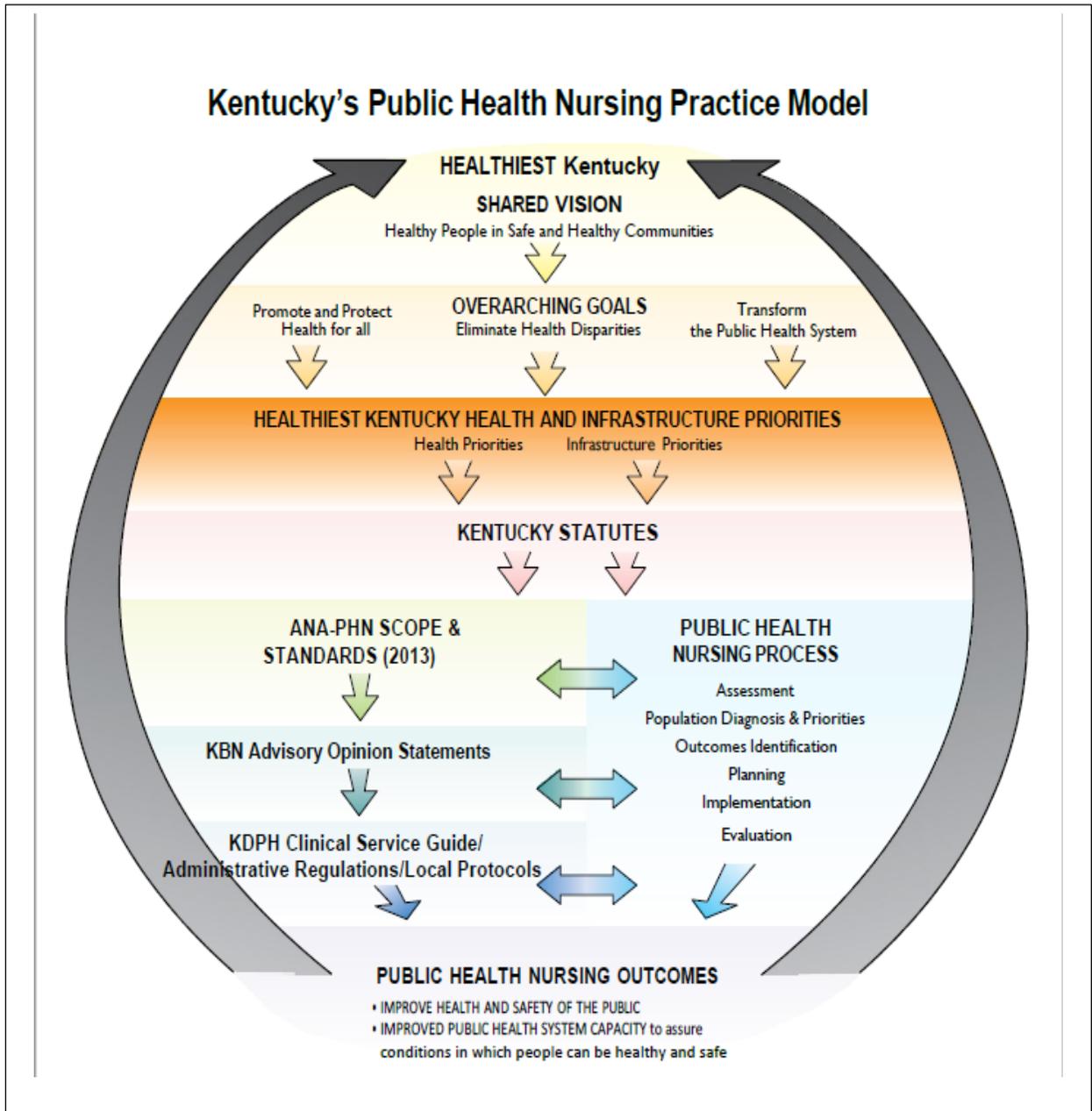
In 2017, the QCC appointed a Competency Review Task Force charged with review and revision of the CCPHN. The QCC reviewed and approved the [Community/Public Health Nursing \(C/PHN\) Competencies](#) on April 13, 2018.

Currently the [Council of Public Health Nursing Organizations](#) (CPHNO-formerly the Quad Council Coalition of Public Health Nursing Organizations) provides a voice and visibility for public health nurses, sets a national policy agenda on issues related to public health nursing, and advocates for excellence in public health nursing education, practice, leadership, and research. The CPHNO will continue to crosswalk the Community/Public Health Nursing (C/PHN) Competencies with the CoL’s Core Competencies for Public Health Professionals.

The DPH Director of Nursing/Nursing Office, in partnership with the Nurse Executive Council (NEC) and the Kentucky Vaccine Program nurse leadership, developed the first competencies for the entry-level Kentucky public health nurses who provide immunization services in the clinic or community setting. Domains were selected according to their relevance to the target population and program setting.

In 2019, The Kentucky DPH Core Competencies for Public Health Nurses were updated to be consistent with the QCC 2018 approved C/PHN Competencies. The [Kentucky DPH Core Competencies for Public Health Nurses](#) are located on the [DPH Nursing Office](#) webpage. Public health competencies may be used for many purposes, including a new employee orientation tool, demonstration of annual competencies, for clinical staff meeting discussions, for personnel evaluations and for accreditation purposes. When used in conjunction with the Performance Management tool, you must manually add the goal into the standardized plan. It is recommended that at least one of the KDPH Core Competencies for Public Health Nurses be added for the clinical nurse aligning with the appropriate tier; the basic or generalist level (Tier 1); the specialist or mid-level (Tier 2); the executive nurse (Tier 3) is unlikely to be used in the local health department setting. Subsequent competencies may be developed by the [DPH Nursing Office](#) and the NEC in conjunction with other public health programs and/or QCC updates as needed.

The Nurse Executive Committee FY22-23 developed and approved the KDPH Nursing Practice Model as follows:



Additionally, KDPH and the LHDs came together in a Public Health Nurse Competency Workgroup in August of 2022 with the goal to identify the unique and personalized core competencies for Kentucky public health nurses. This included the following:

- Identify role/job categories across the three tiers.
- Identify and prioritize the knowledge, skills and behaviors of the domains for each of the three tiers.
- Identify the overall critical behaviors, and essential knowledge, skills and behaviors of each tier.

The results of this workshop can be found in the [Nurse Competency Workshop Outcome](#)

# Environmental Health Services

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## **ENVIRONMENTAL HEALTH SERVICES**

The [Division of Public Health Protection and Safety](#) (PHPS) is located within the Department for Public Health (DPH) and supports local environmental health services programs. This Division has five branches that support environmental health activities and programs across the Commonwealth.

The PHPS supports the LHDs by providing education, technical assistance, consultation, and monitoring in the operation of environmental programs. The Cabinet for Health and Family Services with local health departments (LHDs) acting as their agents regulate temporary food service establishments; food service establishments; food and beverage vending machines; retail-food establishments; bed and breakfast establishments; retail food stores; tattoo and body piercing artists; tattoo and body piercing studios; ear piercing studios; hotels and motels; mobile home and recreational vehicle parks; youth camps; public rest rooms; tanning facilities; schools; state confinement facilities; shellfish processors; public swimming and bathing facilities; private water supplies; bird roosts; public health nuisances; lead; methamphetamine contaminated properties; private sewage; radon education; septic tank cleaning companies and vehicles and land application sites; on-site sewage disposal systems; construction standards for components of on-site sewage disposal systems; and certification of on-site system installers. LHDs and their Boards of Health may in addition, establish and implement local ordinances and programs to further address and protect the public's health in environmental areas of concern.

Two of the Division's five branches, Food Safety and Environmental Management Branch, work directly with LHD environmental programs to provide training, technical assistance and support. Many of the programs operated under this Division are mandated public health services. Other branches and programs within the Division include Milk Safety, Radiation Health, Public Safety, and Food Manufacturing Programs. These programs use primarily state personnel to carry out their environmental activities.

The Food Manufacturing program conducts inspections of food warehouses; bakeries; mills; grain storage facilities; bottling plants; food and cosmetic salvage processors and distributors; general food processors; food distributors; food transporting vehicles; frozen food lockers; raw agricultural commodities (for pesticide residues); and farmers market microprocessors. LHD environmental health personnel carry out the majority of the remaining environmental programs in accordance with statutes, regulations and state and local guidelines.

### **Statutes Governing Environmental Services**

All environmental activities/services are to be conducted in accordance with the following Statutes and Administrative Regulations:

[KRS 194A.050](#); and [211.090](#); [211.180](#); [211.210](#); [KRS 211.345](#); [211.350 to 211.380](#); [211.760](#); [211.905](#); [211.920 to 211.945](#); [211.970](#); [211.9061 to 211.9079](#); [322.990 and 211.995](#), [211.972 to 211.982](#) and [211.995](#); [212.210](#); [212.245](#); [217.005 to 217.285](#); [217.808 to 217.812](#); [217.920-217.928](#), [217.992](#); [219.011 to 219.081](#); [219.310 to 219.410](#) and [219.991](#); [221.010 to 221.110](#), [221.990](#); [223.010 to 223.080](#) and [223.990](#); [224.01-410](#); [258.005 to 258.085](#), and [258.990](#)

### **902 KAR Chapter 1: Administration**

[400 Administrative Conference](#)

## **902 KAR Chapter 7: Public Accommodations**

[010 Hotel and Motel Code](#)

## **902 KAR Chapter 9: State and Local Confinement Facilities**

[010 Environmental Health](#)

## **902 KAR Chapter 10: Sanitation**

- [010 Public restrooms](#)
- [030 Sanitarians](#)
- [040 Kentucky youth camps](#)
- [060 On-site sewage disposal application fee](#)
- [081 Construction standards for components of on-site sewage disposal systems](#)
- [085 Kentucky on-site sewage disposal systems](#)
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- [120 Kentucky public swimming and bathing facilities](#)
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- [140 On-site sewage disposal system installer certification program standards](#)
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- [190 Splash pads operated by local governments](#)

## **902 KAR Chapter 15: Manufactured Home, Mobile Home and Recreational Vehicle Communities; Community Standards**

- [010 Manufactured and mobile homes](#)
- [020 Recreational vehicles](#)

## **902 KAR Chapter 45: Food and Cosmetics**

- [005 Kentucky food code](#)
- [020 Kentucky shellfish dealer standards and requirements](#)
- [065 Tattooing](#)
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- [090 Home-based processors and farmers market home-based microprocessors](#)
- [100 Vending machines; food and beverages](#)
- [110 Permits and fees for retail food establishments, food manufacturing plants, food storage warehouses, salvage processors and distributors, vending machine companies, and restricted food concessions](#)
- [120 Inspection and permit fees, hotels, manufactured or mobile home communities, recreational vehicle communities, youth camps, and private water supplies](#)
- [150 School sanitation](#)
- [160 Kentucky food processing, packaging, storage, and distribution operations](#)

## **902 KAR Chapter 47: Hazardous Substances**

[200 Public Health Methamphetamine Regulation](#)

## 902 KAR Chapter 48: Lead Selection and Abatement

- [010 Definitions for 902 KAR Chapter 48](#)
- [020 Training and certification requirements for persons who perform lead-hazard detection or lead-hazard abatement](#)
- [030 Accreditation of training programs and providers of educational programs for individuals who perform lead-hazard detection and abatement](#)
- [040 Permit fees, permit requirements and procedures, and standards for performing lead-hazard detection and abatement](#)

### Coordination Of Services

To fully serve, the health needs of the community, environmental programs and staff often interact with other programs and disciplines within and outside their agency. Some activities requiring coordination include:

- Investigation of food-borne and waterborne illness
- Childhood lead poisoning
- Rabies prevention
- Laboratory submissions (Water, Rabies, Food Specimens for example)
- Disaster and Emergency Response
- Epi-Rapid Response Teams
- Local County Agencies (such as Planning and Zoning and Disaster and Emergency Services)
- State Plumbing

### Personnel Qualifications And Training

LHD personnel working in environmental program areas are required to meet the following criteria:

- All staff engaged in environmental health activities are required by [KRS 223.010 to KRS 223.080](#) to become registered as a Registered Sanitarian (R.S.) or a Registered Environmental Health Specialist (R.E.H.S.) and to earn annual continuing educational credits to maintain registered status. This registration shall be obtained within one year of employment and shall be renewed annually.
- Environmental staff shall attend CORE Training offered by the Division for Public Health Protection and Safety regarding Food Branch Programs and General Sanitation Programs soon after employment; plus attend in-service, special training and short courses as required by the DPH to insure program effectiveness.
- All staff employed to work in the on-site sewage program shall be required to obtain certification as a Certified Inspector in accordance with the provisions of [KRS 211.360](#).
- Each independent health department or district health department shall have employed on staff a Retail Food Specialist who has been standardized in accordance with the 2013 [FDA Model Food Code](#).

### Environmental Fees

- Environmental Fees are established by statute or regulation for most environmental program areas. Environmental fee information may be found in the Environmental Coding Manual.
- The LHD may establish local fees to cover the cost of environmental program activities where fees have not been formally established by regulation or statute. [KRS 211:355](#) allows LHDs to set fees for the operation of the onsite sewage program.

- LHDs shall maintain fee processing records in accordance with the DPH policies and procedures that comply with the provisions of [KRS 211.170](#). The details for the money handling guidance for local health agencies can be found in [The Environmental Fee Revenue Procedures Guidance](#) section of the AR.
- LHDs shall establish a separate bank account for deposit of all environmental fee receipts hereby referred to as the Environmental Holding Account. The Cabinet shall be notified of the bank name and address, the name of the account and the account number, as well as any subsequent changes.
- All environmental health fees shall be processed using the Environmental Health Management Information System (EHMIS) in accordance with the internal control policies established by the LHD. All LHD internal control policies should comply with the Environmental Fee Revenue Procedures Guidance. The EHMIS system is a comprehensive system designed to collect data for all environmental health program areas.
- State environmental health fee receipts shall be transmitted to the DPH, by the 10th of each month.
- Permit issuance shall be conducted through EHMIS.

## **Record Keeping**

Record keeping is a vital part of all environmental programs and shall adhere to the minimum standards below.

- A separate file shall be established on each regulated entity or establishment containing documentation that includes inspection sheets, notices, correspondence and all other pertinent information.
- Inspection data shall be entered into the Environmental Health Management Information System (EHMIS) in a timely manner.
- All record reports and inspections shall be maintained in accordance with the LHD Records Retention Schedule adopted by the State Archives and Records Commission.
- All record keeping shall be neat, orderly and current.
- A separate file shall be established for nuisance control complaints while under investigation and shall include all pertinent information including any official correspondence and inspections. Records relative to the investigation of a complaint or an illness may be held from release until such time that the investigation is complete. Closed investigation records may be kept in a joint file with the exception of complaints involving permitted facilities, which shall be maintained in the establishment file after the investigation is completed.
- In accordance with [200 KAR 1:020](#) and [KRS 61.870](#) (Kentucky's Open Records Law), public records of all agencies of Kentucky State Government, subject to certain exceptions, are open for inspection. If the person requesting to inspect the document is not the person to whom the document pertains, personal information such as home address and home phone numbers may be blocked out prior to inspection. All open record requests shall be handled in accordance with local policies and procedures. For more information see "Open Records" in the AR, [Local Health Operations \(LHO\) section](#).
- Some requests may be denied under the provisions of [KRS 61.878](#).

## **Reference Materials**

Access to reference manuals and materials shall be available for use by LHD personnel in the operation of environmental programs.

- LHD environmental staff shall keep an adequate supply of forms, pamphlets, regulation booklets, etc. or have [electronic access to forms](#), pamphlets, etc. to enforce the regulation and to provide for distribution to interested parties. For information on ordering Environmental documents/pamphlets, please refer to the "[LHD Information webpage](#)". *A Pamphlet Library Inventory document is available for review and the CHFS-1210 Pamphlet Library Request Form is available for use when an order is needed.*
- LHD's environmental staff shall maintain at least one applicable trade and or professional journal, textbook or reference manual or have access to such reference material online.
- Health Departments engaged in swimming pool inspections shall have access to a listing of the NSF ([National Sanitation Foundation](#)) approved circulation system components and reference materials on the care, operation and maintenance of swimming pools.
- LHDs shall have available a copy of the Registered Sanitarian Field Handbook Rev. 2004, for reference available from the [Registered Sanitarian webpage](#).
- LHDs shall have access to at least one reference material or textbook relative to the etiology of food-borne illness or have access to such reference material online.

### **Program Compliance Standards**

Program compliance unless otherwise stated shall be achieved when the program is operated in accordance with their respective statutory and regulatory authority.

- Satisfactory sanitation compliance levels for regulated entities or establishments shall be an average of 85% compliance or above with no critical items debited and operation in accordance with applicable statutory and regulatory requirements for the respective program area.
- Satisfactory administrative compliance level for each LHD shall be an evaluation rating score of 85% or higher for administrative procedures, equipment, personnel, and training, publicity and consumer education, and record keeping.
- Private Water shall be considered in compliance if a private water supply suspected of causing illness has been inspected and water sampled upon the owner's request or that of his physician.

Programs investigated under [KRS 212.210](#) shall be considered in compliance when 85% of public health nuisances are abated, eliminated, or otherwise investigated in a manner satisfactory for the protection of public health.

### **Program Publicity And Consumer Education**

- LHDs shall be responsible for at least semi-annual dissemination of information to the public through local news media, presentations to local civic organizations, or displays at public gatherings to keep the consumer informed about environmental health activities.
- LHDs should strive to provide food service training for food industry personnel; this type of training shall be offered no less than one time every three years.
- LHDs shall maintain access to regulations and program guidance so as to assist interested persons.

### **Enforcement Procedures**

Administrative Enforcement Action is initiated when the permit holder has been issued a routine or follow-up inspection report that specifies in writing items found contrary to provisions of the law or administrative regulation and which specifies a time in which corrections are to be made. Official Enforcement Action is initiated when the permit holder or establishment operator has failed to

comply with an administrative enforcement notice, within a specified time, issued under the provisions of law or administrative regulations.

- All enforcement notices shall be issued in accordance with the applicable law or regulation of the program area and shall conform to the policies of the LHD. State Technical Consultants are available for consultation with local staff relative to enforcement actions.
- All reports, inspections and investigations should be reviewed for completeness by the inspector's supervisor or in accordance with the local Quality Assurance policy, prior to the issuance of an official enforcement notice. The operator or permit holder shall be afforded an Administrative Conference to provide for "due process" whenever an Official Enforcement Action or Notice has been initiated. Administrative conferences shall be offered in accordance with [KRS Chapter 13B](#); and [902 KAR 1:400](#) and the applicable statutory and regulatory requirements of the respective program areas.
- [902 KAR 1:400](#), Section 4(1) provides that an appellant may file an appeal with the department by mailing a letter of appeal within 10 days of the receipt of final action by the LHD to the Commissioner, DPH.

- **Equipment**

Environmental staff shall be provided with the necessary equipment to enforce the regulations and to carry out the provisions of the regulations.

### **Environmental Scheduling and Inspections**

- Routine inspections of permitted facilities should be made during normal hours of business operation whenever possible. Due to the nature of some businesses this may require the environmentalist to operate outside normal office hours. LHDs should establish policies for work conducted outside normal office hours. Temporary food inspection is one program area that routinely operates outside the normal operational hours of the health department.
- Generally routine inspections are to be unannounced; however, prior scheduling may be used under certain circumstances; for example, when the facility has irregular hours and days of operation.
- Routine inspections should be conducted at a frequency in accordance with the statutory and regulatory requirements of the specific program area
- Inspection times may vary based on the size of the establishment, the conditions found during the inspection, and the length of travel time, etc. A list of standard hours is provided to assist you in estimating the time involved in various inspectional activities. These times are provided to aid you in workload scheduling and planning. The actual times may vary depending on the circumstances of the inspections.
- Follow-up or compliance inspections shall be conducted as necessary to enforce the regulations and to insure program effectiveness. The estimated average time required for a follow-up or compliance inspection including travel, recording and administrative time are listed on the following page.



Complaint or investigative inspections shall be handled upon request or as LHD protocols warrant. The initial inspection/investigation should be conducted within five (5) working days from the date of receipt of the complaint. Complaint investigations, which require further legal action for correction, may necessitate additional time for the development of evidence and the initiation of court action. Private water samples will be scheduled upon request and may exceed the five working days timeframe due to sampling submittal criteria.

Other administrative activities such as office services, field visits and surveys shall be conducted as necessary to ensure program compliance.

### **Construction And Plan Review**

Construction plans are required to be submitted on most permitted public facilities regulated by the LHD. Specific details regarding the submittal of construction plans are addressed in the respective regulations and vary according to the type of facility.

- Construction plans, showing the complete layout of the facility, shall be submitted to and reviewed by the LHD on all new or extensively altered **permitted** public facilities in conformance with the requirements of the Department of Housing, Building and Construction and in accordance with the statutory and regulatory requirement for each program area, including Food Manufacturing Program.
- The applicant shall supply additional sets of construction plans when construction plans must be forwarded for review and approval by other regulatory agencies.
- Plans shall be thoroughly reviewed for accuracy and completeness by the regulating authority. Adequate time should be allowed for plan review.
- LHDs may establish reasonable fees for the review of plans.
- New facilities should be inspected prior to final approval and permit issuance for conformance to the approved construction plans with regard to the requirements of the respective program regulation.

On the following pages is a summary matrix of Environmental Health Services. The matrix includes by service type:

- Description of Service
- Target Population
- Category of Service
  - I.A. Foundational Services (Services required by statute or regulation.)
  - I.B. Preventive service for a specific population from appropriate funds.
  - I.C. Local option service, provided after mandated services are assured.
- Laws or regulation pertaining to the service
- Funding
- Staff Requirements
- Training Required
- Reporting (How service is reported, references pertaining to the service, and Division responsibility for the guidelines.)

### **Additional Requirements:**

- Maintain separate files on permitted entities, complaints, construction plans, etc. in accordance with the most current [Records Retention Schedule](#) as outlined in the AR, [Medical Records Management section](#).

- Maintain an adequate number of educational/informational booklets, inspection sheets, [forms](#) and applications.

**Summary of Environmental Health Services**

<b>KEY:</b> <i>*use key for the following tables*</i>			
<b>Category I.A.</b>	Foundational service, required by statute or regulation.	<b>TA</b>	Trust and Agency (fees)
<b>Category I.B.</b>	Preventive service for specific populations from appropriated funds.	<b>GF</b>	General Fund or Local Taxes
<b>Category II.</b>	Local option service, provided after mandated services are assured.	<b>RS</b>	Registered Sanitarian
<b>EHMIS</b>	Environmental Health Management Information System		

	<b>Bed &amp; Breakfast</b>	<b>Body Piercing</b>	<b>Confinement Facilities</b>
<b>DESCRIPTION</b>	<ul style="list-style-type: none"> <li>• Review construction plans on new structures.</li> <li>• Issue permits.</li> <li>• Inspect facilities for sanitary operation.</li> <li>• Take enforcement action when necessary.</li> </ul>	<ul style="list-style-type: none"> <li>• Review application and issue registration for body piercer.</li> <li>• Review application and issue certification to body piercing studio.</li> <li>• Inspect body piercing studios twice per year to ensure compliance with the regulation.</li> </ul>	<ul style="list-style-type: none"> <li>• Inspect confinement facilities for sanitary operation.</li> </ul>
<b>TARGET</b>	Bed and Breakfast Establishments	Body Piercers	Confinement Facilities
<b>CATEGORY</b>	I.A.	I.A.	I.A.
<b>LAWS AND REGULATIONS</b>	<a href="#">KRS 217.005-217.215, 217.992 &amp; 902 KAR 45:005 Section 5</a>	<a href="#">KRS 211.760 &amp; 902 KAR 45:070</a>	<a href="#">KRS 211.920-211.945 &amp; 902 KAR 9:010</a>
<b>FUNDING</b>	TA & GF	TA & GF	GF
<b>REPORTING</b>	EHMIS (608)	EHMIS (644)	EHMIS (645)
<b>STAFF REQUIREMENTS</b>	R.S., Food Core	R.S., Food Core	R.S., Environmental Management Core

	<b>Ear Piercing</b>	<b>Food Manufacturing</b>	<b>Food Salvage Operations</b>
<b>DESCRIPTION</b>	<ul style="list-style-type: none"> <li>Review application and issue registration for ear piercer.</li> <li>Review application and issue certification to ear piercing studio.</li> <li>Inspect ear piercing studios once per year to ensure compliance with the regulation.</li> </ul>	<ul style="list-style-type: none"> <li>Review construction plans for food manufacturing facilities and refer to area food manufacturing inspector for permitting and inspection.</li> </ul>	<ul style="list-style-type: none"> <li>Reviews construction plans.</li> <li>Permits food salvage distributors.</li> <li>Inspects facilities for compliance with the regulation.</li> <li>Takes enforcement action when necessary.</li> </ul>
<b>TARGET</b>	Ear Piercers	Food Manufacturing Facilities	Food Salvage Distributors
<b>CATEGORY</b>	IA	I.A.	I.A.
<b>LAWS AND REGULATIONS</b>	<a href="#">KRS 211.760 &amp; 902 KAR 45:070</a>	<a href="#">KRS 217.005-217.215, &amp; 217.992</a>	<a href="#">KRS 217.005-215 &amp; 217.992, 902 KAR 45:080</a>
<b>FUNDING</b>	TA & GF	TA & GF & Federal Contract.	TA & GF
<b>REPORTING</b>	EHMIS (643)	EHMIS (615)	EHMIS (610, 615)
<b>STAFF REQUIREMENTS</b>	R.S. Food Core	R.S., Food Core	R.S., Food Core

### Summary of Environmental Health Services

	<b>Food Service/Retail Food Establishments</b>	<b>Hotel/Motel</b>	<b>Lead</b>
<b>DESCRIPTION</b>	<ul style="list-style-type: none"> <li>Review construction and alteration plans.</li> <li>Issue permits.</li> <li>Inspect facilities for sanitary operation in accordance with regulation.</li> <li>Take enforcement action when necessary</li> <li>Investigate food-borne illness outbreaks</li> <li>Quarantine of adulterated products.</li> <li>Provide training to food industry personnel (at least once every 3 years)</li> </ul>	<ul style="list-style-type: none"> <li>Review construction and alteration plans.</li> <li>Issue Permits</li> <li>Inspect facilities for sanitary operation.</li> <li>Take enforcement action when necessary to ensure compliance with the regulation.</li> </ul>	<ul style="list-style-type: none"> <li>Some LHDs act as Lead Risk Assessors in conjunction with federally funded CLPPE program.</li> <li>Some LHDs provide educational outreach and training for Lead Safe Work Practices Classes.</li> <li>Some LHDs do enforcement.</li> </ul>

<b>TARGET</b>	Food Service and Retail Food Establishments	Hotel and Motel Operators, General Public	Children with elevated blood lead levels and their residences
<b>CATEGORY</b>	I.A.	I.A.	I.A.
<b>LAWS AND REGULATIONS</b>	<a href="#">KRS 217.005-217.285 &amp; 902 KAR 45:005</a>	<a href="#">KRS 219.011-219.081 &amp; 902 KAR 7:010</a>	<a href="#">KRS 211.900-905, KRS 211.9061-9079</a>
<b>FUNDING</b>	TA & GF	TA & GF	Federal/GF
<b>REPORTING</b>	EHMIS (605, 607, 610)	EHMIS (620)	EHMIS (684)
<b>STAFF REQ.</b>	R.S., Food Core Training, Retail Food Specialist in accord with <a href="#">902 KAR 45:005 Section 8</a>	R.S., Environmental Management Core Training	R.S., Refer to Lead Program Guidance

	<b>Manufactured Home, Mobile Home &amp; Recreational Vehicle Communities</b>	<b>Methamphetamine</b>	<b>Nuisance Control</b>
<b>DESCRIPTION</b>	<ul style="list-style-type: none"> <li>Review construction plans on all new or altered facilities.</li> <li>Issue permit to construct.</li> <li>Issue permit to operate.</li> <li>Inspect for compliance with the regulation and for safe and sanitary operation of facility.</li> <li>Take enforcement action when necessary.</li> </ul>	<ul style="list-style-type: none"> <li>Notify the owner of a property posted as having methamphetamine contamination by law enforcement.</li> <li>Notify the owner when the property has been released by EEC.</li> </ul>	<ul style="list-style-type: none"> <li>Investigate complaints.</li> <li>Document the existence of a public health nuisance.</li> <li>Issue notices for the correction of public health nuisance. Take enforcement action if necessary to gain abatement.</li> </ul>
<b>TARGET</b>	Manufactured/Mobile Home & Recreational Vehicle Parks	General Public	General Public
<b>CATEGORY</b>	I.A.	I.A.	I.A.
<b>LAWS AND REGULATIONS</b>	<a href="#">KRS 219.310-219.410 &amp; 902 KAR 15:010, 902 KAR 15:020</a>	<a href="#">KRS 224 Subchapter 1; KRS 212.210</a> <a href="#">902 KAR 47:200</a>	<a href="#">KRS 212.210</a>
<b>FUNDING</b>	TA & GF	GF	GF
<b>REPORTING</b>	EHMIS (625)	EHMIS(667)	EHMIS (660)
<b>STAFF REQUIREMENTS</b>	R.S., Environmental Management Core	R.S.	R.S., Environmental Management Core

	<b>On-Site Sewage</b>	<b>Private Sewage</b>	<b>Private Water</b>
<b>DESCRIPTION</b>	<ul style="list-style-type: none"> <li>• Conduct on-site soil evaluations.</li> <li>• Review pre-installation drawings.</li> <li>• Issue installation permits.</li> <li>• Issue variances in accordance with regulation and local policies.</li> <li>• Inspect installed systems for compliance with the regulation.</li> <li>• Inspect installed system components for compliance with the regulation</li> <li>• Review installation drawings</li> <li>• Provide installer training as needed.</li> <li>• Verify Installer Liability Insurance</li> <li>• Take enforcement action when necessary.</li> </ul>	<ul style="list-style-type: none"> <li>• Investigate private sewage complaints.</li> <li>• Conduct existing system inspections of private septic systems as resources allow.</li> </ul>	<ul style="list-style-type: none"> <li>• Collect and submit water samples on private water where illness is suspected or upon owners request as agency resources allow.</li> <li>• Provide educational material on the disinfection and protection of private water supplies.</li> </ul>
<b>TARGET</b>	On-site Sewage Installers, Homebuilders, General Public.	General Public	Citizens using a private water supply.
<b>CATEGORY</b>	I.A.	I.A.	I.A.
<b>LAWS AND REGULATIONS</b>	<a href="#">KRS 211.350-211.380, 211.990 &amp; 902 KAR 10:081</a> <a href="#">902 KAR 10:085</a>	<a href="#">KRS 211.180, KRS 212.210</a>	<a href="#">KRS 211.345</a>
<b>FUNDING</b>	Local Funding	LHD may establish fees.	TA & GF
<b>REPORTING</b>	EHMIS (680)	EHMIS (685)	EHMIS (655)
<b>STAFF REQUIREMENTS</b>	R.S., Environmental Management Core Training, Cert. Insp. <a href="#">KRS 211.360</a>	R.S., Environmental Management Core	R.S., Environmental Management Core

	<b>Public Restroom</b>	<b>Rabies Prevention</b>	<b>Radon</b>
<b>DESCRIPTION</b>	<ul style="list-style-type: none"> <li>• Investigate complaints regarding public restrooms.</li> </ul>	<ul style="list-style-type: none"> <li>• Document human exposure to animal bites.</li> <li>• Quarantine animals and</li> </ul>	<ul style="list-style-type: none"> <li>• Provide public information</li> </ul>

	<ul style="list-style-type: none"> <li>• Take enforcement action when necessary.</li> </ul>	<p>enforce quarantine.</p> <ul style="list-style-type: none"> <li>• Release animals from quarantine.</li> <li>• Assist with the submission of laboratory samples.</li> <li>• Co-sponsor mass vaccination clinics.</li> <li>• Coordinate with medical staff on administration of prophylaxis rabies treatment.</li> </ul>	<p>regarding health risks and abatement measures</p> <ul style="list-style-type: none"> <li>• Provide access to testing devices</li> <li>• Act as a referral agent for mitigation services</li> </ul>
<b>TARGET</b>	Public restrooms	General Public & Pet Owners	Homeowners General public
<b>CATEGORY</b>	I.A.	I.A.	I.B.
<b>LAWS AND REGULATIONS</b>	<a href="#">KRS 212.210 &amp; 902 KAR 10:010</a>	<a href="#">KRS 258.005-.085</a>	
<b>FUNDING</b>	GF	GF	Federal Grant/ GF
<b>REPORTING</b>	EHMIS (630)	EHMIS (697)	EHMIS(676)
<b>STAFF REQUIREMENTS</b>	R.S., Environmental Management Core	R.S., Environmental Management Core	R.S.

### Summary of Environmental Health Services

	<b>Restricted Food Concessions</b>	<b>School Sanitation</b>	<b>Septic Tank Pumpers</b>
<b>DESCRIPTION</b>	<ul style="list-style-type: none"> <li>• Review application and issue permit</li> <li>• Inspect concession for sanitary operation in accordance with regulation.</li> <li>• Take enforcement action when necessary.</li> </ul>	<ul style="list-style-type: none"> <li>• Review construction plans.</li> <li>• Issue permits.</li> <li>• Inspect public and private educational facilities excluding private individuals teaching their own children for safe and sanitary operation in accordance with the regulation.</li> <li>• Prepare written summary of inspectional findings for school board</li> <li>• Take enforcement action when necessary to ensure compliance with the regulation.</li> </ul>	<ul style="list-style-type: none"> <li>• Permit and Inspect Pumper Trucks.</li> <li>• Evaluate and Inspect Land Application Disposal Site.</li> <li>• License Pumper.</li> <li>• Verify Surety Bond.</li> </ul>

<b>TARGET</b>	Restricted Food Concession Operators	Public & Private facilities used for educational purposes, excluding day care centers and private individuals teaching their own children.	Septic tank pumpers
<b>CATEGORY</b>	I.A.	I.A.	I.A.
<b>LAWS AND REGULATIONS</b>	<a href="#">KRS 217.005-217.285 &amp; 902 KAR 45.005</a>	<a href="#">902 KAR 45:150, KRS 211.180, 211.210, 211.990</a>	<a href="#">902 KAR 10:130-170, KRS 211.970</a>
<b>FUNDING</b>	TA & GF	GF	TA & GF
<b>REPORTING</b>	EHMIS (603)	EHMIS (635)	EHMIS (640/641)
<b>STAFF REQ.</b>	R.S. Food Core	R.S., Environmental Management Core	R.S., Environmental Management Core

	<b>Swimming Pools &amp; Bathing Beaches</b>	<b>Tanning Regulation</b>	<b>Tattoo Studio/ Tattoo Artist</b>
<b>DESCRIPTION</b>	<ul style="list-style-type: none"> <li>Review construction plans and forward to state.</li> <li>Issue permits.</li> <li>Conduct routine inspections of all public swimming pools and bathing beaches.</li> <li>Conduct monthly monitoring inspections.</li> <li>Take water samples as needed to ensure good water quality.</li> <li>Take enforcement action when necessary to ensure compliance with the regulation.</li> </ul>	<ul style="list-style-type: none"> <li>Register tanning facilities</li> <li>Monitor facility at opening and on complaint basis</li> <li>Take enforcement action if necessary to suspend registration.</li> </ul>	<ul style="list-style-type: none"> <li>Review application for and issue registration as a tattoo artist.</li> <li>Review application and issue certification to the tattoo studio in accordance with the regulation.</li> <li>Inspect facilities twice per year to ensure compliance with the regulation.</li> </ul>
<b>TARGET</b>	Public Swimming and Bathing Beaches	Tanning facility operators, general public	Tattoo Artists and Tattoo Studios
<b>CATEGORY</b>	I.A.	I.A.	I.A.
<b>LAWS AND REGULATIONS</b>	<a href="#">KRS 211.180 &amp; 211.990</a> <a href="#">902 KAR 10:120</a>	<a href="#">KRS 217.926</a>	<a href="#">KRS 211.760 &amp; 902 KAR 45:065</a>
<b>FUNDING</b>	TA & GF	TA & GF	TA & GF

<b>REPORTING</b>	EHMIS(695/696)	EHMIS(677)	EHMIS(634)
<b>STAFF REQ.</b>	R.S., Environmental Management Core	R.S.	R.S., Food Core

	<b>Vector Control</b>	<b>Vending</b>	<b>Youth Camp</b>
<b>DESCRIPTION</b>	<ul style="list-style-type: none"> <li>• Make nuisance inspections concerning vectors of public health significance pursuant to <a href="#">KRS 211.210</a>.</li> <li>• Provide public information as it relates to vector control.</li> <li>• Take enforcement action when necessary.</li> </ul>	<ul style="list-style-type: none"> <li>• Review and submit the application for vending machine companies to the state.</li> <li>• Inspect vending machine locations at least once every three years for sanitary operation.</li> <li>• Take enforcement action if necessary.</li> </ul>	<ul style="list-style-type: none"> <li>• Review construction plans on all new or altered facilities.</li> <li>• Inspect facility for compliance with the regulation in accordance with the regulation.</li> <li>• Take enforcement action when necessary.</li> </ul>
<b>TARGET</b>	General Public	Vending Machine Locations and Commissaries	Youth Camps
<b>CATEGORY</b>	I.A., II	I.A.	I.A.
<b>LAWS AND REGULATIONS</b>	<a href="#">KRS 212.210</a>	<a href="#">KRS 217.808</a>	<a href="#">KRS 211.180 &amp; 902 KAR 10:040</a>
<b>FUNDING</b>	GF	TA & GF	TA & GF
<b>REPORTING</b>	EHMIS(670)	EHMIS(606)	EHMIS(650)
<b>STAFF REQUIREMENTS</b>	R.S., Environmental Management Core, Pesticide Certification if applying from Dept. of Ag.	R.S., Food Core	R.S., Environmental Management Core

## KENTUCKY REGISTERED SANITARIAN ETHICS

The Kentucky Registered Sanitarian has long adhered to a fundamental theme of ethical behavior encircling the public's health. As a member of this profession, a Registered Sanitarian must recognize responsibility not only to the public we serve, but also to our communities, other Sanitarians, and to ourselves. The following are not laws, but standards of conduct, which define the essentials of honorable behavior for Registered Sanitarians.

- A person shall be duly qualified in order to become a Kentucky Registered Sanitarian, and further, shall be duly qualified to conduct Public/Environmental health activities.
- A Kentucky Registered Sanitarian shall be dedicated to providing competent service.
- A Kentucky Registered Sanitarian shall deal honestly with society and colleagues, and shall not engage in fraud, bribery, deception, conflict of interest, falsification of documents or other illegal activities.
- A Kentucky Registered Sanitarian shall respect the rights of individuals, of colleagues, and other Sanitarians, and shall safeguard confidentiality within the constraints of the law.
- A Kentucky Registered Sanitarian shall recognize a responsibility to promote and uphold high standards and a positive and ethical image, and should avoid any perception of conflict of interest or unethical behavior.
- A Kentucky Registered Sanitarian shall strive at all times to act in the best interest of the Commonwealth, protecting the health and well-being of our citizens.

## MRSA GUIDANCE AND PROTOCOLS

There has been elevated public awareness of skin infections specifically, *Staphylococcus aureus* "Staph" infections, as a result of nationwide media attention. Staph is commonly carried on the skin or in the nose of healthy people and is spread by close contact with infected people. Staph can also come off infected skin onto shared objects and surfaces and then transfer onto the skin of another person who uses the object or surface, leading potentially to a skin infection. In light of this increased public concern and our desire to improve the health of our citizens, the Cabinet of Health and Family Services, DPH has developed guidelines to assist you in educating parents, students and citizens regarding MRSA infections and steps that can be taken to prevent them.

Included are two sets of public health guidelines, a cleaning [\*\*\*General Guidance\*\*\*](#) for all school and similar environments and [\*\*\*Guidance for Athletic Departments\*\*\*](#). These guidelines are also useful in helping control many other communicable diseases, not just MRSA.

## **PUBLIC HEALTH CLEANING GENERAL GUIDANCE:**

### *Guidelines to Help Prevent the Spread of Skin Infections:*

*The most effective means of controlling the spread of viruses and bacteria (germs) in the environment is frequent, thorough and effective hand hygiene. Schools should implement protocols to emphasize hand hygiene among students and staff by encouraging them to:*

- Wash hands frequently!
- Use an alcohol-based hand sanitizer if soap and water are not available and hands do not look dirty.
- Soil and other debris on the hands can diminish the effectiveness of alcohol-based sanitizers to kill germs.

Students and staff with any skin problems should be reported to the school nurse, coach, or a health care provider. Individuals with skin lesions, sores or rashes should cover the entire wound with a secure water-proof bandage, particularly if the wound is draining. The bandage should be kept clean and dry. If the bandage becomes wet or soiled it should be replaced.

Dispose of bandages and tissues in the regular trash but to prevent others from coming in contact with this garbage, make sure to use a zippered bag or tie securely in a plastic bag.

In addition, as part of routine custodial practices, cleaning and disinfecting of surfaces in the school is essential to keeping the environment healthy. Clean all hard surfaces frequently with particular attention to commonly touched areas such as doorknobs, light switches, tabletops, desks, floors and lockers.

Use detergent-based cleaners to initially clean dirt and debris from surfaces followed by Environmental Protection Agency (EPA)-registered disinfectants to remove germs from the environment. Disinfectants are readily available at stores but make sure that the label indicates it is a disinfectant and follow the label instructions.

Germs must be in contact with wet disinfectant for a long enough period of time to be killed: allow the surface to air dry, it is best not to rinse or wipe the object or surface right away in order to allow the disinfectant to be in contact for the correct time.

It is important to read the instruction labels on all disinfectants to make sure they are used safely and appropriately. Environmental cleaners and disinfectants should not be used to treat infections.

The EPA provides a [list of EPA-registered products](#) effective against MRSA. A 5-6% sodium hypochlorite (household) bleach solution is an easy way to make an appropriate disinfectant: mix one tablespoon of bleach into one quart of water. It can be used in a spray bottle, as a soaking solution or applied directly by mops for larger surfaces.

For effective disinfection, the solution must be in contact with a surface for a minimum of 2 minutes. Mix a fresh solution every day, leftover solution should be discarded at the end of the day and never mix bleach with any other household chemicals or products containing ammonia. Mixing these chemicals with bleach will produce hazardous gases.

Cleaners and disinfectants can be irritating and have been associated with health problems such as asthma. Therefore, it is important to read the instruction labels on all cleaning products to make sure they are used safely and appropriately - with disinfection, more is not better. For

suggestions on implementing a “green cleaning program” please refer to [Hospitals for a Healthy Environment \(H2E\) 10 Step Guide to Green Cleaning Implementation](#).

**Here are some answers to commonly asked questions:**

Should schools close because of an MRSA infection?

Not Typically. Only in rare cases will it be necessary to close schools because of an MRSA infection in a student.

The decision to close a school for any communicable disease should be made by school officials in consultation with local and/or state public health officials. However, in most cases, it is not necessary to close schools because of an MRSA infection in a student. It is important to note that MRSA transmission can be prevented by simple measures such as hand hygiene and covering infections.

Should the school be closed to be cleaned or disinfected when an MRSA infection occurs?

Not Typically. Only in rare cases will it be necessary to close schools to “disinfect” them when MRSA infections occur.

Covering infected skin lesions and rashes will greatly reduce the risks of surfaces becoming contaminated with MRSA. In general it is not necessary to close schools to "disinfect" them when MRSA infections occur. MRSA skin infections are transmitted primarily by skin-to-skin contact and from contact with surfaces that have come into contact with someone else's infection. When MRSA skin infections occur, cleaning and disinfection should be performed on that are likely to contact uncovered or poorly covered infections.

**GUIDANCE FOR ATHLETIC DEPARTMENTS:**

Encourage athletes to do the following:

- Wash hands frequently with soap and warm water or use an alcohol-based hand sanitizing gel if hands do not look dirty and soap and water are not available.
- Shower with soap and water as soon as possible after direct contact sports, and use a clean, dry towel.
- Keep cuts and scrapes clean and covered with a clean, dry bandage until healed.
- Avoid contact with other people’s lesions or bandages.
- Do not share towels (even on the sidelines at a game), water bottles, soap, razors, or other personal care items.
- Do not share ointments or antibiotics.
- Wash towels, uniforms, scrimmage shirts, and any other laundry in hot water and ordinary detergent immediately after each practice or game and dry on the hottest cycle.

- Inform parents of these precautions if laundry is sent home (laundry must be in an impervious container or plastic bag for transporting home).
- Avoid whirlpools or common hot tubs, especially when having open wounds, scrapes, or scratches.
- Students should inform their coach or athletic trainer if they think they have a lesion, sore or rash on the skin.

An athlete should be referred to a health care provider if:

There are concerns over any lesion, sore, or rash on the skin, especially those that are red, swollen, or draining fluid.

- The athlete has other signs of illness such as fever or vomiting.
- Multiple athletes have similar symptoms.
- An athlete may be excluded from competition or practice if there is concern regarding a lesion, sore, or rash until evaluated by a health care provider. Additionally, an athlete should be excluded from competition if the evaluating health provider deems it appropriate.
- All skin lesions, sores or rashes should be covered by a clean, dry bandage when participating in practice or competition. If lesions cannot be covered completely, or if drainage (or “pus”) is wetting the bandage or seeping out between the bandage and skin, athletes should be excluded from competition until the lesion can be safely and completely covered.
- If an athlete with skin lesions is participating in a sport that requires frequent skin-to-skin contact (e.g., wrestling), then consideration should be given to excluding that athlete from participation until the lesion is fully healed, since maintaining the bandage in place may be difficult.
- An athlete may return to competition or practice after consulting with the athlete’s health care provider, coach, and specific sports league rules.

**Procedures for cleaning athletic area and equipment should be established and staff and athletes must be educated about these procedures:**

- Make sure equipment is in good working condition without rips, tears or other damage. Replace items rather than using tape to repair damaged areas since the tape may interfere with the disinfectant process.
- Clean the athletic area and sports equipment routinely—at least weekly— using EPA-registered disinfectant or a fresh (mixed daily) household bleach solution (1 tablespoon bleach to 1 quart of water) after practices / matches. Please refer to the manufacturer’s directions for recommended contact times for the various disinfectants. Household bleach solutions must be in contact for a minimum of 2 minutes.
- Clean mats and other high-use equipment before each practice and several times a day throughout a tournament, using an EPA-registered disinfectant or a fresh (mixed daily) household bleach solution.
- Locker rooms, including any shower areas should be cleaned daily, if used.
- If soap is furnished, it should be accessible from a wall dispenser

- Ensure that athletic areas, locker rooms and restrooms all have separate cleaning mops and buckets, and that all mops (washable micro-fiber heads or disposable mop cloths preferred) and buckets are cleaned regularly.

### **Wrestling Room and Mats:**

- Wipe down padding along walls, benches and door pulls/knobs with an EPA-registered disinfectant or a fresh (mixed daily) household bleach solution after practices / matches. Please refer to the manufacturer’s directions for recommended contact times for the various disinfectants. Household bleach solutions must be in contact for a minimum of 2 minutes.
- Clean floors after mats are stored and before mats are used again.
- Use “dedicated” mops to clean athletic areas and wash mop heads on a regular basis. May use disposable mop cloths that are discarded after each use
- Clean and disinfect mats before and after practice and matches. All sides of mats should be cleaned before they are rolled up.
- Use “dedicated” mop heads for mat surfaces. Wash these mop heads on a regular basis.

### **Weight Room:**

- Wipe down grips on weights and lifting belts at least daily.
- Clean floors, benches, supports, pads, light switches and door pulls/knobs daily.

### **Sports Equipment:**

- Schedule regular cleaning and disinfection for sports equipment: balls (football, basketballs, baseballs, softballs, volley balls, soccer balls), racket grips, bats, etc.
- Avoid using tape to wrap gripping areas of rackets, bar bells etc. as this may provide an environment for germs to thrive.
- Clean and disinfect sports equipment that comes in direct contact with the skin of players, such as wrestling headgear, football helmets, gloves, and pads.

For more information, please refer to the [Centers for Disease Control and Prevention \(CDC\)](#) or [NIOSH Safety and Health Topic: MRSA and the Workplace.](#)

## **MERCURY AWARENESS AND INFORMATION**

Mercury exposure has been a topic of discussion and planning over the past year by multiple state agencies. Events involving mercury spills in schools have prompted our office and other partnering agencies to develop guidelines for your use if a mercury spill occurs in one of your school facilities. These guidelines have been developed by a collaborative effort of the Kentucky Department for public Health, the KDE, and the Kentucky Department of Environmental Protection in an effort to provide you and your school facilities with a plan of action should such an event occur. Included below are “Public Health Instructions for School Officials Regarding Mercury Spills”.

Also included in this information is the “Health Limit For Mercury Exposure” memo that established the state health threshold.

## **Food Transportation Vehicle Incident Response Guidance**

Truck and train wrecks can occur at any time. Having a response plan in place beforehand is essential. Plans should include a notification and support system with area first responders in order to react quickly, efficiently, and uniformly. By developing a good working relationship with local police, fire, and EMS services, you'll likely be notified quickly when a food transportation vehicle incident occurs.

It is also important to understand what the role of the LHD is during a food transportation vehicle accident. The primary responsibility is response to vehicles transporting foods, drugs, or cosmetics. The following is a helpful list of things to keep in mind when preparing and responding to food transportation vehicle accidents:

### **PREPARING FOR THE EVENT:**

- Contact local first responders, advise them on the types of wrecks you should be contacted about and establish a notification procedure should an event occur. Provide them with after-hours contact information or alternate contact information should you be unavailable.
- Keep emergency contact information available at your home/office for support agencies such as local and KY State Police, Disaster and Emergency Response, USDA, Alcohol Beverage Control, Drug Enforcement and Professional Practices Branch, and State Food Branch Personnel.
- Keep a response kit readily available in your home/office of essential things you'll need during an incident, including: quarantine/voluntary destruction forms & tags, contact numbers, and emergency response guidance sheets, thermometers, flashlights, safety equipment, etc.

### **INITIAL RESPONSE TO THE EVENT:**

- Upon arrival at the scene report immediately to the police or person in charge.
- **NEVER** approach or enter any vehicle until you have been given safety clearance from the incident commander and the vehicle is secured.
- Review the shipping manifest to determine what products are involved. If the manifest is not available due to destruction or loss during the wreck, officials can obtain one by contacting the firm's owners.
- Determine from the manifest if products are involved that fall under dual jurisdiction such as alcohol, drugs, or USDA regulated products. Notify the appropriate agency or contact the Food Safety Branch for assistance in determining jurisdiction.
- Determine from the manifest if products are involved that require temperature control. When the product temperature cannot be immediately assessed, record the weather conditions and outside air temperature. This may help later when determining how long product has been out of temperature.

### **TRUCK OR TRAIN WRECKS INVOLVING REFRIGERATED PRODUCTS:**

- If the cargo area is still sealed, there is no visible exterior damage, and the refrigeration equipment is still functioning, you may enter the cargo area to check the contents. Look for impact damage such as shifting of cargo, breakage, punctures, dents or leakage of refrigerant or other toxics or fluids. Products requiring temperature control should be randomly sampled to assure that proper holding temperature is being maintained. The temperature and time of sampling should be documented.

- In cases where the refrigeration equipment on the vehicle is NOT functioning, do not enter the cargo area. Opening sealed doors can cause a rapid increase in food product temperatures. Instead, evaluate the option of placing the entire cargo under blanket quarantine, using [environmental form, Quarantine Form DFS 222](#) located on the [LHD Forms, Documents and Administrative Reference webpage](#), until a refrigerated transfer/salvage vehicle arrives on site. Then you should check contents for impact damage, cross-contamination, adulteration and product temperatures before allowing transfer of any cargo.
- In cases where there has been no damage to the trailer, the product is free from any evidence of contamination, and proper temperatures have been maintained, the food may be immediately released to a representative of the transport company for removal and reentry into commerce.
- In all cases where there is visible damage to the vehicle or cargo, an immediate blanket quarantine of the entire contents should be issued, until a full assessment of the damage can be made.

## DAMAGE ASSESSMENT

- Review the [KY Food Safety Branch Vehicle Incident Report](#), and Instructions for Completing Vehicle Incident Report [located on the LHD Forms, Documents and Administrative Reference webpage](#).
- The damage assessment should consider whether or not product may have been compromised by vehicle fuel, refrigerants or other chemicals, smoke, fire, exposure to the environment, cross-contamination, temperature abuse, or etc. [Review the damage assessment guidance document](#).
- Once the damage assessment has been made, contents which are not salvageable shall be recorded on environmental form, [Voluntary Destruction Form DFS-222](#); or held under continued quarantine until an alternate disposal or diversion method can be arranged. [The exact location and method of disposal/diversion/destruction shall be recorded on DFS-222](#).
- The Food Safety Branch staff, including Area Retail Food Technical Consultants and/or Area Food Manufacturing Inspectors can provide guidance, where necessary.

## QUARANTINE OF PRODUCT

- [KRS 217.115](#) of the Kentucky Food Drug and Cosmetic Act gives the Cabinet or its LHD Agents the authority to quarantine food, drug, and cosmetic products which they know *or suspect* of being adulterated. Proof of adulteration is not required in order to place product under quarantine.
- The environmental form, [Quarantine Notice \(DFS 222\)](#), should be issued to the owner of the product or to the trucking representative if they are available. If neither is available, the quarantine notice may be issued to the wrecker service or to the person in charge of the cleanup or accident site.
- Depending on the circumstances of the accident, quarantined product may be immediately assessed on site for damage and possible salvage or it may be transported under quarantine to another secure location for further evaluation. Whenever possible, refrigerated or frozen products should be transported and held under refrigeration during the damage assessment, to prevent further loss.
- In some cases, a vehicle or its products may be towed or transported from one county to another. To maintain the integrity of quarantined product whenever it is being transferred to another Health Department's jurisdiction for evaluation, you should:
  - Obtain the vehicle description, license number, driver's identity, destination (company name, address, telephone number), and estimated time of arrival.

- Assure that vehicles where products are off-loaded are clean and in good repair, and that the transportation method will not further contaminate products. This is especially important where there is a likelihood that product may be salvageable. Dump trucks, farm trucks, and flatbed trucks should only be used for product destined for destruction. These types of vehicles are not usually used in food transportation, given that they are not routinely cleaned, and are not typically capable of protecting food from environmental contamination (road dust, etc.).
- If potentially hazardous/time-temperature control for safety (TCS) foods are involved, assure that the transport vehicle is capable of maintaining safe temperatures during transport.
- Check off quarantined items released for transport on your quarantine forms and add statement that cargo is to remain in the vehicle until released for inspection by health official at the destination site. Give a copy of the quarantine sheet to the driver.
- Seal cargo area of transport vehicle once loading is complete with some method of seal which will indicate tampering and record the truck seal number when it is applicable. When cargo is being transported in an open unit such as by flatbed trailer or dump truck, the inspector should provide the transporter with a copy of the quarantine paperwork. The inspector can use photos, quarantine tags or tape to ensure the cargo is not altered in route.
- Immediately notify LHD at the destination/receiving point by telephone and provide the necessary information so officials can meet the vehicle upon arrival to its destination. Contact the Food Safety Branch if assistance is needed in locating or notifying health officials in other counties/states.

#### **SALVAGE/VOLUNTARY DESTRUCTION/RELEASE OF PRODUCT:**

- When voluntary destruction action is taken, written agreement of the cargo owner, freight carrier or insurer must be obtained *before* the product is transported to an approved disposal site (waste incinerator, landfill, etc.) and *before* product is destroyed. You, another health official or a law enforcement agent must accompany cargo to the disposal site and witness its destruction.
- Salvaged cargo should be segregated from unsalvageable product and may be released for transfer on [Environmental Form DFS 222](#), with a note identifying the party assuming control of the product.

#### **WRECKS INVOLVING USDA REGULATED PRODUCTS:**

- Wrecks involving exclusively USDA regulated product, including meat and poultry, require that the USDA be immediately notified. Please contact the Food Safety Branch for assistance in notifying a USDA representative. Following notification, the LHD should proceed as with any other food vehicle incident unless directed otherwise. The USDA office covering Kentucky is located in Jackson, MS and can be reached at (601) 965-4312 (24-Hour Emergency: 1-800-647-2484).
- Mixed cargo loads containing only portions of USDA regulated products should be handled the same as above.

### **WRECKS INVOLVING FLUID MILK/MILK TANKERS:**

- When the wreck involves fluid milk as the exclusive cargo, the LHD should immediately contact the Milk Safety Branch at (502) 564-3340. The Food Safety Branch can also be contacted at (502) 564-7181 if unable to contact Milk Safety Branch representatives.

### **WRECKS INVOLVING ALCOHOLIC BEVERAGES:**

- Where the wreck involves alcoholic beverages as all or a portion of the cargo the LHD shall immediately notify the office of the Kentucky Alcoholic Beverage Control Commissioner at (502) 563-4850. The Trade Investigations Division of the federal ATF should also be notified at (440) 871-6055. The Food Safety Branch can also be contacted at (502) 564-7181 for assistance in notifying appropriate state/federal alcoholic beverage control officials.

### **WRECKS INVOLVING OVER-THE-COUNTER AND PRESCRIPTION MEDICATIONS:**

- The Drug Enforcement and Professional Practices Branch operates under the authority of Kentucky Food Drug and Cosmetic Act. Therefore, where the wreck involves over-the-counter or prescription drugs as all or a portion of the cargo, handle as below:
  - Over-the-counter medications may be handled as any other food item and may be quarantined, voluntarily destroyed or released by the health department personnel without prior notification to the Drug Enforcement and Professional Practices Branch.
  - Where significant amounts of over-the-counter medications are involved, the Drug Enforcement and Professional Practices Branch should receive courtesy notification at (502) 564-2815. Generally speaking, an incident involving large amounts of OTC medications may be handled as any other food item and may be quarantined, voluntarily destroyed or released by the health department personnel, unless directed otherwise.
  - Where controlled substances and prescription medications are involved, the LHD should contact local law enforcement authorities and/or Drug Enforcement Administration (DEA) officials. DEA field offices closest to Kentucky are located in Atlanta (Telephone 404-893-7000), Chicago (Telephone 312-353-7875) and St. Louis (Telephone 314-538-4600).

### **FINAL REPORT:**

- LHDs should complete the [Vehicle Incident Report](#) for each incident, and forward a copy to the Food Safety Branch. Both the Vehicle Incident Report and the Instructions for completing this report are located on the LHD Forms webpage.
- Following the conclusion of action taken by the health department, all quarantine notices and other actions shall be entered into EHMIS.

### **WATER EMERGENCY GUIDELINES FOR FOOD SERVICE ESTABLISHMENTS**

These guidelines are for establishments that provide food service to the public. During a water supply emergency, water may serve as a source of contamination for food, equipment, utensils, and hands. Unsafe water is also a vector in the transmission of disease. Therefore, in order to provide protection to consumers and employees, water shall be obtained from sources regulated by law and shall be handled, transported and dispensed in a sanitary manner.

**IN THE EVENT OF CHEMICAL CONTAMINATION OF THE WATER SUPPLY, THE ESTABLISHMENT SHALL CEASE OPERATION AND NOT RESUME OPERATION UNTIL THE CABINET OR LOCAL HEALTH DEPARTMENT ASSURES THAT SAFE OPERATIONAL PROCEDURES INCLUDING THE FOLLOWING ARE IN PLACE:**

- **Shut off the following:** Ice machines, drinking fountains, produce misters, bottled water refill machines, fountain drink equipment, and running water dipper wells.
- **Discard:** Ice and beverages made with contaminated water.
- **Ice:** Use only packaged ice from commercially approved facilities outside the affected area. Leave the unit off until the water is OK again, then clean and sanitize the unit following manufacturer's suggested guidelines. Make ice for one (1) hour and dispose of the ice.
- **Water:** Use only bottled water for drinking, cooking, food preparation, and washing produce.
- **Food:** Only prepackaged ready-to-eat food items and commercially prepared salads in deli areas. No cutting or grinding of meat.
- **Drinks:** Use only canned or bottled drinks. Coffee and tea shall be made from bottled water.
- **Hand washing:** Temporary handwashing stations shall be set up for all food service operations with only transported water from approved sources. Hand washing shall be followed up with hand sanitizer.
- **Food service operations shall be limited to the following:** Carry out only, cook and serve only, and minimal cutting and slicing.
- **Single service eating and drinking utensils:** Only single service items shall be used.
- **Utensil washing:** Utensils shall be washed, rinsed, and sanitized using only water from approved sources.
- **Employee information:** Post signs or copies of the water system's health advisory. Develop a plan to notify and educate employees about water emergency procedures

**Environmental Services: Childhood Lead Poisoning Prevention and Management of Elevated Blood Levels**

Guidance on the environmental management for elevated blood lead levels (EBLL) for the LHD environmentalist and certified risk assessor from the Kentucky Childhood Lead Poisoning Prevention Program (KCLPPP) and the Environmental Lead Program.

**Statutes/Regulations for Lead Poisoning Prevention:** [KRS 211.900-KRS 211.905](#) and [KRS 211.994, KRS 211.210, 902 KAR 4:090](#)

**Statutes/Regulations for Lead-Hazards Detection and Abatement:** [KRS 211.9061 to KRS 211.9079](#) and [KRS 211.990, 902 KAR 48.010- 902 KAR 48.040.](#)

**Service Description and Key Roles and Responsibilities:**

In order for blood lead screening to be a meaningful prevention service, identification of a child with an EBLL must trigger services that will lower the child's BLL. Treatment regimens that do not eliminate lead exposure are inadequate. Services needed by a child with an EBLL can include environmental investigation to identify the source of the exposure; lead hazard control to eliminate its pathway; and case management services to ensure that the child receives all necessary public health, environmental, medical, and social service interventions.

Environmental Management of the child’s living environment is one component of an on-going process related to the elimination of childhood lead poisoning as a public health problem. The LHD environmentalist is often part of the LHD collaborative team which helps to assure children who are identified with EBLL’s receive appropriate interventions.

**Management of the Environment:**

Upon receipt of EBLL results, the LHD Case Manager will assess the need for an environmental investigation and make the appropriate referrals to the environmentalist and if needed the risk assessor, depending on the blood lead level.

For children identified as having:

- A second (2<sup>nd</sup>) BLL of 5-14.9ug/dL or greater, a Visual Investigative Home Visit is to be completed at the child’ primary resident to identify potential sources of lead. The visual investigation may be completed by the environmentalist or at the time of a home visit by a trained home visiting nurse or allied health professional.

For children identified as having:

- A **Confirmed** EBLL of 15µg/dL or greater (lead poisoning), in addition to the Visual Investigative Home Visit, a lead risk assessment must be completed by a certified risk assessor.

For LHDs or Districts which do not employ a certified Risk Assessor, please contact the KCLPPP to arrange for a list of Certified LHD Risk Assessors.

**Visual Investigative Home Visit:**

The LHD Lead Case Manager is responsible for making referrals for environmental assessments. Assessments should be completed within the timeframes recommended by CDC’s when at all possible. (**See Table 1**). The case manager should continually collaborate with the environmentalist to assure a decrease in the patient BLL’s.

**Table 1: Visual Investigative Home Visit**

Blood Lead Level	Time Frame for Visual Assessment and/or Risk Assessment
>70 µg/dL	24 hours; refer for lead risk assessment
45-69.9 µg/dL	48 hours; refer for lead risk assessment
20-44.9 µg/dL	1 weeks; refer for lead risk assessment
15-19.9 µg/dL	2 weeks; refer for lead risk assessment
BLL 5-14.9µg/dL*	30 days, for EBLL’s that are not decreasing and persistent (>6 months) in the 5-14.9µg/dL range, refer for lead risk

*\*KCLPPP recommends timeframe of two (2) weeks for 2nd (12 weeks of initial) BLL of 5-14.9 ug/dL*

A thorough visual investigation of the child’s home identifies possible sources of lead hazards. The investigation should survey both the interior and exterior environment of the home with special attention given to child-accessible painted surfaces, dust and soil. Other potential sources of lead should be considered during the environmental assessment i.e., water, family occupation, hobbies, etc.

The person conducting the visual investigative home visit should obtain any pertinent information from the child's parent/guardian/care giver that may not have been supplied on the referral questionnaire, Part I. The information should be gathered from someone who routinely observes the child's activities and behaviors. A child's environmental history can provide information about the child's possible exposure to residential and other sources of lead. It should include:

- How long has the child lived at this address,
- Supplemental address information or other locations where the child spends extended periods of time,
- Number and names of other children that live or visit here,
- Property owner's name, address and phone number; if it is someone other than that of the caregiver,
- Child's play areas, sleep areas, habits,
- Child's behaviors such as sucking on fingers/hands, hand-to-mouth or pica, a disorder characterized by the appetite for non-nutritive substances such as clay, dirt, paint.
- Parent's occupations, hobbies, ethnic customs, and other possible sources. (i.e. caregiver work in or around lead products; hobbies such as fishing, work with stained glass, or pottery; use of ethnic products such as cosmetics or medicines; use of imported pottery; outside sources that could be being brought in from work or outside the home). See [Lead Poisoning Verbal Risk Assessment](#).

At the time of the environmental assessment, lead poisoning preventive education should be reviewed with the parents/guardian/care giver. Preventive education includes discussing the child's potential source of lead-based hazards and how to prevent further exposure to those sources. Temporary measures to reduce further exposure may include but are not limited to:

- Blocking child from potential hazardous area with a barrier, (i.e. door, child gate);
- Using furniture to block child's access to the hazard (i.e. furniture in front of a chipping window sill);
- Use of duct/masking tape and plastic or cardboard to cover an area of chipping/peeling surface until permanent work can be conducted;
- Daily damp dust, wet mop or vacuum with a Hepa-vac especially in the child's play area; Wipe child's toys clean, keep toys in clean dry tote, and placing tote in clean play area and limiting the child's play to this area; (especially if child is crawling and/or in hand-to-mouth exploration stage);
- Keep child's hands washed with soap and water, (germ gel does not remove lead), wash hands before snacks and meals and before any nap or bedtime (especially if child is crawling and/or in hand-to-mouth exploration stage);
- Exploring the possibility to relocate child(ren) and pregnant women from the home while renovation/remediation work is in progress.
- Assure the family is using lead safe work practices during renovations (walk off areas, containment areas, remove shoes/clothing before entering living spaces, daily clean up and vacuuming of work and walk off areas). [Brochures on renovation can be found and ordered online](#).

### **Certified Lead Risk Assessments**

According to [KRS 211.905](#), an inspection of the property where a child routinely spends more than six (6) hours per week should be completed to determine the existence of lead-based hazards. An individual who is certified by the KY DPH Environmental Lead Program should perform the certified risk assessment.

Priority should be given to the child’s primary place of residence. If the BLL remains elevated, increases, or is not decreasing in 8-12 weeks; a supplemental environmental investigation may be conducted at property(ies) where the child routinely spends more than six (6) hours a week.

Collaboration with the LHD Lead Case Manager assures that referrals made for lead risk assessments are on children identified with **confirmed** EBLLS (lead poisoning), BLL's >15µg/dL. A Lead Risk Assessment is required according to [KRS 211.905](#) (1).

The assessment should be conducted by a certified risk assessor within the appropriate time frames per CDC’s recommendations (**See Table 2**). These guidelines can be found online - [Managing Elevated Blood Lead Levels Among Young Children](#).

<b>Table 2: Lead Risk Assessment</b>		
<b>Blood Lead Level</b>	<b>Time Frame</b>	<b>for Type of Assessment</b>
>70 µg/dL	Within 24 hours*	Lead Risk Assessment
45-69.9µg/dL	Within 48 hours*	Lead Risk Assessment
20-44.9 µg/dL	Within 1 weeks*	Lead Risk Assessment
15-19.9 µg/dL	Within 2 weeks*	Lead Risk Assessment
Persistent BLL 10-14.9 µg/dL	Within 4 weeks*	Lead Risk Assessment

KCLPPP requests that the updated electronic standardized [lead risk assessment template](#) be used for reporting to KCLPPP. Use of this template assures consistency of report results are captured in the CLPPP/environmental database. Guidance for completion of the assessment is included on the template. Please delete highlighted guidelines before printing the final report.

The lead risk assessment report should be submitted within 30 days of receiving the sample lab results. For LHD’s waiting on assessment reports, this report can take up to 60 days to process and receive.

Copies of the Risk Assessment Report shall also be forwarded to the

1. Parents/Guardians of the lead poisoned child
2. LHD Director/Local Health Officer (LHO)
3. LHD Environmentalist
4. KCLPPP Program and

The Risk Assessor shall notify the property owner in writing, of the existence of identified lead-based hazards according to [KRS 211.905\(2\)c](#) and [902 KAR 4:090 Section 3\(4\)](#) and shall include correction guidance.

If the Risk Assessment identifies lead hazards in the residence and it is determined that those hazards present a public health risk to the child, the LHD Director or designee shall send environmental form [Notice to Abate/ Notice to Correct](#) to the property owner allowing the owner a reasonable period of time to abate the lead hazards identified, typically 60 days (this is included in the updated [CRA electronic standardized form](#)). A copy of the lead risk assessment report and correction guidance should be included with the Notice to Correct.

Per, [KRS 211.905 \(4\)](#), in the event that the owner does not remove, replace, or securely and permanently cover the identified lead-based hazards within the sixty (60) days, the local health officer or designee is responsible for posting the property named in the lead risk assessment report.

The posting should identify the property as containing lead-based hazards and the declaration that the property is unfit for occupation for those persons under seventy-two (72) months of age. The property shall remain posted until the owner has complied with the orders of the cabinet. [View example of the Warning Poster](#) . Further legal action may be initiated under [KRS 211.994](#) to gain compliance.

The Risk Assessor should discuss with the property owner the results of the assessment; the notice for correction and timeframes; abatement plan of action and strategies; acceptable and unacceptable practices; and resident and worker safety during abatement, including protection of at risk children and pregnant women.

**Acceptable techniques include:**

- Replacement of building components (doors, windows, trim pieces, etc.);
- Stripping of lead based paint down to the substrate using chemical strippers and wet scraping;
- Encapsulation of lead surfaces with permanently affixed lead free coverings which are incapable of being readily chewed through, torn from the surface, pierced or otherwise removed as to expose the surface below, and
- Enclosure of lead surfaces with a rigid, mechanically affixed barrier

**Unacceptable techniques include:**

- Use of open flame torch;
- Use of heat guns with high temperature settings without proper worker safety protection;
- Power sanding of surfaces without proper containment practices, HEPA vacuum attachments or clean-up equipment; and
- Use of methylene chloride strippers.

Lead Hazard removal should be completed by a Certified Abatement contractor in a confirmed-EBLL child-occupied dwelling. After the lead hazards are properly abated, the Lead Hazard Abatement professional shall request a clearance inspection from a third party agency in accordance with [902 KAR 4:090](#).

The local health officer should inform families of an EBLL child who rent of [KRS 211.905](#) that allows for the release from a rental agreement without prejudice to the occupant, if lead-hazards, related to an EBLL, are found. If the property is vacated by the EBLL occupant, the property shall not be let or occupied by any other person until the corrective order is complied with [902 KAR 4:090 4\(3\)](#).

**INVESTIGATIONS OF SUPPLEMENTAL ADDRESSES:**

Supplemental addresses are addresses the EBLL child routinely spends more than six (6) hours per week. If there is sufficient risk, it may be recommended that environmental investigations

be completed to determine the existence of lead-based hazards at supplemental addresses. Supplemental addresses may include but are not limited to:

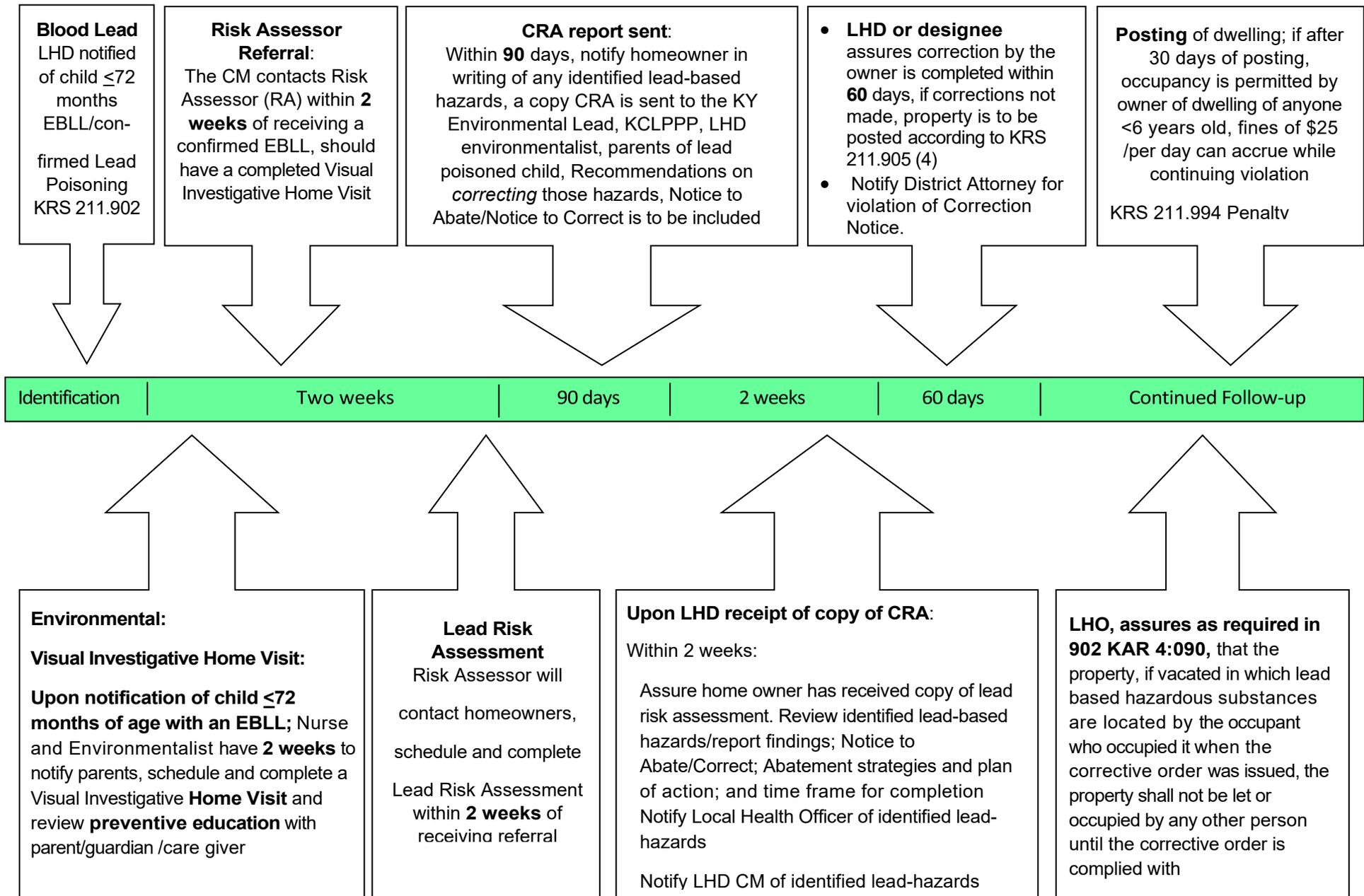
- Day-care facilities, sitter's home;
- Neighbor's, playmate's or relative's home;
- Exterior of neighboring homes or outbuildings within child's immediate environment; Playground, alley, vacant lot or other play areas; or
- Church or school.

Supplemental addresses are inspected as time, resources and circumstances allow. The procedures for inspection remain the same as for primary address.

#### **REMOVAL OF THE CHILD FROM THE HOME:**

Parents/caretakers should be advised of the hazards associated with the abatement process. The family is encouraged to remove the child and pregnant women from the home and/or affected areas whenever possible.

If a child with an EBLL is determined to be at imminent public health risk due to continued residence in an unabated environment; the LHD Director or Case Manager may refer the case to the Dept. for Community Based Services to determine if immediate action is needed to remove the child from that environment.



## **ENVIRONMENTAL HEALTH FEE REVENUE PROCEDURES GUIDANCE:**

### **Recommended Minimum Standards for LHD Environmental Internal Control Procedures**

The following are recommendations for LHD Internal Control Procedures. Each bulleted item has been identified as a key component of a functioning and efficient Internal Control Program used to monitor and control Environmental Program revenues. Environmental revenues are those funds generated by the payments of permits and fees collected through programs administered by the Environmental Health Program of the Local and District Health Departments. Environmental revenues should include both fees obtained from mandated services and those services operated by the individual county or district health departments. These recommendations were developed by the Division of Public Health Protection and Safety (PHPS) with guidance and recommendations provided by the Office of Inspector General (OIG) in order to serve as a minimum standard of operation for LHD environmental programs' and their fee handling process.

These recommendations are geared towards developing a process that will assure, but not provide absolute assurance, an agency can secure and safeguard environmental revenues from the time they originate until the time they are deposited into designated bank accounts. These controls should be considered minimum guidelines only. LHDs may incorporate additional measures and/or controls into their Internal Control Procedure where needed in order to fully protect and safeguard organizational funds. It is imperative that management become familiar with all aspects of the internal control procedure in order to properly monitor and safeguard against loss.

Furthermore, it is recommended that all new and current employees be trained as to their responsibilities with regard to internal control procedures and be provided additional training and notification when the process is revised or updated.

### **Minimum Internal Control Recommendations**

- **Designated Collector of Fees:** LHDs should designate an individual or individuals as the primary collector(s) of fees. This can include clerical, environmental or support staff, however it is recommended that no individual employee be designated as the primary collector of fees if they are also involved with the entry of data into the system, verification of data or making deposits.
- **Types of Payments Accepted:** LHDs have the authority to mandate the types of payments they accept. Types may include money order, cashier's check, personal check, and credit card. Cash, however should be discouraged as a method of payment for all programs, but can be accepted if no other form of payment is possible. LHDs that utilize credit card payment systems are encouraged to routinely evaluate handling fees associated with such services.
- **Environmental Holding Accounts:** Local and District Health Department must establish and maintain an Environmental Holding Account that will be used for all environmental programs. This account is mandated by statute. All fees generated by environmental services and programs are to be documented and entered into the EHMIS system on a regular basis; and prior to deposit into the Environmental Holding Account. The exception to this will be with District Health Departments who are

allowed to deposit fees into separate bank accounts, which are then reconciled into one district account and entered into EHMIS by district personnel. In all cases, the Environmental Holding Accounts are to be checked against Report 49 and 50 each month. Based on those reports, the Environmental Holding Account should be "zeroed" out at the end of each month with a check being issued to the KY State Treasurer through the Division of Public Health Protection & Safety and a check issued to the local or district health department's general account. Monthly balances and transactions should be reviewed and approved by management prior to close out of each month and documented with the date and initials of the person performing the review.

- **Cash Handling Procedure:** The LHD should have a clear and detailed cash handling procedure in the event cash money is deemed an acceptable form of payment for permits or environmental services. At a minimum this policy shall include a documented pre-numbered receipt for all cash transactions. This pre-numbered receipt should include the amount, the name of the person or entity making the payment, the date of transaction, name of the person accepting the payment and the purpose of the payment. In the case of fees collected in connection with temporary food events, a pre-numbered permit application may suffice as the receipt as long as the necessary information is included on the application.
- **Petty Cash:** If an environmental petty cash account is maintained, access to these cash funds should be limited to authorized personnel only. All deposits and withdrawals from this account should be documented and witnessed by authorized personnel. It is recommended that this account be balanced at least monthly and that a periodic review of the Petty Cash account be made by someone other than the custodian of the account. This review should be documented by the date and initials of the person assigned that responsibility.
- **Money Storage and Transfer Procedures:** All monies collected by the LHD and environmental leadership should be stored in a fireproof, locked drawer, safe or similar storage container during and after normal business hours, prior to depositing. Access to such containers should be limited. Typically, access will be restricted to the person or persons assigned to process the money and the Director or their delegate. Monies needed to be transported from one location to another, such as from the local offices to a district shall be transported in a locked money bag or similar sealed conveyance. A pre-numbered receipts log should be developed that documents daily transactions and totals while funds are being held prior to deposit. This log can also serve as a verification tool when funds are transferred from person to person and during reconciliation ([view example](#)). Funds should be deposited as soon as practical. The Cabinet recommends that funds be held no longer than three business days; or five business days in the case of districts. Regular postal mail is discouraged as a means of transferring funds.
- **Tiered Handling Process:** Funds coming into the health department should be accounted for and verified before being passed from one person to another for processing, reconciliation or deposit as a form of checks and balances. A signed or initialed deposit slip along with total payment amount and pre-numbered receipts or applications should be used to track and document transfers of monies from one

employee to another ([view example](#)). These records should be maintained for review by an authorized individual, the person delegated to review such transactions should not be a person involved in fee collection or reconciliation.

- **Environmentalists Handling Fees:** All agency personnel should be discouraged from accepting fees for service in the field whenever possible. All routine transactions should take place at the LHD. In the event this is unavoidable, such as some Temporary Food Events, the LHD should establish a system to assure fees are returned to the health department along with documented pre-numbered receipts or applications and stored in secured manner as described above as soon as reasonably practicable. Vendors prepaying should be encouraged to assure proper security and tracking of these funds.
- **Designated Receipt Requirements:** Issuance of pre-numbered receipts should be included in all fee transactions conducted for environmental programs. These requirements should include at minimum the person/company paying fee, type of payment, amount received, receipt number, person accepting payments and date. LHDs may require additional information as needed. The permit application may suffice as the receipt provided the necessary information is included on the pre-numbered application and a copy is available for both the applicant and to the agency. For all other non-documented services, a pre-numbered receipt should be issued whenever monies are received.
- **Documentation of Monies Received:** Internal Control Measures should include measures to properly document and track payments received by the agency. This can be included as part of the Receipt Requirements but should at minimum allow for tracking of payments back to the specified permit and/ or program code. For On Site Sewer fees, it is recommended that a separate log be created to track pertinent information including but not limited to customer name, site address, installer name, permit number, date, method of payment, receipt number, and person receiving payment. ([view example](#)). Other information may be included as deemed necessary by the agency.
- **Verification of Funds Through Cash Receipt Report:** Internal Control Procedures should include a monthly Cash Receipt Report that can be checked against the CDP Report 50 and EHMIS system. These reports serve to total all fees taken in by the LHD each month and identify shortcomings or errors in funds received and those previously deposited. These reports should be monitored and reviewed by management and/ or supervisors each month.
- **Deposit Guidelines:** Procedures including specific timelines, transport methods and responsible person should be created to insure all agency funds are properly deposited into local bank accounts. Deposits into the environmental holding account should be made at least every three business days for independent health departments and within one week for district health departments. The person tasked with making deposits should be different than the person collecting and processing fees. Records of deposits should be maintained by the agency and reviewed by authorized personnel.

- **Segregation of Duties:** All Internal Control Procedures should include a well-defined segregation of duties in order to prevent and discourage potential loss. This segregation is to assure that no one individual employee is a part of the fee process from time of collection, entry into the system, verification and deposit. The segregation of duties can include multiple individuals but should be designed to prohibit any manipulation of the fee handling process by any one or group of employees.
- **Refunds and Write Offs** The appointing authority or supervisor must approve all Requests for Refunds prior to completion. If the refund includes state fees that have already been processed, the agency must mail the completed "Request for Refund Form" to the Cabinet for processing of the refund. If the refund involves local money only, the "[Request for Refund Form](#)" is completed and signed off on by appointing authority or supervisor. This fee can then be backed out of the EHMIS system and include the reason for the reversal and with who authorized and completed it. A check should be issued from the local Environmental Holding Account if the refunded payment was received within the current month. All other refund checks would be issued from the agency's General Operating Account if this payment was made in previous months.
- **Write-offs:** Writing off uncollectable debts should be completed on a regular basis to reflect current outstanding fees. The appointing authority or supervisor must approve all write off of bad debts. All write offs should be completed in the EHMIS system to identify monies being written off according to the reason for the write-off. All refund and write off documentation should to be reported to the appointing authority and or supervisory staff each month for monitoring and review and maintained with other financial documentation.
- **Returned Checks:** Upon notification from the bank that you have a check returned due to insufficient funds notify management and/or the immediate supervisor to inform them of the situation. Upon their approval, document the check number, amount, name of customer and associated establishment or address. At that time, the check should be backed out of the EHMIS system. The appointing authority or supervisor should then contact the person issuing the check notifying them the check has been returned. If deemed appropriate by the health department, written notification can be used to as means of notification however; notification should be completed in a timely manner.
- **Annual Audit:** In accordance with [902 KAR 8:165](#) LHDs shall conduct an annual audit. Environmental fees and collection practices should be included in this audit in order to verify program fees and the effectiveness of the Internal Control Procedures. Upon completion, agency management and supervisors should review audit results to determine the effectiveness of fee collection and internal control procedures.

# Financial Management

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**OMB 2CFR Part 200 Subpart E (Cost Principles) – General Provisions** [\[external link\]](#)

## **FINANCIAL MANAGEMENT**

DPH has established uniform procedures for use by all LHDs.

**LHDs must follow all provisions of this Administrative Reference (AR).** LHDs whose governing board of health (BOH) is not appointed by the Cabinet for Health and Family Services (CHFS) must obtain a waiver from DPH for any financial policies or procedures that are different from the provisions outlined in the AR. All interpretations of the provisions of this reference shall be made by DPH and such determinations shall be final and conclusive.

DPH will conduct Compliance Reviews at regular intervals (e.g., every two to four years) for each health department. Review the description of the [COMPLIANCE REVIEWS](#) in this section.

### **Regulatory References**

[902 KAR 8:160](#) – Local Health Department Operations Requirements

[902 KAR 8:165](#) – Local Health Department Accounting/Auditing Requirements

[902 KAR 8:170](#) – Local Health Department Financial Management Requirements

The in-state and out-of-state travel reimbursements for mileage, lodging, and subsistence shall not exceed the Finance and Administration Cabinet's official reimbursement travel rates. Travel regulations are maintained and updated on the [Finance and Administration Cabinet's website: eMARS and Accounting Support](#). Travel regulations (e.g., mileage reimbursement rate) may also be found on the DPH website: [LHDs Information webpage](#).

### **Financial Planning And Budget Preparation**

In accordance with [902 KAR 8:170](#), DPH, Division of Administration and Financial Management (AFM) will provide *annual budget* preparation instructions and training to the LHDs. LHDs must submit their budget and plans to AFM electronically.

[902 KAR 8:170](#), Section 1, contains the definitions for the LHD financial management requirements. Sections 2 through 9 provide the requirements for the LHDs financial management.

DPH's AFM, [Budget Branch](#), Local Health Budget Section is available to answer questions and provide technical assistance as needed.

LHDs will submit a 6-month projection by January 31<sup>st</sup> each year to AFM. An updated projection template will be available on the L drive each year by mid-December. Pursuant to [902 KAR 8:170](#), Section 2 (7) and (8) if the health department has a projected deficit a stabilization plan must be submitted with the projection outlining the steps that will be taken to remediate the projected deficit.

## **ACCOUNTING AND ANNUAL AUDITS**

### **Local Health Department Accounting and Auditing Requirements**

LHDs will adhere to the requirements outlined in Administrative Regulation [902 KAR 8:165](#).

#### **Local Health Department Audits**

Audits shall be in accordance with Section 2 of [902 KAR 8:165](#).

LHDs must solicit proposals for external accounting firms to conduct the annual audit and the [OMB 2CFR Part 200 Subpart F](#) portion of the audit, if required. A separate contract must be executed each year regardless if the price and scope of service is unchanged.

The auditor selection process shall follow the guidance provided in the Request for Proposal (RFP) template located at L:\LHDcontracts.

Adherence to the RFP template will ensure requirements are included and a defensible process is followed.

#### **UNRESTRICTED FUNDS BALANCE EXCESS:**

[902 KAR 8:170](#), **Local health department financial management requirements**, states in *Section 3 (4c)*: "The LHD accumulates an unrestricted fund balance, as of June 30 of a fiscal year, in excess of thirty (30) percent of that year's expenditures for non-fee programs plus forty (40) percent of that year's expenditures for fee for service programs, or \$100,000, whichever is greater. The LHD shall submit, to the Department of Public Health, a written plan of use for the amount of the excess. If approved, the funds shall be placed into a local restricted fund to be used solely for the purpose(s) approved."

#### **FINANCIAL REPORTING**

**LHD financial reports are available to DPH/AFM as follows:**

##### **Employee Time Reporting**

A fiscal year to date American Standard Code for Information Interchange (ASCII) file of each employee's paid hours by pay period is due 10 days after the ending of the last pay period in a month. The file should include the Ending Date, Health Department Identification Number (HID#), Employee ID#, Cost Center, and Function Codes.

Contact AFM, Budget Branch, for the specifications of the ASCII File.

##### **Time Reporting**

All employees, including personal services contractual employees, are to report hours worked, in 15-minute increments, by Payroll Classification, Cost Center, and Function Code.

LHDs are to maintain an employee-leave accrual system, either manual or computerized. The system must maintain an accurate record of leave earned, leave used, and a current leave balance. Accrual is to be based on the rates provided by Kentucky Administrative Regulation [902 KAR 8:120](#), Sections 2, 3, 4, 5, 20, and 21. The system should transfer any accumulated annual leave above the maximum allowable to the employee's sick leave balance.

## General Ledger

An ASCII file is due by the 10<sup>th</sup> of the following month. The file must include fiscal year to date balances and current month transaction totals by Period Ending Date, HID#, Cost Center, General Ledger, Minor Object, and Account Description.

Contact AFM, Budget Branch, for the specifications of the ASCII file.

## Indirect Cost Procedures

All LHDs will use the following indirect cost procedures unless they are approved by their federal agency to use different procedures.

As stated in [OMB 2CFR Part 200 Subpart E Cost Principles § 200.412](#) "There is no universal rule for classifying certain costs as either direct or indirect (F&A) under every accounting system. A cost may be direct with respect to some specific service or function, but indirect with respect to the Federal award or other final cost objective. Therefore, it is essential that each item of cost incurred for the same purpose be treated consistently in like circumstances either as a direct or an indirect (F&A) cost in order to avoid possible double-charging of Federal awards.

Guidelines for determining direct and indirect (F&A) costs charged to Federal awards are provided in this subpart." The general definition of direct cost included in [OMB 2CFR Part 200 Subpart E §200.413](#) is: "Direct costs are those costs that can be identified specifically with a particular final cost objective, such as a Federal award, or other internally or externally funded activity, or that can be directly assigned to such activities relatively easily with a high degree of accuracy. Costs incurred for the same purpose in like circumstances must be treated consistently as either direct or indirect (F&A) costs. [See also §200.405 Allocable costs.](#)"

The general definition of indirect cost included in [OMB 2CFR Part 200 Subpart F Appendix VII](#) "Indirect costs are those that have been incurred for common or joint purposes. These costs benefit more than one cost objective and cannot be readily identified with a particular final cost objective without effort disproportionate to the results achieved. After direct costs have been determined and assigned directly to Federal awards and other activities as appropriate, indirect costs are those remaining to be allocated to benefitted cost objectives. A cost may not be allocated to a Federal award as an indirect cost if any other cost incurred for the same purpose, in like circumstances, has been assigned to a Federal award as a direct cost.

## Accounting System Organization

In keeping with the definitions of direct and indirect cost, and the requirements of

[OMB 2CFR Part 200 Subpart E Cost Principles, Cost Allocation Plans and Indirect Cost Proposals](#), the LHD accounting system is organized using Cost Centers to which direct costs associated with each Cost Center's activities must be charged.

Costs for patient visits at non-school sites are first charged to the 700 Cost Center and are then allocated on a monthly basis to the 712, 800 – 813 Cost Centers using Medicare resource based relative value (RBRV) factors. Costs for patient visits provided at a school site are coded directly to cost center 858. Costs for clinic procedures that are provided by contracted providers at offsite locations are charged directly to the 712, 800 – 813 Cost Centers.

Costs for radiology, laboratory and pathology are first charged to the 718 Cost Center and are then allocated on a monthly basis to the 712, 800 – 813 Cost Centers. Costs for radiology,

laboratory and pathology tests and procedures that are provided by contracted providers at offsite locations are charged directly to the 712, 800 – 813 Cost Centers.

There are seven indirect cost pools.

- 897 - Space
- 898 - Departmental (benefits all categories of direct service projects)
- 899 - Clinic (benefits only the 700 & 718 clinic operation Cost Centers)
- 900 - Other Medical (benefits only Medical projects)
- 901 - Environmental (benefits only Environmental projects)
- 902 - Other projects (benefits only Other projects)
- 903 - Home Health (benefits only Home Health Agency projects)

## **Payroll Related Expenditures:**

### **Salaries**

Accounting, budgeting, payroll, data processing, departmental management, personnel administration, and purchasing may often be performed by employees who also have substantial direct project activities. To properly reflect these circumstances, the accounting system does not permanently assign employees to any direct or indirect Cost Center, but allows each employee to charge payroll expense to any direct or indirect Cost Center that is appropriate for the activity being performed. To ensure consistency, the official budgetary process requires the LHD Director to list the amount of time each employee will charge to each Direct Cost Center and Indirect Cost Center.

### **Leave Pay**

Payroll expenditures for authorized types of leave pay for each employee are accumulated in the 895 Allocable Direct Reporting Area. 895 expenses are separated into seven accounts (Departmental, Environmental, Medical, Clinic, Home Health, Home Health On-Call, and Other) based on where the majority of the employees' time is coded.

Year-to-date departmental leave pay expenditures are allocated to all Direct Cost Centers and to the Departmental Indirect Cost Center (898) according to the proportion of year-to-date salaries in each of these Cost Centers. Year-to-date environmental leave pay expenditures are allocated to each Direct Environmental Cost Center and to the Environmental Indirect Cost Center (901) according to the proportion of year-to-date environmental salaries in each of these Cost Centers. Year-to-date clinic leave pay expenditures are allocated to all Direct Clinic Cost Centers (700, 715, and 718) and to the Clinic Indirect Cost Center (899) according to the proportion of year-to-date salaries in each of these Cost Centers. Medical, Home Health, and other leave pay expenditures are allocated on a similar basis.

### **Fringe Benefits**

Payroll related fringe benefit expenditures are accumulated in the 895 Allocable Direct Reporting Area. Year-to-date fringe benefit expenditures are allocated to all Cost Centers according to the proportion of year to date salaries and leave pay recorded in each Cost Center for full-time employees and according to the proportion of year-to-date salaries recorded in each Cost Center for part-time employees.

## **Non-Payroll Related Expenditures**

The General Guidelines that may be used to determine if a non-payroll related expenditure that benefits more than one Cost Center should be charged indirectly or directly are as follows:

- Expenditures for items that will benefit two or three Cost Centers may be allocated to each Cost Center as a direct cost at the time the expenditure is made. The allocation should be based upon the planned usage of the items in each Cost Center as documented by the planned number of services requiring the item listed in the local departments approved service plans. Actual services provided in each Cost Center must be sufficient to validate the allocation amounts, or appropriate adjustments to the accounts must be made on a timely basis.
- Expenditures for items that benefit four or more Cost Centers may be charged to the appropriate Space, Departmental, Clinical, Medical, Home Health, Other, or Environmental Indirect Cost Center according to the Cost Centers benefited. However, if the expenditures can be readily allocated to each specific Cost Center benefited by the use of the procedures listed in (1) above and if the effort to accomplish this allocation is not disproportionate to the results achieved, then the procedures in (1) should be used and the expenditure items recorded as direct expenditures.

## **Indirect Cost Rates and Allocation Procedures**

*Initially, all indirect cost rates are based on expenditure amounts included in each LHD's approved annual budget.*

- The Departmental indirect cost rate is determined by dividing the total expenditures in the Departmental Indirect Cost Pool (898) by the total direct Payroll Expenditures of the LHD.
- The Space indirect cost rate is determined by dividing the total expenditures in the Space Indirect Cost Pool (897) by the total square footage of health department facilities that are used for Direct Cost Center activities.
- The Clinical indirect cost rate is determined by dividing the total expenditures in the Clinical Indirect Cost Pool (899) by the total direct payroll expenditures of the Direct Clinical Cost Centers (700 & 718) of the LHD.
- The Medical indirect cost rate is determined by dividing the total expenditures in the Other Medical Indirect Cost Pool (900) by the total direct Payroll Expenditures of the direct Medical Cost Centers (700 – 859 and 878 – 879, 882 – 884 and 890) of the LHD.
- The Home Health indirect cost rate is determined by dividing the total expenditures in the Home Health Indirect Cost Pool (903) by the total direct Payroll Expenditures in the Direct Home Health Agency Cost Centers (860 – 869) of the LHD.
- The Other indirect cost rate is determined by dividing the total expenditures in the Other Indirect Cost Pool (902) by the total direct Payroll Expenditures in the other Direct Cost Centers (870 – 877, 880 – 881, and 885 - 889) of the LHD.
- The Environmental indirect cost rate is determined by dividing the total expenditures in the Environmental Indirect Cost Pool (901) by the total direct Payroll Expenditures of the Direct Environmental Cost Centers (500 – 595) of the LHD.
- Allocation of indirect cost is made in the financial statements of LHDs based upon actual rates rather than on the budgeted rates determined above. Thus, each month, seven new year-to-date rates are computed using the procedures listed above. Then, year-to-date actual amounts of indirect cost are allocated to each applicable direct Cost Center from the seven indirect cost pools by use of the seven computed

rates multiplied times the year-to-date direct Payroll Expenditures in each Cost Center.

- Only the Departmental indirect cost rate will be applied to Cost Centers that are established for DPH State level positions that are paid through LHDs.

### **REQUESTS FOR OVER-RIDING SERVICES**

LHDs wanting to provide services at a different rate than what DPH has determined on the applicable Service/Charge File must submit a request, in writing, to the Division of Administration and Financial Management (AFM) via the [Local Health Operations \(LHO\) Branch](#).

**The request must include the service(s)/code(s), requested rate(s), accompanied with a detailed explanation and validation of the request being made.** LHDs shall not override charges unless they receive written approval from AFM or as specified in the "LHD Contracts" subsection of this AR document. The AFM Division Office will review requests and make a determination. **Approved requests will expire annually on June 30.** Further, all over-ride requests are subject to additional review and change at any time.

**NOTE:** Requests must be submitted by the LHD Director or staff person designated by the Director to the LHO Branch. LHO will work with the AFM Division Office regarding the determination of the request. It is the responsibility of the LHD to ensure a timely request is submitted. **Allow up to 10 business days for AFM review and response.**

### **ACCOUNTS RECEIVABLE (A/R) WRITE-OFFS**

Write-off procedures must follow the internal control policy for all programs or services that charge or generate fees. Appropriate audit trails must be maintained for all write-offs.

Specific to clinical services, the following **write-off procedures** are to be followed:

Payor Code 1 (Self-Pay)

Fees charged but not collected will be removed monthly from accounts receivable in the following manner:

- **For accounts \$10 or less** and the date of service and account balance greater than 6 months the patient account will automatically be written off as a bad debt (via computerized program).
- **For accounts over \$10;** date of service is over six months; and the account balance over six months old, the bill is to be written off by the LHD within 30 days after it is deemed uncollectible.

Internal control procedures should be followed for the below payor codes:

Payor Code 2 (Medicaid)

Payor Code 3 (Medicare)

Payor Code 8 (Contract)

Payor Code 9 (Private/Commercial Insurance)

Payor Code 15 (Co-pay)

**Outstanding balances should not go beyond a twelve month period of time to reduce liabilities and financial risks to the LHD.** Contact the Local Health Budget section for additional clarification.

An example of an internal control policy regarding receipts management and an aging report may be viewed on the [LHD Information webpage](#) under LHD Documents/LHD Budget.

## LHD CONTRACTS

**LHDs have the authority to contract for services not otherwise available (KRS 212.245).** All funds of the LHD must be used for the operation of the health department. Contracts that fund the operation of programs in other agencies are not allowable. Further guidance is provided in [902 KAR 8:170](#).

### Contract Basics:

There are three factors necessary to create a contract:

- 1) an offer,
- 2) acceptance, and
- 3) consideration.

When writing a contract, remember a central principle to contract law: **any ambiguities or uncertainties will be resolved *against* the writer.**

For [CH-52](#) contracts as related to Payor Code 8: LHDs have the option to contract with other public or private entities to provide needed health services, as funds are available. Billing/Payor Code 8 contracts should **never** be with an individual, unless the individual is the public or private entity. The [CH-52](#) is the DPH provided standardized contract template to be used and completed annually each fiscal year. LHDs may negotiate service rates with the contractor; however, they should be treated as third party payors and the expectation would be they are charged at 100% of the cost of the service. Nominal or zero charges would not be acceptable if those same types of services are being provided to other clients of the LHD and the LHD is also billing for those with Medicaid eligibility. LHDs will need to assure the total (direct and indirect) costs of contracted services are covered. Federal funding should not be used to cover these contracted service costs.

*The [LHD Network Systems](#) service/charge files are reviewed annually and updates to CPT code rates (fees) are made during the 1st quarter of the calendar year. Rates will also be updated throughout the year, as needed, following protocols established by the LHO Branch. RBRV (weights) are updated annually in July (start of new fiscal year) by the AFM Budget Branch, Local Health Budget Section.*

**Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreement (BAA)** is required if the contractor receives Protected Health Information (PHI) through the contract, and is providing any of the following services: legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, and financial.

**A BAA must be completed with the initial Billing/Payor Code 8 contract** as applicable. BAAs would not need to be recreated each year unless there is a significant language change. Billing/Payor Code 8 contracts shall be completed prior to providing the needed health services agreed upon. More information on when a BAA is and is not required can be found on the [Health and Human Services website](#).

LHDs are allowed to over-ride rates and enter them in the charge (Chrg/Qty) field, only when the negotiated rate is greater than the DPH service/charge file assigned rate, without submitting a written request to over-ride charges to AFM. A rate is required for services rendered and an appropriate audit trail must be documented. Invoices **shall not** be setup as ZERO ("0").

Considerations should be made when entering into Payor Code 8 contract agreements with correctional facilities for incarcerated individuals. [KRS 441](#) provides information regarding the

responsibility of jails to provide access to and payment for necessary care for prisoners. **Negotiated rates shall not be less than the KY Medicaid Physician's Fee Schedule rates.** Federal, state and local funding should not be used to cover the cost of Payor Code 8 provided services.

Contractual agreements between other CHFS departments and DPH allow for specific Hepatitis vaccinations to be provided to those contracted department's First Aid Safety Team (FAST) designated employees. Contract codes will be established by DPH through Payor Code 8, services will be queried quarterly by DPH staff, electronic transfer payments will be made to LHD by DPH quarterly (listed as "state vaccinations"). LHDs should not direct bill the CHFS departments under these DPH contractual agreements.

DPH will mitigate agreements on behalf of LHDs to provide Hepatitis B vaccinations to firefighters approved through the KY Fire Commission. CH-52 contracts, with completed language, will be available for LHDs to complete with their agency-identifying information.

All Payor Code 8 contracts must be saved on the **L-drive**. Any amendments and/or changes must also be saved on the L drive as a separate document.

**Personal Service Contracts:** Contracts for services of a professional or technical nature not available through the LHD merit system.

The two types of Personal Service Contracts:

**Payroll/Employment Contract (CH-51):** Under common-law rules, anyone who performs services is an employee if you can control what will be done and how it will be done. IRS requires employment tax withholding/reporting whether employee is paid via contract, master agreement, petty cash, or standard payroll system.

**Independent Contract (CH-53M):** All Personal Service Contracts that are not employment contracts. The general rule is that an individual is an independent contractor if the payer has the right to control or direct only the result of the work, not the means and methods of accomplishing the result. Since professionals, such as physicians, are always responsible for the means and methods of their practices, there are special rules used to determine the independent contractor status of professionals.

In drafting a contract, a decision shall be made concerning whether the provider of the service is an "independent contractor". Refer to the Court of Appeals of Kentucky, now the [Supreme Court of Kentucky](#), Courier Journal & Louisville Times Co. v. Akers, 175 S.W.2d 350, 352 (Ky. 1943) that:

*"One who is engaged in a distinct occupation or business, using his own means or instrumentalities in the execution thereof, and agrees to perform service for another according to his own method and manner, free from direction and control of the principal in all matters relating to the performance of the work, except as to result, is an 'independent contractor'."*

There is no single test to determine the proper classification of workers. According to the IRS, the classification depends on the occupation and the factual context in which the services are performed.

Over the years, the IRS and the courts have developed 20 common law factors to consider in determining the proper classification of a worker. The IRS has incorporated the 20 factors into a [Form SS-8](#), which may be filed for a determination by the IRS of the proper classification. The 20 factors are following:

<b>Factor</b>	<b>Employee Characteristics</b>	<b>Independent Contractor Characteristics</b>
<b>Instructions</b>	Worker must comply with employer's instructions on when, where, and how to work.	Worker is accountable to employer for <b>results</b> of services, but generally not the methods.
<b>Training</b>	Employer provides training.	Worker uses his/her own methods and/or obtains his/her own training.
<b>Integration</b>	The success of continuation of the employer's business depends significantly upon the performance of the worker's services.	The worker's services are incidental or secondary in the employer's business.
<b>Services Rendered Personally</b>	Worker must render the services personally.	Services may be performed by the worker or by an agent, employee, or subcontractor of the worker.
<b>Hiring, Supervising, and Paying Assistants</b>	Employer is responsible for hiring, supervising, and paying assistants for the worker.	Worker provides the labor for services and is responsible for hiring, supervising, and paying assistants.
<b>Continuing Relationship</b>	Relationship is continuous and/or frequently recurring.	Term of relationship is finite.
<b>Set Hours of Work</b>	Employer establishes set hours of work.	Worker determines hours of work.
<b>Full Time Required</b>	Worker must devote substantially full time to the employer	Worker is free to work when and for whom he/she chooses.
<b>Work on Employer Premises</b>	Work is performed on the premises of the employer and/or the employer dictates a designated route, territory, or location.	Work may be performed off the premises of the employer, such as at the worker's own home or place of business.
<b>Order or Sequence</b>	Worker must perform services in the order or sequence set by the employer.	Worker may determine the order or sequence of services.
<b>Oral or Written Reports</b>	Worker must submit regular or written reports to the employer.	Regular reports are not required - the worker is only accountable for final results.
<b>Payment by Hour, Week, or Month</b>	Worker is paid based on time incurred in performance of services.	Worker is paid by the job or on a commission.
<b>Payment of Business Expenses</b>	Employer pays the worker's business and/or travel expenses.	Worker is responsible for his/her own business and/or travel expenses.

<b>Factor</b>	<b>Employee Characteristics</b>	<b>Independent Contractor Characteristics</b>
<b><i>Furnishing of Tools and Materials</i></b>	Employer furnishes significant tools, materials, and/or equipment.	Worker furnishes significant tools, materials, and equipment.
<b><i>Significant Investment</i></b>	Worker is dependent on employer for facilities used in the performance of services.	Worker invests in facilities used in the performance of services that are not typically maintained by employees.
<b><i>Realization of Profit or Loss</i></b>	Worker is compensated for time/efforts and does not realize a profit or suffer a loss as a result of the services.	Worker can realize a profit or suffer a loss as a result of services.
<b><i>Multiple Employers</i></b>	Worker performs substantially all services for one employer.	Worker performs services for multiple employers at the same time.
<b><i>Marketing Services to the Public</i></b>	Worker performs services exclusively for employer, possibly subject to non-compete agreements, etc.	Worker consistently offers similar services to the public.
<b><i>Right to Discharge</i></b>	Employer has the right to discharge the worker.	Worker cannot be discharged so long as he/she produces the results specified in the contract.
<b><i>Right to Terminate</i></b>	Worker has the right to terminate relationship without incurring liability.	Worker may be subject to penalties or other loss for premature termination of relationship.

Potential costs of challenges to worker classification are:

- Noncompliance with IRS, Medicare, or Social Security regulations may result in liabilities for employment taxes, penalties, and interest;
- Noncompliance with Fair Labor Standards Act, federal or state unemployment regulations may result in minimum wage, overtime, and unemployment claims;
- Noncompliance with merit system regulations may result in back payments for employee benefits;
- Noncompliance with Workers Compensation regulations may result in possible assumption of liabilities for workers' job-related injuries, accidents, etc.;
- Noncompliance with federal and state unemployment laws may result in civil or criminal charges for violation of federal and state employment laws;
- Challenges of worker classification may result in litigation and settlement costs.

Employee Identification Code categories E1, G1, K1, K2, K3, K4, L1, L2, M1, M2, M3, M4, N1, N2, N4, N5, N6, N7, N8, N9, and S1 are used for payroll contractors.

Minor object codes including 200, 201, 202, 204, 205, 211, 215, 217, 218, 219, 220, 221, 222, 225, 227, 229, 240, 241, 242, 245, 250, 255, 260, 265 are used to identify independent contractors.

## Submission of Proposed Contracts to DPH for Program Review

When submitting a contract to DPH for Program Review, [902 KAR 8:170](#), Section 7(10) states, "All local health contracts and amendments **are subject to review** by the DPH."

Each proposed contract must be saved on the [L-drive](#). **Requested information from each LHD contract must be entered on the Excel LHD Contract Tracking Spreadsheet** for the fiscal year and saved to the [L-drive](#), and the Department is to be contacted via e-mail to [LHDContracts.ProgramReview@ky.gov](mailto:LHDContracts.ProgramReview@ky.gov).

- If the district/health department does not have access to the [L-drive](#), contact the LHO Branch ([LocalHealth.HelpDesk@ky.gov](mailto:LocalHealth.HelpDesk@ky.gov)) for further instructions. **DPH recommends all LHD staff working with LHD contracts have [L-drive](#) access.**
- **The proposed LHD contracts must be saved on the [L-drive](#) by May 15 each year**, unless state budgeting issues necessitate a delay in this process, at which point DPH, AFM Division Office shall designate a later date. After saving all contracts to the [L-drive](#), the LHD Director or designated LHD contract staff sends an announcement (notification) email to [LHDContracts.ProgramReview@ky.gov](mailto:LHDContracts.ProgramReview@ky.gov). DPH program review staff will then know to begin the contract review process. A DPH program review cannot begin until the requested tracking spreadsheet is accurately completed by the LHD and saved to the [L-drive](#) and the notification email is sent.
- Contracts **MUST** be prepared on the Microsoft Word [contract template](#) file for:
  - CH-50–Wildcard Associates
  - CH-51 – Personal Service/Employment Contract
  - CH-51(a) – Amendment
  - CH-52 – LHD Contract to Provide Services
  - CH-52(a) – Amendment
  - CH-53M – Personal Service/Independent Contract
  - CH-53M(a) – Amendment
  - CH-54 – LHD Audit Contract
  - CH-58 – Public Health Taxing District to Purchase Audit Services
  - School
  - LHD Lease Agreement

All proposed personal services contracts with individuals (not companies or corporations) will be evaluated by [Local Health Personnel \(LHP\) Branch](#).

- If the contract is determined to be a full time employment contract and **if the services are available through the LHD merit system**, the LHD will be instructed to obtain the services through the LHD Merit System.
- If the services are not available through the LHD merit system, the contract may be reviewed by AFM, LHP Branch staff.

### Content:

- All information requested on the contract template forms must be supplied, including the contract maximum amounts, by contract section.
- The description of services to be provided must be sufficiently detailed to clearly describe the specific duties and responsibilities of both parties. (For example, see Mammography Provider Requirements in the AR, Breast and Cervical Cancer Screening Program.)
- The terms of the contract must indicate whether the patient and/or other third-party payer may be billed by the contractor for any part of the services provided under the contract.
- Omissions will result in the contract(s) language being rejected and the

contract(s) returned to the LHD, which may delay any program funding of the LHD contract(s).

- Contracts must reflect service standards pertinent to the delivery of services and consideration of available funds.

**Explanation of Contract Numbering System:**

For Independent **and** Employment Contracts:

- All contracts shall be numbered using the current fiscal year end, the LHD Identification Codes (HID#), and the Provider Class Identification Number in the space provided on the contract forms. The first two digits of the contract ID# represent the last two digits of the fiscal year end. For example, FY 20 would be designated 20. Digits 3 – 5 represent the HID#. A list of the HID#'s can be found at the end of this AR section. A list of [Provider Codes and Classes](#) as outlined above is found on the [LHD Information webpage](#) under Contract Information.
- When saving/naming the computerized files, use current fiscal year number, the HID# and the Provider Class Identification Number as the file name.
- Contracts will be returned for correction if the file numbering system is not utilized.

**For Employment Contracts:**

- Digits 6-7 represent the Employee class categories (MO) for payroll contract expenditures. General Classification Codes are listed on the [LHD Information webpage](#) under Contract Information.
- Digits 8-10 represent the individual portion of the Employee Class ID# (ID).
- Employee class ID# for each employment contractor must be assigned by the LHO Branch. Contact the LHO Branch at (502) 564-6663 to obtain this number.
- **Note:** It is an LHD Merit System guideline that part-time employees (less than 100 hours) **cannot** supervise.

	20000K1300
20	Fiscal Year
000	HID #
K1	Employee Provider Class No.
300	Individual number

**For Independent Contracts:**

- Digits 6-8 represent the minor object code for independent contracts.
- Digits 9-10 represent the individual portion of the Contract Class ID# (ID).
- Digits 6-10 are assigned by the LHO Branch. Contact the LHO Branch at (502) 564-6663, option 1 to obtain the number.
- For services that are to be entered in the system, only minor object codes from 201 to 260 may be used for this part of the contract number. Do not use the 301 to 315 minor object codes.
- For the contracts that do not involve services reported in the system, any applicable minor object code may be used.

	2000026004
20	Fiscal year
000	HID #
260	Independent Contractor MOC
04	Individual number

### Third-Party Billing

You must indicate on each contract section of the [CH-53M](#) if the contractor is authorized to bill third parties for all services included in the contract or section. This must correspond with the **Y** or **N** at the top of page of the contract. **There must be third party billing language for every contract number included in the lead contract.**

When the LHD is responsible for billing Medicaid for services provided under a [CH-53M](#) contract, it is required that a Medicaid Statement of Authorization ([CH-55](#)) for each medical provider be attached. The [CH-55](#) template can be found on the L-drive.

*Please note: LHDs shall not contract with outside reference labs to bill any third parties on the lab's behalf.*

### Board of Health (BOH) Contracts

If a contracting medical professional is a governing BOH member, then an automatic exception to the conflict of interest provision of the contract policies is made if the annual amount will not exceed \$10,000. Contracts exceeding \$10,000 must be approved by the Commissioner of DPH before any payments will be processed.

If a contract is proposed with a governing BOH member for more than \$10,000, a letter or justification indicating the necessity and rationale for contracting with a board member must be submitted to the Commissioner of DPH in conjunction with the proposed contract.

If an exception for such a contract has been previously granted and circumstances surrounding the need for the contract have not changed, a letter indicating this situation is all that is necessary.

### Review of Contracts

**Once the LHD notifies [DPH](#) that ALL of their contracts and the required tracking spreadsheet are completed and saved to the **L-Drive**, the DPH Program Review will begin and communication from that point will be between the DPH program reviewer and the LHD. **It is important to ensure the [LHO Branch](#) is copied on all the email communication.****

The LHO Branch will assist with keeping the **review status of the contract tracking spreadsheet** updated if the LHD has completed the required information on the contract tracking spreadsheet and saved it to the L-Drive. Status updates will be based solely on the email communication between the DPH program reviewer and the LHD (with LHO copied on the email communication).

***The LHD will use the email correspondence from DPH program review staff, the contract tracking spreadsheet saved to the L: drive and appended contract file names (NR, FINAL) to determine review status of contracts.***

### **LHD Contract Review Procedural Training and Technical Support**

An LHD Contract Review Process training (via YouTube Link) is available on the [LHD Information webpage](#), under [Contract Information](#). This information will *only be updated* when procedural or programmatic changes are needed. Address specific subject matter program questions or concerns related to the DPH program training (YouTube link) directly to [program staff](#). Address questions or concerns regarding the [LHD contract review procedures](#) by email to the [LHO Branch](#) or by calling (502) 564-6663, Option 1. DPH will no longer provide formal face-to-face or webinar LHD contract training.

### **INTERNAL CONTROLS**

Internal controls are a required LHD management tool to provide assurance to DPH that organization funds and assets are being controlled and used for the purposes intended. Internal control procedures are necessary to demonstrate that due diligence has been addressed in managing the affairs of any LHD. Smaller organizations have a higher risk due to a lesser ability to distribute duties. Internal controls are to be reviewed quarterly and updated as needed. New and updated internal controls must be reviewed by the BOH and approved.

[902 KAR 8:165](#), Section 3, governs Internal Control Procedures, and Section 4 addresses Incorporation by Reference. For assistance in the development of LHD Internal Controls Program Guidelines, visit the [LHD Information webpage](#): LHD Documents subheading, Local Health Budget (LHB) section; or contact the LHB Section by calling (502) 564-6663 and selecting Option 2.

## CHART OF ACCOUNTS - BALANCE SHEET/GENERAL LEDGER

### Assets

104	Local Bank
106	Petty Cash
107	Money Market
111	Time and Certificates of Deposit
116	Passbook Savings Account

### Liabilities

140		Accounts Payable
	▪ 140002	Passport
	▪ 140101	Molina
	▪ 140201	United
	▪ 140501	Anthem
	▪ 140601	Aetna/Coventry
	▪ 140701	KY Spirit
	▪ 140801	Wellcare
	▪ 140901	Humana
141		Notes Payable
142		Federal Income Tax Withheld
143		State Income Tax Withheld
144		Social Security Tax Withheld
145		Health and Dental Insurance Deductions
146		Credit Union Deductions
147		Life Insurance Deductions
148		City Tax Withheld
149		County Tax Withheld
150		Retirement Withheld
151		Refundable Safety Seat Deposits
152		Deferred Compensation
153		Retirement Loan Deductions
154		Flexible Spending Accounts
159		Other Deductions/Withholdings

### Fund Balance

171	Undesignated - (Unrestricted) Fund Balance (Account for Local Restricted Fund Balance)
172	Restricted Fund Balance - State
173	Restricted Fund Balance - Federal
174	Restricted Fund Balance - Fees

- \* Necessary Minor Object Codes within each balance sheet account may be established at the discretion of each LHD.
- \* Unrestricted and Restricted Fund Balance Minor Object Codes are the Cost Center codes of the restricted funds.

## LHD - CHART OF ACCOUNTS - COST CENTERS

**DPH Program Descriptions include DPH program staff contacts, and scope of work. These are available on the L-Drive (<L:\LHDBudgets\Program Descriptions>).**

*NOTE: If an LHD employee user access to the L-Drive is needed, submit an [L-Drive security request form](#) to the LHO Branch by **following procedures outlined in the AR, [LHO Section](#)**.*

*NOTE: If an LHD employee user access to the L-Drive is needed, submit an [L-Drive security request form](#) to the LHO Branch by **following procedures outlined in the AR, [LHO Section](#)**.*

- 500 FOOD** – Used to charge all allowable direct expenditures made for the programs defined by the Division of Public Health Protection and Safety (PHPS) that are included in this Cost Center. *(Limited Food Concessions, Temporary Food Service Establishments, Food Service Establishments, Vending Machine Companies, Retail Food Establishments, Bed & Breakfast, Food-borne Diseases, Retail Food Stores, Produce and Farmers Market, Food Handlers, Food Managers, Food Processing or Storage Establishments, Frozen Food Lockers, Raw Agriculture Sump., Drugs Quarantine)*
- 520 PUBLIC FACILITIES** – Used to charge all allowable direct expenditures made for the programs defined by the Division of Public Health Protection and Safety that are included in this Cost Center. *(Hotels or Motels, Boarding Homes, Mobile Home/Recreational Vehicle Parks, Public Buildings/Recreation Facilities, Tattoo Studios, Schools, Septic Tank Cleaning Vehicles, Septic Tank Disposal Sites, Ear Piercing, Body Piercing, Confinement Facilities, Youth Camps, Lead, Swimming Pools General, Private Swimming Pools, Swimming Areas, Beaches)*
- 540 GENERAL SANITATION** – Used to charge all allowable direct expenditures made for the programs defined by the Division of Public Health Protection and Safety that are included in this Cost Center. *(Private Water, Nuisance Control, Grass and Weeds, Housing, Vectors, Mosquito Control, Birds, Insects, Rodent Control, Rabies)*
- 560 ON-SITE SEWAGE** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description. *(Electrical Permits, Onsite Sewage Disposal, Wetland Testing, Private Sewage)*
- 580 SPECIAL PROJECT (ENVIRONMENTAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 590 SPECIAL PROJECT (ENVIRONMENTAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 591 RADON** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 592 SPECIAL PROJECT (ENVIRONMENTAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 593 SPECIAL PROJECT (ENVIRONMENTAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.

- 594 SPECIAL PROJECT (ENVIRONMENTAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 595 SPECIAL PROJECT (ENVIRONMENTAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 598 SPECIAL PROJECT (ENVIRONMENTAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 599 SPECIAL PROJECT (ENVIRONMENTAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 700 ALL PREVENTIVE – PRES/PROB VISITS** – All allowable expenditures (provider-related only and only to the extent included in the Medicare RBRV determination) made to provide the following are directly charged to this Cost Center: Patient Evaluation and Management Services, Surgery and Medicine procedures as defined by the American Medical Association (AMA) Physicians Current Procedural Terminology (CPT) edition. Also includes authorized Health Care Financing Administration Common Procedure Coding System (HCPCS) Level II procedures and authorized HCPCS Level III procedures. Health Department Procedural Terminology (HDPT) services and procedures are also included.
- Providers are physicians, mid-level practitioners, nurses, nutritionists, social workers acting as health educators, and therapists. Other staff are included as providers for time spent rendering services that are reportable in the system. Examples of reportable services by support staff include safety seat loans or food instrument issuance.
- Expenditures that are charged to minor objects 302 – 315 and 205 are excluded and should be charged directly to the applicable 800 – 817 Cost Center. Expenditures for clinical training benefitting a single Cost Center are excluded and should be charged directly to the applicable 800 – 817 Cost Center. Only anonymous AIDS/HIV services are excluded and should be charged directly to 842. No revenue should be coded to this cost center.
- 712 DENTAL SERVICES** – All direct expenditures made to provide dental visits either in-house or contracted.
- 715 SPECIAL PROJECT (MEDICAL)** – All direct expenditures made to operate a licensed pharmacy in the health department.
- 718 LAB/TESTING/RADIOLOGY** – All expenditures related to the processing of Radiology/Pathology/Laboratory tests in a health department. This includes expenditures for both the technical and professional components of Radiology/Pathology/Laboratory tests provided by outside laboratories and professionals. Expenditures for independent contractors in minor object codes 302 –315 and for environmental laboratory tests are excluded. Expenditures for Rad/Path/Lab training that benefits a single Cost Center are excluded and should be charged directly to the applicable 800 – 817 Cost Center. No revenue should be coded to this cost center.
- 722 ASTHMA EDUCATION** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description

- 723 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 724 MONKEYPOX WRAP AROUND SERVICES** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 725 COVID VAC COM OUTREACH & EQUITY** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 726 SEASONAL FLU AND COVID 19 CO-ADMINISTRATION** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 727 NEEDLE EXCHANGE PROGRAM** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 728 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 729 FENTANYL TEST STRIPS** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 730 BREAST CANCER TRUST FUND** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 731 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 732 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 733 PUBLIC HEALTH DENTAL HYGIENE PROGRAM** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 734 SPP EXPANSION PROJECT**– Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 735 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 736 COMMUNITY HEALTH ACTION TEAMS (CHAT)** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 737 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 738 COVID IMMUNIZATION SUPP** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 739 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.

- 740 SPECIAL PROJECTHANDS ARPA** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 741 HANDS SPECIAL PROJECT** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 742 ENVIROHEALTHLINK** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 743 FEDERAL HANDS SPECIAL PROJECT** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 744 CHW EXPANSION OHE** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 745 CHW FOR COVID RESPONSE AND RESILIENT COMMUNITIES** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 746 ENVIRONMENTAL STRIKE TEAM DEVELOPMENT** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 747 SPECIAL PROJECT (MEDICAL)** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 748 SPECIAL PROJECT (MEDICAL)** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 749 SPECIAL PROJECT (MEDICAL)** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 750 SPECIAL PROJECT (MEDICAL)** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 751 HIV INVESTIGATIONS** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 752 SPECIAL PROJECT (MEDICAL)** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 753 SRAE** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 754 HANDS GF TA, QA & TRAINING** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 755 HEALTH EQUITY HARM REDUCTION SSP** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 756 PREP** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 757 SPECIAL PROJECT (MEDICAL)** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.

- 758 STAYWELL** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 759 SPECIAL PROJECT (MEDICAL)** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 760 SPECIAL PROJECT (MEDICAL)** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 761 DIABETES PREVENTION AND CONTROL INNOVATION** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 762 SPECIAL PROJECT (MEDICAL)** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 763 SPECIAL PROJECT (MEDICAL)** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 764 SPECIAL PROJECT (MEDICAL)** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description..
- 765 TOBACCO PROGRAM FEDERAL FUNDS** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 766 MCH COORDINATOR** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 767 SPECIAL PROJECT (MEDICAL)** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 768 NEONATAL ABSTINCENCE SYNDROME/HEART** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 769 ELC COVID 19**– Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 770 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 771 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 772 ENV PUBLIC HEALTH COVID WASTE WATER**- Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 773 SPECIAL PROJECT (MEDICAL)** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 774 SPECIAL PROJECT (MEDICAL)** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or

program description.

- 775 KY STATE PHYSICAL ACTIVITY & NUTRITION PROGRAM** Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 776 MONKEYPOX IMMUNIZATION FUNDS** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 777 STRENGTHENING PUBLIC HEALTH INFRASTRUCTURE** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 778 LUNG CANCER SCREENING** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 779 STRENGTHENING PUBLIC HEALTH INFRASTRUCTURE A-2** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 780 MONKEYPOX SUPPLEMENT** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 781 SPECIAL PROJECT (MEDICAL)** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 782 SPECIAL PROJECT (MEDICAL)** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 783 SPECIAL PROJECT (MEDICAL)** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 784 SPECIAL PROJECT (MEDICAL)** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 785 SPECIAL PROJECT (MEDICAL)** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 800 PEDIATRIC/ADOLESCENT SERVICES & OUT/FOLLOW** – Expenditures made for group activities reported in the Patient Services Supplemental Reporting System; reportable disease activities; identification, prevention, and control of outbreaks and epidemics including rapid response activities;; training and assistance; and management of these activities are directly charged to this Cost Center. Also includes expenditures for prescription drugs from pharmacies (minor object code 358). (Excludes activities specifically listed in Cost Centers 802 – 809.)
- All expenditures made to provide pediatric/adolescent personal health and Radiology/Pathology/Laboratory services will be allocated to this Cost Center from the 700 and 718 Cost Centers.
- 801 IMMUNIZATIONS** – Expenditures made to provide non-personal health Community Immunization Services as required in the annual Immunization grant application to the Federal Centers for Disease Control and Prevention.
- 802 FAMILY PLANNING SERVICES & OTHER SERVICES/ACTIVITIES** – Expenditures made for Family Planning group activities reported in the Patient Services Supplemental Reporting System; training and assistance; and management of these activities will be directly charged to this Cost Center. Also, anesthesia (minor object code 205), sterilization expenditures (minor object code 312), and contraceptives (minor object code 362) will be directly charged to this Cost Center.

All expenditures made to provide Family Planning Personal Health Services and Radiology/Pathology/Laboratory will be allocated to this Cost Center from the 700 and 718 Cost Centers.

**803 MATERNITY SERVICES & OTHER SERVICES/ACTIVITIES** – Expenditures for maternity classes and their management will be directly charged to this Cost Center. Also, expenditures for anesthesia (minor object 205), delivery and related services (minor object 303), and newborn assessment/circumcision services (minor object 306) will be directly charged to this Cost Center.

All expenditures made to provide Maternity Personal Health Services and Radiology/Pathology/Laboratory will be allocated to this Cost Center from the 700 and 718 Cost Centers.

**804 WIC VISITS & OTHER ACTIVITIES** – Expenditures for WIC vendor related activities, group nutrition and breast-feeding counseling, and other WIC activities not related to individual patient visits will be directly charged to this Cost Center.

All expenditures made to provide WIC screening, enrollment, certification visits, food instrument issuance/electronic benefit transfer (EBT), personal nutrition education, and personal breast-feeding education services and lab tests associated with these visits will be allocated to this Cost Center from the 700 and 718 Cost Centers.

**805 NUTRITION** – Expenditures for group activities reported in the Patient Services Supplemental Reporting System; training and assistance; and management of these activities will be directly charged to this Cost Center.

All expenditures made to provide personal nutrition counseling services will be allocated to this Cost Center from the 700 and 718 Cost Centers.

**806 TUBERCULOSIS (TB) VISITS & OTHER ACTIVITIES** – Expenditures for TB reportable disease activities; identification, prevention and control of outbreaks and epidemics; TB group activities reported in the Patient Services Supplemental Reporting System; training and assistance; and management of these activities will be directly charged to this Cost Center.

All expenditures made to provide TB Personal Health Services and Radiology/Pathology/Laboratory will be allocated to this Cost Center from the 700 and 718 Cost Centers.

**807 SEXUALLY TRANSMITTED DISEASE (STD)/ VISITS & OTHER ACTIVITIES** – Expenditures for STD/STI reportable disease activities; identification, prevention and control of outbreaks and epidemics; STD/STI group activities reported in the Patient Services Supplemental Reporting System; training and assistance; and management of these activities will be directly charged to this Cost Center.

All expenditures made to provide STD/STI Personal Health Services and Radiology/Pathology/Laboratory will be allocated to this Cost Center from the 700 and 718 Cost Centers.

**808 COMMUNICABLE DISEASE** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.

**809 DIABETES** – Expenditures for diabetes group activities reported in the [LHD Network System\(s\)](#) - (e.g., Clinic Management (Portal) System, Patient Services Supplemental Reporting System), CATALYST or DiaWEB; training and assistance; approved community diabetes activities, and management of these activities will be directly charged to this Cost Center.

All expenditures made to provide Diabetes Personal Health Services and Radiology/Pathology/Laboratory will be allocated to this Cost Center from the 700 and 718 Cost Centers.

**810 ADULT SERVICES & FOLLOW CARE**– Expenditures made for Adult group activities reported in the Patient Services Supplemental Reporting System; reportable disease activities; identification, prevention and control of outbreaks; training and assistance; and management of these activities will be directly charged to this Cost Center. (Excludes activities specifically listed in Cost Centers 802 – 809 and 811 – 813.)

All expenditures made to provide adult personal health and radiology/pathology/laboratory services will be allocated to this cost center from the 700 and 718 Cost Centers.

**811 LEAD SERVICES** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.

**812 SPECIAL PROJECT (MEDICAL)** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description..

**813 BREAST AND CERVICAL CANCER** – Expenditures for Breast and Cervical Cancer diagnostics and case management will be directly charged to this Cost Center.

**814 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.

**815 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.

**816 SPECIAL PROJECT (MEDICAL)** –Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.

**817 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.

**818 COMMUNITY** – Expenditures for approved community based activities for Pediatrics/Adolescents; Family Planning including CBEI and Special Initiatives; Maternity; Medical Nutrition; Adult Services; Dental; School Health; and the training, planning and management of these activities will be directly charged to this Cost Center.

**821 PREPAREDNESS COORDINATION:** Preparedness Planning and Readiness Assessment - Preparation of the local and regional preparedness plans for bioterrorism, other outbreaks of infectious disease, and response to other public health emergencies.

**822 EPIDEMIOLOGY/SURVEILLANCE:** Surveillance and Epidemiology Capacity - LHDs design, enhance, and develop systems for detection and response to bioterrorism and other outbreaks through the establishment of epidemiological capacity to investigate and mitigate such outbreaks.

**823 MEDICAL RESERVE CORP:** Health Alert Network/Communications and Information Technology - Enable LHDs to establish and maintain a network for exchange of key information, training and the insurance of protection of data to respond to bioterrorism and other public health emergencies.

**824 EXERCISE & TRAINING:** Communicating Health Risks and Health Information Dissemination - Ensure that state and local public health organizations develop capacity

for timely information dissemination on bioterrorism activities and other public health emergencies.

- 825 TRAINING COORDINATION:** Education and Training - Assessment of training needs of key personnel including infectious disease specialists, emergency personnel and other healthcare providers to ensure preparedness for responses to bioterrorism and other public health emergencies.
- 826 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 827 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 828 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 829 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 830 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 831 SPECIAL PROJECT (MEDICAL)** – Cost Center reserved for local special project that does not have a personal health component.
- 832 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 833 BREAST-FEEDING REGIONAL COORDINATORS (WIC)** – All expenditures for specified breastfeeding Regional Coordinators in agencies designated by the WIC State Office will be charged to this Cost Center. The expenditures will be for breastfeeding promotion activities to increase the breastfeeding rate. Expenditures will not be for direct one-on-one services to WIC participants.
- 834 SPECIAL PROJECT (MEDICAL)** – Cost Center reserved for local special project that does not have a personal health component.
- 835 SPECIAL PROJECT (MEDICAL)** – Cost Center reserved for local special project that does not have a personal health component.
- 836 TOBACCO** – All expenditures made for a tobacco education/consultation program (community) that does not have a personal health component.
- 837 SPECIAL PROJECT (MEDICAL)** –Cost Center reserved for local special project that does not have a personal health component.
- 838 SPECIAL PROJECT (MEDICAL)** – Cost Center reserved for local special project that does not have a personal health component.
- 839 SPECIAL PROJECT (MEDICAL)** – Cost Center reserved for local special project that does not have a personal health component.
- 840 SPECIAL PROJECT (MEDICAL)** –Cost Center reserved for local special project that does not have a personal health component.

- 841 DIABETES COALITION** - All expenditures made for Diabetes Today activities as defined by the federal funding source and/or program description.
- 842 HIV COUNSELING AND TESTING SERVICES** – All expenditures made to provide anonymous HIV counseling services and related lab tests will be directly charged to this Cost Center.
- 843 HIV PREVENTION AND PLANNING** – All expenditures made for an HIV Prevention and Planning project as defined by the Division of Epidemiology and Health Planning (EPI).
- 844 STATE CARE COORDINATOR AND CONSORTIA** - All expenditures made for a State Care Coordinator or Consortia project as defined by the funding source and/or program description.
- 845 RYAN WHITE SERVICES** – All expenditures made for a Ryan White Services project as defined by the funding source and/or program description.
- 846 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 847 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 848 HEALTHY START IN CHILD CARE (Childcare Health Consultation)** – All expenditures made for a Healthy Start in Child Care project as defined by the funding source and/or program description.
- 849 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 850 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 851 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 852 SPECIAL PROJECT (MEDICAL)** – All expenditures made for a Resource Persons project as defined by the funding source and/or program description.
- 853 HANDS Funds** – All expenditures related to HANDS home visitation services.
- 854 WIC MONITORS** – All expenditures made for a WIC field staff project as defined by the state WIC office and/or program description.
- 855 SPECIAL PROJECT (MEDICAL)** – All expenditures made for this project as defined by the funding source and/or program description
- 856 ARTHRITIS** – Expenditures for group activities reported in the Patient Services Supplemental Reporting System. Training, assistance; and management of these activities will be directly charged to this Cost Center.
- 857 PHYSICAL ACTIVITY** – Expenditures for group activities reported in the PSRS or Portal system. Training, assistance; and management of these activities will be directly charged to this Cost Center.

- 858 SUPPLEMENTAL SCHOOL HEALTH** – All expenditures made in schools or school associated centers for group activities reported in the Patient Services Supplemental Reporting System and for school activities that are not included in other projects.
- 859 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 860 SPECIAL PROJECT (HOME HEALTH)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 861 HOME HEALTH** – All expenditures made for this project as defined by Medicare and Medicaid.
- 862 SPECIAL PROJECT (HOME HEALTH)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 863 HOME HEALTH SERVICES FOR THE MEDICALLY INDIGENT** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 864 HOME HEALTH HIGH RISK INFANT ASSESSMENT** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description
- 865 HOME HEALTH EPSDT** – All expenditures made for this project as defined by the Department for Medicaid Services.
- 866 SPECIAL PROJECT (HOME HEALTH)** –Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source
- 867 SPECIAL PROJECT (IN-HOME CARE, HOME HEALTH)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description
- 868 HOME AND COMMUNITY WAIVER SERVICES, HOME HEALTH** – All expenditures made for this project as defined by the Medicaid Home and Community Based Service Waiver Program Manual.
- 869 HOSPICE (HOME HEALTH)** – All expenditures made for this project as defined by Medicare and Medicaid regulations.
- 870 SPECIAL PROJECT (OTHER)** – All expenditures made for this project as defined by the funding source and/or program description.
- 871 SPECIAL PROJECT (OTHER)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 872 SPECIAL PROJECT (OTHER)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 873 SPECIAL PROJECT (OTHER)** –. Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 874 SPECIAL PROJECT (OTHER)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.

- 875 SPECIAL PROJECT (OTHER)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
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- 878 SPECIAL PROJECT (OTHER)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 879 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 880 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 881 HOMELESS MITIGATION** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 882 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 883 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 884 SPECIAL PROJECT (MEDICAL)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 885 SPECIAL PROJECT (OTHER)** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 886 SPECIAL PROJECT (OTHER)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 887 IMMUNIZATION GRANT SPECIAL PROJECT** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 888 SPECIAL PROJECT (OTHER)** - Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 889 SPECIAL PROJECT (OTHER)** – Used to charge all allowable direct expenditures made for this Cost Center as defined by the funding source and/or program description.
- 890 CORE PUBLIC HEALTH ASSESSMENT AND POLICY DEVELOPMENT-** All expenditures made for vital records, identification of community risk, analysis of health trends, and other Core Public Health Assessment activities not included in another Cost Center. Also includes community-based assessment and planning, modification of state and federal initiatives, information sharing, disaster plans and evaluation, and other Core Public Health Policy Development activities not included in another Cost Center.
- 891 DPH PREVENTIVE MEDICAID MATCH** – All expenditures made are invoiced by AFM.
- 892 MINOR RESTRICTED** – Used for expenditures (excluding salaries and fringe benefits) made for minor items not chargeable elsewhere.
- 893 EXPENDITURES FOR OTHER HEALTH DEPARTMENTS** – All expenditures made by one LHD for services provided at another LHD.
- 894 CAPITAL** – All capital expenditures that do not have specific restricted funding.

- 895 ALLOCABLE DIRECT** – Used as a suspense fund for close-out receipts, leave pay, fringe benefits, and other authorized items to include Preventive, Environmental, and State Unrestricted.
- 897 SPACE COSTS** – All indirect expenditures made for space occupancy purposes that are allocated on a square footage basis. No revenue should be coded to this cost center.
- 898 DEPARTMENTAL INDIRECT** – All indirect expenditures made that benefit environmental, medical, home health, and other Direct Cost Centers. No revenue should be coded to this cost center.
- 899 CLINIC INDIRECT** – All expenditures made for clinic scheduling, medical records, medical reception, medical service reporting, clinic supervision, and medical billing/accounts receivable activities that benefit the 700, 715, and 718 Cost Centers. May include general clinic training, general continuing education, or attendance at general purpose conferences for providers or support staff. No revenue should be coded to this cost center.
- 900 OTHER MEDICAL INDIRECT** – All indirect expenditures that benefit the direct medical Cost Centers (700 – 859, 878 – 879, 882 – 884, and 890). May include general medical training, general continuing education, or attendance at general purpose conferences for providers or support staff. No revenue should be coded to this cost center.
- 901 ENVIRONMENTAL INDIRECT** – All indirect expenditures that benefit the direct environmental Cost Centers (500 – 595). No revenue should be coded to this cost center.
- 902 OTHER INDIRECT** – All indirect expenditures that benefit the **OTHER** activities’ Cost Centers (870 – 877, 880 – 881, and 885 - 889). No revenue should be coded to this cost center.
- 903 HOME HEALTH INDIRECT** – All expenditures made for the Direct Home Health Cost Centers’ medical records, reception, service-reporting, and billing/accounts receivable activities (860-869). Also includes any other indirect expenditures that benefit the Direct Home Health Cost Centers. No revenue should be coded to this cost center.

**LHD - CHART OF ACCOUNTS – EXPENDITURE CODES**

<b>GENERAL LEDGER ACCOUNT:</b>	<b>MINOR OBJECT CODE:</b>	<b>DESCRIPTION:</b>
<b>571</b>		<b>Full Time Employee Salaries &amp; Leave</b>
	<b>100</b>	Salaries – Full Time& Part-Time (PT) 100
	<b>160</b>	Departmental Leave Pay
	<b>165</b>	Environmental Leave Pay
	<b>168</b>	Clinic Leave Pay
	<b>170</b>	Medical Leave Pay
	<b>175</b>	Other Leave Pay
	<b>178</b>	Home Health On-Call Leave Pay
	<b>179</b>	Home Health Leave Pay
<b>572</b>	<b>100</b>	<b>Personal Service Contract and Part-Time Employees Salaries and Wages</b>
<b>573</b>		<b>Fringe Benefits Expenditures</b>
	<b>180</b>	Combined for Allocation Purposes

	<b>181</b>	FICA
	<b>182</b>	Life Insurance
	<b>183</b>	Hospitalization
	<b>184</b>	HMO (Health Maintenance Organization)
	<b>185</b>	KERS
	<b>186</b>	Unemployment Insurance
	<b>187</b>	Dental
	<b>188</b>	Workers' Compensation
	<b>189</b>	Flexible Benefits
<b>575</b>		<b>Independent Contract Expenditures for Medical and Environmental Services</b>
		<b>Provider Service Type Accounts</b>
		<i>(Use only if Specific Service Type Accounts are not available.)</i>
<b>200 &amp; 201</b>		Physician Services (not included in another account)
	<b>202</b>	Board Certified Obstetrician/Gynecologist Services
	<b>204</b>	Ophthalmologist/Optomtrist
	<b>205</b>	Anesthesiologist Services
	<b>211</b>	Dentist Services
	<b>215</b>	Nurse Practitioner, Nurse Midwife and Physician Assistant Services
	<b>217</b>	Other Nurses Services
	<b>218</b>	Social Worker Services/Health Educator
	<b>219</b>	Nutritionist Services/Registered Dietician
	<b>220</b>	Physical Therapist Services
	<b>221</b>	Speech Therapist Services
	<b>222</b>	Occupational Therapist Services
	<b>225</b>	Other Therapist Services, Developmental Interventionist
	<b>227</b>	Audiologist Services
	<b>229</b>	Laboratory Technician Medical Assistant
	<b>230</b>	Inpatient/Observation Hospital Services
	<b>240</b>	Physical Therapist Assistant
	<b>241</b>	Speech Therapist Assistant
	<b>242</b>	Occupation Therapist Assistant
	<b>245</b>	X-Ray/Other Testing Services
	<b>250</b>	Laboratory Services
	<b>255</b>	Environmental Services
	<b>260</b>	Outpatient Procedures/Other Provider of Health Services
	<b>265</b>	Medical Support - Clerk
	<b>270</b>	District Coordinating Agency, Lead Agency, Program Transfer Services
		<b>Specific Service Type Accounts</b>
		<i>(See Clinic or Radiology/Laboratory/Pathology Service Plan for Services that are charged to each account.)</i>
	<b>303</b>	Physician Delivery and Related Services - <i>(All general practitioners and specialists except Anesthesiologists.)</i>
	<b>304</b>	Mammogram Follow-up - <i>(All professionals and provider agencies.)</i>

	<b>305</b>	Pap-Smear Follow-up – <i>(All professionals and provider agencies.)</i>
	<b>306</b>	Newborn Assessment Services – <i>(All professionals and provider agencies.)</i>
	<b>308</b>	Initial Mammogram Services – <i>(All professionals and provider agencies.)</i>
	<b>309</b>	Ultrasound Services – <i>(All professionals and provider agencies.)</i>
	<b>310</b>	Inpatients Hospital Services
	<b>311</b>	Observation Hospital Services
	<b>312</b>	Sterilization Services – <i>(All professionals and provider agencies.)</i>
	<b>315</b>	Patient Prenatal Classes – <i>(All professionals and provider agencies.)</i>
<b>577</b>		<b>Travel Expenditures</b>
	<b>326</b>	In State
	<b>327</b>	Out of State
	<b>328</b>	Board Members
	<b>329</b>	Advisory Committee
	<b>330</b>	Volunteer Travel
<b>580</b>		<b>Space Occupancy Expenditures</b>
	<b>331</b>	Rent
	<b>332</b>	Utilities
	<b>333</b>	Janitorial Supplies
	<b>334</b>	Property Insurance
	<b>335</b>	Building Maintenance and Repair
	<b>336</b>	Janitorial and Lawn Care Services
<b>581</b>		<b>Office Operating Expenditures</b>
	<b>340</b>	Printing and Duplicating
	<b>341</b>	Telephone
	<b>342</b>	Postage
	<b>343</b>	Office Supplies – Stock Items
	<b>344</b>	Medical Record Supplies
	<b>345</b>	Computer Services
	<b>346</b>	Office Equipment Maintenance and Repair
	<b>347</b>	Office Equipment Rental
	<b>348</b>	Office Equipment/Non-Capital
	<b>349</b>	Office Supplies – Non-Stock Items
<b>582</b>		<b>State Central Support Charges/Taxes</b>
	<b>356</b>	Provider Tax
	<b>357</b>	State Central Support Services
<b>583</b>		<b>Medical Supply Expenditures</b>
	<b>358</b>	Prescription Drugs from Pharmacies/Pharmacist Consulting Services
	<b>359</b>	Consumable Medical Supplies for Multiple Project Use
	<b>360</b>	Oxygen for Resale
	<b>361</b>	Biologicals and Drugs/Clinic Use
	<b>362</b>	Contraceptives
	<b>363</b>	Consumable Medical Supplies for Single Project
	<b>364</b>	Ancillary Medical Supplies for Single Project
	<b>365</b>	Durable Medical Equipment for Resale
	<b>366</b>	Laboratory Supplies

	<b>367</b>	DME/Oxygen for Rental
	<b>368</b>	Medical Equipment Maintenance and Repair
	<b>369</b>	Medical Equipment/Non-Capital
<b>584</b>		<b>Automotive Expenditures</b>
	<b>370</b>	Leasing of Vehicles
	<b>371</b>	Gas and Oil
	<b>372</b>	Automobile Insurance
	<b>373</b>	Automobile Maintenance and Repair
	<b>374</b>	Motor Pool
<b>585</b>		<b>Other Operating Expenditures</b>
	<b>380</b>	Administrative Services from Other Health Departments – <i>(Written Contract Required)</i>
	<b>381</b>	Dues and Subscriptions
	<b>382</b>	Registration Fees
	<b>383</b>	Tuition Assistance
	<b>384</b>	Insurance
	<b>385</b>	Educational Supplies
	<b>387</b>	Laundry
	<b>388</b>	Legal
	<b>389</b>	Other
	<b>390</b>	Advertising and/or Recruitment
	<b>391</b>	Audits – <i>(Written Contract Required)</i>
	<b>392</b>	Home Modifications
	<b>393</b>	Program Supplies
	<b>394</b>	Staffing Agency Services
<b>601</b>		<b>Capital Expenditures</b>
	<b>670</b>	Furniture and Equipment – <i>(Except Data Processing and Vehicles)</i>
	<b>671</b>	Data Processing Equipment
	<b>672</b>	Land and Buildings
	<b>673</b>	Purchase of Vehicles
<b>680</b>		<b>Indirect Expenditures</b>
	<b>955</b>	Home Health Indirect
	<b>956</b>	Other Indirect
	<b>957</b>	Departmental Indirect
	<b>958</b>	Environmental Indirect
	<b>959</b>	Clinic Indirect
	<b>960</b>	Other Medical Indirect
<b>973</b>	<b>000</b>	Preventive Medical Allocation
<b>974</b>	<b>000</b>	Preventive Counseling Allocation
<b>975</b>	<b>000</b>	Problem Medical Allocation
<b>976</b>	<b>000</b>	Problem Counseling Allocation
<b>977</b>	<b>000</b>	Breastfeeding Counseling Allocation
<b>979</b>	<b>000</b>	Rad/Lab/Path Allocation

## NARRATIVE DESCRIPTION OF SELECTED GENERAL LEDGER/MINOR OBJECT CODES

### 573 Fringe Benefits

Included in fringe benefits expenditures are: employers' share of F.I.C.A., employer's retirement, employer's health insurance, employer's life insurance, Worker's

Compensation, Unemployment Insurance, and any other employer paid fringe benefit allowed or required by the policies of DPH.

## **575 Independent Contract Expenditures for Medical and Environmental Services**

These accounts are separated into two groupings:

- **Provider Service Accounts:** Expenditures are recorded in the same categories as the Contract Provider Class ID Number categories in the LHD Network System (e.g., Patient Services Reporting System, CMS Portal System).
- **Specific Service Accounts:** Used when more detailed financial information is needed than can be provided by the Provider Service Account categories.

Services are always reported using only the Provider Class Categories while expenditures may be recorded using either or both of the contract groupings. Due to the detailed requirements of the service costing system extreme care should be taken to ensure that expenditures for independent contractors are recorded in the correct account.

### **Definitions for selected minor object codes used for Independent Contracts:**

**205 Anesthesiologist Services** – Includes payments to anesthesiologists and nurse anesthetists.

**270 District Coordinating Agency, Lead Agency, and Program Transfer Services** – Used to record payments for Family Planning District Coordinating Agency contract services and Lead Agency Contract Services between LHDs and other payments between LHDs if the department receiving the payment reports the services in the System.

**303 Physician Delivery and Related Services** – Used to record payments for contracted physician services made for delivery and related services. Includes payments to nurse midwives. Used only in the 803 Cost Center.

**304 Mammogram Follow-up Services** – Used to record payment made for services related to Mammogram Follow-Up as defined in the [Clinical Service Guide](#) (CSG).

**305 Pap-Smear Follow-Up Services** – Used to record payment for services related to Pap-Smear Follow-Up as defined in the CSG. Does not include office visits.

**306 Newborn Assessment Services** – Record payment for these services as defined in the Patient Services Manual.

**308 Initial Mammogram** – Used to record payment made to providers for initial mammogram services as defined in the Patient Services Manual.

**309 Ultrasounds** – Used to record payments to contracted providers for the performance of the ultrasound procedure and payments to contracted physicians to interpret the results.

**310 Inpatient Hospital Services** – Used to record all payments made to a hospital as the result of an inpatient stay by a LHD patient. This includes x-ray, lab, other tests, drugs, supplies, and daily room charges. When an ancillary service is provided by a hospital to a LHD patient on an outpatient basis, these expenditures shall not be charged to 310 Inpatient Hospital Services, but shall be charged to the appropriate contract expenditure account, such as 250 laboratory services or 245 X-ray/other testing services.

**311 Observation/Outpatient Hospital Services** – Record payments made to a hospital as a result of observations or other Outpatient Service. Does **not** include physician services. Includes X-ray, lab, other tests, drugs, supplies, and observation/outpatient charges.

**312 Sterilization Services** – Used to record payments made to all providers for male or female sterilization services.

## **580 Space Occupancy Expenditures**

**335 Building Maintenance and Repair** – Does not include capital improvements to the building. For assistance determining if an expense is a capital improvement or maintenance and repair, contact the AFM.

## **581 Office Operating Expenditures**

**340 Printing and Duplicating** - Used to record all expenditures for in-house or outside printing and duplicating. This includes leases and maintenance agreements for copy machines and duplicating supplies including copy paper.

**343 Office Supplies – Stock Items** - Items not directly identifiable to a specific program area should be charged to an indirect Cost Center.

**345 Computer Services** - Includes payments to service bureaus, communications charges, lease payments, maintenance on CRTs, printers, etc., and supplies such as diskettes, printer supplies, and paper.

**349 Office Supplies – Non-Stock Items** –Items that can be directly associated or identified to a specific program area should be charged to a Direct Cost Center.

## **583 Medical Supply Expenditures**

**358 Prescription Drugs from Pharmacies / Pharmacist Consulting Services** – Should not be charged to the 700 Cost Center.

**359 Consumable Medical Supplies for Multiple Project Use** - Should be charged to an Indirect Cost Center.

**363 Consumable Medical Supplies for Single Project** - Should be charged to a Direct Cost Center.

**366 Laboratory Supplies** - Used to charge all items associated with the performance of in-house laboratory tests. Services provided by outside laboratories are charged to the laboratory services contract account (250). Used primarily in the 718 cost center.

## **LHD - CHART OF ACCOUNTS – FUNCTION CODES**

**110 Clinic, Dental, or Rad/Lab/Path Services** – Used to charge all allowable expenditures made in providing evaluation and management visits, anesthesia, surgery, radiology, laboratory, and medicine services for the prevention, diagnosis, treatment, and rehabilitation of illness or injury. Excluded from this function is time spent by RNs or LPNs assisting a physician, physician’s assistant, nurse practitioner, or other mid-level provider (see function code 115).

**115 Higher Provider Assistance (Clinic or Rad/Lab/Path)** – Used to charge all time spent by RNs or LPNs assisting a physician, physician’s assistant, nurse practitioner, or other mid-level provider in providing clinic, dental, or Rad/Lab/Path Services.

- 117 Clinic or Rad/Lab/Path Abnormal Follow-up Coordination** – Used to charge all allowable expenditures made in providing the coordination of follow-up services for patients who have abnormal results from tests or procedures. Does not include follow-up for services that will be provided at the health department clinic.
- 118 Travel Time** – Used to charge all allowable expenditures related to travel expense incurred by clinic staff and environmental staff in traveling from their home base clinic/county to another clinic/county to support like functions. For clinic staff, this function should only be utilized when time related to the travel purpose will be coded to either function codes 110, 115, or 117. For environmental staff, this function should only be used when traveling to another county to provide a direct environmental function. This function is not to be utilized for travel for any other purpose such as training, HANDS visits, etc.
- 120 Supplemental Services** – Used to charge all allowable expenditures made in providing services reported in the LHD Supplemental Services Reporting system. The following are excluded from this function code: expenditures in the HANDS program (see [function codes 135-137](#)), expenditures for breastfeeding nutrition education (see [function code 139](#)), and expenditures for other nutrition education (see function code 138).
- 125 Community Services** – Used to charge all allowable expenditures made in the preparation for or the provision of services reported in the LHD Community Services Reporting system. The following are excluded from this function code: expenditures for breastfeeding nutrition education (see [function code 139](#)) and expenditures for other nutrition education (see [function code 138](#)).
- 129 Program General** – Used to charge all allowable expenditures made in a program and not included in a more specific function code. Cost centers which will always use this function code are 830 Community Cancer Coalitions, 836 Tobacco Cessation, 848 Healthy Start, and 900 Other Medical Indirect.
- 130 Patient Transportation** – Used to charge all allowable expenditures made in providing transportation for patients of the clinic.
- 134 HANDS Supervision** – Used to charge allowable expenditures for reflective supervision as described in the HANDS program guidance.
- 135 HANDS Family Assessment/Professional Service** – Used to charge all allowable expenditures made in providing assessments and professional visits in the HANDS program.
- 136 HANDS Paraprofessional Service** – Used to charge all allowable expenditures made in providing paraprofessional visits in the HANDS program.
- 137 HANDS General** – Used to charge all allowable expenditures made in the HANDS program and not included in a more specific function code.
- 138 Other Nutrition Education** – Used to charge all allowable expenditures made in providing nutrition education services (other than breast-feeding) that are reported in the LHD Supplemental Services Reporting system or made in the preparation for or the provision of nutrition education services (other than breastfeeding) reported in the LHD Community Services Reporting system.
- 139 Breast-feeding Nutrition Education** – Used to charge all allowable expenditures made in providing breastfeeding nutrition education services that are reported in the LHD Supplemental Services Reporting system or made in the preparation for or the provision of

breastfeeding nutrition education services reported in the LHD Community Services Reporting system.

- 110 Home Health Skilled Nursing Visits** – Used to charge all allowable expenditures made in providing skilled nursing visits in the patient’s home.
- 140 Home Health Physical Therapy Visits** – Used to charge all allowable expenditures made in providing physical therapy visits in the patient’s home.
- 141 Home Health Speech Therapy Visits** – Used to charge all allowable expenditures made in providing speech therapy visits in the patient’s home.
- 142 Home Health Occupational Therapy Visits** – Used to charge all allowable expenditures made in providing occupational therapy visits in the patient’s home.
- 143 Home Health Aide Visits** – Used to charge all allowable expenditures made in providing home health aide visits in the patient’s home. Includes the nursing participation required by federal or state regulations.
- 144 Waiver Respite Care** – Used to charge all allowable expenditures made in providing Waiver Respite Care in the patient’s home.
- 145 Home Health Supplies** – Used to charge all allowable expenditures made in providing home health supplies to home health patients.
- 146 Home Health General** – Used to charge all allowable expenditures made in the Home Health Cost Center that are not included in a more specific function.
- 147 Secondary Third-Party Payer** – Used to charge all expenditures made to independent contractors for patient services when the LHD does not have primary responsibility for payment. If the patient’s private third-party payer is responsible for any part of the payment for the services, then any remaining amount properly owed by the department is to be charged to this function. No entry of the services is to be made in the Patient Services Reporting System. If the patient’s private third-party payer is not responsible for any part of the payment for the services, then the services are reported in the system and this function is not used.
- 148 Waiver Attendant Care** – Used to charge all allowable expenditures made in providing Waiver Attendant Care in the patient’s home.
- 149 Home Health Social Work Visits** – Used to charge all allowable expenditures made in providing social work visits in the patient’s home.
- 150 Environmental Activities** – Used to charge all allowable expenditures made to provide service types 7, 8, and 10 as reported in the Environmental Health Management Information System (EHMIS).
- 153 Environmental Services** – Used to charge all allowable expenditures made to provide service types 1-6, 9, and 11 as reported in the Environmental Health Management Information System (EHMIS).
- 152 Investigation, Data Entry, Surveillance** – Used to charge all allowable expenditures made to provide investigation, data entry, and/or surveillance of reportable disease, food borne illness, etc. Used in cost centers 800 and 810.

- 154 Waiver Assessment and Reassessment** – Used to charge all allowable expenditures made in providing Waiver Assessment and Reassessment.
- 155 Waiver Case Management** – Used to charge all allowable expenditures made in providing Waived Case Management services.
- 156 Waiver Homemaker** – Used to charge all allowable expenditures made in providing Waiver Homemaker services in the patient’s home.
- 157 Waiver Personal Care** – Used to charge all allowable expenditures made in providing Waiver Personal Care in the patient’s home.
- 158 Waiver General** – Used to charge all allowable expenditures made in the Waiver Cost Center that are not included in any more specific function.
- 160 Departmental Administration/Facility** – Used in 898 Departmental Indirect to charge all allowable expenditures made to provide the administration activities of the health department. Also used in 897 Space Indirect to charge all allowable expenditures made for the use and maintenance of the physical plant of the health department including housekeeping and maintenance, security, utilities, and rental.
- 165 Environmental General** – Used in Environmental Cost Centers to charge all allowable expenditures not included in a more specific function.
- 170 Assessment** – Used to charge all allowable expenditures made in providing the assessment activities of the health department that are not included in a more specific function. Assessment is the collection, analysis, and dissemination of information on the health and health related factors of the area served by the department.
- 173 Policy Development** – Used to charge all allowable expenditures made in providing the policy development activities of the health department that are not included in a more specific function. Policy development is the use of scientific knowledge of disease and health risks to develop comprehensive plans for the improvement of health in the area served by the department.
- 175 Assurance** – Used to charge all allowable expenditures made in providing the assurance activities of the health department that are not included in a more specific function. Assurance is the carrying out of activities to meet goals and plans developed in the policy development function.
- 180 Employee Training** – Used to charge all allowable expenditures made in providing training to the employees and other staff of the department. Excludes expenditures made for on the job training to bring new employees up to the minimum expected level of job performance.
- 181 Bioterrorism Training Coordinator** – Used to charge allowable expenditures made in coordinator training to the employees and other staff of the department.
- 185 Leave Pay/Fringe Benefits** – Used to charge all allowable expenditures made for any type of employee leave pay and employee fringe benefits.
- 200 Safe to Sleep for Child Care Providers** – Used to charge allowable expenditures for time, activities, or supplies needed for education of child care providers, or child care partners about safe sleep practice to reduce infant mortality, assist with locating professional staff, as recommended by the AAP or development of child care

policies/protocols related to safe sleep practices in an effort to reduce infant mortality. Used in Cost Center 766.

**201 Child Fatality Review Teams & Injury Prevention**– Used to charge allowable expenditures for time, activities, or supplies needed for education or collaboration with community partners, or for community education and outreach related to safe sleep practices in an effort to reduce infant mortality. Used in Cost Center 766.

**202 Prevention of Abusive Head Trauma (AHT)** – Used to charge allowable expenditures for time, activities, or supplies needed to educate families, increase community partners and health care providers and educate on ways to prevent AHT to prevent near fatalities or fatalities of infants and children due to abuse head trauma. Used in Cost Center 766.

**203 Cribs for Kids for Community Partners** – Used to charge allowable expenditures for time, activities, educational supplies, or Cribs for Kids kits, used for identified families who are unable to provide a safe sleep environment for infant(s) in an effort to reduce bed sharing that may result in infant mortality. NOTE: A 50/50 cost match to the purchase of crib kits requires a match of funds from a community partner and there must be a signed agreement. Reported monthly for MCH 123 Perinatal/Infant Mortality by the MCH Coordinator. Used in Cost Center 766.

**204 Prenatal Referrals** – Used to charge allowable expenditures for time, activities, or supplies spent for interactions with the LHDs pregnant population providing education of local resources, referral to resources such as payor source for prenatal care, prenatal provider, smoking cessation, substance use treatment programs, 17-OHP, etc. LHD follows up with woman listed on E-Report 439 to assure attended first prenatal visit. Expenditures include time spent on follow-up activities to ensure ongoing engagement of programs to promote a healthy pregnancy and delivery. Used in Cost Center 766.

**205 Healthy Babies are Worth the Wait** – Used to charge allowable expenditures for time, activities, or supplies spent with community partners, birthing hospitals and pregnant women promoting reduction of early elective, preventable preterm deliveries, and/or developing hard stop policies. Used in Cost Center 766.

**206 No Assigned Package**

**207 Nurturing the Thriving Mind (NTM)** – Used to charge allowable expenditures for time, activities, or supplies needed to promote mental health awareness & education in schools, and support safer learning environments for students, teachers and staff. in all Kentucky schools. Used in Cost Center 766.

**208 Whole School, Whole Child, Whole Community (WSCC)** – Used to charge allowable expenditures for time, activities, or supplies needed for collaboration with Kentucky schools to “assist with meeting the need for greater emphasis on both the psychosocial and physical environment as well as the increasing roles that community agencies and families play in improving childhood health behaviors and development” [Whole School, Whole Community, Whole Child \(WSCC\) | Healthy Schools | CDC](#) Partners will be involved with existing school health councils’ committees to improve both district and school wellness policies to better support opportunities for physical activity; to increase access to healthy foods; and, to create tobacco free campuses. Used in Cost Center 766.

- 209 Fluoride Varnish for Children thru Fifth Grade** – Used to charge allowable expenditures for time, activities, or supplies needed for support activities evaluating and providing fluoride varnish applications to children through the fifth grade. Note: Varnish activity should be coded to 712 KIDS Smile Dental Services and coordinated activities. Use PED-122 in cost center 766.
- 210 Healthy People, Active Communities** – Used to charge allowable expenditures for time, activities, or supplies needed to increase collaboration with community partners and residents by promoting healthy eating, physical activity, and finding ways to remove barriers to meeting the 5-2-1-0 healthy behaviors collaborative action plan. Used in Cost Center 766.
- 211 State MCH Designated Special Programs** – Used to charge allowable expenditures for time, activities, or supplies needed to promote pilot projects as agreed upon with state MCH leadership. This code may only be used as directed to those LHDs participating in the defined pilot program. Used in Cost Center 766.
- 212 Domain 1: Incident Management for Early Crisis Response** - Used to charge all allowable expenditures made in a program and not included in a more specific function code.
- 213 Domain 2: Jurisdictional Recovery** - Used to charge all allowable expenditures made in a program and not included in a more specific function code.
- 214 Domain 3: Information Sharing** - Used to charge all allowable expenditures made in a program and not included in a more specific function code.
- 215 Domain 4: Countermeasures and Mitigation** - Used to charge all allowable expenditures made in a program and not included in a more specific function code.
- 216 Domain 5: Surge Management** - Used to charge all allowable expenditures made in a program and not included in a more specific function code.
- 217 Domain 6: Biosurveillance** - Used to charge all allowable expenditures made in a program and not included in a more specific function code.

## **LHD - CHART OF ACCOUNTS - RECEIPTS**

### **STATE**

- 422 STATE RESTRICTED** – Receipts from state appropriations made by the General Assembly that must only be used for a designated project.
- 423 STATE RESTRICTED CARRY OVER** – Receipts from a LHD’s Restricted Fund Balance - State used for current year purposes.
- 425 FOUNDATIONAL FUNDING** – These funds will be allocated and paid to **895 425**. Funds may be used for purposes specifically prescribed by DPH. Any funding not used in a fiscal year will remain in cost center 895, and restricted to 172 895 on the balance sheet
- 426 RETIREMENT** – Receipts from state appropriation made by the General Assembly that must only be used for Retirement.

**427 STATE BLOCK GRANT** – One time supplemental funds that can be used to support Public Health Transformation costs in Foundational and Core areas and LHD Infrastructure projects

**428 PUBLIC HEALTH TRANSFORMATION FUNDING** – General Fund receipts from appropriations made by the General Assembly to LHDs to support the costs of workforce and operations.. Shall only be used in Foundational and Core cost centers prescribed by DPH.

### **FEDERAL**

**431 TITLE V MCH BLOCK GRANT** – Federal receipts received under Title V that must be used only to operate a project under federal guidelines.

**432 TITLE X FAMILY PLANNING** – Federal receipts received under Title X that must be used only to operate a family planning project under federal guidelines.

**433 CORONAVIRUS PREPAREDNESS & RESPONSE (CPRSA)** – Funding is for Coronavirus Preparedness and Response Supplemental Appropriations Act.

**434 PAYROLL PROTECTION ACT (PPA)** - Federal receipts received under this grant that must be used only for a designated project.

**435 PREVENTIVE SERVICES BLOCK GRANT** – Federal receipts received under this grant that must be used only for a designated project.

**436 CORONAVIRUS RESPONSE AND RELIEF (CRR)** - Federal receipts received under this grant that must be used only for a designated project.

**437 CARES ACT** - Federal receipts received under this grant that must be used only for a designated project. **NOTE: Funding THAT is part of the Coronavirus Aid, Relief, and Economics Security Act and received directly by the LHD from HRSA, during a fiscal year closeout, funds recorded to this account can be moved to cover deficits in any clinic cost centers and/or Home Health (861).**

**438 FEDERAL GRANT - DPH** – Federal receipts, listed in this section, received from DPH to operate a designated project. Funds are available for use on total project operation and expenditures. Payments on a per-service basis that result from individual patient billings and include individual patient accounts receivables (service fees) must **not** be included in this account.

**439 FEDERAL GRANTS - DIRECT** – Federal receipts, except the ones specifically listed, received to operate a specific project and received directly by the LHD from the Federal Government. Funds are available for use on total project operation and cost. Payments on a per service basis that result from individual patient billings and include individual patient accounts receivables (service fees) must **not** be included in this account.

**440 FEDERAL RESTRICTED CARRY OVER** – Receipts from a LHD’s Restricted Fund Balance - Federal used for current year purposes.

**441 AMERICAN RESCUE PLAN (ARPA)** - Federal receipts received under this grant that must be used only for a designated project.

### **LOCAL**

**451 TAX APPROPRIATIONS** – Receipts that come from a Public Health Taxing District to support the health department.

- 452 COUNTY APPROPRIATIONS** – Receipts that come from the general funds of a county government to support the health department.
- 453 CITY APPROPRIATIONS** – Receipts that come from the general fund of a city government to support the health department.
- 456 DONATIONS** – Receipts received from any private source that is of an altruistic nature and has no relationship to any services provided to the donor.

**SERVICE FEES**

- 459 SCHOOL BOARD CONTRACTS** – Receipts from local school boards for public health services related to schools.
- 460 PROGRAM ADMINISTRATION CONTRACTS** – Money received as payment for services rendered under the terms of a program administration contract.
- 461 FEDERAL** – Federal money from sources other than those listed below that is received on a fee-for-services basis. Final payment may be contingent upon the costs of the services. Federal bills paid by Federal money. (CHAMPUS [VA])
- 462 TITLE XVIII** – Federal money received as payment for services rendered to Medicare eligible patients.
- 463 TITLE XIX** – Federal money received by a LHD for services rendered to Medicaid eligible patients. Includes cost report settlement payments.

- 000 EPSDT
- 001 Preventive Medicaid
- 002 Passport – Clinic/Primary Care
- 003 Home Health
- 036 Home Health Prior-Year Cost Settlement
- 004 Passport – Home Health
- 046 Passport Home Health Prior-year Cost Settlement
- 006 HANDS Prior-Year Cost Settlement
- 007 HANDS
- 101 Molina - Preventive
- 201 United – Preventive
- 501 Anthem – Preventive
- 601 Aetna/Coventry – Preventive
- 701 KY Spirit – Preventive
- 801 Well Care – Preventive
- 901 Humana – Preventive
- 103 Molina – Home Health

203 United - Home Health  
503 Anthem – Home Health  
603 Aetna/Coventry – Home Health  
703 KY Spirit – Home Health  
803 Well Care – Home Health  
903 Humana – Home Health  
106 Molina - Prior-Year Cost Settlement  
206 United - Prior-Year Cost Settlement  
506 Anthem – Prior Year Cost Settlement  
606 Aetna/Coventry – Prior Year Cost Settlement  
706 KY Spirit – Prior Year Cost Settlement  
806 Well Care – Prior Year Cost Settlement

- 464 PROGRAM INCOME CARRY OVER** – Receipts from a LHD’s Restricted Fund Balance - Service Fees used for current year purposes.
- 465 SELF-PAY COINSURANCE AND DEDUCTIBLES** – Payments received from individuals for Coinsurance and Deductibles related to Medicare covered services.
- 466 SELF-PAY - OTHER** – Money received from individuals or companies/corporations (non-insurance) as payment for services rendered.
- 467 INSURANCE** – Money received from private insurers as payment for services rendered to individual patients. Actual payment may be made by the patient if assignment of insurance benefits was not obtained.
- 468 OTHER HEALTH DEPARTMENTS** – Any money received by one LHD from another LHD for services rendered.
- 469 OTHER** – Any other money not classified above received as a fee for service or received from the sale of surplus assets.
- 480 INTEREST RECEIVED** – Interest received by a LHD from money invested in federally insured institutions or other authorized investments.
- 490 DEPARTMENT CARRY-OVER** – Receipts from the LHD’s undesignated fund balance used for current year purposes.

**LHD - IDENTIFICATION CODES**

<b>LOCAL HEALTH DEPARTMENT:</b>	<b>HID:</b>
<b>Allen County</b>	<b>102</b>
<b>Anderson County</b>	<b>103</b>
<b>Bell County</b>	<b>107</b>
<b>Bourbon County</b>	<b>109</b>
<b>Boyd County (Ashland-Boyd)</b>	<b>110</b>
<b>Boyle County</b>	<b>111</b>
<b>Bracken County</b>	<b>112</b>
<b>Breathitt County</b>	<b>113</b>
<b>Breckinridge County</b>	<b>114</b>
<b>Bullitt County</b>	<b>115</b>
<b>Calloway County</b>	<b>118</b>
<b>Carter County</b>	<b>122</b>
<b>Christian County</b>	<b>124</b>
<b>Clark County</b>	<b>125</b>
<b>Estill County</b>	<b>133</b>
<b>Fayette County (Lexington-Fayette)</b>	<b>134</b>
<b>Fleming County</b>	<b>135</b>
<b>Floyd County</b>	<b>136</b>
<b>Franklin County</b>	<b>137</b>
<b>Garrard County</b>	<b>140</b>
<b>Graves County</b>	<b>142</b>
<b>Grayson County</b>	<b>143</b>
<b>Greenup County</b>	<b>145</b>
<b>Harlan County</b>	<b>148</b>
<b>Hopkins County</b>	<b>154</b>
<b>Jefferson County (Louisville Metro)</b>	<b>156</b>

<b>LOCAL HEALTH DEPARTMENT:</b>	<b>HID:</b>
<b>Jessamine County</b>	<b>157</b>
<b>Johnson County</b>	<b>158</b>
<b>Knox County</b>	<b>161</b>
<b>Laurel County</b>	<b>163</b>
<b>Lawrence County</b>	<b>164</b>
<b>Lewis County</b>	<b>168</b>
<b>Lincoln County</b>	<b>169</b>
<b>Madison County</b>	<b>176</b>
<b>Magoffin County</b>	<b>177</b>
<b>Marshall County</b>	<b>179</b>
<b>Martin County</b>	<b>180</b>
<b>Mercer County</b>	<b>184</b>
<b>Monroe County</b>	<b>186</b>
<b>Montgomery County</b>	<b>187</b>
<b>Muhlenberg County</b>	<b>189</b>
<b>Oldham County</b>	<b>193</b>
<b>Pike County</b>	<b>198</b>
<b>Powell County</b>	<b>199</b>
<b>Todd County</b>	<b>210</b>
<b>Whitley County</b>	<b>218</b>
<b>Woodford County</b>	<b>220</b>
<b>Lincoln Trail District</b>	<b>302</b>
<b>Barren River District</b>	<b>303</b>
<b>Purchase District</b>	<b>304</b>
<b>North Central District</b>	<b>305</b>
<b>Lake Cumberland District</b>	<b>309</b>
<b>Northern Kentucky District</b>	<b>310</b>
<b>Kentucky River District</b>	<b>312</b>

<b>LOCAL HEALTH DEPARTMENT:</b>	<b>HID:</b>
<b>Cumberland Valley District</b>	<b>313</b>
<b>Green River District</b>	<b>314</b>
<b>WEDCO District</b>	<b>315</b>
<b>Gateway District</b>	<b>316</b>
<b>Three Rivers District</b>	<b>317</b>
<b>Pennyrile District</b>	<b>318</b>
<b>Buffalo Trace District</b>	<b>321</b>

**LHD COMPLIANCE REVIEWS PURPOSE:**

The purpose of the LHD compliance reviews is to carry out DPH clinic medical coding, documentation, and fiscal oversight and monitoring duties and responsibilities imposed by:

- Federal and State Regulations;
- DPH/DMS Preventive Health Services Provider Agreement requirements;
- Joint DPH and Women, Infants & Children (WIC) plan requirements

Therefore, DPH shall have and maintain a strong LHD compliance review program. DPH will conduct Compliance Reviews at regular intervals (e.g., every two years) for each health department. LHDs will comply with DPH staff scheduling requests in order to conduct these compliance reviews. This compliance review program is managed by AFM.

As part of the LHD compliance review program, AFM will provide guidance to LHDs concerning clinic medical coding and documentation; and fiscal issues.

**CLINIC MEDICAL CODING COMPLIANCE REVIEW PROCEDURE:**

The LHO Branch of AFM will perform clinic medical coding and documentation compliance reviews. Clinic medical coding/documentation compliance review procedures and timeframes will be determined by the LHO Branch following the duties and responsibilities outlined in the LHD Compliance Review Purpose heading above. During the medical clinic coding/documentation compliance review, LHO staff will review **original** printed and/or electronic source documentation to determine the accuracy and compliance of:

- Level of evaluation and management (E & M) visits reported and documented
- [Local Health Network System\(s\)](#) Patient Encounter Entries (reported and documented), Patient Encounter Form (PEF) documentation, and any other reporting and documentation from a DPH approved patient encounter entry/reporting system.
- Clinic service authorization and verification that service was provided

## **CLINIC MEDICAL CODING COMPLIANCE REVIEW NOTIFICATION:**

The LHD Director and, if known, other appropriate LHD staff will be contacted by an LHO Branch Coding Specialist and provided a date for the clinic medical coding/documentation compliance review. Flexibility with scheduling conflicts will be considered, within reason, when determining a date for the required compliance review. Requests for dates may be up to sixty (60) calendar days in advance. Also, clinic medical coding compliance reviews may be conducted without an onsite visit. When a compliance review is not conducted onsite, a telephone and/or Go to Meeting/Webinar exit review conference should be held when administratively feasible within five (5) business days following completion of the clinic medical coding/documentation compliance review. When onsite, LHO staff will provide an exit review conference at the conclusion of a compliance review and notify the LHD Director and/or other appropriate LHD staff when ready.

When an onsite visit is determined as needed, each LHD Director and, when known, other appropriate LHD staff will be notified of the information required to perform the clinic medical coding/documentation onsite compliance review up to three (3) business days prior to the onsite visit.

AFM's Division Office may be included in email communication concerning the need to reschedule onsite medical coding compliance review visits.

## **CONDUCTING THE CLINIC MEDICAL CODING COMPLIANCE REVIEW CONFERENCE:**

When an onsite visit is determined as needed, a date and approximate time of arrive will be provided. LHO staff will also notify the LHD Director of the information needed to conduct the compliance review. It is expected that the LHD Director will ensure all requested information is onsite, available, organized and ready for review prior to the arrival of LHO staff.

At the completion of the medical coding/documentation compliance review, an exit conference with the LHD Director and/or designee will be conducted and *preliminary findings* will be discussed by the lead reviewer. Any follow-up communication will be with the lead reviewer. **It will be the responsibility of the LHD Director to ensure appropriate LHD staff is present during the exit review conference.** LHO will submit the final compliance review findings to the LHD Director following the procedures outlined below.

## **CLINIC MEDICAL CODING COMPLIANCE REVIEW WRITTEN REPORT:**

The LHO Branch will provide an electronic report to the LHD Director within 30 business days of the completion of the Clinic Medical Coding/Documentation Compliance Review. *Adhering to regulatory and Administrative Reference (AR) requirements outlined within the [Board of Health \(BOH\) and Agency Functions section](#)*, the **LHD Director will provide the electronic report and findings spreadsheet to their BOH Chair within three (3) business days of receipt and will discuss the compliance review report and findings, as well as any Corrective Action Plan (CAP), at the next scheduled BOH meeting.** If a CAP is required, the LHD Director must submit the CAP to the LHO Branch within 30 days of the date shown on the electronic report. If there are any significant problems noted during the clinic medical coding and documentation compliance review, a Go to Webinar or if determined necessary an onsite training may be requested.

LHO may follow-up with the LHD on significant issues as addressed in the compliance review findings report and/or conduct focused coding compliance reviews at any time to ensure the LHD's CAP and DPH coding and documentation guidelines are being followed.

### **FISCAL COMPLIANCE DESK REVIEW PROCEDURE:**

The Budget Branch, Local Health Budget (LHB) Section, of AFM will perform a fiscal compliance desk review of all LHDs by following the oversight and monitoring duties and responsibilities outlined in the LHD Compliance Review Purpose heading above. During the fiscal compliance desk review, LHB staff will review source documentation to determine the accuracy and compliance of:

- Cash reconciliation procedures and daily cash balance tracking procedures
- Time and travel reporting of employees to determine compliance with the indirect cost allocation policies and procedures required by the DPH Administrative Reference for LHDs
- Indirect cost allocation procedures required in instances of charges to both direct and indirect cost centers for the same items of expense

[902 KAR 8:170](#) requires LHDs to follow policies and procedures contained in [OMB 2CFR Part 200 Subpart E](#).

### **FISCAL COMPLIANCE DESK REVIEW NOTIFICATION:**

Each LHD Director and, when known, other appropriate LHD staff will be notified of the date their desk review is requested.

Each LHD Director and, when known, other appropriate LHD staff will be notified of the information required to perform the fiscal compliance desk review up to five (5) business days prior to submission deadline. It is expected that the LHD will have all requested fiscal information delivered to the appropriate LHB Section staff by fax, email or US Postal Service by the designated deadline.

AFM's Division Office may be included in email communication concerning rescheduling of desk reviews.

### **CONDUCTING THE FISCAL COMPLIANCE DESK REVIEW EXIT CONFERENCE:**

An exit conference with the LHD Director and/or designee will be conducted by the AFM review team via phone or a Microsoft Teams Meeting/webinar conference. Preliminary findings will be discussed and submitted to management as appropriate.

### **FISCAL COMPLIANCE DESK REVIEW WRITTEN REPORTS:**

A written report will be sent to the LHD Director within 30 business days of the completion of the fiscal compliance desk review. If a corrective action plan (CAP) is required, the LHD Director must submit the CAP within 30 calendar days of the date shown on the written report using the template provided by DPH. *Adhering to regulatory and Administrative Reference (AR) requirements outlined within the [Board of Health \(BOH\) and Agency Functions section](#), **the LHD Director will provide the written report to their BOH Chair, within three (3) business days of receipt, and will discuss the report and findings at the next scheduled BOH meeting.***

If there are any significant problems noted during the fiscal desk review, an onsite review may be conducted. AFM may follow-up on significant issues at any time.

# Incident Reports

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## **Function/Purpose**

An incident report is not part of the patient's chart, but it may be used later in litigation. A report has two functions:

1. It informs the administration of the incident so management can prevent similar incidents in the future.
2. It alerts administration and the facility's insurance company to a potential claim and the need for investigation.

Regulations issued under OSHA require all employers with more than ten employees at any time during the previous calendar year to maintain records of recordable occupational injuries and illnesses.

Review the DPH Administrative Reference (AR) sections on [OSHA Bloodborne Pathogens Exposure Control Plan](#); and [Local Health Personnel section on OSHA Compliance](#) as well as the US Department of Labor, [OSHA Guidelines Section 1910.1030 Bloodborne Pathogens Occupational Control Plan](#) for additional information.

## **When to Report**

Incidents that must be reported and documented include:

1. Exposure Incidents: skin, eye, mucous membrane or parental contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.
2. Accident, Injury: patient, visitor, employee slips or falls, or other incident, which results or may result in injury.
3. Event, Behaviors, or Actions: incidents that are unusual, contrary to agency policy or procedure or which may result in injury.
4. [Vaccine Adverse Event Reporting System](#): reaction to vaccine administered at agency (use VAERS form, instructions and sample in Immunization section).
5. Medication reaction: reaction to any drug administered at or provided by health department. Complete [Adverse Drug Reaction Form](#). For more information, call **1-800-332-1088**.
6. Property damage or missing articles.
7. Administration of wrong medication or vaccine.
8. Improper administration of medication or vaccine.

## **OSHA Recordkeeping Requirements:**

[OSHA 300](#) Log-recordable and non-recordable injuries are distinguished by the treatment provided; i.e., if the injury required medical treatment, it is recordable; if only first aid was required, it is not required, it is not recordable. However, medical treatment is only one of several criteria for determining recordability. Regardless of treatment, if the injury involved loss of consciousness, restriction of work or motion, transfer to another job or termination of employment, the injury is recordable. An explanation, with examples, is included on the backside of the [OSHA 300 Form](#). Review the [OSHA Guidelines, Section 1904.7](#) General Recording Criteria.

(a) You must consider an injury or illness to meet the general recording criteria, and therefore to be recordable, if it results in any of the following: death, days away from

work, restricted work or transfer to another job, medical treatment beyond first aid, or loss of consciousness. You must also consider a case to meet the general recording criteria if it involves a significant injury or illness diagnosed by a physician or other licensed health care professional, even if it does not result in death, days away from work, restricted work or job transfer, medical treatment beyond first aid, or loss of consciousness.

### **Who Should Report**

Only people who witness the incident should fill out and sign the incident report. Each witness should file a separate report. Once the report is filed, the nursing supervisor, department heads, administration, the facility's attorney, and the insurance company may review it.

Because incident reports will be read by many people and may even turn up in court, you must follow strict guidelines when completing them. If an incident report form does not leave enough space to fully describe an incident, attach an additional page of comments.

Document the incident as it occurred in the patient's medical record, "Incident Report Completed" should never appear in the patient's record. The incident report should never be referred to in any way in the medical record.

### **Employee Responsibility**

All employees are responsible for preparing an incident report as soon as possible and reporting immediately to their supervisor or in the supervisor's absence report to the administration any incident or injury including near misses. Recommendations and appropriate changes shall be discussed with the supervisor and necessary corrections implemented to prevent further accidents.

### **Supervisor Responsibility**

Upon receiving a report of an incident, written or oral, the supervisor shall conduct an investigation. Following the investigation, supervisors are to review and complete the Incident Report and initiate Worker Compensation Report if indicated for the LHDs insurance carrier. The supervisor shall take action to implement corrective measures immediately when the investigation reveals such actions are necessary.

The supervisor shall provide a copy of the Incident Report and the Worker's Compensation Report (if necessary) to the LHDs Safety Officer within five working days of the accident.

Reports of all incidents and near misses should be discussed during meetings with employees of the work unit to prevent problems of the same nature in the future.

### **Tips for Reporting Incidents:**

1. Include essential information, such as identity of the person involved in the incident, the exact time and place of the incident and the name of the doctor you notified.
2. Document any unusual occurrences that you witnessed.
3. Record the events and the consequences for the patient in enough detail that administrators can decide whether or not to investigate further.
4. Write objectively, avoiding opinions, judgments, conclusions, or assumptions about who or what caused the incident. Tell your opinions to your supervisor later.
5. Describe only what you saw and heard and the actions you took to provide care at the scene. Unless you saw a patient fall, write "found patient lying on the floor".

6. Do not admit that you are at fault or blame someone else. Steer clear of statements like "better staffing would have prevented this incident".
7. Do not offer suggestions about how to prevent the incident from happening again.
8. Do not include detailed statements from witnesses and descriptions of remedial action; these are normally part of an investigative follow-up.
9. Do not put the report in the medical record. Send it to the person designated to review it according to your facility's policy.

Sample copies of "Incident/Complaint Report Form", "Laboratory Incident Form", "Post-exposure Incident Exposed Employee Consent Form", and "Patient Consent Form-Infectious Disease Exposure (OSHA Bloodborne Pathogens)" are available on the [LHD Forms, Documents, and Administrative Reference webpage](#). Some agencies may use incident reports supplied or recommended by their insurance carrier.

**DPH GUIDELINES:  
LHD BLOODBORNE PATHOGENS EXPOSURE CONTROL PLAN -  
OSHA COMPLIANCE**

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## **DUTIES:**

Each employer shall:

- A. Furnish to each of his employees' employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees;
- B. Comply with occupational safety and health standards promulgated under this Act.

*Each employee shall comply with occupational safety and health standards and all rules, regulations and orders issued pursuant to the Act, which are applicable to his own actions and conduct.*

## **POSTING:**

[Post the 300-A](#) summary page form February 1 to April 30 of the year following the year covered by the form.

The **Standard Industrial Code** (SIC) used by all LHDs on the [300-A](#) summary page is **9431**. You will receive notification of code change when applicable. Revision/update of this document is listed on page 19 in bold type.

## **COMPLIANCE/INFORMATION:**

OSHA information may be obtained at no cost from the [Labor Cabinet's website: Standard Forms, Documents, Reports and Publications](#).

Kentucky Labor Department: (502) 564-4102  
Education and Training  
1047 US 127 South, Suite 4  
Frankfort, Kentucky 40601

US OSHA Publications and US Department of Labor Federal are available at:

[US Department of Labor – OSHA Publications](#)  
[US Department of Labor – Compliance Forms](#)  
[US Department of Labor – OSHA Free Workplace Poster](#)

OSHA information is also addressed in the Administrative Reference for LHDs in Kentucky, [Local Health Personnel Section](#).

## **CONTACT FOR QUESTIONS:**

[Division of Epidemiology and Health Planning](#) for medical information and infection control at 502-564-3261.

[Division of Administration and Financial Management](#) for personnel classifications and records retention/archiving at 502-564-6663, Option 5 ([Local Health Personnel Branch](#)) and for medical records management/clinic coding documentation, Option 1 ([Local Health Operations Branch](#)).

# KENTUCKY LHD BLOODBORNE PATHOGENS EXPOSURE CONTROL COMPLIANCE PLAN

## I. Introduction and Summary

Hepatitis B (HBV) has long been recognized as a hazard for health care workers who are exposed to blood. In the mid-1980's reports documenting the transmission of Human Immunodeficiency Virus (HIV) to health care workers were published. Several other diseases carry varying risks. In response to these concerns, the Occupational Safety and Health Administration, U.S. Department of Labor, on December 6, 1991, published a final standard on the prevention of occupational exposure to Bloodborne pathogens.

On November 6, 2000 President Bill Clinton signed the [Needle-stick Safety and Prevention Act, P.L. 106-430](#). This Act directed OSHA to revise the Bloodborne Pathogens standards to reflect the requirements of the Act. OSHA subsequently implemented federal Occupational Exposure to Bloodborne Pathogens Needle sticks and Other Sharps Injuries Final Rule on January 18, 2001).

## II. Exposure Determination

- A. For the following LHD, **all employees have** occupational exposure as part of their normal work routine:

### **Nursing Series Classifications with the exception of:**

2170-Epidemiologist

2171-Senior Epidemiologist

### **Medical Services Support Series to include:**

2210-Clinical Assistant

2211-Senior Clinical Assistant

2302-Home Health Aide

2303-Senior Home Health Aide1

### **Laboratory Support Series to include:**

2701-Laboratory Supervisor

2702-Medical Technologist

2703-Laboratory Technician

2704-Laboratory Assistant

2708-Environmental Laboratory Analyst I

2709-Environmental Laboratory Analyst II

2710-Environmental Laboratory Supervisor

2711-Environmental Laboratory Director

### **Physician/Health Officer Series to include:**

4001-Public Health Clinician

4002-Health Officer

4003-Medical Director

### **Personal Service Contracts to include:**

K1 General Practitioners and Family Practitioners

K2 Obstetricians/Gynecologists (board certified)

K3 Pediatricians

K4 Other Physician Specialists

L1 Dentists

L2 Dental Hygienists

M1 Nurse Practitioners/Physician Assistants

M2 Public Health Nurses

M3 Other Registered Nurses

M4 Licensed Practical Nurse (LPN) and Licensed Vocational Nurse (LVN)

- B. For the following, some employees have **limited** occupational exposure:

**Medical Services Support Series to include:**

2220-Family Support Worker I/Home Visitor    2221-Family Support Worker II/Home Visitor

**Program Management Series (all classifications)**

**Nursing Series to include:**

2170-Epidemiologist

2171-Senior Epidemiologist

**Medical Services Support Series (all classifications)**

**Nutrition Services Series (all classifications)**

**Environmental Services Series (all classifications)**

**Maintenance Series (all classifications)**

**Personal Services Contracts to include:**

N4 Occupational Therapists

N6 Audiologist

N7 Speech Therapist

N8 Physical Therapist

N9 Respiratory Therapist

S1 Other

C. For the following, **employees do not have** occupational exposure:

**Public Health Director Series (all classifications)**

**Administrative Support Series (all classifications)**

**Accounting Financial Series (all classifications)**

**Secretarial/Office Coordinator Series (all classifications)**

**Social Services Series (all classifications)**

**Health Education Series (all classifications)**

**Medical Support - Administrative Series (all classifications)**

**In all three classifications**, the individual responsibilities of each employee must still be reviewed to determine the potential for exposure to Bloodborne pathogens.

Review the US Department of Labor, OSHA SIC Groupings for additional information:

[OSHA Major Group 94](#): Administration of Human Resources Programs

[OSHA Major Group 80](#): Health Services

D. The **following examples** are groups of closely related tasks and procedures that are performed by employees where their job classifications have occupational exposure or where some employees have limited occupational exposure as part of their normal work routine, and may result in occupational exposure to Bloodborne pathogens:

1. The performance of venipunctures, heel sticks or finger sticks.
2. The performance of intravenous, intramuscular, intrathecal, subcutaneous, or intradermal administration of vaccines or medications.
3. The use and handling of needles, sharp instruments, scalpels or similar devices during routine clinical procedures or diagnostic examinations. The cleaning of used instruments, and the disposal of needles, blades, and other sharps.
4. The collection and handling of all smears, cultures and specimens of the following fluids:

- blood and all body fluids, except sweat, whether or not they contain visible blood; and any other fluid. The collection and handling of unfixed tissue from a human, living or deceased.
5. The physical examination of the pelvis, rectum, and genitalia; contact with all mucous membranes, including the nose and mouth.
  6. The performance of invasive procedures: the manipulation, cutting or removal of any oral tissue including tooth structures: the handling of intra-oral devices; contraceptive implant and insertion.
  7. The performance or assistance in vaginal delivery; and in handling the placenta or newborn infant's skin.
  8. The performance of wound care, tracheostomy or enterostomy care, dressing changes, enemas, removing of impactions, or catheter care.

### **III. Schedule and Method of Implementation of Occupational Exposure Prevention Plan**

#### **A. Methods of Compliance, Standard Precautions**

Universal precautions are OSHA's required methods of control to protect employees from exposure to all human blood and other potentially infectious materials. The term "universal precautions" refers to a concept of Bloodborne disease control which requires that all human blood and other potentially infectious materials be treated as if known to be infectious for HIV, HBV, Hepatitis C Virus (HCV) or other Bloodborne pathogens, regardless of the perceived low risk status of a patient or patient population.

Alternative concepts in infection control, such as Standard Precautions, are acceptable alternatives to universal precautions, provided that facilities utilizing them adhere to all other provisions of the OSHA standard. Based upon the Centers for Disease Control and Prevention (CDC), "[\(2007\) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings](#)" the Department for Public Health (DPH) recommends that LHDs use Standard Precautions for all patients. These precautions are applied to blood, vaginal secretions, semen, all other body fluids, (except sweat), *whether or not they contain visible blood*, and non-intact skin and mucous membranes. Therefore, the use of protective barrier precautions are recommended when performing tasks involving contact with blood, body fluids, non-intact skin and mucous membranes.

Standard Precautions is an approach to infection control in which all human blood and human body fluids (review examples above) are always treated as if they are potentially infectious and may contain HIV, HBV, HCV and other Bloodborne pathogens.

Standard precautions for health care workers may be summarized by the following principles:

- Treat all blood and body fluids as being potentially infectious.
- Use personal protective equipment when coming into contact with blood or body fluids or when the potential for exposure to blood or body fluid exists. Personal Protective Equipment includes: latex or vinyl gloves, gowns, masks, and protective eyewear.
- References and examples of tasks requiring the use of Standard Precautions are also contained in the [Clinical Service Guide](#).
- Do not bend, break, shear, or recap needles. Needles must not be removed from disposable syringes. Disposable needles, syringes and other sharp's items must be placed in puncture-resistant containers for disposal. The containers are to be located as close as practical to the area in which the items were used.
- Wash hands thoroughly before and after patient care, and between patients and

- between sites on the same patient.
- Clean up blood spills immediately.
- Follow nationally published guidelines for sterilization, disinfection, housekeeping, and waste disposal.
- Keep mouthpieces and resuscitation equipment readily available if use is likely.
- Refrain from patient care when the caregiver has weeping dermatitis or exudative lesions.

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Additional isolation precautions may be necessary for patients with an infection transmissible by the airborne route (such as tuberculosis, varicella and measles), droplet, or contact. Transmission-based Precautions is the second tier of the CDC, "[\(2007\) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings](#)". DPH recommends that LHDs use [Transmission-based Precautions](#). These precautions should be used *in addition to Standard Precautions*.

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#### B. Engineering/Work Practice Controls for Health Departments and Home Health Employees

The revision of the Bloodborne Pathogens, Needle-sticks and other Sharps Injuries standard requires the employer to institute engineering and work practice controls as the primary means of eliminating or minimizing employee exposures. "Engineering controls" has been modified to include "safer medical devices, such as sharps with engineered sharps injury protections and needleless systems".

The revised standard adds two additional terms to the definition section "Engineering controls" mean controls that isolate or remove the Bloodborne pathogens hazard from the workplace. Examples include needleless devices, shielded needle devices, blunt needles, and plastic capillary tubes.

A "**Needleless System**," is defined as "a device that does not use needles for collection of body fluids or withdrawal of body fluids after initial venous or arterial access is established; the administration of medications or fluids; or any other procedure involving the potential for occupational exposure to Bloodborne pathogens due to percutaneous injuries from contaminated sharps".

The Bloodborne pathogens standard reflects how employers implement new developments in control technology; requires employers to solicit input from non-managerial (e.g., frontline) health care workers that identifies, evaluates, selects safety-engineered sharp devices (e.g., needleless devices, shielded needle devices, and plastic capillary tubes) and identifies proper work practices (e.g., no-hand procedures in handling contaminated sharps).

Employee input shall be documented in an "Exposure Control Plan" developed by the LHD. Methods for soliciting employee input are not prescribed. The engineering controls must be incorporated in the exposure control plan to be reviewed and updated at least annually and whenever necessary to reflect new or modified tasks and procedures which affect occupational exposure.

The revised standard must reflect changes in technology that eliminate or reduce exposure to Bloodborne pathogens; and consideration and implementation of appropriate

commercially available and effective safer medical devices designed to eliminate or minimize occupational exposure. The plan must reflect new or revised employee positions with occupational exposure. This information must be documented annually in the plan. The exposure plan must document the engineering controls put into place by the employer and must document engineering controls effectiveness to eliminate or minimize Needlesticks and other sharp injuries. The exposure plan must demonstrate the procedure used to decrease or eliminate exposures.

**The LHD must assign an employee to be responsible for assuring the exposure plan is reviewed and updated** as needed and must at a minimum, annually, establish and maintain a log of percutaneous injuries from contaminated sharps. The primary agents of concern in the current occupational settings are HIV, HBV, and HCV.

DPH determined that the following engineering controls and/medical devices would be used to reduce the likelihood of Needle-stick and other sharps injuries:

**The effectiveness/usefulness of these controls was evaluated in the following manner:**

- With the exception of the Bloodborne pathogens standards revisions effective April 18, 2001, the specifications of this subsection will be observed by LHD staff and will be reviewed as part of the annual program/service planning process.
- The LHD will provide hand washing facilities which are readily accessible to employees.
- When conducting clinics or performing services at sites in the home or outside a health center where hand washing is not available, the health department will provide either alcohol based antiseptic towelettes or an appropriate alcohol based waterless hand cleanser. When alcohol-based hand cleansers or towelettes are used, hands will be washed with soap and running water when the employee returns to a place where hand washing facilities are available.
- The LHD will instruct employees to wash their hands prior to and immediately after removal of gloves or other personal protective equipment.
- The LHD will ensure that employees wash hands, and any other skin with soap water, or flush mucous membranes with water immediately following contact of such body areas with blood or other potentially infectious materials.
- Contaminated needles and other contaminated sharps will not be bent, recapped, or removed from an attached device unless the employee can demonstrate that no alternative is feasible or that such action is required by a specific medical procedure. Recapping or needle removal must be accomplished through the use of a mechanical device or a one-handed technique. Shearing or breaking of contaminated needles is prohibited. Employees giving care in the home should instruct patients and/or caregivers the need to use puncture resistant containers for the disposal of contaminated needles or other contaminated sharps.
- LHDs should also evaluate the safety of using glass capillary tubes. Food and Drug Administration (FDA), National Institute of Occupational Safety and Health (NIOSH) and the Occupational Safety and Health Administration (OSHA) recommend blood collection devices less prone to accidental breakage *including:*

- (1) Capillary tubes that are not made of glass (but made of plastic)
- (2) Glass capillary tubes wrapped in puncture – resistant film
- (3) products that use a method of sealing that does not require manually pushing one end of the tube into putty to form a plug or
- (4) Products that allow the hematocrit to be measured without centrifugation.

- Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited for employees while in the health center or while giving care in a patient’s home, where there is a reasonable likelihood of occupational exposure to potentially infectious materials.
- Food and drink will not be kept in refrigerators, freezers, shelves, cabinets, on countertops or bench tops, or in portable insulated coolers where blood or other potentially infectious materials are present.
- All procedures involving blood or other potentially infectious materials will be performed in such a manner as to minimize splashing, spraying, spattering and generation of droplets.
- Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited.
- Equipment which may become contaminated with blood or other potentially infectious materials will be examined prior to servicing or transporting and will be decontaminated as necessary unless the LHD can demonstrate that decontamination of such equipment or portions of such equipment is not feasible.
- A readily observable label as described in this AR Section, DPH Guidelines for LHD Bloodborne Pathogens Exposure Control Plan for OSHA Compliance, Schedule and Method of Implementation of Occupational Exposure Preventive Plan, [Communication of Hazards, Warning Signs/Labels](#) will be attached to the equipment stating which portions remain contaminated.
- The LHD will ensure through training and education of staff that appropriate precautions are taken prior to use of or contact with the equipment by employees, the servicing representative, and/or the manufacturer, prior to handling, servicing or shipping.
- Specimens of potentially infectious materials will be placed in a container which prevents leakage. Special care shall also be given to the transport of the capillary tubes to prevent leakage.

An "Exposure Control Plan" needs to include the following:

- Allow for the LHD to solicit input from at least three employees representing clinical and laboratory staff.
- Include the date the input was obtained.
- Identify the employee that is designated to annually review the exposure control plan and recommend necessary updates/revision.

C. Personal Protective Equipment

The provisions of this subsection will be observed as requirements of the [Needlestick Safety and Prevention Act of 2000](#).

a. Provision:

For the [employees listed in II A. and B. of this section concerning "exposure determinations"](#), the LHD will provide, at no cost to the employee, personal protective equipment appropriate for the services provided and accessible on-site at the location of use. Examples of protective equipment include gloves, gowns, laboratory coats, face shields or masks, eye protection, mouthpieces, resuscitation bags, pocket masks or other ventilation devices. Personal protective equipment will be considered "appropriate" only if it does not permit blood or other potentially infectious materials to pass through to reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes. Barrier protection should be used when coming in contact with blood and all body fluids, except sweat, whether or not there is visible blood.

b. Utilization:

LHD employees will use the equipment as specified below.

When an employee declines to use personal protective equipment, the employee will document the instance in writing and the LHD Director, Director's designee, or the Director of Nursing of the LHD will investigate to determine what changes can be instituted to prevent future occurrences.

c. Accessibility:

The LHD will ensure that personal protective equipment in the appropriate sizes is readily accessible at the work site or is issued directly to employees. Hypoallergenic gloves, glove liners, powder less gloves, or other similar alternatives will be readily accessible to those employees who are allergic to the gloves normally provided.

d. Cleaning, Laundering, and Disposal:

The LHD will clean, launder, and dispose of personal protective equipment at no cost to the employee.

1. If a garment(s) is penetrated by blood or other potentially infectious materials, the garment(s) will be removed immediately.
2. All personal protective equipment will be removed prior to leaving the LHD. Home Health personnel will remove the personal protective equipment prior to leaving the patient's home.
3. When personal protective equipment is removed it will be placed in an appropriately designated area or container for storage, washing, decontamination or disposal.

e. Repair and Replacement:

The LHD will repair or replace personal protective equipment as needed to maintain its effectiveness, at no cost to the employee.

f. Gloves:

Gloves will be worn when it can be reasonably anticipated that the employee may have hand contact with blood, other potentially infectious materials, mucous membranes, and non-intact skin; when performing vascular access procedures

except as specified in paragraph b (Use) above; and when handling or touching contaminated items or surfaces. These include procedures outlined above.

1. Disposable (single use) gloves, such as surgical or examination gloves will be replaced immediately when contaminated, torn, punctured or whenever their ability to function as a barrier is compromised.
  2. Hand hygiene will be performed prior to donning new glo.
  3. Disposable (single use) gloves will not be washed or decontaminated for re-use.
  4. Utility gloves may be decontaminated for re-use if the integrity of the glove is not compromised. However, they must be discarded if they are cracked, peeling, torn, punctured, or exhibits other signs of deterioration or whenever their ability to function as a barrier is compromised.
  5. Health Care Workers should always wear gloves when:
    - Touching blood and body fluids.
    - Touching mucous membranes (e.g., inside mouth, rectum, vagina).
    - Touching non-intact skin of all patients. Health care workers with exudative skin lesions, un-intact skin, or weeping dermatitis should refrain from direct patient contact, or handling patient care equipment, until the skin condition resolves.
    - Handling items or surfaces soiled by blood or other body fluids when processing blood or body fluid specimen.
    - Hands should be washed before gloving.
    - Gloves must be changed after contact with each patient and hands must be thoroughly washed with soap and water or use a waterless alcohol-based hand cleanser.
    - Change gloves between tasks and procedures on the same patient after contact with materials that may contain a high concentration of microorganisms.
- g. Hands or other skin must be immediately and thoroughly washed if contaminated with blood or body fluids: Hands must always be washed before and after the examination and before leaving the examination room. Hand washing should be with soap (preferably liquid, not bar) and warm water (not hot). Rub hands together using friction creating lather for 10–15 seconds. Rinse and pat dry with a disposable towel. Waterless alcohol-based hand cleansers may be used for cleaning hands, if hands are not visibly soiled or when coming into contact with spore forming organisms, such as *clostroides difficile* or Norovirus. In this instance, hands should be washed with clean water and soap.
- h. Masks, Eye Protection, and Face Shields: Masks in combination with eye protection devices, such as goggles or glasses with solid side shields, or chin-length face shields, will be worn whenever splashes, spray, spatter, or droplets of blood or other potentially infectious materials may be generated and eye, nose or mouth contamination can be reasonably anticipated, such as tracheostomy care. Most LHDs do not perform these procedures. (Those that do will add a specific list of procedures to this paragraph.) The list for home health agencies will include tracheostomy care, wound irrigation, enema, or any care for a patient with infectious tuberculosis.
- i. Gowns, Aprons, and Other Protective Body Clothing: Appropriate protective clothing such as, but not limited to, gowns, aprons, lab coats, clinic jackets or similar outer garments shall be worn in occupational exposure situations that are

likely to generate splashes of blood or other body fluids. The type and characteristics will depend upon the task and degree of exposure anticipated.

- j. Resuscitation/ Ventilation Devices: Although saliva has not been implicated in the transmission of HIV, to minimize risks during emergency mouth-to-mouth resuscitation, mouthpieces, resuscitation bags, or other ventilation devices should be available for use in areas where the need for resuscitation might arise. This includes health department settings where anaphylaxis may develop as a result of parenteral penicillin or other drug therapy.

#### D. Infectious Waste Management

- a. Definitions:

**Regulated waste** is defined to be consistent with the published [OSHA standard](#), as follows:

1. [The body fluids listed in section II, Exposure Determination, D. 4.](#) (Blood and cervical/vaginal fluids are the most likely fluids to be encountered in the health department setting.)
2. Used disposable sharp items (such as needles, blades, and broken tubes.)
3. Microbiologic laboratory waste -- this consists of viral, bacterial, fungal, or parasitic cultures in which the biologics have multiplied to higher levels than would be seen in a person; bacterial culture dishes are the major item of this category seen in health departments.
4. Pathological waste -- any unfixed tissue or organ, other than intact skin, from a human, living or dead.
5. The primary agents of concern in current occupational settings are HIV, HBV, and HCV.
6. Contaminated items that would release blood or other liquids enumerated in [Exposure Determination, D. 4.](#) above if compressed.
7. Items that are caked with dried blood or other liquids - enumerated in [Exposure Determination, D. 4.](#) above and are "capable of releasing these materials during handling" (this means, enough caked blood to cause a dusty aerosol if shaken, NOT an item like a gauze pad which has been used to cover a finger stick or antecubital venipunctures).
8. Regulation Waste Items as outlined above in 1 through 4 are defined as infectious by CDC and by Kentucky infectious waste regulations for hospitals, nursing homes, and special clinics. These are referred to as "Class A infectious wastes." Regulated Waste Items in 5 through 8 above are referred to as "Class B infectious wastes."

- b. Plan of Treatment and Disposal:

Class A:

Sharps will be placed in puncture-resistant containers which will be located in each room of the health department where venipunctures or injections are performed, or other places where sharps are expected to be used. The [containers will be labeled as outlined below within the Schedule and Method of Implementation of Occupational Exposure Preventive Plan, item H. 1.](#) of this section.

Containers will be maintained upright during use and will not be allowed to overfill.

They will be constructed so as to prevent leakage during handling, storage, transport, or shipping and must be closed prior to transport.

A contract or arrangement, filed with this plan, will be executed with a hospital, medical facility, or waste transporter to take the sharps containers to a site where they will be incinerated or treated by one of the approved alternative technologies.

[Blood and other fluids outlined in Exposure Determinations, D. 4.](#) will be carefully poured down the sanitary sewers. Microbiologic wastes will be placed in bags which are closeable and prevent leakage, [labeled as outlined below within the Schedule and Method of Implementation of Occupational Exposure Preventive Plan, item H. 1.](#) of this section, and either autoclaved within the health department, or an arrangement made for transport as for sharps. Pathologic wastes (if any) will be placed in bags that are properly labeled and closeable, prevent leakage, and transported to incineration.

When Class A infectious wastes are generated in a home setting during a visit by a home health agency employee, the same standards for storage, labeling, transport, treatment and disposal will be observed as if the wastes were generated in a clinic setting.

The employee will be responsible to transport the waste containers, when filled, to the health department or a medical facility for treatment or pickup.

Receptacles may be left in the home between visits if not yet filled, provided residents of the home are instructed regarding potential hazards. For liquids, sewer disposal in the home is permitted if the home is connected to a municipal or community sewer system, or to on-site sewage disposal which meets the standards described in [902 KAR 10:085](#).

When Class A infectious wastes are generated in a setting (such as a correctional facility) where sharps containers cannot safely be left, one will be carried by the employee for immediate use and removed when the employee leaves the site.

Class B:

Infectious wastes must be placed in closeable and leak proof containers and will be [labeled as outlined below in the Schedule and Method of Implementation of Occupational Exposure Preventive Plan, item H. 1.](#) of this section. They will be transported (as described for class A) at the option of the individual health department, or will be grouped with ordinary solid waste. They are not required to receive special treatment prior to disposal.

Infectious wastes generated in the home setting must be bagged and labeled as if generated in the clinic setting. However, no special requirements for transport, treatment, or disposal apply. This plan applies to wastes generated in the home only if generated by the activities of a home health care provider or other health department staff person.

#### E. General Housekeeping

The LHD will ensure that the work site is maintained in a clean and sanitary condition. A written schedule for cleaning and decontaminating the work site will be observed based on the following criteria:

- a. Location within the department
- b. Type of surface to be cleaned
- c. Type of soil present
- d. Tasks and procedures being performed in the area

All equipment and environmental and working surfaces will be cleaned and decontaminated after contact with blood or other potentially infectious materials using an EPA approved healthcare grade disinfectant.

Contaminated work surfaces will be decontaminated with an EPA approved healthcare grade disinfectant, as follows:

- a. After completion of procedures.
- b. Immediately or as soon as feasible when surfaces are overtly contaminated or after any spill of blood or other potentially infectious materials.
- c. At the end of the workday if the surface may have become contaminated since the last cleaning.

Protective coverings, such as plastic wrap, aluminum foil or imperviously backed absorbent paper used to cover equipment and environmental surfaces, will be removed and replaced as soon as feasible when they become overtly contaminated or at the end of the workday if they may have become contaminated during the day.

All bins, pails, cans and similar receptacles intended for reuse which have a reasonable likelihood for becoming contaminated with blood or other potentially infectious materials will be:

- a. Inspected and decontaminated on a regularly scheduled basis.
- b. Cleaned and decontaminated immediately or as soon as feasible upon visible contamination.

Broken glassware which may be contaminated will not be picked up directly with the hands. It will be cleaned up using mechanical means, such as a brush and dustpan, tongs, or forceps.

Reusable sharps that are contaminated with blood or other potentially infectious materials will NOT be stored or processed in a manner that requires employees to reach by hand into the containers where these sharps have been placed.

#### F. Laundry

Contaminated laundry will be handled as little as possible with a minimum of agitation and will be bagged or placed in a leak proof container at the location where it was used. It will NOT be sorted or rinsed in the location of use.

Contaminated laundry will be placed and transported in bags or containers [labeled or color-coded as described below in the Schedule and Method of Implementation of Occupational Exposure Preventive Plan, item C.1](#). When the LHD utilizes universal precautions in the handling of all soiled laundry, alternative labeling or color-coding is sufficient if it communicates the information that the containers require compliance with universal precautions.

When contaminated laundry is wet and presents a reasonable likelihood of soak-through or leakage from the bag or container, the laundry will be placed and transported in bags or containers which prevent soak through and/or leakage of fluids to the exterior. The LHD will perform the following:

- a. Ensure that employees who have contact with contaminated laundry wear protective gloves and other appropriate personal protective equipment, i.e., gown or apron.
  - b. When shipping contaminated laundry off-site, the LHD will place the laundry in bags or containers which are [labeled or color-coded as described below within the Schedule and Method of Implementation of Occupational Exposure Preventive Plan, item H. 1.](#)
  - c. When the LHD has a contract/agreement with a company to provide laundry services; the contract/agreement will include the required cleaning schedule and which facility will be responsible for transporting the items.
- G. Hepatitis B Control

The provisions of this section will be observed as of July 1, 1992.

1. Vaccination

Each employee in job classes enumerated within [Exposure Determinations A. and B.](#) above will, within 10 days of employment or assignment, be scheduled an appointment with the nursing director or nurse supervisor of the LHD (or designee) and will either:

- a. Provide evidence of having received three doses of hepatitis B vaccine or
- b. Provide evidence of a positive Antibody to Hepatitis B Surface Antigen (anti-HBs) laboratory marker; or
- c. Sign a form consenting to be vaccinated or to finish an incomplete vaccination series; or
- d. *Specifically decline vaccination by signing the **Declination for Hepatitis B Vaccine form** located on the [LHD Forms, Documents and Administrative Reference webpage.](#)*

For those who do not have an immunocompromised medical condition, booster doses of vaccine are not currently recommended except when there is exposure to a Hepatitis B Surface Antigen (HBsAg)-positive source. Thus, dates and results of anti-HBs testing should be recorded as well as dates of vaccine doses, for use in case exposure. A positive anti-HBs in a person never having received vaccine is due to natural infection and is considered permanent.

It is the responsibility of the employer/LHD to purchase Hepatitis B Vaccine for its employees. If the employee consents to be vaccinated, he will be evaluated to ascertain that there are no medical contraindications to vaccination. These include hypersensitivity to yeast or an adverse reaction to a previous dose of hepatitis B vaccine. If no contraindications exist, then the employee will receive three (or the remaining) doses of hepatitis B vaccine at 0, 1, and 6 months.

Two months following the last dose, a test for anti-HBs will be ordered to determine immune status. It is the responsibility of the employer/LHD to arrange and pay for this testing. [The Division of Laboratory Services](#) will provide testing free of charge for LHD employees, as resources allow.

If the employee declines vaccination, he must sign a **Declination for Hepatitis B Vaccine form** located on the [LHD Forms, Documents, and Administrative Reference](#)

[webpage](#) and employee will be informed quarterly for one year that if their decision changes to return and consent to receive vaccination at any time.

## 2. Post-exposure evaluation

When an LHD employee experiences an incident involving parenteral contact or contact of eye, mouth, other mucous membrane, or non-intact skin with a [body fluid defined above within the Exposure Determination, item D. 4.](#) a report will be made as described in IV. below. The source blood (two, red-top tubes) will then be sent to the [Division of Laboratory Services](#) (attention-[Virology](#)) for testing for HIV and HBV.

The **General Consent for Health Services form CH-5** must also be obtained. The laboratory will notify the designated person at the LHD of the result (by telephone if positive, in writing if negative).

Post-exposure evaluation for Hepatitis C (HCV) is also required by OSHA however, the DPH, [Division of Laboratory Services does not provide this particular testing](#). It is the responsibility of the employer/LHDs to arrange for HCV testing.

Current references may be found on the CDC website:

"[Morbidity and Mortality Weekly Report \[MMWR\]](#), November 25, 2011 / 60(RR07);1-45

## H. Communication of Hazards

### 1. Warning Signs/Labels

Standard Orange Fluorescent Biohazard warning labels must be affixed to all regulated waste containers, refrigerators containing blood or other potentially infectious material and any other containers used to store, transport or ship blood or other potentially infectious materials.

Containers or vacutainers of blood or blood products that are labeled as to their contents and are being clinically tested within the facility are exempt from the labeling requirements. Red bags or red containers may be substituted for labels. Individual containers that are placed in a larger labeled container for storage, transport, or shipment need not be individually labeled.

The labels on regulated waste will have an "A" or "B" underneath the biohazard symbol indicating the class of infectious waste. If the container has a mixture of types, the letter "A" will be used. Labels must be affixed as closely as feasible to containers by string, wire, adhesive, or another method to assure that labels are not lost or unintentionally removed. Labels are also required for any contaminated laboratory equipment and must state which portion(s) of the equipment is contaminated. Regulated waste that has been decontaminated does not need to be labeled.

### 2. Information and Training of Staff

LHDs must ensure that all employees identified as having the potential for an occupational exposure participate in an annual training program provided at no cost to the employee and during working hours. To comply with federal regulations, the initial training program for staff must occur prior to August 15, 1992. An initial training program to assure compliance with the new Needlestick Safety and

Prevention Act must be provided by the LHD within a reasonable time frame after receiving these guidelines (but prior to August 15, 2001).

New staff identified as having the potential for exposure must receive training during the orientation period or prior to undertaking tasks where exposure may take place. LHDs are obligated to provide additional training if an employee's change in duties increases the chance of exposure. An instructor familiar with infection control theory and practice should be responsible for providing the training and for assessing the effectiveness of the training. Initial and annual training programs must contain (at a minimum) the following components:

- a. A general explanation of the epidemiology, modes of transmission, and symptoms of infection with Bloodborne pathogens.
- b. An explanation of the LHD's exposure control plan, the location of the plan, and how the employee can obtain a copy.
- c. An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials.
- d. An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices, and *personal protective equipment*.
- e. Information on the types, proper use, location, removal, handling, decontamination and disposal of *personal protective equipment*.
- f. An explanation of the basis for selection of *personal protective equipment*.
- g. The review of the *Respiratory Plan and Personal Protective Equipment (PPE) guidelines* located on the [LHD Information webpage](#).
- h. Information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge.
- i. Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials.
- j. An explanation of the procedure to follow if an exposure incident occurs including the method of reporting the incident and the medical follow-up that will be made available. Please note that the blood of the source patient may be sent for testing immediately after an exposure incident if the patient signed the **General Consent for Health Services form CH-5**.
- k. Information on the post-exposure evaluation and follow-up that the LHD provides for an employee following an exposure incident.
- l. An explanation of the signs and labels and/or color-coding in use by the LHD.
- m. Ample opportunity for questions and answers. Copies of federal OSHA regulations ([29 CFR 1910.1030, Occupational Exposure to Bloodborne Pathogens](#)) outlining the requirements for employers and the LHD's exposure control compliance plan must be available and easily accessible to each trainee.

## I. Recordkeeping

### Employee Medical Records:

The LHD must include in the medical file of each employee with potential exposure, documentation of an up-to-date hepatitis B vaccination. If the employee has no documentation to this effect, that fact must be noted in the employee's medical file. Follow the guidelines outlined in the [Medical Records Management Section](#) of the AR.

If the employee is vaccinated by LHD staff, an immunization record must be initiated and filed as a medical record with a copy filed in the employee's medical record. The date of each vaccination must be included as well as any allergic reaction to the vaccine. Should an employee have an exposure incident, a copy of the incident report and all results of post exposure testing and follow-up must be filed in the employee's medical record including a copy of the physician's written opinion and a copy of any written information provided to the employee.

**In accordance with local health policy, these records are confidential and cannot be disclosed without the employee's express written consent.** Records must be retained for 30 years following termination of employment in accordance with [29 CFR 1910.20](#). Employee medical files must be kept separate from the personnel records.

In order to account for the Hepatitis B vaccine distributed, a [patient encounter form \(PEF\)](#) will be initiated on each employee receiving HBV. *The PEF code of 361 for Hepatitis B #1, 362 for Hepatitis B #2 and 363 for Hepatitis B #3 will be used.* The payor code will be overridden to payor code 4 (non-assigned).

#### Records of Training Received by Employees:

Information on employee training on occupational exposure must be contained on the **Record of Training on Exposure Guidelines and Requirements form** located on the [LHD Forms, Documents, and Administrative Reference webpage](#). The form is to be completed by the trainer(s) and a copy must be filed in a general training file with a copy in each employee's personnel file. This form contains the following information:

- The dates of each training session.
- Content-specific syllabus and any information distributed to employees.
- The name(s) and qualifications of the person conducting the training.
- Names and job titles of all persons attending the training.

*Records will be retained for three years from the date of training. Records shall be made available to state agency staff and OSHA representatives upon request. [A CH-23, Authorization for Release of Patient Information](#), located within the [LHD Forms, Documents and Administrative Reference webpage](#) must be completed should an employee terminate employment with the LHD and wish to have his records transferred to another employer.*

#### **IV. Procedure for Reporting and Managing Exposure Incidents**

In the event of any applicable exposure to blood or other potentially infectious material, the health department employee will report the date, time and type of exposure to the immediate supervisor; and initiate an **Unusual Occurrence/Incident Report Exposure to Blood or other Potentially Infectious Materials form** located on the [LHD Forms, Documents, and Administrative Reference webpage](#) to include, but not be limited to:

- a. Employee activity at the time of exposure.
- b. Extent to which appropriate work practices and protective equipment were used; and
- c. Description of the source of the exposure.

Report the incident to the LHD director or director's designee. Initiate a [General Consent for Health Services form \(CH-5\)](#), if indicated, and based on the type of exposure, initiate the [Physician Treatment Related to Unintentional Exposure to Blood or Other Potentially Infectious Substances form](#). Adhere to follow-up

treatment regimen and/or testing as prescribed by the physician.

### **Reporting/Recording of Needlestick and Sharps Injuries:**

All work-related Needlestick injuries and cuts from sharp objects that are contaminated with another person's blood or other potentially infectious material (human body fluids, tissues, and organs); or other materials infected with HIV, HBV or HCV such as laboratory cultures or tissues must be recorded on the [OSHA 300](#) (Log of Work-Related Injuries and Illnesses) and the [OSHA 301](#) (Injury and Illness Incident Report) as an injury.

If an employee is splashed or exposed to blood or other potentially infectious materials without being cut or scratched, the incident is recorded on the [OSHA 300](#) Log as an illness.

If the incident results in the diagnosis of a Bloodborne illness (HIV, Hepatitis B, or Hepatitis C) or it meets one or more of the following criteria, do not record the employee's name on the OSHA 300 Log:

- a. days away from work;
- b. restricted work;
- c. transfer to another job;
- d. medical treatment beyond first aid;
- e. loss of consciousness;
- f. death or it involves a significant injury or illness diagnosed by a physician or other licensed health care professional even if it does not meet one or more of the criteria previously listed.

In these instances, enter "privacy case" in the space for the employee's name. The following injuries and illnesses are designated "privacy concern cases":

- a. An injury or illness to an intimate body part or the reproductive system;
- b. An injury or illness resulting from a sexual assault;
- c. Mental illnesses;
- d. HIV infection, hepatitis, or tuberculosis;
- e. Needlestick injuries or cuts from sharp objects that are contaminated with another person's blood or other potentially infectious material;
- f. Other illnesses, if the employee independently and voluntarily requests that his/her name not be entered on the Log.

For these "privacy concern cases," the LHD must keep a separate, confidential list of the case numbers and employee names so the cases can be updated and the LHD can provide federal and/or state government appropriate information if requested.

The "classification of the case" contained on the Log must be updated if the injury later results in days off work, restricted work, job transfer, or death. The description of the case must also be updated to identify the infectious disease and to change the case classification from an injury to an illness. Information must be entered on the [OSHA 300](#) Log and [OSHA 301](#) Incident Report within seven (7) calendar days of receiving information that a recordable injury or illness has occurred.

### **Retention and Updating:**

The LHD must retain the [OSHA 300](#) Log, the privacy case list, the Annual Summary ([OSHA 300-A](#)) and the [OSHA 301](#) Incident Report for five (5) years following the end of the calendar

year.

The OSHA 300 Logs must be updated over the five year period to include any newly discovered recordable injuries or illnesses and to show any changes that have occurred in the classification of previously recorded injuries and illnesses. If the description or outcome of a case changes, the LHD must remove or line out the original entry and enter the new information. Updating the [OSHA 300-A](#) (Annual Summary) and the [OSHA 301](#) Incident Report is voluntary (there is no requirement to update these two documents).

The employer or designee will:

1. Report the incident to the DPH, Division of Epidemiology and Health Planning, if a reportable condition is involved. File and retain the reports in his medical record.
2. Provide the following information to the evaluating physician:
  - a. A copy of this regulation and its appendices and
  - b. Description of the affected employee's duties as they relate to the employee's occupational exposure.
3. Physician's written opinion. For each evaluation under this section, the employer shall obtain and provide the employee with a copy of the evaluating physician's written opinion within 15 working days of the completion of the evaluation. The written opinion will be limited to the following information:
  - a. The physician's recommended limitations upon the employee's ability to receive Hepatitis B vaccination.
  - b. A statement that the employee has been informed of the results of the medical evaluation and that the employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials, which require further evaluation or treatment.
  - c. Specific findings or diagnoses, which are related to the employee's ability to receive Hepatitis B vaccination. Any other findings and diagnoses shall remain confidential.

In the event the employee refuses to be treated according to the guidelines for treatment of an exposure incident the employee's supervisor will:

Complete the ***Unusual Occurrence/Incident Report***, located on the [LHD Forms, Documents and Administrative Reference webpage](#), based on the oral report of the employee and have the employee sign the report.

- a. Have the employee indicate on the Incident Report his/her refusal for care.
- b. Report the incident and refusal of the employee to the appropriate personnel in the LHD.
- c. Report the incident to the DPH, Division of Epidemiology and Health Planning, if a reportable condition is involved.
- d. File and retain the reports in his medical record.

### **Department for Public Health OSHA Online Trainings**

**Part One:** Kentucky Department for Public Health (DPH) / Local Health Department (LHD) Occupational Health and Safety (OSHA) Online Training Program Two-Part TRAIN Module: 1074371

**Course Description:** This course is designed to review OSHA Bloodborne Pathogen Standards. The module identifies the three most commonly encountered bloodborne pathogens, discussed their symptoms, and how the pathogens can be

transmitted. This course stresses the importance of Standard Precautions and outlines the work practice controls that are in place to protect LHD employees.

**Part Two:** DPH Occupational Safety Health Administration (OSHA) Bloodborne Pathogen

**Course Description:** This course will discuss the appropriate use of personal protective equipment and how to properly handle blood and other potential infectious materials. It will include housekeeping procedures to reduce the risk of exposure and the steps to take if an exposure occurs.

**INFORMATION CONCERNING BLOODBORNE PATHOGENS STANDARDS:**

[The National Institute for Occupational Safety and Health \(NIOSH\) - ALERT DOCUMENT 84](#)

[Tips for Improving Your Bloodborne Pathogens Exposure Control Plan](#)

**US Department of Labor:** [Federal Register 29 CFR Part 1910 Occupational Exposure to Blood borne Pathogens; Needle-sticks and Other Sharps Injuries; Final Rule 1/18/2001](#)

**US Department of Labor:** [KENTUCKY OSHA STATE PLAN](#)

**US Department of Labor:** [OSHA STANDARDS INTERPRETATION AND COMPLIANCE LETTERS 12.15/2000 ENGINEERING CONTROLS MUST BE USED TO PREVENT NEEDLE-STICKS WHERE FEASIBLE.](#)

[Federal Regulations/Recordkeeping/ \(Federal Regulations/Vol. 76, 2011/Rules and Regulations\)](#)

[OSHA Fact Sheet – OSHA Bloodborne Pathogens Standard](#)

**OSHA Office located at:**

[Kentucky Labor Cabinet](#)

**Education and Training**

1047 U.S. Highway 127 South, Suite #4

Frankfort, Kentucky 40601

PH: (502) 564-3070 Direct # to Labor Cabinet

Federal OSHA inquiries: (502) 227-7024

[Publications](#) and federal [posters](#) can be downloaded from federal [OSHA website](#).

# LHD FACILITIES AND EQUIPMENT

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## **FACILITY OWNERSHIP**

Requirements for LHD facilities that are owned by fiscal courts are found in Administrative Regulation Title [902 KAR 8:160](#), Section 7.

When necessary and expedient, health departments may rent space using standard lease agreements reviewed and approved by DPH, Administration and Financial Management Division, **prior to implementation**.

DPH shall be contacted for guidance should a health department build a facility or lease space from or in conjunction with other public agencies, non-profit agencies, and/or health care providers. This shall be done to assure that the assets and interests of the health department are protected and that the LHD complies with provisions of [OMB 2CFR Subpart E](#).

When incurring a building or facility debt, the LHD may make use of other funds with the approval of their BOH and DPH. To retire a building or facility debt in excess of the annual anticipated revenue of the health department less annual expenses, the BOH shall comply with [Section 158 of the Kentucky Constitution](#) that limits such indebtedness to 2% of the value of the taxable property of the county.

For requirements for disposition of assets, surplus, or excess property, see Administrative Regulation title [902 KAR 8:170](#), Section 9.

## **FACILITY STRUCTURAL REQUIREMENTS**

Facility structural requirements for all LHDs' facilities, whether owned or leased by the LHD are:

- Compliance with applicable state and local building, fire, and safety codes and ordinances as stated in [902 KAR 8:160](#), Section 8 (2);
- Compliance with federal Health Insurance Portability and Accountability Act ([HIPAA](#)) statutes;
- Accessibility for the disabled and compliance with the [Americans With Disabilities Act \(ADA\)](#) if patients or the public are seen in the facilities;
- Compliance with [Occupational Safety and Health Administration \(OSHA\)](#) by having developed plans which address emergency evacuation procedures and fire prevention and control for each facility;
- Compliance with federal and state mandates that all LHD clinic sites including outdoor property areas be smoke, tobacco, and e-cigarette/vape free.

The Administrative Regulation Title [902 KAR 8:160](#), Section 8 (3), addresses construction or modification requirements for an X-ray room.

## **ACCESS TO FACILITIES, WEBSITES AND DIGITAL SERVICES**

Ensure that individuals with disabilities are not excluded from programs and services because facilities are unusable or inaccessible to them in accordance with the Department Of Justice 2010 ADA Standards for Accessible Design at [https://www.ada.gov/2010ADASTandards\\_index.htm](https://www.ada.gov/2010ADASTandards_index.htm).

## **CAPITAL CONTRUCTION REQUIREMENTS**

Administrative Regulation Title [902 KAR 8:160](#), Section 8, outlines construction requirements for new construction, building expansion, or renovation projects that are funded by the cabinet.

Prior to implementation, plans and specifications for the project as well as contracts and agreements for architects and contractors shall be submitted to DPH for review and approval. Written assurances regarding construction and cost overruns shall also be submitted. Quarterly status and progress reports are required along with a closing report upon completion of the project.

## **CAPITAL EXPENDITURES**

The Administrative Regulation Title [902 KAR 8:170](#), Section 4, governs expenditure policies.

If a LHD has funding for capital items available in a local restricted fund, the LHD may budget and expend the funds as approved by DPH in the written plan establishing the fund, [902 KAR 8:170](#), Section 3 (3)(c).

The plan shall comply with [OMB 2CFR Subpart E](#) (referenced in Administrative Regulation Title [902 KAR 8:170](#), Section 4), that may be viewed at the US Office of Management and Budget website. For additional guidelines on Capital Expenditures, "Financial Planning and Budget Preparation", review the [Financial Management Section](#) of the AR.

## **FACILITY DESIGN AND LAYOUT**

Newly constructed LHD service sites and LHDs being renovated shall be designed in such a manner as to promote efficient patient flow and convenience, accessibility, privacy and comfort. LHDs shall consider federal ([HIPAA](#)) privacy, security and confidentiality requirements and Communicable Disease requirements as part of design planning. Safety and convenience of staff and accommodation of future growth shall also be important design considerations.

Facilities should be designed to provide programs, activities, and services in the most integrated setting that enables individuals with disabilities to interact with individuals without disabilities to the fullest extent possible.

Plans and specifications for each cabinet funded project must be submitted to DPH for review and approval, per [902 KAR 8:160](#).

The LHD must involve DPH, Division of Administration and Financial Management, in the planning process for new construction or expansion of LHDs.

## **FACILITY SAFETY**

LHD Facility Safety Guidelines are:

- Each LHD must, in accordance with federal guidelines, have posted throughout the facility a clearly visible floor plan depicting emergency exits and escape routes;
- Each LHD facility must ensure that emergency equipment (e.g. fire extinguishers, emergency exit signs, automated defibrillators, emergency lighting, etc.) is checked and

maintained in good working order at all times. Review the [Clinical Service Guide \(CSG\)](#), **Emergencies Section**, for more detailed information;

- Each LHD is strongly encouraged to schedule periodic inspections by local fire, police, and emergency management officials to identify fire and safety hazards and take appropriate measures to correct them;
- Each LHD facility must have an appointed individual (e.g., safety officer) who shall ensure compliance with this AR section and all facility safety guidelines as well as life and safety codes.

## **USE OF FACILITIES**

LHD facilities shall be used for:

- Patient oriented health services;
- Group or community education and health promotion services;
- Administrative, clinical and environmental health department staff working space;
- Medical contractors performing services for the health department;
- Services or meetings of nonprofit agencies for the purpose of furthering the mission of public health; and
- Office space for district plumbing inspector, in accordance with [KRS 211.365](#), if requested, however, phone expenses and office supplies, etc., are not part of the state requirement.

LHD facilities may be used for any community activity/service, which makes a positive contribution to improving the health and safety of the community on a continuing or temporary basis with board approval. LHD staff should ensure the board is aware of any potential liability issues prior to decision-making.

**LHD facilities, quarters, or personnel may not be used by contracted physicians providing clinical services or acting as medical consultants in pursuit of their private practices** (except when approved by the BOH in public health disaster/emergency conditions or other community crisis situations with a foreseeable endpoint). LHD may allow the use of space to another nonprofit agency for its operations or as meeting space if the purpose of use furthers the mission of the LHD or public health. Rental contracts for the use of LHD facilities by another agency **must be reviewed by DPH, [Division of Administration and Financial Management](#) (AFM) and approved by the local BOH.**

## **INSURANCE REQUIREMENTS**

Insurance requirements for LHDs are found in Kentucky Administrative Regulation, Title [902 KAR 8:160](#), Section 9.

# Local Health Operations

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## **APPOINTMENT AND SCHEDULING REQUIREMENTS FOR HEALTH SERVICES**

To promote efficiency in LHD operations and patient population needs, a patient appointment system is essential. The computer system(s), software(s) and application(s) used by the LHDs will be referred to in general as the [LHD Network System\(s\)](#). Prior to entering patient appointments by providers into a LHD Network System, the calendar and provider record files must be created in order for the actual [scheduling process](#) to begin.

### **Calendar Record**

Following [KRS 18A.190](#), [KRS 2.110](#) and [KRS 2.190](#), the LHD calendar must contain all the state government observed holidays. Until Kentucky state holiday dates are released by the [Kentucky Personnel Cabinet](#) it will be up to the LHDs to ensure they do not schedule during dates that are typically observed as state holidays. Therefore, by January 1 of each year, all calendar dates are to be available so LHD scheduling can occur to avoid delays.

Once the Kentucky Personnel Cabinet determines and releases each year's state holidays, AFM will make those dates available on the [Local Health Personnel webpage](#). At that time, [appointment/provider scheduling](#) calendar updates will need completed.

### **Provider Record:**

Each LHD employee (provider) or group of providers must be setup as a separate record. The individual health department is responsible for setting up these providers.

Since the employee making the appointment must enter their employee number, it will be necessary to identify those employees making appointments to the employee file prior to their being able to enter and modify appointments. A security system has been set up for employees who are authorized to set up the provider's schedules. To obtain security access/clearance, the LHD director or his/her designee must present a security access request to the LHO Branch following procedures outlined within this section.

### **Provider Schedule:**

Each provider must be set up with a schedule for available hours per week. These [provider schedules](#), entered in the Clinic Management System (CMS/portal system), can be created up to 12 months in advance.

For additional information on how to setup a provider record or provider schedule, reference the [CDP Clinic Management \(Portal\) System User Manual](#) for general guidelines regarding patient appointments with specific requirements for the Women, Infants and Children (WIC) program in accordance with federal regulations and state policy.

### **All LHD Health Services**

Every effort shall be made to provide health services at the LHD within ten (10) calendar days from a patient's request for an appointment. Appointments for services may only exceed the ten (10) calendar days guideline when due to limited provider schedules. Subsequently, those appointments should be scheduled within reasonable time frames based on service availability.

LHDs may elect to operate utilizing appointments; same day scheduling; or some combination of the two according to program needs. The option(s) available to obtain an appointment should be clearly visible in the lobby, registration area of the LHD and on the LHD website.

### **Appointments/Scheduling for WIC Applicants**

- The time frame for migrants, pregnant women and infants is a maximum of ten (10) calendar days from their request for services.
- The time frame for all other WIC applicants to be served should be ten (10) calendar days from their request, but in no event shall the time frame exceed twenty (20) calendar days. Reference the [WIC and Nutrition Manual](#) found on the DPH website for more explanation.
- Each LHD that does not routinely schedule appointments shall schedule appointments for *employed adult individuals* seeking to apply or reapply for participation in the WIC Program for themselves or on behalf of others so as to minimize the time such individuals are absent from the workplace due to such application. Reference federal regulation [7 CFR – 246.7\(b\)\(4\)](#). The scheduled appointment should consist of a specific date and time.
- The name, address, telephone number and date of request for WIC services shall be recorded for all applicants.

### **Late Arrivals or Missed Appointments for WIC Services**

- Pregnant women missing initial WIC certification shall be contacted regarding their appointment.
- Priority shall be given to providing services within the pregnant woman's first trimester.
- WIC patients who are late for their food instrument pick-up appointments shall be served on the day of the appointment.
- Missed appointments for WIC certification shall be rescheduled as soon as possible, but not to exceed thirty (30) calendar days of the missed appointment. Reference the [WIC and Nutrition Manual](#) found on the DPH website for more explanation.

### **Walk-In Patient for Immunizations**

Based upon the terms of the LHD deputization agreement, "walk-in" VFC-eligible children should be provided services the day they present to the clinic or be scheduled for services as soon as possible.

### **Making the Appointment System Functional**

- If these appointment/scheduling objectives cannot be met, the health department director shall perform an analysis of the appointment/scheduling process, patient caseload, patient/clinic flow, community assessment, and staffing complement. Following the analysis, the director shall make any necessary changes to the appointment/scheduling process to ensure the appointment/scheduling objectives are met.
- The DPH will provide input and guidance, if requested.

## **Notice of Privacy Practices statement under HIPAA**

A health care provider must provide a notice to the patient that explains how the provider may use and share the patient's health information and how the patient can exercise their health privacy rights. Covered health care providers shall give the notice to their patients at the patient's first service encounter (usually at the first appointment) and the patient can ask for a copy at any time. The provider cannot use or disclose information in a way that is not consistent with their notice. The law requires the provider to ask the patient to state in writing that the patient has received the notice that day. A covered entity must give a copy of the notice to anyone who asks for one. If a covered entity has a website for customers, it must post its notice in an obvious location there. Specific requirements may be found at [45 CFR 164.520\(b\)](#) and [164.520\(c\)\(2\)\(iv\)](#).

## **Confidential Communication Requirements**

Covered health care providers must permit individuals to request an alternative means or location for receiving communications of protected health information by means other than those that the covered entity typically employs, [45 C.F.R. § 164.522\(b\)](#). For example, an individual may request that the provider communicate with the individual through a designated address or phone number. Similarly, an individual may request that the provider send communications in a closed envelope rather than a post card. Review the [Summary of the HIPAA Privacy Rule](#).

## **No Home Contact Individuals**

Individuals receiving family planning services may choose to be indicated as "[No Home Contact](#)". These individuals would be identified as such on the patient's master record in the Clinic Management (Portal) System. All LHDs must safeguard and ensure patient confidentiality. "[No Home Contact](#)" should also be indicated on the [Patient Encounter form \(PEF\)](#). LHD must ensure that no communication will be sent to the home of a "No Home Contact" patient, including billing statements, payer Explanation of Benefits (EOBs) regarding the visit, lab results, etc.

Ensure reasonable efforts are performed to collect charges at each visit but without jeopardizing patient confidentiality. If a "[No Home Contact](#)" patient has a previous balance containing family planning or STD/STI services, the bill screen will display with the current date of service charges and only non-family planning and non-STD/STI previous balances. If the patient is alone and/or if the entire account including previous family planning or STD/STI charges is needed, an "A" is entered in the bill screen box. All balances displayed will be included on the printed bill/receipt.

## **Appointment Reminder System**

- If a covered entity wants to contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits that may be of interest to the individual, the Notice of Privacy Statement under HIPAA must include a separate statement that such information will be provided to the client without the client authorization, and a description and example must appear in the Privacy Notice. [§ 164.520 \(b\) \(iii\)\(A\)](#).
- **KENTUCKY LHD BLOODBORNE PATHOGENS EXPOSURE CONTROL COMPLIANCE PLAN**
- The Notice of Privacy shall also state that the individual will be provided this information electronically, but has the right to request alternative means of communications under [§ 164.522 \(b\) \(1\) \(i\)](#). If the patient or individual requests

another form of communication other than electronic, then the covered entity must accommodate the reasonable request. It would not be reasonable for the communication to be delivered by Federal Express, but would be reasonable to have it by mail if the person does not have the capability to receive a text or email.

## HOUSEHOLD SIZE AND HOUSEHOLD INCOME OVERVIEW

Registrations and Income Determination, Authorizations, Certifications and Consents Forms are available on the [LHD Forms, Documents and Administrative Reference webpage](#) and/or the [CSG](#).

Household size and household income is not required for a health department service if the applicant is receiving at least one of the following:

- Medicaid/MCOs, including Medicaid Presumptive Eligibility (MPE), Medicaid Breast and Cervical Cancer Treatment Program (MBCCTP), Medicaid that is issued under Affordable Care Act (ACA), Kentucky Children's Health Insurance Program (KCHIP) Phase I, and KCHIP Phase II, or
- Medicaid as a "deemed eligible newborn" infant. A infant that was born to a mother who received Medicaid in Kentucky at the time of the newborn's birth is considered deemed eligible. This includes receipt of Medicaid in any category, including Modified Adjusted Gross Income (MAGI) Medicaid, Non-MAGI Medicaid, Time-Limited Medicaid, SSI, or K-TAP. **Once deemed eligible, the newborn is guaranteed Medicaid from the birth month through the 12th month regardless of whether the mother and/or other case members remain eligible to receive Medicaid.** Medicaid must be issued for a deemed eligible newborn even if the mother does not want the coverage. A child is considered a deemed eligible newborn even in situations where: 1) the Medicaid application for the mother is made after the birth of the newborn, as long as the birth month is the month of application or one of the three (3) retroactive months for which the mother is approved; 2) the mother is approved for spend down eligibility and the excess is obligated on or before the newborn's date of birth.) Department of Community Based Services, Division of Family Support Operation Manuals, Volume IVB MAGI Medicaid, APTC/CSR and QHP, Operation Manual Transmittal Letter (OMTL) – 457, effective 4/1/14, or
- KCHIP Phase III, except when the service is WIC certification and household size and income is required. Refer to the WIC and Nutrition Manual, Certification and Management, WIC Income Eligibility Requirements.

**Medicaid eligibility must be verified through the [KYHealth-Net System](#)** and/or through the patient Medicaid MCO plan, (which shows Medicaid eligibility and the type of Medicaid coverage,) or the local Department for Community Based Services (DCBS) office. The WIC Program requires verification of Medicaid Eligibility through the KY Health-Net System or the local DCBS due to KCHIP III.

Once eligibility is obtained, you may verify continued eligibility by one of the following methods by:

- contacting the Automated Voice Response System at (800) 807-1301
- using the Web-based [KYHealth-Net System](#)
- purchasing and using a swipe card reader

**FOR BILLING PURPOSES: A copy of the [KYHealth-Net System](#) screen showing Medicaid eligibility must be printed/made available and included in the individual's**

**medical record at the provision of the first and subsequent billable service. If the patient has coverage with a KY Medicaid MCO, eligibility needs to be verified with that MCO plan.** Until eligibility can be maintained in an Electronic Health Record format, that is approved by DPH and available, a copy (printout) of this screen is the only acceptable documentation of eligibility for re-submission of billings that have been denied due to “patient not eligible at time of service”. For MPE and MBCCTP, a copy of the identification sheet for MPE or MBCCTP should be made and filed in the individual’s medical record at the provision of the first billable service of the month.

**Household size and *current* household income is required for:**

- All services for which the [Uniform Percentage Payment Schedule](#) is applied. This schedule, along with the household income, determines the patient’s fee/payment for the service. **Payment percentage is determined prior to the delivery of services.**
- WIC certification when adjunct eligibility or transfer of eligibility does not apply. Refer to the [WIC and Nutrition Manual](#), Policy 206, Determining Household Size and Household Income.

Household size and household income shall be determined in a confidential manner and at no cost to the applicant. Income and sliding scale fees shall be assessed on a “[No Home Contact](#)” client based on the individual’s personal income, not household income.

Obtaining verified information of household income is not required for any services except WIC certification. Refer to the [WIC and Nutrition Manual](#), Policy 206, Determining Household Size and Household Income.

Household size and household income must be documented for each individual when applying the Uniform Percentage Payment Schedule or WIC Income Eligibility Guidelines and filed/saved in that individual’s medical record. Documentation is done by completing the CMS Portal Patient Registration Screen, printing registration/income labels and completing the applicable [Registration, Authorizations, Certifications, and Consents form](#) (CH-5 or CH-5WIC). **If the automated system is unavailable**, the [Patient Registration and Income Determination form](#) (CH-5B) must be completed and filed/saved in the medical record, and data subsequently entered in the system once available.

Once determined and documented, household size and household income is valid for six (6) months except for WIC certification. If household size and household income has been established within the past six (6) months or within the current pregnancy for pregnant women, it is not required to collect household income again when the patient presents for additional services unless otherwise specified in this document. If household income was determined more than six (6) months from the date that the patient presents for services, household size and household income must be determined. If the household size and household income remain the same as that collected six months ago, the patient may sign and date the current registration form for all services except WIC certification. Refer to the [WIC and Nutrition Manual](#), Policy 206, Determining Household Size and Household Income.

Current household income or the household income during the past twelve (12) months may be considered to determine which more accurately reflects the status. To clarify the definition of “current income” – it is income RECEIVED by the HOUSEHOLD during the month (30 days) PRIOR to the date of the application.

Income for persons who are unemployed shall be the income during the period of unemployment.

Persons who are on leave that they themselves requested (i.e., maternity leave or a teacher not being paid during the summer) are not considered unemployed. Therefore, the person's income earned during the regular employment period must be averaged to determine annual income.

The weekly, bimonthly or monthly income shall be converted to annual household income for application of the Uniform Percentage Payment Schedule. The exception applies to the WIC Income Eligibility Guidelines.

WIC Income Eligibility Guidelines are calculated based on the individual's frequency of pay. The system is programmed to compare the weekly, bimonthly, semi-monthly, or monthly income to the WIC Income Eligibility Guidelines.

### **Determining Household Size**

Household is defined as a group of related or non-related individuals who are living together as one economic unit. Household members share economic resources and consumption of goods and/or services. The terms "economic unit" and "household" are sometimes used interchangeably. Residents of a facility, such as a homeless facility or an institution, shall not all be considered as members of a single household/economic unit.

It is reasonable that persons living in the residence of others, whether related or not, are likely to be receiving support and some commingling of resources. This would make them members of the economic unit with which they live. However, a household may consist of more than one economic unit. Appropriate questioning must be done to make a reasonable determination of whether resources are shared or not.

To determine the size of the household, consider the guidance below:

#### **Unmarried Couple:**

An unmarried couple living together as one household counts the income of both parties and counts both in the household size. Income for all persons supporting the household is counted.

#### **Child:**

A child is counted in the household size of the parent, guardian or caretaker with whom he/she lives.

#### **Foster Child:**

A foster child is a separate household of one as long as he/she is the legal responsibility of a welfare agency, social service, or other agency. Foster children less than 18 years of age are eligible for Medicaid and the Department for Community Based Services applies for Medicaid on behalf of the child. The foster child's Medicaid eligibility cannot be used to establish WIC eligibility of other members of the household.

*Questions To Ask:* Is the child the legal responsibility of a welfare agency or social service agency? If yes, the applicant is a household of one.

#### **Joint Custody:**

In joint custody, or cases where the child may live with both parents equally, the child is counted in the household of the parent or guardian who is seeking services for the child.

The child may NOT be counted in the household of the other parent. The parent who made application receives WIC benefits. It is the responsibility of the two parents to mutually agree on sharing the child's WIC food benefits.

**Child Residing With Caretaker:**

A child in the care of a friend or relative is considered a part of the household of the caretaker with whom he/she is residing. All persons with income supporting the household are considered, including any monetary support provided from the parent(s).

**Adopted Child:**

An adopted child or a child for whom a family has accepted the legal responsibility is counted in the household size with whom he/she resides.

**Student:**

A child residing in a school or institution, who is being supported by the parent/caretaker, is counted in the household size of the parent/caretaker.

**Alien/Foreign Individual:**

It is legal for an alien/foreign individual and his/her family to apply for services. He/she/they are members of the household in which he/she/they reside.

**Military:**

Military personnel serving overseas or assigned to a military base, even though they are not living with their families, are counted as members of the household, along with the military personnel's gross income.

Military Family in Temporary Residence of Friends or Relatives: When military personnel are deployed or assigned to a military base and temporarily absent from home, their family (children [if parents are deployed], children and one parent, or spouse) may temporarily move in with friends or relatives. In this situation, flexibility is allowed to ensure minimal impact on military family member's eligibility and/or receipt of services. The "military family" household size is determined through the following options:

- Count the "military family" as it was prior to the deployment/assignment of the military person(s) as a separate economic unit. This option counts the deployed person(s) and gross income. Use of this option is dependent on whether the total gross income for this economic unit can be reasonably determined.
- Count the "military family" as it is now as a separate economic unit without the deployed person(s). This option does not count the deployed person(s). To consider as a separate economic unit, the unit must have its own source of income, e.g., allotment to the spouse and/or children.
- Count the "military family" as part of the household of the person(s) with whom they reside. All persons and all income for this household are counted. Refer to the [WIC and Nutrition Manual](#), Policy 206, Determining Household Size and Household Income.

**Homeless:**

Individuals whose primary residence is a shelter providing temporary living accommodations or who lack a fixed and regular nighttime residence are considered homeless and are considered a separate household.

Questions To Ask Individual: Do you lack a fixed and regular nighttime residence? If yes,

count as a separate household. Is your primary nighttime residence a shelter for temporary living accommodations? If yes, count as a separate household.

**Separate Economic Unit:**

A person or group of persons living in the same house with other individuals may be a separate economic. To be considered a separate household, the individual must have their own source of income and cover their own expenses, such as rent, food and utilities.

*Questions to Ask:* Do you share income and expenses with other people? If yes, count all members as one household. Does the household provide you food, clothing, shelter, etc., with no expectation of payment or in-kind benefits? If yes, count all members as one household. Do you pay the household for living in their home or exchange household chores for living expenses? If yes, the applicant is a separate household.

**Pregnant Woman:**

A pregnant woman’s household is increased by one for each unborn child. If she is expecting one child, count her as two; if she is expecting twins, count her as three; and so on. The increased household size should be used for other household members applying for services when determining their household size. Also see information related to [Medicaid Presumptive Eligibility](#)(MPE) within this section.

*NOTE:* If the applicant has a cultural or religious objection to counting the unborn child/children, this shall not be done. The objection should be documented in the patient medical record since it affects household size and income determination.

**Exceptions:**

**Maternity Services Exception ONLY:** A pregnant woman who conceives prior to her 21<sup>st</sup> birthday and resides with her parents/guardian, but whose parents/guardian will not be providing her with financial support for maternity care, shall be counted as a separate household. (If the pregnant woman is married or has dependent children living with her, her husband, her children and she are a separate household.)

**Clarification for Minor Family Planning Patients:** Unless a minor is completely emancipated under state law, regulations as to ability to pay must be based upon the minor’s household income. Only when a minor is unable to pay for services without having to inform his/her parents and the minor requests services on a confidential basis should the project look solely to the minor’s income.

**Determining Household Income**

*Household Income is any money that is earned, unearned and received by all members of the household, which includes:*

**Gross income** (before deductions for income taxes, employee’s social security, insurance premium, etc.) for the following:

- Monetary compensation for services, including wages, salary, commissions, fees, and overtime.
- Public assistance or welfare payments (KTAP, Supplemental Security Income [SSI], etc.).
- Pensions or retirement.
- Black lung or other disability payment.

- Social Security benefits.
- Government civilian employee or military retirement or pensions or veterans' payments/benefits.
- Unemployment compensation or worker's compensation.
- Alimony and child support payments.
- Payment from the military including food and clothing allowance. Do not include housing allowance.

**The following income sources must also be included:**

- Regular contributions from person not living in the household.
- Dividends or interest on savings or bonds, income from estates, trusts, or investments.
- College or university scholarships, grants, fellowships, and assistance except as excluded below.
- Strike benefits.
- Payments or winnings from gaming, gambling, lottery, and bingo.
- Cash received or withdrawn from any source, including savings, investments, trusts.
- **Lump sum payments. These are defined as follows:**
  - Payments that represent new money intended for income is counted as income. Examples include: gifts, inheritance, lottery winnings, worker's compensation for lost wages, severance pay, and insurance payments for "pain and suffering." Lump sum payments for winnings and proceeds from gaming, gambling, and bingo are also counted as income.
  - Payments that represent reimbursement for lost assets or injuries should *not* be counted as income. Examples include: amounts received from insurance companies for loss or damage of personal property, such as home or auto; payments that are intended for a third party to pay for a specific expense incurred by a household, such as a payment of medical bills resulting from an accident or injury.
  - The lump sum payment may be counted as annual income or may be divided by 12 to estimate a monthly income, whichever is most applicable.
- **Net income** for self-employed and farm (determine net by subtracting operating expenses from the total amount made) only for the following:
  - Net royalties.
  - Net rental income.
  - Net income from farm (money from tobacco, crops, etc.) or non-farm self-employment.

Income cannot be reduced for hardships, high medical bills, child care payments, taxes, child support, alimony, insurance, or other deductions.

**The following shall NOT be considered as income:**

- Non-cash benefits, in-kind housing, and in-kind benefits such as employer paid or union-paid portion of health insurance or other employee fringe benefits, food, or housing received in lieu of wages.
- Capital gains, the sale of property, a house, or a car.
- One-time payments from a welfare agency to a family or person who is in temporary financial difficulty.
- Tax refunds.

- Federal non-cash benefits programs: [Medicare](#), [Medicaid](#), [National School Lunch Act](#), [Child Nutrition Act of 1966](#), [Food Stamp Act of 1977](#).
- Payments or allowances from the [Home Energy Assistance Act of 1981](#); Reimbursements from the Home Energy Assistance Act of 1981; payment to volunteers under Title I (VISTA and others), Title II (RSVP foster grandparents and others) of the [Domestic Volunteer Service Act of 1973](#); payment to volunteers of the [Small Business Act \(SCORE and ACE\)](#); payments received under the [Job Training Partnership Act \(JTPA\)](#).
- Educational grants and tuition assistance received from any program funded in whole or in part under [Title IV of The Higher Education Act of 1965](#) (Pell Grants, State Student Incentive Grants, National Direct Student Loans, Supplemental Educational Opportunity Grant, State Student Incentive Grants, PLUS, College Work Study, And Byrd Honor Scholarship programs).
- Cash or non-cash payments from a Child Care and Development Block Grant or other purchase of child care subsidy.
- Earned Income Tax Credit (EITC) payment/refund.
- Loans to which the applicant does not have constant or unlimited access.
- Family Subsistence Supplemental Allowance (FSSA). This is a payment made to certain members of the Armed Forces and their families by the Department of Defense.
- **For military personnel:**
  - Military Housing allowance (off-base and on-base housing allowances). Such housing allowances include Basic Allowance for Housing (BAH), Family Separation Housing (FSH) and Overseas Housing Allowance (OHA).
  - Overseas Continental United States cost of living allowance (OCONUS COLA) provided to military personnel in high cost of living areas outside the contiguous United States.
  - Combat Pay:  
For additional guidance in exclusion of Combat Pay from WIC income eligibility determination, refer to WIC Income Eligibility Requirements, [Appendix I: Guidance for the Exclusion of Combat Pay from WIC Eligibility Determination](#).

**Computing Household Income:**

- Consider the current **household** income or the household income during the past 12 months to determine which indicator more accurately reflects the status. **Current income** is defined as **all income RECEIVED** by the household during the month (30 days) **prior** to the date of the application. If the income assessment is being done prospectively (e.g. a household member has been laid off but has been authorized to receive unemployment benefits for the next six months), “current” refers to income that will be available to the household member in the next 30 days.
- Clarification for number of paycheck stubs recommended for review. If an applicant indicates they are paid weekly, it would be reasonable to look at four paystubs from the past four weeks (30 days). The table below indicates the number of paystubs recommended to review for EACH type of pay period.

<b>Pay Period:</b>	<b>Request to Review Paystubs:</b>
Monthly	1
Weekly	4
Twice a Month (Semi-Monthly)	2
Every 2 Weeks	2 to 3

**Exceptions to the provision are:**

- Unemployed person (including laid-off workers), use income that will be available to the household member in the next 30 days.
- Self-employed or seasonally employed person whose household income fluctuates through the year, use annual.
- Person on temporary leave (maternity, family leave, extended vacation), use annual. (This is not considered unemployed.)
- Teacher paid on ten (10) month basis, use annual.
- Person on strike, use income that will be available to the household member in the next 30 days, including any strike benefits.
- Sources of income for the household may not be the same timeframe (weekly, monthly, etc.).

**NOTE: The system is programmed to convert income to common terms to determine the total household income [WIC and Nutrition Manual](#), Policy 206, Determining Household Size and Household Income.**

**Applicant Reporting Zero Household Income**

- An applicant declaring zero income must be asked for information as to how basic living necessities such as food, shelter, medical care, and clothing are obtained. Persons living together and sharing resources are members of **one** economic unit.
- When the interviewer is satisfied that the person's income is zero, obtain the applicant's signature on the CH-5/CH-5-WIC as documentation that income has been reported accurately. For WIC certification, see the [WIC and Nutrition Manual](#), Policy 207 Required Proofs Not Present.

**Verification of Household Income**

Verification of income is not required *but is strongly encouraged* especially if the agency personnel have reasonable cause to believe the applicant's income is in excess of the income reported **OR** when the agency's policy is to verify income for all clinical services provided, as applicable. **(For WIC income verification, refer to WIC income requirements).**

If verification is requested due to reasonable cause, documentation of the reason for requesting verification shall be made in the person's medical record.

When requesting proof of income due to reasonable cause, any difference in income shall be discussed with the patient and the patient shall be asked to explain. **All documentation shall be entered into the medical record.**

To verify the income of an individual/household, the following procedures shall apply:

**Proof of Income:**

Written proof of income for the household must be presented at every 6 months income determination or as applicable. (See "Household Income Definition")

Examples of acceptable proof of income, but not limited to, are:

- Current paystub with **GROSS** amount and the pay timeframe (weekly, bi-weekly, semi-monthly, monthly, etc.)

- Signed statement from employer indicating gross earnings for a specified pay period or any responsible person who can accurately verify income if the employer refuses to do so. *No person may be denied participation in services solely because the employer refuses to verify income.*
  - W-2 forms or income tax return forms for the most recent calendar year. Additional documentation or signed written statements of income may be requested to update this to "current income". **W-2 forms and income tax returns are ONLY APPLICABLE for Self-Employed individuals.**
  - Income tax return for most recent available calendar year. (Use the adjusted net income indicated on the Federal tax return.) Additional documentation or written statements of income may be requested to update this to current income.
  - Unemployment letter/notice.
  - Check stub/award letter from Social Security stating current amount of earnings.
  - Tax returns for self-employed. Use the adjusted net income.
  - Court decree or copies of checks for alimony or child support.
  - Letter from person(s) contributing resources.
- NOTE CONCERNING PAYCHECK STUBS: If the pay is standard (*does not vary*), one paycheck for the most recent pay period prior to the application for services will be sufficient. However, if the pay varies (shift work, overtime, commissions, etc.), paycheck stubs during the month prior to application should be averaged to represent the amount received.

The type of proof(s) of income should be documented in the patient record either by electronic entry or on service note.

**Applicant Failing to Bring Proof of Income:**

- For an applicant who has proof of income but fails to bring it, inform of the requirement for proof of household income; and
- Make a new appointment within a reasonable timeframe for appointment scheduling. Refer to this section for "Appointment and Scheduling Requirements for Health Services".

Applicant Unable to Provide Proof of Income

- An applicant who has no written proof of income, such as a migrant, a homeless person, or a person who works for cash, or who reports income as zero, can self-declare income and must provide a signed statement. An applicant where military service personnel are temporarily absent from home and proof of gross military income cannot be produced, may self-declare income and must provide a signed statement.
- The statement must include why **written proof** of income cannot be provided, (i.e., homeless, migrant), the date, and the person's signature. For zero income, an explanation of how living expenses are met must be included.
- The statement must be filed/saved in the patient's record.
- The statement is applicable only to the income assessment period for which it was provided. When the need for a new income assessment is required, if the person still has no proof of income, another statement must be obtained for this assessment period.

An optional form, Statement of No Proof (**CH-NP**), is available on the [LHD Forms webpage](#) **The WIC Program requires the Statement of No Proof (WIC-NP) form**

## to be used for WIC Services

### New Income Information:

If the local agency staff has reason to believe that income information or household size provided at the time of service was **not accurate or complete**, the agency should reassess the income for that time period. The reason for reassessment should be documented in the patient's record and any fees/charges assessed should be reviewed and corrected, as applicable.

**A participant/caretaker reports a change in income or Medicaid status.** If after a new income assessment has been completed and it is determined the income has changed, the new income determination will be used from that date forward until a new income assessment is required. For those patients determined to have Medicaid coverage, the agency will bill Medicaid for all applicable services and refund any payments received from the patient for those same services. **Refer to the WIC Income Eligibility Requirements for new income information guidelines that are specific to the WIC Program, [WIC and Nutrition Manual](#), Policy 206, Determining Household Size and Household Income.**

### Patient chooses NOT to provide income:

If the patient will not receive a service that is based on federal or state regulations requiring "income eligibility" to participate in the program **AND** chooses to not provide their income; the patient may sign the appropriate box required for "Financial Certification signature" on the CH-5 Registration document and **will be charged at 100% of the set rate for the service(s) provided** and in accordance to applicable Rules and Regulations.

## OVERVIEW OF PATIENT FEES & SERVICES

Public health services benefit the entire population. The LHD shall make [Foundational and Core Public Health Services](#) available to all persons within the appropriate guidelines prescribed by DPH. With the exception of communicable diseases, family planning services, and WIC; *priority* should be given to residents of the health department's service area.

LHDs do not possess the discretionary authority to exclude immigrants (*NON* United States citizens) solely based on their alien or immigration status. Federal regulations require Family Planning Programs funded through Title X to provide services regardless of residency or referral from other providers.

### Patient Fees

Using income accurately provided by the patient, the LHD may assess the patient a fee for health services provided (except Prenatal at or below [185% poverty](#); WIC; and HANDS) unless otherwise directed by law, regulation, or grantor requirements. Review [902 KAR 8:170](#), Section 3 [4] for specific requirements regarding patient fees.

**Patient fees are determined through an income assessment** unless otherwise directed by law, regulation, or policy. (See [Income Determination](#) as outlined above).

Fees are assessed, on each service date, as follows:

**[Uniform Percentage Payment](#)** (*Patient's Sliding Fee Schedule*)

- The Uniform Percentage Payment Schedule is based on the annual Federal Poverty Level Guidelines, with the fee determined by the patient's ability to pay. **The patient sliding fee schedule** is based on the [Uniform Percentage Payment Schedule](#) beginning at 0% for patients with an income below 101% poverty and ending at 100% pay for patients with an income above 250% poverty.
- The [Uniform Percentage Payment Schedule](#) is calculated using the annual 100% to 250% Federal Poverty Level as published by the United States Department for Health and Human Services (DHHS) under the authority of 42 U.S.C. 9902(2) in the [Poverty Income Guidelines section of the Federal Register](#) Document Citation.
- The [Uniform Percentage Payment Schedule](#) is updated annually and made available on the [LHD Information webpage](#).
- Unless otherwise notified, the effective date of the annual update to the **Uniform Percentage Payment Schedule** will be April 1 of each year. The Clinic Management System (CMS) and the Patient Services Reporting System (LHD Network Systems) will be updated to reflect the April 1<sup>st</sup> implementation schedule.

Poverty level as per DHHS Poverty Income Guidelines published annually in the Federal Register.

- **Nominal fee up to five (5) dollars**

A nominal fee (flat fee) up to five (5) dollars **per CPT code** or as determined by Kentucky Administrative Regulation is charged for **communicable disease** services, when those services are the primary reason for the visit. Those communicable diseases, as allowed and determined by DPH through [902 KAR 8:170](#), Section 3(4)(b), are tuberculosis (TB), sexually transmitted diseases (STDs)/sexually transmitted infections (STIs), and the human immunodeficiency virus (HIV). Review the information under [Fixed Full Charge](#) (below) for individuals seeking TB screening and testing services.

***The following is applicable to the programs administered within the Kentucky Immunization Branch (KIB):***

**Underinsured:**

- A person who has health insurance, but the coverage does not include vaccines.
- A person whose insurance covers only selected vaccines. Children (individuals under 19 years of age) who are underinsured for selected vaccines are VFC-eligible for non-covered vaccines only.
- Underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under a LHD with an approved deputization agreement.

**Fully Insured**

Anyone with insurance that covers the cost of vaccine, even if the insurance includes a high deductible or co-pay, or if a claim for the cost of the vaccine and its administration would be denied for payment by the insurance carrier because the plan's deductible had not been met are **not eligible** for the Kentucky Immunization Branch (KIB) program vaccines unless special circumstance occur and guidance will be provided by KIB.

## Fixed-Full Charge

- LHDs may option to apply Fixed-Full Charge patient fees for pediatric and adult immunizations *that have been purchased with LHD funds* without written request from the DPH.
- Rates for Fixed-Full Charge (FFC) fees will be maintained by DPH and listed on the Service/Charge File(s). The rates will be reviewed annually and updated as needed based on the Medicare resource-based relative values geographically for Kentucky.
- For individuals seeking TB screening and testing services related to initial employment, ongoing occupational health and/or entrance to post-secondary education a FFC may be made at the current [Medicaid Preventive Health fee schedule rate](#)

If LHDs have questions about service/charge file rates or if a particular service may be processed as a FFC, contact the [Local Health Operations Branch](#).

LHDs **may not override** patient fees assigned by the system, unless specifically authorized, in writing, by DPH, Division of Administration and Financial Management (AFM). A DPH authorized override is only approved and valid through June 30 of each year. An LHD must submit another timely override request for DPH/AFM approval. LHDs should allow up to 10 business days from receipt of override submission for the AFM review and response. Review the [Financial Management section](#) for additional override requirements.

**The [LHD Network System\(s\)](#) will automatically compute the correct fee.** *Service/Charge files are reviewed annually and updates to CPT code rates (fees) are made as needed during the 1st quarter of the calendar year.* Rates will also be updated as needed following protocols approved by the LHO Branch.

The *State Average Cost* is based on values established by the Centers for Medicare and Medicaid Services, a federal government agency. The Relative Value Unit (RVU) assignment is adjusted by the geographic region; otherwise known as, Geographic Practice Cost Index (GPCI). The RVU is a measure of value used in the Medicare reimbursement formula for physician services. RVUs are a schema used to determine how much money medical providers should be paid.

**LHDs may provide services at a FFC (referenced in the table below as Exceptions) without requests for Approval by DPH/AFM.** All Charge rates including the FFC rates in the Service/Charge File(s) will be maintained by AFM using web-based software approved by the American Medical Association (AMA). AFM will use the current RVU (weight) per code and, where available, for VACCINES the Center for Disease Control and Prevention (CDC) PRIVATE SECTOR per dose price rates will be used.

<b>LHD – PATIENT SELF-PAY FEE MATRIX</b>		
<b>COST CENTER:</b>	<b>DEFAULT PATIENT SELF-PAY FEES:</b>	<b>EXCEPTIONS TO DEFAULT FEES:</b>
800 Pediatrics/Adolescents	Sliding based on State Average Cost	Fixed Full Charge for NON-VFC/KVP/Special Grant Funded Pediatric/Adolescents Immunizations
802 Family Planning	Sliding based on State Average Cost	
803 Maternity	Sliding based on State Average Cost	
805 Medical Nutrition	Sliding based on State Average Cost	
806 Tuberculosis	Nominal of 50% of State Average Cost with \$5.00 max	Fixed Full Charge for services NOT included in the CSG
807 Sexually Transmitted Diseases	Nominal of 50% of State Average Cost with \$5.00 max	
809 Diabetes	Sliding based on State Average Cost	Fixed Full Charge for services NOT included in the CSG
810 Adult	Sliding based on State Average Cost	Fixed Full Charge for Adult Immunizations
		Fixed Full Charge for Flu and Pneumonia Immunizations
811 Lead	Sliding based on State Average Cost	
	Sliding based on State Average Cost	

**Inability to Pay Patient Fees**

A patient’s percentage pay based on household size and household income should be an indicator of the patient’s ability to pay their percentage amount of the services delivered. In accordance with [902 KAR 8:170](#), Section 3 (4) (b) 2 a, inability to pay the assessed patient fee shall not be a barrier to services.

The [LHD Network System\(s\)](#) will determine the appropriate charge amounts for services delivered based on the accurate income entered at the time of service by the LHD

The LHDs ability to collect payments or determine write-offs will be based on LHD policy. LHDs should post signage stating an individual’s inability to pay will not prevent the individual from being provided services. This signage should be posted in the lobby and at the registration desk(s).

**Health Insurance**

A patient who has health insurance coverage shall be billed the full *usual and customary* charge for each service/procedure (CPT code) provided. A Medicaid “spend down” patient shall be billed at 100 percent of charges. A balance not covered by health insurance shall be charged to the patient, except that the amount charged shall not exceed the amount that a patient without health insurance coverage would be

charged, using standard discounts as applied to total charges for services rendered, [902 KAR 8:170](#), Section 3(4)(e). [Medicaid Recipient Cost Sharing](#) regulatory information may be reviewed at 907 KAR 1:604.

### **Medicaid Presumptive Eligibility (Maternity Patients Only)**

Patients coming in for pregnancy tests are registered as usual.

- **Income screening is performed since pregnancy testing is a Family Planning service.** If pregnancy test is negative, PEF entry and checkout is performed as usual.
- If pregnancy test is positive and patient meets criteria for **Medicaid presumptive eligibility (PE)**, patient should return to registration desk for determination of PE.
- Instructions given by Medicaid in PE trainings must be followed.
- After PE is determined, the PE eligibility or denial document is printed **at the time of application**, and the document is received/provided with the following steps taken:
  - Patient will have a new registration completed using the PE. **REMEMBER:** The positive pregnancy adds one additional member to the household size.
  - For PE, the WIC income proof code will be the same as the code for a person who has a Medicaid card or who has KCHIP I or II.
  - A new PEF label is initiated/printed containing the newly determined eligibility information.
  - The original PEF and the new PEF are stapled together. The original PEF number is voided at checkout.
  - The new PEF is entered into the system under the new PEF number with the information contained on both the original and new PEFs.
- **Patient are instructed to go to the local DCBS, Family Support office and apply for Medicaid as soon as possible and prior to their PE ending date.**

When the patient returns for **billable** services after the end of the PE period, they will need to bring with them information where they have both applied and qualified for Medicaid or have a Medicaid denial.

**If the patient has a Medicaid DENIAL or cannot prove they applied for Medicaid beyond "PE";** the patient is screened for income per the Public Health Prenatal Program (PHPP) eligibility requirements. The patient must be at or below 218% FPL and have no other payer source to participate in the PHPP.

WIC policies that are currently in place will apply to PE patients as they do to those patients having Medicaid or KCHIP I or II.

### **KY Medicaid PE Website**

PE may be granted to a woman if she meets the following criteria:

- Meets eligibility criteria established in [907 KAR 20:050](#), Section 3;
- Meets income guidelines established in [907 KAR 20:050, Section 3\(2\)\(b\)](#).

**LHD patients should call Medicaid's Division of Member Services** at the toll free number(s) **if they want to select a certain MCO** on the date of the PE application approval or if they have questions concerning their MCO assignment.

**Currently, the PE approved member can contact DMS at 1-855-446-1245 on the day of approval and select an MCO** or the following day to determine what MCO was system assigned. If PE member wishes to change the system assigned MCO, the change is effective the first day of the following month, provided they call before the monthly cut off. Changes requested in the last eight working days of each month are not effective the next month but the following month. The cut off is necessary to submit membership records for the following month to the assigned MCO.

The MCO assignment is processed the evening of the approval, that information is then transmitted to the MCO. The MCO should receive the member information the following morning and load the member into their system that day, as many of the MCOs have subcontractors, the member information is then pushed out to the subcontractors and that may take an additional day.

PE members needing services immediately can call the Medicaid Member Service line at 1-800-635-2570, member reps can then make contact with the assigned or selected MCO and request an urgent member add. In the event the MCO states they do not have a member showing on their system, a call to DMS member line would be the appropriate next step, as DMS staff can work with the assigned MCO and ensure the member's eligibility is reflected in the MCO systems.

**Both toll free lines listed are answered by DMS staff.** Ask to speak with the Member Services Director's office if a member services staff member is not able to assist.

## **CLINIC BILLING GUIDELINES**

### **PATIENT SELF-PAY**

Monthly statements for patient pay account balances are generated on the 597 E-report. The 597 runs the first weekend following the end of the month. E-report 598 contains statement labels. These statements are made available to LHDs to utilize in billing patients for outstanding self-pay invoices. Receipts for any self-pay payments received should be provided to the patients.

### **MEDICAID /MEDICAID MCO BILLING**

For LHDs that participate in the Kentucky Preventive Health Services Program, the system will automatically bill for covered services for patients enrolled in traditional Kentucky Medicaid or a Medicaid MCO.

Each of the **service providers** for your department has a third party billing status in their provider master record. This status is used to determine if any third parties may be billed for each provider's services to a covered patient. All employees (providers) are automatically set to yes. Independent contractors are individually setup based upon the information in their contract and entered at the state level.

DPH recommends that a Kentucky Medicaid Preventive Health Services Program Statement of Authorization – Other Providers form be obtained for each independent contractor and other provider used by your department.

At the end of each month, the Applied Potential Medicaid report (E-report # 375) is available. The report lists all patients (and their PEFs with covered services) who were marked as applied potentially eligible for Medicaid/Medicaid MCO. PEFs containing WIC only services will not be listed. [Medicaid Recipient Cost Sharing](#) regulatory information may be reviewed at 907 KAR 1:604.

**TO SETUP A NEW LHD CLINIC SITE:**

Contact the LHO Branch for procedural instructions and guidelines concerning the site-naming format, Medicaid, NPI, CLIA, and Taxonomy numbers.

After receiving Medicaid/NPI/CLIA/Taxonomy numbers from payor source (e.g. Medicaid/MCO, private insurance company, Medicare) contact the LHO Branch to notify ready to complete the setup process to start billing for services at the new clinic site. Be advised that the LHO Branch is not a Medicare or private insurance provider and cannot provide assistance with obtaining provider information. Additionally, LHO cannot provide claim adjudication or billing error assistance/support with these agencies due to HIPAA guidelines.

**CH-45, PATIENT ENCOUNTER FORM (PEF) and the PEF CODING SHEET are available** on the [LHD Forms, Documents and Administrative Reference webpage](#). *The PEF collects data, categorizes the service information by type of visit through the use of universally accepted and American Medical Association (AMA) approved [CPT \(procedure\)](#) and [ICD \(diagnosis\)](#) codes and provides third party billing information. It is designed to relieve the health department service providers from some of the reporting burden. However, **the service provider maintains full responsibility and accountability for what is coded to the PEF.** Oftentimes, the provider simply checks or enters the CPT/HDPT procedure codes, the ICD codes and their provider number. The LHD network system assigns the Cost Center and the payment source, i.e., Medicaid, MCO, Medicare, patient pay, etc.*

**REASON FOR VISIT CODES**

Consistent with the DPH and LHDs' philosophy of patient centered health care, the reason for appointment/visit addresses broad categories of services; preventive medical, preventive counseling, other medical, other counseling, laboratory, radiology, etc. **As a rule, LHD specific reason for visit codes will not be incorporated into the LHD Network System(s) unless they can be used statewide.** This decision will be made by the LHO Branch.

The [reason for visit code](#) is used to identify the purpose of the appointment being made. If an appointment has not been made and the patient is seen without an appointment, the [reason for visit](#) is required to be entered on the registration screen. This code is used to trigger certain flags for the appointment/registration staff, e.g., patient income information is required, health checkup is due so an appointment can be made, and proof of identity, residence and income are needed for WIC certification or re-certification. Also it is necessary to know the type of provider staff to schedule

**TO BUILD AN INSURANCE OR CONTRACT IDENTIFICATION CODE FOR BILLING IN THE CMS-PORTAL SYSTEM:**

On the CMS-Portal home page, on the left side of the page under "Applications" and click on "Insurance or Contract Search".

- [HH Received](#)
- [HH Cancel Transfer](#)
- [Immunization Registry](#)
- [Insurance or Contract Search](#)
- [PEF Assigned Actions](#)
- [Patient Search](#)
- [Scheduling \(old\)](#)
- [Holiday](#)

On the Insurance/Contract Search page you may choose by Name of health clinic, by health department "District" (*required*), Type (*insurance company, contract*), and the Record Status. Searching by "**District**" **only** will provide a complete list of both insurance and contract records.

The screenshot shows the 'Insurance / Contract Search' interface. At the top, there are 'PORTAL' and 'LOGOUT' buttons. Below that, the search form includes fields for 'Name', 'District \*', 'Type', and 'Record Status'. There are 'SEARCH' and 'CLEAR' buttons. At the bottom of the form, there are navigation buttons: 'NEW', left arrows, 'Page 1 of 0', right arrows, 'Size: 10', and 'GO'. The message 'There are no results to display.' is shown below the search form.

After a Search page has been opened, you have the option to edit an existing record or build a new insurance or contract record.

The screenshot shows the search results for 'Local Health' in the 'District' field. The 'NEW' button is circled in red. The results table is as follows:

District	Name	Type	Ins. Code	Contract Code Alpha	Contract Number	E-Billing?	Copay?	Percentage	Flat Rate	Record Status
50	CAB. FOR FAMILIES & CHILDREN	Contract	956			No	No			Active
500	CAB. FOR WORKFORCE DEVELOPMENT	Contract	957			No	No			Active
500	HUMANA	Insurance Company	9000			Yes	No			User Delete

To build a new insurance or contract record, complete all required fields and any optional fields; then Save. For editing existing records, make changes and then Save.

The screenshot shows a web form titled "ADD INSURANCE/CONTRACT". The form includes the following fields and controls:

- District: 500
- Code: \* [input field]
- Contract Code Alpha: [input field]
- Contract Number: [input field]
- Type: \* [dropdown menu]
- Copay: [input field]
- Copay Percentage: [input field]
- Flat Rate: [input field]
- Payor Source: \* [input field]
- Name: \* [input field]
- Address 1: \* [input field]
- Address 2: [input field]
- Address 3: [input field]
- City,State ZIP: \* [input field]
- Zip Code 2: [input field]
- Phone Number: [input field]
- Fax Number: [input field]
- Electronic Billing?: [dropdown menu]
- NEIC Number: [input field]
- Bill Nurse Visits?: [dropdown menu]
- Anthem?: [dropdown menu]
- Email: [input field]
- Record Status: [dropdown menu, currently set to "Active"]

At the bottom left, there are two buttons: "SAVE" (circled in red) and "CANCEL".

A more detailed PowerPoint instruction document titled "How to Use CMS-Portal to Build Insurance Companies or Contract P8s" may be found on the [CDP website](#). Contact CDP Customer Support for all technical assistance.

### **PATIENT ACCOUNTS RECEIVABLE CREATION AND ADJUSTMENTS**

Individual patient's account receivables (A/R) are automatically created by the PEF entry system for patient, Medicaid, Medicaid MCO's, Medicare, insurance, other third party.

The patient pay account receivable is created immediately upon entry of the PEF into the system. Immediate corrections to the PEF on the day of entry will also immediately correct the patient pay A/R.

Medicaid, Medicaid MCO's, Medicare, insurance and other third party and A/Rs for each patient are automatically created as part of the automated billing procedures for these payors.

Consult your LHD internal control procedures for write off rules.

### **ELECTRONIC POSTING OF PAYMENTS**

Payments from the Medicaid Preventive Health Program and Medicare Physicians Program can be automatically posted to the patient's account through Portal. Electronic remittances from those payors are used to make the payment entries. Please consult with EACH Payor for their Electronic Data Interchange (EDI) instructions.

Errors in the electronic posting process are listed on e-reports 580 (Medicaid), 119 (Medicare), 120 (Rail Road Medicare), and 2580 (Lead Medicaid). It is the LHD's responsibility to review these reports and ensure any errors are corrected.

**PowerPoint training material on using the CDP CMS/Portal [PEF Entry System](#) is available on the L-Drive at the following paths:**

**Off State Network:**

[\\10.1.3.80\lhdcommon\LHD-Documents](#)

**On State Network:**

[\\172.26.55.80\lhdcommon\LHD-Documents](#)

**LHD's should contact CDP for clarification and questions related to the training material and for system-related technical support.**

### **COMMUNICATING WITH THE PUBLIC**

Keeping the public informed about services available through the LHD is an important function. DPH recommends that annually, information about available services be disseminated through the local news media, broadcast on TV, through websites and/or brochures. **LHDs are to ensure their website is ADA compliant and up to date with current information, including website links, community assessment information, DPH and LHD program guidelines, data and relevant information, and community event dates/times, etc.**

In accordance with [KRS 424.220](#) the annual financial statement for the LHD is to be published in the local newspaper. Information regarding environmental health activities is to be disseminated to the public at least semi-annually. (See Environmental Health Services Guidelines in the AR [Environmental Health Services Section](#).)

In case of a disaster, the public is to be informed by the LHD by providing the community with accurate and appropriate situations that include health related information, educational materials, media releases, and health alerts.

#### **Notice of LHD Hours of Operation to the Public:**

DPH determined that the LHD's *normal working hours* are Monday through Friday from 8:00 AM to 4:30 PM and LHDs may offer extended hours as outlined below.

In accordance with [902 KAR 8:160](#), Section 11, the LHD shall post the hours of operation near the main entrance. This posting shall also include when the LHD will close for lunch, if applicable. The posting shall be current and plainly visible from the outside. During emergencies, the LHD shall post, in a location visible from the outside, an emergency contact/phone number. If the LHD has a website, this information must also be available on the LHD site's main webpage.

A listing of current [LHDs hours of operation](#) may be found at the [LHD Information webpage](#) on the DPH website. Each LHD is responsible for making DPH aware of changes to their normal hours of operation and *ensuring their LHD website is up to date*.

Except for emergencies, the LHD shall publicize, in advance, if the department is to be closed during normal working hours. The notice shall be available on the LHD website and be prominently displayed at the main entrance and visible from the outside; indicate where and how staff may be reached; and indicate when the office(s) are expected to re-open.

LHDs are expected to be open on all days except those listed in [902 KAR 8:120](#), Section 18, *Holidays. Review AR: [Local Health Personnel Section](#)*. The actual day the holiday is observed is routinely established by the Kentucky Governor's office or the Secretary of the Personnel Cabinet.

**The following are exceptions to the hours of operation:**

- Inclement weather that causes the LHD to close.
- Staff meeting(s) and/or training session(s) that require attendance of all employees.

All other closures for either a partial day or a longer period of time must be communicated, in writing, to the DPH. **The written communication must be submitted in advance of the closure** to the attention of the AFM Division Director and indicate provisions that have been made for services a patient may need during the time of the closure such as WIC, Home Health visits, etc. Except for emergency or other unplanned situations, and to ensure sufficient advance notice is given, LHDs should attempt to provide the advance written notice to DPH at minimum two (2) business days before scheduled closure.

**Extended Hours**

In order to accommodate the working public, LHDs/Boards of Health shall assess the feasibility of offering extended hours. Early morning, late afternoon, evening and weekend hours shall be considered in addition to the DPH designated normal working hours. Extended hours shall be a decision of the governing Board of Health with input from LHD patients and a community assessment. The decision of the Boards of Health approving or disapproving extended hours shall be reflected in the Board's Minutes.

If the Patient Services Reporting System (PSRS/Bridge) and the Clinic Management System (CMS/Portal) will be needed for the extended hours, prior arrangements must be made with the DPH Administration and Financial Management (AFM) Division, *Local Health Operations (LHO) Branch*. See "[Custom Data Processing \(CDP\) Extra Hours Procedures](#)" located in this section.

Employee work schedules need to be adjusted (in conjunction with LHD management) to ensure adequate office coverage during all times of service activities.

**STANDARD PROCEDURES FOR INTERPRETATION SERVICES**

This administrative and operational guideline addresses the standard procedures for interpreters either employed or contracted by LHDs. Review the [Local Health Personnel Section](#) of the Administrative Reference for additional information concerning [Title VI, Civil Rights Act of 1964 and Limited English Proficiency \(LEP\)](#) compliance requirements.

LHDs must make interpretation services available to all eligible persons benefiting from programs provided and funded by Federal monies. Failure to provide quality interpretive services may prevent eligible persons from receiving benefits to which they are entitled.

LHDs are responsible for *assuring* quality interpretive services are provided. There are standard procedures for interpretive services LHDs should adopt as best practices, some of which include:

- Knowledge and understanding of the language needed interpreted.
- Appreciation of cultural differences and assumptions.

- Knowledge and understanding of health care terminology and the ability to interpret and give detailed explanation.
- The ability to translate brief written text such as application forms, signage or medication labels.
- Knowledge of and adherence to mainstream standards of interpretive practice.
- The ability to apply the LEP patient's primary language using knowledge of medical terminology and cultural understanding in a cross linguistic interview.

To ensure that services are delivered to patients identified as having LEP, LHDs, and their contracted providers, shall follow steps in the "[Compliance with Title VI](#)" of the [Local Health Personnel](#) section of the AR.

## **INFORMATION TECHNOLOGY**

Public Health information technology uses high capacity computers linked through the Cabinet for Health and Family Services (CHFS) and/or the Commonwealth Office of Technology (COT) networks. A local information technology training program is necessary as a means of staff empowerment and effectiveness. ***DPH and every LHD must adhere to the following:***

### **Policies And Procedures**

CHFS follows the COT policy and procedural guidance ([Enterprise IT Policies](#) and [Security Policies, Standards and Procedures](#)) related to information technology (IT) used in the CHFS network environment. Users connected to the CHFS network must comply with these COT policy and procedural guidelines. Although highly recommended and encouraged to follow COT guidelines, health department computers and other work-related technology devices not connected to the CHFS network need not comply with COT/state standards for hardware and software.

For those computers/devices that do connect to the CHFS network and/or utilize the [@ky.gov email](#) domain; state standards, Commonwealth Office of Technology (COT), and Cabinet policies and procedures must be followed. Health department compliance and assistance is critical to protect patient information and the integrity of the network.

### **Computer Use/Access**

LHDs must have a computer use/access policy and procedure for authorizing access to computer equipment. This policy and procedure is to be reviewed **annually** with authorized LHD users during the employee's year-end evaluation review. Each user at an LHD must have a user specific security access authorization and security password assigned in order to sign on and use LHD computer software and equipment, including the LHD Network Systems. An LHD generic user account allowing multiple users to access the system(s) is not permissible.

Consult with the Local Health Personnel Branch to view a copy of the confidentiality agreement document pertaining to access as an employee. **Users shall not share security access** authorizations (e.g., PSRS KY #'s and other LHD network system assigned user names). It also creates the risk of improper access or manipulation of accounting and personnel data in the system. *Each LHD shall have an IT Administrator who manages local access and coordinates support issues* with their IT vendor, LHO, and/or with COT.

Each user is responsible for proper use and access to the software and equipment, and for helping safeguard the integrity of the network. Security breaches or compromises, including phishing emails, are to be reported immediately to supervisors. Failure to do so risks inappropriate access to patient health information, which is a violation of the federal Health Insurance Portability and Accountability Act (HIPAA). **LHDs should contact their attorney on inquiries related to HIPAA, Privacy and Confidentiality laws.**

LHD users needing access to a COT Network computer, receiving emailed phishing scams to their @ky.gov email address, or having other concerns/problems with or needing to reset their COT **network** password must contact the COT Commonwealth Service Desk toll-free at (800) 372-7434 or by [email](#).

The Local Health Operations (LHO) Branch only assists with security access issues related to the [LHD Network Systems](#) (e.g., Patient Services Reporting System (a.k.a., Bridge) and the Clinic Management System (a.k.a., Portal). LHDs must follow the guidelines outlined in this section concerning security access.

### **Support and Maintenance**

Computers and technology devices are the property of the LHD unless otherwise provided by an external agency such as WIC. Routine support and maintenance of those computers, technology devices, software and peripherals are the responsibility of each health department. A limited number of federally provided computers and/or printers have been made available for WIC and Environmental use, but with the understanding that care and maintenance will be provided by LHDs. They are also specifically tagged as state property.

Health departments have agreed to abide by state standards, including those standards under the administrative authority of the Commonwealth Office of Technology (COT), for computers/devices and should check with DPH before purchasing new or replacement equipment if the computer/device will be used on the COT/CHFS Network. Health departments are also responsible for virus protection software to protect the COT/CHFS Network from compromise. The state has provided initial software support to create the working environment.

Health departments are encouraged to develop in-house support capability or enter into support agreements for the care and maintenance of their devices, equipment and website as a way of ensuring continuity and equipment availability. Larger health departments and district health departments may find that adding an IT administrator to permanent staff might be more cost effective. **Health departments having a website are to ensure the content on that site is up-to-date.** An IT administrator should be responsible for maintaining the content of the website.

Health departments will maintain a master inventory of equipment and accessories on hand. It is important to keep track of each equipment item's capacity when purchased, and date of purchase to permit life cycle replacement planning. A life cycle replacement plan is encouraged as a way of maintaining the viability of the information technology capability of the health department. Average life cycle is four to five years. Age, use of equipment, loaded software, and changes in software technology are some but not all of the considerations to make in creating and maintaining the plan.

The current COT recommended standards for desktop and laptop computers, tablets and mobile devices, and internet/bandwidth speed are outlined on the [COT Client Computing](#)

[Support](#) webpage. Contact the COT [Commonwealth Service Desk](#) for questions or clarification concerning the webpage and recommended standards.

DPH has responsibility for maintaining operation of the **LHD network systems**. Custom Data Processing, Inc. (CDP) is the contracted vendor to provide support and resolution to all system-related **LHD Network systems** issues pertaining to the **Patient Services Reporting System** (PSRS) and **Clinic Management System** (CMS); CDP's web-based **E-Report software** reporting issues and requests; and **PSRS financial/accounting, personnel and payroll data** for most health departments.

For direct system-related/technical support questions concerning the above referenced LHD Network Systems and software, contact CDP customer support toll-free at (866) 237-4814 or by [email](#). When contacting the LHO Branch, depending on the reported issue, the LHO Branch will either provide the support (e.g., reset password, unlock account) or initiate the action needed to assist with resolution of the reported issue (e.g., system-down, not working properly).

**Issues not related to password resets and unlocking accounts are to be submitted to the LHO Branch by the LHD IT Administrator.** COT will provide routine maintenance and assistance, as appropriate and where possible, for maintaining viability of the COT network. For issues not under the scope of work for the LHO Branch, and depending on the problem/concern, the LHD IT Administrator or LHD Director will be responsible to communicate with CDP and/or COT if a network issue related to areas under COT control and authority is reported, detected or suspected. An LHD choosing to have an email account (e.g., @ky.gov) that is not under the Kentucky.Gov domain and part of the COT network, will need to work with COT and the DPH Commissioner's Office about receiving email/global email distribution listing (DL) updates via the ky.gov Global Address Listing (GAL). The LHO Branch does not provide this type of support.

### **Technical Support and Security Access**

*Each LHD must have an assigned IT administrator who will serve as the main point of contact for IT related issues and maintain the LHD website and its content.*

LHDs should use care in selecting the individual for the IT administrator position as this individual will need to be the most IT knowledgeable person.

**The LHD IT Administrator is the [first local-level](#) avenue of support** for LHD network users (staff) to contact and will:

- Provide advice, guidance and hands-on support to local users.
- Serve as the primary point of contact with the COT/Office of Infrastructure Services (desktop support).
- **Serve as the LHD Director's authorized designee and primary point of contact with the LHO Branch concerning [LHD Network Systems](#) (PSRS and CMS) [security access requests](#) and issues.**

The **LHO Branch** will have and maintain normal operating hours of 8:00 AM to 4:30 PM (Eastern Time) each state-designated work day. The LHO Branch service desk contact information is [LocalHealth.HelpDesk@ky.gov](mailto:LocalHealth.HelpDesk@ky.gov) or (502) 564-6663, option 1. *Email is the preferred method of communication when available.*

The purpose of the LHO Branch is to:

- Provide guidance to LHDs in the appropriate medical coding and related service/procedural documentation of medical records and management of DPH approved/authorized [clinic health \(CH\) forms](#).
- Provide guidance to LHDs on the appropriate completion of [Patient Encounter Form \(PEF\)](#) entries.
- Provide guidance to LHDs on correcting [Medicaid and Managed Care Organizations \(MCO\) billing errors](#) for the Kentucky Preventive Health Services Program, **after** the LHD contacts their Medicaid/MCO provider representative and cannot obtain a sufficient resolution. *NOTE: LHO is not responsible for Medicare and private/commercial insurance billing issues. Those must be resolved only by the LHD with their designated Medicare/Insurance provider representative.*
- Review and authorize [security access](#) to the Patient Services Reporting System (PSRS) and/or the Clinic Management System (CMS) referred to as the **LHD network systems**.
- Assist in the *coordination of the review process* for LHD contracts following the guidelines outlined in the Administrative Reference, [Financial Management Section](#).
- Maintain the [LHO webpage](#) and assist with maintaining the [AFM Division webpage](#), DPH website and the DPH intranet site and the LHD intranet site.

**COT/Office of Infrastructure Services** (desktop support) will have and maintain a permanent IT Service Desk capability. It will be manned from 8:00 AM (Eastern Time) until 4:30 PM (Eastern Time) each work day. The COT/Office of Infrastructure Services (desktop support) contact information is **CommonwealthServiceDesk@ky.gov** or toll-free at (800) 372-7434 or direct-toll at (502) 564-7576.

The purpose of the COT Service Desk is to:

- Provide COT/CHFS network support to health departments.
- Serve as liaison to work planning issues, network issues, and related technology issues as outlined in the COT [Enterprise IT Policies](#) and [Security Policies, Standards and Procedures](#).
- Provide limited CHFS network user support to health departments, within capability and scheduling.

The **WIC Program Help Desk** is available from 8:00 AM to 4:30 PM (Eastern Time) Monday through Friday. The purpose of this WIC Help Desk is to provide *first line support* on WIC policy and procedures related to [WIC Systems](#) such as WIC CMS, eWIC (EBT), and WIC security.

### **Systems Planning**

LHDs have responsibility for local hardware and software. Each LHD is responsible for creating and maintaining a local systems replacement plan and accompanying fiscal plan for life cycle replacement of hardware and software used. Replacement items must meet state standards as provided by COT for all operating systems, equipment/devices and/or software. The COT is available to provide assistance with CHFS network systems planning. Use of information technology to create business solutions is encouraged. The Cabinet, through COT, provides all reasonable assistance to help create local area networks and other applications that provide cost savings and efficiencies in accomplishing the mission of public health.

## **Web Development**

Use of the Internet to communicate office hours and closures; as well as program updates, information, and ideas is strongly encouraged. Health Departments should take full advantage of this effective media to communicate. All LHD website content, including an LHD Facebook page, should be reviewed at minimum, MONTHLY and REMAIN CURRENT.

*LHD program content, LHD community event activities and planning, LHD guidelines/information and LHD office hours located on **the LHD website AND the LHD Facebook page must be consistent and match** to ensure appropriate communication is provided to patients, clients and the community.* LHDs must make sure to follow the Cabinet's Internet and Electronic Mail acceptable use policy found at the [COT Enterprise IT Policies](#).

Ensure that individuals with disabilities are not excluded from programs and services because facilities are unusable or inaccessible to them in accordance with the DOJ 2010 ADA Standards for Accessible Design at [https://www.ada.gov/2010ADASTandards\\_index.htm](https://www.ada.gov/2010ADASTandards_index.htm).

Ensure accessibility to websites and digital services for individuals with disabilities ([https://www.ada.gov/websites2\\_scrn.pdf](https://www.ada.gov/websites2_scrn.pdf)).

Additionally, ensure individuals with limited English proficiency are not excluded from programs and services because vital information on websites and digital services is not available in frequently encountered languages.

## **LHD Internal Computer System(s) Security Policies and Procedures**

Health departments must create internal policies and procedures, using COT standards as a guideline, for access to computer equipment/devices, rules for day to day use, and purging and protecting the network when users (employees) no longer are granted access. Policies will include guidance for disposition of computer/device hard drives when made available for surplus, if the hard drive has ever contained protected health information (PHI). Policies will also include the disposition of CDs, printer ribbons, flash drives, etc. which may contain confidential information.

Security policy includes a security and confidentiality statement related to proper use of the equipment, safeguarding of information (including passwords), and monitoring of systems access.

The policy will outline uses of equipment, risk management to protect patient identifiable information, and how to participate in security management. COT provided a password security policy and procedure for access to and use of equipment that accesses and/or communicates with the CHFS/COT network. Annually, users must be made aware of the contents of the procedure and the reasons for its existence. Staff must know how the procedure works to ensure appropriate and timely access to computers/devices for daily function. Training will be accomplished on system admission, at minimum, annually. The following pages are the computer security and password policy.

## **Procedures for Requesting LHD Network System(s) Security Access from the LHO Branch**

*The LHD Director or the director's authorized designee (e.g., IT Administrator) on file with the LHO Branch obtains the appropriate [security access request form\(s\) from the LHD Forms, Documents and Administrative Reference webpage](#); then*

1. Following procedures outlined on the [security request form\(s\)](#), completes the security request form(s) by authorizing what access the user needs based on employee's assigned duties and **attaches the request form(s) to an email** that is forwarded to the LHO Branch at [LocalHealth.HelpDesk@ky.gov](mailto:LocalHealth.HelpDesk@ky.gov) or by fax at (502) 564-4057. **When faxing a security request; each faxed request must be signed by the LHD Director or authorized designee to ensure authenticity of request.** Unsigned faxed security requests or any emailed requests not submitted from the LHD Director's or authorized designee's computer (work email) will not be processed by the LHO Branch.

**NOTE: Due to HIPAA requirements: a user's Social Security Number must not be emailed (faxed only under the LHD's cover page to ensure confidentiality/privacy).**

2. Once the security request form is received and correctly completed, *unless a mass setup/update is requested by the LHD*, the LHO Branch will issue the authorized access for the identified user within two (2) business days following date of receiving an accurately completed request. LHDs should consider this timeframe when submitting [security access requests](#) to ensure access for each user is available on the date needed. LHO is not responsible for errors made by the LHD when completing or submitting a security access request form. **LHO does not consider emergency security access requests** since generally LHDs are aware days in advance of an employee's start date and know to submit requests at that time.
3. Once the LHO Branch processes the requested security access the LHD Director or their authorized designee will receive an email from the LHO Branch. The LHD Director or designee will notify the employee (user) of their authorized security access. If a KY# and PEF logon ID was requested to access PSRS, the KY# and PEF Logon ID as well as the default password will be provided in the email.

**The LHD is responsible for maintaining a current listing of their employees' security access**, such as but not limited to, an assigned PSRS KY#s; authorized Clinic Management (Portal) System/Patient Services Reporting System (Bridge) security group(s); PEF logon ID; L-Drive; e-reports; and SplashBI. The LHD is to ensure a user's security credentials are not shared or used by other LHD employees. Each LHD employee (user) must have their own security access credentials. HIPAA, privacy and confidentiality guidelines must be followed.

#### **LHD Global Email Distribution Listings Procedures for the ky.gov domain**

- **LHD employees having an @ky.gov email address and/or having an email address appearing on the ky.gov address book/Global Address Listing (GAL)**, the LHD Director or their authorized designee on file with the LHO Branch shall follow the procedures for requesting security access from the LHO Branch as outlined above; and
- The LHD Director or authorized designee shall only use the current [LHD Global Distribution Email Listing Request Form](#).

**The LHO Branch cannot add an individual's email address to any global email distribution listing (DL) that is NOT currently available on the ky.gov address book/Global Address Listing (GAL).** It is the responsibility of the LHD Director or their authorized designee to communicate with COT to determine what is needed logistically and to submit requests to COT ([CommonwealthServiceDesk@ky.gov](mailto:CommonwealthServiceDesk@ky.gov)) to have an email address added to the GAL. **The LHO Branch does not assist with these requests.**

The LHD Director/director's authorized designee should contact the LHO Branch for questions concerning PSRS KY #'s, Portal system access, and other LHD security and global email distribution listing access issues under the purview of the LHO Branch. *The LHD Director must notify the LHO Branch of any additions/changes/deletions to their authorized designee.* New LHD Directors must submit the name of their authorized designee even if that person was designated as the previous director's designee. **Only the LHD Director or authorized designee on file with the LHO Branch is permitted to submit** any security request action (add, update/modify, delete) and LHD Global Distribution Email Listing Request Form.

*Only the current [LHD security access request forms](#) maintained and provided on the [LHD Forms, Documents and Administrative Reference webpage](#) will be accepted. **Security access forms shall not be saved to a computer desktop for future use as they may become obsolete.** These forms may be updated by LHO, as necessary, without advance notice. Old/obsolete versions of any security access request form will not be processed. It is permissible and recommended to save the URL (internet link) to the user's favorites toolbar to the [LHD Forms, Documents and Administrative Reference webpage](#) on the DPH website for easy access.*

## **CDP CLINIC MANAGEMENT SYSTEM (PORTAL) SECURITY ACCESS GUIDELINES**

In order to access CDP's **web-based** Clinic Management System (CMS) – **PORTAL**, a secured user name must be obtained. Access to PORTAL is controlled through permissions given to specific groups available within the CMS/PORTAL web-based system.

*As with all [LHD Network Systems Security Access](#), [LHD employees shall not share CMS/Portal user accounts](#).* Additionally, generic accounts cannot be setup for multiple user to access. Each user must have their own user access setup within CMS/Portal.

To obtain [security access clearance](#), the LHD Director or his/her authorized designee must submit a signed/authorized request to the LHO Branch following the [Procedures for Requesting LHD Network System\(s\) Security Access from the LHO Branch](#).

Please note that email is the preferred method of submitting security requests. However, **if a security request contains the user's SSN, the [security request form](#) MUST be FAXED due to HIPAA guidelines/requirements.** The LHD Director must sign the security request when form is faxed to ensure authenticity.

Mailed security requests are also accepted, when the request form is signed by the LHD Director, and forwarded to the following address:

Department for Public Health  
Division of Administration and Financial Management  
Local Health Operations Branch  
**ATTN: LHD Network System Security Officer**  
275 East Main St., HS1W-B  
Frankfort, KY 40621

### **Automated CMS/PORTAL Forgot Password Procedures**

- On the CDP Portal LOGIN screen where the user enters the Username and Password; locate the "Forgot Password" tab in the upper left corner just under the CDPEhs logo; then
- Click on the "Forgot Password" tab and enter the Username and User's Email Address; and
- Click Send.
- Once send is clicked; Portal will determine if the Username and User's Email Address match what is stored within the CDP Portal database and if no errors will send an email to the user providing the user's current Portal password.
- The user will then enter the Username and correct password provided in the email and follow the prompts to LOGIN to Portal.

Should the User continue having trouble logging into the system(s) or cannot remember the answers to their CMS/Portal security question(s); contact the [LHO BRANCH](#) to reset the password back to the default password. As a reminder, LHO does not know or maintain the user's security question answers or their password. It is recommended users change their PSRS/Bridge and CMS/Portal password each time they update their network password or at minimum every 30 days. LHDs are also to maintain their own tracking spreadsheet of security permissions (per system) for each LHD employee/user.

### **COMPUTER SECURITY USE OF PASSWORDS**

#### **Policy and Procedures**

DPH and all LHDs shall follow the guidelines established by COT concerning standard password procedures and security passwords. These procedures include the periodic changing of computer access passwords and password usage. **Review COT's [Enterprise Policy CIO-072, "UserID/Password Policy](#), and COT's [Security Standard Procedures Manual \(SSPM\)](#): Sections 8.3.0 User ID/Password Standard Procedure, and 8.3.2 Password Usage.**

The purpose is to minimize the risk of inappropriate access to or disclosure of health department information. Users who violate this policy will be held responsible for a breach of security, will be subject to disciplinary action, and will be accountable for any impact a violation may have on the integrity of data or performance of the network. For additional information on User ID, storage of confidential information and password policy, reference the [COT Enterprise IT Policies](#).

#### **Background**

Password violations are the number one security problem on networks today. This policy is designed to ensure that all Public Health and individual data stored on the network are protected through reasonable and appropriate use of password security. This policy is part of compliance

requirements of the Health Insurance Portability and Accountability Act (HIPAA), a federal statute intended to assure the privacy and confidentiality of patient identifiable information.

A temporary password is set for the user at the time they receive their account;. For access, a user is expected to change the password during the first login. This action provides secure access to the CHFS/DPH/LHD Domain.

Examples of activities, which will jeopardize a user's privilege to access the computer resources, include:

- Writing down their password and posting it in the work area.
- Sharing their password (in person, by email or by phone) with other individuals whether known or unknown.
- Keying in their password for others to use.
- Sending their password over the Internet or through E-mail.
- Including their password in a macro or function key to automate the log-in;
- Store their password in any file, program, command list, procedure, macro, or script where it is susceptible to disclosure or use by anyone other than the owner;
- Vendor default passwords (default passwords must be changed immediately upon use);
- Hard code password into software developed (unless permission is obtained by the agency security office);
- Store their password in communications programs or internet browsers at any time;
- Record their password in system logs unless the password is encrypted in the log.

*NOTE: LHD Network System passwords reset to the default password that are not immediately changed by the user must be changed prior to leaving/logging off for the day otherwise the LHD user must contact the LHO Branch again the next business day to reset password to default.*

The [Computer/Network Security Policy](#) outlines the consequences of making passwords available to other users. Should a password be compromised, the owner should change his/her password immediately to avoid future unauthorized access. Immediately after making such a change, the individual must contact their local IT Administrator to report the suspected compromise. Otherwise, passwords are required to be changed every 30 days as a routine practice. The computer system will alert you a few days before expiration.

**SplashBI/L-Drive/E-Reports/DataMart Security request forms** are available on the [LHD Forms, Documents and Administrative Reference webpage](#).

## **CUSTOM DATA PROCESSING, INC (CDP) - EXTRA HOURS PROCEDURES**

*The LHD emails extra hours request form (**located on the [LHD Forms, Documents and Administrative Reference webpage](#)**) to the Division of Administration and Financial Management's (AFM), [Local Health Operations \(LHO\) Branch](#) – with the following information:*

- *Name of Health Department*
- *Date(s) requesting extra hours*
- *Hour(s) (include time zone)*
- *Reason extra hours requested*
- *Name, phone number and email of Person at Health Department submitting request*

The LHO Branch will review, authorize, and email completed request form to CDP Customer Support. If the email system is unavailable, fax a request to the LHO Branch (502) 564-4057 and LHO will either email (if available) or fax the completed request form to CDP (Chicago Office) at 708-352-3177 to confirm if system can be up for specified time.

Once CDP Chicago confirms the extra hours request they will:

- Authorize the extra hours request form; and
- Forward the authorized request form to the LHO Branch at [LocalHealth.HelpDesk@ky.gov](mailto:LocalHealth.HelpDesk@ky.gov).

The LHO Branch will:

- Update the Clinic Management System (CMS), [Portal News Page](#), notifying all LHDs of the availability of the system; then
- Forward the authorized request form to the requesting Health Department as confirmation of submitted request.

All extra hours requests need to be submitted at minimum ten (10) business days in advance of the date extra hours are needed to ensure adequate notice is given and allow other health departments to plan their clinics, etc. during the same time the system is available. An extra hours request may not be honored if not submitted within the requested timeframe.

#### **OPEN RECORDS - [KRS 61.870 THROUGH KRS 61.884](#)**

In accordance with [KRS 61.876](#) and [61.872](#) the LHD shall have written policies and procedures for complying with the [Open Records](#) statute. These policies and procedures shall be posted in a conspicuous location that is accessible to the public. According to [KRS 61.870](#), public record means all books, papers, maps, photographs, cards, tapes, discs, diskettes, recordings, software or other documentation regardless of physical form or characteristics, which are prepared, owned, used, in the possession of or retained by a public agency.

The **internal policies and procedures of the LHD** must name an official record custodian to handle releases of information. Policy shall specify conditions under which information shall be released, for example:

- Patient information shall be released under a patient/parent or guardian signed release;
- Financial information of the agency is considered a public record;
- Environmental inspections are public records;
- What employee information is considered a public record; and
- Method for accessing vital records.

The health department has up to three working days to respond to the open records request. Respond does not mean information requested must be released. The health department would not release information on **pending** actions, inspections, and investigations. The requestor

may be asked to put the request in writing and be told a time to return. The DPH Local Health Personnel (LHP) Branch provides the [LHD Open Records Request Form](#) available within the [LHD HR Staff webpage](#) on the [LHP Branch webpage](#). Any request for records concerning WIC vendors shall be referred to the State DPH [Nutrition Services Branch](#).

**The following procedures shall also be adhered to:**

- If the LHD to whom the application is directed does not have custody or control of the public record, the custodian shall notify the applicant and shall furnish the name and location of the custodian of the public record, if such facts are known;
- If the public record is in active use, in storage or not otherwise available, the records custodian shall immediately notify the applicant and shall designate a place, time and date for inspection of the public records, not to exceed three working days from receipt of the application, unless a detailed explanation of the cause is given for further delay and the place, time and earliest date on which the public record will be available for inspection.
- If the applicant places an unreasonable burden on the LHD or if the custodian has reason to believe that repeated requests are intended to disrupt other essential functions of the LHD, the official custodian may refuse to permit inspection of the public records or to mail copies of the records. However, in accordance with the [Open Records Law](#), refusal shall be sustained and documented by clear and convincing evidence.

**ADMINISTRATIVE HEARINGS**

All Kentucky Administrative Hearing procedures are governed by [KRS Chapter 13B](#).

**The following are eligible for an administrative fair hearing:**

- Persons denied services;
- Persons whose participation in a service was discontinued;
- Persons who were notified to repay the cash value of improperly received WIC benefits;
- Persons who have not had a grievance resolved to their satisfaction; and
- Public and certain classes of citizens who were adversely affected as a result of the interpretation/enforcement of an environmental law, regulation or ordinance.

The [KRS Chapter 13B](#) applies to all local health departments (LHDs) in Kentucky. The Cabinet for Health and Family Services adopted a general uniform hearing procedure as outlined in Kentucky Administrative Regulation [902 KAR 1:400](#). However, due to stringent federal time frames for fair hearings than required by [KRS Chapter 13B](#), the WIC Program's fair hearing policies for applicants, participants and vendors are governed by Kentucky Administrative Regulation [902 KAR 18:040](#) and [902 KAR 18:081](#).

Complaints of discrimination are not handled through the Fair Hearings Process. Federally Funded Programs must provide the complainant the address to file their civil rights discrimination complaint directly with that program's federal agency, i.e. WIC including WIC FMNP and WIC Breastfeeding Peer Counseling Program's applicants and participants must be provided the address to file a complaint directly with USDA. See WIC and Nutrition Manual, Policy 306, Civil Rights.

**All requests for an administrative hearing shall be honored unless:**

- The request is withdrawn in writing by the requesting party or his/her representative;

- The requesting party or his/her representative fails, without good cause, to appear at the originally scheduled hearing or any “make-up” hearing; or
- The requesting party has already had a hearing on the issue in question and cannot provide evidence that circumstances have changed sufficiently to justify another hearing.
- The request is not received within the time limits set by [902 KAR 1:400](#) or for the WIC Program [902 KAR 18:040](#) and [902 KAR 18:081](#).

**When an administrative hearing request is received, the local health department shall in all cases:**

- Establish and maintain an administrative hearing file documenting all correspondence and contacts with the party requesting a hearing; and
- Notify the appropriate DPH division and branch of the administrative hearing request.

Persons aggrieved by an action of the LHD may request an opportunity to present his/her views before the Cabinet or its designated agent. The procedures will be in accordance with [902 KAR 1:400](#) which sets forth a uniform hearing procedure for the Cabinet for Health and Family Services and/or any other applicable laws and regulations. WIC Program Fair Hearing procedures are governed by Program [902 KAR 18:040](#) and [902 KAR 18:081](#).

**The following are general procedures and timeframes:**

- The requesting party or his/her representative has a right to a conference hearing if requested within ten (10) days of the date of the notice of proposed adverse action.
- Within five (5) days of the conclusion of the conference hearing, a report will be issued to the requesting party detailing the settlement and providing further right to appeal.
- The requesting party may file a written request to appeal to the Commissioner of the Department for Public Health, Cabinet for Health and Family Services, 275 East Main Street, Frankfort, Kentucky 40621 within ten (10) days of receipt of the conference hearing report.
- The notice of appeal and the appeal procedures shall be in accordance with Kentucky Administrative Regulation [902 KAR 1:400](#) and [KRS Chapter 13B](#).

**REPORTING AND REPORTING SYSTEMS**

LHDs shall report services/activities in accordance with the following guidelines:

**Patient Encounter Entry and Reporting System**

For clinic services provided to the patient and reported through the Patient Encounter entry and Reporting System, Patient and Household Registration is to be completed through the Clinic Management System (CMS)-Portal web-based system. Consistent with the DPH and LHDs’ philosophy of patient centered health care, the reason a patient is at the clinic for an appointment or visit addresses broad categories of services; preventive medical, preventive counseling, other medical, other counseling, laboratory, radiology, etc.

A statewide [reason for visit code](#) is used to identify the general categorized purpose of the appointment being made. If an appointment has not been made and the patient is seen without

an appointment, the reason for visit is required to be entered on the registration screen. This code is used to trigger certain flags for the appointment/registration staff, e.g., patient income information is required, health checkup is due so an appointment can be made, and proof of identity, residence and income are needed for WIC certification or re-certification. Also it is necessary to know the type of provider staff to schedule. Using the combination of visit type, provider type and Cost Center, the reason for the appointment or visit is further defined or clarified. **As a rule, the LHO Branch does not allow *LHD specific reason* for visit codes included in the system as these visit codes are used statewide.**

The **[Clinic Management System \(CMS\) User Manual](#)** and the **[Patient Services Reporting System User Manual](#)** are available on the **[LHO webpage](#)**. Review the webpage subheading titled, ***Local Health Department Network Systems Information.***

**Patient and Community Health Services Reporting and Billing System**

The DPH contractor for the Patient and Community Health Services Reporting and Billing System is Custom Data Processing, Inc. (CDP). Services reported through the CDP Patient and Community Health Services Reporting and Billing System are to be reported using standardized Current Procedural Terminology (CPT), Healthcare Common Procedure Coding Systems (HCPCS), and International Classification of Diseases, ICD-10 codes or their successors.

The [Patient Encounter Form](#) (PEF) and [Patient Services Supplemental Reporting Form](#) are the data collection/billing forms used through the Patient Services Reporting System (PSRS) or the Clinic Management (Portal) System. Community-based activities provided through the following Cost Centers may be reported using the **Community Health Services Report**:

Division of Epidemiology		Division of Maternal and Child Health		Division of Women’s Health	
<b>801</b>	Immunizations	<b>736</b>	Healthy Communities		
<b>806</b>	TB	<b>805</b>	Nutrition	<b>813</b>	Breast & Cervical Cancer - Community
<b>807</b>	STD/STI	<b>818</b>	CH4 Community School-Based Services	<b>818</b>	CH111.1 Family Planning
<b>842</b>	HIV Prevention	<b>818</b>	CH5 LEAD	<b>818</b>	CH111.2 Teen Pregnancy Prevention
		<b>818</b>	CH7 Injury & Violence Prevention	<b>830</b>	Cancer Coalitions
		<b>818</b>	CH9 Oral Health		
		<b>818</b>	CH12 Maternal, Infant & Child Health		
		<b>818</b>	CH23 Mental Health		
		<b>753</b>	Sexual Risk Avoidance Education (SRAE)		
		<b>756</b>	Personal Responsibility Education Program (PREP)		

[The Community Health Services Report \(CH-48\)](#) is used to report all community-based activities provided with 818 funds as well as the other Cost Centers listed on the back of the report form. The data is to be entered into the system within 15 calendar days of the event/activity. Please note that each event/activity may be reported only once, regardless of the number of providers.

Each health department should contact the LHO Branch at (502) 564-6663, Option 1, to designate a new primary and/or secondary contact for community-based activities if they change during the fiscal year.

**Community Action on Tobacco Evaluation System (CATALYST)**

CATALYST is a web-based reporting system used by organizations under contract with the Washington State Department of Health’s Tobacco Prevention and Control Program. It is

currently used by Kentucky and several other states. The Kentucky DPH is under contract with CATALYST technical developer (C-Quest) to provide technical support, maintenance and system adaptations/improvements. LHDs are required to enter a work plan into the system based on their proposed budget for use of program allocations and then use the system to report implementation of their approved work plan throughout the fiscal year. CATALYST will also be used by the Tobacco Program, Diabetes Program and the Preparedness Program.

<b>COMMUNITY COST CENTERS USING CATALYST</b>			
<b>Division of Prevention &amp; Quality Improvement</b>		<b>Division of Epidemiology</b>	
<b>809</b>	Diabetes	<b>821</b>	Preparedness Coordination
<b>836</b>	Tobacco	<b>822</b>	Epidemiology & Surveillance
<b>841</b>	Diabetes Today Coalition	<b>823</b>	Medical Reserve Corps
		<b>825</b>	Training Coordination
		<b>875</b>	Hospital Preparedness Program
		<b>876</b>	Cities Readiness Initiatives

### **Home Health Reporting**

Home Health Services provided by LHDs with licensed home health agencies report services through the **Custom Data Processing (CDP) Local Health Network Home Health Billing System** in accordance with Kentucky Licensure and Regulations Guidelines. There are approximately fifteen (15) LHDs with home health agencies. Contact CDP for LHD home health reporting and billing issues or questions.

### **Environmental Reporting**

Environmental Services, as of February 2011, are reporting services through [CDP Environmental Health Management Information System](#) (CDP-EHMIS) a web-based system.

CDP's Environmental Health Solution is a distributed, secure, web-based system that will provide access to all environmental data that are collected by your department. CDP's Environmental Health solution is a commercial, off-the-shelf, automated surveillance and environmental reporting system.

The primary feature of CDP's Environmental Health Solution is its capability to provide access to a variety of widely dispersed environmental data. Various levels of access will be provided to users depending on their job duties and supervisory responsibilities. CDP's Solution will also provide a toolset for data analysis, reporting, and monitoring. It will provide important security and protection for sensitive or critical data and systems.

Key benefits of CDP's Environmental Health Solution include the capability to:

- Provide timely information to all users;
- Allow broad analysis across geographic boundaries;
- Promote interoperable systems via compliance with standards;
- Increase environmental public health capacity;
- Provide the means to enhance and improve data; and
- Provide extensive reporting through different means.

### **Public Health Division of Laboratory Services Reporting**

The [DPH Division of Laboratory Services](#) has an electronic lab ordering and reporting system, **OUTREACH**. This system allows electronic placement of orders as the first step in the specimen

submission process to the DPH Division of Laboratory Services. Additionally, reports can be viewed electronically and printed from the Web Outreach system. Newborn Screening requests are electronically ordered through KY-Child and reported via fax, phone, and/or mail. Benefits to the end users are:

- Quicker turnaround time to receive results and reports
- Order entry and retrieval of results are available from any computer connected to the internet
- Outreach generated requisitions
- Availability of medical record in the Health Information Exchange

### **HANDS Reporting**

[HANDS Billing and Evaluation data](#) is reported through HANDS web-based system, an online system operated by CHFS. A user logon and password are required to sign on.

### **Kentucky Early Intervention System (KEIS) Program Reporting Program Reporting**

KEIS is the state's early intervention system that provides services to children with developmental disabilities from birth to age 3 and their families. KEIS offers comprehensive supports and services through a variety of community agencies and service disciplines and is administered by the DPH in the Cabinet for Health and Family Services. [KEIS](#) uses the Technology-Assisted Observation and Teaming Support System (TOTS) web-based program for reporting of services. Access the [Early Childhood Development Branch webpage](#) for more information about KEIS and TOTS.

### **Healthy Start in Childcare (Childcare Health Consultation) Reporting**

Consultative health, safety and nutrition services provided by the LHD Healthy Start in Childcare Consultants for out-of-home childcare facilities is reported through the Local Health Network, Healthy Start in Childcare Data System.

### **Immunization Registry**

Information pertaining to the [Kentucky Immunization Registry \(KYIR\)](#) can be found online. Click here to access the [KYIR secured website portal](#). Reference the [Training Guidelines and Program Descriptions Section](#) for information related to Immunization Linkage Intervention.

### **Birth and Death (Vital Statistics) Reporting**

In accordance with [KRS 213.036](#), each county constitutes a registration district for vital statistics. The CHFS Secretary shall, upon recommendation of the State Registrar, designate a Local Registrar in each registration district to aid in the efficient administration of the system of Vital Statistics.

LHDs, through the assignment of an employee as the county's Local Registrar shall facilitate the filing of a birth and death record. Local Registrars should appoint one (1) or more Deputy Registrars to serve during the Local Registrars absence and to assist with the registrar duties.

LHDs should review the [Registrar Guidelines](#) for responsibilities and procedures for Local Registrars and Deputy Registrars. For additional resource information and assistance; access the [Office of Vital Statistics website](#).

## **DiaWEB™ Reporting**

DiaWEB™ is a comprehensive diabetes management software specifically developed for diabetes education and support programs. This web-based software is hosted on a server operated by Custom Data Processing, Inc. (CDP), which is responsible for assuring that the software is accessible to all Healthy Living with Diabetes sites and a select few others, coordinating software upgrades from the software developer (Chiron Data Systems/Healthways), conducting data backups and assuring data recovery.

DiaWEB™ is an intuitively designed system which provides extensive patient management and reporting capabilities, including human resource management, professional credential documentation, CEU documentation, staff productivity reporting and supporting CQI and CPI processes. The system is fully HIPAA compliant with security protections such as:

- User Authentication
- Password Encryption
- Account Lockout
- Date and Time Stamp for All Entries
- Record Change Log/Edit Trail

The Healthy Living with Diabetes, Kentucky DPH DEAP Accreditation Program uses this software, as well as sites that hold a separate DSMES Accreditation.

## **Kentucky AIDS Drug Assistance Program (KADAP) and Ryan White CARE Ware for the Kentucky HIV Care Coordinator Program (KHCCP)**

The HIV/AIDS Program collects data for the Ryan White Part B program through a centralized system. For additional information contact the Kentucky DPH HIV/AIDS Section at (502) 564-6539 or by viewing the [HIV/AIDS website](#).

## **HIV/AIDS Reporting System (eHARS) and EvaluationWeb**

These systems are both CDC programs, used by the State, with eHARS used to collect and submit reported HIV/AIDS cases to CDC surveillance and EvaluationWeb is used to collect and submit HIV testing and other prevention data. For additional information contact the [Kentucky DPH HIV/AIDS Section](#) at (502) 564-6539.

# Local Health Personnel

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**[LHD Personnel Systems Online Reference Manual](#)** [External]

## **Purpose of the Personnel Program**

The Department for Public Health (DPH) administers a personnel program for local health departments (LHDs) in Kentucky. The purpose of the Local Health Personnel program is to promote the recruitment of qualified individuals for the public health workforce, retain employees with a program of benefits and compensation, and protect the rights of employees during their service.

## **How the Personnel Program Is Administered**

Administrative Regulations [902 KAR 8:040 through 902 KAR 8:140](#) have been promulgated to provide for the various aspects of the personnel program for fifty-eight (58) of Kentucky's sixty-one (61) health departments. The Louisville Metro Health Department, the Lexington-Fayette County Health Department, and the Northern Kentucky District Health Department have a separate personnel program based on their respective authorizing legislation.

## **Local Health Department Personnel Support Services from DPH**

The Local Health Personnel Branch (LHP) is the administrative unit within DPH, under the Division of Administration and Financial Management (AFM) that carries out the daily administrative support for LHDs. This includes interpreting the statutes and administrative regulations regarding personnel actions, reviewing applications to determine if applicants meet the minimum requirements for a particular position, approving salary adjustments, serve as a liaison with issues relating to the statewide computerized public health personnel system referred to as PSRS/Bridge, Human Resources related issues pertaining to LHDs, and providing training for supervisory and management staff.

## **Local Health Department Procedural Instructions for Personnel Actions**

An instructional manual "The LHD Personnel System Reference for Personnel Actions" assists in data entry for the various Bridge computer screens.

## **LHDs' Responsibilities Regarding Personnel**

- **Access to the "Administrative Regulations applicable to county and district health departments of Kentucky"**  
A current copy shall be available at each LHD and every employee shall have access to a copy by accessing the [Local Health Personnel Branch webpage](#).
- **Other personnel policies and procedures developed by local boards**  
Boards of health may develop other personnel policies and procedures to carry out an effective personnel administration program.
- **Maintenance of file concerning current personnel policies** - All LHDs shall maintain a file of current personnel policies and procedures under which they operate.

## **Local Health Personnel (LHP) Branch Webpage on the DPH Website**

The [LHP Branch webpage](#) provides classification information, administrative regulations applicable to LHDs, forms, advertising templates, compensation plan, employment information, the application for employment, Civil Rights, Kentucky state holidays, and links to other personnel/human resources related sites and other personnel related information.

## **Recruiting**

There are two (2) ways to recruit at the LHD level.

1. Closed recruitment - the LHD advertises for a position during a specified timeframe. Applications are reviewed by LHP, qualified applicants are placed on a register. The LHD interviews and hires from the approved register. NOTE: once the end date of the advertisement has expired applications are no longer accepted.
2. Continuous open recruitment - the LHD requested to continuously accept applications for a certain position. LHP qualifies them as they are received and the LHD request a register when they are ready to hire.

### **Furloughs, Layoffs, Travel and Budget Restrictions for WIC (Full Use of Federal Funds)**

[Section 361 of the Healthy, Hunger-Free Kids Act of 2010](#) addresses the full use of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC Program) federal funds. State agencies are required to exclude from budget restrictions or limitations including at a minimum, hiring freezes, work furloughs, and travel restrictions.

The funding is intended to support activities such as certification of participants, outreach, nutrition education and breastfeeding support, health care referrals, as well as other participant benefits. This law applies to staff that are fully and partially federally funded.

For local agencies, federal funds retain their integrity as federal funds and are subject to the restrictions. In cases where the staff positions are partially federally funded, the budgetary restrictions should be prorated. If a local agency is in a furlough or layoff situation, in order to prorate, the agency would review timesheets and the Encounter Summary Report to determine the amount of time/time equivalent to ensure continuation of the appropriate amount of time equivalent is provided for WIC services.

This also applies in cases where the local agency has an existing union agreement.

### **CLASSIFICATIONS AND COMPENSATION PLAN FOR LOCAL HEALTH DEPARTMENTS OF KENTUCKY**

The Administrative Regulation [902 KAR 8:060](#) establishes the LHD [Merit System Classifications - Cabinet for Health and Family Services \(ky.gov\)](#) and the [COMP Plan 2022.pdf \(ky.gov\)](#)

### **CONFLICT OF INTEREST AND WORK OUTSIDE THE LOCAL HEALTH DEPARTMENT**

LHD employees are expected to devote their work activities primarily to functions of the LHD. Staff may engage in extramural activities. Such activities shall not detract from performance and responsibilities to the LHD. Extramural activities are any work not performed as an LHD employee, compensated or not compensated. Extramural activities will take place outside of the employee's designated work time.

#### **Conflict Of Interest**

The Administrative Regulation [902 KAR 8:160](#), Section 3 defines conflict of interests for LHD employment.

Staff shall not engage in any activities or outside employment that may result in a conflict of interest. A conflict of interest exists if financial interests or other opportunities for personal

benefit may exert a substantial and improper influence upon an employee's professional judgment in exercising any LHD duty or responsibility.

Staff shall not use their positions to secure anything of value, financial gain, or personal benefit that would not ordinarily accrue to them in the performance of their official duties. Nor shall they accept any compensation from any other agency or individual for work performed in the course of their employment at the LHD, except under the limited circumstances permitted in a formal conflict of interest management agreement. In addition, the following shall not be allowed:

1. A LHD employee who is employed by or related to a WIC vendor shall not process the WIC vendor application, monitor, or revalidate food instruments for that vendor.
2. Procedures must be in place to provide WIC services to employees, relatives and household members of employees without conflict. See the [WIC and Nutrition Manual](#), Policy 301, Program Integrity- Conflict of Interest.

### **Guidelines to Prevent Conflict Of Interest**

1. **Extramural activities** - Staff engaging in extramural activities must avoid the use of information or procedures that may involve a conflict of interest with assigned LHD responsibilities. Failure to adequately perform LHD responsibilities due to involvement in extramural activities is considered a neglect of duty and may result in disciplinary action up to and including termination, regardless of whether the activity is approved.
2. **Prior approval** - Requests to engage in extramural activities during a time normally designated as schedule work time must have the prior approval of the appointing authority. Extramural activities conducted outside of designated work time, which present a potential conflict of interest, must be reported.
3. **Use of LHD name** - Staff members engaging in extramural activities shall not use the name of the LHD, its units, or any other LHD service in such a manner as to suggest institutional endorsement or support of a non-LHD enterprise, product, or service. Neither business cards bearing the LHD name, address, telephone numbers nor LHD stationery is to be used in such a manner as to suggest institutional endorsement or support of a non-LHD enterprise, product, or service.

### **EMPLOYEE ETHIC CONSIDERATIONS**

The following employee ethical considerations/guidelines were developed by the Kentucky Registered Sanitarian Examining Committee for Kentucky Registered Sanitarian Ethics. These guidelines are generally applicable to all employees of the LHD.

### **ETHICAL CONSIDERATIONS FOR ACCEPTANCE OF GIFTS**

The following are guidelines developed by the [Executive Branch Ethics Commission](#) concerning the acceptance of gifts by state employees. *Even though these guidelines were developed for state employees, they are applicable to all public health governmental employees.* All employees must be aware of the laws.

1. **The basic rule:** An employee, his spouse and his dependent children are prohibited from accepting gifts totaling a value of more than \$25 in a single calendar year; or

travel expenses, meals, alcoholic beverages, lodging or honoraria of any value, from any person or business that does business with, is regulated by, is seeking grants from, is involved in litigation against, or is lobbying or attempting to influence the actions of the state agency for which the employee works.

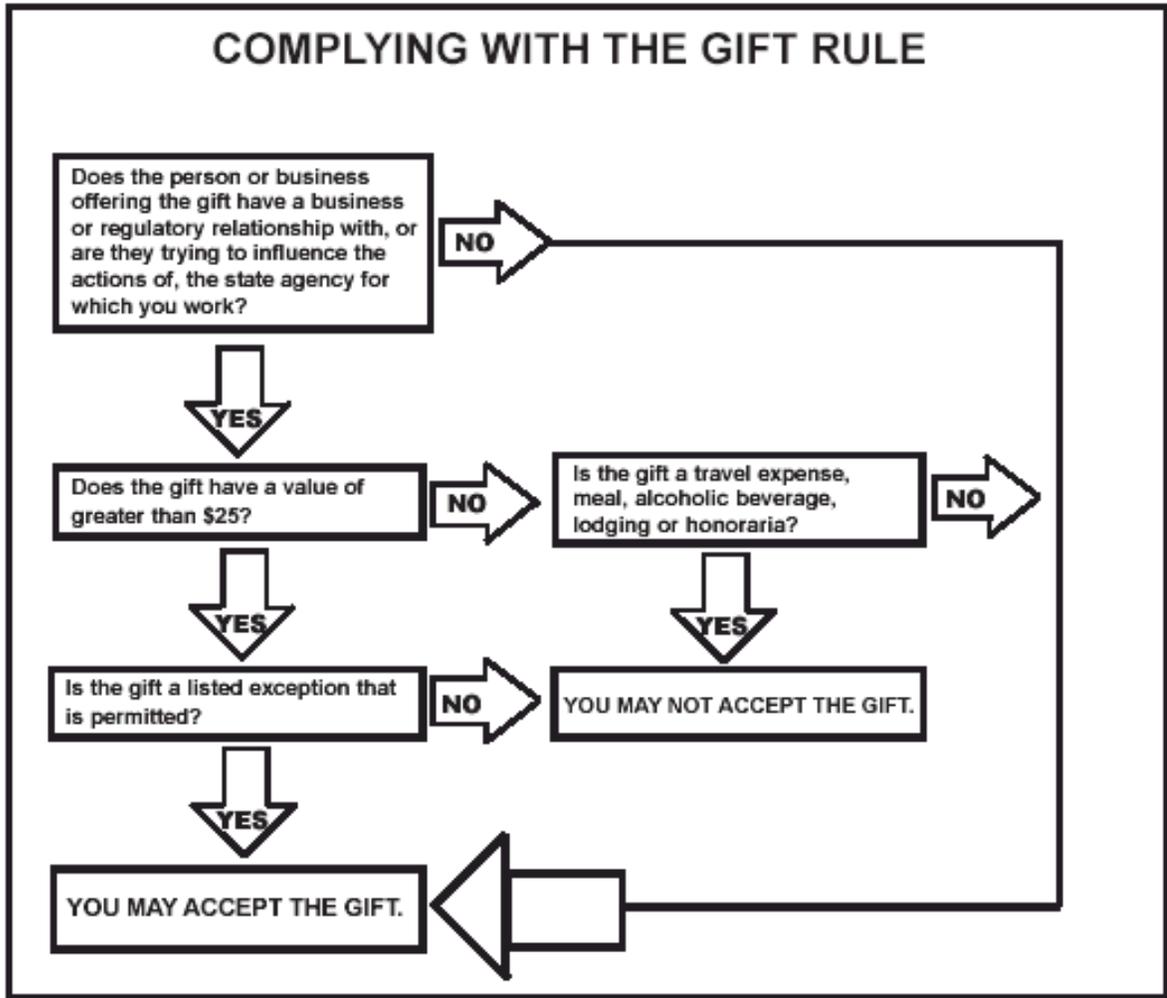
2. **Gifts to an agency:** Gifts that may not be accepted by an employee also may not be accepted by a state agency if the agency has a business, regulatory, or influential relationship with the gift giver.
3. **In-house gift policies:** Some agencies within the executive branch may have in-house policies regarding the acceptance of gifts. Such agencies must, at a minimum, comply with the gifts law in [KRS 11A](#), but are not prohibited from implementing more restrictive policies in addition to the gifts law.

### **Gifts Which Are Permitted**

The following items are exceptions to the basic rule and may be accepted by an employee, spouse, or a dependent child:

- Coffee, soft drinks, pastries or similar refreshments;
- Food consumed at a public event to which 25 or more individuals are in attendance if the event is also open to participants other than members of the donor's industry;
- Meals, beverages and free admission to an event, if the employee, as part of his official duty, is a speaker or has a significant role in the program;
- A campaign contribution to an employee's own campaign if in compliance with the campaign finance laws;
- A gift from a family member who is not acting as intermediary for a person from whom the gift would otherwise be prohibited;
- Food, clothing and shelter in times of natural disaster or other emergency;
- Door prizes, if open to other than state employees and members of the donor's industry and all participants have an equal chance of receiving the prize;
- Gifts that are modest, reasonable and customary, received on special occasions such as marriage or retirement;
- Awards of modest and reasonable value, such as plaques, that are publicly presented in recognition of public or charitable service;
- Prizes awarded based solely on skill, such as in golf or tennis tournaments, if such tournaments are open to participants other than state employees and members of the donor's industry;
- Meals at conferences or seminars which are included as part of the dues paid or the registration fee and are available to all attendees;
- A single copy of a textbook received by an educator for review;
- A gift or gratuity received by an employee working directly on an economic incentive package or seeking to bring tourism to the state that was not solicited by the employee and was accepted in the performance of the employee's official duty.

## COMPLYING WITH THE GIFT RULE



## **DEFINITIONS**

### **“Does business with” or “doing business with”**

Means contracting, entering into an agreement, leasing, or otherwise exchanging services or goods with a state agency in return for payment by the state, including accepting a grant, but not including accepting a state entitlement fund disbursement. [KRS 11A.010](#) (14)

### **“Gift”**

Means a payment, loan, subscription, advance, deposit of money, services, or anything of value, unless consideration of equal or greater value is received. [KRS 11A.010](#) (5)

[KRS 11A](#) is from the statutes governing the executive branch of state government. While not specifically applicable to LHDs, these guidelines reflect the department’s position for conduct and ethical considerations of LHD employees. For additional information, visit the [Executive Branch Ethics Commission](#) website.

### **What to Do With Gifts That Cannot Be Accepted**

An employee who has received a gift that cannot be accepted shall return the item to the gift-giver or pay the gift-giver the market value of the gift. When it is not practical to return an item (something perishable), the item may be donated to charity or destroyed, and the disposal should be documented in writing and included in the employee’s personnel file.

## **EMPLOYMENT OF RELATIVES**

The Administrative Regulation [902 KAR 8:160](#) Section 6 defines and lists restrictions in regards to the employment of relatives.

## **APPOINTMENT OF DOG WARDENS**

In accordance with [KRS 258.195](#) the Fiscal Court shall employ a Dog Warden. A LHD employee shall not accept appointment or be employed as a Dog Warden.

LHD personnel, however, are encouraged to cooperate with other local officials, including Dog Wardens, in controlling stray dogs, confining dogs suspected of being rabid, or otherwise carrying out the provisions of [KRS 258.005 – KRS 258.085](#).

Reference – [902 KAR 8:160](#), Section 3.

## **PROMOTION, TRANSFER AND DEMOTION OF EMPLOYEES**

The Administrative Regulation [902 KAR 8:090](#) describes the provision and requirements for promotion, transfer, and demotion of LHD employees.

## **POLITICAL ACTIVITIES**

The Administrative Regulation, [902 KAR 8:130](#), lists the prohibited political activities by classified service employees.

- LHD employees are encouraged to register and vote. Since it is each citizen's responsibility to be informed about the issues affecting society, [KRS 118.035](#) (2), the

LHD allows no less than four hours of paid leave to eligible employees to vote during work hours.

- It would be a violation of the statute to encourage or coerce an employee in any manner not to exercise his/her right to take four (4) hours paid leave to vote.
- If the employee, on his/her own, decides to take less than four (4) hours paid leave to vote, this should be documented in writing and signed by the employee.
- If a LHD, because of significant difficulty in providing needed services during this time, chooses to close the agency, then the following considerations should be addressed:
  - All employees must have requested the right to vote.
  - For employees not registered or choosing not to vote, the agency shall not require the employee to use accumulated leave, if the health department chooses to close.
  - If the agency closes, the employee that did not request voting leave can be placed on special leave with pay during that time.
  - As protection from political pressures in the job, certain restrictions apply to political activities.

### **Discrimination and Political Activities Prohibited**

No person shall be appointed or promoted to, or demoted or dismissed from, any position in the classified service, or in any way favored or discriminated against with respect to employment in the classified service because of his/her political or religious opinions or affiliations, or ethnic origin, sex, or disability or age.

The use or promise of political influence based upon an official position, whether actual or anticipated, of favorable or retaliatory treatment of an employee or position is a violation of law.

Employees may not be solicited to make contributions of money or services to political parties or candidates.

Employees may not be actively involved in partisan political campaigns or candidates for elective political office but may run for non-partisan office if no salary other than a per diem payment is involved.

The following guidelines are taken from 'political' [Opinions of the Attorney General](#) (Kentucky), which interpret the political activities law.

**Registration and voting:** Classified employees may register and vote in any election.

**Expression of opinions:** All persons subject to the personnel rules have a right to privately express their opinions on all political subjects and candidates, but they may not take an active part in political management or political campaigns.

**Contributions:** It is lawful for classified employees to make voluntary cash contributions to political parties, candidates, or organizations. However, it is unlawful for classified employees to make contributions of goods, services, or labor.

**Membership in political clubs:** Classified employees may join a political club and attend its meetings but may not hold office or serve on committees of the club. Attendance at political

rallies, conventions, etc. are permitted and classified employees may participate in the selection of committeemen and committeewomen. Classified employees may vote at the lowest level of the selection process for delegates to the party conventions.

**Political pictures and signs:** It is lawful for classified employees to display political pictures or signs on their property.

**Badges, buttons and stickers:** It is lawful for classified employees to wear political badges or buttons and voluntarily display political stickers on their private automobiles, however, no political badges, buttons or other designations may be worn while on official duty or while the employee is conducting official business for the Commonwealth.

**Precinct election officers:** Classified employees may serve as precinct election officers at the polls.

**Constitutional amendments, referenda, etc.:** Classified employees may work actively for or against constitutional amendments, referenda or municipal ordinances in which they are interested, provided that LHD working time and resources are not used for this purpose.

**Transporting voters:** Classified employees on their own time may transport friends or relatives to the polls as a civic gesture, but may not transport voters to the polls as part of an organized service to a political party, faction, or candidate.

## **EMPLOYEE INFORMATION, PROOF OF ACTIVE DRIVER'S LICENSE**

LHDs have positions in their agency requiring employees to operate a motor vehicle and possess a valid operator's license. It is imperative the LHDs ensure the employee's driver's license is valid. Administrative Regulation [902 KAR 8:100](#), Section 1 Item (1) "an appointing authority may discipline an employee for: (f) failure to obtain or maintain a current license or certificate or other qualifications required by law or rule as a condition of continual employment."

### **Development of LHD Policy**

LHDs should develop a policy requiring employees who operate a motor vehicle as an official part of their job to report to their supervisor or appointing authority any changes that occur regarding their license. If an employee's license has been suspended, revoked or taken away, immediate disciplinary procedures may be initiated. The employee with a suspended license may be moved to a position that does not require driving until the status of the license is obtained and a determination made of whether it can be reinstated within a reasonable time period.

### **Verification of Valid Driver's License**

To verify an employee, has a valid driver's license, an agency may obtain a copy of the employee's driving record. The agency would obtain one by contacting the local [Circuit Court Clerk's Office](#) or through the [Department of Transportation](#).

**STAFF TRAINING (Including Annual Required Trainings)**All new LHD staff shall receive orientation regarding the organization and function of LHDs, as well as training and instruction on their specific job duties. At a minimum, a core-training program for all staff shall consist of the following elements:

- Review of LHD policies, handbook by supervisory, personnel, and management staff.
- **Review of Health Insurance Portability and Accountability Act (HIPAA) requirements** pertaining to LHDs, confidentiality requirements and Employee Agreement; (**All** employees, including contractors, janitors, etc., are required to review the requirements **annually**.)
- Explanation of job duties by supervisory staff;
- Observation of job duties performed by staff in the same job position within the health department, or when not available within the organization, observation at another health department;
- Discussion of the LHD's role, function, and responsibilities within the community by supervisory and/or management staff; brief overview of basic manuals/references in use by the LHD and location of these manuals/references;
- Observation of the job duties of other service providers when appropriate, in order to provide the new employee with an understanding of the job responsibilities and functions of other staff and an understanding of the organization; and
- Participation in professional training mandated by the Cabinet for Health and Family Services (CHFS). LHDs have the opportunity for input as to the effectiveness of these training programs and may make suggestions to the Cabinet for improving such programs. Click on this link to go to the Appendix where the trainings are listed.
- Review and discuss DPH protocol for Narcan.
  - <https://www.narcan.com>
  - <https://www.narcan.com/pdf/NARCAN-Patient-Information.pdf>
  - <https://www.evzio.com/patient/about-evzio/index.php>
  - <https://www.evzio.com/patient/pdfs/Evzio-Patient-Information.pdf>
  - <https://www.evzio.com/pdfs/Evzio-Patient-Information.pdf>
- Feedback from supervisory staff on the employee's progress. Feedback/discussion shall be both verbal, which shall be intermittent as needed, and written which shall occur at a minimum of six months as reflected in the probationary evaluation; the employee shall also have the opportunity to discuss any questions or concerns he/she may have about the job or the LHD.

## **NEW EMPLOYEE ORIENTATION**

Each new employee should receive an extensive orientation or onboarding process acquainting the employee with the general operation of the LHD and the specific job responsibilities and duties of the position, including HIPAA guidelines. Onboarding and orientation are to help the new employee learn about their job responsibilities and to prepare them to be competent members of the health department.

### **Employee Handbook**

The employee must receive a handbook pertaining to the LHD operational procedures and guidelines. The "[Checklist for New Employee Orientation](#)," and onboarding forms may be used to assist the health department and employee. These forms may be altered to fit the needs of the LHD or the LHD may develop and use their own orientation form(s).

Each area of the orientation form is to be checked and signed by the appropriate staff and the new employee and placed in the employee's file. The orientation may be conducted by staff of the LHD Personnel Office, by the supervisor of the incoming employee or by different staff covering specific areas.

## **IDENTIFICATION CARDS FOR LHD EMPLOYEES**

All LHD employees shall wear identification (ID) cards that identify employees as official representatives of the health department.

### **Employees on Extended Leave or Terminated**

Terminated employees or employees placed on extended leave of absence, shall have their ID card collected and/or destroyed. An employee's lump sum payment for accumulated annual leave may be held by the LHD until the employee who has terminated for any reason returns his/her ID card, agency credit cards, any keys, or other agency property in the possession of the employee, in accordance with [902 KAR 8:080](#), Section 11 (3).

### **Staff Providing Services within the Health Department**

ID cards worn by employees providing services within the health department facility shall contain at a minimum the first name and professional discipline of the employee.

### **Staff Providing Services outside the LHD Facility**

ID cards worn by staff who provide services outside the facility shall contain at a minimum the name and professional discipline of the employee, the name of the LHD, and a recent photograph of the employee on the front of the card.

### **Cost**

The cost of the photograph and encasing the ID card in plastic shall be assumed by the LHD. The LHD may charge the employee to replace lost or damaged IDs.

## **DRUG-FREE WORKPLACE ANTI-DRUG ABUSE ACT**

In compliance with the [Anti-Drug Abuse Act](#), LHD employees are notified that: "the unlawful manufacture, distribution, dispensation, possession or use of any controlled substance is strictly prohibited in the workplace and any employee found to be in violation will be subject to disciplinary action by the Appointing Authority for misconduct which may include sanctions up to and including dismissal from LHD service, in accordance with administrative regulation."

### **Drug-Free Awareness Programs/Health Insurance Coverage**

Each agency will continue to improve drug-free awareness programs through cooperation with local and/or state agencies to eradicate the dangers that drugs in the workplace create for employees. Health insurance programs provide coverage for employees referred to or seeking treatment for drug and alcohol related problems.

### **Reporting Convictions Of Drug Statute Violations Occurring In Workplace**

Employees are notified that compliance with drug-free workplace requirements is a condition of continued employment with an agency. Each employee is obligated to report any conviction he/she receives as a result of a violation of any criminal drug statute violation occurring in the workplace within five (5) days of such conviction. Failure to report a conviction may result in disciplinary action. Such a report is to be made to the employee's Appointing Authority and is required by federal law and the agency is obligated to report such conviction to the federal grantor within ten (10) days after it receives notice.

### **Violation Penalties**

Employees found to be in violation of drug-free workplace requirements may face disciplinary action up to and including dismissal or may be required to satisfactorily participate in a drug abuse assistance or treatment program.

Employees who have questions concerning this directive are encouraged to contact their supervisor or appointing authority.

### **DRUG-FREE WORKPLACE ACT REQUIREMENTS**

LHDs shall comply with the "[Drug-Free Workplace Act of 1988](#)" by taking the following steps:

- Publish and give a policy statement ([eLaws - Drug-Free Workplace Advisor](#)) to all covered employees informing them that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited in the covered workplace and specifying the actions that will be taken against employees who violate the policy.
- Establish a drug-free awareness program to make employees aware of:
  - The dangers of drug abuse in the workplace;
  - The policy of maintaining a drug-free workplace;
  - Any available drug counseling, rehabilitation, and employee assistance programs; and
  - The penalties that may be imposed upon employees for drug abuse violations.
- Notify employees that as a condition of employment, the employee must:
  - Abide by the terms of the policy statement; and
  - Notify the employer, within five calendar days, if he or she is convicted of a criminal drug violation in the workplace.
- Notify DPH within 10 days after receiving notice that a covered employee has been convicted of a criminal drug violation in the workplace.
- Impose a penalty on — or require satisfactory participation in a drug abuse assistance or rehabilitation program by — any employee who is convicted of a reportable workplace drug conviction.
- Make an ongoing, good faith effort to maintain a drug-free workplace by meeting the requirements of the Act.

### **Certification Of Compliance**

The annual MOA with DPH must include a certification of compliance with the above stated requirements of the "[Drug-Free Workplace Act of 1988](#)."

### **SEXUAL HARASSMENT**

Federal and state laws prohibit unwelcome sexual advances, requests for sexual acts or favors (with or without accompanying promises, threats, or reciprocal favors or actions), or other verbal or physical conduct of a sexual nature that has the purpose of or creates a hostile or offensive working environment. Examples of prohibited conduct include, but are not limited to, lewd or sexually suggestive comments; off-color language or jokes of a sexual nature; slurs and other verbal, graphic or physical conduct relating to an individual's gender; or any display of sexually explicit pictures, greeting cards, articles, books, magazines, photographs or cartoons. Employees are strictly prohibited from using agency equipment to view and distribute sexually offensive material.

### **Filing a Sexual Harassment Complaint**

Any employee who has a complaint of sexual harassment at work by anyone, including supervisors, co-workers, visitors, clients or customers should immediately bring the problem to the attention of agency management personnel. Employees may notify another supervisor if the complaint involves the employee's immediate supervisor. Sexual harassment complaints may also be filed with the Equal Employment Opportunity Commission.

### **Responsibility of Management**

Management personnel will promptly and carefully investigate all complaints of sexual harassment. Employees shall be assured that they will be free from any and all reprisal or retaliation from filing such complaints. Supervisors may face legal action in both their professional and personal capacities should retaliation occur.

### **VIOLENCE IN THE WORKPLACE**

#### **No Tolerance Policy**

The LHD will not tolerate any actions that threaten its employees. Management personnel will deal with any such action immediately. This includes verbal and physical harassment, verbal and physical threats and any actions that may cause others to feel unsafe in the workplace.

#### **Responsibility Of Management**

Management personnel are responsible for protecting staff from what could be a dangerous situation in the workplace. Emergency procedures must be developed and staff must be trained on how to deal with violent situations.

If a violent act should occur, management personnel will investigate and take appropriate action. It is important for the LHD to provide employees affected, supportive and/or counseling services.

If an employee is the responsible party, the appointing authority may place the employee on leave using accumulated leave credit or immediately suspend the employee without pay.

#### **Employee's Responsibility for Reporting**

All employees are responsible for reporting to management any threatening actions whenever they occur.

### **HOME VISITING & SAFETY GUIDELINES**

Home visits may be performed for specific programmatic reasons or they may be performed due to referrals from private physicians and/or hospitals. All home visits must meet [907 KAR 3:130](#) and may be performed by various LHD professionals, including but not limited to registered nurses, family support workers and environmentalists.

Several programs, such as lead and tuberculosis, have specific guidance regarding home visiting in the [Clinical Service Guide](#). LHD staff should contact DPH program staff if they have a question regarding a specific program including if home visits are allowable for a specific program.

All LHD should have a policy and/or training plan for employees who may provide home visits. These documents should ensure that employees are aware of safety precautions when making home visits to clients in your community. Refer to Kentucky statutes that address your right to protect yourself ([KRS 503.050](#)) and another ([KRS 503.070](#)).

### **FAMILY AND MEDICAL LEAVE**

All LHDs shall comply with the [Family Medical Leave Act](#) (FMLA). This Act is intended to balance the demands of the workplace with the needs of families, to promote the stability and economic security of families, and to promote national interests in preserving family integrity. It was intended that the Act accomplish these purposes in a manner that accommodates the legitimate interests of the employers, as well as minimize the potential for employment

discrimination on the basis of sex, while promoting equal employment opportunity for men and women.

General guidance, fact sheets, posters, applicable laws and regulations and other information related to [FMLA](#) is found on the Department of Labor's website.

## **PRIVACY AND SECURITY OF PROTECTED HEALTH, CONFIDENTIAL AND SENSITIVE INFORMATION GUIDELINES**

The LHD, in each of its organizational components, and by each of its organizational components, and by each of its agents or employees, will act as a responsible steward of all information. The LHD will take reasonable and prudent measures to insure the privacy and security of protected health, confidential and sensitive information. **All medical information will be handled in accordance with applicable law, this includes but is not limited to "The Health Insurance Portability and Accountability Act of 1996,"** other applicable Federal Law, the [Kentucky Revised Statutes](#) and the regulations promulgated thereunder. Medical information will only be collected, used, distributed or disclosed for the betterment of public or individual health and in support of the payment, integrity, accountability, reliability, quality and delivery of health services. The LHD should contact their attorney for questions or concerns related to HIPAA.

At all times, every employee will strive to protect the confidentiality, integrity and accuracy of all information maintained by the LHD in any form. It is the responsibility of every employee of the LHD, whether or not they may be a classified or non-classified employee, a personal service contracted employee, a volunteer, a co-op, an intern, or a contractual entity or its employees, to diligently safeguard protected health, confidential and sensitive information, which includes a patient's record. Each person engaged in the duties of the LHD shall be deemed charged with the obligation to comply fully with their assigned tasks but to do so while limiting their access to, and knowledge of, protected health, confidential and sensitive information to the minimum necessary for the accurate and timely completion of their duties.

Protected health, confidential and sensitive information is information that is either protected by law or is of such personal or private nature that it is normally not treated as public record. Neither the LHD, nor any of its agents or employees will obtain, maintain, release, use, disclose or distribute any information in any form in contravention of currently applicable State or Federal law and the regulations promulgated thereunder. Employees who violate these standards may be subject to progressively severe disciplinary action up to and including dismissal.

The Privacy and Security Agreement lists and briefly describes many of the major laws and regulations pertaining to confidential information. There is information not covered specifically by these laws, which is also sensitive and must be safeguarded because of the potential for its misuse. Examples include, but are not limited to the following: social security number, home address, home telephone number, date of birth, height, weight, race, gender, political affiliation, employment history and any other information of a purely personal nature. In addition, a LHD or office may also have additional requirements necessary to protect information relative to that organizational unit's necessary functions.

## **Responsibility**

An employee's responsibility extends to all situations where employees are accessing, using, circulating, maintaining, disclosing and disposing of reports or documents, or is given information through conversations or observations that contain protected confidential or sensitive information.

### **Specifically:**

- Employees shall not release protected health, confidential and sensitive information to themselves or to other persons, entities or employees outside the scope of their duties. Such information may be in any form, e.g. verbal (discussions/conversations), paper or electronic.
- Employees shall not seek access to, or inquire about protected health, confidential and sensitive information in excess of the minimum necessary to efficiently discharge the documented responsibilities within the scope of their duties.
- At no time will employees allow the use of their USER ID and Password by another person to access computer data. Allowing access includes, but it is not limited to leaving a written notation of a USER ID or Password on or near a computer terminal. Follow the computer use/access and security guidelines and procedures outlined in the [LHO Section](#) of the Administrative Reference.
- Employees shall familiarize themselves with the [HIPAA laws pertaining to Privacy and Security of Protected Health, Confidential and Sensitive Information](#) in order to comply with those restrictions and take an annual refresher course. This information should be available from your LHD Director or their designee. Annually, a Privacy and Security of Protected Health, Confidential and Sensitive Information document must be reviewed and signed.
- Employees shall familiarize themselves with what types of information are considered protected health, confidential, personal or sensitive information and do their utmost to protect it. For an example, when documents or reports are circulated that contain such information, the sender will alert the receiver(s) to ensure the confidentiality of the data.
- Employees are not to include protected health, confidential, personal or sensitive information on site visit or other administrative reports/records or documents. If there is a need to address specific patient records, these records are to be addressed by code with specific identification provided separately via phone or via a separate key/listing, which is to be destroyed upon completion of the investigation.
- Employees, when sending mail, faxes or other correspondence containing protected health, confidential, personal or sensitive information to any person, the sender will indicate "Personal and Confidential" on the envelope or fax cover page to ensure that only the addressee opens/reads it. Extreme caution shall be taken when mailing identifying information to assure that the envelopes or other mailing containers are securely closed and that the information is mailed to the correct location/address and addressed to the appropriate individual.
- **Unless using encryption software approved by COT**, protected health, confidential, personal or sensitive information must not be included in e-mails.
- In cases when it is necessary to fax protected health, confidential, personal or sensitive information, employees are to take extreme caution to assure:
  - The correct fax number is entered;
  - The message or cover page includes a confidentiality notice indicating the faxed material is for the sole use of the intended recipient and may contain confidential information; and
  - That only an authorized person is available to receive the information.

- Interviews with patients or family members where information of a personal and confidential nature such as medical histories, medical treatments, family income, etc. is discussed must be conducted in areas where patient privacy can be expected and maintained.
- Computer screens with person specific data are not to be visible to unauthorized personnel or public areas.
- When it is necessary to leave the computer/computer monitor, even for a short period, during the workday the computer shall be locked.
- The computer shall be locked or logged off before leaving at the close of the workday.
- Printouts or any hard copy records with person specific information shall be covered to prevent the identifying information from being exposed and accessible to unauthorized personnel.
- Originals, copies, or excerpts from patient medical records shall be maintained in locked cabinets or locked storage areas when unattended.
- Person specific data shall be discussed only with authorized personnel and then only within the context of providing patient care/services, assisting with a reporting, billing, record keeping, or specific health care management problem and should be discussed in a private location.
- Person specific/patient information obtained through conversation or observation by employees of the LHD is confidential and such info shall not be disclosed without the individual's written consent, except as required by law.
- Permission shall be obtained from the patient as to how and/or if the patient may be notified or reminded regarding appointments, billings or any other message regarding health department services.
- Employees will take reasonable and appropriate measures to protect identifying numbers. Of particular concern is the social security number and date of birth. Because it appears on a myriad of documents and reports, it is one of the most difficult pieces of data to protect, but all employees should do their utmost to safeguard it.
- When no specific guidance is provided regarding responding to requests for information and a written request for information is received, only release the information with the written authorization of the affected party.
- When no specific guidance is provided regarding responding to an oral or unwritten request for information, where no written request for information is received, only release the information after verifying and documenting the authorization of the affected party. Verification includes, but is not limited to: obtaining the patient's full name; date of birth; state issued ID (e.g., Driver's License); last 4-digits of Social Security Number; and physical/ mailing address. Contact the [Local Health Personnel Branch](#) for further clarification.
- All employees shall dispose of documents that contain protected, health, confidential, personal or sensitive information. Paper documents or reports shall be placed in a "shred" box that is removed from the work site and destroyed prior to disposal or recycling, rather than placing the documents in a regular solid waste or recycling receptacle. All protected, health, confidential, personal or sensitive information in electronic form must be erased or destroyed in a manner that prevents reconstruction prior to disposal.
- All electronic or paper records with protected health, confidential or sensitive data shall be accessible only to authorized personnel; indexed; maintained in a secure location, and retained for only the period deemed necessary by the [Records Retention Schedule](#). The retention period shall not be permanent unless authorized by Federal or State Law.

- Employees should understand there may be other information that must be protected that is not specifically listed in this procedure or on the “LHD Employee Privacy and Security of Protected Health, Confidential and Sensitive Information Agreement.” When in doubt, the employees should consult with their supervisor/health department director.
- Employees shall not disclose protected health, confidential, personal or sensitive information even after their employment with the Health Department ceases. State and Federal law regarding protected health, confidential, personal or sensitive information also applies OUTSIDE the employment relationship and criminal or civil penalties including fines and imprisonment could apply.
- Employees shall be informed that disregard of the privacy and security of protected health, confidential, personal or sensitive information might result in disciplinary action, up to and including dismissal. Additionally, employees may subject themselves to civil and criminal liability for the disclosure of confidential information to unauthorized persons. (See the following information for further guidelines on the employee and agency responsibilities regarding the [Health Insurance Portability and Accountability Act of 1996](#)).

#### **Procedure For “New” LHD Employees\***

All new LHD employees shall be given a copy of these guidelines and the “LHD Employee Privacy and Security of Protected Health, Confidential and Sensitive Information Agreement” at orientation to sign and take an annual refresher course. By signing the agreement, the employee is acknowledging he or she has read the agreement, understands the agreement, and agrees to abide by the terms of the agreement. The signed Agreement will be placed in the employee’s folder in the LHD Personnel File.

#### **Procedure For “Current” LHD Employees\***

All current employees will be provided a copy of this procedure and required to sign the “LHD Employee Privacy and Security of Protected Health, Confidential and Sensitive Information Agreement”, which will be placed in their personnel file. This agreement should be signed annually to ensure current understanding.

- \* **Includes all persons.** For example: contracted employees, students, co-ops, interns, volunteers, etc., who may have access to protected health, confidential, or sensitive information and also utilize [LHD network computer systems](#).

### **HEALTH INSURANCE PORTABILITY AND CCOUNTABILITY ACT OF 1996 (HIPAA)**

#### **Agency Responsibility**

HIPAA addresses the following five (5) areas:

- Standardization & Code Sets
- Privacy – The basic requirements of the privacy regulation apply to protect health information and individually identifiable health information, whether said information is oral or recorded in any form or medium – electronic or paper, (past, present and future. A HIPAA Privacy notice must be posted in plain view in the LHD building(s), and copies shall be provided to patients.
- Security
- Unique Identifiers
- Electronic Signatures

Each LHD is a covered entity and must follow HIPAA guidelines. As a covered entity, LHDs must have policies and procedures in place to comply with the HIPAA statute, and will provide guidance for employees, temporary staff and volunteers. Through contractual agreement, business associate agreement or confirmation of statutory role, each agency will ensure business partners are also HIPAA compliant.

### **Agency and Employee Responsibility**

The following statement should be included in each employee's performance plan, starting with the 2003 Plan:

*"The employee shall be familiar with the HIPAA statute and safeguard protected health information (**PHI**) and other personal or sensitive information within their trust in the course of LHD (LHD) business by applying appropriate safeguards. You will share only the information required to deliver health department services. Personal or sensitive information overheard or seen by the employees will be kept confidential by not sharing it with others, on or off the work-site grounds."*

*All employees, contracted employees, volunteers, co-ops, students, and interns will sign a confidentiality agreement that includes HIPAA compliance as part of the condition of employment. The HIPAA compliance should be reviewed annually with another agreement signed by employee. The appointing authority shall take appropriate action to investigate allegations of HIPAA violation. A memo must be created for the record that states: "This health department will use the state merit system as the basis for inquiry into HIPAA complaints related to staff." A sample EMPLOYEE PRIVACY AND SECURITY OF PROTECTED HEALTH, CONFIDENTIAL AND SENSITIVE INFORMATION AGREEMENT that is HIPAA compliant is located on the [LHD Forms, Documents and Administrative Reference webpage](#) for LHD use. The LHD should contact their attorney for inquiries related to HIPAA, Privacy, Security of Protected Health, and Confidential and Sensitive Information.*

### **OSHA COMPLIANCE**

All LHDs shall comply with applicable [Occupational Safety and Health Administration](#) (OSHA) laws and regulations. Health departments shall be required to follow all OSHA guidance provided in the Administrative Reference (e.g., [Incident Reporting](#) and [Bloodborne Pathogen](#) sections).

### **TUITION ASSISTANCE AND EDUCATIONAL LEAVE**

The Administrative Regulation [902 KAR 8:160](#) Sections 4 and 5 outline Tuition Assistance and Education Leave. The contract and forms can be found on the Local Health Personnel webpage under [Forms](#) located in the LHD HR Staff subheading.

### **WORK ASSIGNMENT – INABILITY/RELUCTANCE TO PERFORM**

The **Local Health Personnel Branch** is frequently asked about the ramifications when an employee refuses to accept an assignment. The employee's decision regarding accepting or making work assignments is based on his or her moral, ethical and professional obligation to assume individual responsibility for his or her judgment and action. These refusals must not be taken lightly since it is the health department's obligation to ensure that patients are given safe, competent health care and that all customers receive good customer service. We recommend the following procedure to ensure that all potential employees and current employees understand the agency's expectations.

## **APPLICANTS**

- Clearly state the job duties on the job description. We recommend you distribute the job description with applications. During the interview, duties should be discussed and a copy of the job description given to the applicant.
- Ask the applicant if there are any job duties listed that he/she may not be able to perform. If the applicant identifies such duties, rationale with supporting documentation should be requested.
- The agency may negotiate an alternate plan including reassignment to an area in which these assignments are least likely to be needed **if a vacancy exists**. In making the decision to negotiate an alternative plan, the agency must consider such issues as: Is there a job available in an area where this assignment is least likely to be needed? Are there other employees in the agency who can perform these job duties? Is this duty a large percentage of the essential functions of the job?
- Both parties should understand that the employee will retain responsibility for carrying out the alternate plan and/or assuring that the service is provided. Failure to do so may result in disciplinary action, up to and including dismissal.
- If an alternate plan cannot be negotiated, the applicant may be determined to be ineligible due to inability to carry out the required job responsibilities.

## **CURRENT EMPLOYEES**

- An employee's inability/reluctance to accept a work assignment should be submitted to the supervisor in writing, with supporting documentation including a request and suggestions for an alternate plan that assures services will be provided.
- Management staff must review the request and determine whether the agency can develop an alternate plan that assures services will be provided. It is imperative that requests be submitted in advance rather than at the time the service is needed whenever possible.
- The agency may negotiate an alternate plan that may include reassignment to an area in which these assignments are least likely to be needed **if a vacancy exists**. In making the decision to honor the request, the agency must consider such issues as: Is there a job available in an area where this assignment is least likely to be needed? Are there other employees in the agency who can perform these job duties? Is this duty a large percentage of the essential functions of the job?
- Both parties should understand that the employee will retain responsibility for carrying out the alternate plan and/or assuring that the service is provided. Failure to do so may result in disciplinary action, up to and including dismissal.
- Refusal to follow a previously negotiated alternative plan or to carry out assignment may be grounds for disciplinary action up to and including dismissal.

**EXAMPLE:** A family planning nurse refuses to dispense an Emergency Contraceptive Pill (ECP) when a patient presents for treatment. There was no prior written agreement between the employee and the agency. Assuming that the employee was fully aware of the job duties

and had filed no written request for refusal, the appointing authority may initiate disciplinary action.

## **GRIEVANCE/COMPLAINT PROCEDURES FOR ANY MEMBER OF THE PUBLIC OR PATIENT**

All LHDs shall establish an internal grievance procedure to assure prompt and equitable resolution of complaints alleging discrimination, unfair or inappropriate treatment of any member of the public or any patient(s).

These procedures shall be sufficiently broad to address complaints concerning medical/clinical and environmental health services and shall be in accordance with [902 KAR 8:160, Section 12](#).

Federally Funded Programs must provide the complainant the address to file their civil rights discrimination complaint directly with that program's federal agency, i.e. WIC including WIC FMNP and WIC Breastfeeding Peer Counseling Program's applicants and participants must be provided the address to file a complaint directly with USDA. See WIC and Nutrition Manual, Policy 306, Civil Rights. 902 KAR 8:160, Section 12 does not apply to civil rights discrimination complaints for federally funded programs.

Complaint procedures shall be developed to protect the rights of the complainant, to meet due process requirements, and assure compliance with federal laws and regulations governing equal opportunity, Americans with Disabilities Act (ADA), and participation in certain federal grant programs.

In addition, the following elements shall be included in the complaint procedure:

Complaints may be written, verbal, or anonymous. Complaints shall contain the name and address of the person filing the complaint, if the complaint is not anonymous. The following information shall be obtained on all complaints:

- The date(s) the alleged incident occurred;
- The location at which the alleged incident occurred;
- The employee or contracted agent against which the complaint is filed; and
- A description of the alleged incident.

*A complaint shall be filed within 60 days of the alleged incident. However, Civil Rights and ADA grievances allow 180 days after the complainant becomes aware of the alleged violation. Only the Secretary of each federal agency or their designee can extend this time frame for good cause.*

## **EMPLOYEE GRIEVANCES AND COMPLAINTS**

Occasionally employees are faced with situations that cannot be resolved through informal complaint processes. In such cases the employee may wish to file a formal grievance with his/her agency. The employee grievance procedure allows many matters to be resolved in-house through a formal structure designed to save employees and their agencies both time and unnecessary effort. All LHDs shall establish an internal grievance policy per [902 KAR 8:160](#), Section 12.

### **Definition Of A Grievance**

A grievance is a complaint filed by an employee which concerns some aspect of his/her conditions of employment over which the agency has control and which has been alleged to have occurred or which the employee has become aware of, through the exercise of due diligence, within 30 days prior to filing.

### **Rights**

Any employee in the classified service who believes that he/she has been subjected to unfair or unjust treatment concerning his/her conditions of employment may file a grievance.

An employee utilizing this procedure is entitled to file a grievance without interference, coercion, discrimination, or reprisal.

### **Actions Not Appropriate For Grievance Procedures**

Actions which are appealable under Administrative Regulation [902 KAR 8:110](#) would not proceed through the grievance process but would be appealed directly to the LHD Employment Personnel Council.

### **Procedures Should Include Provisions For:**

- A grievance to be filed with an employee's immediate supervisor within 30 days following alleged occurrence or the employee becoming aware, through the exercise of due diligence, of the action that is the subject of the grievance. If the action or conduct of the first line supervisor is the basis of an employee's grievance, the grievance may be filed with the second line supervisor.
- An employee to state in writing the basis of the grievance or complaint together with the corrective action desired. If an employee wishes to submit additional information or documentation, it should be attached to the grievance.
- Interviews by management/administrative staff/appropriate committee to evaluate or investigate the grievance outside of normal work hours. Compensatory time/paid overtime (as applicable to the position) for the grievant or for other employees.
- Interviews by management/administrative staff/appropriate committee to evaluate or investigate the grievance held with the grievant or other employees that do not require the use of leave time.
- Grievant to have a representative present during interviews with the grievant at each step of the grievance procedure.
- A grievance template is available on the Local Health Personnel Branch webpage under [Forms for HR Staff](#). Modify the template to fit your agency per regulation 902 KAR 8:160, Section 12.

### **PERSONNEL FILES**

The LHD is the primary custodian of all employee personnel files. These files are subject to state and federal audit. They must be retained in accordance with the [Records Retention Schedule](#).

The current schedule, approved June 13, 2013, stipulates that these files may be destroyed 60 years from the date the individual was first employed. See Medical Records Management Section for the Records Retention Schedule.

Generally, personnel files are maintained by the Human Resources (HR) Department. The files are to be secured at all times. While employees may review their own personnel files, an employee may view information in the file of another employee only on a "justifiable need-to-know basis." HIPAA privacy requirements apply to employee files.

### **General Personnel Files**

General personnel files are accessible to an employee (for his/her own file), appointing authority, and immediate supervisor. These files for each employee usually contain:

- Job application.
- Job testing data, if applicable.
- Notification of appointment, including starting pay rate.
- Certification appointed form, if applicable (SSN's of other applicants must be redacted).
- Job description.
- Wage and Hour Exemption status form.
- Report of personnel actions approved or denied (P-2's).
- Performance evaluations.
- Disciplinary actions.
- Training records.
- Professional licensure, certification and/or education verifications.
- Confidentiality agreements.

Any information not specifically related to employee wage and hour status or job performance should be scrutinized to determine whether it reveals any private fact about an individual. If it does, it should be placed in a general confidential file rather than the personnel file.

### **General Confidential Files**

General confidential files are accessible to employees, appointing authority, and HR Department. These files usually contain:

- Financial and credit information.
- Background investigation results.
- Records of participation in the agency's Employee Assistance Program (may go in medical file).
- Driver's license verification, any record checks and if applicable, car insurance verifications.
- Requests for educational financial assistance.

### **Medical Files**

Medical files are extremely confidential and must be locked in a separate filing cabinet. These files usually contain an employee's:

- Reimbursement requests for medical expenses.
- Drug testing results.
- Post-offer physical examination results.
- Substance abuse rehabilitation records.
- Fitness for duty/return to work forms.
- Any documents relating to the FMLA or the ADA.
- Accident incident reports.

## **Immigration And Naturalization Services Form (I-9's)**

An I-9 must be obtained within three (3) days after hiring an employee and the I-9 must be maintained in a separate file. In addition to the I-9's for current employees, these forms must be retained for one (1) year after termination or three (3) years after date of hire, whichever is longer. The file should have three (3) categories: Current Employees, Terminated, and Suspense/Pending. Each category should be sorted by year, with the most recent on top.

## **DEFICIT REDUCTION ACT OF 2005**

### **§6032 EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERY**

The purpose of this policy is to fulfill the terms of the Deficit Reduction Act which requires DPH to establish a policy which provides detailed information about the Federal Civil False Claims Act, the Federal Program Fraud Civil Remedies Act, state laws pertaining to false claims, and whistleblower protections under such laws.

### **FEDERAL CIVIL FALSE CLAIMS ACT**

The Civil False Claims Act (31 U.S.C. §3729 *et seq.*) is a statute that imposes civil liability on any person who:

- Knowingly presents, or causes to be presented, a false or fraudulent claim, record or statement for payment or approval;
- Conspires to defraud the government by getting a false or fraudulent claim allowed or paid;
- Uses a false record or statement to avoid or decrease an obligation to pay the Government, and other fraudulent acts enumerated in the statute.

The term "**knowingly**" as defined in the [Civil False Claims Act](#) ("FCA") includes a person who has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

The term "**claim**" includes any request or demand for money or property if the United States Government provides any portion of the money requested or demanded.

**Potential civil liability** under the FCA currently includes penalties of between five thousand five hundred and eleven thousand per claim, treble damages, and the costs of any civil action brought to recovery of such penalties or damages.

The **Attorney General of the United States** is required to diligently investigate violations of the FCA, and may bring a civil action against a person. Before filing suit the Attorney General may issue an investigative demand requiring production of documents and written answers and oral testimony.

The FCA also provides for **Actions by Private Persons** (*qui tam* lawsuits) who can bring a civil action in the name of the government for a violation of the Act. Generally, the action may not be brought more than six years after the violation, but in no event more than ten. When the action is filed it remains under seal for at least sixty days. The United States Government may choose to intervene in the lawsuit and assume primary responsibility for prosecuting, dismissing or settling the action. If the Government chooses not to intervene, the private party who initiated the lawsuit has the right to conduct the action.

In the event the government proceeds with the lawsuit, the *qui tam* plaintiff may receive fifteen to twenty-five per cent of the proceeds of the action or settlement. If the *qui tam*

plaintiff proceeds with the action without the government, the plaintiff may receive twenty-five to thirty per cent of the recovery. In either case, the plaintiff may also receive an amount for reasonable expenses plus reasonable attorneys' fees and costs.

If the civil action is frivolous, clearly vexatious or brought primarily for harassment, the plaintiff may have to pay the defendant its fees and costs. If the plaintiff planned or initiated the violation, the share of proceeds may be reduced and, if found guilty of a crime associated with the violation, no share will be awarded the plaintiff.

**Whistleblower Protection.** The Civil False Claims Act also provides for protection for employees from retaliation. An employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in terms and conditions of employment because of lawful acts conducted in furtherance of an action under the FCA may bring an action in Federal District Court seeking reinstatement, two times the amount of back pay plus interest, and other enumerated costs, damages, and fees.

### **State Medicaid False Claims Act**

Kentucky law imposes criminal and civil penalties on any person who commits a fraudulent act on the Kentucky Medicaid Program. See [KRS Chapter 205.8451](#) et seq. A "fraudulent act" includes those acts set forth in [KRS 205.8463](#). Specifically, a person has committed a fraudulent act when the person (1) intentionally, knowingly, or wantonly makes, presents or causes to be made or presented to an employee or officer of the Cabinet for Health and Family Services any false, fictitious or fraudulent statement, representation or entry in any application, claim, report or document used in determining rights to any benefit or payment; (2) knowingly or wantonly devises a scheme or plans a scheme or artifice, or enters into an agreement, combination, or conspiracy to obtain or aid another in obtaining payments from any medical assistance program under [KRS Chapter 205](#) by means of any fictitious, false, or fraudulent application, claim, report or document submitted to the Cabinet for Health and Family Services, or intentionally engages in conduct which advances the scheme or artifice; or (3) engages in any other act set forth in [KRS 205.8463](#). Any person who commits a fraudulent act as defined in [KRS 205.8463](#) shall be guilty of anywhere from a Class A misdemeanor, imprisonment for not more than twelve (12) months and/or a fine of five hundred dollars (\$500) to a Class C felony, imprisonment for not less than five (5) years nor more than ten (10) years and/or a fine of not less than one thousand dollars (\$1,000) and not greater than ten thousand dollars (\$10,000) or double the offender's gain from commission of the offense, whichever is greater. See [KRS 205.8463](#), [532.005](#), [532.030](#), [532.060](#), [532.090](#), [534.030](#) and [534.040](#). In addition to these penalties, any provider who has been found by a preponderance of the evidence in any administrative process to have knowingly submitted or caused claims to be submitted for payment for furnishing treatment, services or goods under a medical assistance program provided for under [KRS Chapter 205](#), which payment the provider was not entitled to receive, shall be liable for restitution; civil payments and interest; legal fees; and costs of investigation and enforcement as well as be subject to removal as a participating provider for a specified period of time. See [KRS 205.8467](#). The State shall also have a lien against all property of any provider or recipient who is found to have defrauded the Medicaid program for the amount equal to the sum defrauded plus any interest and penalties. See [KRS 205.8471](#). The terms and conditions of a State imposed lien is set forth in [KRS 205.8471](#).

Any person who knows or has reasonable cause to believe that a fraudulent act and/or a violation of [KRS Chapter 205](#) has been or is being committed by any person, corporation, or

entity, shall notify the state Medicaid Fraud Control Unit or the Medicaid Fraud and Abuse hotline and provide the information required under [KRS 205.8465\(1\)](#). Any person making such a notification regarding the offenses of another shall not be liable in any civil or criminal action based on the report if the report was made in good faith. See [KRS 205.8465](#). Additionally, no employer shall, without just cause, discharge or in any manner discriminate or retaliate against any person who in good faith (1) makes a report required or permitted by [KRS 205.8451 to 205.8483](#) or (2) testifies, or is about to testify, in any proceeding with regard to any report or investigation. See [KRS 205.8465](#).

The state agency administering the Medicaid Program may also impose administrative sanctions on providers convicted under the Statute. See [907 KAR 1:671](#).

### **State Administrative Sanctions Against Medicaid Providers**

Administrative sanctions also may be invoked against a Medicaid provider who has been determined to have engaged in unacceptable practices. See [907 KAR 1:671](#). "Unacceptable practices" means conduct by a Medicaid provider which constitutes "fraud" or "provider abuse" as defined in [KRS 205.8451\(2\)](#) or (8) or willful misrepresentation, and includes those practices identified in [907 KAR 1:671](#), Section 1, Paragraph (40). Specifically, unacceptable practices include, but are not limited to, presenting a false claim for services; submitting false information to obtain greater compensation than that to which the provider is entitled; submitting a claim by a provider terminated or excluded from the Medicaid Program; conversion; soliciting or accepting bribes or kickbacks; engaging in conspiracy, complicity or criminal syndication; failing to meet disclosure requirements; and other acts. See [907 KAR 1:671](#), Section 1, Paragraph (40).

"Fraud" means an intentional deception or misrepresentation made by a recipient or a provider with the knowledge that the deception could result in some unauthorized benefit to the recipient or provider or to some other person. See [KRS 205.8451 \(2\)](#). It includes any act that constitutes fraud under applicable federal or state law. See [KRS 205.8451\(2\)](#).

"Provider abuse" means practices of a health care provider that are inconsistent with sound fiscal, business or medical practices and that result in unnecessary cost to the Medical Assistance Program established pursuant to [KRS Chapter 205](#), or that result in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. See [KRS 205.8451\(8\)](#). It also includes practices that result in unnecessary cost to the Medical Assistance Program. See [KRS 205.8451\(8\)](#).

Sanctions may include but are not necessarily limited to liability for civil payments; restitution of overpayments; costs of investigation and enforcement of civil payments; legal fees; withholding of payments; and termination and exclusion from the Medicaid Program. See [KRS 205.8467](#) and [907 KAR 1:671](#), Section 5, Paragraph (2).

The factors considered in determining sanctions or the duration of exclusion are as follows: (1) the number and nature of the unacceptable practice incidents; (2) the nature and extent of the adverse impact the violations had on recipients; (3) the amount of damages to the Medicaid Program; (4) past criminal records of activities involving a child, patient or adult in matters of abuse, neglect, sexual abuse, malpractice, or the personal involvement in fraud or another violation of 42 U.S.C. 1128a-b13, that may have been discovered as a result of the investigation of the unacceptable practice or other related material facts that may impact the health, safety and well-being of Medicaid recipients; and (5) the previous record of violations

by the provider under Medicare, Medicaid or other program administered by the Department for Medicaid Services located within the Cabinet for Health and Family Services. See [907 KAR 1:671](#), Section 5, Paragraph (5).

### **State Insurance Fraud and Reporting Immunity Act**

Kentucky provides for criminal and civil penalties related to insurance fraud and have established within the Office of Insurance a Division of Insurance Fraud Investigation to investigate and prosecute violations. See [KRS 304.47-010 et seq.](#) Generally speaking, a “fraudulent insurance act” includes, but is not necessarily limited to, acts made with knowledge and the intent of obtaining an undeserved economic benefit or to deny another a benefit in connection with an insurance transaction. A “fraudulent insurance act” includes all those acts set forth in [KRS 304.47-020\(1\)](#). Any person who commits a fraudulent act under [KRS 304.47-020\(1\)](#) is, depending upon the amount received and number of offenses committed, guilty of anywhere from a misdemeanor, imprisonment for not more than a year, and/or a fine, per occurrence, of not more than one thousand dollars (\$1,000) per individual nor five thousand dollars (\$5,000) per corporation or twice the amount of gain received as a result of the violation, whichever is greater, to a felony, imprisonment for not less than ten (10) years nor more than twenty (20) years and/or a fine, per occurrence, of not more than ten thousand (\$10,000) per individual nor one hundred thousand dollars (\$100,000) per corporation or twice the amount of gain received as a result of the violation, whichever is greater. [KRS 304.47-020](#). The person committing the fraudulent act also may be ordered to make restitution to any victim who suffered a monetary loss. [KRS 304.47-020](#).

In addition to criminal liability, a person who violates the statute may be liable for civil payments and damages and all reasonable investigation and litigation costs including attorneys’ fees. See [KRS 304.47-020](#).

The following individuals having knowledge or believing that a fraudulent insurance act or any other act or practice which may constitute a felony or misdemeanor under [KRS 304.47-010 et seq.](#) is being or has been committed **shall** notify the Insurance Fraud Division: (a) any professional practitioner licensed or regulated by the Commonwealth except as provided by law; (b) any private medical review committee; (c) any insurer, agent or other person licensed under this chapter; and (d) any employee of the persons named in paragraphs (a) to (c) above. See [KRS 304.47-050](#). Any other person having knowledge or believing that a fraudulent insurance act or any other act or practice which, upon conviction, constitutes a felony or misdemeanor under [KRS 304.47-010 et seq.](#) is being or has been committed **may** notify the Insurance Fraud Division. See [KRS 304.47-050](#).

Notwithstanding the above, any person having knowledge or believing that a fraudulent insurance act or any other act that may be prohibited under [KRS 304.47-010 et seq.](#) is being or has been committed, **may** notify any law enforcement agency. See [KRS 304.47-050](#). Reporting to any other agency **does not** relieve those listed above of their mandatory duty to report to the Insurance Fraud Division. See [KRS 304.47-050](#).

If the reporter acts without malice, fraud or gross negligence, the reporter is immune from any civil liability for libel, slander, or related cause of action arising out of the report. See [KRS 304.47-050](#).

### **State Employment Protection Act**

State employees who report violations of state or federal law or regulation are provided protection against retaliation or disciplinary action related to the report pursuant to the "Kentucky Whistleblower Act." See [KRS 61.101](#) et seq. The Act prohibits an employer from subjecting to reprisal or directly or indirectly using, or threatening to use, any official authority or influence, in any manner whatsoever, which tends to discourage, restrain, depress, dissuade, deter, prevent, interfere with, coerce, or discriminate against any employee who in good faith reports, discloses, divulges, or otherwise brings to the attention of identified personnel any facts or information relative to an actual or suspected violation of any law, statute, executive order, administrative regulation, mandate, rule, or ordinance of the United States, the Commonwealth of Kentucky, or any of its political subdivisions, or any facts or information relative to actual or suspected mismanagement, waste, fraud, abuse of authority, or a substantial and specific danger to public health or safety. See [KRS 61.102](#). Additionally, no employer shall subject to reprisal or discriminate against, or use any official authority or influence to cause reprisal or discrimination by others against, any person who supports, aids, or substantiates any employee who makes public any wrongdoing set forth above. See [KRS 61.102](#).

"Employer" means the Commonwealth of Kentucky or any of its political subdivisions and any person authorized to act on behalf of the Commonwealth, or any of its political subdivisions, with respect to formulation of policy or the supervision, in a managerial capacity, of subordinate employees. See [KRS 61.101](#).

"Identified personnel" means the Kentucky Legislative Ethics Commission, the Attorney General, the Auditor of Public Accounts, the General Assembly of the Commonwealth of Kentucky or any of its members or employees, the Legislative Research Commission or any of its committees, members or employees, the judiciary or any member or employee of the judiciary any law enforcement agency or its employees or any other appropriate body or authority. See [KRS 61.102](#).

Employees alleging a violation of the Kentucky Whistleblower Act may bring a civil action for appropriate injunctive relief or punitive damages, or both, within ninety (90) days after the occurrence of the alleged violation. See [KRS 61.103](#).

Employees alleging a violation of the Kentucky Whistleblower Act also are afforded administrative remedies granted by KRS Chapters 16, 18A, 78, 90, 95, 156 and other chapters of the Kentucky Revised Statutes. See [KRS 61.103](#).

Notwithstanding the Kentucky Whistleblower Act, an employer may discipline or impose punitive action on an employee who discloses information which the employee knows (1) to be false or which the employee discloses with reckless disregard for its truth or falsity; (2) to be exempt from required disclosure under the provisions of [KRS 61.870](#) or [61.884](#); or (3) is confidential under any other provision of law. See [KRS 61.102](#).

### **State Computer Crime Act**

Kentucky provides criminal penalties related to knowingly and willfully, directly or indirectly, accessing, causing to be accessed or attempting to access a computer without the effective consent of the owner, (1) for the purpose of devising or executing any scheme or artifice to defraud or obtaining money, property or services for themselves or another by means of

false or fraudulent pretenses, representations or promises; (2) which results in loss or damage; or (3) which does not result in loss or damage. See [KRS 434.840 et seq.](#)

A “computer” includes any device, equipment, or facility that uses a computer program or other instructions, stored either temporarily or permanently, to perform specific operations including but not limited to logical, arithmetic, or memory functions with or on data or a computer program that can store, retrieve, alter, or communicate the results of the operations to a person, computer, computer program, computer system, or computer network or any part thereof. See [KRS 434.840](#). For additional definitions of these terms, please see [KRS 434.840](#).

Depending on the purpose for which the crime was committed and whether any loss or damage was sustained as a result of commission of the crime, any person convicted of a computer crime is guilty of anywhere from a Class B misdemeanor, imprisonment for not more than ninety (90) days and/or a fine of a two hundred fifty dollars (\$250) to a Class C felony, imprisonment for not less than five (5) years nor more than ten (10) years and/or fine of not less than one thousand dollars (\$1,000) and not greater than ten thousand dollars (\$10,000) or double the offender’s gain from commission of the offense, whichever is greater. See [KRS 434.840 et seq.](#), [532.005](#), [532.030](#), [532.060](#), [532.090](#), [534.030](#) and [534.040](#).

## **FAIR HEARINGS**

All administrative hearing procedures are governed by [KRS Chapter 13B](#).

The following are eligible for a fair hearing:

- Persons who have been denied services;
- Persons whose participation in a service has been discontinued;
- Persons who have been notified to repay the cash value of improperly received WIC benefits;
- Persons who have not had a grievance resolved to their satisfaction; and
- Public and certain classes of citizens who have been adversely affected as a result of the interpretation/enforcement of an environmental law, regulation or ordinance.

The [KRS Chapter 13B](#) applies to all local health departments (LHDs) in Kentucky. A general, uniform hearing procedure for the Cabinet for Health and Family Services has been adopted, Administrative Regulation [902 KAR 1:400](#).

However, due to tighter federal time frames for fair hearings than is required by KRS Chapter 13B, the WIC Program’s fair hearing policies for applicants, agencies, participants and vendors are governed by Administrative Regulation [902 KAR 18:040](#).

**Complaints of discrimination are not handled through the Fair Hearings Process. Federally Funded Programs must provide the complainant the address to file their civil rights discrimination complaint directly with that program’s federal agency, i.e. WIC including WIC FMNP and WIC Breastfeeding Peer Counseling Program’s applicants and participants must be provided the address to file a complaint directly with USDA. See WIC and Nutrition Manual, Policy 306, Civil Rights.**

## **All requests for hearings shall be honored unless:**

- The request is withdrawn in writing by the requesting party or his/her representative;
- The requesting party or his/her representative fails, without good cause, to appear at the originally scheduled hearing or any “make-up” hearing; or

- The requesting party has already had a hearing on the issue in question and cannot provide evidence that circumstances have changed sufficiently to justify another hearing.

**When a hearing request is received, the LHD shall in all cases:**

- Establish and maintain a hearing file documenting all correspondence and contacts with the party requesting a hearing; and
- Notify the appropriate DPH division or branch of the hearing request.

Persons aggrieved by an action of the LHD may request an opportunity to present his/her views before the Cabinet or its designated agent. The procedures will be in accordance with [902 KAR 1:400](#) which sets forth a uniform hearing procedure for the Cabinet for Health and Family Services and/or any other applicable laws and regulations.

The requesting party or his/her representative has a right to a conference hearing if requested within ten (10) days of the date of the notice of proposed adverse action.

**COMPLIANCE WITH TITLE VI (Persons with Limited English Proficiency)**

In order to ensure compliance with [Title VI of the Civil Rights Act of 1964](#), Policy Guidance Document: Enforcement of Title VI of the Civil Rights Act of 1964--National Origin Discrimination Against Persons With Limited English Proficiency ("[LEP Guidance](#)"), a LHD must ensure that a person identified as having a limited English language proficiency (LEP), where English is not the person's primary language, and who is eligible for services in the LHD has meaningful access to the benefits. (Civil Rights brochures and other information are located on the [Local Health Personnel Branch](#).)

LEP persons are defined as persons who cannot speak, read, write, or understand the English language at a level that permits them to interact effectively with providers. To facilitate the patient's treatment and ensure effective communication to each patient enabling the understanding of his/her care and make informed choices, the LHD shall have interpreter services and/or other adaptive equipment made available to the individual or staff member.

More information on Civil Rights and LEP can be found on the [Local Health Personnel Branch webpage](#).

**COMPLIANCE WITH AMERICANS WITH DISABILITIES ACT (ADA)**

The Department of Public Health and all LHDs are committed to the full implementation of the Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendments Act of 2008 (ADA). It is the policy of the department to maximize the full inclusion and integration of people with disabilities in all aspects of employment and all programs, services and activities. LHDs shall ensure their services, facilities and practices conform with the requirements of ADA, and to the extent feasible, modify services, policies and practices to conform to the ADA requirements.

## EQUAL OPPORTUNITY FOR INDIVIDUALS WITH DISABILITIES DEFINITIONS

- **Disability:** Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendments Act of 2008 define disability with respect to an individual: a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment. (See 7 C.F.R. § 15b(3)(i), 28 C.F.R § 35.108, 28 C.F.R. § 36.105, 45 CFR § 84.3(j) and 28 CFR 42.503.)
- **Major Life Activity (for disability):** (i) Caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, sitting, reaching, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, writing, communicating, interacting with others, and working; and (ii) The operation of a *major bodily function*, such as the functions of the immune system, special sense organs and skin, normal cell growth, and digestive, genitourinary, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, hemic, lymphatic, musculoskeletal, and reproductive systems. The operation of a major bodily function includes the operation of an individual organ within a body system.
- **Qualified Interpreter (Disability):** 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, and cued-language transliterators.
- **Reasonable modification:** A change in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity. 28 CFR 35.130(b)(7).
- **Companion (for disability):** A family member, friend, or associate of an individual seeking access to a service, program, or activity of a public entity or public accommodation who, along with such individual, is an appropriate person with whom the public entity or public accommodation should communicate.
- **Auxiliary Aids and Services: (1)** Qualified interpreters on-site or through video remote interpreting (VRI) services; notetakers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunications products and systems, including text telephones (TTYs), videophones, and captioned telephones, or equally effective telecommunications

devices; videotext displays; accessible electronic and information technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing;

- **(2)** Qualified readers; taped texts; audio recordings; Brailled materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs (SAP); large print materials; accessible electronic and information technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision; **(3)** Acquisition or modification of equipment or devices; and **(4)** Other similar services and actions.

### **EQUAL OPPORTUNITY ACCESS TO SERVICES FOR THOSE WITH DISABILITIES**

- Notify person with disabilities about the availability of reasonable modifications and auxiliary aids and services and how to request them in a format that they can understand.
- See WIC and Nutrition Manual, Policy 306 Civil Rights Policy for additional information for the WIC Program. This includes an available WIC Tagline which is available to assist in this notification.
- Ensure that communication with people with these disabilities is equally effective as communication with people without disabilities. This includes communication with the patient, parent, caretaker, spouse or companions in appropriate circumstances who have hearing, vision, and speech disabilities.
  - Provide qualified interpreters, and other auxiliary aids such as materials in an alternate format such as large print, Braille, electronic format or audio, giving primary consideration of the choice or aid or service requested by the person with a disability.
  - The auxiliary aid or service for effective communication requested and provided is to be documented in the medical record.
  - If the requested aid or service was not provided, this must be documented in the medical record and elevated to the most senior staff member for written justification for not providing the requested service. The alternative aid or service provided is to be documented in the medical record.
  - See the WIC and Nutrition Manual, Policy 306, Civil Rights, Disability Access to WIC Program Section for additional information regarding providing WIC Services to individuals with Disabilities.
- Provide Programs, activities and services in the most integrated setting that enables individuals with disabilities to interact with individuals without disabilities to the fullest extent possible.
- Ensure that individuals with disabilities are not excluded from programs and services because facilities are unusable or inaccessible to them in accordance with the DOJ 2010 ADA Standards for Accessible Design at [https://www.ada.gov/2010ADASTandards\\_index.htm](https://www.ada.gov/2010ADASTandards_index.htm).
- Ensure accessibility to websites and digital services for individuals with disabilities ([https://www.ada.gov/websites2\\_scrn.pdf](https://www.ada.gov/websites2_scrn.pdf)).

- Provide and document reasonable modification requested, offered and provided when necessary to ensure services are equally accessible to all protentional patients/clients/participants.
  - Examples of reasonable modifications include but are not limited to:
    - Changing a policy, practice, or procedure when necessary to enable equal access for individuals with disabilities.
    - Providing wheelchair access to WIC Clinic locations. This provides equal access to individuals using wheelchairs, mobility aids and other power-driven mobility devices.
    - Ensuring access to individuals who require the assistance of a service animal. See the WIC and Nutrition Manual, Policy 306, Civil Rights, Reasonable Modification Section for additional information regarding providing WIC Services to individuals with Disabilities.
  - If the requested modification, aid, or service was not provided, this must be documented in the medical record and elevated to the most senior staff member for written justification for not providing the requested service. The alternative modification, aid or service provided also must be documented in the medical record. The reasonable modification and/or auxiliary aid or service for requested and provided must be documented in the medical record.
  - Local Health Departments are not required to provide the requested auxiliary aid or service or to modify its policies, practices or procedures if the entity can demonstrate that providing the auxiliary aid and service or making the modification would fundamentally alter the nature of the service, program or activity. If the aid and service or modification requested would cause undue financial burden on the program or activity to the level that it would make continued operation of the program unfeasible, the modification need not be provided. However, denying an auxiliary aid and service or modification(s) under the fundamental alteration exception should not result in the denial of access to the program or other benefits or services. The decision not to provide the requested accommodation must be made by the most senior level staff.
  - A public entity is not required to permit an individual to participate in or benefit from the services, programs, or activities of that public entity when that individual poses a direct threat to the health and safety of others [Note: Direct threat to others - not to self.] Direct Threat means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices or procedures, or by the provision of auxiliary aids or services as provided in 28 CFR § 35.139.
  - Local Health Departments may impose legitimate safety requirements necessary for the safe operation of its services, programs, or activities. However, the LHD must ensure that its safety requirements are based on actual risks, not on mere speculation, stereotypes, or generalizations about individuals with disabilities

## **LOCAL HEALTH DEPARTMENT 504/ADA COORDINATOR(S)**

- Local Health Departments should designate staff to serve as Section 504/ADA Coordinators to ensure compliance with Section 504, the American with Disabilities Act.
- Section 504 requires recipients of federal financial assistance (FFA) that employ fifteen or more persons to designate at least one person to coordinate its efforts to comply with Section 504. [7 CFR 15b.6\(a\)](#).
- Title II of the ADA states, "A public entity that employs 50 or more persons shall designate at least one employee to coordinate its efforts to comply with and carry out its responsibilities under this part, including any investigation of any complaint communicated to it alleging its noncompliance with this part or alleging any actions that would be prohibited by this part. The public entity shall make available to all interested individuals the name, office address, and telephone number of the employee or employees designated pursuant to this paragraph." [28 CFR 35.107\(a\)](#).
  - Federally Funded Programs must provide the complainant the address to file their civil rights discrimination complaint directly with that program's federal agency, i.e. WIC including WIC FMNP and WIC Breastfeeding Peer Counseling Program's applicants and participants must be provided the address to file a complaint directly with USDA. See WIC and Nutrition Manual, Policy 306, Civil Rights.
- One person can serve the role of both Section 504 and ADA Coordinator.
  - If a local health department is not a public entity (state or local government), but receives FFA, it only would be required to have a Section 504 Coordinator if it employs 15 or more people.
  - If a local health department is a public entity that receives FFA, has fewer than 50 employees, the local health department would only be required to have a Section 504 Coordinator if it employs 15 or more people.
  - This does not preclude the agency from compliance with Section 504 and ADA regulations.
- Local Health Departments may have more than one designated 504/ADA Coordinator.
  - The 504/ADA Coordinator is responsible for ensuring local agency self-assessments are conducted as required by Section 504 and Title II of the ADA 7/CFR 15b.6, 45 CFR 84.5(c), and 28 CFR 35.105).
  - The 504/ADA Coordinator will assist in requests for an auxiliary aid or service for effective communication, providing a resource for both staff and the public.
  - The 504/ADA Coordinator will ensure compliance with Section 504 and Title II of the ADA 7/CFR 15b.6, 45 CFR 84.5(c), and 28 CFR 35.105).
- The Cabinet for Health and Family Services 504/ADA Coordinator may serve as a resource for Local Health Departments.

### **All employees must comply with the following policies regarding the ADA:**

- Discrimination Prohibited: employees with disabilities who are otherwise qualified may not be discriminated against in any areas of employment including, but not limited to,

job application and compensation procedures, fringe benefits available by virtue of employment and activities sponsored by the state.

- Limiting, Segregating, and Classifying: employees with disabilities shall not be limited, segregated, or classified in a way that adversely affects their employment opportunities or status.
- Contractual or Other Arrangements: LHDs will not participate in contractual or other arrangements or relationships that would subject qualified employees with disabilities to the discrimination prohibited by the ADA.
- Reasonable Accommodations: LHDs will make reasonable accommodation to the known physical or mental limitations of an otherwise qualified employee with a disability, unless it can be shown that the accommodation would impose an undue burden. After a qualified employee requests reasonable accommodation, all agencies will make every reasonable effort to find out what is needed and provide the appropriate accommodations. This is to be an interactive process with the agency consulting with the employee with a disability.
- Retaliation and Coercion: LHDs will not coerce, intimidate, threaten, harass, or interfere with any individual exercising or enjoying his/her rights under Title I of the ADA or because that individual aided or encouraged any other individual in the exercise of rights granted or protected by Title I of ADA. Employees may file a complaint as set forth in Employee Grievances or with the Office of Civil Rights.

More information is available at [American Disabilities Act](#) (ADA).

#### **LHD ANNUAL TRAINING MODULES AVAILABLE ON “[TRAIN Kentucky](#)”**

- KY DPH Ergonomics Module – [1020100](#)
- KDPH Occupational Safety Health Administration (OSHA) Bloodborne Pathogens Module – [1103084](#)
- KY DPH Occupational Safety Health Administration (OSHA) Bloodborne Pathogen Part 2 Module – [1020109](#)
- KY DPH Occupational Safety Health Administration (OSHA) TB Module- [1074371](#)
- KY DPH HIPAA Employee Orientation Module – [1020107](#)  
KY DPH Limited English Proficient (LEP) Persons Module – [1020091](#) (this is **not** applicable for WIC Staff, this is included in the CIVIL Rights Training)
- KY DPH Civil Rights Training Module – [1020093](#) (a revised training for will be released in FY23)–[1086294](#)

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**Local Health Department (LHD) [Personnel Reference Manual](#) [External]**

# Medical Records Management

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**LHD ONLINE RECORDS RETENTION SCHEDULE - *KDLA Website [external]***

**LHD Medical Abbreviations**

**DPH Nursing Office webpage**

## **Medical records shall be maintained in accordance with the following guidelines:**

### **Content**

- The medical record shall contain sufficient information to identify and assess the patient and furnish evidence on the course of the patient's health/medical care.
- The record shall include accurate and legible documentation of any LHD activity involving or affecting the patient's health to include but not be limited to assessment, tests, results, and treatment. Red or fluorescent allergy stickers may be displayed on the front of a medical record to alert the health care provider of a potential emergency that can interfere with a patient's medical care or treatment. Allergies may also be written in red within a medical record.
- All medical records must be maintained in a standard format with entries and forms filed in chronological order with the most recent on top.
- Each form/document filed within the record shall include the patient's name, identification number and clinic identifier. (The computer generated 1 or 2 label may be used.) **NOTE: Post-It-Notes are not allowed in medical records.**
- Each entry in the record shall contain the date of service, description of service, provider's signature and title.

A service providers' legend must be maintained which contains the signature, title of provider, provider's initials and employee ID number. It is to be retained permanently and kept current of new certifications or license privileges. (See "[Scope of Practice](#)" located on the [Nursing Office webpage](#) for instructions on updating license/certification of personnel.)

### **Filing and Maintenance of Medical Records**

- Each patient receiving personal health services shall have a record initiated. Exception: **anonymous** HIV test/counseling patient.
- The medical record shall be maintained in the health department (service delivery site) where services are delivered.
- Medical records may be filed in alphabetical or numerical order.
- A Master Patient Index shall be maintained permanently as a locator system for the records at each health center where the service was initiated/provided.
- The Master Patient Index must be in alphabetical order by patient's last name.
- The patient index shall include the complete patient name, patient identification number, date of birth, gender, race, file number (if numeric system is used), father's full name, mother's full maiden name or legal guardian (if such information is necessary for identification of the patient), and location of record, if it is not in the active file.
- All documentation regarding the patient (including the Immunization/Master Record with documentation) shall be filed in one record (unit record) with the exception of patients of

the licensed home health agencies and if the LHD elects to maintain Health Access Nurturing Development Services (HANDS) records separately.

- HANDS records may be maintained separately but LHDs are encouraged to integrate these records with the unit record.
- Documentation of immunizations must be made on the Immunization Record/Master Record using cardstock.
  - Effective July 1, 2022 immunization records should be permanently retained in [Kentucky Immunization Registry \(KYIR\)](#).
  - KYIR is the chosen documentation record for immunization after July 1, 2022. All immunization records prior to that date should be maintained according to the retention schedule. Any supplement record used during mass vaccination clinics and recorded in KYIR but using the form for financial should follow the retention schedule for financial not immunization.
- Records for recipients of mass flu immunization clinics when only an influenza administration record is initiated and maintained are not required to be part of the index. They should be filed by year in alphabetical order by patient's last name placed in a file drawer where they are secure and can be easily accessed.
- Records for recipients of mass COVID-19 immunization clinics or when only the COVID-19 vaccination administration record is initiated and maintained are not required to be part of the Immunization Record/Master Record. **All doses of COVID-19 vaccine must be documented in the [Kentucky Immunization Registry \(KYIR\)](#) within 24 hours of administration.**

Clinics may use the [COVID-19 Vaccine Administration Form](#) or the [LHD COVID-19 Vaccination Supplemental](#) PEF during the clinic. They should be filed by year in alphabetical order by patient's last name and should be secured but accessible and maintained per the normal records retention schedule.

The [CH-2A Vaccine Administration and Tuberculosis Testing Record](#) *may be used but is not required* for administration of COVID-19 vaccines.
- Records for the KIDS Smile Program shall be kept as follows:
  - If a child does not have a complete medical record and receives the dental varnish in the health department, the personal record for KIDS Smile shall be retained by the LHD in a folder marked KIDS Smile, with current year in alphabetical order, by patient name. These forms should be kept for fiscal year and not calendar year. For offsite Fluoride Varnish screenings and applications (schools, etc.), place the personal record for KIDS Smile and any related forms in a folder with the date (i.e. KIDS Smile –current year-) and keep in alphabetical order by the name of preschool/school or offsite location where the fluoride varnish was applied. Do not file these forms/records for offsite Fluoride Varnish screenings and application with the [Patient Encounter Form](#) (PEF) forms.

- When services are provided in the clinic, the personal record (screening, application of fluoride varnish, providing a preventive health message and referral to a dentist if necessary) shall be retained in the child's medical record if such a record exists.
- When the medical record is pulled from the active file for serving the patient or when working with the record, an "out guide" is to be used in the place of the record. The "out guide" identifies the location of the record and stays in the file until the folder/chart is filed back.
- Medical records are to be returned to the centralized record section upon completion of services and/or before the facility is closed on evenings, weekends, or holidays.
- Medical records shall be filed in a secure location that is locked during non-clinic hours to safeguard against loss, tampering, or use by unauthorized personnel. Care shall be given to assure that the area containing medical records is secured during clinic hours from patient or visitor access and that records are sufficiently distant from patient or visitor accessible areas to prevent viewing names or medical information. (For guidelines, see "Privacy and Security of Protected Health, Confidential and Sensitive Information Guidelines" in AR [Personnel Section](#).)
- Medical records shall be retained in accordance with the LHD [Record Retention and Disposal Schedule](#).

### **Ownership of Records**

- The medical record is the property of the LHD. Records shall not be taken from the facility except by court order. This does not preclude the routing of copies of the patient's records or portions thereof, including X-ray film, to physicians for consultation; or in those instances where delivery of services calls for it e.g., Home Health.
- When the LHD provides services off-site, such as in a private physician's office, clinic, or schools the documentation/record of these services is property of the LHD and shall be maintained separately/apart from the medical record of the contracted agency/physician(s).

### **Releasing Patient Information**

- All medical records shall be regarded as confidential and must meet HIPAA guidelines.
- Medical record information may be released only with the consent of the patient, parent or legal guardian of the patient, or as directed by law.
- LHDs should contact their attorney for questions and concerns related to HIPAA and/or releasing of information.
- Immunization information may be shared, without authorization from the patient or the patient's parent or guardian, if the patient is a minor, if the person or agency requesting the information provides health related or education services on behalf of the patient or has a public health interest or is an institution which requires evidence of immunizations pursuant to state law. Some of those entities that may report and exchange information under this exemption are: LHDs within and outside the state, childcare facilities, pre-schools, public and private schools and other providers outside of the LHD who are providing health care to the patients simultaneously or subsequently. Review Administrative Regulation [902 KAR 2:055](#) for a complete list of entities that may report and exchange immunization information.
- Patient information regarding Sexually Transmitted Diseases (STD)/Sexually Transmitted Infections (STI), the HANDS program, mental health and drug and alcohol abuse shall be

considered privileged information (protected health, confidential, personal or other sensitive information) and must be specifically authorized in the written release signed by the patient or legal guardian prior to the release of these records, unless other applicable laws apply.

- Policies and procedures regarding releases of information shall be established and a designated custodian and a designee appointed to handle day-to-day occurrences.
- The policies regarding the release of medical records shall be posted, according to the "Open Records" laws, in a conspicuous place for the public to see. Information regarding "Open Records" laws provided by the Kentucky Attorney General can be found on the [Kentucky Attorney General website](#) under **[Open Records and Open Meetings Decisions](#)**.
- All matters relating to releasing information shall be referred to the designated custodian.
- The policies shall address each type of information the custodian can release and the conditions under which the information shall be released.
- In accordance with Kentucky Law, a patient who receives service from a LHD may have access to his/her medical record upon presentation of appropriate identification; however, the same law allows the health department up to three working days to decide if the request is appropriate.
- Medical records shall be made available, when requested, for inspection by duly authorized representatives of the Kentucky Cabinet for Health and Family Services and contracted insurance companies to comply with [Healthcare Effectiveness and Data Information Set \(HEDIS\)](#) and other allowed patient information requests. Any refusal to honor an authorization for the release of information shall be documented and the reason stated.
- For guidelines and procedures on releasing patient information, subpoenas and court orders, see [Authorization for Use and Disclosure of Patient Health Information](#) in this section.
- *Demographic information on the [CH-5](#) is not considered part of the medical record. LHDs are not required to release this information as part of the medical record.*

### **Transferring the Medical Record When a Health Delivery Service Sites Closes Within the Same County**

- The medical record may be transferred from one health delivery site to another within the same county if a site closes.
- When the record is transferred, the sending site shall note the date of transfer and the name of the site to which the record is being transferred on the Master Patient Index.
- The medical record being transferred shall be placed in a sealed envelope to ensure confidentiality and safety while in route to the receiving health delivery site.
- These records are to be retained in accordance with the current Records Retention Schedule.

### **Transferring the Medical Record Within County School Sites**

- The medical record may be transferred from one school site to another within the same county.

- When the record is transferred, the sending school site shall note the date of transfer and the name of the school site to which the record is being transferred on the Master Patient Index.
- The medical record being transferred shall be placed in a sealed envelope to ensure confidentiality and safety while in route to the receiving health delivery site.
- Upon the student's leaving the school system, the record should be returned to the health department and integrated with the health department chart if one is available.
- These records are to be retained in accordance with the current [Records Retention Schedule](#).

## **"Health Insurance Portability and Accountability Act" (HIPAA) and the "Family Educational Rights and Privacy Act" (FERPA)**

[HIPAA vs FERPA infographic 2018 \(cdc.gov\)](#)

[Know Your Rights: FERPA Protections for Student Health Records | Protecting Student Privacy \(ed.gov\)](#)

[Family Educational Rights and Privacy Act: Guidance for School Officials on Student Health Records | Protecting Student Privacy](#)

**Both HIPAA and FERPA provide equal protection.** When schools handle information, they use FERPA. When health departments are in the school and providing information that will be put in the school files, the LHD acknowledges FERPA. However, the copy of information that is to be removed for health department filing is protected by HIPAA.

**When a school provides health care to students in the normal course of business, such as through its health clinic, it is also a "health care provider" as defined by HIPAA.** If a school also conducts any covered transactions electronically in connection with that health care, it is then a covered entity under HIPAA. As a covered entity, the school must comply with the HIPAA Administrative Simplification Rules for Transactions and Code Sets and Identifiers with respect to its transactions.

However, many schools, even those that are HIPAA covered entities, are not required to comply with the HIPAA Privacy Rule because the only health records **maintained by the school** are "education records" or "treatment records" of eligible students under FERPA, both of which are excluded from coverage under the [HIPAA Privacy Rule](#). Review the exception at paragraph (2)(i) and (2)(ii) to what is considered "protected health information" (PHI) at [45 CFR § 160.103](#). In addition, the exception for records covered by FERPA applies both to the [HIPAA Privacy Rule](#), as well as to the [HIPAA Security Rule](#), because the Security Rule applies to a subset of information covered by the Privacy Rule (i.e., electronic PHI).

The term "*education records*" is broadly defined to mean those records that are: (1) directly related to a student, and (2) **maintained** by an educational agency or institution or by a party acting for the agency or institution. Review [34 CFR § 99.3](#). "Treatment records" under FERPA, as they are commonly called, are records on a student who is eighteen years of age or older, or is attending an institution of postsecondary education."

However, **maintaining the records** by the school according to FERPA **differs** from a qualified medical professional **actually providing the medical services** and electronically billing those

services. As a covered entity, all services provided (delivered) by a qualified medical provider and electronically billed are subject to [HIPAA Administrative Simplification rules](#) compliance.

Information on: [HIPAA Privacy Rule](#), [Health Information Privacy](#), and [Other HIPAA Administrative Simplification Rules](#) is available at the provided links.

Information on [Joint Guidance on the Application of FERPA and HIPAA to Student Health Records](#) (Published: US Department HHS and US Department of Education. November 2008). LHDs should contact their attorney for questions or concerns related to HIPAA or FERPA.

## **FORMS AND DOCUMENTATION LHD RESPONSIBILITIES**

LHDs are responsible for documentation of services and activities of their respective organization. Many of the programs within DPH furnish the required hard copy or electronic forms for documentation that collect information necessary to comply with their program's current laws, regulations or guidelines for documentation purposes. Other programs have electronically developed the format and/or have succinctly identified data elements to record to enable the LHDs to create and/or print their own for documentation purposes. It is the LHD's responsibility to ensure the current laws, regulations or guidelines are being followed.

When the DPH has not mandated use of the printed form or electronic form, or the format and the LHD has elected to develop its own, the LHD has the responsibility for assuring the form being used is current and contains the specific data elements required to comply with the current applicable laws, regulations and guidelines.

Best medical record practice dictates that documentation should not be duplicated in the medical record. If a LHD elects to collect/record duplicate information that results in inconsistencies, the LHD will be liable for audit exceptions that could result in loss of federal and state funds.

## **DOCUMENTATION/MEDICAL RECORD**

A medical record is the documentation kept about the medical care of patients. It contains sufficient information to identify and assess patients and furnish evidence of the appropriate course of the patient's health care by the provider(s) responsible for the delivery of the health care services.

**Each patient receiving health care services shall have a record initiated.** (Exception: anonymous HIV test/counseling patient and court-ordered HIV testing)

Medical record documentation has a universal effect on organizational operation, evaluation of care and services, compliance, and reimbursement. The quality, type of care, services, on-going planning and assessment delivered to the client are determined through documentation and rely heavily on the quality and accuracy of the medical record. The medical record is also used to serve as a source document for legal proceedings.

## **LEGAL DOCUMENTATION STANDARDS**

This section will review the legal documentation standards for entries in and maintaining the medical record. Health information is collected in various formats – paper-based, electronic client records, and computerized client databases. The legal documentation standards have mainly applied to a paper medical record, however, most are also applicable to documentation in an electronic medical record as well.

This section is divided into topics and will address the following issues:

- Purpose of the medical record and definition of the legal medical record
- Legal documentation standards that apply to medical records
- Proper methods for handling errors, omissions, addendum, and late entries.

### **Purpose and definition of the Legal Medical Record**

A patient's health record plays many important roles:

- A. It provides a view of the client's health history - In other words, it provides, a record of the client's health status including observations, measurements, history and prognosis, and serves as the legal document describing the health care services provided to the patient.
- B. The medical record provides evidence of the quality of client care by -
  - Describing the services provided to the client
  - Providing evidence that the care was necessary
  - Documenting the client's response to the care and changes made to the plan of care
  - Identifying the standards by which care was delivered
  - Documenting adherence to standards of care and policies/procedures
  - It provides a method for clinical communication and care planning among the individual healthcare practitioners serving the client.
  - It provides supporting documentation for the reimbursement of services provided to the client.
  - It is a source of data for clinical, health services, outcomes research as well as public health purposes.
  - It serves as a major resource for healthcare practitioner education.
  - It serves as the legal business record for a health care organization and is used in support of business decision-making.

### **Legal Documentation Standards**

#### **Defining Who May Document in the Medical Record:**

- Anyone documenting in the medical record should be credentialed and/or have the authority and right to document as defined by facility policy.
- Individuals must be trained and competent in the fundamental documentation practices of the facility and legal documentation standards.
- All writers should be trained in and follow their agency policies and procedures for documentation (i.e. following timeframes for documentation).

#### **Linking each entry to the client; Client Identification on Every Page/Screen**

- Every page in the medical record or computerized record screen must be identifiable to the client by name and medical record number.
- Client name and number must be on every page including both sides of the pages, every shingled form, computerized print out, etc.
- Computer generated labels (C and D) that contain client's name; identification number and clinic ID are available for print. All computer-generated labels contained in the medical record shall be printed in black ink.
- When double-sided forms are used, the client name and number should be on both sides since information is often copied and must be identifiable to the client.

- Forms both paper and computer generated with multiple pages must also have the client name and number on all pages.

### **Date and Time on Entries**

- Every entry in the medical record must include a complete date – month, day and year.
- Charting time as a block (i.e. 7-3) especially for narrative notes is not advised.
- For assessment forms where multiple individuals are completing sections, the date and time of completion should be indicated as well as who has completed each section.

### **Timeliness of Entries**

- Entries should be made at the time patient care is provided or as soon as possible after an event or observation is made.
- An entry should never be made in advance.
- Entries should always be dated and should be done at the same time as patient care.
- Late entries should reflect the date/time entry is made, and reflect date/time of the event being referenced.
- Make the late entry in the next available space, do not try to squeeze in or write in margins.
- Identify the entry as a late entry, and cross-reference to the part of the chart being supplemented.

### **Pre-dating and back-dating**

- It is both unethical and illegal to pre-date or back-date an entry.
- Entries must be dated for the date and time the entry is made. (See section on late entries, addendum, and clarifications).
- If pre-dating or back-dating occurs it is critical that the underlying reason be identified to determine whether there are system failures. The cause must be evaluated and appropriate corrective action implemented.

### **Authentication of Entries and Methods of Authentication**

- Every entry in the medical record must be authenticated by the author – an entry should not be made or signed by someone other than the author. This includes all types of entries such as narrative/progress notes, assessments, flow sheets, orders, etc. whether in paper or electronic format.
- Each facility must identify the proper and acceptable method of authentication for the type of entry taking into consideration state regulations and payer requirements.
- Entries are typically authenticated by a signature. At a minimum the signature should include the first initial, last name and title/credential.
- A facility can choose a more stringent standard requiring the author's full name with title/credential to assist in proper identification of the writer.
- If there are two people with same first initial and last name both must use their full signatures (and/or middle initial if applicable).
- Facility policies should define the acceptable format for signatures in the medical record.

### **Countersignatures**

- Countersignatures should be used as required by state law (i.e., student nurses who are not licensed, therapy assistants, etc.).

- The person who is making the countersignature must be qualified to countersign. For example, licensed nurses who don't have the authority to supervise should not be countersigning an entry for a student nurse who is not yet licensed).
- Practitioners who are asked to countersign should do so carefully. If there is a procedure involved, there should be some observation (i.e. view treatment) to assure that it was done properly.

### **Initials**

- Any time a facility chooses to use initials in any part of the record for authentication of an entry there has to be corresponding full identification of the initials on the same form or on a provider legend.
- Initials can be used to authenticate entries such as flow sheets, medication records or treatment records, but should not be used in such entries as narrative notes or assessments.
- **Initials should never be used where a signature is required by law.**

### **Fax Signatures**

- Unless specifically prohibited by agency policy, fax signatures are acceptable.
- When a fax document/signature is included in the medical record, the document with the **original signature** should be retrievable.

### **Electronic/Digital Signatures**

- **Electronic signatures are acceptable providing the following standards are met:**
  - Message Integrity: The message sent or entry made by a user is the same as the one received or maintained in the system.
  - Non-Repudiation: Assurance that the entry or message came from a particular user. It will be difficult for a party to deny the content of an entry or creating it.
  - Authentication: Confirms the identity of the user and verifies that a person really is who he says he is.

### **Authenticating Documents with Multiple Sections or Completed by Multiple Individuals:**

- Some documentation tools such as health history and physical assessments are set up to be completed by multiple staff members at different times.
- At a minimum, there should be a signature area at the end of the document for staff to sign and date. Staff who have completed sections of the assessment should either indicate the sections they completed at the signature line or initial the sections they completed.

### **Provider Legends**

- A provider legend may be used to identify the author and full signature when initials are used to authenticate entries.
- Each author who initials an entry must have a corresponding full signature on record.
- A provider legend is to be maintained and readily available in the facility.
- At a minimum the provider legend should contain the initials, full signature, and title of staff.

### **Permanency of Entries**

- All Papers and forms in the chart must be secured. Sticky notes containing medical information, counseling, test results are subject to HIPAA Privacy Rules and should be transcribed into the medical record and destroyed after completion.
- All entries in the medical record regardless of form or format must be permanent (manual or computerized records).
- For hard copy/paper records facilities shall document in black ink only.
- No other colored ink should be used in the event any part of the record needs to be copied.
- Red ink may be used to designate Immunizations that were given at an off-site agency.
- Allergies may also be written in red ink within a medical record but must appear in a consistent location, i.e. top of the [CH-12](#), [CH-2A](#), or the [History and Physical Adult and Pediatric Forms](#).
- **The ink should be permanent (no erasable or water-soluble ink should be used).**
- **Never use a pencil to document in the medical record.**

### **Printers**

When documentation is printed from a computer for entry in the medical record, the print must be permanent. (i.e. a laser printer is permanent vs. an ink jet printer which is usually water-soluble).

### **Fax Copies**

When fax records are maintained in the medical record the assurance must be made that the record will maintain its integrity over time. For example, if thermal paper is used for the receipt of a fax that will become part of the medical record, a copy must be made for filing in the medical record since the print on thermal paper fades over time.

### **Photo Copies**

- The medical record should contain original documents whenever possible. There are times when it is acceptable to have copies of records and signatures particularly when records are sent from another health care facility or provider.
- The Medical record is a legal document and as such it is very important that all photographically reproduced records and any copies subsequently made from the reproductions are completely legible.

### **Use of Adhesive Labels and Stickers in the Medical Record**

- Each form in the record must have the patient's name, identification number and clinic identifier. These are available on the computer-generated labels C or D – through the CDP System.
- All computer-generated labels contained within the medical record shall be printed in black ink.
- When labels are computer-generated, the printer ink must be permanent
- The use of adhesive labels in the medical record is an accepted practice. Labels or label paper (adhesive-backed paper) are used for a variety of reasons including, but not limited to, client demographics, transcription of dictated progress notes, printing of physician orders for telephone orders, known allergies, medication or treatment records. **POST-IT NOTES are not to be used and cannot be part of the medical record.**
- Allergy status must be prominently displayed in a conspicuous location. Red or fluorescent allergy stickers are recommended for use on the front of a medical record to alert the health care provider of a potential emergency that can interfere with a patient's medical care or treatment.

- LHDs may use a color-coded sticker system on the outside of the Medical Record to denote "Tobacco Use Status". A color-key must be kept at the LHD for reference.
- When labels are used in the record, the agency must assure:
  - The labels retain their adhesiveness
  - If the label is used for documentation such as a progress note or order, the date and signature should also be included on the label.
  - If an error was made on a label, another label should never be placed over the original. Proper error correction procedures should be used for the entry.
  - Labels must never be placed over other documentation in the medical record. This would be the equivalent of using whiteout or blacking out an entry in the record and is not acceptable.
  - A pocket folder could help to contain any labels that may have become dislodged from the backing sheet over time.
  - Post-It Notes are not used in place of an adhesive label and are not to be included as part of the record.

### **Subjectivity**

- In writing entries use language that is subjective rather than vague or generalized.
- Do not speculate when documenting. The record should always reflect factual information (what is known vs. what is thought or presumed) and be written using factual statements.
- Examples of generalizations/vague words: Client doing well, appears to be, confused, anxious, status quo, stable, as usual.

### **Objectivity**

- Chart the facts and avoid the use of personal opinions when documenting. By documenting what can be seen, heard, touched and smelled entries will be specific and objective. Describe signs and symptoms, use quotation marks to quote the client, and document the client's response to care.
- When documenting an observation, be able to back them up with facts, not conclusions.
- When documenting a patient's behavior, be objective when describing noncompliant actions. Behavior is considered noncompliant when the patient's actions are inconsistent with what has been prescribed or ordered, and not in the patient's own best interests.
- **Do not get personal in your entries.** Never let your personal values or judgments about a patient or his/her behaviors enter your notes.
- Avoid use of derogatory adjectives, however if the patient's appearance or behavior is relevant to the patient, his problems, treatment, and care, document in objective terms; i.e., rather than saying the "patient was rude and unresponsive", record "patient did not respond to history questions and refused to allow blood to be drawn".
- Where possible, use quotes from patients on important elements of history or complaints. Reflect the patient's own words with quotation marks or if unable to recall exact words, try to paraphrase as closely as possible.

### **Appropriateness of Entries – Keep Documentation Relevant to Client Care**

- The medical record should only contain documentation that pertains to the direct care of the client.
- Do not let emotions show up in charting.
- Charting should be free from jousting statements that blame, accuse, or compromise other care givers, the client, or his/her family.

- The medical record should be a compilation of factual and objective information about the client.
- The record should not be used to voice complaints (about other care givers, departments, physicians or the facility), family fights, fights between disciplines, gripes, staffing issues, vendor issues, etc.

### **Completeness**

- Document all facts and pertinent information related to an event, course of treatment, client condition, response to care and deviation from standard treatment (including the reason for it).
- Always be aware of "Not Charted-Not Done" – relying on "routine practice" to prove that something occurred in a given case is much less credible than if the event is charted specifically.
- Make sure entry is complete and contains all significant information. If the original entry is incomplete, follow guidelines for making a late entry, addendum, or clarification.

### **Use of Abbreviations**

- This reference sets a standard for acceptable abbreviations to be used in the medical record based on Marilyn Fuller DeLong's Medical Acronyms, Eponyms & Abbreviations, 3rd Edition or later as well as sources that are nationally acceptable and published by such agencies as the Centers for Disease Control and Prevention (CDC), medical references, the MERCK Manual, and medical dictionaries such as Dorland's Medical Dictionary. Review [LHD Medical Abbreviations](#) located within the [CSG webpage](#).
- Each LHD should keep a log of non-medical abbreviations that are used in their agency, such as MCHS – Madison Central High School, Tues. – Tuesday, CBH – Central Baptist Hospital, etc.
- When there is more than one meaning for an approved abbreviation, facilities shall chose one meaning or identify the context in which the abbreviation is to be used.
- In instances where the abbreviations may be ambiguous or misleading, write out the word(s) in their entirety.

### **Legibility**

- All entries in the medical record must be legible.
- Illegible documentation can put the client at risk.
- Readable documentation assists other caregivers and helps to assure continuation of the client's plan of care.
- If an entry cannot be read, the author should rewrite the entry on the next available line, define what the entry is for by referring back to the original documentation and legibly rewrite the entry. Example: "Clarified entry of (date)" and rewrite entry, date and sign.
- The rewritten entry must be the same as the original.
- Printing documentation is acceptable when handwriting cannot be deciphered.

### **Continuous Entries**

- Entries should be documented on the next available space – do not skip lines or leave blanks.
- There must be a continuous flow of information without gaps or extra space between documentation.
- A new form should not be started until all previous lines are filled. If a new sheet was started, the lines available on the previous page must be crossed off.

- If an entry is made out of chronological order it should be documented as a late entry.

### **Completing all Fields**

- Some of the questions or fields on documentation tools such as assessments, flow sheets, checklist documents may not be applicable to the client.
- Assure that all blank spaces and sections are filled in to meet the [Clinical Service Guide](#) program guidelines/protocols, coding and billing requirements, clinician discretion, or patient preferences. Sections may be "X'd out" if not appropriate to the service or designated as "deferred" if omitted because of patient preference. Leaving blank spaces exposes the health care provider to questions that information may have been "filled in" information or "tampered" with.
- Fields left blank may be suspect to tampering or back-dating after the document has been completed and authenticated.
- Tampering with the record involves any of the following:
  - Adding to the existing record at a later date without indicating the addition is a late entry
  - Placing inaccurate information into the record,
  - Omitting significant facts,
  - Dating a record to make it appear as if it were written at an earlier time,
  - Rewriting or altering the record
  - Destroying records
  - Adding to someone else's notes.

### **Anyone making entries in a medical record can be prosecuted for falsifying a legal document.**

- Fraudulent addition to a record for the purposes of covering up an incident can be detected by current technology. This will enable them to detect differences in ink, look for indentations caused by writing on sheets above the questioned document, and perform chemical analysis of the document. There are [clues](#) used to detect altered records.
- Tampering with the records complicates the successful defense of a malpractice case and raises questions about the quality of care that was rendered. Once the accuracy of the record is challenged, the integrity of the entire record becomes suspect. It can be argued in court that the records were intentionally altered or lost because of conspiracy or fraud. Successful arguing of "aggravated or outrageous conduct" can result in the granting of punitive damages

### **Continuity of Entries – Avoiding Contradictions**

- All entries should be consistent with the concurrent entries
- The progress notes are the "roadmap" for medical record documentation and should guide the health care worker in following the patient's progress. Other forms in the medical record – the [CH12](#), [CH2A](#), [H&P forms](#), assessments, physician's orders, medication and treatment records, etc. should be referenced in the progress notes as part of the visit if applicable.
- Avoid repetitive (copycat, canned or parrot) charting. The current entry should document current observations, outcomes/progress.
- If an entry is made that contradicts previous documentation, the new entry should elaborate or explain why there is a contradiction or why there has been a change.
- Every change in a client's condition or significant client care issues must be noted and charted. Documentation that provides evidence of follow-through is critical and

documentation of return to clinic (RTC) allows the next provider to monitor the patient's plan of care. All appointments should be documented in the progress notes, dated, and signed by the appropriate staff, including any appointments that have been rescheduled. All telephone calls regarding the patient's appointments should be documented, including dates of the conversation as well as the new appointment time. When the patient presents early for an appointment, it would be sufficient to document that the patient came in prior to their designated date and the original appointment would be cancelled in the system at that time.

### **Notification or Communications**

- If notification to the client's physician or family is required, or a discussion with the client's family occurs regarding the care of the client, all such communication (including attempts at notification) should be charted.
- Medical records should always reflect "No Shows" (DNKA), when a patient is noncompliant in keeping appointments.
- Include the time and method of all communications or attempts.
- The entry should include any orders received or responses, the implementation of such orders, if any, and the client's response. Messages left on answering machines should be limited to a request to return call and does not meet the definition of notification
- Document all telephone conversations with the client. Documentation should include problem/reason of the call, and any advice or instruction given. The date and time of call should be noted as well.
- Telephone calls should be treated no differently than an in-patient visit as far as documentation requirements.
- All telephone calls to a physician regarding a patient's care should be documented in that patient's medical record. The documentation should reflect that this conversation was by telephone with the patient's physician, reason for the call, action taken and the date/time call was made or received.

### **Delegation**

- The lead nurse is responsible for ensuring that all entries by are complete and consistent within the medical record.
- The lead nurse is responsible for all delegated nursing acts, including charting of such care in the client's medical record.
- Delegation of health services can be done by MDs, APRNs, RNs or LPNs within their scope of practice. All disciplines should follow their professional standards and Board advisory opinions. It should be noted that LPNs have a scope of practice but need to function under the delegated authority of an APRN, RN, MD. The delegating physician or nurse must provide training and approve the delegation in writing and a copy is to be filed in that same employee's personnel file. The LHD employee must acknowledge receipt of training in writing.

### **Incidents**

- When an incident occurs, document the facts of the occurrence in the progress notes.
- Do not chart that an incident report has been completed or refer to the report in charting.
- See AR [Incident Report](#) section and [OSHA Bloodborne Plan](#) section in the AR.

## **Legal guidelines for handling corrections, errors, omissions, and other documentation problems**

There will be times when documentation problems or mistakes occur and changes or clarifications will be necessary. Proper procedures must be followed in handling these situations.

### **Proper Error Correction Procedure:**

- Draw line through entry (thin pen line). Make sure that the inaccurate information is still legible.
- Initial and date the entry.
- State the reason for the error (i.e. in the margin or above the note if room).
- Document the correct information. If the error is in a progress note, it may be necessary to enter the correct information on the next available line/space documenting the current date and time and referring back to the incorrect entry.
- Do not obliterate or otherwise alter the original entry by blacking out with marker, using white out, erasing, writing over an entry, etc.
- Correcting an error in an electronic/computerized medical record system should follow the same basic principles.
- The system must have the ability to track corrections or changes to the entry once the entry has been entered or authenticated.
- When correcting or making a change to an entry in a computerized medical record system, the original entry should be viewable, the current date and time should be entered, the person making the change should be identified, and the reason should be noted.
- In situations where there is a hard copy printed from the electronic record, the hard copy must also be corrected.

### **Handling Omissions in Documentation - Making a Late Entry**

- When a pertinent entry was missed or not written in a timely manner, a late entry should be used to record the information in the medical record.
- Identify the new entry as a "late entry"
- Enter the current date and time – do not try to give the appearance that the entry was made on a previous date or an earlier time.
- Identify or refer to the date and incident for which late entry is written
- If the late entry is used to document an omission, validate the source of additional information as much as possible (where did you get information to write late entry). For example, use of supporting documentation on other forms.
- When using late entries document as soon as possible. There is not a time limit to writing a late entry, however, the more time that passes the less reliable the entry becomes. (General Rule of Thumb is "late entries should not be more than 24 hours after the service is provided".)

### **Entering an Addendum**

- With this type of correction, a previous note has been made and the addendum provides additional information to address a specific situation or incident.
- With an addendum, additional information is provided, but should not be used to document information that was forgotten or written in error.
- When making an addendum -- Document the current date and time. Write "addendum" and state the reason for the addendum referring back to the original entry.
- Identify any sources of information used to support the addendum.

- When writing an addendum, complete it as soon after the original note as possible.
- **Do not use a Post-It Note when entering an addendum.**

### **Entering a Clarification**

- Another type of late entry is the use of a clarification note.
- A clarification is written to avoid incorrect interpretation of information that has been previously documented. For example, after reading an entry there is a concern that the entry could be misinterpreted.
- To make a clarification entry – Document the current date and time.
- Write "clarification", state the reason and refer back to the entry being clarified.
- Identify any sources of information used to support the clarification.
- When writing a clarification note, complete it as soon after the original entry as possible.

### **Omissions on Medication, Treatment Records, other Flow sheets**

- It is considered willful falsification and illegal to go back and complete and/or fill-in signature "holes" on medication and treatment records or other graphic/flow records in the medical record.
- A time frame should be established in the agency's policy in which the omissions can be completed. If the practitioner recalls administering the medication/treatment and no more than 24 hours go by, a practitioner may complete a medication/treatment only when there is a clear recollection of administering the medication/treatment or information pertinent to the medical record.
- LHDs should use concurrent monitoring to assure that documentation is complete and timely for all medications and treatments administered. When problems are identified corrective action should be implemented. If an omission is older than 24 hours or the staff member does not have a clear recollection or there is not supporting documentation (i.e. worksheets, medication records, drug delivery records, initials and dates, etc.), the record should be left blank. At no time should the records be audited after a period of time (i.e. end of month) with the intent of identifying omissions and filling in "holes."

### **Telehealth**

- Questions regarding telehealth documentation standards and HIPPA may be found at <https://www.hhs.gov/hipaa/for-professionals/faq/telehealth/index.html>

### **LANGUAGE ACCESSIBLE SERVICES/USE OF INTERPRETERS**

- LEP, Limited English Proficiency persons are defined as persons who cannot speak, read, write, or understand the English language at a level that permits them to interact effectively with providers. Other patients that need interpreters: persons who speak more English than they understand, persons who understand more than they speak, and those that request an interpreter. For any patient that demonstrates the above, use an interpreter.
- Language access is defined as: Providing interpreter (verbal) and translation (written) services to those LEP persons at no cost and without unreasonable delay.
- Working with an interpreter effectively even if the provider is not bilingual is possible. By learning about the roles of an interpreter, interpretation techniques, ethics of interpreters, professional instinct, and being aware of body language cues (especially side conversations that can take place between interpreter and patient) non-bilingual providers can maintain control of the interview and establish a good patient/provider rapport.

- Use of a pre-session with all interpreters to establish your “ground rules” for the interpreted session.
- The use of interpreters or translators must still provide the same level of confidentiality afforded to non-LEP customers of the LHD.
- Using an interpreter correctly will ensure accurate documentation and provide for early intervention.
- Children, intimate partners, friends and other family should not be used as interpreters if at all possible as this could compromise service effectiveness and result in breach of confidentiality.
- Always speak directly to the patient. Avoid addressing the interpreter and saying, “ask her/him”. Remember, if your patient spoke English, you would address her/him directly.
- Speak in short sentences and remember not to use slang or jargon...there may not be a linguistic equivalent in the second language.
- Ask the patient to repeat to you what you have discussed so that you can check for understanding.
- The services of an interpreter or interpretive phone service must be utilized if LHD staff is unable to communicate with the customer well enough to provide services, even if the customer says that he/she does not need an interpreter and declines free interpretation services.

## **LANGUAGE ACCESSIBLE SERVICES/USE OF TRANSLATED MATERIALS**

- **Qualified, competent translators must be used when translating Program Materials.**
  - **A qualified, competent translator is a highly trained individual who is able to render text from a source language into a target language while preserving meaning and adhering to generally accepted translator ethics and principles, including confidentiality.**
  - **Qualified translators understand the cultural context of the source and target languages as well as demonstrate competency to translate through an independent language assessment.**
  - **A qualified interpreter may or may not be a qualified translator.**
- **Contact the State WIC office for translations of WIC Program materials vital to an individual’s participation including forms related to applying for the program, documents that require a response, denial letters or notice of ineligibility.**
- **Local and state agency developed materials should routinely be simultaneously translated as the updated English materials are updated in the LEP languages identified**
- **See the WIC and Nutrition Manual, Civil Rights Policy, 306 for more information on utilizing translated materials for WIC Services and conducting a self-assessment to determine the need for translated materials.**

## **GUIDELINES FOR DOCUMENTATION WHEN USING AN INTERPRETER/TRANSLATED MATERIALS**

- Document the language that the patient speaks in the medical record on initial visit, then update as needed.
- Document the steps taken to arrange for an interpreter.

- A master list of names and phone numbers of available interpreters is recommended to be on file in the agency.
- If an interpreter was used to obtain a patient's consent, record the interpreter's name in the medical record.
- If a family member acted as an interpreter, record in the medical document that the patient agreed to this.
- Document any language needs on referral forms to other providers of LEP persons.
- If a LEP person declines free services and asks to use a relative or friend, staff must document in the medical record that the offer was declined and then request that a qualified interpreter sit in on the interview or use interpretive phone services to ensure accurate interpretation during the visit.
- Document use of Translated Materials.

### **GUIDELINES FOR DOCUMENTATION OF EQUAL OPPORTUNITY ACCESS FOR INDIVIDUALS WITH DISABILITIES**

- Provide auxiliary aids and services and reasonable modifications when necessary to ensure services are equally accessible to all potential and existing patients/clients/participants.
- Examples of reasonable modifications include but are not limited to:
  - Changing a policy, practice, or procedure when necessary to enable equal access for individuals with disabilities.
  - Providing wheelchair access to WIC Clinic locations. This provides equal access to individuals using wheelchairs, mobility aids and other power-driven mobility devices.
  - Ensuring access to individuals who require the assistance of a service animal.
  - Examples of Auxiliary aids and services are qualified sign language interpreters, large print and Brailled materials, assistive listening devices, and more.
- The reasonable modification and/or auxiliary aid or service for requested and provided must be documented in the medical record.
- **If the requested modification, aid, or service was not provided, this must be documented in the medical record and elevated to the most senior staff member for written justification for not providing the requested service.**
  - If an alternative modification, aid or service is provided, the requested modification and the alternative modification provided must be documented in the medical record.
  - Document any modifications, aids or services offered and declined.
- See the WIC and Nutrition Manual, Policy 306, Civil Rights, Reasonable Modification Section for additional information regarding providing WIC Services to individuals with Disabilities.
- Refer to Compliance with Americans with Disabilities Act (ADA) in the AR: Local Health Personnel Section, and Access to Facilities, Websites, and Digital Services in the AR: LHD Facilities and Equipment Section.

## SOAP DOCUMENTATION

Documentation should contain the following, based on **SOAP documentation:**

- S** Subjective information (e.g., what the patient or caregiver tells you)
- O** Objective information (e.g., what is seen through laboratory results, etc.)
- A** Assessment information (e.g., description of what you think is happening with the client and establishment of goals for the client)
- P** Plan information (e.g., description of client goals, understanding, treatment, etc.)

## HISTORY

Reason for the encounter and relevant history (**Subjective**)

- History of Present Illness
- Review of Systems
- Past, Family, and/or Social History.

## EXAM

- Physical findings and prior or current diagnostic test results (**Objective**)
- General Multisystem Exam,
- Diagnostic Procedures Ordered.

## DECISION-MAKING

- Assessment and identification of health risk factors, clinical impression, or diagnosis, i.e., Presenting Problems Management Options Categories. (**Assessment**)
- Plan for care, i.e., recommendations, prescriptions for medications, diet or exercise modification, health education and counseling, and a plan of return to clinic. i.e., Management Options. (**Plan**)

**\*Date and legible identity of provider.**

## TYPES OF HISTORY

HISTORY OF PRESENT ILLNESS (HPI) - The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptoms or from the previous encounter to the present.

- **LOCATION:** Are s/s diffused or localized, unilateral, or bilateral, fixed or migratory? i.e., breast tenderness, rt. ankle swollen, discharge from left ear.
- **QUALITY:** Specific pattern of complaint, or character/quality of the s/s. Ex. sharp, dull, throbbing, constant or intermittent, acute, or chronic, stable, improving or worsening, malodorous, cloudy, or clear, i.e., sharp abdominal pain, foul vaginal discharge.
- **SEVERITY:** Presence, absence and/or severity of any condition/discomfort, sensation, or pain? Or does history indicate the absence of any condition/discomfort, s/s. i.e., no c/o's today, denies pain with exercise, c/o headache, n/v.
- **DURATION:** Does history indicate the duration of the s/s or problems? i.e., BTB x 3 mo., pain in left shoulder for 2 weeks.
- **TIMING:** Does history indicate the onset or cessation of the s/s or problems? i.e., LMP, EDC, pain started yesterday
- **CONTEXT:** Does the history describe the patient's locale or activity when the s/s began? When is the problem aggravated or relieved? i.e., pain with exercise, burning upon urination.

- **MODIFYING FACTORS:** Does history indicate what the patient has done to obtain relief? Has the patient used OTC drugs or attempted to see a MD and did it improve the condition? Exposure to STD/STI/HIV, toxins TB, etc.? i.e., seen per MD for URI, Tylenol for headache.
- **ASSOCIATED S/S:** Does the history list any associated s/s? such as n/v, headache, sweating, vaginal bleeding, rash, etc.?
- **CHRONIC/INACTIVE CONDITIONS:** Does history indicate the status of at least 3 chronic/inactive conditions? i.e. hypertension, diabetes, migraine headaches, arthritis, asthma, etc. These can be found primarily on the [H&P 13 and H&P 14](#).

### **REVIEW OF SYSTEMS (ROS)**

- ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms, which the patient may be experiencing or has experienced.
- **CONSTITUTIONAL SYMPTOMS:** i.e., fever, weight change, appetite, fatigue. i.e., history of weight loss or gain, decreased or increased appetite, unexplained tiredness.
- **EYES:** sclera, conjunctiva, pupils, etc.
- **CARDIOVASCULAR:** lungs, heart, vascular, abdomen. i.e., SOB
- **RESPIRATORY:** nose, mouth, lungs, heart, peripheral vascular, or skin (nails). i.e., history of asthma, TB contact.
- **GASTROINTESTINAL:** eyes – in relation to icterus, mouth & pharynx, lymphatic, abdomen, rectal, skin – in relation to jaundice, liver, gallbladder.
- **GENITOURINARY:** breasts, abdomen, back, external genitalia, vagina, cervix, uterus, adnexa, ovaries, penis, scrotum, testicles/epididymis, prostate, spermatic cord.
- **MUSCULOSKELETAL:** joints, muscles, bones, range of motion
- **INTEGUMENTARY:** (skin and/or breast), lymphatic, peripheral vascular, sensory nerves
- **NEUROLOGICAL:** higher cortical function, cranial nerves, motor nerves, coordination, gait and station
- **PSYCHIATRIC:** orientation, mood, and affect, thought flow, thought content, attention, concentration, knowledge, abstract reasoning, judgment, insight, pathological reflexes
- **ENDOCRINE:** thyroid, goiter, tumors
- **HEMATOLOGIC/LYMPHATIC**
- **ALLERGIC/IMMUNOLOGIC**

### **PAST FAMILY AND SOCIAL HISTORY (PFSH)**

- **Past History:** The patient's experience with illness, operations, injuries, and treatment.
  - Current medications
  - Prior major illness and injury
  - Prior operations
  - Prior hospitalizations
  - Allergies
  - Genetic abnormalities
  - Age-appropriate immunization status
- **Family History:** A review of medical events in the patient's family, including diseases that may be hereditary or place the patient at risk.
- Health status
- Genetic abnormalities
- Cause of death of parents, siblings, children, father of baby
- Specific diseases related to problems identified in the chief complaint, history of present illness, and/or review of systems.

- Social History: An age-appropriate review of past and current activities
- Marital status and/or living conditions
- Employment
- Occupational history
- Use of drugs, alcohol and tobacco
- Dietary habits
- Extent of education
- Sexual history

## **GENERAL MULTI-SYSTEM EXAMINATION**

CONSTITUTIONAL: i.e., WN/WD (well nourished, well developed)

- Measurement of any 3 of the following 7 vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be recorded by ancillary staff)
- General appearance of patient = i.e., development, nutrition, body habitus, deformities, attention to grooming.

EYES:

- Inspection of conjunctiva and lids
- Examination of pupils and irises (i.e., reaction to light and accommodation, size, and symmetry)
- Ophthalmoscopy examination of optic discs (i.e., size, C/D ratio, and appearance) and posterior segments (i.e., vessel changes, exudates, hemorrhages)

EARS, NOSE, MOUTH AND THROAT:

- External inspection of ears and nose (i.e., overall appearance, scars, lesions, masses)
- Otoscope examination of external auditory canals and tympanic membranes
- Assessment of hearing (i.e., whispered voice, finger rub, tuning fork)
- Inspection nasal mucosa, septum and turbinate
- Inspection of lips, teeth, and gums
- Examination of oropharynx, oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx

NECK:

- Examination of neck (i.e., masses, overall appearance, symmetry, tracheal position, crepitus)
- Examination of thyroid (i.e., enlargement, tenderness, mass)

RESPIRATORY:

- Assessment of respiratory effort (i.e., intercostal retractions, use of accessory muscles, diaphragmatic movement)
- Percussion of chest (i.e., dullness, flatness, hyper-resonance)
- Palpation of chest (i.e., tactile fremitus)
- Auscultation of lungs (i.e., breath sounds, adventitious sounds, rubs)
- Palpation of heart (i.e., location, size, thrills)

CARDIOVASCULAR:

- Auscultation of heart with notation for abnormal sounds and murmurs
- Examination of:
  - Carotid arteries (pulse, amplitude, bruits)
  - Abdominal aorta (size, bruits)
  - Femoral arteries (pulse, amplitude, bruits)
  - Pedal pulses (pulse, amplitude)
  - Extremities for edema and/or varicosities

#### CHEST:

- (BREASTS) Inspection of breasts (symmetry, nipple discharge)
- Palpation of breasts and axillae (masses or lumps, tenderness)

#### GASTROINTESTINAL: (ABDOMEN)

- Examination of abdomen with notation of presence of masses or tenderness
- Examination of liver and spleen
- Examination for presence or absence of hernia
- Examination of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses
- Obtain a stool sample for occult test when indicated

#### GENITOURINARY:

##### Male:

- Exam of scrotum (front, sides and posterior) and perineum:
  - Inspect for the following:
    - Skin changes – rash/ulcers/erythema
    - Scars – may provide clues to previous operations (e.g., vasectomy or testicular fixation)
    - Testicular Masses (abnormal bulge or lumps)
    - Hydrocele (swelling)
    - Spermatic Cord Torsion (tenderness)
    - Spermatocele (epididymis)
    - Perineum bruising
- Exam of penis (shaft, dorsal vein, glans, urethral meatus, median raphe)
- Digital rectal exam of prostate gland (size, symmetry, nodularity, tenderness)

##### Female:

- Pelvic exam with/without collection for smears and cultures
- Exam of external genitalia (general appearance, hair distribution, lesions) and vagina (general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele)
- Exam of urethra (masses, tenderness, scarring)
- Exam of bladder (fullness, masses, tenderness)
- Cervix (general appearance, lesions, discharge)
- Uterus (size, contour, position, mobility, tenderness, consistency, descent or support)
- Adnexa/par ametria (masses, tenderness, organomegaly, nodularity)

#### LYMPHATIC:

- Palpation of lymph nodes in 2 or more areas:
  - Neck
  - Axillae
  - Groin
  - Other

#### MUSCULOSKELETAL:

- Examination of gait and station
- Inspection and/or palpation of digits and nails (clubbing, cyanosis, inflammatory conditions, petechia, ischemia, infections, nodes)
- Examination of joints, bones, muscles of 1 or more of the following 6 areas: 1) head and neck, 2) spine, ribs, and pelvis, 3) right upper extremity, 4) left upper extremity, 5) right lower extremity, 6) left lower extremity.

- The examination of a given area includes:
  - Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions
  - Assessment of range of motion with notation of any pain, crepitation or contracture
  - Assessment of stability with notation of any dislocation (luxation), subluxation, or laxity
  - Assessment of muscle strength and tone (flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements

SKIN: i.e., Skin w/d, no rashes or lesions

- Inspection of skin and subcutaneous tissue (rashes, lesions, ulcers)
- Palpation of skin and subcutaneous tissue (induration, subcutaneous nodules, tightening)

NEUROLOGICAL:

- Test cranial nerves with notation of any deficits
- Examination of deep tendon reflexes with notation of pathological reflexes (Babinski)
- Examination of sensation (touch, pin, vibration)

PSYCHIATRIC: i.e. A & O x 4 (alert and oriented)

- Description of patient's judgment and insight
- Brief assessment of mental status, including:
  - Orientation of time, place, person, and date
  - Recent or remote memory
  - Mood and affect (depression, anxiety, agitation)

## **DECISION MAKING - PRESENTING PROBLEMS MANAGEMENT OPTIONS CATEGORIES**

### **RISK**

- Number of self-limited or minor problems, i.e., cold, insect bite, tinea corporis, headache, lice, dermatitis; no apparent contraindications to immunizations/contraceptive methods.
- Acute uncomplicated illness or injury, i.e., cystitis, URI, allergic rhinitis, pharyngitis, simple sprain, STD's, STI's, OM.
- Number of chronic illnesses with mild exacerbation, progression, or side effects of treatment, i.e., uncontrolled diabetes or hypertension.
- Undiagnosed new problem with uncertain prognosis, i.e., lump in breast, abnormal pap smear, chest pain, developmental delay; true contraindication to immunization/contraceptive methods.
- Acute condition or illness with systemic symptoms, i.e., pregnancy, pyelonephritis, pneumonitis, colitis, TB.
- Acute complicated injuries, i.e., head injury with loss of consciousness
- Number of chronic illnesses with severe exacerbation, progression, or side effects of treatment.
- Acute or chronic condition, illness or injury that may pose a threat to life or bodily function, i.e., AIDS, high-risk pregnancy.
- Abrupt change in neurological status, i.e., seizure, TIA, weakness or sensory loss.

### **DIAGNOSTIC PROCEDURES ORDERED** - Labs performed or ordered

- Laboratory tests, venipuncture/capillary; skin tests\

- X-rays, chest/extremities; EKG/EEG; mammography; axial tomography
- Cultures, i.e., strep Urinalysis, i.e., urine dip, pregnancy tests
- Ultrasound, i.e., echocardiography
- Cystologic/microscopic tests, i.e., Pap smears, wet preps, hemocults
- Developmental tests, i.e., Denver, DASE Physiologic tests not under stress, i.e., pulmonary function, fetal non-stress, malabsorption allergy
- Non-cardiovascular imaging studies with contrast or air injection, i.e., barium enema
- Superficial needle biopsies. Skin biopsies.
- Blood gases Physiologic tests under stress, i.e., cardiac stress test, fetal contraction test
- Diagnostic endoscopies with no identified risks, i.e., colposcopy
- Deep needle, incisional biopsy, excisional biopsy, i.e., conization, LEEP
- Cardiovascular imaging studies with contrast and no identified risks, i.e., arteriogram, cardiac cath.
- Obtain fluid from body cavity, i.e., lumbar puncture, thoracentesis, culdocentesis, aminocentesis, colposcopy
- Cardiovascular imaging studies with contrast with identified risk factors
- Cardiovascular electrophysiological tests
- Diagnostic endoscopies with identified risks, i.e., arthroscopy, thoracoscopy, laparoscopy
- Discography, MRI

**MANAGEMENT OPTIONS SELECTED** - *Performed, Referred or Ordered*

- Rest, limit activity, guidance for follow-up care. i.e., RTC (appt. date)
- Gargles, ointments, creams
- Minor procedures – nonsurgical i.e., irrigation of wound or ear
- Superficial dressings, band aids, gauze, elastic bandages, i.e., ACE
- Over-the-counter drugs, management/instructions. Ex Condoms
- Minor surgery with no identified risk factors
- Physical therapy; occupational therapy; skilled nursing (HH)
- Counseling, i.e., general diet, behavioral risk, health education
- IV fluids without additives
- Minor surgery with identified risk factors; emergency room treatment; referral to specialist, i.e., OB/GYN, Pediatrician, etc.
- Hospital admission with/without elective major surgery (no identified risk factors)
- Medical nutritional counseling, referral to RD
- Therapeutic nuclear medicine, i.e., radiation treatments
- IV fluids with additives, prescriptive drug management, therapeutic injection, i.e., Rocephin, immunizations
- Closed treatment of fracture or dislocation without manipulation
- Subsequent E/M visits for intensive monitoring of high-risk pregnancy
- Elective major surgery (with identified risk factors)
- Emergency major surgery
- Parenteral controlled substances, i.e., chemotherapy
- Drug therapy requiring intensive monitoring for toxicity

The [Clinical Service Guide](#) and the **Administrative Reference** contain the current specific data collection and documentation requirements that comply with state and federal laws, regulations and guidelines. Always ensure the most current guide and reference are being used.

**General Consent and Informed Consent for Health Services can be found in the [Consent for Services section](#) of the Administrative Reference.**

## AUTHORIZATION FOR USE AND DISCLOSURE OF PATIENT HEALTH INFORMATION

### Authorization to Release Information (Who May Sign)

The guidelines as to who may sign an authorization to release information are those applicable to the signing of consents for services. Consent/Authorization for Services is located in the [Clinical Service Guide](#). The "Authorization to Release/Request Patient Information" Form ([CH-23](#)) is located in the [LHD Forms, Documents and Administrative Reference webpage](#).

### Exceptions to the Use of Written Release

In the event the LHD has a written agreement(s) with a hospital, private clinic, or primary care center, etc., to provide services which necessitate the sharing of medical information, a written release need not be completed, provided the agreement states that confidentiality shall prevail and the patient (or legal representative) has been informed that the information will be exchanged only for the purpose of assuring "appropriate and continuous health care." Patient records may be disclosed for Treatment, Payment, or Operations without the patient's written consent.

### The HIPAA "minimum necessary rule" shall be followed.

- Other exceptions include:
  - Research studies - Patient authorization is not required if identifying patient information is not released and/or included in research projects.
  - Third party payors - Specifically Medicare and Medicaid. (Permission to share is given when assignment of benefits is properly executed [signature, date, and name of agency providing the information]).
  - Sharing childhood immunization information among providers.
  - Sharing WIC screens, certification, and issuance information with other Kentucky WIC sites.

### Other Considerations

- Demographic information on the [CH-5](#) is not considered part of the medical record. LHDs are not required to release this information as part of the medical record.
- When releasing the medical record, entries related to protected health, confidential, personal or other sensitive information, such as, STDs/STIs, Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS), HANDS, alcohol and drug abuse, or psychological/mental problems shall be omitted from the record unless specifically authorized in the written release signed by the patient or guardian.

*Exception: Any STD/STI on a child under 12 years of age shall be reported to the LHD or Social Services Office as a possible child abuse case*

[Kentucky Revised Statutes website: KRS 620.030 and KRS Chapter 510](#)

### KY laws relating to confidentiality of HIV and STDs/STIs:

[KRS Chapter 214](#): 214.420, 214.181, 214.625, 214.645, 214.995

- When **confidential information is released over the telephone** (e.g., to a physician, a hospital, or in a medical emergency), a reasonable attempt shall be made to verify the identity of the persons and/or facility receiving the information. **Such information shall not be given to a patient or parent/legal guardian via telephone.**

When someone alleges they are the legal guardian or custodian of a child and wishes to see the child's medical record, the individual must complete a written request for information and provide a copy of the court-ordered document verifying the guardianship or custodianship. The information shall be copied onto a personal immunization record and given to the individual. Other information such as the child's address and phone number shall not be released. *(It should be noted that a non-custodial parent may have a copy of his/her child's medical record provided that the non-custodial parent's parental rights have not been terminated.)*

- When medical records are viewed or photocopied for release and the record contains a report and/or correspondence from other agencies, these external reports become a part of the medical record of the receiving agency and may be released as such.
- The Release of Information form shall serve as the official request of patient information and shall be filed in the medical record (Administrative Section). HIPAA requires a record of any disclosure of patient records be made available to the patient upon request.
- Workmen's Compensation - Although consent for release of information is implied, the patient has the right to withhold consent in which instance the health department shall comply. (Workmen's Compensation proceedings will cease at this point.)
- Certification(s) - Health departments may be requested to issue a "certification" of a specific service(s) they have provided (e.g., PPDs, to meet occupational requirements). Such certification shall be issued to the patient, who then has the responsibility to advise the employer. (No results of the service(s) shall be released to other than the patient without specific consent.) HIV test results are prohibited from use in employment or eligibility determination for health or life insurance.
- Upon a patient's written request, the LHD shall provide, without charge to the patient, a copy of the patient's medical record. A copying fee, not to exceed one dollar (\$1) per page, may be charged by the LHD for furnishing a second copy of the patient's medical record upon request by the patient. For businesses, lawyers and others, the LHDs may charge a nominal and reasonable fee according to their agency's policy.

### **Coroner's Cases**

A Coroner is a public official whose duty it is to make inquiry into the causes and circumstances of all sudden, unexplained, unnatural, or suspicious deaths.

The Coroner has authority, according to [KRS 72.020](#), to "take possession of any objects, medical specimens or articles which, in his opinion, may be helpful in establishing the cause of death, and he can make or cause to be made such tests and examination of said objects as may be necessary or useful in determining the cause of death." [KRS 72.415](#) gives coroners and deputy coroners the authority to "require the production of medical records" in carrying out their duties as peace officers in this state.

### **Additional Resources**

For authorization and Coroner's exemptions refer to the [HIPAA](#) privacy regulations [164.508](#) and [164.512\(c\)](#). LHDs should contact their local attorney for further clarification.

[Kentucky Coroners Association](#)

## **HIPAA FINAL OMNIBUS RULE**

On [January 17, 2013](#) the U.S. Department of Health and Human Services (HHS) issued a press release announcing “the most sweeping changes to the HIPAA Privacy and Security Rules since they were first implemented in the form of the HIPAA Final Omnibus Rule.

**The final rule was effective March 26, 2013 with full compliance by September 23, 2013.** LHDs should contact their local attorney for HIPAA related issues.

The changes in the final rulemaking provide the public with increased protection and control of personal health information. Every covered entity and business associate (and now subcontractor to business associates), no matter the size, should have a reliable compliance program in place to meet these compliance obligations.

The [Omnibus Rule](#) provides changes in the following areas:

- **Makes Business Associates (contractors and subcontractors) of covered entities directly liable for compliance with HIPAA [Privacy](#) and [Security](#) Rules’ requirements**

New definitions in the HIPAA rules have been added at section [160.103\(3\)](#) which state that a Business Associate includes: “(iii) A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.”

- **Limitation on Use and Disclosures of [PHI](#) for marketing purposes**
  - The Final Rule requires authorization for all treatment and health care operations communications where the covered entity receives financial remuneration for making the communications from a third party whose product or service is being marketed.
  - Existing prohibitions on marketing must be reviewed and a risk assessment conducted to determine if any treatment and health care communications are subsidized by third parties.
- **Use and Disclosures of [PHI](#) for fundraising purposes**
  - Provision prohibiting the conditioning of treatment or payment on an individual’s choice with respect of the receipt of fundraising communications.
  - The Notice of Privacy Practices must inform individuals that a covered entity may contact them to raise funds for the covered entity and an individual has a right to opt out of receiving such communications.
- **Expands individuals’ rights to receive electronic copies of their patient [protected health information](#) (PHI)**
  - The Privacy Rules establishes, with limited exceptions, an enforceable means by which individuals have a right to review or obtain copies of their PHI, to the extent it is maintained in the designated records set(s) of a covered entity.
  - The Privacy Rules requires covered entities to provide access to the PHI in the form or format requested by the individual, if it is readily producible in such form or format as agreed to by the covered entity and the individual.

- Covered entities that use electronic records (e.g., EHRs or electronic claims systems) will want to remain cognizant that the right of access applies regardless of the information's format.
  - The Privacy Rule's specific standards also address individuals' requests for access and timely action by the covered entity, including the provisions of access, denial of access, and documentation.
  - The Privacy Rules supports covered entities' offering individuals the option of using electronic means (e.g., e-mail, web portal) to make requests for access.
- **Restricts disclosures to a health plan concerning treatment for which the individual has paid out-of-pocket in full**

When individuals pay by cash, they can instruct their provider not to share information about their treatment with their health plan

- **Require modifications to, and redistribution of, a covered entity's Notice of Privacy Practices**
  - The Final Rules adopts the modification to [164.520\(b\)\(1\)\(ii\)\(E\)](#), which requires certain statements in the NPP regarding uses and disclosures that require authorization.
  - The NPP must contain a statement indicating that most uses and disclosures of psychotherapy notes, PHI for marketing purposes, and disclosures that constitute a sale of PHI require authorization, as well as a statement that other uses and disclosures not described in the NPP will be made only with authorization from the individual.
  - The Privacy Rule allows covered entities to require individuals to make requests for access in writing, provided they inform individuals of such a requirement. The NPP should contain information about using electronic means, if applicable to the covered entity.
  - NPP must contain a statement informing an individual of their right to access PHI in the format in which the covered entity maintains the PHI.
  - NPP must inform individuals of their new right to restrict certain disclosures of PHI to a health plan where the individual pays out of pocket in full for the health care item or service.
  - Covered entities are required to include in their NPP a statement of the right of affected individuals to be notified following a breach of unsecured PHI.
- **HHS states these are "material changes" to the Notice of Privacy Practices that require re-distribution.**
  - The revised NPP must be available to existing patients upon request and must be posted both to the provider's website (if your agency has a website) and in a prominent location on the premises.
  - Covered entities that are healthcare providers are only required to distribute the modified NPP to new patients.

### **Modify the individual authorization to facilitate research**

The Final Rule permits compound authorizations, or authorizations for more than one clinical trial, and authorizations for future, unspecified research. This change permits a single document to include consent and authorization for a clinical trial and a future study, as long as

the authorization contains a general description of the types of research that may be conducted.

- **Creates the final rule modifying the HIPAA Privacy Rule as required by the Genetic Information Nondiscrimination Act of 2008 (GINA)**

The definition of "health information" is expanded to include genetic information. GINA clarifies that genetic information is protected under the HIPAA Privacy Rule and prohibits most health plans from using or disclosing genetic information for underwriting purposes.

- **Disclosure of child immunization proof to schools**

The Final Rules amends [164.512\(b\)\(1\)](#) by adding a new paragraph that permits a covered entity to disclose proof of immunizations to a school where State of other law requires the school to have such information prior to admitting the student. Written disclosure is no longer required to permit this disclosure. The covered entity would still be required to get oral or written consent and document the agreement obtained. ***KY law 902 KAR 2:055 allows for the exchange of immunization records for the above reason.***

- **Enable access to decedent information by family members or others**

- The Final Rule defines that PHI extends to the information of a deceased person up to a period of 50 years after death.
- The Final Rule amends [164.510\(b\)](#) to permit covered entities to disclose a decedent's PHI to family members and others who were involved in the care or payment for care of the decedent prior to death, unless doing so is inconsistent with any prior expressed preference of the individual that is known to the covered entity.

- **Adopt the additional HITECH Act enhancements (such as, enforcement of noncompliance with the HIPAA Rules due to willful neglect)**

- "Willful Neglect" is defined as "conscious, intentional failure or reckless indifference."
- The Final Rule also revised the definition of "reasonable cause" to "an act or omission in which a covered entity or business associate knew, or by exercising reasonable diligence would have known, that the act or omission violated an administrative simplification provision, by which the covered entity or business associate did not act with will neglect."
- The civil penalty tiers remain unchanged:
  - Did Not Know (and could not have known): \$100-\$50,000 per violation;
  - Reasonable Cause: \$1,00-\$50,000 per violation;
  - Willful Neglect – corrected within 30 days of discovery: \$10,000-\$50,000 per violation; and
  - Willful Neglect – not corrected within 30 days of discovery: \$50,000
  - All violations of an identical provision in a calendar year shall not exceed a fine of \$1,500,000.

- **Creates the final rule on Breach Notification for Unsecured PHI under the [HITECH Act](#) (see information below)**

- **Incorporates the increased and tiered civil money penalty structure**

The Final Rule implements the penalty structure mandated by the HITECH Act for violations occurring after February 18, 2009, in which the amount of the penalty increase with the level of culpability, with maximum penalties of the same HIPAA provision of \$1.5 million per year.

**The Final Rule now presumes that any access to PHI which is not permitted by law, constitutes a breach unless the covered entity or business associate can demonstrate that there is a “low probability” that the PHI has been compromised based on a risk assessment of at least the following factors:**

- The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification.
- The unauthorized person who used the PHI or to whom the disclosure was made.
- Whether the PHI was actually acquired or viewed.
- The extent to which the risk to the PHI has been mitigated.

Be prepared to defend any conclusion that a security event is not a reportable breach in the form of the investigative action plan, action review, and expert consultations and the potential impact on the consumers. Breaches that cannot be defended through the above risk assessment outline must be reported to HHS. LHDs should contact their local attorney for HIPAA related issues.

Helpful Web Links:

*US Health and Human Services (HHS) – ([Health Information Privacy](#))*  
*Omnibus HIPAA Rulemaking – [Federal Register](#)*  
*Omnibus HIPAA Rulemaking – [HHS Press Release](#)*  
*(HHS) [Business Associates Agreement provisions](#)*  
*(HHS) [Health Information technology](#)*  
*(HHS) [HIPAA/Privacy Compliance Enforcement](#)*

**[Electronic Code of Federal Regulations: CFR Title 45 – PUBLIC WELFARE](#)**

**[CFR Title 45, §164.510](#)** – Uses and disclosures requiring an opportunity for the individual to agree or to object

**SUBPOENAS AND COURT ORDERS: [KRS Chapter 422, \(422.300 through KRS 422.330\)](#)**

The subpoena is the typical mechanism for obtaining records from someone who is not a party to a case. A subpoena directs the person named in it to appear at a designated time and place, often with certain records. In responding, a health department and its employees must balance their duty to protect confidential information against their duty to respond to the subpoena's commands.

A subpoena is usually not sufficient to authorize disclosure of confidential information. Most confidentiality laws, especially those dealing with medical information, impose stricter conditions, such as entry of an order by a judge or prior notification of the individual who is the subject of the records. If you receive a subpoena for confidential information, you must consider the particular statute or regulation governing the information and determine the conditions under which records may be disclosed.

An attorney who issues a subpoena should likewise be wary of examining confidential information on the strength of the subpoena alone. In some circumstances, an attorney who reviews confidential information without appropriate authorization may be subject to sanctions or even civil liability.

## **The Two (2) Types Of Subpoenas**

### **1. Subpoena**

The subpoena is a command to appear at a certain time and place to give testimony upon a certain matter.

A subpoena is valid if it:

- Is issued by the court clerk or other authorized officer, but usually not the presiding officer of the court;
- States the name of the court and the title of the action; and
- Commands the person to whom it is directed to attend and give testimony at a time and place for a specified party.

### **2. Subpoena Duces Tecum**

A subpoena duces tecum is a subpoena with the added command to bring along certain documents or papers pertinent to the issues of a controversy.

For additional resources – Refer to [HIPAA](#) privacy regulations 164.512(e) and (f). LHDs should contact their local attorney for HIPAA related questions.

A subpoena issued by someone other than a judge, such as a court clerk or an attorney in a case, is different from a court order. A LHD may disclose information to a party by issuing a subpoena only if the notification requirements of the Privacy Rule are met. Before the covered entity may respond to the subpoena, the Rule requires that it receive evidence that reasonable efforts were made to either:

- notify the person who is the subject of the information about the request, so the person has a chance to object to the disclosure (this would be an attached letter of assurance the individual has been notified of the request and has had reasonable amount of time to respond to the request), or to
- seek a qualified protective order for the information from the court.

The LHD may notify the individual of the request and seek written authorization to disclose. The LHD should contact their attorney for any questions or concerns relating to subpoenas and releasing of information.

A qualified protective order is an order of a court or a stipulation by the parties that prohibits the parties from using or disclosing the protected health information for any purpose other than the litigation or proceeding for which such information was requested; and requires the return to the covered entity or destruction of the protected health information (including any copies) at the end of the litigation or proceeding. The party requesting the information must provide a written statement and accompanying documentation that demonstrates:

- the parties to the dispute have agreed to a qualified protective order and have presented it to the court; or
- the party seeking the protected health information has requested a qualified protective order from the court.
- [May a covered entity disclose PHI in response to a lawful process not accompanied by a court order](#)
- ["Satisfactory Assurances" – what must a covered entity receive before responding to a subpoena](#)

### **Court Order**

A LHD may disclose protected health information required by a **court order**. A court order is a command signed by the presiding judge of the court. However, the provider may only disclose the information specifically described in the order. Kentucky has specific laws regarding the disclosures of STD/STI, HIV, Drug/Alcohol Treatment records, etc. For further information on this topic, please refer to [45 C.F.R. § 164.512\(e\)](#) and US, HHS, [OCR's HIPAA Frequently Asked Questions](#) (FAQs for Professionals).

### **Power To Issue**

The power to subpoena is given by statute to judges, clerks of courts, referees, arbitrators, municipal corporations, legislative committees, various boards and commissioners including the State Board of Medical Licensure.

### **Responding To A Subpoena**

Recipient is the person named in the subpoena to appear or produce documents or other materials.

A subpoena may be served in accordance to the Kentucky Rules of Civil Procedure (CR). The actions listed below were ascertained from "[CR45.03 \(Subpoena\) Service; Notice, CR 4.01 Summons; issuance; by whom served and CR 4.04 Personal service; summons and initiating document](#)" of the Rules.

A subpoena may be served in person or by mail.

- If by person, the person delivering the subpoena should be over eighteen (18) years of age and should deliver the subpoena to the person to whom it is directed.
- If by mail, it should be as registered mail or certified mail return receipt requested with instructions to the delivering postal employee to deliver to the addressee only and show the address where delivered and the date of delivery.

Further information about Kentucky Rules of Civil Procedures may be found on the [Kentucky Bar Association](#) website.

The service of a subpoena must be made to the person named in the subpoena. Service is valid when it is served within the territorial jurisdiction of the court that issued it.

- State - a subpoena issued by a state district or circuit court is valid only within the boundaries of the state in which the court is located.
- Federal - A subpoena issued by a federal court is valid within the federal court district or within one hundred (100) miles of the location where the witness is required to attend, even though the place of service may be outside of the federal court district.

### **Responsibility Of Recipient**

The named recipient at the LHD should require proper service. When a subpoena is received through the mail, is sent from outside the court's jurisdiction, or is served improperly in any other way, the recipient should notify the attorney who initiated the subpoena of improper service. A form letter may be prepared to respond to such occasions.

### **Contempt Of Court**

Failure to respond to a subpoena in Kentucky is punishable as contempt of court. Failure to compensate the witness for expenses is not sufficient grounds for failure to respond to a subpoena.

### **The Custodian Of Medical Records As Witness**

When medical record information is subpoenaed, the custodian of medical records, i.e., either the medical record director or someone else with knowledge of the recipient's record maintenance procedures, will be asked to testify as to the authenticity of the medical records either through deposition, appearance at court or written certification.

### **Deposition**

A deposition is the testimony of a party or witness, made under oath but not in open court and written down or videotaped to be used during discovery or trial proceedings.

The deposition is a means of pretrial discovery. It may direct the response to questions and/or production of records related to the case.

The attorney issuing the subpoena for a deposition to discover medical records usually will call the medical record custodian to set a time and place for the disposition. Those present at the deposition are the following:

- Custodian of medical records.
- Attorney requesting the deposition.
- Opposing attorney, and
- Court reporter or person with a video camera commissioned to record the deposition proceedings.

The medical record custodian will be sworn in and questioned in the same manner as if appearing in court. The attorney who issued the subpoena will be given a copy of the record when and if it is requested. If an attorney objects to the answering of a question during a deposition, the question is still answered. Whether or not an answer given during deposition will be introduced in court will be determined by the judge at a later time.

### **Safeguarding of Subpoenaed Records Prior to Court/Deposition**

A medical record subpoenaed for a legal case should be filed in a secure place until the case is terminated to prevent altering, tampering, or removing the record or any of its contents. Changes in the record occurring after the commencement of a lawsuit tend to display an admission of guilt. To provide the necessary security:

- Number each page in the record.
- Make a clear copy of the record.
- File the original and the copy in a secure, locked place; and  
Allow the original record to be viewed only under proper supervision.

To prevent anyone from making changes to the record after a suit has been filed, it is recommended that a second copy of the record be used for viewing by appropriate parties instead of the original/first copy that will be sent to court.

### **Appearance In Court**

Prior to appearance in court, the medical record custodian should:

- Make a clear copy of the record,
- Number the pages on the copy, and
- Read through the entire record for familiarity with the terms should it become necessary that portions have to be read in court at the deposition.

On the day appearance in court is requested, the medical record custodian should:

- Call the attorney who subpoenaed the record and verify the time to be present, and
- Bring the original and the copy of the record along to court.

Upon arrival at the court the medical record custodian should:

- Acknowledge the custodian's presence to the subpoenaing attorney or the clerk of court.
- Wait in the designated area until requested to take the witness stand and do not reveal the contents of the records to anyone until directed to do so by the judge.

The reasons a medical record custodian is asked to serve as a witness are to identify the record and answer questions needed to make the record admissible in court. Questions that must be answered positively for admissibility are:

- Was the record made in the regular course of business; and
- Was it the regular course of business to make such records at or near the time of the matter recorded?

When serving as a witness in court or at a deposition, the medical record custodian should answer questions briefly and directly. In addition to the two questions stated above, other usual questions are:

- What is your full name and title?
- For which facility do you work?
- Do you have in your possession the medical records of \_\_\_\_\_  
\_\_\_\_\_?

In the event an attorney asks, "do you have ALL the records of \_\_\_\_\_  
\_\_\_\_\_?" the custodian must think of the filing system used and determine if ALL records were brought, including the HANDS record if filed separately.

The medical record custodian may read parts of the record if asked but may not interpret any medical information in the record. "I am not qualified to answer that," is a perfectly acceptable response when questions fall beyond the area of competence. All answers are subject to cross examination(s) in a court of law.

If any attorney objects to a question, the question should not be answered until the judge rules whether or not the question is to be answered.

### **Procedure for Mailing Records to Court**

[KRS Chapter 422](#) (422.300 through KRS 422.330) provide for the mailing or personal delivery of a certified copy of the medical record to the clerk of court, unless the record contains information regarding sexually transmitted diseases, HANDS, mental health or drug and alcohol abuse. In this event, the judge must be notified that privileged information on a specific patient is not subject to subpoena.

To comply with these statutes, the custodian of medical records or person charged with such responsibility shall promptly notify in writing the attorney causing service of the subpoena of the recipient's decision to submit a certified copy. Also included would be the cost of reproducing the record.

Upon payment of the copying expenses:

1. Prepare a certification with the following information:

- Full name of the patient;
- Patient's medical record number;
- Number of pages in the medical record; and
- This statement:  
"The copies of records for which this certification is made are true and complete reproductions of the original (or microfilmed) records which are housed in (name of facility). The original records were made in the regular course of business, and it was the regular course of (name of facility) to make such records at or near the time of the matter recorded. This certification is given pursuant to KRS 422.300 – KRS 422.330 by the custodian of the records in lieu of personal appearance."

2. Notarize the certification;

3. Enclose the copies and notarized certification in an inner envelope labeled with the following:

- Copies of medical records;
- Title and number of the legal action or proceeding;
- Date of the subpoena;
- Name of the provider;
- Full name of the patient;
- Patient's medical record number, and
- Name and business phone number of the employee signing the certification.

4. Seal the envelope and enclose the inner envelope containing the copies and certification into an outer envelope and address it to the attorney causing service of the subpoena or to the clerk of the court; and

5. Promptly deliver either personally or by certified or registered mail to the addressee.

If delivered personally, have the person receiving the records sign a receipt containing the following information and retain the receipt as proof of the delivery:

- Name of the facility;
- Full name of the patient;

- Patient's medical record number and;
- The date the copies were delivered. When delivered via mail, retain the receipt issued by the post office and signed by the court representative as proof of delivery.

### **Original Record to Be Left In Court**

If the original record is to be left in the court, the medical record custodian should obtain a receipt from the clerk of court indicating that the record will be retained in the clerk's custody and that arrangements will be made for the return of the record when the case is terminated.

### **Microfilmed Records in Court**

If a subpoenaed record is on microfilm and it is necessary for the custodian to appear in court, the film containing the records should be taken to court with copies of the filmed records. If copies are legible, the filmed records ordinarily are not needed.

Should the court request the viewing of film that contains records of other patients, the custodian should explain that violation of the confidentiality of other patients' records is at stake. Such film should not be left with the court since the records may be needed for patient care.

Upon the admission of microfilm records in court, the medical record custodian may be asked if the original records were destroyed in the regular course of business. Records are destroyed "in the regular course of business" when they are destroyed in a routine manner after microfilming and not for the purpose of destroying evidence.

### **Interrogatories**

Interrogatories are a set or series of written questions asked by one party of another party or witness in a lawsuit. The person receiving the interrogatory is requested to answer the questions in writing and to sign an oath that all answers are correct to the best of his/her knowledge. Answers are mainly used to discover evidence; however, the answers themselves may be admitted as evidence.

A recipient of a subpoena who is asked to answer an interrogatory or set of interrogatories should turn the questions over to his/her legal counsel for response.

### **Waiver of Privilege**

A privilege may be waived only by the person whose information is held to be privileged. The recipient of the subpoena should never assume that a patient has waived privilege, for example, when a psychiatric patient sues his psychiatrist. Only the presiding officer of a court may determine that a patient has waived privilege.

## **PROCEDURES FOR IMPLEMENTING THE RECORDS RETENTION AND DISPOSAL SCHEDULE FOR MEDICAL RECORDS**

### **Retention Time Period for Medical Records**

If the patient was less than 18 years of age on his/her last date of service, the record must be kept until he/she reaches age 18 plus 5 years, or 10 years whichever is the longer time period.\*

If the patient was 18 years of age or older on his/her last date of service, the record must be kept for 10 years from the last date of service. \*

For all patients (without regard to age), the immunizations (other than influenza), positive Purified Protein Derivative (PPD)s and any patient record with **documentation of Tuberculosis (TB) infection or disease treatment must be kept permanently.**

If information on completed/ recommended treatment regimen, allergies, and sensitivities, regarding TB, is extracted and entered on the permanent immunization/master record, the record may be destroyed when it reaches the assigned retention period.

### **Master Patient Index**

The Master Patient Index is the locator system for **all clients/patients registered** with your facility and must be **kept permanently**. This should include, but may not be limited to, medical, Women Infant & Children (WIC), and HANDS services. It shall be **all-inclusive** to contain the name and location of all active, inactive and destroyed patient records. When the record is removed from the active file, a notation on the index shall indicate where the record is and if the record is reactivated, a notation is to be made. If the record meets the retention period and is destroyed, a note is to be included to indicate the record was destroyed and the date of destruction.

**The Master Patient Index that includes all the above criteria may be kept on paper, electronically or a combination of the two and should be easily accessible.**

### **Procedures for Archiving**

Following are procedures to use in archiving medical records in accordance with the December 2001 Records Retention Schedule:

The medical records retention schedule is based on three factors:

- The last date of service;
- Patient's age (minor – less than 18 years of age and adult – 18 years of age and older); and
- Type of service the patient has received, i.e., Immunizations and positive tuberculosis (TB) test and TB infection or disease treatment.

The record retention criteria necessitate the date of birth being included on the label of the folder.

- When the patient has not received a service within the past five years, the record is considered inactive and may be removed from the active files.
- In establishing the inactive files, consider the following:
  - Minor patient records;
  - Adult patient records; and
  - Permanent records.

### **Location of Inactive/Archived Records**

LHDs are responsible for the storage of inactive/archived records. The records must be stored in an orderly, accessible manner and in a secure location. The State Archives Center may not be used for storing LHD records.

Inactive/ Archived Records and/or Reports may be retained in electronic formats to provide a better source of storage to LHDs. The access should be easy, fast, and readily available when needed. The inactive/archived records and/or reports should be maintained according to the records retention schedule and properly disposed of once the retention period has ended.

### **Destruction of Medical Records**

If the medical record has met the required retention period, it should be destroyed. To destroy the record, it must be *burned or shredded*. A Records Destruction Certificate (**Form PRD-50**) is to be completed and **mailed to the Department for Libraries and Archives**, 300 Coffee Tree Road, Frankfort, Kentucky 40602. The PRD-50 forms may be obtained from the DPH Record Officer, Administration and Financial Management Division, phone number 502-564-6663, **LH**

**Personnel Branch, Option 5. A copy of the Destruction Certificate is to be permanently maintained at the LHD.**

Click to view: [LHD ONLINE RECORDS RETENTION SCHEDULE](#)

### **GUIDELINES FOR LHD MEDICATION PLANS**

Every LHD should have in place a medication plan, in accordance with [KRS 212.275](#) that:

- Is signed by and developed in consultation with the Local Board of Health pharmacist or designee;
- Is approved by the Local Board of Health and reviewed and signed annually;
- Includes purchasing, storage, inventory, dispensing, and reporting of medication errors; and
- Is consistent with the DPH, Board of Pharmacy and other relevant laws and guidelines.
- Only additional in-house medications that are specific to the LHD must be included in the LHD Medication Policy. Medications listed throughout the [CSG](#) need only be referenced in their local policy as "all medications listed in the [CSG](#)."

CHFS legal counsel has advised that LHDs prescribing drugs not in the [CSG](#) assume responsibility specific to the service being provided and do so under local authority and individual licensees (physicians, nurse practitioners, etc.) without the specific endorsement by or liability to CHFS or DPH. The LHD also assumes responsibility for conforming to pharmacy and other relevant statutes.

Definitions and additional guidelines for nurses regarding medication (prescribing, dispensing, administering and delivering).\*:

*Prescription* means an authorization to obtain a prescription drug.

- This authorization can be given to a pharmacist via piece of paper, telephone call, fax, or an electronic scan.
- An MD, PA, or an APRN (within their scope of licensed practice and collaborative agreements) may authorize a prescription.
- Prescriptions may be provided to patients with public or private insurance (under [ACA](#) guidelines most contraceptives are covered without cost sharing for the patient).
- Prescriptions may be provided to clients without insurance in the following circumstances\*\*:
  - Patient specifically requests a prescription for a method not available at LHD
  - Patient specifically requests a prescription for a method temporarily out of stock; or
  - LHD is unable to obtain a particular method because the LHD has met the manufacturer's purchasing quota.

*Dispense* means to give a patient a drug to consume or use later. Dispensing is legal for RNs and APRNs only in LHDs following the CSG guidelines and LHD Medication Policy. [KRS 314.011](#) has a provision for "dispensing" which is an exception for LHDs.

Per the Board of Pharmacy, a RN or APRN can dispense a medication from a multi-dose bottle to be sent home with the patient to be taken later. \*\*\*

The drug must be packaged, labeled and recorded according to Pharmacy Law. Pharmacy labeling is an FDA requirement (therefore regulations will not be found in Kentucky Law documents). The requirements for proper labeling of medications to be dispensed include:

- Patient's name
- Date
- Name of provider prescribing medication
- Name of medication being dispensed
- Specific instructions to patient for proper usage (example: take 1 tablet every 12 hours)
- Quantity of pills/medication being dispensed
- Name and telephone number of the facility

Dispensing of *sample drugs* within their scope of practice is legal only for APRNs.

*Administer* means to put a drug into a patient's body.

- This can occur by giving an injection, oral medication, applying a cream or ointment, or use of an inhaler.
- Administration of a single dose is legal for LPNs, RNs, and APRNs upon the authorization of an MD or APRN.

*Deliver* means hand over a previously dispensed drug.

- LPNs and unlicensed personnel may deliver meds that have been properly dispensed.
- It is recommended that this be done in the LHD under the delegated authority of an APRN or RN.
- For DOT guidelines, Review [TB section in the CSG](#).

\* Also included are other brands or generic forms of medications containing identical amounts of the same active drug ingredient in the same dosage form (this needs to be considered).

- Dosages may be adjusted based on weight and age.
- For DOT Guidelines, Review [TB section in the CSG](#).
- Before crushing or giving any medication mixed with food, check with the prescribing clinician for instructions.

\*\* Each LHD should include in their internal medication plan who is responsible for the cost of a prescription when given to an uninsured patient.

\*\*\* [KRS 314.011](#) Definitions for chapter.

As used in this chapter, unless the context thereof requires otherwise:

"Dispense" means to receive and distribute non-controlled legend drug samples from pharmaceutical manufacturers to patients at no charge to the patient or any other party; or

To distribute non-controlled legend drugs from a local, district, and independent health department, subject to the direction of the appropriate governing board of the individual health department.

Review a sample medication plan on the [LHD Forms, Documents and Administrative Reference webpage](#).

An **LHD Medical Abbreviations** document is located on the [DPH Nursing Office webpage](#) to assist with clinic charting/documenting. The DPH Chief Nursing Officer and NEC will be responsible for keeping this document updated.

# EMERGENCY PREPAREDNESS AND RESPONSE

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## **EMERGENCY PREPAREDNESS AND RESPONSE**

The federal government, through such actions as the Pandemic and All Hazards Preparedness Act (PHAPA), presidential orders and cooperative agreements, require states and local agencies to prepare for any emergency or disaster that may affect a community. This includes developing emergency operations plans, establishing partnerships and agreements, purchasing and maintaining equipment and supplies, and training, exercising and evaluating plans and procedures. All of these activities will help ensure public health and medical personnel have the skills and capabilities to effectively prepare for, respond to and recover from any all-hazard incident.

The Department of Health and Human Services (HHS), through the Office of the Assistant Secretary for Preparedness and Response (ASPR) and Centers for Disease Control and Prevention (CDC), issues the Hospital Preparedness Program (HPP) and the Public Health Emergency Preparedness (PHEP) Cooperative Agreement, respectively. These agreements provide clear expectations and priorities for public health agencies and healthcare coalitions (HCCs), while providing funds to ensure that HPP and PHEP awardees and sub-recipients focus on activities that advance progress toward meeting the goals, domains, and capabilities listed in the following federal guidance documents:

- [The 2018 Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health](#)
- [Hospital Preparedness Program \(HPP\) Cooperative Agreement Funding Opportunity Announcement \(FOA\)](#)
- [Public Health Emergency Preparedness \(PHEP\) Cooperative Agreement](#)

The Department for Public Health (DPH) is the “Awardee” of these funds and through collaboration with sub-recipients, must increase or maintain levels of effectiveness across the following six key preparedness domains:

- Community Resilience
- Incident Management
- Information Management
- Countermeasures and Mitigation
- Surge Management
- Bio-Surveillance

### **Department for Public Health Responsibilities**

DPH is responsible for coordinating and implementing preparedness activities with local health departments (LHDs) and other Emergency Support Function (ESF) 8 Support Agencies. As the state’s awardee of federal funds, DPH is responsible for coordinating with local, state, and federal agencies to meet both HPP and PHEP Cooperative Agreement funding and reporting requirements. The Public Health Preparedness Branch provides guidance, technical assistance and field staff support to HCCs and LHDs. More information can be found in the following state guidance documents:

- Preparedness Deliverables Guidance for Kentucky’s LHDs and Regional Healthcare Coalitions

- Hospital Preparedness Program Guidance for Kentucky’s Regional Health Care Coalitions
- Multi-provider contractual agreement

### **LHDs’ Responsibilities**

The Kentucky ESF 8 Public Health and Medical Services Annex outlines the Concept of Operations for the preparedness, response, and recovery phases in preparation for emergencies, disasters, and planned events. To assure an effective preparedness program, the following minimum actions should be taken to prepare for, respond to, and recover from a public health emergency/disaster:

### **Community Partnerships**

Collaborate with community emergency response partners to conduct jurisdictional risk assessments and identify vulnerabilities, planning gaps, resources and capabilities to ensure that public health and medical services and resources are coordinated and available when needed.

### **Planning**

Develop and maintain comprehensive public health emergency operation plans that incorporate the concepts and principles of the National Incident Management System (NIMS) and are consistent with the county emergency operations plans. These plans should include but not limited to;

- All Hazards Emergency Operations Plans (EOPs Strategic National Stockpile (SNS) Plan
- CHEMPACK (sustainable repository of nerve agent antidotes) Plan
- Disease Outbreak Support Plan (DOSP)
- Pandemic Influenza Response Plan
- Continuity Of Operations Plan (COOP) Department Operations Center (DOC) Support Plan (if applicable)
- Facility Lockdown Guidelines

### **Incident Management Personnel**

Identify LHD and ESF 8 representatives who are trained to provide support and technical assistance during a response to an emergency or disaster. These persons must maintain up-to-date contact information in Kentucky’s ReadyOp and have access to Kentucky’s WebEOC System.

### **Inventory Management**

- Assets purchased with federal funds must be stored, tracked, safeguarded and maintained in an operational status. Refer to the Preparedness Deliverables Guidance document for LHDs and Regional HCCs for inventory processes.
- **Training and Exercises:** LHDs are encouraged to coordinate their training and exercise efforts with DPH and their community partners based on federal requirements, potential threats, vulnerabilities, baseline levels of preparedness, and exercise needs. Refer to the Preparedness Deliverables Guidance document for LHDs and Regional HCCs for training and exercise requirements.

### **Alert and Notification**

Coordinate with DPH to maintain Kentucky’s ReadyOp public health alert and notification system to ensure 24/7 notification capability. Refer to the Preparedness Deliverables Guidance document for LHDs and Regional HCCs for further guidance.

**Incident Management and Communication Systems**

Ensure at least two persons are trained on the information sharing systems referenced in the Preparedness Deliverables Guidance document for LHDs and HCCs.

**Allowable/Non-Allowable Expenditures**

Federal funds allocated to LHDs can be used to meet preparedness deliverables as specified by the federal cooperative agreements and DPH. This can include staff time for ESF 8-related planning, assessments, organization, training, exercises, evaluation, travel, equipment purchases, equipment maintenance, supplies, and information technology expenses. Federal funds cannot be used for the purchase of motorized vehicles, new construction or major renovations, backfilling costs for staff, furniture or equipment, clothing (e.g., jeans, cargo pants, polo shirts, jumpsuits or T-shirts), clinical care and research.

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## **Adolescent Health Sexual Risk Avoidance and Personal Responsibility Education**

### **Sexual Risk Avoidance Education (SRAE) Grant:**

The purpose of the Title V State Sexual Risk Avoidance Education (SRAE) Program is to implement education exclusively on sexual risk avoidance that teaches youth to voluntarily refrain from sexual activity. The program is designed to teach youth personal responsibility, self-regulation, goal setting, healthy decision-making, a focus on the future, and the prevention of youth risk behaviors such as drug and alcohol use without normalizing teen sexual activity.

Local jurisdictions, health departments or contracted vendors are required to use Kentucky approved evidence-based approach curricula and/or effective strategies to educate youth on the optimal health behavior of avoiding non-marital sexual activity and other risky behaviors.

### **Personal Responsibility Education Program (PREP) Grant:**

Through the State Personal Responsibility Education Program (PREP), Kentucky Maternal and Child Health agencies to educate young people on both abstinence and contraception to prevent pregnancy and sexually transmitted infections, including HIV/AIDS.

State PREP programs must target services to youth, ages 10–19, who are at high-risk for pregnancies. This group includes youth in or aging out of foster care, homeless youth, youth with HIV/AIDS, victims of human trafficking, pregnant and/or parenting youth who are under age 21, and youth who live in areas with high teen birth rates. Programs must place substantial emphasis on both abstinence and contraception education for the prevention of pregnancy and STIs. State PREP projects must educate young people in at least three of the six congressionally mandated subject areas below:

- Healthy relationships, including marriage and family interactions
- Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects
- Financial literacy
- Parent-child communication
- Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity
- Healthy life skills, such as goal setting, decision making, negotiation, communication and interpersonal skills, and stress management
- Local jurisdictions, health departments or contracted vendors are required to use Kentucky approved evidence-based approach curricula and/or effective strategies to educate youth on the optimal health behavior of avoiding non-marital sexual activity and other risky behaviors.

### **Target Population:**

The program targets youth ages 10–19 who are homeless, in foster care, live in rural areas or in geographic areas with high teen birth rates, or come from racial or ethnic minority groups. The program also supports pregnant and parenting youth.

**Funding:**

US Department of Health and Human Services, Administration for Children and Families, Family and Youth Services Bureau grants. SRAE is federal grant number 2201KYSRAE and PREP SRAE is federal grant number 2201KYPREP. Reimbursement for services is based upon fidelity of program delivery, compliance for dose, reach, survey, and reporting requirements as provided by the SRAE/PREP Adolescent Health state program. Other activities outside of the specified curricula is not a reimbursable cost.

**Cost Centers:** SRAE 753 and PREP 756

**Staff Requirements:** Adolescent Health Educators can have position titles of a health educator who may be nurses, counselors, social workers, Family Resources and Youth Service Center staff (FRYSC) or other educational degrees.

**Training:**

Training for specific state approved curricula is required. Training is provided by certified curricula instructors at no cost to the local agencies. Prior to providing services to local youth, all staff must be certified to provide training by the state agency.

**Reporting Requirements:**

The Adolescent Health Educator will report SRAE/PREP activities in the DPH approved reporting system every month for each grant the local has received funding for. Reporting will be monitored closely. DPH Adolescent Health will implement reallocation of funds for those who have not reported activities as required to other agencies that are compliant with grant deliverables and reporting. The Adolescent Health Educator will ensure reporting requirements are met according to grant guidelines every month before close of business on the 5<sup>th</sup> day of the month following when services were rendered. Specific reporting requirements will be listed for each grant. All reports must include all designated fields as per the survey tool used. Additional reporting as requested by the state agency is to be completed as per guidance of the Adolescent Health program leaders within Maternal and Child Health (MCH).

Annually, a workplan submission is required prior to allocation planning. Every 2 years, the local agency must submit a complete application per the Notice of Funding Opportunity provided by the Adolescent Health Program.

Any LHD accepting funds from Cost Center 753 and 756 must comply with these reporting standards. Non-compliance may cause reimbursement delays and/or loss of funds in this cost center. For ongoing non-compliance issues, payment will be held until all compliance issues have been resolved by the state Adolescent Health Program.

### **Program Accountability and Compliance:**

Accountability is required through monthly Adolescent Health Reporting. Missed reports will automatically generate the following actions:

1. Compliance email #1: Missing report of 30 days or more past deadline will result in a reminder email.
2. Compliance email #2: Missing reports up to 60 days past deadline will result in a reminder email to educator and director. Additionally, the educator will receive a telephone communication to provide active technical assistance to resolve the issue.
3. Compliance email #3: Missing report of 90 days past deadline will be a notification that payment is held in the appropriate cost center 753 and/or 756. This notification is sent directly to the director and the Administration and Financial Management Division of DPH.

### **Allowable expenses are:**

1. Staff time & fringe as directly related to provision of SRAE/PREP curriculum instruction.
2. In-state travel for activities and trainings directly for SRAE/PREP curriculum instruction only.
3. Approved curricula materials and workbooks
4. Printing or duplication materials
5. MCH Adolescent health review required for other SRAE/PREP requests

### **Non-allowable expenses are:**

Any cost center other than 753 or 756 expenses, food except for after school activities specially associated with the TOP curricula, and capital building expenses. Expenses outside of curricula instruction must have prior approval of the Adolescent Health Program.

### **Special Equipment Requirements:**

Staff implementing SRAE/PREP programs must have access to a computer for trainings, webinars, and data reporting. Equipment is to be provided by the LHD receiving and accepting cost center 753 and 756 allocations.

All Adolescent Health curricula are available for review by sending an email request to the [Adolescent.Health@ky.gov](mailto:Adolescent.Health@ky.gov). For additional information visit the [Child and Family Health Improvement Branch](#) webpage.

## **Kentucky Women’s Cancer Screening Program (KWCSF)**

In 1990, legislation (KRS 214.554) established the [Kentucky Women’s Cancer Screening Program \(KWCSF\)](#) in the Department for Public Health (DPH), with the Division of Women’s Health and provides breast and cervical cancer screenings, diagnostic follow-up services and case management for the Program’s target population:

- Women 21 years of age or older
- Household income at or below 250% of the federal poverty level
- Uninsured (no Medicare, no Medicaid and no private health insurance)

For program details review [AR section – KWCSF – Breast and Cervical Cancer Screening.](#)

### **Funding**

The Program is 100% percent funded by the Center for Disease and Control and Prevention’s National Breast and Cervical Early Detection Program. The Program has been funded continually for thirty plus years.

### **Health Department Responsibilities:**

LHDs may accept KWCSF federal funds to provide breast and cervical cancer screening services. Additionally, LHDs may determine these services are offered by community providers *and decline* the KWCSF federal funds. It is the expectation of DPH that if an LHD makes the determination to terminate KWCSF services, the LHD must contact the DPH KWCSF program to report the community providers that are willing and able to accept KWCSF clients. If the LHD terminates KWCSF services, it is hoped the LHD will remain a KWCSF Champion and continue to link persons in need of cancer screening to community-based providers. For more guidance review [AR section– KWCSF – Breast and Cervical Cancer Screening.](#)

[LHDs are required to collect and submit cancer screening data to the Program. Required data collection drives program outreach direction, targeting those in need of services. Data collection also measures the quality of services provided, as well as indicates the need of support from federal funds.](#)

### **KWCSF Responsibilities**

[The Program staff is committed to providing technical assistance, as needed to LHDs, as well as provide training modules and videos. Staff will work with LHDs to ensure data collection and submission is achieved.](#)

## **Child Fatality Review and Injury Prevention**

### **Laws, Regulations, Guidelines:**

The Kentucky Child Fatality Review and Injury Prevention Program was established in 1996 through statute KRS211.680-686. The law authorizes and establishes the state program to prevent child fatalities, including a state child fatality review team, annual report, and local teams, confidentiality of team proceedings and records. The local teams are to assist the coroner in accurately identifying the manner and cause of the death and identify trends and opportunities for prevention.

- KRS.029 requires the coroners to notify public health upon the death of a child, and to submit a report to the on each child's death.
- KRS 213.161 "Sudden Infant Death Syndrome Program" including surveillance, public education, and grief counseling.
- KRS 189.125 Requirements for use of seat belts, child restraint systems, and child booster seats in motor vehicles
- KRS 314.073 requires training for nurses to complete 1.5 hours of continuing competency requirements covering the recognition and prevention of pediatric abusive head trauma.

### **Target Population:**

Target population is children birth through 17 years of age, including prevention efforts for those at risk, child fatality reviews for those children who die, and grief counseling services for families of children who have died.

### **Funding:**

The Kentucky Child Fatality Review and Injury Prevention Program is funded through the Title V Block Grant (cost center 766) and State General Fund (Public Health Block Grant).

### **Special Requirements:**

- **Staff Requirements**  
The LHD staff (nurses, social workers, registered dieticians, HANDS supervisors, or health educators) who have been designated by their agency. Staff will assist the coroner in facilitation of the local child fatality review team, offer grief counseling to families whose child has died, and assist with coordinating and reporting injury prevention efforts. The MCH Coordinator may be responsible for these activities.
- **Training Requirements**
  - CFR coordinator should complete
    - Abusive head trauma training (TRAIN course #1090482)
    - [A Program Manual for Child Death Review from National Center For Child Death Review](#)
    - Health department staff may, but are not required to, seek certification as a car seat installation technician. The state program will provide a list of training opportunities for certification upon request.
    - Documentation of these trainings shall be maintained by the LHD in the staff member's personnel file.
    - Families should be referred to local resources for grief counseling.

### **Reporting Requirements:**

DPH does require that your staff report activities in the MCH Coordination REDCap system monthly. Failure to report monthly, may result in payments being withheld.

- Record all injury prevention events the LHD has participated in including who led the event, length and location of the event, type of event (parent group meeting, teen parenting class, etc.), successes and barriers, etc. in REDCap.
- Report any education provided.
- Enter planning activities for future events.
- Please be outcome focused and report audience types and numbers accurately.
- Monthly reports in CFR REDCap are due on or before the 20<sup>th</sup> of the month following the month for which you are reporting (e.g., report for July – due by COB August 20).

**Billing and Collection Procedures:**

Staff time for providing the Services as described above may be reimbursed via Cost Center 766 up to the budgeted amount as determined in the Health Departments’ plans and budgets. Both staff time and funding of prevention activities can come from the Public Health Block Grant. Depending on the extent of the prevention activities, local funds may also be used. AFM notifies each health department of allocation amounts. Contact the **AFM Budget Branch, Local Health Budget Section** at (502) 564-6663, **Option 2** for budget and allocation inquiries.

**Program Specific Offerings:**

See web-based trainings. Other offerings can be arranged upon request. Technical Assistance including attendance at local CFR team meetings can be provided by the DPH CFR coordinator. The program contracts with a university-based pediatric injury prevention specialist for training and technical assistance to local teams and groups such as HANDS staff.

**Program Specific Requirements:**

Above mentioned documentation be submitted in a timely fashion and billing to be coded appropriately.

**Services Description and Key Roles and Responsibilities of Health Department:**

1. Child Fatality Review—  
LHDs must identify a **local CFR coordinator**.
  - a. KRS 72.410 requires the coroner to notify the LHD in case of a child death, so the CFR coordinator must be identified to the local coroner, in addition to notifying the state MCH program.
  - b. The CFR coordinator shall assist the local coroner with the logistics of a team meeting when needed.
  - c. The local CFR Coordinator must represent Public Health at the local CFR team meetings and provide a report of the meeting to the State CFR coordinator. This includes providing records to the coroner, prepared according to LHD policy and HIPPA compliance, if the child was a previous LHD client.
  - d. The local CFR Coordinator must maintain confidentiality forms for the local team and assure that each participating member has signed a form. Any violations of confidentiality should be reported to the State CFR coordinator.
  - e. Child fatality teams may meet on the call of the coroner, at regularly scheduled times, or as members of the team feel is appropriate.
  
2. Grief Counseling - The local CFR Coordinator, or their designee, shall provide information on **grief counseling** to local families who have had a child 0-17 die. This information, usually provided through a letter, must include condolences, suggest counseling, provide a list of local resources for counseling, and a number to call if the family wishes to request help finding counseling.

- a. If the family calls to request assistance, the local CFR coordinator shall link them to a local resource with training for grief counseling for infant/child deaths. These may include local grief support groups, genetics for genetic counseling if indicated, or other resources per the family's preference/request.
  - b. If a LHD wishes to train LHD staff in grief counseling, DPH will assist in arranging the training.
3. Pediatric Injury Prevention - The local CFR Coordinator, or their designee, shall coordinate injury prevention activities and projects,
- a. Vehicular accidents are the leading cause of death in children.  
At a minimum, LHD should educate all caregivers of infant/pediatric clients on proper use of child safety seats. Any child under age 12 should ride in the back seat with an appropriate child safety restraint, as described below.  
Kentucky Law requires that:
    - i. Infants up to 20 pounds and up to 1 year should ride in the back seat in a rear-facing federally approved child safety seat
    - ii. Infants over 20 pounds and at least 1 year of age should ride in the back seat in a forward-facing federally approved child safety seat
    - iii. Children over 40 pounds should ride in a federally approved child restraint until the car's lap/shoulder belt fits correctly – this is typically about age 4 to at least age 8
      - 1. Children with a height 40 inches and under should be in a federally approved child restraint seat. [Child Safety Advocates recommend a booster seat from about 40 pounds to about 80 pounds and a height of 57" (4 ft 9 in)]
      - 2. Children with a height over 40 inches, depending on the proper fit of the seatbelt, may be in a federally approved child restraint seat, booster seat, integrated car seat, or seat belt.
    - iv. Violations may result in fines and other legal assessments.
  - b. LHD must assure that local resources are available to families for checking car seats for proper installation.
  - c. To report observation of an unrestrained child in a vehicle call 1-888-235-8KID and give the license plate number of the vehicle.
  - d. For additional information and patient handouts, LHD staff can contact the National Highway Traffic Safety Administration at 1-888-327-4236 or web site [nhtsa.dot.gov/people/injury/child](https://www.nhtsa.dot.gov/people/injury/child).
  - e. Purchasing or providing child safety seats is not a requirement and is optional for LHDs. LHDs should follow local policy regarding car seat loan programs and returns, when applicable.
  - f. LHD's should collaborate with local Safe Kids Coalitions where appropriate.
4. Child Maltreatment is the other leading cause of injury death in KY. All LHD nurses and staff who see pediatric patients must complete a state-approved course on Abusive Head Trauma.

**Minimum Patient Responsibility:**

These are population-based services. The patient has no financial responsibility for these services.

**Services (Arranged and Paid) Include:**

This is a public health service funded through Public Health Block Grant. Staff time (salary/benefits only) for Services as described above may be charged to Cost Center 766, MCH Coordinator. Activities, materials, and additional staff time (not covered by 766), will be funded from the Public Health Block Grant or local funds.

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## Comprehensive Group Diabetes Self-Management Education/Training (DSMES/T)

Diabetes Self-Management Education & Support (DSMES) services facilitate the knowledge, decision-making and skills mastery necessary for optimal diabetes self-care and incorporate the needs, goals, and life experiences of the person with diabetes. The overall objectives of DSMES are to support informed decision making, self-care behaviors, problem-solving, and active collaboration with the health care team to improve clinical outcomes, health status and well-being in a cost-effective manner (Diabetes Care, Supplement 1, 2022).

A DSMES intervention refers to all encounters, engagement, and interactions with the person with diabetes. A DSMES intervention includes individual and/or group sessions and is initiated with an assessment of the individual's current concerns, needs, and priorities to create a DSMES plan of care guided by the person's preferred delivery method and timing. The DSMES plan guides the delivery of sessions, utilizing a variety of methods, while supporting and reinforcing positive self-care behaviors (2022 National Standards of DSMES, 02/2022).

2022 National Standards for Diabetes Self-Management Education and Support

### Healthy Living with Diabetes

The Kentucky Diabetes Prevention and Control Program (KDPCP) has achieved national accreditation from the Association of Diabetes Care and Education Specialists (ADCES) and recognition status from the American Diabetes Association (ADA). The name of Kentucky's program is "Healthy Living with Diabetes, Kentucky Department for Public Health" (HLWD). HLWD is an umbrella DSMES program coordinated by KDPCP state staff in partnership with LHDs who have achieved national accreditation/recognition as part of this program. DSMES services offered through the KDPCP will be offered only through the HLWD Program sites via one of the approved delivery methods, face-to-face, telehealth (virtual), facilitated remote, or telephonic.



- KDPCP guidance states that DSMES is a series of group sessions taught by licensed DSMES team members who are part of Healthy Living with Diabetes and meet accreditation/recognition requirements.
- The content can be taught in one day or over a series of days and includes the minimum topics required by the ADA/ADCES: *Healthy Eating, Being Active, Monitoring, Taking Medications, Problem Solving, Healthy Coping, and Reducing Risk*
- Based on individualized needs, it may be deemed necessary to complete DSMES individually rather than in a group.

### Delivery Methods for DSMES

- Face-to-Face DSMES
  - HLWD branches can provide face-to-face DSMES in their regions when allowable.
  - LHDs who are not part of a HLWD branch/site will promote DSMES by telehealth or Facilitated Remote DSMES (FRDSMES) described below.
- DSMES via /Virtual Models
  - Virtual DSMES is delivered to individuals via their personal device (phone, tablet, or computer).
  - Facilitated Remote DSMES is delivered to an in-person group at a location arranged by a non-HLWD LHD. Diabetes self-management educational content will be provided virtually by a HLWD Educator with local facilitation support (when group activities are

allowed). The partnership between non-HLWD and HLWD programs will be coordinated by State Staff.

- LHDs will be responsible for marketing the telehealth opportunity via their LHD social media platforms or other marketing strategies. A current calendar of virtual DSMES offerings can be found at:

<https://chfs.ky.gov/agencies/dph/dpqi/cdpb/Pages/diabetes.aspx>

**Target Audience:** DSMES/T services will be offered to individuals diagnosed with diabetes and their family members or those at risk for diabetes.

**Staff/Training Requirements:** Only licensed clinical professionals such as RNs and RDs who have completed the KDPCP Training to teach DSMES and are working within an accredited/recognized branch of HLWD are eligible to teach the KDPCP Curriculum. If you are unsure of your eligibility, please contact Becki Thompson for more information on starting the online training process at: [becki.thompson@ky.gov](mailto:becki.thompson@ky.gov).

**Billing/Coding:** If the health department is eligible to bill (i.e., is accredited), and chooses to bill for the service, LHD required forms including HIPAA, Release of Information, and the Patient Encounter Form (PEF) should be utilized. The code **G0109** (diabetes outpatient self-management training services, group session) is the code that should be used. This code is specified in 30-minute units; therefore the appropriate number of units for the time spent should be entered (e.g., if instruction time in a class is 2 hours, the code is G0109 with the number of units being 4). *Contact the [Medicaid MCOs](#), [Medicare](#), or LHD contracted third party carriers for possible limitations on reporting the G0109 code.*

**Cost of Service:** Third party payers should be billed for those patients with Medicaid, Medicare, or another third-party coverage. Patients without third party coverage will be assessed a fee on the [Uniform Sliding Fee schedule](#) in accordance with the rules applied to other LHD health services. *Attendees will be informed that no person will be denied services because of an inability to pay.* The LHD may provide the services at no cost to the attendees, but the LHD *shall not bill any* third parties for those services. If a health department is a Recognized Provider of Diabetes Self-Management Training (DSMT) – Medicare’s terminology for DSMES, and plans to bill Medicare, the Medicare guidelines for DSMT must be followed.

**Record Keeping:** A Class Roster including all participants and their contact information must be completed on each date of class attendance for each attendee **diagnosed with diabetes**. This, along with the associated LHD forms and class documents (assessment, survey, etc.), should be maintained according to LHD policy and HIPAA standards by the primary coordinator of the class series.

**Reporting/Outcome Measurements:** Reporting of DSMES activities will be entered into the diabetes self-management platform utilized by the KDPCP for required reporting and tracking outcomes.

- If the LHD is accredited under the DPH Healthy Living with Diabetes Program, or independently accredited, additional requirements will apply.
- **Contact the Diabetes Program for further information at (502) 564-7996.**

Only health departments who are accredited to provide Diabetes Self-Management Education/Training by the American Diabetes Association (ADA) or the American Association of Diabetes Educators (AADE) – including Healthy Living with Diabetes Branches, are able to bill Medicare for DSMT.

If a health department is a Recognized Provider of DSMT and plans to bill Medicare, the Medicare Guidelines for DSMT must be followed.

**Reference:** [National Standards for Diabetes Self-Management Education and Support](#)

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## Family Planning Program (Title X)

### Title X Background, Program Priorities & Regulations

The Title X Family Planning Program was established in 1970 when Congress enacted Title X of the Public Health Service (PHS) Act and is the only domestic federal program dedicated solely to family planning and related preventive health services. It is administered by the Office of Population Affairs (OPA) within the Office of the Assistant Secretary for Health (OASH) in the United States Department of Health and Human Services (HHS) and implemented through competitively awarded grants to a diverse network of public and private nonprofit health and community-based clinics.

Each year the Office of Population Affairs (OPA) establishes program priorities that represent overarching goals for the Title X program. [Kentucky Family Planning Program](#) project plans are developed to address the OPA designated Title X program priorities. Title X Priorities include all of the legal requirements covered within the [Title X statute, regulations, and legislative mandates](#). All subrecipients must comply with the requirements regarding the provision of family planning services according to [Title X of the Public Health Service Act, 42 U.S.C. § 300 et seq.](#), and implementing regulations.

Expectations regarding the provision of family planning services under Title X are set out in the implementing regulations which govern project grants for family planning services ([42 CFR Part 59, Subpart A](#)). In addition, sterilization of clients as part of the Title X project must be consistent with Public Health Service sterilization regulations ([42 CFR Part 50, Subpart B](#)). Training to support family planning service delivery can be found at ([42 CFR Part 50, Subpart C](#)). Grants administration regulations at [45 CFR Part 75](#) ("Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards") and other relevant regulations also apply to Title X awards. The [2021 Final Rule](#) was effective November 8, 2021.

### Family Planning Services

Family planning services delivered by Title X subrecipients include a broad range of medically approved services, or referral, which includes all Food and Drug Administration approved contraceptive products and natural family planning methods for clients who want to prevent pregnancy and space births; pregnancy testing and counseling; assistance to achieve pregnancy; basic infertility services; sexually transmitted infection services; adolescent-friendly and other preconception health services. Family planning services are provided to females and males in-person or via telehealth.

### Family Planning Funding

The Department for Public Health Family Planning Program allocates awarded federal Title X funds first to local health departments who commit to provide family planning services in their area, then to federally qualified health centers or look-a-like providers in areas where local health departments are not providing services or are providing limited family planning services (See KRS 311.715). Allocations are determined annually based on a formula that includes the availability of funds, the number of unduplicated family planning clients seen in the previous calendar year and the extent of family planning services being provided by the subrecipient. Allocations are automatically reimbursed monthly, dependent upon the adherence of Title X and program requirements, including quarterly submission of the Title X Kentucky Family Planning Quarterly Report

All annual funding is provided through either Memorandum of Agreements with local health departments or through contractual agreements with universities, federally qualified health centers or other healthcare providers.

## **I. Title X Clinical Requirements**

Regardless of the extent of family services provided, Title X subrecipients must adhere to all clinical requirements.

### **A. General Expectations**

1. Family planning services must be voluntary and offered in a competent, non-discriminatory manner, trauma-informed manner, respecting client confidentiality. Services should ensure equitable and quality service delivery consistent with nationally recognized standards of care.
2. Family planning services must be provided without subjecting individuals to any coercion to accept services or to employ or not employ any particular methods of family planning. Any agency who is found to coerce or try to coerce any person may be fined or subject to prosecution.
3. Family planning services must be client-centered care that is respectful of, and responsive to, individual client preferences, needs, and values. Client values should guide all clinical decisions.
4. Family planning services must be inclusive and demonstrate health equity by providing services without regard to religion, race, color, national origin, disability, age, sex, sexual orientation, gender identity, sex characteristics, social position, number of pregnancies or marital status. Cultural and linguistically appropriate services are respectful and responsive to the health beliefs, practices, and needs of diverse patients.
5. Subrecipients may not provide, promote, or encourage abortion as a method of family planning.
6. Title X clinics must have written policies that are consistent with the HHS Office for Civil Rights policy.
7. Subrecipients should provide for coordination and use of referrals and linkages with primary healthcare providers, other providers of healthcare services, local health and welfare departments, hospitals, voluntary agencies, and health services projects supported by other federal programs, who are in close proximity to the Title X site, when feasible, in order to promote holistic health and provide seamless continuum of care including services which may be necessary to facilitate clinic attendance.
8. Subrecipients must provide adolescent-friendly health services. They must encourage family participation in a minor's decision to seek family planning services and, with respect to each minor client, ensure that the records maintained document the action taken to encourage such family participation or the specific reason why family participation was not encouraged. See the 'Services to Adolescents' section for more information regarding care to minors.
9. Family planning services must be provided without the imposition of durational residency or a requirement that the client be referred by a physician. Imposition of durational residency means that family planning services are to be provided regardless of where (county or state) a patient lives or the amount of time lived at the residence. For example, a patient who just moved from another country or another state and lives across county lines shall receive services at any Title X service site.
10. A client's acceptance of family planning services must not be a prerequisite to eligibility for, or receipt of, any other services, assistance from, or participation in, any other program that is offered by the grantee or subrecipient.

11. Individuals may be subject to prosecution if they coerce or endeavor to coerce any person to undergo an abortion or sterilization procedure by threatening such person with loss of, or disqualification for the receipt of, any benefit or service under a program receiving federal finances.
12. Provide for medical services related to family planning (including consultation by a clinical services provider, examination, prescription and continuing supervision, laboratory examination, contraceptive supplies), in-person or via telehealth, and necessary referral to other medical facilities when medically indicated and provide for the effective usage of contraceptive devices and practices.
13. Provide that priority in the provision of services will be given to clients from low-income families.
14. Provide orientation and in-service training for all project personnel.
15. Email FamilyPlanning@ky.gov of any clinic closure, deletions, additions, or changes to the name, location, street address and email, services provided on-site, and contact information for Title X recipients and services sites. Changes must be reported within 30 days of the official change.
16. Enroll in the 340B Program and comply with all 340B Program requirements, including annual recertification and avoiding diversion or duplicate discounts.
17. Acknowledge Title X federal funding when issuing statements, press releases, publications, requests for proposal, bid solicitations and other documents – such as toolkits, resource guides, websites, and presentations.
18. Family Planning clients shall have the opportunity to review or receive *Family Planning Bill of Rights*

## **B. Personnel Requirements**

**Family Planning Providers(s):** A family planning provider is the individual who assumes primary responsibility for assessing a client and documenting services in the client record. Providers include those agency staff that exercise independent judgment as to the services rendered to the client during an encounter. Family planning medical services are performed under the direction of a clinical services provider, with services offered within their scope of practice and allowable under state law, and with special training or experience in family planning. Two general types of providers deliver Title X family planning services: advanced practice providers and other services providers.

1. **Advance Practice Providers** – A medical professional who receives at least a graduate level degree in the relevant medical field and maintains a license to diagnose, treat, and counsel clients. Advance practice providers are physicians, physician assistants, nurse practitioners, certified nurse midwives who are trained and permitted by state-specific regulations to perform *all aspects* of the patient(male and female) physical assessments recommended for contraceptive, related preventive health, and basic infertility care. Advance practice providers should offer client education, counseling, referral, follow-up, and clinical services (physical assessment, treatment, and management) relating to a client’s proposed or adopted method of contraception, general reproductive health, or infertility treatment.
2. **Other Service Providers** – Include other agency staff that provide any level of service to family planning clients. This includes registered nurses (RNs), licensed practical nurses (LPNs), certified nurse assistants, health educators, and social workers.
  - The following duties may be performed by any adequately trained service provider:

- Obtain samples for routine lab tests (e.g., urine, pregnancy, STD, and cholesterol and lipid analysis).
- Perform routine clinical procedures that may include some aspects of the client's physical assessment (blood pressure evaluation).
- Client education, contraceptive counseling, preconception health counseling, referral, or follow-up services relating to the client's proposed or adopted method of contraception, general reproductive health, basic infertility counseling.
- The following duties must be performed by an advance practice provider, RN, or LPN:
  - Provide contraceptive injections (Depo-Provera) and provide contraceptive methods to a client.

### 3. **Certified Comprehensive Reproductive Exam Training (CRET) RN**

- Registered nurses who have completed CRET training and preceptorship are permitted to perform clinical breast exams (CBE), cervical cancer screening (Pap testing and HPV testing), contraception resupply, and male or female STI testing. CRET nurses may refer a client with an abnormal CBE for a diagnostic mammogram. See the Kentucky Women's Cancer Screening Program description for more information.
- Clients will need to be referred to an advanced practice provider for specific gynecological problems, change in current contraceptive method, abnormal cervical screening results, abnormal results in a CBE, and pregnancy counseling.

### 4. **STI Enhanced Role RN**

- Registered nurses who have completed the STI Enhanced Role RN training and preceptorship are permitted to perform adult STI examinations and STI services per the STI program recommendations.

### 5. **Medication Guidelines**

Each local health department shall establish and maintain a medication policy and guidelines for all staff to follow. These guidelines shall be written and developed in accordance to the DPH administrative guidelines for local policy and procedures.

## **C. Client Education, Counseling**

1. Client education and counseling should be client centered. Provide all education and counseling in a culturally competent manner to meet the needs of all clients, regardless of religion, color, national origin, disability, age, sex, sexual orientation, gender identity, sex characteristics, social position, race, number of pregnancies or marital status.
2. Clients must have a reproductive life plan assessment, which outlines personal goals about achieving or avoiding pregnancy. Assessment of reproductive life plan may identify unmet reproductive health care needs. The American College of Obstetricians and Gynecologists strongly supports women's access to comprehensive and culturally appropriate reproductive life planning and encourages providers to use every patient encounter as an opportunity to talk with patients about their pregnancy intentions.
  - If the client indicates that he/she prefers to have a child at a time in the future and is sexually active with no use of contraceptive, offer or refer for contraceptive services.
  - If the client is not pregnant and indicates desire to have a child now, then provide or refer for services to help the client achieve pregnancy.

3. English and Spanish versions of family planning educational materials (FPEMs) are located in the [Forms and Teaching Sheets section of the CSG.Clinical Service Guide \(CSG\)](#).
4. Initiation of a new method of contraception should include education and counseling to help the client understand correct and consistent use, and document client understanding. Provide a follow-up appointment if indicated or if client understanding is not confirmed.

#### **D. Consents**

All consent forms are available in English and Spanish on the [Forms and Teaching Sheets section of the CSG](#).

Special consents are only required for the following family planning methods and procedures:

1. IUD Insertion and/or Removal (ACH-280),
2. Contraceptive Implant Insertion (FP-3) and/or Removal (FP-4), and
3. Sterilization Consent (See *Sterilization* section)

#### **E. Adolescent Services:**

1. Adolescents may consent for reproductive health services without the consent of a parent (KRS 214.185).
2. All adolescents must be counseled on the following:
  - Sexual abstinence is an effective way to prevent pregnancy and STDs.
  - Ways to resist being coerced into engaging in sexual activities.
  - To the extent practical, Title X projects should encourage family participation. However, Title X projects may not require consent of parents or guardians for the provision of services to minors, nor can any Title X project staff notify a parent or guardian before or after a minor has requested and/or received Title X family planning services.
  - Documentation on adolescent counseling must be clearly noted in the medical record. Likewise, documentation should clearly indicate the reason(s) why counseling was not provided.

#### **F. Pregnancy Testing and Counseling**

Title X funds are intended only for family planning (achieving or avoiding pregnancy).

All local health departments receiving any level of Title X funding should offer pregnancy testing. Counseling clients with negative pregnancy results include reproductive life plan, contraceptive methods, and provision of a quick start or other contraceptive or provide a referral for the client to get started on a method of contraception, unless a client desires to achieve pregnancy.

##### **Positive Pregnancy Test Result (42 CFR Part 59.5)**

Confirmation that a family planning client is pregnant should prompt a referral to a healthcare provider for prenatal care. Adequately trained staff who are involved in providing family planning services to a client may provide information and counseling to pregnant clients. Clients with positive pregnancy test results include the opportunity to discuss, if requested by client, prenatal care and delivery; infant care, foster care, or adoption; and pregnancy termination to the extent state law allows.

Any counseling should be neutral, factual information and nondirective.

Any licensed clinic staff may provide the following information and resources:

- A list of licensed, qualified comprehensive primary health care providers, including prenatal care providers;
- A list and/or referral to social services, community agencies and/or adoption agencies;
- Information about maintaining the health of the mother and unborn child during pregnancy.

### **G. Mandatory Reporting Requirements**

Title X subrecipients shall comply with all state and local mandatory reporting laws requiring notification of child abuse, child molestation, sexual abuse, rape, incest, intimate partner violence or human trafficking. A subrecipient must have a plan that can be implemented. The plan should include the following:

- policies and procedures that address obligations of the organization and individuals to comply with mandatory reporting laws;
- adequate annual training of all individuals serving clients;
- documentation in the medical record of the age of a minor client, and the age of the minor client's partner;
- screening for abuse, neglect, and victimization of all clients, especially adolescent/minor clients.

### **H. Confidentiality/No Home Contact**

All information as to personal facts and circumstances obtained by the subrecipient staff about individuals receiving services must be held confidential. Only information necessary to provide services to the patient, or as required by law, may be disclosed without documented consent. Reasonable efforts to collect charges without jeopardizing client confidentiality must be made. Recipient must inform the client of any potential for disclosure of their confidential health information to policyholders where the policyholder is someone other than the client. Confidentiality of information may not be used as a rationale for noncompliance with laws requiring notification or reporting of child abuse, child molestation, sexual abuse, rape incest, intimate partner violence, human trafficking, or similar reporting laws (42 CFR Part 59.10).

Some family planning clients will need an extra layer of confidentiality in place because of personal circumstances. These individuals should be classified as "no home contact" clients and indicated on the PEF and in the PSRS. Local health departments must ensure that no communication (billing, lab results, EOBs, etc.) will be sent to the home of a client marked as "no home contact".

Income and sliding scale fees shall be assessed on a "*no home contact*" client based on the individual's personal income, not household income. Inability to pay shall not be a barrier to treatment; and a billing statement or other communication should never be sent to the client's home. Specific instructions regarding billing procedures for clients designated as "no home contact" can be found in the [Local Health Operations](#) section.

### **I. Information and Education Advisory (I&E) Committee and Community Participation, Education, and Project Promotion Plan Requirements**

Every Title X Family Planning subrecipient, regardless of the level of services provided, is responsible for ensuring any materials made available for family planning clients are reviewed and approved by an I&E Advisory Committee prior to distribution. Subrecipients must also have a Community Participation, Education, and Project Promotion Plan (CPEP) to promote the activities of the local family planning program.

## **Informational and Educational Advisory Committee (I&E)**

Guidance can be found on the [Kentucky Family Planning I&E and CPEP Reference Page](#). Guidance is for any I&E committee, including statewide or local.

District health departments may choose to have one I&E Committee or multiple I&E committees when one committee cannot adequately represent the different populations served. Committee members should be broadly representative of the population or community for which the materials are intended. Considerations should be made in terms of demographic factors such as race, ethnicity, color, national origin, disability, sex, sexual orientation, gender identity, sex characteristics, age, marital status, income, geography, and including but not limited to individuals who belong to underserved communities, members of religious minorities, LGBTQ+ persons, persons who live in rural areas, and persons otherwise adversely affected by persistent poverty or inequality.

**Submit meeting minutes and roster to [FamilyPlanning@ky.gov](mailto:FamilyPlanning@ky.gov) by December 31<sup>st</sup> of each year.**

## **Community Participation, Education, and Project Promotion Plan (CPEP)**

Guidance can be found on the [Kentucky Family Planning I&E and CPEP Reference Page](#).

Title X programs must provide opportunities for community education, participation, and engagement to achieve community understanding of the availability of services, and to promote participation by diverse persons to whom services may be beneficial to ensure access to equitable affordable, client-centered, quality family planning services.

\*During solicitation of clients to serve on committee or to obtain feedback, remind clients that participation on the committee is voluntary, and does not impact the services they receive.

### **J. Training Requirements for Family Planning Staff**

Trainings and time frame requirements are listed on the [Family Planning Training Calendar](#)

### **Billing and Collection**

Title X clients are to be billed according to a sliding fee scale, based on family/household income, using the latest federal Uniform Percentage Guideline Scale in the AR Volume II, PSRS. This schedule reflects discounts for individuals with family incomes based on a sliding fee scale between 100–250% of poverty. Additional billing guidelines include:

- Ensure that the inability to pay is not a barrier to services.
- Be based on a cost analysis of services, bills showing total charges shall be given directly to the patient or another payment source.
- Ensure that patients at or below 100% of poverty are not billed, although obligated third-party payers shall be billed total charges.
- Ensure that discounts for minors requesting confidential services without the involvement of a principal family member are based only on the income of the minor.
- Household income should be assessed before determining whether copayments of additional fees are charged. With regard to insured clients, clients whose family income is at or below 250% FPL should not pay more (in copayments or additional fees) than what they would otherwise pay when the schedule of discounts is applied.

- Clients without adequate contraceptive services coverage from employer-paid insurance should be treated as uninsured for family planning. These charges should be invoiced to the Family Planning Program.
- Maintain reasonable efforts to collect charges without jeopardizing patient confidentiality (see No Home Contact section).
- Allow voluntary donations.
- Ensure that patient income is re-evaluated at least annually and maintain a method for “aging” outstanding accounts. Take reasonable measures to verify client income, without burdening clients from low-income families. Recipients that have lawful access to other valid means of income verification because of the client’s participation in another program may use those data rather than re-verify income or rely solely on clients’ self-report. If a client’s income cannot be verified after reasonable attempts to do so, charges are to be based on the client’s self-reported income.
- Abnormal Pap smear or mammogram follow-up and treatment should be coded to the Women’s Cancer Program 813 cost center, using an appropriate ICD 10 code.
- Self-pay and/or adult vaccines should be placed on a separate PEF from the family planning visit. Vaccines should be full charge and not included in the sliding fee schedule for family planning services. Title X services do not require the provision of vaccines.
- Clients who present for STI testing **only** may be charged \$5.00 per CPT code instead of the sliding scale fee when the sliding scale fee is more than a \$5.00 per CPT code amount. See the PSRS Section for guidelines to override charges.

## **II. Specific Title X Family Planning Services Guidance**

### **A. Contraceptive Services**

Local health departments who choose to provide all family planning services may include a broad range of medically approved services, which includes Food and Drug Administration-approved contraceptive products and natural family planning methods, for clients who want to prevent pregnancy and space births, pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility services, sexually transmitted infection services, and other preconception health services. While the health department does not have to offer every form of contraception, a variety of the most effective contraceptive methods, including, but not limited to IUD, hormonal implant, Depo-Provera, oral contraceptives, hormonal patch and contraceptive vaginal ring should be available either on site, or must be able to provide a prescription to the client for their method of choice or by referral to another provider, as requested. Clients 100% at or below the federal poverty level must not be required to pay for a contraceptive method and should receive the desired method without a cost to the client. Condoms should be made available to all clients as a method of contraception and/or STI prevention.

Contraceptive counseling and education should be provided to all clients and should include information on non-hormonal contraception including, but not limited to, condoms, fertility awareness-based methods and sexual abstinence. Education is an integral component of the contraceptive counseling process that helps clients to make informed decisions and obtain the information they need to use contraceptive methods correctly. See the CSG Family Planning Program section for specific information on contraceptive methods.

### **Sterilization**

- Individuals may be subject to prosecution if they coerce or endeavor to coerce any person to undergo a sterilization procedure by threatening such person with loss of, or disqualification for the receipt of, any benefit or service under a program receiving federal finances.
- Local health departments who choose to provide all family planning services should plan and budget for at least one sterilization annually. A contract should be in place with local providers who can provide a vasectomy or tubal ligation. Contracts with providers for sterilizations must adhere to the federal requirements, including but not limited to the following language: *The federal sterilization Consent For Services form is available in [English](#) and [Spanish](#) shall be signed at least 30 days (no less) prior to the date of surgery. The procedure should be performed within 180 days of signature.*
- If a client of reproductive age is sterilized and desires to continue gynecological or related preventive health services from the site, the encounter is considered a family planning encounter. The agency may continue to count the client as a family planning client.

## **B. Sexually Transmitted Infection Services**

Local health departments receiving any level of Title X funding should offer sexually transmitted infection (STI) testing and treatment. Services should be offered in accordance with STI & HIV testing & treatment clinical protocols in the Clinical Service Guidelines. Family planning STI services include assessment and screening, including the reproductive life plan. STI treatment is provided through the STI Program.

## **C. Achieving Pregnancy and Basic Infertility Services**

A client's clinic visit will include a medical history, reproductive health history, appropriate physical exam, and a reproductive life plan assessment. When a client (male or female) reports difficulty to achieve a desired pregnancy, additional reproductive history should include pertinent screenings related to achieving pregnancy. See the CSG Family Planning Section, and the [CDC Quality Family Planning Services](#). All clients reporting difficulty with achieving pregnancy should be referred to an appropriate advanced practice provider for further evaluation and treatment.

## **D. Preconception Health Services and Preventive Health Services**

Local health departments who choose to provide all family planning services should provide preconception health services and appropriate related preventive health services to female and male family planning clients on site and/or through a contracted provider.

Preconception health services for clients aim to identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcomes through prevention and management of those risks. It promotes the health of women of reproductive age before conception, and thereby helps to reduce pregnancy-related adverse outcomes, such as low birthweight, premature birth, and infant mortality. Preconception health includes a medical history screening and counseling for risks such as tobacco use, substance use, obesity, blood pressure, intimate partner violence, diabetes, immunizations, and depression. See the [CSG](#) for additional guidelines.

Related preventive health services include appropriate health screening and referral for treatment including cervical cytology (Pap testing and HPV co-testing), clinical breast exams, mammograms, etc.

[Providing Quality Family Planning Services](#), Recommendations of CDC and the U.S. Office of Population Affairs *provides* the standards of care and guidelines for all family planning services.

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### **Health Access Nurturing Development Services (HANDS) Program**

**Laws, Regulations, Guidelines:** [902 KAR 4:120](#) Health Access Nurturing Development Services (HANDS) Program

RELATES TO: [KRS 13B.080-13B.160](#), [200.700](#), [211.090](#), [211.180](#), [211.689](#)  
STATUTORY AUTHORITY: [KRS 194A.050\(1\)](#), [211.690](#)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 194A.050(1) requires the secretary of the Cabinet for Health and Family Services to promulgate administrative regulations necessary to operate the programs and fulfill the responsibilities vested in the cabinet. KRS 211.690 authorizes the Cabinet for Health and Family Services to implement a voluntary statewide home visitation program for the purpose of providing assistance to at-risk parents during the prenatal period until the child's third birthday. This administrative regulation establishes the eligibility criteria, services, provider qualifications, and hearing rights for participants of the Health Access Nurturing Development Services (HANDS) Program.

[907 KAR 3:140](#) Coverage and payments for the Health Access Nurturing Development Services (HANDS) Program.

RELATES TO: [KRS 194A.030\(2\)](#), [205.520](#), [211.690](#), 42 U.S.C. 1396a-d, 1396n(g)  
STATUTORY AUTHORITY: [KRS 194A.050\(1\)](#), [205.520\(3\)](#), [205.560](#)

NECESSITY, FUNCTION, AND CONFORMITY: Department for Medicaid Services, has the responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the Cabinet for Health and Family Services by administrative regulation to comply with any requirement that may be imposed, or opportunity presented by federal or state regulation for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes requirements for coverage and payment for Health Access Nurturing Development Services (HANDS) provided through an agreement with the state Title V agency, the DPH.

The HANDS program also has publications on the [HANDS webpage](#) with FAQs and recommended best practice and policies.

**Target Population:** In order to receive HANDS services, an individual shall be a pregnant person who has not reached their 20<sup>th</sup> birthday; a pregnant person who is at least 20 years old and a risk is deemed likely for the pregnancy or the infant; an infant up to 90 days of age whose parent/legal guardian is determined to be at risk. HANDS services consist of the following services: a screening to determine eligibility of an applicant in a face-to-face interview. If an individual's screening indicates eligibility for HANDS services, the individual shall be referred for a comprehensive needs assessment conducted by a social worker, or a registered nurse employed directly or contracted by the LHD. If the assessment results in a determination that the individual meets the criteria, home visitation services shall be

provided. The frequency of services shall be provided in accordance with the level of need of the parent or family and shall lessen as the family meets goals agreed to by the provider and the participant.

**Funding:** HANDS is a multi-funded program that includes state general funds, Master Tobacco Settlement funds, Medicaid reimbursement and federal grant funds. The Kentucky Early Childhood Advisory Council (ECAC) designates state funding through the Tobacco Settlement dollars to the HANDS program. Amounts vary each year but average around \$7.5 million dollars. The HANDS program is fee-for-service.

**Staff/Provider Requirements:** The assessment or professional home visits shall be conducted by a social worker, a registered nurse, or a graduate of a four-year program in a human service or a related field with one year experience performing case management services. A master's degree in a human services field may be substituted for the one-year experience. This employee may conduct any HANDS services. A Family Support Worker, who conducts regularly scheduled home visits, shall be high school graduate or holder of a GED who is at least 18 years of age and has received specialized training in HANDS practices and curriculum and is supervised by a public health nurse or licensed social worker.

**Training:** for all staff engaging in home visitation is required. Completion of Core and [Growing Great Kids® \(GGK®\)](#) Curriculum trainings are the beginning of the learning process. Core training provides the philosophical foundation and the how-to strategies and opportunities for practice in areas pertinent to implementation/delivery of HANDS services. GGK® is the curriculum training which focuses basic care, social and emotional development, cues and communications, physical and brain development and how to stimulate development through play. To maintain program effectiveness, staff must maintain and expand upon existing skills. Opportunities to continue growth and development of skills occur through supervision, wraparound and advanced training components.

**Reporting Requirements:** All HANDS sites have requirements to enter all client participation information into the HANDS web-based application. The HANDS web-based application adheres to specific business rules of the HANDS *Program*, and is designed to offer an intuitive, user-friendly, and convenient web-system for HANDS sites to use. All HANDS participant information is to be submitted into the HANDS web-based application before the first Wednesday of the following month.

**Billing and Coding Procedures Specific to Program:** HANDS is not based on income. It requires billing to the proper payor source. Billing and collection procedures are as follows:

- At the [determination of Medicaid eligibility](#), sites will bill Medicaid directly through the HANDS 2.0 web-based application.
- Submit billing using Parent/Legal Guardian (1)'s eligibility until birth of the baby.
- Submit billing using infant's eligibility the day of and after birth.
- If ineligible for Medicaid, federal grant, or state funding (tobacco) picks up the cost.
- Only one billable service per day may be billed per family.
- The fee for the service program reimburses LHDs on a monthly basis.

**Program Specific Requirements:** All sites must use the Growing Great Kids® Curriculum, provide quarterly visits utilizing the Helping HANDS for Healthy Homes resources, screen for developmental delays, , screen for perinatal depression, complete home safety checklist,

assess child and family interactions, support families working toward identified goals, make referrals to appropriate agencies and meet all documentation policies.

**Service Description & Key Roles & Responsibilities Of Health Department:** All HANDS eligible parent/legal guardian's will be screened as early in pregnancy as feasible or until the infant is 90 days of age, using a universal screening assessment for indicated "stress factors" with the following procedures:

1. Screens can be completed by HANDS staff who are appropriately trained.
2. Screens are completed on Parent/Legal Guardian (1).
3. HANDS staff must get the HANDS Screen Consent form completed and signed by the parent or legal guardian **before** the screening process can be completed.
  - *When the child is in temporary custody, the screen must be done with the birth parent(s).*
4. HANDS staff must complete the HANDS Screen for primary risk factors and determine the score.
5. All completed screens will be kept on file at the Local Implementing Agency (LIA).
6. All negative screens will be offered community resources that support pregnancies, newborns, infants and/or toddlers.
7. If Parent/Legal Guardian (1) is less than 20 years of age (teen parent) and the HANDS Screen is negative, they shall be offered an assessment to determine eligibility for high-intensity home visitation services. When a teen parent refuses the assessment, the LIA must then offer monthly home visits until the infant is one year of age.
8. All refused screens will:
  - Be compiled together in a separate file, in a locked cabinet with the HANDS charts.
  - Not be filed in the medical chart.
  - Not be entered in the HANDS web-based system.
  - Be counted on an annual basis, with this number being provided at the annual site visit.
9. Completed positive screens must be filed in the mother's chart.
10. All negative screens must be filed in a secure location for five (5) years.

Assessments shall be offered to families with a positive screen, not to exceed 90 days of birth for the infant, by a professional home visitor who shall:

1. Contact the family, within five (5) business days, not to exceed thirty (30) calendar days of receiving the screen to set up the assessment visit.
2. Make a minimum of three (3) attempts to schedule the assessment.
3. Gather information from the parent/legal guardian(s) through a face-to-face contact:
  - With the baby present if occurring postnatally.
  - With the home visit being a minimum of 30 minutes.
  - Completing required documentation.
  - The assessment can be completed on both parents separately but can only be billed for one.
  - The home visitor can use the information given by the parent(s)/legal guardian(s), or other information documented (i. e. in their LHD medical

record) to complete the assessment. Must note where this information was obtained.

- If only one parent/legal guardian is present for the assessment, information about the absent parent/legal guardian is to be gathered from the parent/legal guardian participating in the assessment.
  - If the baby is in Neonatal Intensive Care Unit (NICU), the assessment can be done with the parent/legal guardian; but cannot be billed because the baby is not present.
- 4 Provide a referral packet to all families participating in the assessment process.
  - 5 Score the assessment and complete documentation within 1 business day of intake.

Participation in Home Visiting Services is voluntary. Families may receive home visiting services until a child is:

- One (1) year of age for low intensity services (Teen Only).
  - Two (2) years of age for high intensity services (Adults and Teens).
  - Three (3) years of age, if the family remains on Level-1 when the child reaches two (2) years of age.
- 
- If positive (a score where either or both parents score 25 or above; does not have to be the first-time parent):
    - All families should be offered information and referral to appropriate community resources and intensive home visitation services based on availability within caseloads.
    - If intake is closed (no FSW Services available), the Parent Visitor will make appropriate referrals to other community resources. Should services become available within the twelve (12) weeks, services should be offered to these families. (Also see V-E, page 5 of 6 – next page)
  - If negative (a score where both parents score below 25):
    - All adult parents will be provided with information on community agencies and referrals are made for services as needed.
    - All teen parents will be referred for monthly home visitation to occur until the infant is one (1) year of age.
    - Teens who initially screened negative can be surveyed at any time before the infant reaches twelve (12) weeks of age and offered high intensity home visitation services if survey is positive.
  - In the event that Home Visiting is not offered or refused:
    - The Parent Visitor will make referrals to appropriate agencies based on concerns learned during the Parent Survey Process.
    - Provide the family with a resource packet.
    - If family refused home visitation and the child is not born at time of Parent Survey, the family will be asked if HANDS can contact them once the baby is born to see if they would be interested in home visiting services at that time or family can contact HANDS if they reconsider.
4. Attend monthly team meetings.

Participation in Home Visiting Services is voluntary. Families may receive home visiting services until a child is:

- One (1) year of age for low intensity services (Teen Only).
- Two (2) years of age for high intensity services (Adults and Teens).
- Upon Completion of family goals (Level 4).
- Three (3) years of age if the family remains on Level-1 when the child reaches two (2) years of age.

Upon acceptance of Home Visiting Services families will:

1. Complete the Consent for Services and
2. Complete the Consent Packet for:
  - Parent prenatal; and
  - Baby postnatal.
3. Be assigned an Ongoing Home Visitor through the LIA by a designated staff person, within 2 business days after a positive assessment based upon:
  - Caseload weight / caseload availability;
  - Matching needs of families to the level of experience and skills of the home visitor;
  - Cultural diversity issues (example: a Spanish speaking home visitor will be more equipped to work with a family who predominantly speaks Spanish in the home); and
  - Geographic location of the families (especially for LIAs serving multiple counties).
4. The home visitor will make contact with the family within 2 business days after completion of the assessment to schedule first home visit:
 

The home visit shall be completed within seven (7) business days of a positive assessment. The home visitor shall complete the required documentation within one (1) business day.

Remember to update pertinent information such as, child's social security number and Medicaid eligibility when applicable.

- The home visitor will schedule on-going home visits with the family per the family's assigned Level and complete required documentation within one (1) business day.

Families accepting services will be offered home visits using the required Growing Great Kids® (GGK®) curriculum. With intensity being determined by the Supervisor and Family Support Worker, based on the criteria outlined on the Level Sheet.

HANDS Supervisors are vital to program success. Reflective supervision provides the foundation upon which successful strategies are built to engage families and keep them interested in HANDS. The supervisor and the home visitor can develop successful strategies for completing visits and discuss addressing concerns with families the worker is having difficulty engaging.

**Minimum Patient Responsibilities:** HANDS is a voluntary service where the only participation requirements are that the parent/legal guardian is in the state of Kentucky, the child is present and 75% of all services occur in the home.

**Services (Arranged and Paid) Include:** HANDS is a *fee for services* program that is contracted with the LHDs and three private agencies: [Lexington Family Care Center](#) (Lexington, KY); [Family and Children's Place](#) (Louisville, KY); and [Every Child Succeeds](#) (Northern KY/Cincinnati, OH area).

## KDPH Harm Reduction Program

The KDPH Harm Reduction Program is housed within the Division of Public Health Protection and Safety. Harm reduction is a set of ideas aimed at reducing negative consequences associated with substance misuse for individuals, their families, and communities by meeting people where they are. The practice extends to many services including disease prevention, syringe exchange, safer use practices and linking people to housing, food access, insurance, medical care, substance use treatment and behavioral health services. Harm reduction practices are used by everybody, every day.

**Harm Reduction Program Funding:**

Kentucky Opioid Response Effort (KORE)

Substance Abuse and Mental Health Services Administration (SAMHSA)

Overdose Data to Action (OD2A)

Strengthening Public Health Infrastructure

**KDPH Harm Reduction Advisory Committee:**

The Harm Reduction Advisory Committee, established in January 2023, will provide guidance to support the Kentucky Department for Public Health’s (KDPH’s) Harm Reduction Program efforts in reducing the negative consequences associated with substance use, misuse, and abuse for marginalized and underserved populations throughout the state of Kentucky. Committee membership consists of designated personnel from the Kentucky Opioid Response Effort (KORE), KDPH’s Commissioner’s Office and designated program personnel from four (4) out of the seven (7) divisions located within KDPH to include, Maternal and Child Health, Women’s Health, Public Health Protection and Safety, and Epidemiology and Health Planning:

- a. Center for Foundational Health
- b. Family Planning
- c. Harm Reduction Program
- d. Health Equity
- e. Viral Hepatitis
- f. HIV/AIDS
- g. Immunizations
- h. Kentucky Perinatal Quality Collaborative
- i. Maternal Mortality Review
- j. Neonatal Abstinence Syndrome
- k. School Health
- l. STD
- m. TB

**Naloxone:**

Naloxone is a prescription medication that can reverse an overdose that is caused by an opioid drug. When administered during an overdose, naloxone blocks the effects of opioids on the brain and restores breathing. It can be given as an injection into a muscle or as a nasal spray.

Pharmacists are uniquely positioned to help reduce morbidity and mortality associated with opioid overdose by dispensing naloxone to at-risk patients or their friends and family

members and educating them on the proper use of these products. This non-patient specific prescription (standing order) authorized by the Kentucky Department for Public Health (KDPH) establishes the protocol that allows Kentucky-licensed naloxone protocol trained pharmacists to dispense naloxone to at-risk patients and third parties in pharmacies located in Kentucky.

### **Syringe Services Programs:**

Syringe services programs (SSP), also known as syringe exchange programs (SEP), have existed and been studied extensively in the United States since 1988. Community-based SSPs provide access to sterile needles and syringes free of cost, facilitate safe disposal of used needles and syringes and offer safer injection education. SSPs in Kentucky also provide participants with access to critical services and programs, including substance use disorder treatment programs; overdose prevention education; screening, care and treatment for HIV and viral hepatitis; prevention of mother-to-child transmission; hepatitis A and hepatitis B vaccination; screening for other sexually transmitted diseases and tuberculosis; partner services; and other medical, social and mental health services.

### **Harm Reduction Laws and Regulations:**

Harm reduction services are provided at many local health departments in Kentucky as established in [Senate Bill 192](#). Services are available free of cost to any person who uses drugs, regardless of method. These programs are a great resource to obtain harm reduction supplies such as sterile syringes, naloxone, wound care kits and fentanyl test strips. Additionally, these programs provide linkages to critical services and programs, including substance use treatment, HIV and viral hepatitis screening, vaccinations, social and behavioral health services, employment opportunities and other clinical and social programs. For more information about legality, please see [KRS 218A](#).

### **KDPH SSP Guidelines:**

[Long Version](#)

[Short Version](#)

### **Recommended Best Practices for Effective Syringe Service Programs in the United States**

SSPs are central to reducing disease and other health burdens among people who inject illicit drugs. Three decades of research has demonstrated the effectiveness of SSPs in preventing HIV and other blood-borne infections, as well as connecting people who inject drugs with a range of vital medical and social services and supports. Recommended Best Practices Report from the New York City Department of Health and Mental Hygiene with the Drug Policy Alliance summarizes the consensus among United States SSP experts of the underlying principles and programmatic elements that enable or constrain SSP effectiveness. Effective SSPs have the support of local governing bodies and match sound operational characteristics with responsiveness to the unique features of their host communities. New or expanding SSPs may benefit from technical assistance from the considerable expertise of those experienced in operating SSPs around the country. The panel highlighted operational characteristics that are critical for effective SSPs, and measures to be avoided because they undermine the primary goal of SSPs: to make new, sterile syringes available to Persons Who Inject Drugs (PWIDs).

### **Kentucky Harm Reduction Summit:**

[2021 and 2022 Session Recordings](#)  
[2020, 2021, and 2022 Endured Materials](#)

**Harm Reduction Billing Procedures:**

Cost Center 734 Allocations: Expenses related to Harm Reduction Expansion Project Awardees  
Cost Center 729 Allocations: Expenses related to Fentanyl Test Strips

**Harm Reduction Request Forms:**

[Kentucky Drug Overdose Alert System \(KDOAS\) Contact Request](#)  
[Fentanyl Test Strip Request for Approval](#)  
[First Responders – Comprehensive Addiction and Recovery Act \(FR-CARA\) Naloxone Request](#)  
[FR-CARA Naloxbox Request](#)  
[LHD Naloxone Request](#)  
[Office of Drug Control Policy \(ODCP\) Law Enforcement Naloxone Request](#)  
[Kentucky SSP REDCap Data Request](#)  
[Kentucky Harm Reduction Contact List Request](#)  
[Mobile Harm Reduction Unit Request Form](#)

**Harm Reduction Reporting Requirements:**

KDPH SSP REDCap Survey  
[Fentanyl Test Strips Monthly Distribution Report](#)  
[LHD Naloxone Distribution Data Collection Form](#)

**KDPH Harm Reduction Partners:**

[Kentucky Injury Prevention and Research Center \(KIPRC\)](#)  
[Drug Overdose County Profiles](#)  
[Kentucky Opioid Response Effort](#)  
[Kentucky Office of Drug Control Policy](#)  
[Prescription Drug Disposal Program](#)  
[Kentucky Harm Reduction Coalition](#)  
[VOCAL Kentucky](#)  
[Kentucky Income Reinvestment Program \(KIRP\)](#)  
[Kentucky Pharmacists Association \(KPhA\)](#)  
[FindHelpNowKY.org](#)  
[FindRecoveryHousingNowKY.org](#)

**Harm Reduction Resources:**

[KDPH Harm Reduction Program](#)  
[KDPH SSP Webpage](#)  
[National Harm Reduction Coalition](#)  
[Substance Abuse and Mental Health Services Administration \(SAMHSA\) Harm Reduction](#)  
[CDC SSP Fact Sheet](#)

## **Child Care Health Consultation for a *Healthy Start* in Child Care**

**Laws, Regulations, Guidelines:** 902 KAR 4:130. Healthy Start in Childcare Program.

RELATES TO: KRS 199.892-199.896

STATUTORY AUTHORITY: KRS 194A.050, 211.180

NECESSITY, FUNCTION, AND CONFORMITY: KRS 199.8945 authorizes the Cabinet for Health Services to implement a Healthy Start in Childcare Program for the purpose of improving the quality of care specific to health, safety, and nutrition of children in childcare. This administrative regulation establishes the services provided by the Healthy Start in Childcare Program and the requirements for organizations and individuals that provide these services.

Implemented in July 2000, Healthy Start in Child Care is a Kids NOW Initiative to provide consultation on health, safety, and nutrition to childcare providers. Trained Healthy Start Child Care Consultants from the LHDs participate in joint activities with the resource and referral agencies in their area to ensure collaboration and coordination regarding health, safety and nutrition issues impacting the quality of childcare. During the first five years, children of full-time working parents may spend more time in out-of-home childcare facilities than the total hours spent in school from kindergarten to high school. This makes it critical to utilize this window of opportunity to provide accurate health, safety and nutrition information to parents and childcare providers.

**Target Population:** Children and their families receiving out of home care including licensed child care centers and certified family care homes.

**Funding:** DPH provides allocations to LHDs awarded funding through RFA process.

**Staff/Provider Requirements:** A Bachelor of Arts or Bachelor of Science degree from an accredited college or university;

- Registered Nurse; or
- A public health administrator

**Training:** Healthy Start in Childcare Consultants are required to complete an intensive training based on the standardized curriculum of the National Institute for Childcare Health Consultants.

- "Fundamentals of Effective Training" Seminar (15 hours) which leads to a Kentucky Early Childhood Trainer's Credential
- Required to attend the 1-day orientation course for Early Childhood Trainers as prerequisite for the Trainer's Credential

**Reporting Requirements:** Consultants shall complete monthly hardcopy reporting forms, DPH identified web-based data entry, and designated DPH reporting forms for program pilots such as asthma, obesity prevention, etc.

**Service Description & Key Roles & Responsibilities Of Health Department:** *To provide 1.0 FTE Consultant providing Child Care Health Consultants (CCHC) Program responsibilities below:*

- Provide consultation to licensed childcare centers and certified family homes on health, safety, nutrition, and social/emotional issues.
- Collaborate with the CCHC Technical Assistance Center (and DPH Central Office staff) who will act as a triage point/referral source and may call upon a Consultant to assist follow-up phone consultation or limited on-site consultation.
- Travel beyond county or district as necessary to assist in the consultation and training of licensed childcare center or certified family homes in need of on-site consultation per the direction from LFHD Technical Assistants/Trainers, Central Office Staff, or through collaboration with other statewide Consultants.
- Collaborate with local Child Care Resource and Referral agencies to develop or enhance existing relationship to provide consultation and training to licensed childcare centers and certified family homes.
- Have Early Care and Education Trainer's Credential from the Division of Child Care and provide trainings and technical assistance to childcare providers and other community partners as appropriate.
- Provide consultation to childcare providers asking for assistance with social emotional issues. [Training and resources to be provided by the state CCHC Technical Assistance Center].
- Demonstrate knowledge of appropriate local referral agencies or other sources that could assist the childcare provider or individual family's needs with social and emotional issues. Make a follow up contact with both provider and referral source.
- Coordinate or participate in area meetings (face to face, teleconference, list serves, etc.) with surrounding early childhood professionals (CCR&R, CECC, ECMH Specialist, IMPACT RIAC, LIAC, etc.) to collaborate training efforts within the CCHC Program, as well as with other child serving agencies.
- Assist with consultation and training in providing support for early care and education centers working toward a STARS rating or improving a STARS rating.
- Assist with consultation and referrals from the Office of Inspector General or Division of Regulated Child Care of centers and homes with deficiencies in health and safety.
- Attend quarterly trainings (at least 2 face to face) and mandatory training per Central Office staff.
- Complete web-based data reports and adhere to requirements for data entry by Central Office staff as revisions are made to improve the measurable outcomes for this program.

**Services (Arranged and Paid) Include:** Consultation by phone or on-site at the childcare program and group trainings.

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### **Viral Hepatitis Prevention Coordinator (AVHPC) Program**

The Viral Hepatitis Program (VHP) provides the technical expertise necessary for the management and coordination of activities directed toward prevention of viral hepatitis infections and integration of viral hepatitis prevention services into healthcare settings and public health programs (e.g., STD, HIV, immunization, correctional health, substance abuse treatment, syringe exchange) that serve adults at risk for viral hepatitis.

**Laws, Regulations, Guidelines:** [KRS 214.187 Statewide hepatitis C education, awareness, and information program](#), directs that DPH shall develop a statewide education, awareness, and information program on hepatitis C. The program may be incorporated into other existing health education programs.

**Target Population:** Serves all populations but especially those who have or who are at risk for: Sexually Transmitted Diseases (STD)/Sexually Transmitted Infections (STI), Men who have sex with men (MSM), HIV/AIDS, and individuals with substance use disorder (SUD), especially persons who inject drugs (PWID). Settings include all health care facilities, corrections, Hemodialysis clinics, and long-term care facilities.

**Funding:** Funded by the Centers for Disease Control and Prevention. The Viral Hepatitis Program is in the Cabinet for Health and Family Services, Kentucky DPH, Epidemiology and Health Planning Division.

**Staff/Provider Requirements:** Review the requirements for a [health department registered nurse](#). Contact the [Local Health Personnel Branch](#) for clarification.

**Training:** Participate in continuing education efforts regarding viral hepatitis from KDPH.

**Reporting Requirements:** DPH is required to periodically report to the Interim Joint Committee on Health and Welfare on the status of the "statewide Hepatitis C education, awareness, and information program. LHD staff will continue surveillance efforts for acute hepatitis cases by reporting to Kentucky DPH Reportable Diseases section.

**Other Special Requirements:** Continue to offer counseling, screening, and testing referral to clients requesting information on viral hepatitis or clients who are in a high-risk population for viral hepatitis.

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## Kentucky HIV/AIDS Section

**Laws, Regulations, Guidelines:** The [Kentucky DPH HIV/AIDS Section](#) assesses the current and future impact of HIV in Kentucky. The section is composed of Surveillance, Prevention, Ending the HIV Epidemic (EHE) and Ryan White Part B Service programs.

State regulation [902 KAR 2:020](#) requires testing facilities to report HIV and AIDS cases to Kentucky DPH HIV/AIDS Surveillance within five (5) business days of diagnosis. The Surveillance program is responsible for the documentation, investigation, and maintenance of the HIV/AIDS cases reported by HIV testing entities.

The Prevention program provides HIV prevention services (such as testing, education, awareness, outreach and interventions) to those at risk for infection and technical assistance and expert support to trained professionals providing interventions. The HIV/AIDS Continuing Education program follows [KRS 214.605/610/620/625/650](#) by reviewing and approving continuing education courses.

The EHE program works to reduce new HIV infections in the commonwealth with an overall goal of ending the epidemic by 2030. The EHE initiative has identified effective strategies, organized into four (4) pillars - diagnose, treat, prevent and respond to guide program efforts.

The Services program receives the Ryan White Treatment Extension Act, Part B Grant. The Ryan White Program (otherwise known as the Services program) is a federal mandate that was created to address health care and service needs of persons with HIV (PWH). The intent of the Services program is to facilitate the provision of quality care and services to PWH in a timely manner that is consistent across a continuum of care. These services are mainly provided via

a network of programs established at local health departments (LHD), local clinics and community-based organizations in various regions of the state.

Other statutes regarding testing and confidentiality issues are dictated by:

[KRS 214.181](#) (General consent to testing for HIV – Emergency procedures -- Disclosures of test results -- Voluntary testing programs in each county.)

[KRS 214.625](#) (Consent for medical procedures and tests including HIV infection -- Physician's responsibility -- Confidentiality of results -- Exceptions -- Disclosure -- Network of voluntary HIV testing programs.)

[KRS 214.995](#) (Penalties for disclosure of HIV test results or identity of person upon whom test is performed -- Exceptions.)

[KRS 218A.500 §5](#) (LHDs may operate a substance abuse treatment outreach program which allows participants to exchange hypodermic needles and syringes.)

[KRS 438.250](#) (Mandatory testing for HIV, hepatitis B and C, tuberculosis, and other diseases for criminal defendants, inmates, and state patients under specified conditions -- Effect of refusal to be tested -- Costs.)

[KRS 510.320](#) (HIV testing for defendants accused of certain sexual offenses -- Results -- Counseling when test positive -- Cost -- Effect of appeal.)

[KRS 529.090](#) (Person convicted required to submit to screening for HIV infection -- Prostitution or procuring prostitution with knowledge of sexually transmitted disease or HIV.)

[KRS 635.110](#) (HIV testing for juveniles accused of certain sexual offenses -- Results - - Counseling when test positive.)

[23RS HB 349](#) (Allows for HIV self-testing kits effective June 29, 2023.)

**Target Population:** The HIV/AIDS section serves all citizens of the commonwealth by providing education and resources to ensure that -

- All people at risk for HIV infection know their sero-status;
- Those who are not infected with HIV remain uninfected;
- Those infected with HIV do not transmit HIV to others;
- Health department personnel, health educators, nurses, allied health professionals, counselors, case managers, social service and other community-based agency staff, HIV/AIDS educators, mental health and substance abuse counselors, social workers, teachers, and HIV/STD/STI counseling and testing personnel attain needed training and skills for provision of timely and quality services to populations impacted by HIV disease..

**Funding:** The programs within the HIV/AIDS section are predominately federally funded from the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). Contracts and Memoranda of Agreements are negotiated with various community-based organizations, universities and LHDs to provide HIV/AIDS Prevention, Surveillance, EHE and Services throughout the state.

**Training:** All HIV/AIDS section staff and other non-health care staff conducting HIV testing are required to complete the Implementing HIV Testing in Nonclinical Settings course.

- Commonwealth of Kentucky HIV continuing education requirements are per [KRS 214.605/610/620/625/650](#).

**The HIV/AIDS Prevention and EHE Programs:** Report client demographics and encounters through the EvaluationWeb database. All contractors provide client data to the Prevention team, who inputs the information into EvaluationWeb.

- Receives HIV test forms from all counseling and testing sites, including LHDs.
- All HIV testing contractors and LHDs are expected to provide linkage to care information for persons testing positive for HIV disease and pre-exposure prophylaxis (PrEP) resources, as appropriate, for persons screening negative for HIV infection.

**The HIV/AIDS Services and EHE Programs:** Report client demographic and service utilization through the CAREWare Database.

**The HIV/AIDS Surveillance Program:** Reports HIV and AIDS cases by way of the CDC enhanced HIV/AIDS Reporting System (eHARS) Database.

**Billing and Coding Procedures Specific to the Program:** *The HIV/AIDS section does not charge a fee for service.* HIV/AIDS programs will be provided without regard to religion, race, color, national origin, sexual orientation, disability, age, sex, number of pregnancies or marital status.

**Other Special Requirements:** The HIV/AIDS section follows [42 CFR 59.11](#) in regards to confidentiality.

**Advisory Council Requirement:** The Kentucky HIV/AIDS Planning and Advisory Council (KHPAC) is a body appointed through the Secretary of CHFS to carry out the provisions of [KRS 214.640](#), the CDC's HIV Prevention Community Planning Guidance, and HRSA's Planning Bodies Manual. KHPAC works in collaboration with the HIV/AIDS section of the Kentucky DPH to advise regarding HIV/AIDS Prevention activities, Services, EHE strategic planning and policies designed to meet the needs of the people of the Commonwealth of Kentucky.

KHPAC consists of the commissioners of the departments for Public Health and Medicaid Services, and up to 28 additional appointed members who represent HIV/AIDS stakeholders, including people with HIV/AIDS, high-risk populations, AIDS service providers, HIV/AIDS prevention workers, mental health providers, community-based organizations and friends and family of people with HIV/AIDS.

**All Kentucky LHDs shall:**

Collaborate with the HIV/AIDS [Prevention Program](#) to:

- Provide information on HIV which shall include but not be limited to methods of transmission and prevention.
- Provide anonymous and confidential HIV/AIDS testing.
- Provide pre and post-test counseling.
- Provide partner counseling and referrals for the sex and needle sharing partners of persons who test positive for HIV.
- Submit HIV test forms to the HIV/AIDS Prevention program on a twice monthly basis.

Collaborate with the HIV/AIDS Surveillance Program to:

- Report all HIV and AIDS cases as mandated by Kentucky Reportable Disease Surveillance Regulation ([902 KAR 2:020](#)). Kentucky requires HIV to be reported by name; address; date of birth; sex; race/ethnicity; risk factor as identified by CDC; county of residence; name of facility submitting report; date and type of HIV test performed; results of CD4+ cell count and CD4+%; results of viral load testing; results of RNA, DNA, HIV culture, HIV antigen and HIV antibody if performed; result of TB testing if available; results of previous HIV testing; history of PrEP or PEP treatment; antiretroviral treatment; HIV status of person's partner, spouse or children; current pregnancy status for females; opportunistic infections diagnosed; and date of onset of illness.
- Report HIV and AIDS cases to the Kentucky HIV/AIDS Surveillance program within five (5) business days using the Adult or Pediatric HIV Confidential Case Report Form.
- Know how to report a case, how to ascertain a client's risk factor and the latest HIV/AIDS Statistics. This information may be found on the HIV/AIDS Section [Reporting and Statistics webpage](#).

Collaborate with the [HIV/AIDS Ryan White Part B Services Program](#) to:

- Refer all individuals testing positive for HIV, to the respective Ryan White funded Care Coordinator Region.

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### **Kentucky HIV/AIDS Care Coordinator Program (KHCCP) - Client Eligibility Guidelines:**

Clients applying for eligibility for the [Kentucky HIV/AIDS Care Coordinator Program](#) (KHCCP), the [Kentucky AIDS Drug Assistance Program](#) (KADAP) and/or the [Kentucky Health Insurance Continuation Program](#) (KHICP) must meet all of the following:

1. Household Income – The income of ALL individuals over the age of 15 (e.g., the client, a spouse, partner, or family/non-family members that reside together) that occupy a single residence are included in the household income. The income MUST be verified.

EXCEPTION: If an individual does not directly contribute toward the daily living expenses of the other people within the residence (i.e. someone who rents a room, apartment, house, etc. and pays his/her own bills and living expenses separate from the other people that occupy that room, apartment, house, etc.).

Individuals must be at or below 500% of the federal poverty level, adjusted for family size to be eligible under Ryan White funds. Individuals above 500% of the federal poverty level may be eligible under EHE funds. Income must be verified by one of the following:

- Two (2) most recent pay stubs;
  - Most recent W-2 Forms; or
  - Award letter from Social Security Disability/Supplemental Security Income;
  - Check stub from Social Security Disability/Supplemental Security Income; or
  - A signed statement of no income for client(s) who report having no income. Individuals having no income must state how he/she is meeting the needs of daily living.
2. Be HIV positive: Provide complete name-linked verification of HIV+ status within 30 days of initiating the initial interview. The following items may be used to verify HIV status:
    - Positive confidential Western Blot test result; or

- Using the medical documentation form, obtain a signed and dated written statement from a medical care provider; or
  - A counseling and testing counselor may sign and verify HIV status; or
  - A discharge summary or other hospital record that verifies diagnosis; or
  - Medicaid or Social Security document that verifies diagnosis.
3. Be a current resident of the state of Kentucky verified by one of the following, and client verification MUST match the home address record:
    - Valid Kentucky driver's license or state identification card;
    - Copy of a signed lease agreement;
    - Current utility bill; or
    - Statement from the person providing room and board.
  4. Sign and date the *Informed Participation Agreement* form and the agency's *Release of Information* form.
  5. Provide sufficient factual information to complete the initial Intake and Assessment form within 30 days of the initial review.
  6. Agree to participate in the development of the Individualized Care Plan (ICP): Client to cooperate with the interventions, goals, and objectives of the plan; and agree to abide by the established guidelines for conduct.
  7. Provide documentation of health insurance including Medicaid/Medicare and private health coverage, if applicable. Eligibility for [KHICP](#) must meet all of the following criteria:
    - Meet all of the program eligibility requirements listed above.
    - Must have a prescription rider as part of their health insurance policy.
    - For a family to be eligible for a family plan, at least two (2) family members must be HIV positive.
  8. Clients **must** provide a copy of a current receipt or current bill to be eligible for any/all financial assistance from KHCCP.
  9. Incarcerated individuals at the state and federal level who are incarcerated for a period not to exceed 30 days may remain eligible for KHCCP. Clients who are incarcerated for a period greater than 30 days will be documented closed in the client's file and will not be eligible for any care coordinator services during the period they are incarcerated.

A client may re-apply for the KHCCP once released from federal/state jail/prison or within 30 days of release date. If re-application is approved, the client will be eligible for services upon being released from incarceration. The client must provide documentation of residency before eligibility for any monetary assistance (other than case management).

Kentucky Ryan White Part B/ADAP is permitted to provide clinical care and support services to persons with HIV in local jails for those who reside in local jails that have an agreement in place with KDPH.

10. KHCCP is largely a federally funded program and is considered the payor of last resort. Financial assistance is NOT guaranteed. Funding is limited and services may be terminated without cause.

11. Falsification of any information/documentation by any client is grounds for immediate termination without the possibility of reinstatement.

### **Reinstatement Policy:**

Clients who have been dismissed from the Kentucky HIV/AIDS Care Coordinator Program (KHCCP) have the right to reapply to the KHCCP six (6) months after the date of their dismissal, not including the exceptions noted below. It is the client's responsibility to make contact with their respective Care Coordinator Region in order to reapply for the KHCCP after the six (6) month period. Once the client is reinstated into the KHCCP, if, at any time, the client does not adhere to his/her responsibilities outlined within the KHCCP Informed Participation Agreement and the Client Responsibilities Agreement, the client will be dismissed from the KHCCP for a period of one (1) year.

The client may, once again, reapply to the KHCCP by contacting their respective Care Coordinator Region one (1) year from the date of dismissal. Clients must meet all of the eligibility criteria and provide the necessary documentation in order to be considered, at any time, for participation in the KHCCP. If at any time the client does not adhere to his/her responsibilities as outlined within the KHCCP Informed Participation agreement and the Client Responsibilities Agreement, the client will be terminated indefinitely from the KHCCP without the possibility of reinstatement.

### **Exceptions to the Reinstatement Guidelines:**

Reinstatement guidelines do not apply to those incidents in which:

- Clients have become physically abusive or made direct or indirect threats to harm any staff within the Kentucky HIV/AIDS Care Coordinator Program (KHCCP), and
- Clients have falsified documentation or information related to their eligibility for KHCCP.

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## **IMMUNIZATION SERVICES FOR THE VACCINE FOR CHILDREN PROGRAM (VFC) AND DPH (STATE) SUPPLIED VACCINES**

The Immunization Branch encourages the LHDs to provide immunizations and immunization education to promote the health of Kentuckians by decreasing the incidence of vaccine preventable diseases. [KRS 214.034](#), [KRS 214.036](#), [902 KAR 2:060](#)

LHDs should provide or assure immunization services to their community: administration of vaccinations according to the ACIP guidelines and provision of immunization education to patients which would include counseling on risk benefits, side effects, and the importance of completing the series if applicable, immunization education to other healthcare personnel which would include latest recommendations and contraindications, and immunization outreach activities to include off site vaccination clinics, if able to do so, to further reduce barriers to vaccination for the community. Additionally, LHDs shall investigate and report cases of vaccine preventable diseases according to state and DPH requirements.

### **Vaccine for Children's Program (VFC):**

VFC eligibility provides vaccines for Medicaid-eligible, American Indian or Alaska Native, or uninsured children from birth through 18 years of age. *Underinsured have health insurance that does not pay for vaccinations*. To be supported with VFC-funded vaccine, underinsured children must be vaccinated at a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or a LHD deputized by a FQHC. The Immunization Branch may also distribute vaccines purchased with federal 317 funds, state funds, or other monies.

Eligibility is based on federal statutory ([42 U.S.C. 1396s](#)) and state regulatory ([907 KAR 1:680](#)) requirements, childhood and adolescent immunization recommendations of the United States Public Health Service's Advisory Committee on Immunization Practices ([ACIP](#)), state and federal funding, and the availability of the vaccine through the Immunization Branch. Parents of children covered by insurance should be counseled to seek vaccinations from their child's private health care provider as determined by their health insurance plan.

A record of patient eligibility of all children from birth through 18 years of age (i.e., less than 19 years) who receive state-supplied vaccine must be kept at the LHD. LHDs must document patient eligibility screening on the [Kentucky Immunization Registry \(KYIR\)](#) and the Clinic Management (Portal) System as outlined in the Administrative Reference (AR). Eligibility screening must take place with each visit to ensure the child's eligibility status has not changed. Effective January 1, 2018, eligibility must be documented in [KYIR](#). Contact the [Kentucky Immunization Registry \(KYIR\)](#) to obtain access to KYIR or receive KYIR helpdesk assistance. All vaccines procured through the VFC program must be administered according to the [guidelines outlined by the ACIP in the VFC resolutions](#).

### **State-Supplied Vaccines through the DPH Immunization Branch**

Available for those LHD clients from birth through 18 years of age (under 19) at no cost, EXCEPT as provided for under "[Adults, Outbreak Control and Special Situations](#)," in this section. The use of state-supplied vaccine for adults 19 years of age and older is not authorized. Eligibility is based on federal statutory ([42 U.S.C. 1396s](#)) and state regulatory ([907 KAR 1:680](#)) requirements, childhood and adolescent immunization recommendations of the United States Public Health Service's Advisory Committee on Immunization Practices ([ACIP](#)), state and federal funding, and the availability of the vaccine through the Immunization Branch.

LHD should not immunize private health insurance patients to avoid a missed opportunity. Privately insured patients presenting at an LHD should be counseled to seek vaccinations from their child's private health care provider as covered by their health insurance plan. The Immunization Branch is not funded to provide routine vaccination of children with health insurance that covers vaccinations. Should an LHD choose to immunize an insured patient they should do so with LHD purchased vaccine only and not VFC.

Children enrolled in Kentucky Children's Health Insurance Program ([KCHIP](#)) **Phase III** are not VFC-eligible because they are neither Medicaid-eligible nor uninsured. However, the DPH entered into an agreement with the Department for Medicaid Services (DMS) to be the purchasing and distribution agent of vaccines for children enrolled in the KCHIP Phase III program. Therefore, KCHIP providers, who are also VFC providers, may serve KCHIP Phase III recipients with KCHIP vaccines supplied through the Immunization Branch. Providers must bill KCHIP for the administration fee.

LHD clients from birth through 18 years of age (less than 19) must be screened at each visit to determine the eligibility category for state-supplied vaccine by referring to the following criteria:

- Is individual enrolled in Medicaid or a Managed Care Organization;
- Individual does not have health insurance or is uninsured;
- Is individual an American Indian or Alaska Native;
- Is individual underinsured or has health insurance that does not pay for vaccinations;

- A child who has health insurance, but the coverage does not cover vaccines is underinsured; or
- A child whose insurance covers only selected vaccines. VFC-eligible for non-covered vaccines only; or
- A child whose health insurance caps coverage at a certain financial amount and that level has been met so the insurance no longer covers vaccines.

Underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Health Center (FQHC), or Rural Health Center (RHC) or under an approved deputization agreement at a LHD. As a reminder, any patient with private health insurance with a deductible is NOT eligible for VFC vaccine unless the plan does not pay for the vaccine regardless of deductible.

**State-Supplied Vaccines** are subject to availability. As with VFC eligible recipients, a record of client/patient eligibility of all children from birth through 18 years of age (less than 19) who receive state-supplied vaccine must be kept at the LHD. LHDs must document patient eligibility screening on the Clinic Management (Portal) System and the [Kentucky Immunization Registry \(KYIR\)](#). Eligibility screening must take place with each visit to ensure the child's eligibility status has not changed. Effective January 1, 2018, eligibility must be documented in [KYIR](#).

### **Immunization Branch Expectations**

HDs will administer all vaccines necessary for entry and attendance to Kentucky primary or secondary schools (public or private), preschool programs, day care centers, certified family child care homes or other licensed facilities which care for children, in accordance with Kentucky Revised Statutes [KRS 158.035](#), [KRS 158.037](#), [KRS 158.160](#), [KRS 214.034](#), [KRS 214.036](#), [KRS 214.990\(5\)](#), and Kentucky Administrative Regulation [902 KAR 2:060](#).

LHDs will provide or assure immunization services to their community using the following guidelines:

- Administration of vaccinations according to the ACIP guidelines and provision of immunization education to parents and/or patients, which would include counseling on risk benefits, side effects, and the importance of completing the series if applicable;
- Provide to patients or parents the current Vaccine Information Statement (VIS) for each vaccine administered;
- Immunization education to other healthcare personnel which would include latest recommendations and contraindications;
- Immunization outreach activities to include off site vaccination clinics, if able to do so, to further reduce barriers to vaccination for the community; and
- Investigate and report cases of vaccine preventable diseases according to state and DPH requirements.

VFC and State Supplies Vaccines should be handled and stored in accordance with the [Food and Drug Administration](#) (FDA)-approved package insert that is shipped with each product. Additional guidance for selected biologicals is contained in the CDC's Vaccine Management:

[Recommendations for Handling and Storage of Selected Biologicals](#), included in the VFC manual distributed to each LHD.

Administer all vaccines necessary to comply with the current version of the [ACIP Recommended Immunization Schedules](#) including those vaccines needed for entry and attendance to Kentucky primary or secondary schools (public and private), preschool programs, child care centers, certified family child care homes or other licensed facilities which care for children, in accordance with Kentucky Revised Statutes [KRS 158.035](#), [KRS 158.037](#), [KRS 158.160](#), [KRS 214.034](#), [KRS 214.036](#), [KRS 214.990](#)(5), and Kentucky Administrative Regulation [902 KAR 2:060](#).

Develop emergency procedures for protecting vaccine inventories in case of natural disasters or other emergencies. Such emergency procedures should include: emergency backup power generation or identifying an alternate storage facility with back-up power where vaccine can be properly stored and monitored; ensuring the availability of staff to pack and move vaccine; maintaining appropriate packing materials; and, ensuring a means of transport for the vaccine to a secure storage facility. Guidelines for developing clinic specific procedures for the protection of vaccine inventories before and during emergency conditions may be found in the [CDC's Vaccine Storage and Handling Toolkit](#).

Establish Immunization Linkage interventions to ensure children are properly immunized. Utilize [KY WebIZ](#) to generate "Reminder and Recall lists" for parent and/or patient notification. Develop a policy to provide programmatic direction for the prevention of fraud and abuse in the utilization of state-supplied, VFC funded vaccine, [42 U.S.C. 1396s](#), [KRS 205.520](#), [KRS 205.8453](#), [907 KAR 1:675](#), [907 KAR 1:680](#)

#### **Staff Requirements for the Administering, Storage and Handling of Vaccine:**

- Establish and maintain protocols for vaccine administration signed by the LHD Medical Authority.
- Nurses with current Kentucky license who are proficient in administering immunizations both orally and by injections.

#### **Adults, Outbreak Control and Special Situations**

- The DPH Immunization Branch is not funded to provide for routine vaccination of adults aged 19 years and older. However, the DPH Immunization Branch may initiate supply of vaccine and immune globulin for adult disease intervention and other special situations or projects.
- Request for vaccine and immune globulin to support adult vaccination of patients not specifically identified above as eligible needs to be made to DPH Immunization Branch and will need to be accompanied by written justification of need and plan of action. LHDs engaged in routine vaccination of adults should do so with LHD-purchased vaccine.
- State-supplied hepatitis B vaccine may also be given to susceptible adult household, sexual, and needle sharing contacts of hepatitis B surface antigen (HBsAg)-positive

pregnant women who have been reported to the DPH Immunization Branch as a perinatal hepatitis B prevention case.

### **Perinatal Hepatitis B Prevention and Reporting**

[KRS 214.160 \(7\)](#) has required the screening of pregnant women for hepatitis B virus since 1998. Screening for hepatitis B surface antigen (HBsAg) is one of several required blood tests performed at the initial prenatal visit. If the woman is high risk for contracting hepatitis B virus infection, the serological testing should be repeated in the last trimester.

Health Care professionals and health care facilities are required by regulation, [902 KAR 2:020](#), to report HBsAg-positive pregnant women and children born to those women.

- Kentucky Reportable Disease form ([EPID 200](#)): This form is used to report all vaccine preventable diseases and other diseases reportable in Kentucky per 902 KAR 2:020
- Kentucky Reportable Disease form for Hepatitis B Infection in Pregnant Women or Hepatitis B Infection in a Child – [EPID 394](#). This form is used to report all pregnant women or children positive for Hepatitis B.
- Perinatal Hepatitis B Prevention Form for Infants – [EPID 399](#): Used by hospitals to report vaccination status of newborn infants.

### **Perinatal Hepatitis B Prevention Coordination**

LHDs shall have a designated person assigned to be responsible for the follow-up of prenatal women who test HBsAg-positive, their newborn infants, and household, sexual and needle-sharing contacts. The designated person at the LHD will work with private physicians and hospitals to coordinate the care and follow-up of these patients.

The designated person at the LHD will report to the State Perinatal hepatitis B Prevention Coordinator regularly with any current information on patients being case managed. The [EPID-395](#) form is the Kentucky Perinatal Hepatitis B Prevention Case Management Worksheet.

### **Infants Born To HBsAg Positive Women**

Administration of hepatitis B immune globulin, hepatitis B vaccine, and follow-up testing should be conducted in accordance with the most current recommendations of the CDC [Advisory Committee on Immunization Practices](#) (ACIP) and other guidance in the [Clinical Service Guide](#) (CSG) as well as the [Vaccine Index Handouts located on the Immunization Action Coalition website](#).

### **Allowable Expenditures**

Immunization Services Cooperative Agreement Funding

### **Immunization Linkage Interventions Which Must be in Place to Ensure Children are Properly Immunized**

The following interventions must be in place to ensure all children receiving services at a LHD are properly immunized:

- Ensure immunization data for all children is collected and entered into KY regardless of whether the child receives immunization services from a primary care physician or LHD.

- When scheduling appointments, advise parents/caretakers of each infant and child under the age of two (2) that immunization records are requested as part of the health screening process. Explain to the parent/caretaker the importance of ensuring that infants/children are up to date on immunizations. Assure applicants for WIC services that immunization records are not required to obtain WIC benefits.
- Use KYIR for prescreening infants and children who have been scheduled for upcoming visits/services.
- Screen the immunization status of each infant/child at the initial visit and all subsequent visits. The screening must be done by using a documented record, which is either computerized or paper and includes recorded vaccination dates. Examples of a documented record are:
  - A hand-held immunization record from the provider
  - An immunization registry
  - An automated data system, or
  - A medical record
- Immunizations may only be shared in accordance to HIPAA regulations or state law. Immunization records may be disclosed to another provider as part of treatment without a written disclosure from the patient. Additional related information can be found on the HIPAA and Access to Patient Records during AFIX and VFC Visits webpage and at 902 KAR 2:055. HIPAA information regarding a covered health care provider disclosing proof of immunizations about a student or prospective student can be found in the AR, Medical Records Management Section under "Releasing Patient Information".
- If the infant/child is under immunized:
  - Provide information on the recommended immunization schedule appropriate to the current age of the infant/child; and
  - Provide referral for immunization services to the child's usual source of medical care.
- If a documented immunization record is not provided by the parent/caretaker:
  - Provide information on the recommended immunization schedule appropriate to the current age of the infant/child.
  - Provide referral for immunization services; and
  - Encourage the parent/caretaker to bring the immunization record to the next certification visit.
- Use the Provider Self- Assessment Report in KYIR to perform self-assessments of immunization coverage level status of children and adolescents.

### **DPH Responsibility**

DPH will provide program management, guidance, federal grants and reporting coordination, relationships with CDC and vaccine partners, coordination with other state agencies/programs, required and optional trainings/staff development offerings, consultation for financial issues, quality monitoring and quality assurance.

### **Reminder/Recall Policies**

The National Vaccine Advisory Committee developed a set of standards, in February 1992, as to what constitutes the most essential immunization policies and best practices. Research has demonstrated that systems used to remind patients, parents/guardians, and health care professionals when vaccinations are due, and to recall those who are overdue immunizations, improves vaccination coverage. The following are protocols regarding the implementation of immunization reminder/recall policies. Review the CSG.

## **Scheduling Appointments**

The LHDs must schedule the next immunization appointment upon completion of the current immunization encounter. Every effort shall be made to provide health services within (10) calendar days from a patient's request for an appointment. Refer to "Appointment and Scheduling Requirements for Personal Health Services" in the AR: Local Health Operations Section.

## **Reminder Protocol**

- At each immunization encounter, a written reminder shall be given to the patient or patient's parent/guardian with the next scheduled immunization.
- Utilize the Reminder/Recall Report in KYIR to generate lists of due or past due patients for immunizations. The list can be used in an auto-dialer, with a label maker, printed labels for post card printing, traditional phone calling, etc.
- A reminder card or telephone call must be executed in order to remind patient or patient's parent/guardian of the next immunization appointment in advance.
  - FOR HEALTH DEPARTMENTS WITH AUTO DIALER: LHDs with Auto Dialer capabilities must utilize the system to prompt patient or patient's parent/guardian regarding upcoming immunizations.
  - FOR HEALTH DEPARTMENTS WITHOUT AUTO DIALER: LHDs without Auto Dialer capabilities must utilize a manual reminder telephone call or card system.

## **Recall Protocol**

- Attempts should be made to recall patients that miss immunization appointments by employing either a mailed card, telephone call, or other electronic method. A total of three documented attempts to reschedule the appointment should be made before classifying the patient as "moved or gone elsewhere" for immunization purposes.
- Health departments may obtain a missed appointment list daily to assist with this endeavor. If using the Local Health Network System(s) – e.g., Portal System for appointment scheduling and you wish to have this report printed at your health department, contact Custom Data Processing, Inc. (CDP) at (866) 237-4814 or CustomerSupport@cdpehs.com; and request that Report 865 is run for your site(s). Report 864 will print labels for use in contacting these patients. Allow sufficient time to lapse before each attempted contact in order to give the patient or patient's parent/guardian sufficient time to respond.
- Document each attempt including the date of attempt, method of contact, and the outcome.
- If the patient or patient's parent/guardian does not respond to the three attempts, the child has "moved or gone elsewhere" for immunization coverage level assessment purposes. Document appropriately.

## **Quality Assurance Onsite Reviews:**

Kentucky Immunization Branch (KIP) staff complete onsite program reviews at each LHD at least once every 24 months. KIP staff conduct these visits to assist in identifying possible areas for improvement and to assure immunizations are administered in accordance with the guidance from the Center for Disease Control and Prevention (CDC), KY DPH Immunization Branch Standards and applicable statutes and regulations.

During the onsite review, immunization records of children 24-35 months of age are assessed for appropriate vaccination coverage. The reviewer collects data regarding immunizations administered to determine the immunization coverage rate for the LHD. This review also

provides information regarding the standard immunization practice of the LHD (i.e., patients are scheduled for an immunization visit only, immunizations are provided with other scheduled services, follow up is performed for missed immunization appointments, etc.).

Reviewers will assess vaccine storage equipment to assure the LHD is following proper procedures for storing vaccines. When the reviewer discovers issues/concerns, education and guidance will be provided to assist the agency in becoming compliant with the Immunization Branch's vaccine storage and handling guidelines. Immunization educational material, updates, and resources from CDC and other reputable sites will be provided at each visit.

### **LHD Quality Assurance**

All LHDs providing DPH program services commit to carrying out initiatives that are consistent with program standards, guidelines and applicable federal and state regulations.

## **REPORTING AND PREVENTION OF PERINATAL HEPATITIS B**

**Testing and Screening:** [KRS 214.160 \(7\)](#) has required the screening of pregnant women for Hepatitis B since 1998. Screening for Hepatitis B surface antigen (HBsAg) is one of several required blood tests performed at the initial prenatal visit. If the woman is high risk for contracting Hepatitis B, the serological testing should be repeated in the last trimester.

**Reporting Requirements:** Health Care professionals and health care facilities are required by regulation [902 KAR 2:020](#) to report HBsAg-positive pregnant women and children born to these women.

Kentucky Disease Surveillance requires priority reporting: report to the LHD or the state DPH within 1 business day of the identification of a case or suspected case.

Epidemiology reports required:

- Kentucky Reportable Disease form ([EPID 200](#)): This form is used to report all vaccine preventable diseases and other diseases reportable in Kentucky per 902 KAR 2:020
- Kentucky Reportable Disease form for Hepatitis B Infection in Pregnant Women or Hepatitis B Infection in a Child – [EPID 394](#). This form is used to report all pregnant women or children positive for Hepatitis B.
- Perinatal Hepatitis B Prevention Form for Infants – [EPID 399](#): Used by hospitals to report vaccination status of newborn infants.

### **Perinatal Hepatitis B Prevention Coordination**

The DPH's Immunization Branch will have a person designated as the State Perinatal Hepatitis B Prevention Coordinator. The State Perinatal Hepatitis B Prevention Coordinator will be responsible for maintaining a state-wide registry of children born to HBsAg positive mothers throughout the state. The State Perinatal Hepatitis B Prevention Coordinator will provide technical assistance to LHD Perinatal Hepatitis B Prevention Coordinators throughout the state.

LHDs **shall** have a designated person assigned to be responsible for the follow-up of prenatal women who test HBsAg-positive, their newborn infants, and household, sexual and needle-sharing contacts. The designated person at the LHD will work with private physicians and hospitals to coordinate the care and follow-up of these clients. The designated person at the

LHD will report to the State Perinatal Hepatitis B Prevention Coordinator regularly with any current information on clients being case managed.

### **Infants Born To HBsAg Positive Women**

Vaccination and testing for HBsAg and anti-HBs should be conducted in accordance with the most current recommendations of the Advisory Committee on Immunization Practices (ACIP) for Hepatitis B Vaccine.

Infants born to women who are HBsAg-positive will receive Hepatitis B Immune Globulin (HBIG) and three doses of Hepatitis B vaccine in accordance with current recommendations of the ACIP.

The HBIG and the first dose of Hepatitis B vaccine will be administered when the infant is physiologically stable (usually at the birthing facilities), preferably within 12 hours of birth. These infants will be case managed to assure that immunoprophylaxis and post-vaccine testing are continued and completed in a timely manner.

The infants will be tested for HBsAg and anti-HBs three to nine months after the completion of the vaccine series to determine the success of the therapy. The three to nine months after the completion of the vaccine series determine the success for the therapy. In case of therapy failure, these tests will identify infants positive for the virus or those requiring re-vaccination.

Re-Vaccination: Infants negative for anti-HBs and HBsAg should receive a complete second series of Hepatitis B vaccine and retest for HBsAg and anti-HBs one month after the last dose. If the infant continues to be negative for anti-HBs, the infant is considered to be a non-responder. Review the [Perinatal Transmission HBV information on the CDC website](#).

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## **Healthcare-Associated Infection (HAI) - Kentucky State and Regional Infection Prevention and Epidemiology (K-STRIPE)**

### **Laws, Regulations, Guidelines:**

[902 KAR 2:020](#). Reportable disease surveillance

RELATES TO: [KRS 211.180\(1\)](#), [214.010](#), [214.645](#), [333.130](#)

STATUTORY AUTHORITY: [KRS 194A.050](#), [211.090\(3\)](#), [211.180\(1\)](#), [214.010](#)

NECESSITY, FUNCTION, AND CONFORMITY: [KRS 211.180\(1\)](#) requires the CHFS to implement a statewide program for the detection, prevention, and control of communicable diseases, chronic and degenerative diseases, dental diseases and abnormalities, occupational diseases and health hazards peculiar to industry, home accidents and health hazards, animal diseases which are transmissible to man, and other diseases and health hazards that may be controlled. [KRS 214.010](#) requires every physician, advanced practice registered nurse, and every head of family to notify the LHD of the existence of diseases and conditions designated by administrative regulation of the cabinet. This administrative regulation establishes notification standards and specifies the diseases requiring immediate, urgent, priority, routine, or general notification, in order to facilitate rapid public health action to control diseases, and to permit an accurate assessment of the health status of the Commonwealth.

The regulation mandated that healthcare-associated infections (HAI) are reportable to the state health department. This occurs in several areas, multidrug-resistant organisms

(MDRO), outbreaks, and from the National Healthcare Safety Network (NHSN). Targeted MDROs shall be reported through electronic laboratory records (ELR) as defined in the regulation and within five business days.

Any outbreak of an HAI, e.g., two like organisms epidemiologically linked by person, place, and/or time shall be reported immediately. NHSN HAI event data, as defined by the Centers for Medicare and Medicaid Services (CMS) Quality reporting program, shall be reported.

### **Target Population:**

The following is a list of licensed healthcare facilities in Kentucky that are part of the target population for the HAI Prevention Program:

- 117 Hospitals that include Acute Care, Long-Term Acute Care, In-Patient Psychiatric, In-Patient Rehabilitation, and Critical Access Hospitals.
- 320 Long-Term Care facilities including Nursing Homes.
- 40 Ambulatory Surgical Centers
- 120 End Stage Renal Disease Facilities

### **Funding:**

The HAI Prevention Program is reliant on federal grant funding. Funding is for a 12 month period from August 1<sup>st</sup> through July 31<sup>st</sup> each year and part of a five year continuation grant.

Epidemiology and Laboratory Capacity for Infectious Disease  
National Center for Emerging & Zoonotic Infectious Diseases  
Centers for Disease Prevention and Control  
Department for Health and Human Services  
CK14-140104PPHF

### **Staff/Provider Requirements:**

- **HAI Coordinator/Manager:** The staff/personnel who will perform the duties of the HAI Program Manager must be a Registered Nurse, licensed in Kentucky, who is a graduate of an accredited college or university with a Bachelor of Science of Nursing or higher degree in Nursing or related field. Certification in Infection Control from the Certification Board for Infection Control and Epidemiology and at least three years of experience in the last five years as an Infection Preventionist is required.
- **HAI Program Manager:** Will have a valid Kentucky Nursing license and valid Kentucky driver's license.

### **Training:**

A Registered Nurse in the State of Kentucky must obtain 15 CEs (continuing education units) each year for renewal of a valid license. Keeps up to date on the latest medical and nursing literature and advances about HAI prevention and control strategies by reviewing books, pamphlets, journals and other professional materials

### **Reporting Requirements:**

The HAI Prevention Program shall provide required reports and performance measures to the grantor on the prescribed schedule as outlined in the yearly funding opportunity notice.

**Program Specific Requirements:** Maintain the required multidisciplinary statewide advisory committee, Kentucky-State Regional Infection Control and Epidemiology (K-STRIPE). Membership should include key stakeholders and partners from across the state. Current members include the following:

- The Kentucky Hospital Association

- Qsource (Quality Improvement Organization for Kentucky)
- University of Louisville, Infectious Disease Department
- University of Kentucky Infection Prevention and Control
- Norton Hospital Infectious Disease
- Association of Professionals in Infection Control and Epidemiology (APIC) Chapters
- State Dental Director
- Kentucky Pharmacists Association
- Emergency Preparedness
- Kentucky Association of Healthcare Facilities
- Leading Age
- Friedell Committee
- HAI Prevention Program
- Division of Laboratory Services
- LHD
- Kentucky DPH, Infectious Disease Branch

The advisory committee will maintain and update the state HAI plan and will advise and participate in the activities of the HAI Prevention Program.

### **Service Description & Key Roles & Responsibilities:**

#### ***Role of HAI Coordinator/Manager***

1. Plan, develop, manage, coordinate, and evaluate activities directed toward the prevention and control of HAIs.
2. Provide guidance and professional nursing consultation regarding HAI prevention and control strategies to infectious disease nurse consultants and other staff at the Kentucky Department for Public Health (DPH), to nurses and other staff at all types of healthcare settings LHDs, and to other agencies and health care providers.
3. Initiate and conduct needs assessments and identify training requirements and other resources needed to both perform and integrate the core.
4. HAI prevention and control strategies into the delivery of health-care services in Kentucky.
5. Analyze, develop, and recommend HAI prevention and control strategies.
6. Assist in the planning, evaluation and development of medical and nursing strategies, programs, and interventions for the prevention and control of HAIs.
7. Initiate collaboration and education about national prevention targets in the HHS Action Plan to design and implement effective HAI prevention and control programs.
8. Collaborate with the Centers for Disease Control and Prevention, and other federal partners involved in the prevention and control of HAIs.
9. Develop curriculum, arrange training, conduct training, and participate in training on HAI prevention and control strategies, including surveillance, identification of cases, reporting, and outbreak management, for nurses and other health professionals at KDPH and in healthcare settings (e.g. acute care hospitals, long term care facilities, and LHDs), and for other professionals.
10. Establish and maintain on-going working relationships with nurses and other health professionals, clinicians, acute care hospitals, long term care facilities, LHDs and other agencies throughout the state.
11. Carry out the goals and objectives on the CDC approved and funded HAI Prevention grant, including meeting with both CDC and HHS HAI objectives.
12. Provide administrative support to K-STRIPE.

## Division of Laboratory Services

Independent laboratories are responsible for their own certification through the US Department for Health and Human Services, [Centers for Medicare and Medicaid Services](#).

The Public Health Laboratories of Kentucky (PHLOK) sites hold their own Clinical Laboratory Improvement Act (CLIA) certificates. The type of certificate held by each individual health department laboratory is dependent upon the type of testing being performed in the facility.

The PHLOK sites are to notify their assigned Laboratory Surveyors or the [Office of Inspector General \(OIG\)](#); for any major changes such as health department site, personnel, or tests performed. Such changes may require them to update their [CLIA application; form CMS-116](#). The Laboratory Surveyors and OIG provide guidance to PHLOK on CLIA certification.

Considerations on preparations needed prior to performing waived testing that may assist PHLOK to implement and oversee waived testing or to offer a new test under a [CLIA Certificate of Waiver](#).

The following guide provides an overview on the regulatory requirements and resources with examples of microscopy for the PHLOK performing tests under a Certificate of Provider-Performed Microscopy (PPM):

- The "[Clinical Service Guide \(CSG\)](#)" under "References for LHDs" on the [DPH LHD Information webpage](#), contains further specific guidance and checklists for PHLOK, as well as competency and quality assurance forms in the "[CSG forms and teaching sheets](#)" section.
- The Division of Laboratory Services (DLS) in Frankfort maintains a high complexity CLIA certificate and accreditation by the College of American Pathologist.

## Regulations & Guidelines

[KRS 211.190](#) identifies certain services to be provided by the Cabinet for Health and Family Services, including the establishment, maintenance and operation of public health laboratories.

[KRS 211.345](#) requires that the Cabinet provide chemical and microbiological testing of private water supplies without charge.

[KRS 214.625](#) provides for provision of voluntary HIV testing through LHDs.

[KRS 214.155](#) requires testing of all infants for inborn errors of metabolism and that the Cabinet make testing available.

[KRS 214.160](#) requires approval of laboratories performing mandated prenatal tests for syphilis and obligates the laboratory of the Cabinet to provide such testing.

[KRS 215.520](#) specifies the provision of adequate support for out-patient TB clinics by high quality laboratories.

[KRS 217C.040](#) establishes the responsibility for oversight of dairy products.

[KRS 258.085](#) provides for submission of animal heads for rabies testing.

[KRS 333](#) regulates the operation of independent medical laboratories, is under the technical oversight of the DLS.

[KRS 510](#) requires HIV testing to be performed on persons convicted of specific sexual offenses under supervision of the Cabinet.

[KRS 529.090](#) requires HIV testing of convicted prostitutes under supervision of the Cabinet.

[KRS 438.250](#) Mandatory testing for HIV, hepatitis B and C, tuberculosis, and other diseases for criminal defendants, inmates, and state patients under specified conditions.

**Funding:** Laboratory testing performed by LHDs may be reimbursed by Medicaid, Private Insurance or Private Pay. Laboratory testing performed by the [Division of Laboratory Services](#) (DLS), Frankfort, is funded by different funding streams (agency, federal, and state).

### **Staff requirements**

- The health department laboratory must have a sufficient number of individuals who meet CLIA qualifications requirements to be able to perform the volume and complexity of tests offered.
- CLIA guidelines set the standard on who can do a laboratory test and what type of test that individual is authorized to do. A health department that is operating under a waived/PPM certificate is authorized to do a limited number of tests. A list of those approved tests is available through the certificate holder.
- Health department operating under a waived/PPM certificate require that the microscopy tests performed in that facility must be performed by an Advanced Registered Nurse Practitioner (APRN) or Medical Doctor.

Moderate certificate holders must either have an associate degree related to laboratory testing or have earned a high school diploma and training that must be documented for the type of testing being performed by that individual.

### **Training Requirements**

Moderate certificate: Each individual performing PPM/moderate complexity testing must be trained prior to analyzing patient specimens. This training will assure that the individual performing the test has all skills needed to collect, test, and verify the validity of the patient's test results. Guidance to meet the CLIA quality assurance and assessment standards on employee training and competency can be found on [the Provider-Performed Microscopy \(PPM\) Procedures website](#).

### **Reporting Requirements**

Test results that are performed in the health department laboratory are documented in the patient's chart. Any patient testing results from either a contract lab or from the Division of Laboratory Services or from any other licensed facility (i.e. Hospital, Physician Office Laboratory [POL]) that appear on the Reportable Disease List must be reported to the Division of Epidemiology and Health Planning, DPH. The Division of Epidemiology and Health Planning maintains this list and a list is located on the Cabinet for Health and Family Services, [Department for Public Health home website](#).

### **Blood-borne Pathogens and Needle-stick Safety**

A copy of "[The OSHA Standard Bloodborne Pathogens Standard 29 CFR 1910.1030](#)" is kept at each health department and in great detail specifies Bloodborne pathogens and needle-stick safety issues concerning the health department. Click on the link for an [OSHA Fact Sheet on Protecting yourself when handling contaminated sharps](#).

## **Laboratory Services Description and Key Roles and Responsibilities Of LHDs**

- Laboratory services **provided by health departments** under their CLIA certificate, being waived/PPM or Moderate will implement a quality assurance program that covers all phases of the total testing process.
- Each health department site will maintain a master file or manual that discusses the principle of each test performed, describes specimen collection, needed equipment and supplies to perform the test, proper storage of test components, proper disposal of hazardous waste, the test procedure, reporting of results, management guidelines, limitations of the procedure, instrument maintenance, problem solving and references. Relevant forms related to each test should be included.
- The health department laboratory is to notify their certificate holder, assigned Laboratory Surveyor or the Office of Inspector General (OIG), whenever there is a change in laboratory sites, personnel or test method.
- Specimens may be sent to DLS, Frankfort, for tests that are not performed at the LHD.
  - The tests offered by the [Division of Laboratory Services \(DLS\)](#) are available online. Instructions for specimen collection, requisition and shipping requirements are listed for each test.
  - All LHDs are currently using the [DLS OUTREACH system](#) to submit patient samples with requisition forms. If the OUTREACH system is not available, forms are available on the [DLS website](#).

## **Shipping Laboratory Specimens to the KY DPH Division of Laboratory Services (DLS)**

- Shipping containers and shipping labels are provided to the health departments from the Division of Laboratory Services for the purpose of shipping specimens.
- Requirements for packaging and shipping are found in the KY Division of Laboratory Services Packaging and Shipping Guidelines in this section.
- Specimens may be shipped to the DLS by FedEx, UPS, Courier, US Postal Service, or personal delivery. Each method shall be carefully evaluated before choosing the one best suited for a particular specimen. It is important to note that many specimens collected are time sensitive and it is essential that they arrive for testing in a timely manner. Additional information for testing can be accessed in the Reference Lists of Tests located on the [DLS webpage](#).

## **Packaging and Shipping of Infectious Substances**

- Laboratory specimens will be packaged and marked according to United States Department of Transportation (DOT) [49 CFR](#) Subpart H parts 171-180, the United States Postal Service ([USPS, Publications 52](#)), and following International Air Transport Association Dangerous Goods Regulations (IATA/DGR).
- Employees responsible for infectious substance packaging and shipping must be trained every three years for ground (DOT) ground and every two years for air (IATA). The training guidelines are found in [49 CFR 172.704](#) Training Requirements.

## **Contract Laboratory**

- If the LHD purchases laboratory services, the services must be provided by a licensed laboratory. The health department will need to request a copy of the contracted laboratory's CLIA certification that includes their **current** CLIA number so that the health department can present this to Medicaid.
- The contract laboratory will provide the health department with a list of the tests that they perform and information on specimen requirements, forms, time sensitivity and shipping requirements required for submittal.

## **Specimen Collection**

Follow package inserts included in test kits for specimen criteria.

## **Laboratory Safety**

Each health department site should maintain a safety plan that describes policies and procedures that ensure the safety of the personnel who perform testing. The Quality Assessment Manual (QA) for health department laboratory testing is to provide general laboratory safety guidelines. The QA Manual is to include biological, chemical and mechanical hazards with emphasis on prevention and what to do in the case that an incident occurs.

## **Biological Terrorism Laboratory Response**

Environmental or suspicious samples should not be accepted by the LHD. Contact law enforcement and the DLS for guidance.

## **Chemical Threat Laboratory Response**

- Biological samples (Blood and Urine): Contact DLS (502) 564-4446 for the collection and shipping of biological samples for chemical analysis.
- Environmental samples (Air, Soil, and Water): Contact the KY Environmental Response at (502) 564-2380.

## **KY Division of Laboratory Services - Packaging and Shipping of Infectious Substance Guidelines**

### **Biological Substance, Category B only**

To ensure the safety of personnel and integrity of the clinical specimen, the Department of Transportation (DOT), United States Postal Service (USPS), and the International Air Transport Association (IATA) mandate the following procedures for packaging and shipping specimens to the KY Division of Laboratory Services.

Specimens must be classified as an infectious substance in Division 6.2 and assigned to UN2814 Infectious Substance, affecting humans (Category A) or UN3373 Biological Substance, Category B as appropriate. Health Departments in Kentucky will send specimens to the DLS as Biological Substances, Category B.

According to [USDOT 49 CFR 173.134](#) Biological substance, Category B is defined as an infectious substance that is not in a form generally capable of causing permanent disability or life-threatening or fatal disease in otherwise healthy humans or animals when exposure to it occurs. This includes Category B infectious substances transported for diagnostic or investigational purposes. A Category B infectious substance must be described as "Biological substance, Category B" and assigned identification number UN 3373.

**PROPER PACKAGING OF CATEGORY B SPECIMENS:** Category B infectious substances must be packaged in a triple packaging, consisting of a primary receptacle, secondary packaging, and outer packaging, conforming to the following provisions:

- Leak-proof primary receptacle

- Leak-proof secondary packaging
- Absorbent material
- Sturdy outer packaging

The primary receptacle or the secondary packaging must be capable of withstanding without leakage an internal pressure producing a pressure differential of not less than 95 kPa (0.95 bar, 14 psi).

Leak-proof Primary Receptacle may be glass, metal, or plastic. They must not contain more than 1L of liquid. For solid specimens the primary receptacle must be sift proof and must not exceed the outer packaging weight. *Examples: Chlamydia collection tubes and Vacutainers*

Leak-proof Secondary Receptacle prevents contact between multiple primary containers. Place specimens in absorbent tube shuttle and place inside leak-proof secondary receptacle. The secondary container must be marked with the international biohazard symbol. Paperwork goes between secondary container and outer packaging. Make sure rubber gasket is placed inside the metal canister lid. *Examples: White plastic canister, 95kpa bag, small metal canister*

Sturdy Outer Packaging must consist of corrugated fiberboard, wood, metal, or rigid plastic. For liquids the outer packaging must not contain a total of more than 4L. For solids, the outer packaging must not exceed a total of 4kg.

- Packaging must be capable of successfully passing the drop tests at a drop height of at least 1.2 meters (3.9 feet).
- At least one surface of the outer packaging must have a minimum dimension of 100 mm by 100 mm (3.9 inches).
- Must show the name and telephone number of a person who is knowledgeable about the material shipped and has comprehensive emergency response and incident mitigation information, or of someone who has immediate access to the person with such knowledge and information.
- Samples sent by FedEx in smaller boxes that will not accommodate the airbill on top of the box must be placed in the FedEx UN3373 bag.

## MARKINGS

The proper shipping name "Biological substances, Category B" must be marked on the outer packaging adjacent to the diamond-shaped mark in letters that are at least 6 mm (0.24 inches) high.

BIOLOGICAL SUBSTANCE, CATEGORY B



## SPECIMENS SENT TO DLS THAT ARE NONREGULATED

- Dried blood spots for Newborn Screening placed on absorbent filter paper or other material. Spots should be thoroughly dried then fold protective flap over and place in a single envelope. It is no longer necessary to place spots in multiple envelopes.

Do not place in plastic. Use an envelope large enough so form does not need to be folded.

- Environmental samples (including food and water samples) which are not considered to pose a significant risk of infection.

### **ORDERING KITS AND PACKAGING**

- Use the Requisition for Ordering Lab Kits obtained from the [DLS webpage](#).
- Email – [dphlabkits@ky.gov](mailto:dphlabkits@ky.gov) Fax – (502) 564-7019

Questions on Packaging and Shipping - Call (502) 564-4446 or (502) 782-7703.

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## **Childhood Lead Poisoning Prevention Program (CLPPP)**

### **Laws, Regulations, Guidelines**

The Kentucky Childhood Lead Poisoning Prevention Program (KYCLPPP) provides guidance and technical assistance to the LHDs. KY CLPPP refers to [KRS Chapter 211](#) .180; .210; .900 through .904; and .994 and [902 KAR 4:090](#).

KYCLPPP refers to the most current recommendations on blood lead screening of children than 72 months of age and preventive guidelines. These guidelines are provided by both the [Centers for Disease Control and Prevention](#) (CDC) and the [American Academy of Pediatrics](#) (AAP).

### **Target Population**

- **Medicaid Enrolled Children**

Children under 72 months of age who are enrolled in Medicaid are considered high risk for lead exposure and are required to be tested for lead at ages 12 and 24 months. The verbal risk assessment should be used at 6, 9, 12, 18, 24 months, and age 3, 4, 5, and 6 to assess their current risk for lead exposure. Any “Yes” or “I don’t know” responses result in a blood lead test.

- **Not Medicaid Enrolled Children**

- The verbal risk assessment should be used at 6, 9, 12, 18, 24 months, and age 3, 4, 5, and 6. Any “Yes” or “I don’t know” responses must result in a blood lead test. Pregnant Women (See also the prenatal section for Lead Screening Guidelines/ Follow-Up)
- Use the verbal risk assessment to assess a pregnant woman’s risk for lead exposure during their first prenatal visit. Any “Yes” or “I don’t know” responses result in a blood lead test. Document in the medical record at the positive pregnancy test/initial prenatal visit and anytime that the assessment was done, any positive response(s), and action taken according to the class chart guidelines located in the Prenatal section.

Any child or pregnant woman having a positive risk factor but not having a blood lead level (BLL) greater than or equal to the CDC blood lead reference value (BLRV) must be provided preventive lead education in an effort to prevent future exposures.

### **Funding**

DPH Childhood Lead Poisoning Prevention Program is funded through the CDC. Funds may not be used for community testing, abatement, direct patient services, or clearance testing services.

### **Staff Requirements:**

LHD Directors or their designee must identify a Lead Case Manager (CM). If none is identified by the LHD, the Nurse Leader will be the default contact for lead-related issues. LHD Lead CMs should be a licensed professional, e.g.:

- Registered Nurse (RN)
- Social Worker
- Or a Health Educator with a Master's Degree in a relevant field.

If the CM is not a RN, the CM should work with the RN in the appropriate processes of receiving blood lead results.

### **Training Requirements**

The DPH [CSG](#), AR, and educational materials reflect CDC's current recommendations.

- The LHD shall ensure uncontaminated specimen collection through requiring all staff who will be obtaining blood lead specimens view the following training materials prior to drawing blood lead specimens:
  - [CDC's: Guidelines for Collecting and Handling Blood Lead Samples](#) (read the materials and watch the video).
  - KY CLPPP Blood Lead Specimen Collection Guidelines available at [Childhood Lead Poisoning Prevention Program – Cabinet for Health and Family Service](#).
  - The LHD's analyzing lab specimen collection guidelines.
- LHD CLPPP and support staff shall complete required program training updates as provided by the KY CLPPP when posted.

Documentation of these completed trainings shall be maintained by the LHD Staff personnel file and made available for review upon request by DPH CLPPP staff.

### **Reporting Requirements**

Case management home visit form and risk assessment form should be faxed to (502) 564-5766 with Attn: KYCLPPP. Refer to the CSG for reporting of lead results using a LeadCare Point-of-Care Device and case management.

### **LEAD CARE Portable Lead Lab Analyzer:**

All LHDs using LeadCare devices must be familiar with its specific user manual instructions on its use, KY Clinical Laboratory Improvement Amendments (CLIA) obligations and state (KRS 211.902) reporting requirements. A LeadCare device is not acceptable for confirming a BLL greater than or equal to the BLVR of 3.5 micrograms per deciliter ( $\mu\text{g}/\text{dL}$ ). LeadCare devices can only to be used as a screening tool and is not a diagnostic tool.

If your LHD uses a LeadCare device, please contact the KYCLPPP epidemiologist to set up reporting of these lead tests. Visit <https://kog.chfs.ky.gov> to create an account to report these tests to the Cabinet for Health and Family Services as mandated by KRS 211.902.

### **Billing and Collection Procedures**

Childhood lead case management should:

- Ensure that the inability to pay is not a barrier to services.
- For clients not enrolled in Medicaid, billing is to be based on a cost analysis of services and charged according to the sliding fee scale.
- Ensure that patients eligible to enroll in Medicaid or KCHIP are referred to those agencies.
- The LHD should use the appropriate ICD-10-CM T56.0X-4A Diagnosis Codes when providing services for elevated blood lead levels to help track services provided and lead exposures.
- Home visits and medical nutrition therapy services may need MCO preauthorization for reimbursement. To ensure MCO reimbursement, the LHD should check the current MCO preauthorization requirements prior to completing these services. Click on the [Medicaid MCO webpage](#) for MCO contact information.

### **Program Specific Requirements**

Refer to AR Training Requirements: [Training Guidelines](#) and Program Descriptions Section:  
**Lead**

### **Service Description & Key Roles & Responsibilities of Health Department**

The LHD ensures CLPPP CMs and support staff complete necessary training as defined in the Training Requirements/Lead section necessary in providing consistent uncontaminated blood lead screenings and congruent statewide follow-up interventions.

The LHD shall ensure blood lead screenings for all at-risk populations  $\leq 72$  months of age and pregnant women. Anticipatory guidance and preventive education should be provided during screening appointments.

The LHD shall ensure lead poisoning preventive education is provided to the parent/guardian/pregnant woman for all BLLs. The nurse who signs off on all blood lead results should ensure a review of preventive education with the parent/guardian/pregnant woman. Refer to the CSG: Lead section. Education works to help families understand what lead is, how to decrease lead hazard exposure and in reducing blood lead levels.

The LHD shall ensure follow up intervention is provided for children  $\leq 72$  months of age who have a BLL  $\geq 3.5$   $\mu\text{g}/\text{dL}$ .

The LHD shall ensure children  $\leq 72$  months of age with confirmed BLL's  $\geq 15$   $\mu\text{g}/\text{dL}$  are referred to LHD Environmental and receive an environmental lead inspection to identify lead-based hazards through sampling of paint chips and dust.

The LHD shall ensure blood lead specimens collected at the LHD whose blood lead results are  $\geq 2.3$   $\mu\text{g}/\text{dL}$  are reported electronically to the Cabinet for Health and Family Services. LHDs using outside analyzing labs will need to contact the lab to ensure the electronic reporting of all BLLs  $\geq 2.3$   $\mu\text{g}/\text{dL}$ .

Children  $\leq 72$  months of age and pregnant women identified with BLL greater than or equal to the BLVR shall be initiated into case management and followed until case closure. LHD staff should collaborate with local health care providers in ensuring follow up blood tests and in efforts to reduce BLLs.

## **Environmental Management for Elevated Blood Lead Levels**

Review the [Environmental Health Services](#) Section of the AR for requirements for environmental follow up on EBLs.

### **Case Closure:**

Please refer to the Lead section of the [CSG](#) for guidance on CLPPP case closure.

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## **Maternal & Child Health (MCH) Coordination & Improvement Collaborative Grant**

### **Laws, Regulations, Guidelines**

The purpose of the MCH Coordination and Improvement Grant (referred to as MCH Coordination) is to support maternal and child health population-based services and infrastructure at the local level.

The program is designed to promote activities focusing on quality improvement for the following MCH domains: Perinatal Health/Infant Mortality, Women/Maternal Health and Child/Adolescent Health. These domains were identified as being priorities through a statewide needs assessment with stakeholders. These domains and measures are defined by the following statutes and regulations:

MCH Coordination Program Administration: [KRS 211.170](#); [KRS 211.186](#); [KRS 211.187](#); [KRS 211.190](#)

Perinatal Health/Infant Mortality: [KRS 72.025](#); [KRS 72.029](#); [KRS 211.680](#); [KRS 211.682](#); [KRS 211.684](#); [KRS 211.686](#); [KRS 213.161](#); [KRS 620.030](#); [KRS 620.055](#)

Women/Maternal Health: [907 KAR 20:050](#); [KRS 211.180 \(1\), \(e\) & \(f\)](#); [KRS 214.160](#); [KRS 311.378](#)

Child/Adolescent Health: [KRS 211.640](#)

The LHD Directors shall identify an MCH Coordinator from their staff to provide primary oversight of the program. The MCH Coordinator shall ensure activities are carried out in their service area according to guidelines in their chosen MCH packages and all required reporting is completed and submitted as described in each of those packages, in accordance with this Administrative Reference (AR).

The MCH Coordinator shall maintain open communication with DPH/MCH and will assist DPH/MCH with developing and accessing local MCH services. Local MCH Coordinators shall provide feedback to DPH/MCH as well as interpret and apply state program policies and guidelines to local MCH activities.

### **Target Populations:**

The MCH program will be utilized to promote the improvement of the health of pregnant women, women of childbearing ages, infants, preschool and school-age children, and adolescents. [KY StateSnapshot FY 23 \(hrs.gov\)](#).

MCH Packages are dedicated to strengthening community partnerships between stakeholders and LHDs to accomplish MCH program goals. It is a basic tenet that by creating population, evidence-based programs with more stakeholder buy-in, LHDs will have more sustainable support for future activities.

## Funding

Title V MCH Block Grant (Federal Grant #1B04MC47420-01-00)

## Staff Requirements

LHD Directors or their designee must identify a MCH Coordinator. If none is identified by the LHD, the Nurse Supervisor will be the default contact. MCH Coordinators should be program leads and/or in a supervisory role within the LHD and preferably be a licensed professional:

- Registered Nurse
- Social Worker
- Health or Community Educator with a degree, or
- Registered Dietician or Nutritionist with a degree

## Training

MCH Coordination Program training is required for all MCH Coordinators and LHD staff who will be working in the MCH Program in any capacity. Each of the MCH Packages will also have training requirements or options that are related to that package's goals and activities. DPH/MCH will review other training requests not covered to determine if they can be approved on a case-by-case basis.

## Reporting Requirements:

DPH requires that designated LHD staff report MCH activities in the DPH approved reporting system every month for each package chosen. Reporting will be monitored closely. DPH/MCH will implement re-allocations of funds for those who are not reporting activities as required to those who are compliant. The MCH Coordinator will ensure reporting requirements are met according to the guidelines on the MCH Packages chosen by the LHD every month before close of business on the last day of every month. Specific reporting requirements will be listed for each package, and all reports **MUST** include:

- Number of community/partner agencies reached (e.g., childcare facilities, family/parenting groups, school districts and schools, health care providers, civic organizations, etc.), as well as the name of each contacted.
- Title of all MCH program related LHD staff trainings completed must be entered into the section requesting what training or certification was completed; number of staff trained in each training; and, for which package the training is applicable.
- Audience numbers and audience types reached through package activities for the identified priority populations (infants, children/adolescents, and women of childbearing ages).
- Tracking of materials and supplies ordered and distributed, noting the following:
  - Title or name of each item and educational materials distributed (for large items, such as Safe Sleep Survival kits, etc.).
  - Who received the items/materials (the name of the business, community partner, school, etc.).
  - Record when materials are provided to ensure the most current information is being distributed.
- Regular activity reporting in the DPH approved reporting system, as described within each individual package guideline, and to include all data requested in specific packages, must be completed and submitted monthly.
- Successes and/or barriers **MUST** be reported monthly.

Any LHD accepting the 766 MCH allocation is required to comply with these reporting standards. Noncompliance may cause reimbursement delays and/or the loss of funds in cost center (cc) 766 as described in the next section of this AR.

### **Program Accountability and Compliance**

Accountability is required through monthly MCH reporting. Missed reports will automatically generate the following actions:

1. Compliance Email #1-Missing report >30 days past deadline:  
Reminder of monthly report deadline on the last day of every month; and request updated report by end of current reporting deadline sent to LHD MCH Coordinator with read receipt, AR link, and copies of packages in the LHD approved work plans.
2. Compliance Email #2-Missing report >60 days past deadline:  
Reminder of monthly report deadline on the last day of every month; notice of possible cost center 766 payment hold if reports not updated with a deadline for completion provided; live link to this AR; copies of packages in the LHD approved work plan sent to LHD MCH Coordinator, cc'd to LHD Director, and to the CFHI Branch Manager.
3. Compliance Email #3-Final for Missing report >90 days past deadline:  
Notification of cost center 766 payment hold until reports are updated and MCH program compliance is verified; live link to this AR; copies of packages in the LHD approved work plan sent to directly to LHD Director with cc to LHD MCH Coordinator including a read receipt; and cc to CFHI Branch Manager. The CFHI Branch Manager will forward a copy of the emailed compliance history to KDPH MCH Division leadership for determination of next steps.

### **Billing and Coding Procedures Specific to Program**

Allowable Function Codes with descriptions are outlined below

#### **Allowable Expenses**

- Health department staff time for activities directly related to packages in the LHD approved work plan.
- In-state travel for activities directly related to packages in the approved work plan
- Items on the **Approved Materials and Resources List** including shipping and handling.
- Items *requiring preapproval* by MCH using a Purchase Request form provided by [MCHCoordinator@ky.gov](mailto:MCHCoordinator@ky.gov) in order to be reimbursed for the expenses include:
- Items directly related to packages in the approved work plan in excess of \$500 total invoice.
- Training and related expenses as required to MCH and/or any package in the approved work plan that requires overnight travel, meals and/or lodging, which will be subject to current KDPH travel regulations, may be reimbursed ONLY IF PREAPPROVED.
- Designs for printing, duplication, and signage directly related to work plan activities. Once a design has been approved by MCH, replication is allowable if the expense is less than \$500 and the number being ordered is reasonable for the service area and educational purpose. Otherwise, it must be preapproved and included in a Purchase Request form as described above.
- Prevention messaging directly aligned with approved work plans in the form of school and community banners, posters, etc., will be allowable with preapproval of the design by MCH. **However, these cannot be used to advertise private and/or**

**commercial entities regardless of their donor status.** Messaging must be preapproved to assure consistency throughout the Commonwealth.

- All advertising campaigns to promote evidence-based education, prevention, and health promotion programs targeting specific, emergent MCH program related community needs must be preapproved.
- MCH will review other requests on a case-by-case basis.

### **Expenses NOT Allowable**

- Items not found on the **Approved Materials and Resources List** and/or not *preapproved* by MCH.
- Any billable, PEFable, and/or clinical services
- Equipment and/or furnishing purchases or rentals.
- Capital improvements.
- Materials used for mass distribution (e.g., health fairs, community baby showers, etc.)
- Media (except what is **preapproved** by DPH/MCH as prevention messaging as described in the AR and in Allowable Expenses in each MCH package guideline.
- Food and/or lodging not preapproved AND related to LHD approved work plan.
- Any expenses coded to #110, #121, #122, #123, #125, #129, #180
- Any expenses for packages not included in the approved work plan.
- Any expenses for cost centers other than MCH766

### **Special Equipment Requirements**

Staff implementing the MCH Coordination program must have access to a computer for training, webinars, activities, and data reporting. Equipment access is to be provided by the LHD receiving and accepting the MCH cost center 766 allocation.

### **Service Description for MCH Coordination Packages**

The MCH packages are aligned with the domains and goals of the Title V Block Grant, as well as the Commonwealth of Kentucky's identified priorities. LHDs should select the MCH packages most appropriate to the needs of their communities. LHDs MUST choose at least one of the three (3) Infant Mortality packages; they MUST choose the Child Fatality Review Team and Injury Prevention (CFR) package plus one other package; and, may choose a maximum of five (5) total packages. *Exceptions of <3 or >5 packages in a work plan may be considered with documented justification which must be preapproved by KDPH.* LHDs may make changes to their approved work plan throughout the fiscal year as their allocation allows. However, the CFR package plus one Infant Mortality package are requirements to be continued throughout the fiscal year when the MCH 766 allocation is accepted by the LHD.

### **MCH Coordination Program Packages**

The LHD shall choose package #201 Child Fatality Review Team and Injury Prevention Package (CFR); and is also required to choose at least one Infant Mortality package from Codes #200, 202 and/or 203 described below and *in the Financial Management section – Chart of Accounts – Function Codes.*

**#200 Safe to Sleep for Community Partners (SSCP):** *Reduce infant mortality from unsafe sleep practices with the assistance of community partners and stakeholders.*

LHD staff will educate community partners about teaching safe sleep practices using current, recommended best-practices by the American Academy of Pediatrics (AAP). Community partners will educate their clients and will provide them with the most current,

approved safe sleep materials available. Expenses associated with this package are **coded to #766-200**.

**#201 Child Fatality Review Team and Injury Prevention Package (CFR):** *Kentucky counties will develop and maintain a local CFR Team with their local Coroner to review infant and child injuries and deaths that have occurred in their service areas. Local CFR teams will develop and implement prevention plans to address future preventable infant and child injuries and fatalities in their service area based upon case reviews and/or emerging issues in order to reduce risks and decrease occurrences.*

LHDs will collaborate with community partners to provide evidence-based prevention education for families and the community on specific emerging issues when reviewing infant and child injuries and death records. Programs must be evidence-based and preapproved by KDPH. Expenses associated with this package are **coded to #766-201**.

**#202 Prevention of Pediatric Abusive Head Trauma (PAHT):** *Reduce child abuse and infant mortality caused by Pediatric Abusive Head Trauma (PAHT) by increasing the number of community partners and health care providers who offer education and materials to parents about methods to calm crying infants and young children, including those with special health care needs.*

Families with infants and young children will be educated by community partners regarding the prevention of PAHT through evidence-based best practices using the most current materials available. Expenses associated with this package are **coded to #766-202**.

**#203 Cribs for Kids for Community Partners (Cribs):** *Reduce infant mortality from unsafe sleep practices, such as bed sharing, by working with community partners to provide safe sleep education, safe sleep assessments, and cribs for qualifying families.*

Work with community partners (e.g., hospitals, local managed care organizations, etc.) to identify families who are unable to provide a safe sleep environment for infant(s) in their home; and provide them with a Cribs for Kids Safe Sleep Survival Kit, which includes a crib, safe sleep education materials, best-practice demonstrations, and follow-up services.

A 50/50 cost match to purchase crib kits is required between the LHD and its community partners. LHDs using this package must complete and submit a **dated and signed** agreement from each community partner providing a match for crib costs, indicating the financial commitment they are making. Expenses (e.g., LHD staff time, cribs, etc.) associated with this package are **coded to #766-203**.

- All Infant Mortality packages activities, including those for CFR, are required to be reported monthly in the DPH approved data reporting system by the LHD MCH Coordinator or other designated LHD staff. All costs related to any of these four packages must be coded to cost center 766 and the code on the selected package for reimbursement as previously noted.

**#204 Prenatal Referrals (PNR):** *LHDs will follow-up with women who have a positive pregnancy test to verify they have attended their first prenatal (PN) visit and have received referrals for other services as appropriate (e.g., presumptive eligibility, smoking cessation, WIC, HANDS, dental, intimate partner violence, depression/mental health issues, as well as alcohol and other drugs).*

The LHD will follow-up with each woman listed on the Prenatal 439 E-Report (439E) to ensure she has attended her first PN visit. If she has not, LHD staff should assess barriers and provide information that addresses the identified barriers. Expenses associated with this package are **coded to #766-204**.

**#205 Well Woman (WW):** *Promote health for women of childbearing ages about the preventive well woman health visit. Provide education regarding what to expect at the visit including immunizations, screening, and counseling for a healthy lifestyle, how to minimize health risks, and promote health across the lifespan. This includes education/health promotion about nutrition, activity, exercise, and addressing risk factors such as smoking cessation, substance abuse treatment, intimate partner counseling, and/or resources for food and shelter assistance within the community.*

Promote annual well woman exams with an increase of exams locally by 5% of audience served. Establish partnerships with local FQHC, prenatal care providers, and birthing hospital(s) to promote collaborative relationships for community resources to address the needs of women of childbearing age. Using media (social and traditional), as well as other methods, educate women of childbearing age about how healthy lifestyle choices can improve outcomes for them and their babies if they decide to start a family. Expenses associated with this package are **coded to #766-205**.

If either package is chosen, Women and Maternal Health activities are to be reported monthly in the DPH approved data reporting system by the LHD MCH Coordinator or other designated LHD staff. All costs related to these two packages must be coded to cost center 766 and the code on the selected package for reimbursement as previously noted.

**#207 Nurturing the Thriving Mind (NTM):** *To increase the knowledge of mental health awareness and education in schools, and support safer learning environments for students, teachers, and staff.*

Improve mental health awareness and education in schools and communities by supporting implementation of school-wide bullying and suicide prevention programs. Assess selected schools and their social/emotional climate to determine what age-appropriate prevention program will be most effective and engaging for their students. These efforts will include prevention outreach and education on the topic of mental health awareness, bullying, and suicide prevention. This support will provide expansion of outreach services and community partnerships that already exist in the selected schools. Expenses associated with this package are **coded to #766-207**.

**#208 Whole School, Whole Community, Whole Child (WSCC):** *Support the Whole School, Whole Community, Whole Child Model (WSCC) initiatives in local school districts. "Coordinate and enhance the work with schools to assist with meeting the need for greater emphasis on both the psychosocial and physical environment, as well as the increasing roles that community agencies and families play in improving childhood health behaviors and development," [CDC, WSCC Healthy Schools].*

Collaborate with local school districts and schools to enhance policies addressing the health of students and staff resulting in overall improvement in learning and health. Partners will be involved with existing school councils and committees to improve both district and school wellness policies to better support opportunities for physical activity; to increase access to healthy foods; and, to create tobacco free campuses. Implementation of evidence-based best practices referencing the WSCC model identified by Centers for Disease Control and Prevention (CDC) is the goal. It is recommended that LHDs train, support, and assist school districts/schools with utilization of the Alliance for a Healthier Generation's (AHG) Healthy Schools Program assessment tool or the School Health Index from CDC, Healthy Schools. Expenses associated with this package are **coded to #766-208**.

**#209 Fluoride Varnish for Children through Fifth Grade (FV):** *Provide for the coordination of supportive activities to increase the application of fluoride varnish services and oral health education for children through fifth grade in order to improve oral health*

outcomes for children throughout Kentucky. **Varnishes are coded to cost center 712 Dental Services. Support and prevention activities (including education) are coded to cost center 766 MCH Coordination.**

Within the LHD service area, 100% of children (and 40% of public-school students) will be evaluated for fluoride varnish applications provided to protect their teeth by the public health nurse in either the LHD clinic or in the school setting. Age-appropriate oral health education will be provided in person whenever possible, as well as virtually through material distribution and/or social media. Caries prevention education and materials will be provided to parents whose child receives fluoride varnish services. Expenses associated with prevention and education for this package are **coded to #766-209**. Expenses associated with fluoride varnish applications are **coded to cost center 712**.

**#210 Healthy People, Active Communities (HPAC):** *Make healthy nutrition and physical activity safe, easily accessible, and supported by policies that make environmental changes, which support and encourage healthy, sustainable activities within communities.*

Increase community engagement between organizations and local residents. The LHD, organizations, and residents will define the specific issue to gain a shared understanding of the barriers to meeting the 5-2-1-0 evidence-based healthy behaviors model and will identify possible solutions. A collaborative action plan will be developed (or other approved, evidence and population-based model) and will identify possible solutions. A collaborative action plan will be developed and implemented on at least one of the 5-2-1-0 best practices. Expenses associated with this package are **coded to 766-210**.

**Please Note:** KDPH/MCH and the MCH Coordination Program Team acknowledge the barriers and priority shifts all health departments will experience from time-to-time. To address evolving local needs as they occur, KDPH and MCH leadership have created a package to address coordination, community education, and health promotion/prevention/protection marketing costs that may not otherwise have been covered in the prescribed packages above. **This package cannot be utilized unless justified to and approved by DPH leadership.**

- If any Child and Adolescent Health package is chosen, activities are to be reported monthly in the DPH approved data reporting system by the LHD MCH Coordinator or other designated LHD staff. All costs related to these packages must be coded to cost center 766 and the code on the selected package for reimbursement as previously noted.

**#211 MCH Special Projects:** *To build infrastructure and partnerships to support emergent local priority MCH population(s) needs not addressed in the approved packages previously described.*

Develop and support identified MCH need-related education, prevention, and/or protection strategies; expand partnerships and resources to address the identified need(s); develop appropriate provider referral processes; and, utilize available communication methods/venues for dissemination of accurate, consistent education and prevention programs or projects. Expenses associated with this package are **coded to #766-211**.

All MCH Special Project activities are to be reported monthly in the DPH approved data reporting system for reimbursement as previously noted.

All MCH program packages are available at any time via email. Send a request to [MCHCoordinator@ky.gov](mailto:MCHCoordinator@ky.gov). For additional information, visit the [Child and Family Health Improvement Branch](#) webpage.

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## **Newborn Metabolic Screening Program**

### **Laws, Regulations, Guidelines**

The Newborn Screening Program administers the newborn screening for all infants born in Kentucky as authorized by Kentucky law, [KRS 214.155](#), which mandates all infants born in Kentucky undergo a newborn screening test, typically done at the hospital prior to discharge. The screenings include: dried blood spot testing for 53 disorders and a pulse oximetry for critical congenital heart defects. If the initial screening results in a positive test, the program assures that those infants receive a definitive diagnostic evaluation by a state university specialist. The panel of newborn screening tests includes markers for over fifty-three inborn errors of metabolism and genetic conditions and any additional disorders that are recommended for inclusion on the Recommended Uniform Screening Panel (RUSP) by the Department of Health and Human Services (HHS). The description of services is addressed in [902 KAR 4:030](#).

### **Program Description**

KY law requires all newborns in Kentucky be screened for selected conditions that can have serious adverse outcomes if untreated early in life. Early detection, diagnosis and treatment of children with these rare conditions may prevent a child's death, disability or serious illness. The KY Public Health Newborn Metabolic Screening Program includes six components: patient and practitioner education, screening, short term follow-up, diagnosis, treatment and management, and evaluation. This program assures follow-up of all abnormal screens for definitive diagnosis and treatment for inborn errors of metabolism and other disorders recommended by HHS. DPH program staff coordinate the referrals to university specialists, information for the infant's medical home and the child's family. The DPH program staff track infants until the final diagnosis is established and support for the family are in place. Educational materials are provided through this program to healthcare providers, parents, and the general public.

### **Target Population**

Any infant born in the state of Kentucky.

### **Funding**

The LHD activities related to Newborn Screening are funded through the Public Health Block Grant. (State General Funds)

### **Responsibility of the LHD in the Newborn Screening Program**

1. Collecting or verifying the Newborn Screen
  - a. Screening should occur at the LHD when an infant has not received the newbornscreen as a result of:
    - home delivery;
    - early hospital discharge (release less than 24 hours); or
    - the parent has been notified that the newborn screen needs to be repeated.
  - b. Repeat at the request of the DPH Follow-up Program: If a repeat newborn screening test has been requested and not received, the newborn screening follow-up staff will send a letter to the infant's mother or guardian notifying them of the continued need for repeat testing. Letters

requesting repeat tests are generated by the DPH Newborn Screening Follow-up program. These letters are sent to the infant's health caregiver/submitter (physician, hospital, primary care provider or LHD). The LHD may need to perform a newborn screen on an infant if a repeat has been requested. Notification from the Division of Laboratory Services or the Newborn Screening Program shall be presented by the parent at the time of the request.

- c. If repeat testing has been recommended by the Division of Laboratory Services, the LHD should continue to monitor and/or obtain those results during subsequent visits until a normal result is received or a referral has been made to a university specialist for diagnostic evaluation.
  - d. If a newborn screening test is drawn at the LHD, it is the LHD's responsibility to monitor and chart the outcome of the newborn screening test until no further testing is required or the infant has been linked to a university specialist and a local medical home.
  - e. For infants receiving Pediatric Preventive Health services/exams at the LHD, the LHD should verify and chart the results of the Newborn Screening Test at the first well child visit; if those results have not been received, the LHD should contact the DPH Division of Laboratory Services Newborn Screening Lab at (502) 564-4446 ext. 4434 to obtain those results and put them in the infant's chart.
  - f. Repeat newborn screenings should not be performed on infants who are six (6) months of age or older. This includes sickle cell testing. The Division of Laboratory Services does not accept filter paper newborn screening specimens on patient over six (6) months of age *unless they fall under one or both categories*:
    - Prematurity
    - Adoption
  - g. For anyone older than six (6) months of age that does not fit the above criteria, the LHD should recommend a laboratory evaluation by a reference laboratory, other than the Division of Laboratory Services, for the specific disorder in question.
  - h. If the State Lab has recommended a repeat newborn screen and the parent/guardian refuses for the repeat to be performed, please have the parent/guardian sign a refusal of treatment form and fax it to the Newborn Screening Follow-up Program at (502) 564-1510. If you have questions, call the Newborn Screening Follow-up Program at (502) 564-3756 ext. 3761.
2. Case Management for infants with positive or equivocal diagnoses.
- The LHD may be asked to assist in locating the patient. State Newborn Screening Follow-up Program and the Lab refer infants with abnormal results to the primary care provider and the appropriate university specialist who will, in many cases, need to locate the patient/family within hours. The DPH Newborn Screening staff will contact the LHD if this is necessary.
  - The LHD may be asked to assist in finding a medical home for these children. These children need a primary care provider who can diagnose and treat acute illnesses, be available after hours, and have the capability to admit the child to the hospital if needed.
3. LHD's may be called upon to assist these families with locating and obtaining specialized metabolic foods and formulas for Infants with a positive definitive diagnosis of an inborn error of metabolism or genetic condition by specialist. These infants will have a

physician order by the specialist for specialized food and formula for treatment that is administered under the direction of a physician.

- Infants with positive or equivocal tests should be evaluated for WIC eligibility as some special formulas can be obtained through WIC.
- LHDs may contact the Metabolic Foods and Formula Program at (502) 564-2154 to help arrange special foods and formula for infants per [902 KAR 4:035](#):
  - Who are uninsured;
  - Whose coverage of specialized food and formula has been denied by their insurance company; or
  - Whose coverage limits have been exceeded.

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## **Kentucky Oral Health Program**

### **Laws, Regulations, Guidelines**

#### **[902 KAR 115:010](#). Water fluoridation for the protection of dental health.**

RELATES TO: [CHAPTER 211 STATE HEALTH PROGRAMS](#)

STATUTORY AUTHORITY: [KRS 194A.050\(1\)](#); [211.090\(3\)](#); [211.180\(1\)](#); [211.190\(11\)](#)  
NECESSITY, FUNCTION, AND CONFORMITY: [KRS 211.190\(11\)](#) requires the Cabinet for Health and Family Services to provide public health services that include water fluoridation programs for the protection of dental health. This administrative regulation establishes the requirements for the programs.

[KRS Chapter 13B](#) establishes a uniform procedure to be followed by administrative agencies in conducting agency hearings.

#### **[902 KAR 115:020](#) Enforcement of Water Fluoridation Program**

RELATES TO: [KRS 211.190\(11\)](#)

STATUTORY AUTHORITY: [KRS 13B.170](#), [KRS 194A.050\(1\)](#), [KRS 211.090\(3\)](#).

NECESSITY, FUNCTION, AND CONFORMITY: [KRS 194A.050\(1\)](#) and [KRS 211.090\(3\)](#) authorize the cabinet to promulgate administrative regulations to protect the health and welfare of the citizens. This administrative regulation establishes the procedures for the enforcement of the Cabinet for Health and Family Services Community Water Fluoridation Programs as directed by [KRS 211.109\(11\)](#)

#### **[201 KAR 8:562](#) Licensure of Dental Hygienists**

201 KAR 8:562, Section 15: Requirements for Public Health Registered Dental Hygienist Registration. This section states that Public Health Registered Dental Hygienist must meet requirements established in [KRS 313.040\(8\)](#). Which state:

(8) A dental hygienist licensed by the board may practice as a public health hygienist and may provide dental hygiene services if: (a) The services are provided as part of a dental health program; (b) The program for which the hygienist works is operated through the DPH or a governing board of health; and (c) The hygienist performs only accepted standardized protocols which are contained within the scope of practice of dental hygiene and which are reviewed and approved by the Board of Dentistry and either the DPH or the dentist member of the governing board of health, as set out in administrative regulation.

There are no specific statutes or regulations which result in the existence of the Fluoride Supplement Program, KIDS SMILE: Fluoride Varnish Program or Kentucky Sealant Program; these programs would be included in the public health services provided by the cabinet.

### **Programs Description and Target Population**

There are no income requirements for recipients of services through the programs provided by the Kentucky Oral Health Program (KOHP). Specific information is provided for the following oral health programs:

**Rural School Fluoridation Program:** Provides fluoridated water, through an agreement between the school and the KOHP, to school children living in rural areas not served by a fluoridated water supply. Schools voluntarily participating in the program receive equipment to add fluoride to the school's water supply. Funded through state general funds.

- There are no specific training requirements for program staff; however, KOHP fluoridation staff attends the Centers for Disease Control and Prevention's water fluoridation training to receive a [FLO Certification](#).
- State fluoridation staff train school personnel to perform fluoride water testing and procedures for sending the water samples to the DPH Division of Laboratory Services.

Reporting Requirements: School staff performs a fluoride test on school days and sends one sample weekly to the Division of Laboratory Services for testing. Additionally, school staff sends KOHP a copy of their Monthly Operating Report, with their daily test results, that are required to be submitted to the Division of Water.

**Community Water Fluoridation Program:** Assures Kentuckians have optimally fluoridated water through proper levels in their municipal water systems. In Kentucky, fluoridation is mandatory ([KRS 211.190\(11\)](#); [902 KAR 115.010](#)) for community water supplies serving a population of 1,500 or more. Community water supplies serving a population of less than 1,500 may voluntarily fluoridate. In 1994, KOHP became responsible for the enforcement of fluoride regulations. Program staff works closely with water plants through monitoring and technical assistance. Funded through state general funds.

- KOHP fluoridation staff complete the Centers for Disease Control and Prevention's water fluoridation training. State fluoridation staff provide technical assistance and trouble-shoot problems at municipal waters systems as needed.

Reporting Requirements: Water plants must submit two water samples monthly to a state certified laboratory. The KOHP staff also updates the CDC database, Water Fluoridation Reporting System (WFRS). Information entered into the WFRS includes yearly inspections, fluoridation changes of chemicals, personnel changes and updated population numbers for water plants.

**Fluoride Supplement Program:** Primarily serves children from 6 months through 6 years of age with drinking water from a non-fluoridated water source (e.g., well, cistern, spring). The LHD or private provider will supply a water testing kit to determine if the water is low in fluoride and if a fluoride supplement may be required. There is no cost to the families or

providers to participate in this program because the testing supplies and fluoride supplements are provided free of charge. Funded through state general funds.

- KOHP staff administering the Fluoride Supplement Program are trained by supervising nurses locally and act in accordance with the Fluoride Supplement Guidelines of the American Dental Association. Local health care providers (dentists, physicians and public health nurses) receive information current with the Centers for Disease Control and Prevention's guidelines regarding fluoride supplementation.

The LHD staff would be responsible for completing the questionnaire and consent for fluoride supplement program, dispensing water test kits as needed, following up with water test results, contacting the child's parent or guardian regarding water test results, educating parents or guardians regarding fluoride supplements, dispensing fluoride supplements, entering fluoride supplement data into the Division of Laboratory Services, [Outreach System](#), ordering fluoride supplement supplies as needed and storing fluoride supplement supplies and forms.

Reporting Requirements: LHD staff enters information into the Division of Laboratory Services, [Outreach System](#) prior to the water samples kits being provided to parents or guardians to submit to the Division of Laboratory Services for testing. When fluoride supplements are needed for children, the LHD staff enters fluoride supplement dispensing information into the Division of Laboratory Services Outreach System. The KOHP works with Central Data Processing to obtain monthly data for the fluoride supplement program.

**Kids Smile: Fluoride Varnish Program:** Serves infants and children from the eruption of their first tooth through children through age 19. The program trains LHD nurses to provide oral health screenings for infants and children from the eruption of their first tooth through children through age 19; application of fluoride varnish to vulnerable teeth of children; referrals as needed for the child and oral health education messages to the parents or guardians of children participating in the program. Fluoride varnishes are primarily used as a decay prevention therapy for pediatric patients and persons at a high risk for tooth decay. Funded through the Tobacco settlement funds and Medicaid reimbursements.

- The State Dental Director, a Kentucky licensed dentist, trains public health registered and licensed practical nurses with the KIDS SMILE: Fluoride Varnish curriculum. The curriculum for the fluoride varnish training includes pediatric oral health screening, fluoride varnish application, providing an oral disease prevention message and making proper referrals to oral health professionals.

LHDs are responsible for scheduling fluoride varnish training for public health nurses, providing space and time for the nurses to provide dental screening, fluoride varnish application and referrals as needed for the child and education to the parents or guardians. Staff is responsible for ordering fluoride varnish supplies as needed. Staff is responsible for entering fluoride varnish data on the PEF and Clinic Management (CMS) System as well as other reporting systems, such as GenTrack, if appropriate (public health dental hygienists).

Reporting Requirements: LHD staff enters the fluoride varnish code, D1206, into the Patient Encounter Form. The KOHP works with Central Data Processing to obtain monthly data for the fluoride varnish program.

**Kentucky Sealant Program:** Provides screenings and sealants to elementary children's teeth. Sealants are thin, plastic coatings painted on the chewing surfaces of the back teeth to prevent dental decay in the permanent molars. LHDs use various configurations of personnel to conduct this program: hire their dental staff for the LHD to provide screenings and sealants; contract with a local dentist to provide screening and sealant services; or enlist volunteer dental personnel to adopt a school for yearly screenings and sealant applications.

Oral health education efforts include current oral health materials, public and professional education presentations and events, a website and participation with community partners. The KOHP will assist local coalitions in researching and determining the attitudes, beliefs and barriers to oral health. This is an essential step to an effective coalition that will directly meet the oral health needs of the community's stakeholders, including the unserved and underserved. The Kentucky Oral Health Program staff will provide technical assistance in determining and implementing the strategies and will attend coalition meetings in order to provide assistance as needed. The KOHP will work with the coalitions in developing their strategies, goals, timelines, and work plans. Funded through state general funds.

LHDs use various configurations of personnel to conduct this program: hire their dental staff for the LHD to provide screenings and sealants; contract with a local dentist to provide screening and sealant services; or enlist volunteer dental personnel to adopt a school for yearly screenings and sealant applications.

Reporting Requirements: LHDs participating in the sealant program (with local contracted dental professionals) report activity to the KOHP via provided program-specific spreadsheets.

**Public Health Dental Preventive Program:** Employs Public Health Registered Dental Hygienists to provide preventive dental services to populations targeted by the LHD's community assessment. All services in this program are within the scope of practice of a Certified Public Health Registered Dental Hygienist found in the governing laws of the Kentucky Board of Dentistry. This LHD-based program is not required to exist in each health department, but those that chose to establish and maintain such a program will abide by the Board of Dentistry's standards as well as protocols and guidance provided by the Kentucky Oral Health Program. This program provides preventive dental services in accordance with current Kentucky Law and KOHP standards. Funded through State General Funds and Medicaid Reimbursement.

- Public Health Registered Dental Hygienists provide preventive dental services within the requirements of their certification and within the scope of practice of that licensure and certification.

An LHD-based dental hygiene program must be headed by a certified Public Health Registered Dental Hygienist and services must be conducted within the appropriate scope of practice. Support services for this program could be done through various configurations of local agency resources.

Reporting Requirements: LHD staff will enter the services codes through the Patient Encounter Form (PEF), PEF entry system via the [LHD Network System\(s\)](#), or other program specified services reporting system (i.e. GenTrack or current electronic health record).

### **Staff/Provider Requirements**

State Dental Director: Kentucky licensed dentist with public health degree and/or public health experience. Other staff requirements are dependent of specific job duties.

## Medicaid Preventive Health Billing and Coding Procedures Specific to Program

Billing and Coding Procedures are outlined below. Reimbursement protocols follow the current [Medicaid Preventive Health Fee Schedule for health departments](#) for DMS allowed programs including fluoride varnish activity. The Clinic Management System (CMS) generates billing through its reporting for the services provided by the contracted dentists in participating health departments.

### DENTAL (712):

(For information regarding these codes, contact the Oral Health Program at (502) 564-3604)

SERVICE CODE	DEFINITION
D1206	Fluoride Varnish Application

### FLUORIDE (800):

The fluoride program is primarily for pre-school children (6 months – 6 years) who are not presently receiving fluoridated drinking water, other fluoride supplements, or vitamins with fluoride. Whether or not a child is receiving fluoride can be determined by the answers to questions on the questionnaire and consent form ([OH-9](#)).

For patients with abnormal fluoride test results from water samples submitted to the Division of Laboratory Services, issuing of fluoride supplements (drops or tablets) and follow-up should be followed per protocol. If the test results from the water sample are > 2.0 ppm, call the Oral Health Branch Manager at 502-564-3204 for further clarifications and directions.

**FLUORIDE SUPPLEMENTS** – Fluoride supplements given when patient is not in the clinic (e.g., mother picks up the supplement for child) should be reported in the supplemental system using the following codes:

SERVICE CODE	DEFINITION
S0001	Fluoride Drops 1 <sup>st</sup> dose
S0002	Fluoride Drops Refill

**FLUORIDE WATER TESTING** – Water samples tested for fluoride content should be reported in the supplemental system using the following code:

SERVICE CODE	DEFINITION
S0009	Fluoride Water Testing

Type of water specimen should be reported using one of the following codes:

SPECIMEN CODE	TYPE OF WATER SPECIMEN
31	Well Water (Denote well depth)
32	Cistern Water
37	Other

### Other Special Requirements

- All programs dealing with water fluoridation follow state and federal (Centers for Disease Control and Prevention, Environmental Protection Agency) regulations and guidelines dealing with safe fluoride levels in drinking water.
- The Kentucky Oral Health Program follows all [HIPPA guidelines and regulations](#).
- The Kentucky Oral Health Program follows grantor guidelines for administration and implementation of grants.
- The Kentucky Oral Health Program follows the Association of State and Territorial Dental Directors and Centers for Disease Control and Prevention [Best Practices](#) for dental care.

### **Program Specific Requirements**

The KOHP abides by the uniform procedure to be followed by administrative agencies in conducting agency hearings and the procedures to be followed by the DPH in hearing appeals of actions taken under the public health laws of the Commonwealth.

### **Special Equipment Requirements**

- KOHP staff and the schools' employees require fluoride testing equipment (fluoride tester & reagent) for the Rural School and Community Fluoride Programs. Field staff carries spare testers and fluoridation equipment (pumps, saturators, sodium fluoride and flow switches) which are used for school fluoridation and some voluntary community water plants.
- The KOHP provides storage for educational materials, fluoride supplements, forms and water sample kits in the KOHP's office space.
- LHDs provide storage for fluoride supplement materials, water sample kits, sealant materials and fluoride varnish supplies at the LHDs.
- LHDs participating in the Preventive Dental Program must have equipment and supplies common to hygiene programs.

### **Minimum Patient Responsibility**

Parents or guardians of LHD patients are responsible for keeping appointments; placing water to be tested into the test tube and mailer; placing mailing labels on the mailer containing the water sample submitted for testing; and follow-up as required by the water test results. When a water test result indicates a need for fluoride supplementation, parents or guardians of the child are responsible for following directions for providing fluoride supplements to the child; refilling supplements and continuing as needed; and providing the fluoride supplements per LHD nurses' instructions.

- Parents or guardians are responsible for bringing the child to scheduled appointments for fluoride varnish screenings and applications and services provided through a Public Health Preventive Dental Program (Hygiene). Parents or guardians are responsible for following directions provided by dental health providers and public health nurses.

### **Services (Arranged and Paid) Include:**

- **Rural School Fluoridation Program:** None
- **Community Fluoridation Program:** None
- **Fluoride Supplement Program:** None

- **Kids Smile: Fluoride Varnish Program:** Contract with University of Kentucky for purchase, storage, assembly and dissemination of fluoride varnish kits and teaching materials and data related to these tasks.
- **Kentucky Sealant Program:** MOA to LHDs participating in the Kentucky Sealant Program.
- **Kentucky Preventive Dental Program:** MOA to LHDs participating in the Public Health Dental Hygiene Program
- **Oral Health Services:** including but not limited to Fluoride Varnish services, are always subject to program audits for continuous quality improvement

## **Public Health Prenatal Program (PHPP)**

Following guidelines established by the DPH Commissioner’s Office, the PHPP is updated to align with the implementation of the [Kentucky Public Health Transformation](#) model. This includes the transition from direct patient services to population health. LHDs have four key roles and responsibilities. These include assisting pregnant women with enrollment in [Pregnancy Presumptive Eligibility \(PE\)](#), informing women of local prenatal providers, referral to wrap-around services, and reporting.

### **Laws, Regulations, Guidelines**

The following statutes authorize and specify services of the PHPP:

[KRS 211.180](#)(1), (e) & (f); [907 KAR 20:050](#); [KRS 214.160](#); and [KRS 311.378](#)

### **Target Audience**

Pregnant women

### **Funding**

**LHDs do not have to do or assure prenatal care.** MCH will not provide funding for direct patient prenatal services. LHDs will need to identify a funding source other than MCH funds. LHDs may choose to use the Public Health Block Grant funds or other funding sources to provide direct services through an in-house prenatal clinic or to pay a contracted prenatal provider whom they use to refer women.

### **PHPP Eligibility Guidelines**

Financial eligibility for the PHPP is defined in [907 KAR 20:050](#). To be eligible for the PHPP, the pregnant woman’s income shall be **at or below 218% Federal Poverty Level**

### **Key Roles and Responsibilities of the LHD**

**All** LHDs should assist with pregnancy.

**Presumptive Eligibility (PE) Enrollment** - Pregnancy PE is a Kentucky Medicaid program authorized by [907 KAR 20:050](#). More information on Pregnancy PE eligibility, guidelines, forms and covered services may be reviewed on the [DMS Presumptive Eligibility for Pregnant Women webpage](#).

### **LHD PE Process:**

1. **All** LHDs should assist the pregnant women in applying for Pregnancy PE upon a positive pregnancy test or when the pregnant woman presents to the LHD and has not already obtained Medicaid. The local DCBS Family Support office **does not** process PE and pregnant women should not be sent there until after they have qualified and obtained Pregnancy PE.

2. The LHD should instruct the pregnant woman to apply for full Medicaid benefits **prior** to the expiration of the PE period.
  - The day the pregnant woman **applies for full Medicaid** her Pregnancy **PE benefits will end**, even if she is not eligible for Medicaid benefits.
  - LHD staff should work with the woman to receive the immediate prenatal services needed, while she has Pregnancy PE and prior to the expiration.
3. The Pregnant PE applicant has an option to choose her Medicaid Managed Care Organization (MCO) during the application process and will receive Pregnancy PE eligibility notice upon approval. LHD are encouraged to be aware of which MCOs the prenatal providers whom they refer women to will accept. If an MCO is not selected, one will be assigned. The PE applicant, if she so wishes, is not able to change their MCO until the beginning of the following month. The PE approved member may contact DMS at 1-855-446-1245 on the day of PE approval and select the MCO or the following day to find out what MCO was system assigned. If the PE member wishes to change her assigned MCO, the change will be effective the first day of the following month, provided she calls 8 business days before the end of the month (cut off). Changes requested in the last 8 business days of each month are not effective the next month but the following month. Example: Called June 25... effective August 1.

**Duration of PE – Pregnancy PE shall end:**

1. The day preceding the date the presumptively eligible individual is granted full eligibility in the Medicaid Program;
2. The last day of the month following the month in which a qualified provider made the PE determination, if the presumed eligible individual has not applied for the full Medicaid benefit package;
3. The day a woman applies for full Medicaid and is found ineligible or is denied.

**ALL LHDs** should be aware of prenatal providers within their community and be able to provide pregnant women with the name of providers and contact information.

**ALL LHDs** should refer pregnant women to wrap-around services such as HANDS, WIC, and referrals for smoking cessation, substance use, depression and domestic violence as applicable.

**Reporting Requirements**

1. **ALL** LHDs shall report the data below on a quarterly basis to the DPH/MCH/Prenatal Program Coordinator.
2. The PHPP Reporting Form should be completed and faxed to the attention of the Prenatal Program Coordinator at (502) 564-5766.
3. The **reporting schedule** is as follows:  
 The reporting data **is due November 30** (for July – September); **February 28** (for October – December; **May 30** (for January – March); and **July 30** (for April – May).
4. The data should reflect the women that are participating in the PHPP (income at or below 218% FPL). Report the following data:
  - The total number of unduplicated women served in the LHD.
  - The total number of unduplicated women referred from the LHD to a prenatal provider or FQHC.

**Optional LHD Services**

**LHDs do not have to do or assure prenatal care.** If an LHD identifies prenatal services as a *local public health priority*, they may choose to provide services through an in-house prenatal clinic or contract with a prenatal provider to use to refer women. If an LHD chooses to provide prenatal services, DPH recommends the following:

- LHDs are encouraged to **refer to [ACOG guidelines](#)** and the **current edition of Guidelines for Perinatal Care** for the provision of prenatal services. These resources detail the number and type of visits, labs and procedures that are recommended.
- The **[ACOG Antepartum and Discharge/Postpartum Forms](#)** provide standardized documentation. View the [ACOG website](#) for further information.

### **Standard Clinical Requirements**

- Facilities, supplies and equipment align with the ambulatory obstetrical care standards as specified in the current edition of Guidelines for Perinatal Care.
- Clinical equipment used at an in-house prenatal clinic is in proper working order, maintained and calibrated according to manufacturer's directions and is sufficient to provide basic screening tests.

### **Staff Requirements**

- Prenatal care must be provided by appropriately licensed or certified personnel acting within their legal scope of practice. ACOG recommends high-risk patients be seen by an obstetrician.
- Advanced Practice Registered Nurses caring for pregnant women operate within their scope of practice, certified as women's health practitioners and have both training/experience in obstetrics.
- Contracted providers utilize staff from his/her own office for assistance while at the LHD working an in-house prenatal clinic:
  - The staff member should maintain a current professional license and be educated/trained to perform the designated functions in the LHD.
  - The functions which the individual performs should be clearly enumerated within the private physician's contract.

### **Billing and Coding**

- The LHD is not required to pay for prenatal services.
- If the LHD provides prenatal services or refers a woman to a prenatal provider, the LHD should inform the pregnant women in the language/manner (verbal, written) they understand, of what services she will be expected to pay for, if and what services the LHD will pay for, or if she should work with the prenatal provider for all billing matters.
- The LHD should contact the [LHO Branch](#) for medical coding questions.

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## **Preventive Services Protocols: History, Physical Exam, Screening Procedures**

### **Laws, Regulations, Guidelines**

The Preventive Program is provided by DPH under contract with the Kentucky Department of Medicaid Services. The purpose is to assure access to preventive health services for all

Kentuckians, primarily low-income families who do not have a medical home. The incidence of preventable disease, disabilities and injuries is reduced by providing preventive health services to low-income children and by collaborating with community based and state level health and human services providers to develop a system of health care for the benefit of all children.

**902 KAR 4:100. Maternal and child health services.**

RELATES TO: [KRS 194A.050](#) Execution of policies, plans, and programs -- Administrative regulations -- Fees.

STATUTORY AUTHORITY: [KRS 194A.030](#); [200.460](#); [200.470](#); [200.490](#); [211.900](#); [214.155](#); [214.160](#); [214.185](#)

NECESSITY, FUNCTION, AND CONFORMITY: The CHFS, DPH Services is responsible for administering the programs of services in accordance with Title V of the Social Security Act (maternal and child health block grant). [KRS 194A.050](#) empowers the secretary to promulgate such administrative regulations as are necessary to implement programs that qualify for the receipt of federal funds. This administrative regulation sets forth the eligibility requirements for receipt of services under certain maternal and child health programs and describes the minimum types of services under each of those programs.

[907 KAR 11:034](#). Early and periodic screening, diagnosis, and treatment services and early and periodic screening, diagnosis, and treatment special services.

RELATES TO504: KRS [205.520](#), [605.115](#), 42 C.F.R. [441.50-441.62](#), [42 U.S.C. 1396d](#)

STATUTORY AUTHORITY: KRS [194A.030](#)(2), [194A.050](#)(1), [205.520](#) (3)

NECESSITY, FUNCTION, AND CONFORMITY: [KRS 205.520](#) authorizes CHFS, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provision of Medicaid to Kentucky's indigent citizenry. This administrative regulation establishes the provisions relating to the early and periodic screening, diagnosis and treatment service and early and periodic screening, diagnosis and treatment special services for which payment shall be made by the Medicaid Program on behalf of both categorically needy and medically needy children under age twenty-one (21).

**Target Population**

- Persons who are unable to access the services of a medical home for preventive exams and screenings.
- Priority for services will be to persons from low-income families or whose total annual Family income does not exceed 185 percent of the most recent federal Income Poverty Guidelines.
- Charges for services will be made to persons other than those from low-income families.

**Funding**

Preventive services are funded through Medicaid Billing and may be paid from the Public Health Block grant when appropriate.

**Staff/Provider Requirements**

Review the [MCH Coordination and Improvement Collaborative Grant](#) and [Family Planning Program \(Title X\)](#) staff/provider requirements of this AR Program Descriptions section.

## **Training**

Registered Nurses providing preventive services in a LHD must complete the required trainings for the program whose services they are providing.

## **Reporting Requirements**

Reporting of client information is collected through the Clinic Management System (CMS/Portal) or Patient Services Reporting System (PSRS), referred to as the [LHD Network Systems](#).

## **Special Equipment Requirements**

- Providers shall be located in a facility that is constructed, equipped and maintained to ensure the safety of the children and provide a functional, sanitary environment.
- The area utilized during the screening examination shall provide adequate privacy.
- The provider shall have the necessary equipment, in proper working order, to provide the basic screening tests outlined in the [CSG](#).

## **Service Description & Key Roles & Responsibilities of Health Department**

### **PHYSICAL ASSESSMENT**

In the delivery of health services, every patient deserves a general survey at every encounter with a health care provider. A general survey may be described as an overall review or first impression that the health care provider has of a person's well-being. This could be as simple as a visual observation and encompasses the following examples and components dependent to some extent on age.

- Appearance – appears stated age; sexual development appropriate; alert, oriented; facial features symmetric; no signs of acute distress
- Body structure/mobility – weight and height within normal range; body parts equal bilaterally; stands erect, sits comfortably; walk is smooth and well balanced; full mobility of joints
- Behavior – maintains eye contact with appropriate expressions; comfortable and cooperative with examiner; speech clear; clothing appropriate to climate; looks clean and fit; appears clean and well groomed

Deviations from what would generally be considered to be normal or expected should be documented and may require further evaluation or action.

Information about audiometric screening and the Snellen Test for vision screening are covered in this section.

### **HEALTH HISTORY**

A patient history should be done as indicated by the age specific Preventive Health Guidelines.

A comprehensive history (including chief complaint or reason for the visit, a complete review of systems and a complete past family and/or social history) should be obtained on the first preventive health visit by the physician, advanced registered nurse practitioner, physician assistant or nurse. The history should be age and sex appropriate and include all the necessary questions to enable an adequate delivery of services according to the Preventive Health Services and/or the patient's need, visit requirement, Health Guidelines, or request. The completion of the history component of the Health History and Physical Examination Form

will assist in the assessment of the patient's past and current health and behavior risk status. Certain health problems, which may be identified on a health history, are more common in specific age groups and gender. These may be found in the Preventive Health Guideline section as things for which to be alert.

An interval history (including an update of complaints, [reason for visit](#), review of systems and past family and/or social history) should be done as indicated or as identified on the age specific Preventive Health Guidelines.

Completion of all items on the history component of the Interval Health History and Physical Examination Form will give a picture of the patient's current health and behavior risk status. Additional information may be required depending on the specialized service(s) to be provided.

Guidelines for *other than preventive health visits* will require the components of the history appropriate for the presenting special need or conditions. The level of history indicated may be problem focused, expanded problem focused, detailed, or comprehensive. Depending upon the level of history obtained, documentation may be on the history portion of the Health History and Physical Examination form or in the service notes, but some notation must be recorded for each visit; the visit must be coded according to the level of detail and complexity that is documented. Infant and Child Exams should be conducted per the American Academy of Pediatrics (AAP) Periodicity Schedule as define [Bright Futures Guidance Manual](#).

## **PHYSICAL EXAMINATION**

A comprehensive or partial physical examination should be done at appropriate intervals by appropriate staff, and according to the age specific preventive health guidelines for services. The [AMA Guidelines](#) recognize the following body areas and organ systems for purpose of the examination:

**Body Areas:** Head (including the face); Neck; Chest (including breasts and axillae); Abdomen; genitalia, groin, buttocks; Back (including spine); and each extremity.

**Organ Systems:** Constitutional (vital signs, general appearance), Eyes, Ear, Nose, Throat; Cardiovascular; Gastrointestinal; Genitourinary; Musculoskeletal; Dermatological; Neurological; Psychiatric; Hematological/lymphatic/immunological.

[AMA guidelines](#) recognize only a multisystem exam or body areas. At present, either is acceptable for use. When a comprehensive physical examination is indicated on the schedule, the physical examination component on the forms should be completed in its entirety to document the assessment of all body areas and organ systems, as appropriate to the individual's age and medical history. Normal and abnormal findings and pertinent negatives should be recorded.

The examination appropriate for other than preventive services may be problem focused, expanded problem focused, detailed or comprehensive. Except for a comprehensive exam, the pertinent findings may be documented on the Health History and Physical Examination forms.

Certain health problems, which may be identified on a physical examination, are more prevalent in specific age groups and gender. These will be found in the Preventive Health Guidelines as something for which to be alert.

## MEASUREMENTS

Body measurements include length or height, weight, and head circumference for children from birth to 36 months of age. Thereafter, body measurements include height and weight. The assessment of hearing, speech and vision are also measurements of an individual's function in these areas. The Ages and Stages Developmental Screening is a tool to measure an infant's and young child's gross motor, language, fine motor-adaptive and personal-social development. If developmental delay is suspected based on an assessment of a parent's development/behavior concern or if delays are suspected after an assessment of development benchmarks, a written referral is made to a Physician or KEIS for further evaluation. Other developmental tools include a developmental screening assessment, as taught in the Pediatric Assessment Course; age-specific benchmarks in the [Pediatric Preventive Guidelines](#) may be used as a guide.

A patient's measurements can be compared with a standard, expected, or predictable measurement for age and gender. The [Body Mass Index](#) (BMI) chart in this section applies to adults. Age and gender appropriate growth charts in the Forms Section apply to children. Deviation from standards helps identify significant conditions requiring close monitoring or referral.

The significance of measurements and actions to take when they deviate from normal expectations are found in the age-specific Preventive Health Guidelines.

## MEASUREMENT PROCEDURES

### Height:

Obtain height by measuring the recumbent length of children less than 2 years of age and children between 2 and 3 who cannot stand unassisted. A measuring board with a stationary headboard and a sliding vertical foot piece shall be used. Lay the child flat against the center of the board. The head should be held against the headboard by the parent or an assistant and the knees held so that the hips and knees are extended. The foot piece is moved until it is firmly against the child's heels. Read the measurement to the nearest 1/8 inch.

Obtain a standing height on children greater than 2 to 3 years of age, adolescents, and adults. Measurements may be accurately made by using a graduated ruler or tape attached to the wall and a flat surface that is placed horizontally on top of the head. The patient is to be wearing only socks or be bare foot. Have the patient stand with head, shoulder blades, buttocks, and heels touching the wall. The knees are to be straight and feet flat on the floor, and the patient is asked to look straight ahead. The flat surface (or moveable headboard) is lowered until it touches the crown of the head, compressing the hair. A measuring rod attached to a weight scale **shall not** be used.

If recumbent length is obtained for a two-year-old, it is plotted on the birth to 36 months growth chart, whereas, if standing height is obtained for a two year old, plot on the 2 to 18 year growth chart. Plot measurements for children on age and gender specific growth charts and evaluate accordingly.

### Weight:

Balance beam or digital scales are to be used to weigh patients of all ages. Spring type scales are not acceptable. CDC recommends that all scales should be zero balanced and calibrated. Scales must be checked for accuracy on an annual basis and calibrated in accordance with manufacturer's instructions. Prior to obtaining weight measurements, make

sure the scale is “zeroed”. Weigh infants wearing only a dry diaper or light undergarments. Weigh children after removing outer clothing and shoes. Weigh adolescents and adults with the patient wearing minimal clothing. Place the patient in the middle of the scale. Read the measurement and record results immediately. Scales should be calibrated annually. Plot measurements on age and gender specific growth charts (see Forms Section) and evaluate accordingly.

**Body Mass Index:**

The [Body Mass Index](#) (BMI) is a measure that can help determine if a person is at risk for a weight-related illness. Instructions for obtaining the BMI are included within the chart in this section for adults. To calculate BMI for children, see BMI Tables for Children and Adolescents for guidance.

**Head Circumference:**

Obtain head circumference measurement on children from birth to 36 months of age by extending a non-stretchable measuring tape around the broadest part of the child’s head. For greatest accuracy, the tape is placed three times, with a reading taken at the right side, at the left side, and at the mid-forehead, and the greatest circumference is plotted. The tape should be pulled to adequately compress the hair.

**Vital Signs:**

Vital signs, generally described as the measurement of temperature, pulse, respirations and blood pressure, give an immediate picture of a person’s current state of health and well-being. Normal and abnormal ranges with management guidelines are listed in the [CSG](#).

**PROCEDURES FOR MEASURING HEARING (Birth to Adult)**

Hearing is assessed in infants and young children (1–36 months) by observing responsiveness to 3 tones, i.e., voice, bell, rattle. (Do not use a handheld screening audiometer).

**Administration of an acceptable response to:**

1. **Voice:** With the child not facing you, stand behind the child within 6–12 inches of either ear. Place your hand between you and the child so the infant/child does not respond to feeling your breath; whisper the child’s name. Repeat with the other ear. *Hearing is normal if the child turns to the direction of voice for each ear.*

2. **Bell and Rattle:** Hold the bell/rattle to the side and behind the child’s ear, ring the bell/shake the rattle softly. Try again if no response. Repeat with the other ear. *Hearing is normal if the child responds by an eye movement, change in expression, breathing rate or activity.*

*Hearing is assessed in children 3 years and older (depending on understanding and cooperativeness), adolescents, and adults with pure tone screening (audiometers). If unable to test the child using the pure tone screening procedure, assess the hearing as described for younger children.*

**Testing Area:**

The room used for hearing screening should be as quiet as possible, because background noise interferes with the accuracy of the test and leads to false positive results. Examples of background noise are hallways, fluorescent light hum, etc. The tester, who has normal hearing, may test him/herself to be sure that ambient noise does not interfere with testing. The testing room must be at least large enough to accommodate a table for the audiometer

and chairs for the tester and patient. The patient's chair should be positioned so that the patient cannot see the operation of the audiometer.

### **Pure Tone Screening Procedure:**

#### **A: Audiometer**

1. Power: Turn on.
2. Masking: Check to ensure that masking is turned off.
3. Output Selector: Red earphone is for the right ear (*Hint: R for R*)  
Blue earphone is for the left ear.
4. Tone Level or Tone Interrupter: Normally Off. Press down to produce tone.
5. The following test levels shall be followed for these frequencies:
  - a. 1000Hz 2000Hz 4000Hz
  - b. 20dB for soundproof room
  - c. 25dB for exam room
6. Patients being tested with pure tone audiometer are given verbal instructions to raise their hand when the tone is heard. Children age 6 and below may be able to raise their hand, but it is often easier to have them drop a block. Children under age 6 should have a demonstration: Place the headphones on the table or in your lap, present a tone at 90dB and raise your hand/drop a block. Repeat this having the child perform with you simultaneously. Repeat the tone but allow the child to perform alone. **TURN THE TONE BACK DOWN to 20dB**, then place the headphones on the child (adolescent, adult) and proceed with the specified test levels.

#### **B: Screening**

1. Set frequency dial at 1000Hz.
2. Set hearing level at 20dB.
3. Present the tone by pressing the tone level.
4. To be assured that the patient is responding correctly, the tone may need to be presented several times. Once the desired response is received (i.e. drop a block/raised hand), continue the test and complete the screening as follows:
  - a. Soundproof Room
    - i. Test right ear at 1000, 2000, and 4000 Hz at 20dB.
    - ii. Test left ear at 1000, 2000, and 4000 Hz at 20dB.
  - b. Exam Room Area
    - i. Test right ear at 1000, 2000, and 4000 Hz at 25dB.
    - ii. Test left ear at 1000, 2000, and 4000 Hz at 25dB.
5. If the patient **DOES NOT RESPOND** to the first tone presented in the right ear at 1000 Hz at 20dB (25dB) then:
  - a. Increase the hearing level to 30dB (leave on right ear at 1000 Hz)
  - b. If no response, then increase to 40dB
  - c. If no response, then increase to 50dB
  - d. If no response then switch the control to the left ear and follow the same procedure, increase by 10dB and decrease by 5dB.
6. Normal hearing test per audiometer:

20dB each ear, each tone – soundproof room

25dB each ear, each tone – exam room area

- a. The screening test is failed if the patient fails to hear any one tone in either ear.
- b. A rescreening test should be administered in two weeks for the patient, and if the patient fails the second screening, he should be referred for proper follow-up.

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## **PROCEDURES FOR ASSESSING VISION: METHODS OF ASSESSING VISION IN CHILDREN**

### **NEWBORN:**

In newborns, a red reflex should be checked using an ophthalmoscope if this is not documented from the hospital records. If a red reflex is not seen, the baby should be referred for medical evaluation. Newborn vision is tested mainly by checking for light perception by shining a light into the eyes and noting responses such as blinking, following the light to midline, increased alertness, or refusing to open the eyes after exposure to the light.

### **INFANTS AND YOUNG CHILDREN UP TO AGE 36 MONTHS:**

#### Binocularity Test

Normally, children 3–4 months of age achieve the ability to fixate on one visual field with both eyes simultaneously (binocularity). One of the most important tests for binocularity is alignment of the eyes to detect non-binocular vision or strabismus.

Two tests commonly used to detect malalignment are:

1. The corneal light reflex test (also called the red reflex Gemini test). A flashlight or the light of an ophthalmoscope is shined directly into the child's eyes from a distance of about sixteen inches. If the eyes are normal, the light falls symmetrically within each pupil. If the light falls off center in one eye, the eyes are maligned.
2. The cover test. In the cover test, one eye is covered, and the movement of the uncovered eye is observed when the child looks at a near or distant object. If the uncovered eye does not move, it is aligned. If the uncovered eye moves, a malalignment is present.

### **Inspection of Internal Structures**

The nurse inspects the red reflex, the optic disc, the macula, and the blood vessels by performing an ophthalmic examination. In a darkened room, hold the light source at arm's length, draw the child's attention to look directly at the light. Both retinal reflexes should be red or red-orange and of equal intensity.

It is important to remember that the ophthalmoscope permits only a small area of visualization. In order to perform an adequate examination, the nurse must move the ophthalmoscope systematically around the fundus to locate each structure. The fundus derives its orange-red color from the inner two layers of the eye, the choroid and the retina, which are immediately apparent as the red reflex. A brilliant, uniform red reflex is an important sign, because it virtually rules out almost all serious defects of the cornea, aqueous chamber, lens and vitreous chamber.

#### Observation

Observe that the infant or child follows light or a bright colored object.

### **THREE YEARS AND OLDER:**

Testing for Alignment of Eyes

Binocularity, as described above using the Corneal Light Test (Red Eye Reflex Gemini Test) and the cover/Uncover Eye Test are the methods used to test vision of children ages three years and older as well. Both tests are described on the previous page.

#### Inspection of Internal Structures

Ophthalmoscope Examination – Red Reflex Exam

### **AGES THREE YEARS TO ADULT:**

Visual Acuity

Snellen "E" Chart or instrument vision tester, i.e., OPTEC 2000/Titmus, etc.

Supplies you will need for the Snellen Test

- Snellen "E" Chart
- Window card
- Tape measure
- Adequate lighting
- Large symbol "E"
- Individual eye covers (may be made with construction paper cut with rounded corners or cone paper cups) to prevent the spread of infections.

Prepare The Screening Area:

- Select location that is quiet and free from distractions.
- Select location that has light colored wall that has no glare or shadows.
- Attach Snellen "E" chart to wall so that the patient's eye level is on the 20-foot line.
- Light intensity on chart should be 10 – 20-foot candles evenly diffused over chart.
- Cover upper and lower portion of the chart with cover cards.
- Mark exactly 20 feet of distance from chart.

Prepare The Child

- Show the child the large letter "E" so he/she is familiar with the symbol.
- A game can be made with teaching the child to point in the direction the "table legs" of the "E" are pointed so he will understand the various positions of the "E".
- Place child in standing position at the 20-foot mark and facing the chart. A set of footprints affixed to the floor with the heels at the 20-foot mark may help the child keep the proper position.
- Teach the child to keep both eyes open during the test (when covering either eye).

Procedure

- Test both eyes first, then the right eye and the left eye.
- If patient wears glasses, test with and without glasses.
- In testing one eye, occlude the other eye with an occluder or cone cup.

- Begin on the 50-foot line of the Snellen "E" Chart for 3, 4, and 5-year-olds. If that line is read correctly go to the 40-foot line.
- Begin on the 40-foot line of the Snellen "E" Chart for all patients above 6 years of age. If that line is read correctly, go to the 30-foot line.
- With upper and lower portions of the chart covered, use window card to expose one symbol at a time.
- Move window card promptly and rhythmically from one symbol to another at the speed with which the patient seems to keep pace.
- In linear testing, it may be necessary to use a pointer to indicate the letter.
- Patient points with his arm or hand in the direction of the legs of the "E" point.
- To pass a line the patient must see one-half, or more than half, of the symbols on that line.
- Observe for signs of eye problems, i.e., tilting the head, peeking around the occluder.
- Record visual acuity (the last successful line read in the order tested), e.g., both eyes – right eye – left eye.

Record the results as a fraction – e.g., 20/30, 20/40, etc. The numerator represents the distance from the chart; the denominator represents the last line read. A reading of 20/50, for example, indicates that the child read at 20-feet the line that should be read at a distance of 50-feet. The larger the denominator is, the poorer the vision. If unable to assess vision on a three-year-old with the Snellen "E" Chart, counsel parent/caretaker to play the "E" game and schedule a vision screening in 3 or 4 months.

Vision acuity is assessed in the school age child, adolescent and adult by the Snellen alphabet chart or instrument vision tester. Follow the same procedure for testing both eyes, then the right eye and the left eye, occluding the eye not being tested. Begin testing with the line above the referral line and test down to the appropriate line if possible. If the patient wears glasses, test with and without glasses.

When using an instrument vision tester, follow manufacturer's direction for vision assessment.

#### Snellen Test Referral Criteria for Ages 3–5

Refer children to an ophthalmologist or optometrist if visual acuity is poorer than 20/40 or poorer in either eye, if there is a two line difference between the eyes even if in passing range (i.e. 20/25, 20/40), or if signs of possible visual disturbance are present.

#### Snellen Test Referral Criteria for Ages 6–Adult

Refer the individual to an ophthalmologist or optometrist if visual is poorer than 20/30 in either eye if there is a two-line difference between the eyes, even if in passing range (i.e. 20/20, 20/30), or if signs of possible visual disturbance are present.

In accordance with [KRS 200.703](#), Early Childhood Development, all children enrolling in the Kentucky school system must have a vision examination by an optometrist or ophthalmologist before entering school.

### **CONDUCTING SCOLIOSIS SCREENINGS**

While not an absolute "measurement", scoliosis screening is conducted as a part of a Preventive Health Assessment at certain ages. (mass screenings are no longer recommended). Using the appropriate procedure for this screening is essential and is included here for that reason.

Watch the child walk toward you, then turn and walk away. Notice any signs of leg length discrepancies. With back bare, the child should stand straight, feet together, looking straight ahead, arms at his/her side. Examiner will look for the following:

- Head: See if it is centered over the pelvis (a plumb line may be helpful in checking this);
- Alignment: Does the head and base of the neckline up over the center of the sacrum?
- Shoulders: See if they are level; (Is one shoulder higher or lower than the other side or is there a fullness on one side of the neck?)
- Scapulas (shoulder blades): See if one is more prominent than the other;
- Arms: See if they are equal distance from the sides; (Is there a greater distance between the arm and flank on one side or the other?)
- Waist: See if the indentions (waist side curves) are the same; (Is there a deeper crease over one side of the waist than the other?)
- Spine: As noted by observing the spinous processes; (Does it appear to curve?)
- Hips: See if they are level; (Is there an asymmetrical contour of the flanks and hips?)
- The child should then bend forward with head down, the back parallel to the floor and their hands clasped; is there prominence or a bulge on one side of the back or flank?

View the child from the side, looking for:

- One scapula (shoulder blade) being more prominent than the other;
- Kyphosis (round back);
- Lordosis (sway back).

Any one of the findings suggests an underlying scoliosis curve, which deserves further evaluation. The Orthopedic Systems, Inc. Scoliometer is a device that provides a way to measure the degree of rotation of a deformity of the back found on routine spinal examination. The Scoliometer is not used in place of the screening previously described, but if used in concert with the routine screening, it will provide objective guidelines for referral and also reveals small curvatures, which do not require referral, but do need rescreening. If a deformity is suspected, the device is placed across the deformity at right angles to the body and the degree of rotation is read from the scale. The manufacturer's recommendations should be followed regarding positive findings in need of follow-up or referral, or a local medical advisor/physician should determine if and how Scoliometer readings will be followed up. More Scoliosis information may be found [online](#).

### **TANNER STAGES**

Tanner Staging is also called the Sexual Maturity Rating (SMR) or pubertal development stage and is an essential component of the adolescent exam, as well as height and weight. Tanner Stages can give a continuing appraisal of growth and physical maturation; cues for appropriate anticipatory guidance; and indications of nutritional problems, chronic illness, or other diseases.

- a. Physical changes during the late childhood and adolescence are important events, and start at different ages, as early as 8 for some females and not until 13 for other females.
- b. Physical changes during adolescence are important events and start at different ages, as early as 10 years for some males, but not until 14 for other males.

**TYPICAL PROGRESSION - FEMALE**

**TYPICAL PROGRESSION - MALE**

<p><b>1. No Secondary Sex Characteristics</b></p> <p>External genitalia looks like a child's</p>	<p><b>Pre-pubertal:</b> flat breast</p> <p><b>Pubic hair:</b> none</p>	<p><b>1. Reproductive organs:</b> Beginning to mature</p> <p><b>Height/weight:</b> accelerates, increasing body fat</p>	<p><b>Pre-pubertal:</b> testes and penis size similar to early childhood</p> <p><b>Pubic hair:</b> none</p>
<p><b>2. Breast bud formation:</b> breasts enlarge</p> <p>Directly under areola, before early pubic hair growth</p> <p><b>Height Spurt:</b> Increase in body fat deposition, hips widen</p>	<p><b>Breast bud:</b> small and raised</p> <p><b>Pubic hair:</b> downy sparse growth on sides of labia</p>	<p><b>2. Growth spurt:</b> increase in hands/feet and height, fat and muscle are added</p> <p><b>Breast Areola:</b> increases in size and slightly darken with or without association of Gynecomastia</p>	<p><b>Testes:</b> larger as scrotal skin reddens and coarsens</p> <p><b>Pubic hair:</b> downy with sparse growth at base of penis</p>
<p><b>3. Breast enlargement:</b> extends, contour smooths</p> <p><b>Pubic hair:</b> coarsens, darkens, and spreads</p> <p><b>Ovaries:</b> maturing, Leukorrhoea is normal</p> <p><b>Height spurt:</b> peaks late in this stage when menarche occurs</p>	<p><b>Breast:</b> general enlargement, raising of both breast and areola</p> <p><b>Pubic hair:</b> increases in amount, coarsening, and curling</p>	<p><b>3. Gynecomastia appears</b></p> <p><b>Height spurt:</b> shoulders broaden and muscle mass increases</p> <p><b>Facial hair:</b> fine at corners of upper lip</p> <p><b>Facial expression:</b> more adult</p> <p><b>Voice:</b> Larynx cartilage enlarges, voice may crack</p>	<p><b>Testes and Scrotal skin:</b> Stage 2 continues</p> <p><b>Penis:</b> lengthens</p> <p><b>Pubic hair:</b> increase in amount and curling, coarsens, appears in perineum</p>
<p><b>4. Menarche:</b> if has not occurred late in stage 3, should occur</p> <p><b>Axillary hair:</b> appears just before or after menarche</p> <p><b>Ovaries:</b> continue to enlarge, ovulation rarely occurs</p>	<p><b>Breast:</b> areola and papilla (nipple) form contour and separate from breast</p> <p><b>Pubic hair:</b> adult appearance and limited in area</p>	<p><b>4. Axillary hair:</b> appears</p> <p><b>Facial hair:</b> limited to upper lip and chin, darkens, coarsens</p> <p><b>Sebaceous glands:</b> approach adult size and function</p> <p><b>Height:</b> increases decelerate</p> <p><b>Voice:</b> deepens</p> <p><b>Breast:</b> distinct enlargement, slight projection of areola, and gynecomastia regresses</p>	<p><b>Scrotal skin:</b> becomes pigmented</p> <p><b>Penis:</b> broadens</p> <p><b>Pubic hair:</b> adult appearance and limited in area</p>

<p><b>5. Height:</b> increase slows since menarche</p> <p>Average increase 1–1½ inches, but may increase 2–4 inches</p>	<p><b>Breast:</b> have adult appearance, areola and breast in same contour</p> <p><b>Pubic hair:</b> adult appearance, horizontal upper broader</p>	<p><b>5. Facial hair:</b> on sides of face, gynecomastia disappears</p> <p><b>Statural growth:</b> almost complete</p> <p><b>Physique:</b> like mature male, mass not completed</p>	<p><b>Genital area:</b> adult appearance</p> <p><b>Pubic hair:</b> adult appearance, horizontal upper, broader, spreads to thighs</p>
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## Reportable Diseases Section

### Laws, Regulations, Guidelines

The Reportable Diseases section and Surveillance reports to the Division of Epidemiology and Health Planning, Infectious Diseases Branch and is mandated by various sections of [KRS 211](#) and [KRS 214](#) and regulated by the Kentucky Disease Surveillance Administrative Regulation, [902 KAR 2:020](#), Reportable Disease Surveillance, which contains the case definitions required by Center of Disease Control and Prevention (CDC) and Kentucky.

RELATES TO: [KRS 211.180\(1\)](#), [214.010](#), [214.645](#), [333.130211](#)

STATUTORY AUTHORITY: [KRS 194A.050](#), [211.090\(3\)](#), [211.180\(1\)](#), [214.010](#)

NECESSITY, FUNCTION, AND CONFORMITY: [KRS 211.180\(1\)](#) requires the cabinet to implement a statewide program for the detection, prevention, and control of communicable diseases, chronic and degenerative diseases, dental diseases and abnormalities, occupational diseases and health hazards peculiar to industry, home accidents and health hazards, animal diseases which are transmissible to man, and other diseases and health hazards that may be controlled. [KRS 214.010](#) requires every physician, advanced practice registered nurse, and every head of family to notify the LHD of the existence of diseases and conditions designated by administrative regulation of the cabinet. This administrative regulation establishes notification standards and specifies the diseases requiring immediate, urgent, priority, routine, or general notification, in order to facilitate rapid public health action to control diseases, and to permit an accurate assessment of the health status of the Commonwealth.

### Target Population-

Kentucky residents or others that have been identified as having a suspect, probable or confirmed reportable disease or as part of an outbreak.

### Funding

State General Funds

CDC grants

- Epidemiology and Laboratory Capacity (ELC) Grant
- Healthcare Associated Infections Program (HAI)
- Viral Hepatitis Program (VHP)
- TB Program
- STD/STI Program
- Immunization Branch

No **direct** funding is provided for Reportable Diseases section.

**Training requirements:**

All users of the [National Electronic Disease Surveillance System](#) (NEDSS) are to have training in its use. All LHD/state staff involved in outbreak investigation should attend an annual [Epidemiology Rapid Response Training](#) (ERRT) and an ERRT conference offered by DPH.

**Reporting Requirements**

Cases should be reported to LHD or Reportable Diseases section by laboratories, physicians or other health care providers. The LHD should report by entering the case into the NEDSS. For cases that are not reported via the electronic system (NEDSS), an [EPID 200](#), Kentucky Reportable Disease form, is to be used following the time frames listed in the [Diseases Surveillance regulation](#). [HIV](#) cases are not entered into the NEDSS system. [HIV/AIDS has its own reporting forms](#).

**Billing and Coding Procedures Specific to Program**

There is **no** funding code for Reportable Diseases. There is a 152-function code that should be used by LHD nurses for time used for investigating or reporting cases of reportable diseases. Other reportable diseases sections such as immunizations, STD/STI, TB, etc., have their own funding codes. HIV/AIDS is listed in the reportable disease administrative regulation, [902 KAR 2:020](#), Reportable Disease Surveillance, however is a branch unto itself with its own funding mechanisms and codes.

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**Kentucky Reach Out and Read (ROR): Reach Out and Read is a nationally recognized nonprofit organization that recognizes the importance of reading for for promotion of critical brain development. This program provides education/information to parents during routine pediatric check-ups.**

**Laws, Regulations, Guidelines:**

Kentucky Reach Out and Read (ROR)

Maternal and Child Health Division Contact: Jan Bright, 502-564-1366

**KY Initiative Coordinator:** Dr. Donna Grigsby at [dgrigsby@uky.edu](mailto:dgrigsby@uky.edu)

**Target Population:**

Parents and children ages 6 months to 5 years of age, with a special focus of children growing up in poverty.

**Funding:**

ROR program in Kentucky is supported by the state as a component of the Kids Now Early Childhood Initiative.

**Special Requirements:**

- In order for a site to be considered for inclusion and funding in the program by the National Center for Reach Out and Read, the site must serve a significant number of impoverished children and many sites are in health department clinics serving children and families with Medicaid or who are uninsured.
- New sites must be able to demonstrate the ability to fund 100% of their book budgets before they can be approved by the National Center.
- When sites have provided the National Center with 2 progress reports (every 6 months) sites will receive sustainability funding by way of receiving books from the National Center.

- Book budgets are based on the number of Pediatric Preventative Health visits in a 6-month period per report to the National Center.

**Training:**

- KY ROR information and application process has been sent via email to LHD Directors with an invitation for ROR startup program; the AAP literacy toolkit was included in the email. For more information about starting a ROR program, please contact KY Initiative ROR Coordinator.
- When a site has been approved by the National Center, training can be completed with the online training program, or with a training DVD, or can be provided by the Initiative Coordinator for pediatric health care providers including LHDs, pediatricians, Family Practice providers and their nurses. Parents are given guidance about reading aloud to their children and by providing developmentally appropriate books to take home at each pediatric preventative health visit from 6 months to 5 years.
- Ongoing technical support and biennial site visits are required by the National Center for Reach Out and Read by the Initiative Coordinator and are currently scheduled as help is needed.

**Reporting Requirements:**

The sites are required to report Pediatric Preventative Health visits and books distributed to National Center for Reach Out and Read every 6 months.

**Billing and Coding Procedures Specific to Program:**

- Sites are provided with a book budget based on the number of Pediatric Preventative Health visits in a 6-month period per report to the National Center.
- Funds may be placed in a Scholastic account for the approved site, and sites will order directly from Scholastic Inc. for their needed books or used to purchase books from other companies.

**Other Special Requirements:** N/A

**Advisory Council Requirement:**

- Kentucky Reach Out and Read Advisory Committee includes the Initiative Coordinator, Pediatricians, most of which were involved with establishing the original BookStart Program housed in Louisville, KY, Nurses, APRN's, KET Early Childhood Coordinator, and representatives from the ROR.
- Services and policies designed to establish programs to meet the needs of the impoverished areas of the Commonwealth of Kentucky are discussed.

**Reach Out and Read program include:**

- Kentucky's DPH
- LHDs Pediatric Preventative Health programs, Pediatric practitioners, Family Practice practitioners and clinics.
- Local School Districts Pediatric Preventative Health clinics that provide preventive health care services to school age children.
- The College of Medicine, Department of Pediatrics at the University of Kentucky and the University of Louisville.
- The National Reach Out and Read Partnership
- Established early literacy programs in some areas of the state.
- Scholastic Inc.

## **Services Description and Key Roles and Responsibilities of Health Department:**

- Offer parents guidance about reading aloud to their children and provide developmentally appropriate books to take home at each preventative health visit from 6 months to 5 years.
- Sites are to report to the National Center for Reach Out and Read the number of Pediatric Preventative Health visits and number of books distributed in a 6-month period (2 reports/yr.)

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### **School Health: Coordinated School Health & Whole Child, Whole School, Whole Community**

The purpose of the Coordinated School Health Initiative is to improve the health, education, and well-being of young people through coordinated school health (CSH) programs. The WSCC model serves as the foundation for the work that focuses on the student and emphasizes the collaboration between schools, communities, public health, and health care sectors to align resources in support of the whole child. The Whole School, Whole Community, Whole Child (WSCC) model focuses on the child to align the common goals of both sectors to put into action a whole child approach to education and was introduced to expand on the eight elements of CDC's coordinated school health (CSH) approach and is combined with the whole child framework. The two additional components of the WSCC model focus on both the Physical Environment and Social/Emotional Climate. The outcome of these efforts assists schools in reducing priority health risks among youth, especially those risks contributing to chronic disease. The target population is K-12 students. The audience includes school administrators and teachers, health department staff, and state and community partners.

LHDs may partner with school districts to assist schools with addressing the WSCC model components. The Whole School, Whole Community, Whole Child or WSCC model, is CDC's framework for addressing health in schools. The WSCC model is student-centered and emphasizes the role of the community in supporting the school, the connections between health and academic achievement and the importance of evidence-based school policies and practices. The WSCC model has 10 components:

#### [The WSCC model has 10 components:](#)

**Health Education:** Comprehensive school health education includes curricula and instruction for students in pre-K through grade 12 that address a variety of topics such as alcohol and other drug use and abuse, healthy eating/nutrition, mental and emotional health, personal health and wellness, physical activity, safety and injury prevention, sexual health, tobacco use, and violence prevention following the National Health Education Standards (NEHS) and incorporating Characteristics of an Effective Health Education Curriculum that address a variety of topics such as alcohol and other drug use and abuse, healthy eating/nutrition, mental and emotional health, personal health and wellness, physical activity, safety and injury prevention, sexual health, tobacco use, and violence prevention.

**Nutrition Environment and Services:** The school nutrition environment provides students with opportunities to learn about and practice healthy eating through available foods and beverages, nutrition education, and messages about food in the cafeteria and throughout the school campus. School nutrition services provide meals following the [Nutrition Standards for School Meals](#), to accommodate the health and nutrition needs of all students, and help ensure that foods and beverages sold outside of the school meal programs (i.e., competitive foods) meet School [Smart Snacks in Schools](#)

nutrition standards. Access to a variety of nutritious and appealing meals that accommodate the health and nutritional needs of all students. School nutrition programs reflect the U.S. Dietary Guidelines for Americans [U.S. Dietary Guidelines for Americans](#)

and other criteria to achieve nutritional integrity.

**Employee Wellness:** Fostering school employees' physical and mental health protects school staff, and by doing so, helps to support students' health and academic success. Healthy school employees—including teachers, administrators, bus drivers, cafeteria and custodial staff, and contractors—are more productive and less likely to be absent. They serve as powerful role models for students and may increase their attention to students' health. Schools can create work environments that support healthy eating, adopt active lifestyles, be tobacco free, manage stress, and avoid injury and exposure to hazards (e.g., mold, asbestos). A comprehensive school employee wellness approach is a coordinated set of programs, policies, benefits, and environmental supports designed to address multiple risk factors (e.g., lack of physical activity, tobacco use) and health conditions (e.g., diabetes, depression) to meet the health and safety needs of all employees. Partnerships between school districts and their health insurance providers can help offer resources, including personalized health assessments and flu vaccinations. Employee wellness programs and healthy work environments can improve a district's bottom line by decreasing employee health insurance premiums, reducing employee turnover, and cutting costs of substitutes. Healthy School, Healthy Staff, A Guide to Improving School Employee Wellness is a comprehensive guide that provides information, practical tools and resources for school employee wellness programs.

**Social and Emotional Climate:** Social and Emotional Climate refers to the psychosocial aspects of students' educational experience that influence their social and emotional development. The social and emotional climate of a school can impact student engagement in school activities; relationships with other students, staff, family, and community; and academic performance. A positive social and emotional climate is conducive to effective teaching and learning. Such climates promote health, growth, and development by providing a safe and supportive learning environment.

**Physical Environment:** A healthy and safe physical school environment promotes learning by ensuring the health and safety of students and staff. The physical school environment encompasses the school building and its contents, the land on which the school is located, and the area surrounding it. A healthy school environment will address a school's physical condition during normal operation as well as during renovation (e.g., ventilation, moisture, temperature, noise, and natural and artificial lighting), and protect occupants from physical threats (e.g., crime, violence, traffic, and injuries) and biological and chemical agents in the air, water, or soil as well as those purposefully brought into the school (e.g., pollution, mold, hazardous materials, pesticides, and cleaning agents).

**Health Services:** intervene with actual and potential health problems, including providing first aid, emergency care and assessment and planning for the management of chronic conditions (such as asthma or diabetes). In addition, wellness promotion, preventive services

and staff, student and parent education complement the provision of care coordination services. These services are also designed to ensure access and/or referrals to the medical home or private healthcare provider. Health services connect school staff, students, families, community and healthcare providers to promote the health care of students and a healthy and safe school environment. Review the additional information on following page - Services provided for students to appraise, protect, and promote health.

**Counseling, Psychological and Social Services: Prevention and intervention services to support the** students' mental, behavioral, social-emotional and promote success in the learning process. Services include psychological, psychoeducational, and psychosocial assessments; direct and indirect interventions to address psychological, academic, and social barriers to learning, such as individual or group counseling and consultation; and referrals to school and community support services as needed. Additionally, systems-level assessment, prevention, intervention, and program design by school-employed mental health professionals contribute to the mental and behavioral health of students as well as to the health of the school environment. These can be done through resource identification and needs assessments, school-community-family collaboration, and ongoing participation in school safety and crisis response efforts. Additionally, school-employed professionals can provide skilled consultation with other school staff and community resources and community providers. School-employed mental health professionals ensure that services provided in school reinforce learning and help to align interventions provided by community providers with the school environment. Professionals such as certified school counselors, school psychologists, and school social workers provide these services.

**Community Involvement:** Community groups, organizations, and local businesses create partnerships with schools, share resources, and volunteer to support student learning, development, and health-related activities. The school, its students, and their families benefit when leaders and staff at the district or school solicits and coordinates information, resources, and services available from community-based organizations, businesses, cultural and civic organizations, social service agencies, faith-based organizations, health clinics, colleges and universities, and other community groups. Schools, students, and their families can contribute to the community through service-learning opportunities and by sharing school facilities with community members (e.g., school-based community health centers and fitness facilities)

**Family Engagement:** Families and school staff work together to support and improve the learning, development, and health of students. Family engagement with schools is a shared responsibility of both school staff and families. School staff are committed to making families feel welcomed, engaging families in a variety of meaningful ways, and sustaining family engagement. Families are committed to actively supporting their child's learning and development. This relationship between school staff and families cuts across and reinforces student health and learning in multiple settings—at home, in school, in out-of-school programs, and in the community. Family engagement should be continuous across a child's life and requires an ongoing commitment as children mature into young adulthood.

**Physical Education and Physical Activity:** Schools can create an environment that offers many opportunities for students to be physically active throughout the school day. A comprehensive school physical activity program (**CSPAP**) is the national framework for physical education and youth physical activity. A CSPAP reflects strong coordination across five components: physical education, physical activity during school, physical activity before and after school, staff involvement, and family and community engagement. Physical education serves as the foundation of a CSPAP and is an academic subject characterized by a planned, sequential K-12 curriculum (course of study) that is based on the national standards for physical education. Physical education provides cognitive content and instruction designed to develop motor skills,

knowledge, and behaviors for healthy active living, physical fitness, sportsmanship, self-efficacy, and emotional intelligence. A well-designed physical education program provides the opportunity for students to learn key concepts and practice critical skills needed to establish and maintain physically active lifestyles throughout childhood, adolescence and into adulthood. Teachers should be certified or licensed, and endorsed by the state to teach physical education.

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## **School Health: Clinical Services (Nursing)**

### **Laws, Regulations, Guidelines**

[KRS 314.021\(2\)](#) imposes individual responsibility and holds nurses accountable for rendering safe, effective nursing care to clients and for judgments exercised and actions taken in the course of providing care. Acts which are within the permissible scope of practice for a given licensure level may be performed only by those licensees who personally possess the education and skill proficiency to perform those acts in a safe, effective manner. Nursing practice should be consistent with the Kentucky Nursing Laws ([KRS Chapter 314](#)), established standards of practice, and be evidence based.

School Health services are one of the ten components of the WSCC model. "Health Services" are defined in [KRS 156.502](#) and states that health services must be provided within the health care professional's current scope of practice in a school setting by: a physician, of an APRN, RN or LPN licensed under provision of [KRS Chapter 314, or a non-licensed health technician delegated the responsibility to perform the health service](#). Additional guidelines on school health services may be found in the [Kentucky Department of Education \(KDE\), Health Services Reference Guide](#).

#### [KRS 314.011](#)

defines APRN, RN or LPN licensed services, delegations, roles and types of services provided under these provisions. [Delegation and Supervision - Kentucky Board of Nursing](#) provides guidance and resources to determine who is responsible and accountable for delegation of nursing tasks. [KRS 156.501](#) states that KDE shall provide leadership and assistance to local school districts relating to school health services. KDE, working in cooperation with DPH, shall provide contract for services, or identify resources to improve student health services according to provisions outlined in [KRS 156.501\(1\)\(a\)](#) through (d).

### **Target Population**

School aged and adolescent children up to age 21.

### **Funding**

Medicaid, local tax, local reserves and contracts with schools.

### **Special Requirements**

LHD's must assure that staff meet Medicaid provider requirements to provide billable services.

### **Staff/Provider Requirements**

School Health Nursing services are provided by nurses for clinical and nursing functions through contracts with local schools/districts. Other contracted staff as appropriate may include Health Educators, Dietitians, Nutritionists, and support staff.

### **Mandatory Training**

Per KRS [314.021](#) All individuals licensed or privileged under provisions of this chapter and administrative regulations of the board shall be responsible and accountable for making decisions that are based upon the individuals' educational preparation and experience and shall practice with reasonable skill and safety. Each individual nurse must maintain his/her own training as stated depending on any specialty area of practice.

- School Health Nurses are required to obtain BLS Adult, Child and Infant CPR, First Aid and AED (as appropriate) and maintain certification status as required.
- School Health Nurses are required to review and be familiar with the resources provided on the [Student Health Services - Kentucky Department of Education](#) web page, which includes [School Nurse Orientation \\*New 2022\\* - Kentucky Department of Education](#) modules that are consistent with best practice guidelines that were developed to assist both new school nurses as well as act as a refresher course for current school nurses. These modules should be used as a supplement to an orientation program provided by the local school district. School nurses should also be trained in their district policies and procedures.
- **School Health Nurses are required to complete all trainings** specific to services provided as required in the CSG & AR including the annual medical coding compliance review updates/training provided by AFM/[Local Health Operations \(LHO\) Branch](#). Nurses are encouraged to participate in the Kentucky School Nurse Association and the National Association of School Nurses. LHD school health nurses are required to complete all trainings required through KDE.

### **Reporting Requirements**

- LHD School Health Nurses shall report completed services according to KDE and LHD policy and procedures.
- Community Health Services Report and KDE reports are required.
- School health nurses shall report health services as required by KDE.

### **Billing and Coding Procedures Specific to Program**

Billing and coding procedures are to follow AR guidelines and LHD policies and procedures for clinical services and according to services stated in contract with the school or school district.

### **Other Special Requirements**

- In compliance with Federal Regulation, all services of LHDs shall be conducted in a manner that no person will be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination on the grounds of race, color, disability, national origin, sex, age or religion.
- Providers shall comply with the Americans with Disabilities Act and any amendments, rules and regulations of this act.

### **Special Equipment Requirements:**

- Providers shall be located in a facility that is constructed, equipped and maintained to ensure the safety of the children and provide a functional, sanitary environment. **The area utilized during the screening examination shall provide adequate confidentiality and privacy.** The provider shall have the necessary equipment, in proper working order, to provide the basic health screening tests outlined in the [CSG](#) and [AR](#) and as stated in the contract with the school or school district.

## Special Equipment Requirements

Providers shall be located in a facility that is constructed, equipped and maintained to ensure the safety of the children and provide a functional, sanitary environment. **The area utilized during the screening examination shall provide adequate confidentiality and privacy.** The provider shall have the necessary equipment, in proper working order, to provide the basic health screening tests outlined in the [CSG](#) and [AR](#) and as stated in the contract with the school or school district.

## Service Description, Key Roles, and Responsibilities of Health Department

- Participating providers shall provide practice standards recommended by the [American Academy of Pediatrics](#). Really applies to all visits staff do, not just preventative which is what Bright Futures addresses.
- [KDE's Health Services Reference Guide](#) and the [National Association of School Nurses](#) guidelines and recommendations are to be utilized when school health services are provided that are not included in the [CSG](#) and [AR](#). Practice and performance of nursing acts and standard guidelines should be consistent either with the [American Nurses' Association Standards of Practice](#) or with Standards of Practice established by nationally accepted organizations of registered nurses as outlined in [KRS 314.011](#) (6) (e).
- Each satellite clinic site shall have a governing body, legally responsible for the conduct of the clinic, which designates a director or supervisor and establishes administrative and clinical policies.
- Each satellite clinic site shall be under the direction of a registered nurse licensed in the state of Kentucky and shall have a physician licensed in Kentucky acting as a medical director.
- **It is important that staff from the local school district and the LHD delineate which services will be provided by the LHD per contractual agreement.**
- Administrative policies shall outline who is to conduct each clinic service and include procedures for the initial contact, follow-up contacts, maintaining patient records and transfer of information from one provider to another. A copy of this record shall be retained in the provider's files.
- All screenings, especially those with abnormal screening results, shall be discussed in understandable terms with the child **and** his/her parent or guardian. Referral will be made by the screener as appropriate for further assessment, diagnosis, and treatment to the appropriate health care professional

## Clinical Service Guide

American Academy of Pediatrics sets the primary practice standards for LHD staff providing health services in a school setting. Health services provided in a school setting are to be provided in accordance with the CSG guidelines.

LHDs may elect to provide additional school health services not included in the AR/CSG. These additional services are provided under LHD authority without authorization from or liability to KDPH.

Adoption of local guidelines and local Board of Health approval are recommended. Examples of services to be included in local guidelines include training and delegation of nursing functions to unlicensed school personnel and special clinical procedures.

A standardized training curriculum for medication administration by unlicensed school personnel has been developed by the KDE and approved by the Kentucky Board of Nursing to

be in compliance with [201 KAR 20:400](#) (Delegation of nursing tasks). The curriculum is to be utilized by all licensed health professionals who may train unlicensed school personnel.

### **Confidentiality of Student Health Records**

The [Family Educational Rights and Privacy Act \(FERPA\)](#) is the federal law that protects the privacy interest and educational records of the student. FERPA applies to any education agency or institution that receives funds from the U.S. Department of Education.

*The educational institution or agency that employs a school nurse is subject to the Health Insurance Portability and Accountability (HIPAA) regulation if the school nurse or the school engages in a [HIPAA](#) transaction, such as transmitting electronic billing or submitting claims.*

### **Delegation of Medication Administration**

A school employee who is delegated responsibility to perform the health service by a physician, APRN or RN and:

- Has been trained by the delegating physician or delegating nurse for the specific health service, if that health service is one that could be delegated by the physician or nurse within his or her scope of practice; and
- Has been approved, in writing, by the delegating physician or delegating nurse. The approval shall state the school employee consents to perform the health service when the employee does not have the administration of health services in his or her contract or job description as a responsibility, possesses sufficient training and skills and has demonstrated competency to safely and effectively perform the health service. The school employee shall acknowledge receipt of training by signing the approval form. A copy of the approval form shall be maintained in the student's record and the personnel file of the school employee. The delegation to a school employee shall only be valid for the current school year.
- Nursing delegation also requires ongoing monitoring and evaluation.

### **State Level Nurse Consultation and Technical Assistance**

- [KRS 156.501](#) states that KDE shall provide leadership and assistance to school districts relating to school health services.
- Technical assistance is also provided by the [School Health Branch Manager or designated staff](#) specifically for [LHDs providing satellite clinics](#) in the school setting.

### **Minimum Patient Responsibility**

- LHD guidelines shall be followed for satellite clinics in the school setting.
- Client or parent/guardian of client are expected to schedule or maintain scheduled appointment for any recommended follow-up or referral.

### **Recommended Clinical Guidelines**

- The DPH [Clinical Service Guide](#) (CSG)
- Kentucky Department of Education (KDE), Student Health Services – [Health Services Reference Guide](#)
- The National Association of School Nurses resource references

### **Additional Organizational Resources:**

[Kentucky Board of Nursing;](#)  
[Kentucky School Nurses Association;](#)

[National Association of School Nurses;](#)  
[KDE – Coordinated School Health;](#)  
[Kentucky School Boards Association;](#)  
[Kentucky Public Health Association](#)

## **Considerations for Developing a School Health Services Contract and Implementing a Satellite Clinic in the School Setting**

**[KDPH MCH guidance document can be found here.](#)**

- Developing a School Health Services Contract and Implementing a Satellite Clinic in the School Setting
- School policies and considerations
- KDE Guidance for school health services contracts
- LHD contract considerations
- Roles and responsibilities of the nurse in the LHD school satellite clinic (not all-inclusive)
- Confidentiality of student health records
- Coding and billing considerations

A comprehensive health services contract between Local Health Departments (LHD) and local school districts should define the specific roles and responsibilities of each agency/party in providing health services in a satellite clinic to school children. This agreement will depend upon local resources and policies and will vary from county to county. This memorandum of agreement/contract should be written to provide understanding, give direction, and establish specific responsibilities.

In the process of developing and refining the details of the school health contract, it is necessary for key personnel from each agency to meet and assess needs and establish what services are needed and can be provided. The LHD or the local school district may initiate a partnership. Any local school district contract must go before their school board for approval. Contracts must be reviewed, updated, and renegotiated annually. Contracts are to be saved to the appropriate LHD folder on the L-Drive. Procedures for submitting contracts for review are located in the Financial Management Section of the LHD Administrative Reference and are to be followed. Both the LHD and the local school district should have specific responsibilities which are clearly defined in the planning and evaluation of the contract.

## **Framework for 21st Century School Nursing Practice**

NASN's Framework for 21st Century School Nursing Practice (the Framework) provides structure and focus for the key principles and components of current day, evidence-based school nursing practice. It is aligned with the Whole School, Whole Community, Whole Child model that calls for a collaborative approach to learning and health (ASCD & CDC, 2014). Central to the Framework is student-centered nursing care that occurs within the context of the students' family and school community. Surrounding the students, family, and school community are the non-hierarchical, overlapping key principles of Care Coordination, Leadership, Quality Improvement, and Community/Public Health. These principles are surrounded by the fifth principle, Standards of Practice, which is foundational for evidence-based, clinically competent, quality care. School nurses daily use the skills outlined in the practice components of each principle to help students be healthy, safe, and ready to learn.

## **Role of the School Nurse**

The role of the school nurse will vary depending on individual needs of local school districts to facilitate the educational process by removal or modification of health-related barriers to student learning. When school districts and local health departments contract for school health services, the contract should spell out the expectations of each party's duties. Local health departments may be able to bill preventable health services such as, but not limited to school physicals, well-child assessment, dental screenings, administration of immunizations, and staff wellness assessment. The role of the school nurse provided in the KDE [SCHOOL NURSE Job Description \(ky.gov\)](#) will vary depending on individual needs of local school districts to facilitate the educational process by removal or modification of health related barriers to student learning. Listed below, but not all-inclusive, are examples of roles and responsibilities of the nurse in the LHD school satellite clinic. Assure that policies and procedures adhere to legal and regulatory statutes and ethical standards of nursing practice and are provided within the nursing providers scope of work.

1. Provision of direct health care to students and staff
  - Provides care to students and staff who need emergency care due to injury or who present with an acute illness.
  - Within the nurse's scope of practice and state laws, trains and delegates to unlicensed school personnel medication administration and/or the delivery of health services as ordered by a licensed health care provider. Delegation to others involves initial assessment, training, competency validation, supervision and evaluation by the school nurse.
  - Assists faculty and staff in monitoring chronic medical conditions.
  - Coordinate care and student emergency action plans related to diabetes, seizures, asthma, allergies and use of emergency medications i.e., Epi-Pen, Glucagon and Diastat
  - Obtain parental consent for health services.
  - Develop an Individual Health Plan (IHP) for children with chronic disease.
2. Provides leadership for the provision of health services.
  - Assures that school district policies and procedures adhere to legal and regulatory statutes and ethical standards of nursing practice.
  - Serve on advisory committees/consultation for health accommodations necessary to support student individual education care plans, (i.e., 504 & IEP).
  - Assist with the development of school emergency response plans for emergencies and disasters and the training of staff to respond appropriately within applicable state laws.
  - Develop plans/implement plans and evaluate response to interventions.
3. Provides screening and referral for health conditions.
  - Address potential health problems that are barriers to learning or symptoms of underlying medical conditions by coordinating and assisting with mandated screenings, i.e., vision, hearing and scoliosis.
  - Initiates referrals according to state and school policies
4. Promotes a healthy school environment.
  - Provide staff educational in-services (but not limited to), i.e., CPR training and OSHA bloodborne pathogen and infection control updates.
  - Monitors immunizations and reports communicable diseases as required by law.
  - Review immunization records for compliance to state laws and school policies

- Assess the physical environment of the school to improve health and safety, including the assessment of playground, indoor air quality evaluation or review patterns of illness or injury to determine source of concern.
  - Assist in evaluation of school emotional environment to decrease potential bullying and violence and/or an environment that is not conducive to optimal mental health and learning.
5. Promotes health
- Provides health education information directly to individual students, groups of students, or classes or by providing guidance and consultation about health education curriculum.
  - Promotes health awareness activities such fairs for staff and families; consultation with other school staff, i.e., food service personnel or physical education teachers, regarding healthy lifestyles and staff wellness programs
  - Serves as a member of the coordinated school health team that promotes the health and well-being of school members through collaborative efforts
6. Serves in a leadership role for health policies and programs.
- Provides leadership in the development and evaluation of school health policies, programs and the promotion of a health school environment through the collaboration with coordinated school health programs, crises/disaster management teams and school health advisory councils.
  - Oversees the collection of health data and submission of health reports to LHD for immunization and KDE for school health services.
6. Serves as a liaison between school personnel, family, community and health care providers.
- Provides case management through communicating with the family through telephone calls, written communication and home visits as needed.
  - Serves as a representative of the school community and communicates with community health providers and community health agencies and partnerships to promote the health of the community.

**Links:**

[National Association of School Nurses;](#)  
[Kentucky Board of Nursing;](#)  
[Kentucky Department of Education](#)

**STD/STI Control Program**

**Laws, Regulations, Guidelines**

RELATES TO: [KRS 211.180](#), [214.010](#), [214.160](#), [214.170](#), [214.185](#), [214.420](#), [42 U.S.C. 263a](#)

STATUTORY AUTHORITY: KRS [194A.050](#), [211.090](#)

NECESSITY, FUNCTION, AND CONFORMITY: [KRS 211.180](#) requires the Cabinet for Health and Family Services to implement a statewide program for the detection, prevention and control

of communicable diseases and to adopt regulations specifying the information required in and a minimum time period for reporting a sexually transmitted disease. This administrative regulation establishes uniform procedures for the diagnosis, treatment, prevention and control of sexually transmitted diseases (STD)/sexually transmitted infections (STI).

### **Target Population**

Priority for services will be those who have been infected with Chlamydia, gonorrhea, and syphilis, and those who have been exposed above mentioned STDs/STIs. The special priority will be given to pregnant females and those who are dually diagnosed with syphilis and HIV.

Those who are engaged in high-risk behaviors, such as exchange of sex for drugs or money, risky MSM behaviors, and other risky behaviors will be considered as target population as well.

### **Funding**

DPH delegates federal funds to LHDs through Memorandum of Agreement. The state funds allocated to the STD/STI program are utilized to supplement certain salaries of state employees and to purchase condoms for LHDs.

### **Staff/Provider Requirements**

The STD/STI services shall be provided under the general direction of a physician with background in reproductive health or other related expertise.

- A physician, APRN or RN with appropriate training shall provide medical services.
- Health professional staff, including Disease Intervention Specialist with knowledge of STDs/STIs and reproductive health may provide counseling and education to a client.

### **Reporting Requirements**

All reportable STDs/STIs shall be reported to the state using [EPID 200](#).

- All reports of early syphilis shall be reported to the state STD/STI program within 24 hours.
- All other syphilis and STDs/STIs shall be reported to the state program within 5 business days.

### **Other Special Requirements**

All information as to personal facts and circumstances obtained by the staff about individuals receiving services must be held in confidential manner and must not be disclosed without the individual's documented consent, except as may be necessary to provide services to the patient or as required by the law, with appropriated safeguards for confidentiality. Otherwise, information may be disclosed only in summary, statistical, or other forms which do not identify particular individuals.

### **Program Specific Offerings**

RN's seeking to provide STD/STI screenings at their respective facility must first complete as a prerequisite the DPH's:

- Breast and Cervical Cancer Program Assessment,
- The corresponding preceptorship,
- the Adult Preventive Assessment Trainings.

- The corresponding preceptorship.

STD/STI clients identified as needing mid-clinician or higher-level STD/STI services such as anosopic exams, or wet mounts must be referred to the MD/APRN. Each LHD shall establish and maintain medication guidelines (i.e., standing orders) for Expanded Role RNs to follow. These guidelines shall be written and developed in accordance with the [CSG](#).

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## **TB Prevention and Control Program**

### **Laws, Regulations, Guidelines**

Kentucky Revised Statute, [KRS 215](#): 511 through 600 provides guidance relating to tuberculosis (TB) prevention and control.

- [KRS 215.540](#) Recalcitrant tuberculosis patient control, declares that a person diagnosed with active TB disease has a legal duty and responsibility to take precautions to prevent the spread of disease.
- [KRS 215.531](#) Drug susceptibility tests on initial isolates from patients with active tuberculosis, states that every physician shall order drug susceptibility testing on initial isolates from all patients with active TB disease.
- [KRS 215.540 through 215.580](#) provides guidelines for acting upon recalcitrant TB patients.

Kentucky Administrative Regulation, [902 KAR 2:020](#) states that tuberculosis is to be reported to the local or state health department within one business day.

Kentucky Administrative Regulation, [902 KAR 2:090](#) states that the DPH shall authorize an LHD to test first time enrollees in a school within its jurisdiction, if it submits to the department the specified documentation:

- Documentation of continued transmission of at least two (2) years duration of a multidrug resistance pattern, or more virulent strain, of *Mycobacterium tuberculosis*; or
- Laboratory analysis that documents transmission, whether in consecutive or nonconsecutive years, of a multidrug resistance pattern, or more virulent strain of *Mycobacterium tuberculosis*; or
- A documented outbreak of at least two (2) years duration

Kentucky administrative regulations [902 KAR](#) 20:016 through 20:200 provide TB screening guidelines for various facilities, such as hospitals, long term care facilities, personal care homes, and adult day health facilities.

### **Target Population**

Finding and managing persons who have or who are suspected of having TB and ensuring completion of therapy. Finding and evaluating contacts of active TB patients and ensuring completion of appropriate treatment. Targeted tuberculin testing of persons in at risk groups and ensuring completion of treatment for Latent Tuberculosis Infection (LTBI).

### **Funding**

TB program funding is provided through the Centers for Disease Control and Prevention ([CDC Tuberculosis Elimination and Laboratory Cooperative Agreement](#)) and state general funds.

- These funds are to support population-focused TB prevention and control strategies. It is acceptable for a portion of the funds to be utilized for individual clinic services; however, the services should be directly related to TB.
- Federal TB dollars are to be used for prevention efforts; to support personnel; and to purchase equipment, supplies, and services directly related to project activities. Federal TB funds should not be used for the purchase of medications, inpatient care, or construction of facilities.
- Federal TB dollars may also be used for LTBI education and awareness efforts in support of TB prevention and control strategies. Federal TB funds should not be used for the purchase of medications or inpatient care directed at LTBI therapy.

### **Staff/Provider Requirements**

A physician knowledgeable in the field of mycobacterial diseases shall provide care through an LHD contract for TB clinician services. That contract must include the following:

- Provide TB services in accordance with standards of care outlined by the CDC, the American Thoracic Society, and the American Lung Association (See Clinical Services Guide – TB Section)
- Must attend periodic TB updates and training provided by state and/or national TB experts.
- Keep updated by having the latest educational and scientific materials for the prevention and control of TB from the CDC, the American Thoracic Society, and the American Lung Association.

Each LHD and/or district LHD shall have a designated primary TB Nurse Case Manager responsible for tuberculosis services in their county. The TB Nurse Case Manager should be a registered nurse and participate in the following:

- Must attend initial TB Orientation as outlined in the following section.
- Attend periodic TB updates and trainings provided by and/or national TB experts.
- Maintain TB Nurse Case Manager Competency requirements as set forth by the National Tuberculosis Controllers Association:
  - <https://www.tbcontrollers.org/resources/core-competencies/tb-nurse-case-manager/>
- Provide TB services in accordance with standards of care outlined by the Clinical Services Guide.

Outreach workers are recommended in areas of high prevalence. Outreach workers may provide DOT or DOPT services under the supervision of a Registered Nurse or other licensed healthcare provider. The TB-27 "Activities of DOT for Outreach Workers" may be used to guide training.

### **Training**

Orientation for all newly hired TB Nurse Case Managers and support staff who have the potential to be involved in TB prevention and control services shall include the following:

- [CDC Self Study Modules on Tuberculosis: Modules 1-5, 2008; and Modules 6-9, 2000](#))
- [CDC MMWR Treatment of Tuberculosis, June 20, 2003, Vol. 52, No.RR-11](#)

- [CDC MMWR Guidelines for Preventing the Transmission of \*Mycobacterium tuberculosis\* in Health-Care Settings](#), 2005, December 30, 2005, Vol. 54, No. RR-17. Errata 10/11/2007
- [CDC MMWR Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection, June 9, 2000, Vol. 49, No. RR-6](#)
- [CDC MMWR Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis, December 16, 2005, Vol 54, No. RR-15.](#)

Orientation shall be completed according to the following schedule:

- For Nurse Case Managers whose duties are strictly related to tuberculosis these training requirements should be completed within 90 days of employment.
  - Primary Nurse Case Managers should complete the SNTC Nurse Case Management Course within 12 months of employment.
- For TB Nurse Case Managers whose responsibilities include other areas beyond TB and for those staff nurses that may work in the LHD TB program this training requirement should be completed according to the incidence of TB in the community.
  - If 1 case or more of active TB has been identified in the county, in each year of the last five years – complete within 6 months of employment.
  - If 1 case or more of active TB has been identified in the county in some of the last five years, but not each year, complete within 9 months of employment.
  - If zero cases of active TB have been identified in the county in the last five years, complete the requirements within 12 months.

Recommended trainings include:

- [CDC MMWR Controlling Tuberculosis in the United States, November 4, 2005, Vol 54, No. RR-12](#)
- [Attendance at national, state, and regional TB seminars](#)
- [CDC Interactive Core Curriculum on Tuberculosis: What the Clinician Should Know.](#)

### Reporting Requirements

Kentucky disease surveillance requires priority notification of TB cases. Upon recognition, a confirmed or suspected TB case is to be reported to the local or state health department within **one business day**.

The LHD shall report confirmed or suspected TB cases to the DPH, TB Prevention and Control Program (TB Program), within **one business day of notification**.

Upon confirmation of a confirmed case, the LHD will be responsible for sending to the state TB Program the following forms:

*Combined Forms, [CDC 72.9 A-C](#)*

- **Report of verified Case of Tuberculosis (RVCT) (CDC 72.9 A) Follow Up 1 – Initial Drug Susceptibility (CDC 72.9 B)**
- **Follow Up 2 – Case Completion (CDC 72.9 C)**. This form should be sent to the state TB program upon completion of TB treatment.

The contact investigation roster ([TB-2](#)) should be completed on all initiated contact

investigations. A copy of the contact investigation roster should be sent to the state TB program 30 days after initiating the contact investigation.

The contact investigation summary ([TB-2b](#)) should be completed and sent to the state TB program within 30 days of initiating the contact investigation.

The Local Health Department TB Program Monthly Report (TB-32) should be completed and sent to the state TB program monthly during management of a confirmed case.

LHDs are notified of TB classified immigrants and refugees (Class A or Class B1, B2, or B3) that require a medical evaluation for TB be completed within 90 days of arrival. Follow-up information regarding the date the medical evaluation was initiated and completed, tests performed, and the final diagnosis should be documented on the follow-up form and submitted to the state TB Program upon completion of the evaluation.

For LTBI cases:

- Report to the state TB Program using the [TB-1](#) LTBI reporting form. Upon completion of therapy for LTBI the [TB-1](#) form should be re-submitted to the state TB Program with updated completion of therapy information.
- There are numerous state organizations that are required by statute to a.) Initiate TB testing for employment and/or individuals residing in congregate settings and b.) Report TB testing results to either the local or state health departments. LHDs will receive these reports of positive TB testing.
- Refer to Service Description & Key Roles & Responsibilities of Health Department Section of this document for guidance on LHD responsibilities for providing therapy for LTBI.

### **Billing and Coding Procedures Specific to Program**

Inability to pay shall not be a barrier to service.

Patient fees charged for *self-pay* patients:

A nominal (flat) fee up to five (5) dollars shall be charged for *Communicable Disease Services*. [902 KAR 8:170](#) Section 3, Use of receipts. Review the Administrative Reference (AR), [Local Health Operations section](#) for further information. LHDs may use discretion in charging this nominal fee for any individual who is under or non-insured.

LHDs are not required to provide TB screening and testing services for individuals seeking occupational health or post-secondary education admittance. At the discretion of LHD, these services may be provided by their contractual agreement for individual healthcare facilities or establishing fixed-full rates for those individuals seeking these services.

Secondary ICD-10 codes TB000 – TB026 are for data purposes and provided to identify the reason for administering TB testing (skin test or blood assay).

ICD-10 Codes for Tuberculosis Guide Sheet

<b>TB Skin Test</b>			<b>QFT-GIT Testing</b>			
Z11.1	TB Skin Test Negative		Z11.1	QFT-GIT Negative		
R76.11	TB Skin Test Positive		R76.12	QFT-GIT Positive		
<b>T-Spot Testing</b>			R76.8	QFT-GIT Indeterminate		
Z11.1	T-spot Negative		R76.9	QFT-GIT Unsatisfactory		
R76.12	T-spot Positive		Z53.8	QFT-GIT Not Performed		
R76.8	T-spot Borderline		<b>TB Infection</b>			
R76.9	T-spot Invalid		R76.11	TB Skin Test Positive		
Z53.8	T-spot Not Performed		R76.12	QFT-GIT Positive		
			R76.12	T-spot Positive		
<b>TB Suspect (without symptoms)</b>	<b>TB Suspect (with symptoms)</b>	<b>TB Contact</b>	<b>TB Inactive (Healed)</b>	<b>Personal History of TB</b>	<b>B-notification Evaluation</b>	<b>LTBI</b>
Z03.89	Use symptoms code(s)	Z20.1	B90.9 (code first the condition resulting from the sequela)	Z86.11	Z02.89	Z22.7
<b>Symptoms</b>						
R04.2	Hemoptysis		R05	Cough		
R06.02	Shortness of breath		R50.9	Fever		
R61	Night sweats		R63.4	Abnormal weight loss		
<b>Adverse Reaction to Medication</b>			<b>Therapeutic Drug Monitoring (Drug Levels)</b>			
Code for Adverse Effect of Specific Medication			A51.81			
<b>Administrative Purpose</b>			<b>HIV Testing as Part of QFT-GIT Draw</b>			
Z02.9			Z11.4			
<b>Vision Screening</b>						
Z01.00	Encounter for exam of eyes and vision without abnormal findings		Z01.01	Encounter for exam of eyes and vision with abnormal findings (use additional code to identify abnormal findings)		
<b>Hearing Screening</b>						
Z01.10	Encounter for exam of ears and hearing without abnormal findings		Z01.11 (use an additional code for abnormal findings)	Encounter for exam of ears and hearing with abnormal findings		
<b>Pregnancy Testing</b>						
Z32.02	Encounter for pregnancy test, result negative		Z32.01	Encounter for pregnancy test, result positive		
<b>Drug Resistance</b>						
Z16.341	Resistance to single antimycobacterial drug (mono-resistance)					

Z16.342	Resistance to multiple antimycobacterial drugs (use for MDR and XDR)
Z16.35	Resistance to multiple antimycobacterial drugs (poly-resistances not MDR or XDR)
Z16.23	Resistance to quinolones or fluoroquinolones

\*The appropriate 7<sup>th</sup> character is to be added to each code: A—initial encounter, D—subsequent encounter and S—sequela

<b>Directly Observed Therapy**</b>	
99341	Home Visit New Patient
99342	Home Visit New Patient
99343	Home Visit New Patient
99344	Home Visit New Patient
99345	Home Visit New Patient
99347	Home Visit EST Patient
99348	Home Visit EST Patient
99349	Home Visit Est Patient
99341	Home Visit New Patient
99342	Home Visit New Patient
99343	Home Visit New Patient
99344	Home Visit New Patient

\*\*DOT is covered when preformed at home with these codes

<b>Telehealth for V-DOT***</b>	
998970	Qualified nonphysician health care professional online digital evaluation and management service, for an establish patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
998971	Qualified nonphysician health care professional online digital evaluation and management service, for an establish patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
998972	Qualified nonphysician health care professional online digital evaluation and management service, for an establish patient, for up to 7 days, cumulative time during the 7 days; 21 minutes or more
G2010	Remote evaluation of recorded video and/or images submitted by an established patient, including interpretation with follow-up with the patient within 24 business hours.
G2012	Brief communication technology-based service by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient. 5-10 minutes of medical discussion.

<b>Tracking Codes for Tuberculosis</b>	
TB001	School High Risk
TB002	Required by external agency
TB000	Screened TST not needed
TB011	Close contact of a person known/suspected to have TB symptoms
TB012	Foreign-born where TB is common
TB013	Residents/employees Correctional Institutions
TB014	Residents/employees Nursing Home

TB015	Residents/employees Mental Institutions
TB016	Residents/employee other Long Term Residential Facilities
TB017	Residents/employee of Homeless Shelters
TB018	Employment
TB019	Health Care Workers
TB020	Medically underserved, low-income population as defined locally
TB021	High-risk racial or ethnic minority populations
TB022	Infants/Children exposed to adults in high-risk categories
TB023	Persons who inject illicit drugs or substance abusers
TB024	Persons with HIV infection
TB026	Certain medical conditions
TB027	TB Suspect
TB028	Video Directly observed Therapy (V-Dot)

\*\*\*V-DOT is covered using telehealth codes

**Program Specific Requirements**

There are three parts to a successful TB program that each LHD should implement. The components of the program include surveillance, prevention, and control. The priority activities of a successful TB program, in order, include:

1. Identifying and treating persons who have TB disease;
2. Finding and assessing persons who have been in contact with TB patient to determine whether they have latent TB infection (LTBI) or TB disease with providing them with appropriate treatment,
3. Using targeted testing strategies to identify and treat persons with LTBI at risk for developing TB disease; and
4. Identifying settings in which there is a high risk of transmission of *M. tuberculosis* and applying effective infection control measures.

**Surveillance**

Passive: Required reporting of suspected or confirmed TB cases to a public health authority. The LHD should implement efforts to make sure private providers, hospitals, and pharmacies are aware of and understand state reporting regulations. Ensure all LHD personnel are aware of reporting guidelines.

Active: Targeted tuberculin testing among high risk populations. [The June 2000 CDC Guideline for ‘Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection’](#) describes targeted tuberculin testing (TST) as a strategic component of TB control that identifies persons at high risk for developing TB who would benefit by treatment of LTBI, if detected.

**Prevention**

Each LHD should actively pursue prevention activities by raising community education and awareness. Activities should be implemented annually to complete the following objectives.

- Provide TB in-services to 90% of local nursing homes or assisted living communities.
- Collaborate with hospital infection control staff to coordinate prevention activities and reporting strategies.
- Provide TB education to the community once per quarter.

- Provide TB education targeted toward transient population twice per year.
- Provide TB education targeted toward foreign-born populations twice per year.
- Provide LTBI education to the community once per quarter.
- Provide LTBI education targeted toward transient population twice per year.
- Provide LTBI education targeted toward foreign-born populations twice per year.
- Educate individuals about their LTBI diagnosis and refer them to a community to provide treatment.
- Coordinate with community healthcare providers to ensure that education and adequate therapy is prescribed to patients with LTBI diagnosis.

## Control

- Each independent and district health department shall have a TB Nurse Case Manager responsible for TB prevention and control efforts in the LHD and community.
- Each LHD should have a contracted clinician knowledgeable in the care and treatment of tuberculosis.
- Each independent and LHD should have a documented TB exposure control plan in place. The exposure control plan should include respiratory protection guidelines, treatment guidelines, and environmental controls. [Review the Respiratory Plan and Personal Protective Equipment \(PPE\) guidelines located on the LHD Information webpage](#)

## Service Description & Key Roles & Responsibilities Of Health Department

It is the responsibility of the LHD to provide evaluation of patients for TB disease, provide treatment of TB disease, ensure adherence to therapy, conduct contact investigations, and provide treatment for LTBI diagnosed patients who have been identified as:

1. A contact to a smear-positive active TB case
  2. Patient with a B1 or 2 status
  3. High-risk for progressing to active disease which includes.
    - a. Person have been recently infected with TB bacteria.
    - b. Persons with medical conditions that weaken the immune system.
- Upon notification of a suspect or confirmed case of TB the patient's clinical condition should be determined:
    - Immediately if not hospitalized
    - Within 3 days of notification if hospitalized
    - Basic physical exam should be completed within 7 days of notification
  - Patient should be seen by LHD clinician as soon as possible if LHD supplying medication.
  - Directly observed therapy (DOT) is a method for ensuring patients' adhering to therapy.
    - DOT is standard of care for all active TB cases.
    - Health care worker watches patient swallow each dose of medication.
    - DOT can lead to reductions in relapse and acquired drug resistance.
    - Use DOT with other measures to promote adherence.
    - Court ordered DOT may be necessary in some cases.
  - Upon notification of an individual with a positive TB test, the LHDs must assure that the reporting facility or the individual's primary care provider has ruled out suspected or active disease and treatment for LTBI has been recommended.

- Directly observed preventive therapy (DOPT) should be used for some higher risk patients, as well as children.
  - Children and adolescents.
  - Contacts to an active case.
  - Homeless individuals.
  - Persons who abuse substances.
  - Persons with a history of treatment non-adherence.
  - Immunocompromised patients, especially HIV-infected individuals.
- The decision to initiate a contact investigation should be made according to CDC guidelines. Contact investigations are systematic processes which should prioritize setting where transmission of M. tuberculosis is likely, and contacts are at an increased risk for rapid development of TB disease.
  - Health departments are accountable for ensuring contact investigations are performed for TB cases reported in their jurisdictions, even when patients are receiving care outside the health department.
  - Initial contact encounter should occur within three working days of the contact being identified in the investigation.
 

Completion of the evaluation of a contact should be completed according to CDC guidelines that are referenced in the [CSG](#).
- The LHD is responsible for TB outbreak response. A TB outbreak is generally defined as a situation where there are more TB cases than expected within a geographic area or population during a particular time period, and evidence of recent transmission of M. tuberculosis among those cases.

### **Minimum Patient Responsibility**

According to [KRS Chapter 215](#): .540 to .580 the “Kentucky Recalcitrant Tuberculosis Patient Control Law,” a person with active tuberculosis has a legal duty and responsibility to the public to take reasonable precautions to prevent the spread of the disease.

- [KRS 215.550](#), “Responsibilities of persons diagnosed with active tuberculosis,” states that a person diagnosed with active TB disease may not refuse examination or treatment for TB.
- LTBI is noninfectious. For individuals diagnosed with LTBI, treatment is optional.
- However, certain populations are required to submit to routine monitoring to prevent an outbreak of TB.
  - According to 902 KAR 20:200, residents of long-term care facilities with a diagnosis of LTBI may refuse treatment but should submit to routine monitoring.

According to 902 KAR 20:205, healthcare workers diagnosed with LTBI may refuse treatment; however, they are subject to routine monitoring.

## **Pediatric Preventive Health Services**

### **Laws, Regulations, Guidelines**

Pediatric Preventive Health services promote and safeguard the health and wellness of all children through proactive leadership and service. The incidence of preventable disease, disabilities and injuries is reduced by providing preventive and specialized Pediatric Preventive Health Program services to low-income children and by collaborating with community based and state level health and human services providers to develop a system of health care for the benefit of all children.

[902 KAR 4:100](#): CHFS, DPH Services is responsible for administering the programs of services in accordance with Title V of the Social Security Act (maternal and child health block grant).

[KRS 211.180](#) (i) (e), describes a function of the Cabinet as the “protection and improvement of the health of expectant mothers, infants and preschool and school age children and their families.” The Maternal and Child Health subprogram provides an oversight to the services and activities which focuses on these populations, including infant/child preventive health, lead poisoning prevention, injury prevention, sexual risk avoidance and personal responsibility education and coordinated school health in a plan to improve quality of life and positive health outcomes.

The administrative regulation [907 KAR 11:034](#) early and periodic screening, diagnosis, and treatment services and early and periodic screening, diagnosis, and treatment special services establishes the provisions relating to the early and periodic screening (EPSDT), diagnosis and treatment service and early and periodic screening, diagnosis and treatment special services for which payment shall be made by the Medicaid Program on behalf of both categorically needy and medically needy children under age twenty-one (21).

### **Target Population**

- Priority for services will be to persons from low-income families or whose total annual Family income does not exceed 185 percent of the most recent federal Income Poverty Guidelines.
- Emancipated minors who wish to receive services on a confidential basis shall be considered on the basis of their own resources.
- Charges for services will be made to persons other than those from low-income families.

### **Funding**

Medicaid or private insurance billing.

### **Staff/Provider Requirements**

Pediatric Preventive Health services are provided by a MD, Advanced Practice Registered Nurse (APRN) and those who meet the Medicaid provider criteria.

### **Training**

KDPH will not provide the expanded role training. LHDs, individually or through collaborative effort may, if they choose, pursue other options to identify a qualified entity with which to contract to develop, provide, and certify the training.

RN’s and APRN’s that participate in the Kids Smile Fluoride Varnish Program for oral screening or fluoride application are required to complete the training for the Kids Smile Fluoride Varnish Program.

### **Reporting Requirements**

Reporting of client information is collected through the [LHD Network System\(s\)](#). The system supports 1) appointment scheduling; 2) assessment of income and appropriate billing of client and third-party payers; and 3) patient encounters.

### **Billing and Coding Procedures Specific to Program**

The LHDs who provide well child services should establish internal policies and procedures that meet best practice guidelines for licensure level of the provider, billing practices as defined by Department for Medicaid Services and DPH Division of Administration and

Financial Management, and audit tools to ensure compliance. These are not governed or monitored by the KDPH Pediatric Program.

### **Other Special Requirements**

- LHDs shall contact the child's medical home prior to completing preventive health services. If the health care provider is in agreement, the LHD may provide the child's preventive exam services.
- All services of LHDs shall be in compliance with [Federal Regulation](#) and conducted in a manner that no person will be excluded from participation in; be denied the benefits of; or otherwise be subjected to discrimination on the grounds of race, color, disability, national origin, sex, age or religion.
- Providers shall comply with the [Americans with Disabilities Act](#) and any amendments, rules and regulations of this act.

### **Special Equipment Requirements**

- Providers shall be located in a facility that is constructed, equipped and maintained to insure the safety of the children and provide a functional, sanitary environment.
- The area utilized during the screening examination shall provide adequate privacy.
- The provider shall have the necessary equipment, in proper working order, to provide the basic screening tests outlined in the [CSG](#).

### **Service Description & Key Roles & Responsibilities of Health Department**

- To prevent duplication of services, the LHD should collaborate with the child's medical home prior to providing services.
- Minimum services to be provided or arranged in accordance with the standards recommended by the [American Academy of Pediatrics \(Bright Futures\)](#) are to include: health and developmental history; unclothed physical history; unclothed physical examination; development assessment; vision hearing testing; nutritional assessment; laboratory testing; anticipatory guidance and health education; referral for acute, chronic, or handicapping conditions, with preauthorized payment for physician services, pharmacy or laboratory tests for acute conditions identified during the preventive health assessment; and nursing follow-up of referrals.
- Children, birth to twenty-one (21) years, that have a chronic condition or suspected chronic illness or disability not covered by other state or community agencies, should be linked to the appropriate regional pediatric specialist.
- The clinic shall have a governing body, legally responsible for the conduct of the clinic, which designates a director or supervisor and establishes administrative and clinical policies.
- Screening clinics conducted under the direction of a registered professional nurse shall have a physician licensed in Kentucky acting as medical consultant.
- Administrative policies shall outline who is to conduct each test and include procedures for the initial contact, follow-up contacts, maintaining patient records and transfer of information from one provider to another. A copy of this shall be retained in the provider's files.
- If a patient is currently receiving preventive healthcare from another provider, the patient should be referred back to that provider.
- Patients with conditions suspected of falling outside the normal screening parameters should be re-screened when appropriate or recommended for evaluation to the child's medical home/local physicians for further diagnosis and treatment of their acute or chronic conditions. LHD's staff physicians, family practice or pediatric nurse practitioners may diagnose and treat children as appropriate. When no other care is

available, children with chronic medical conditions should be coordinated with local physicians or the Kentucky University Clinics or the appropriate regional pediatric specialist.

- Children with suspected genetics problems should be referred to a [Genetics Network Provider](#) or call the Maternal and Child Health Hotline at 800-462-6122. Children with suspected Developmental Delay should be referred for developmental evaluation and screening (refer to the [KEIS Reporting](#) in the AR, LHO Section, or call (877) 417-8377.

### **Minimum Patient Responsibility**

Any Medicaid eligible child is eligible for EPSDT screenings under the age of 21. Well child comprehensive physicals include ages 0-21 years of age.

- Client or parent/guardian of client is expected to keep appointment scheduled according to periodicity recommendations and any recommended follow-up referrals.

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## **WIC Program**

### **Laws, Regulations, Guidelines**

The WIC Program is authorized by Section 17 of the [Child Nutrition Act of 1966](#), as amended. The [Code of Federal Regulations 7 CFR Part 246](#) governs the operation of the program along with the state Administrative Regulation 902 KAR 18.

When required by the Nutrition Services Branch each local agency will sign a Statement of Assurance of Compliance with Regulations for the Special Supplemental Nutrition Program for Women, Infants and Children for continued participation in the Program.

### **Target Population**

Pregnant, breastfeeding and postpartum women, infants and children up to the age of five (5) must be at nutritional risk. The applicant must be a resident of the state of Kentucky and provide proof of residency, income and identity. The applicant must meet the income qualifications.

### **Funding**

WIC funds are allocated based upon an equitable method based upon participation to cover expected nutrition services administration costs to the extent possible. The allocations are split July-September and October through June in order to coincide with the federal fiscal year and closeout for the state fiscal year. Funds are distributed in a reimbursement method based upon submitted monthly expense reports for allowable Program costs.

Annual WIC expenditures shall provide a minimum of twenty percent (20%) for nutrition education and a minimum amount per breastfeeding participant as specified by USDA. LHDs not meeting these minimum amounts shall be subject to the withdrawal of funds for any year that these levels are not met.

When directed by the Nutrition Services Branch and when funding is inadequate to serve the statewide caseload, all LHDs shall maintain priority waiting list of program eligible persons who are likely to be served.

### **Compliance of Federal and State Regulations and Guidelines for WIC Program**

- Per CFR 246.19(b)(4), at a minimum, each Local WIC agency must receive a Management Evaluation at least once every 2 years, and a minimum of 20% of all

WIC sites at that agency. Additional on-site reviews may be conducted, as necessary with a goal to visit all sites within a 3-to-5-year period.

- Per CFR 246.19(b)(5), As part of the regular monitoring reviews, United States Department of Agriculture, Food and Nutrition Services (FNS) may require the State agency to conduct in-depth reviews of specified areas of local agency operations, to implement a standard form or protocol for such reviews, and to report the results to FNS. No more than two such areas will be stipulated by FNS for any fiscal year and the areas will not be added or changed more often than once every two fiscal years.
- Once the monitoring visit has been completed, a Response Letter will be drafted to include the positive findings, suggestions, requirements and requests from the local agency.

#### Description of ME Monitoring Visits

- The Kentucky WIC Program is required to conduct WIC Management Evaluation (ME) Monitoring per federal regulation 7CFR 246.19(b) (1-6).
- Per 7 CFR 246.19 (b) (1-6), monitoring of local agencies must encompass evaluation of management, certification, nutrition education, breastfeeding promotion and support, participant services, civil rights compliance, accountability, financial management systems, and food delivery systems. Nutrition Monitoring is based upon guidelines from the United States Department of Agriculture (USDA), Food and Nutrition Service, "WIC Nutrition Service Standards", WIC Federal Regulations and the guidelines for WIC and Medical Nutrition Therapy (MNT) included in the WIC and Nutrition Manual and the Administrative Reference (AR).
- Once monitoring visit has been completed, a State Agency Response Letter and monitoring report will be drafted to include the positive findings, suggestions, deficiencies/non-compliance with federal and state policies, and corrective action plan requirements.
  - Any significant civil rights findings are to be reported to the FNS Regional Civil Rights Officer by the State WIC Office. A significant finding is an egregious and repetitive finding or a policy or procedure that has a disproportionate, adverse effect on a particular protected class (disparate impact).
- Deficiencies/non-compliance will include a reference to the policy and procedure in the WIC and Nutrition Manual or Administrative Reference.
- This monitoring report and letter will be emailed to the WIC Coordinator (administrator will be copied) to the local agency within 60 days.
- A Corrective Action Plan will be requested for deficiencies and/or non-compliance to federal and state policies and procedures.
- The state agency may determine that a technical assistance visit is required in order to resolve serious findings.
- A written response can be requested for any issue not listed above if determined appropriate. A response may also be requested if a number of findings are identified.
- The local agency will be provided 30 calendar days to submit their corrective action plan to the state agency for review. The local agency may request additional time to respond.
- The local agency Corrective Action Plan at a minimum should include:
  - Corrective Action- explain clearly how the local agency plans to address and correct the deficiency/non-compliance.
  - Staff Responsible- Identify by name the staff member responsible for assuring the planned corrective action is completed.
  - Implementation Date- Identify the date by which the planned corrective action will be completed.

- Documentation- Provide any relevant documentation, for example training materials or sign in sheets.
- The State Agency will review the submitted Corrective Action Plan and provide an approval of the CAP or may request additional information in order to accept and approve the CAP. Written approval or request for more information will be emailed to the WIC Coordinator and the administrator copied within 30 calendar days of receipt.
  - Per CFR 246.19(b)(4) and 2 CFR 200.338, the state agency must continue to monitor the local agency's implementation of the corrective action plan until all compliance findings have been resolved.
  - State agency staff may schedule on-site reviews, request additional documentation or
  - schedule technical assistance visits depending on the seriousness of the findings.
- Non- Compliance of Corrective Action Plan (CAP)
  - Lack of response from the Local Agency
    - If the state agency does not receive the Corrective Action Plan by the 30-calendar day deadline, a follow-up letter will be sent to the WIC Coordinator and Administrator to request the CAP. An extension may be granted, if requested by the Administrator.
    - If the local agency fails to respond with a CAP, intensive on-site WIC monitoring, on-site technical assistance, annual Management Evaluations and withholding of WIC Program funding may be implemented until a CAP is received.
    - For Civil Rights Corrective Plan, see Resolution of Noncompliance for Civil Rights in WIC, WIC Farmers' Market Program, WIC Peer Counseling Breastfeeding Program **below**.
  - Lack of implementation of the CAP/Resolution of the deficiency/non-compliance
    - All findings should be resolved by 3 months after state agency approval of the CAP unless state agency determines additional time is needed for/with technical assistance.
    - Intensive on-site WIC Monitoring, on-site technical assistance, annual management evaluations and holding of WIC Program funding may be implemented until compliance is met.
    - For Civil Rights Corrective Plan, see Resolution of Noncompliance for Civil Rights in WIC, WIC Farmers' Market Program, WIC Peer Counseling Breastfeeding Program **below**.

**Resolution of Noncompliance for Civil Rights in WIC, WIC Farmers' Market Program, WIC Peer Counseling Breastfeeding Program**

- Noncompliance is a factual finding that any Civil Rights requirement, as provided by law, regulation, policy, instruction, or guidelines, is not being adhered to by local agency or other subrecipient.
- Once noncompliance is determined, steps must be taken immediately to obtain voluntary compliance in accordance with FNS Instruction 113-1.
  - The effective date of the finding of noncompliance is the date of the written notice of noncompliance to the local agency or other subrecipient.
  - After a finding of noncompliance, the State agency will:
    - Provide immediate written notice to the local agency or other subrecipient Local Agencies, will request to voluntarily resolve noncompliance findings by

submitting a Corrective Action Plan and implement the State Agency approved corrective action plan.

- Negotiate with local agency or other subrecipient to achieve compliance.
  - Submit to the Regional Civil Rights Officer a Report of Findings of Noncompliance in letter format on all cases where corrective action has not been completed within 60 days of the finding.
  - Submit documentation per the FNS Instruction 113-1.
- The FNS Regional Office of Civil Rights must determine the next steps of action per FNS Instruction 113-1.

**Staff Requirements:**

- A certifying health professional will determine eligibility, certify persons for the program and prescribe supplemental foods. A certifying health professional is a Registered Dietitian (RD/LD), Registered Dietitian Nutritionist (RDN,LD), Nurse (R.N., L.P.N., APRN), Nutritionist (bachelor’s degree), Certified Nutritionist (master’s degree and certified by the State Board of Certification), Physician’s Assistant or Physician.
- Each local agency shall designate a staff person to serve as WIC Coordinator. It is recommended that this staff person be an RN or Nutritionist who has experience in providing WIC services in an LHD. A list of duties for the WIC Coordinator follows in this section.
- Each local agency shall designate a staff person to serve as Breastfeeding Coordinator to coordinate breastfeeding promotion and support activities. This staff person must be a nutritionist or nurse who has experience in providing WIC services in a LHD and is trained in breastfeeding. An agency must request approval from the Nutrition Services Branch to designate a different classification for this function. A list of duties for the Breastfeeding Coordinator follows in this section.
- Each local agency shall designate a staff person who is a nutritionist or nurse to coordinate nutrition education activities. A list of duties for the Nutrition Education Coordinator follows in this section.
- Each local agency shall designate a staff person who is a nutritionist or nurse to serve as the Designated Breastfeeding Expert (DBE) by October 2024. The Designated Breastfeeding Expert is required to complete the WIC USDA Breastfeeding Curriculum Levels 1-4.

**Training Requirements:**

- Appropriate staff will attend training as required by the Nutrition Services Branch.
- WIC Policy and Procedures Training is available upon request.
- WIC 101 module on [TRAIN Kentucky](#) is recommended for all new staff and as a refresher for all existing staff. The module number is [1033155](#).
- Civil Rights training is required on an annual basis of all frontline staff and frontline supervisors. The [TRAIN Kentucky](#) module WIC DPH Kentucky Civil Rights Training [KY Train 1108316](#) is available for this training requirement. .
- All WIC Staff and local health department staff who interact with WIC applicants and participants must take the WIC USDA Breastfeeding Curriculum Level 1 [KY Train](#) module 1103549.
- See Training Matrix, WIC for additional training requirements.

## Reporting Requirements:

- A monthly report of program operations cost must be submitted. Cost must be broken down by client services, nutrition education, breastfeeding promotion and general administrative cost.
- Reporting of client information is collected through the [LHD Network System\(s\)](#), and benefit issuance through EBT. The systems support 1) appointment scheduling; 2) registration and income; 3) patient encounters; 4) certification information including growth carts; 5) benefit issuance; and 6) billing and households if issuing benefits through EBT.
- Vendor applications, authorizations, training, monitoring and document retention is completed by the Nutrition Services Branch, Department For Public Health.
- Management evaluations and site visits are conducted by the Nutrition Services Branch staff to review program operations as required by USDA and WIC regulations. The WIC Coordinator is informed of any identified deficiencies and/or inappropriate procedures/policies. Corrective action is to be implemented by a specified time frame to be in compliance or a monetary penalty may be assessed.
- An annual Nutrition Education Program Plan must be completed and the plan submitted to the Nutrition Services Branch for review and approval. The evaluation of the nutrition education activities for the prior year is completed and submitted to the Nutrition Services Branch at the same time as the Program Plan.
- A Civil Rights Complaint file must be maintained per the WIC and Nutrition Manual, [Program Integrity Section](#).
- An WIC outreach file must be maintained per the WIC and Nutrition Manual, [Caseload Management Section](#).

## Billing and Coding Procedures:

Adhere to all policies and procedures relating to billing and coding for the WIC Program as outlined in the [WIC and Nutrition Manual](#).

## Other Special Requirements:

- Adhere to timeframes for service delivery as outlined in the Administrative Reference.
- Provide outreach for all categories of participants and disseminate program information as directed by the Cabinet.
- Provide the opportunity to register to vote at WIC application, certification, and transfer for women eighteen (18) years old and older. If a member of the public is not receiving services and requests to register to vote, they must also be accommodated.
- Perform periodic local internal review to ensure adherence to WIC Program federal and state regulations, policies and procedures.
- Publishes information on WIC services and any programmatic changes on at least an annual basis. The Nutrition Services Branch publishes this information on a statewide basis. LHDs are notified of these publications which are to appear statewide. All LHDs are responsible for reviewing the newspaper(s) in their service area to determine if the WIC services announcement(s) appears. If the announcement does not appear, the LHD shall contact the area paper and request the announcement run free of charge. If the local paper does not offer free public service announcements, the LHD shall pay to have the notice published.
- Guarantee computer equipment and internet access is made available to ensure efficient entry of services into the [Clinic Management System](#) (a.k.a., Portal), a web-based system, which includes the issuance through [eWIC via WIC Direct](#). The computers are maintained in accordance with guidance outlined in the [Local Health Operations section](#) of the [DPH Administrative Reference](#).

- All adults applying for the WIC Program for themselves or on behalf of others shall be provided with written information on the Medicaid Program at each certification and recertification. Other information shall be provided as specified by the Nutrition Services Branch.
- Local agencies will make nutrition education available to all participants. During each six-month certification period, at least two nutrition contacts shall be made available to adults and children. Infants and any persons certified for longer than six months shall have nutrition education contacts made available on a quarterly basis.
- Local agencies will obtain prior written approval for the purchase of any item of equipment of \$500.00 or more with WIC funds. Once the equipment has been purchased, the local agency will submit a copy of the invoice, along with the inventory number, to the WIC State Agency. Any purchase requisition in excess of \$5,000 and any procurement of automated information systems, including equipment or software, or management studies, must receive prior approval from USDA, FNS, and the WIC State Agency. Title to such equipment will rest with the WIC State Agency and shall be returned upon request.
- Local agencies shall when purchasing property with WIC funds that falls below the required prior approval category of \$500.00 which is considered a sensitive item (i.e. such as a calculator, camera, etc.) inventory the item and submit a copy of the invoice, along with the inventory number, to the State WIC State Agency. Title to such sensitive items will rest with the WIC State Agency and shall be returned upon request.

**Program Specific Offerings:**

Review the WIC Farmers’ Market Nutrition Program, Breastfeeding Peer Counselor Program, and Regional Breastfeeding Coordinator below.

**WIC Services Description and Key Roles and Responsibilities of The Health Department**

The WIC Program provides nutrition education and healthy foods to pregnant, breastfeeding and post-delivery women, infants and children up the age of five (5) who meet income and health risk guidelines.

The applicant must provide proof that they are a resident of Kentucky, proof of identity and proof of household income eligibility.

The certifying health professional then determines nutritional risk based upon national guidelines. This is determined from an assessment including height, weight, blood test, diet and a brief medical history.

A certifying health professional explains to the person why he/she qualifies for WIC; for example, the child has low iron and would benefit from the WIC foods. The health professional provides nutrition education which may include such topics as recommended infant feeding guidelines, planning a healthy diet or wise shopping ideas. Breastfeeding education such as advantages of breastfeeding, how to breastfeed and the benefits of breastfeeding are provided during the prenatal and post-delivery periods. A food package is prescribed by the health professional based upon category of the participant and individual needs, such as homelessness. The participant is provided up to three (3) months of program benefits which contain the prescribed food packages for specific healthy foods, a list of approved foods that can be purchased and a list of stores that are authorized to cash the food instruments.

Referrals are provided for such services as immunization, pediatric preventive health exams, social services, community services and medical nutrition therapy (extensive individual diet counseling).

**Minimum Participant Responsibility:**

The WIC participant has certain rights but also responsibilities to utilize the program in a proper manner.

- The applicant must provide proof of income, residence and identity. The applicant must be a resident of Kentucky.
- A WIC participant cannot be enrolled or participating in more than one (1) WIC agency/site or in WIC and the [Commodity Supplemental Food Program](#) (CSFP) at the same time.

Each participant must be informed of their rights and responsibilities at certification and recertification. Certain standards exist for participants who have been determined to abuse the program. Review the [WIC and Nutrition Manual](#), Policy 211, Rights and Responsibilities.

**Services (Arranged and Paid) Include:**

WIC services and screenings must be provided at no cost to the applicant/participant.

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**WIC Farmers' Market Nutrition Program (FMNP)****Laws, Regulations, Guidelines**

FMNP is authorized by the Food Stamp Act of 1977, as amended. The [Code of Federal Regulations 7 CFR Part 248](#) govern the operation of the WIC Farmers' Market Nutrition program.

**Target Population**

Pregnant, breastfeeding and postpartum women, infants (over 5 months of age) and children up to the age of five (5) who are WIC participants are the eligible participants.

**Funding:**

Due to limited federal funding, not all agencies have this program. The program is funded by a federal FMNP grant. Funds for the FMNP benefits are allocated based upon an equitable method. FMNP benefits can only be issued to participants up to the allocated funding.

**Reporting Requirements:**

- Reporting of client information is collected through the [WIC FMNP SoliMarket Portal](#).
- WIC FMNP applications, authorizations, training, monitoring and document retention is completed by the Nutrition Services Branch, Department For Public Health. Nutrition Education and promotion FMNP materials developed by the local agency should be submitted to the Nutrition Services Branch for review. Management evaluations and site visits are conducted by the Nutrition Services Branch staff to review program operations as required by USDA and FMNP regulations. The WIC Coordinator is informed of any identified deficiencies and/or inappropriate procedures/policies. Corrective action is to be implemented by a specified time frame to be in compliance or a monetary penalty may be assessed.

**Billing and Coding Procedures:**

Only benefit issuance is coded on the [patient encounter form](#) (PEF).

**Other Special Requirements:**

Adhere to all policies and procedures relating to the FMNP Program as outlined in the [WIC and Nutrition Manual](#).

## **FMNP Services Description and Key Roles and Responsibilities of the Health Department**

FMNP provides participants in the WIC Program with food instruments to purchase fresh fruits and vegetables at local farmers' markets. Through this program, WIC participants receive the nutritional benefits of fresh fruits and vegetables in addition to the regular WIC food package. See WIC and Nutrition Manual for additional information concerning the WIC Farmer's Market Nutrition Program.

The participant is provided with WIC FMNP electronic benefits of \$30 dollars each season (generally June through October) for the purchase of locally grown fresh fruits and vegetables, at authorized Farmers' Markets. A list of approved fruits and vegetables for purchase and the location of the authorized Farmers' Markets is provided to eligible participants.

### **Minimum Patient Responsibility:**

The WIC participant has certain rights but also responsibilities to utilize the program in a proper manner.

- Each participant must be informed of how to use the FMNP benefits through the participant brochure.

### **Services (Arranged and Paid) Include:**

FMNP services must be provided at no cost to the applicant/participant.

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## **WIC Breastfeeding Peer Counselor Program**

The Breastfeeding Peer Counselor Program is designed to provide mother to mother breastfeeding support and basic breastfeeding education to WIC Program mothers who are pregnant or breastfeeding. The goals of the Breastfeeding Peer Counselor Program are to meet the Healthy People 2030 Objectives which are to increase initiation; to increase the proportion of infants who are breastfed exclusively through 6 months to 42.4%, and to increase the proportion of infants who are breastfed at 1 year to 54.1%.

**Target Population:** WIC Program participants who are pregnant or breastfeeding.

**Funding:** The Program is funded by a federal breastfeeding peer grant. Funds are allocated based upon an equitable method to cover expected services and administrative costs to the extent possible based upon the federal funding. Funds are distributed in a reimbursement method based upon submitted monthly expense reports for allowable Program costs. The expenses for this program are limited to those specifically related to Breastfeeding Peer Counseling. Due to limited federal funding, not all agencies have this Program.

### **Staff/Provider Requirements:**

- Peer Counselors must have breastfed at least one baby for six (6) months or longer and were previously or currently a WIC participant.
- Peer Counselors must be a contemporary/cohort/equal to the woman to whom she will be providing information and support. This may include having the ability to speak another language such as Spanish.
- See the additional qualifications for a Breastfeeding Peer Counselor in the Breastfeeding Peer Counseling section of the WIC and Nutrition Manual, Breastfeeding Peer Counselor Agencies.

- Peer Counselors are to be contracted with the agency using the standard Peer Counselor contract, only agencies have been grandfathered in, prior to June 30, 2011, may have the Peer Counselor as a part-time employee.
- The agency must have a Lactation Specialist/Designated Breastfeeding Expert (DBE) who is a health professional (RD, RN or LPN) with certification as an International Board Certified Lactation Counselor (IBCLC), a Certified Lactation Counselor (CLC), or Certified Lactation Specialist (CLS) or completed levels 1-4 of the USDA Breastfeeding Curriculum earning the Designated Breastfeeding Expert (DBE) credential. This person may be an employee of the agency or under contract to receive referrals from the Peer Counselor of mothers who have breastfeeding issues that are outside the peer's scope of practice.
- The agency must have a [Breastfeeding Peer Counselor Supervisor](#) that is an employee of the agency.
- See the duties of the [Breastfeeding Peer Counselor Supervisor](#), [Lactation Specialist/DBE](#) and [Breastfeeding Peer Counselor](#) which follow in this section.

***Training:***

- Prior to being placed under contract or working with pregnant or breastfeeding mothers, Peer Counselors must complete Levels 1 and 2 of USDA Required Breastfeeding Training and receive training by the State Agency or Regional Peer Trainer.
- Prior to initiating the Program in the local agency, the Breastfeeding Peer Counselor Supervisor must have received training from the State Agency and complete the USDA Breastfeeding Training Levels 1-2.
- Each year the Peer Counselor must complete 4 hours of continuing education by attending quarterly Breastfeeding Peer meetings coordinated by the State Agency.
- The Lactation Specialist/DBE must demonstrate proof of award of certification and maintenance of applicable necessary continuing education as an IBCLC, CLC or CLS or DBE.

***Reporting Requirements:***

- Documentation and reporting of all client encounters must be done through the Breastfeeding Peer Counseling database/system.
- Review the [WIC and Nutrition Manual](#) for additional information concerning the Breastfeeding Peer Counselor Program.

**DUTIES OF THE WIC COORDINATOR**

It is recommended that the WIC Coordinator be a Nutritionist or RN. The coordinator should have previous experience providing WIC services.

**RESPONSIBILITIES:**

- Ensures WIC Program operates according to federal and state regulations, procedures and policies as outlined in the WIC and Nutrition Manual. Ensures any local policies and procedures are in compliance with state policies and procedures.
- Ensures all appropriate staff are informed and trained regarding WIC policies, procedures and systems.
- In conjunction with agency administrator, ensure adequate and appropriate staffing to provide WIC services for applicants and participants.  
Ensure agency has designated a point of contact that ensures compliance with all Civil Rights requirements applicable to WIC.
- Responsible for caseload management. Ensures that appointments are made in a

timely manner and that processing standards are met.

- In conjunction with the agency administrator and/or authorized representative, develops and monitors the WIC budget, monitors expenditures and appropriateness of coding of time, function, and travel.
- In conjunction with Nutrition Education Coordinator, develops procedures to provide appropriate and required nutrition education to WIC participants. In conjunction with the Nutrition Education Coordinator and agency administrator or authorized representative ensures that at least twenty percent (20%) of nutrition services administration \ funds are appropriately expended during each fiscal year for nutrition education activities.
- In conjunction with Breastfeeding Promotion Coordinator, develops procedures to provide appropriate and required breastfeeding education and promotion to WIC participants and public and private partners.
- Ensures that voter registration services are provided and documented as outlined by state policies and procedures.
- Ensures Vendor Management policies and procedures are adhered to.
- Ensures that agency's sites have an adequate supply of current forms, **eWIC** cards and handwritten food instruments for program operations. Responsible for compliance with all security requirements for **eWIC** cards, manual food instruments, stamp, formula and breast pump accountability, storage, and inventory at each agency site.
- Reviews management and monitoring reports and ensures appropriate action is taken when necessary. Share management and monitoring findings with agency staff as appropriate or necessary. Ensures correction of identified deficiencies in a timely manner.
- Ensures all appropriate staff are informed of local referral information/sources available to serve the WIC clients according to Federal and State policies and procedures.
- Ensures outreach is conducted at least annually in each local site's community as outlined in the Administrative Reference and the [WIC and Nutrition Manual](#). Ensures outreach file documentation contains up-to-date information.
- Develops procedures for and/or conducts reviews of agency's sites for quality assurance and compliance.
- In conjunction with the Breastfeeding Peer Counselor Supervisor, manages and supervises the Breastfeeding Peer Counselor Program (if applicable).
- Ensures all appropriate staff are informed of WIC Farmer's Market Nutrition Program (FMNP) policies and procedures and that they are adhered to (if applicable). Ensures any local policies and procedures are in compliance with state policies and procedures.

## **DUTIES OF WIC BREASTFEEDING PROMOTION COORDINATOR**

The Breastfeeding Promotion Coordinator shall be a nutritionist or nurse or IBCLC unless written approval is received from the State WIC Office to utilize a different classification for this function. This person should have experience providing WIC services.

### **RESPONSIBILITIES:**

- Provides and/or coordinates breastfeeding training for local agency staff. Training should address technical and promotional aspects of breastfeeding.
- Develops and implements clinical standards to ensure adequate breastfeeding promotion and support.
- Disseminates breastfeeding promotion and education materials to appropriate staff

- and other public or private entities.
- Evaluates effectiveness of agency’s breastfeeding promotion efforts on an annual basis. Develops and implements a plan to increase the incidence and duration of breastfeeding based on annual evaluation.
- Ensures breast pump issuance, inventory and education is provided to WIC participants in accordance with State policies and procedures.
- Receives four (4) hours of continuing education on Breastfeeding management and promotion on an annual basis.
- In conjunction with the WIC Coordinator, and/or Breastfeeding Peer Counselor Supervisor assist in management and supervision of the Breastfeeding Peer Counselor Program (if applicable).

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**RESPONSIBILITIES:**

- Provides and/or coordinates breastfeeding training for local agency staff. Training should address technical and promotional aspects of breastfeeding.
- Develops and implements clinical standards to ensure adequate breastfeeding promotion and support.
- Disseminates breastfeeding promotion and education materials to appropriate staff and other public or private entities.
- Evaluates effectiveness of agency’s breastfeeding promotion efforts on an annual basis. Develops and implements a plan to increase the incidence and duration of breastfeeding based on annual evaluation.
- Ensures breast pump issuance, inventory and education is provided to WIC participants in accordance with State policies and procedures.
- Receives four (4) hours of continuing education on Breastfeeding management and promotion on an annual basis.
- In conjunction with the WIC Coordinator, and/or Breastfeeding Peer Counselor Supervisor assist in management and supervision of the Breastfeeding Peer Counselor Program (if applicable).

**DUTIES OF WIC BREASTFEEDING PEER DESIGNATED BREASTFEEDING EXPERT**

The DBE is a Registered Dietitian (RD) or Nurse (RN or LPN) with certification as an International Board Certified Lactation Consultant (IBCLC), Certified Lactation Counselor (CLC), Certified Lactation Specialist (CLS) or Certified Lactation Educator (CLE) or completed levels 1-4 of the USDA Breastfeeding Curriculum earning the Designated Breastfeeding Expert (DBE) credential, that will provide lactation management and support services for participants of the Breastfeeding Peer Counselor Program when the client is experiencing issues which are outside the scope of practice for the paraprofessional Breastfeeding Peer Counselor.. By October of 2024, the DBE must complete the USDA Breastfeeding Curriculum levels 1-4. Effective October 2024, the DBE must be a health professional who has completed the 4 levels of USDA training and will not be required to have further breastfeeding credentials.

The DBE will:

- Obtain training on all 4 levels of the USDA required Breastfeeding curriculum by October 2024

- Receive referrals from Breastfeeding Peer Counselors for clients who are experiencing complex maternal and infant breastfeeding problems beyond their scope of practice.
- Provide timely follow-up services by telephone, home visit, WIC clinic visits, and/or hospital visits. The follow-up may occur outside of the normal hours of clinic operations.
- Assess breastfeeding situation and provide counseling to mothers.
- Maintain and protect the confidentiality of each client.
- Document services in the medical record in accordance with the guidelines in the Medical Records Management section of the AR Volume I and the Breastfeeding Peer Counselor protocols, as appropriate.
- Codes clinical or community services on the appropriate reporting or billing form in order for the local agency to receive reimbursement for services, as appropriate.
- Coordinate continued follow-up of the client with the Peer Counselor.
- Assist the Breastfeeding Peer Counselor Supervisor in providing initial and ongoing breastfeeding training for Peer Counselors.
- Mentors or assists in mentoring, Peer Counselors through shadowing opportunities and ongoing guidance.
- In conjunction with the Breastfeeding Peer Counselor Supervisor, provides breastfeeding trainings for local agency staff, and in-service education for hospital staff and local health care professionals.
- Teach breastfeeding classes and support groups for pregnant and breastfeeding women (optional).
- Assist in conducting outreach with community organizations to promote WIC breastfeeding and peer counseling services (optional).
- Records and collects data required by State or Local agency.
- Maintains credentials and breastfeeding knowledge and skills through continuing education as required by credentialing organization (minimum of 4 hours of continuing education in breastfeeding management or promotion each year).

### **DUTIES OF WIC BREASTFEEDING PEER COUNSELOR SUPERVISOR**

The Breastfeeding Peer Counselor Supervisor shall be a nutritionist or nurse unless written approval is received from the State WIC Office to utilize a different classification for this function. This person should have experience in providing WIC services in the clinic. The supervisor cannot be contracted.

### **RESPONSIBILITIES:**

- Peer Counselors must complete Levels 1 and 2 of USDA Required Breastfeeding Training and receive training by the State Agency or Regional Peer Trainer.
- Recruit, interview, train and supervise Peer Counselors according to WIC Program policies and procedures.
- Provide and/or ensure that all Breastfeeding Peer Counselors are trained in lactation management using *USDA Breastfeeding Curriculum training* and provide ongoing training as needed.
- In conjunction with agency administrator, ensures adequate and appropriate staffing of Peer Counselors to serve the local WIC caseload of pregnant and breastfeeding women.
- In conjunction with the WIC Coordinator/Breastfeeding Coordinator and agency administrator or authorized representative, ensures that the agency's allotment of funds for Breastfeeding Peer Counseling is appropriately expended in fiscal year.
- Manages and coordinates Breastfeeding Peer Counselor staff and services with agency WIC Program staff and services to assure program quality assurance and compliance.

- Provides supervision and management of Breastfeeding Peer Counselors by monitoring counseling and documentation of services provided. Share management and monitoring findings with staff as appropriate or necessary. Ensures correction of identified deficiencies in a timely manner.
- Maintain communication with the State Breastfeeding Peer Counselor Coordinator to assure continuous quality improvement for the Breastfeeding Peer Counselor Program.
- Attends WIC Program Breastfeeding Peer Counselor meetings and Breastfeeding Peer Counselor Supervisor meetings.
- Receives 4 hours of continuing education on Breastfeeding Management and Promotion each year.

### **WIC BREASTFEEDING PEER COUNSELOR**

The Breastfeeding Peer Counselor will be a contemporary/cohort/equal to the woman to whom she will be providing information and support. This may include having the ability to speak another language such as Spanish, have successfully breastfed an infant for 6 months or longer; be an advocate for breastfeeding; have basic computer skills in the use of email and common Word documents; have the ability to communicate effectively with peers, supervisors and other health department staff; have been or currently is a WIC participant; have reliable transportation; and be readily accessible by phone.

A Peer Counselor scope of practice is to provide basic breastfeeding information, encouragement and support to WIC participants.

A Peer Counselor must refer/yield identified breastfeeding problems or other health issues outside the Peer Counselor scope of practice. See Guidelines for Referring/Yielding. Other referrals shall be provided as specified in the Breastfeeding Peer Counselor protocols.

### **RESPONSIBILITIES:**

- Complete Levels 1 and 2 of the USDA Breastfeeding Curriculum training provided by the state agency, prior to providing counseling through the Peer Program. The Peer Counselor Supervisor will document and maintain on file the successful completion of the modules.
- Demonstrate the ability to work with pregnant and breastfeeding women as observed by the Peer Counselor Supervisor.
- Communicate effectively with Breastfeeding Peer Counselor Supervisor, LHD staff, clients, and other peer counselors, as appropriate.
- Receive an assigned caseload of pregnant and breastfeeding WIC mothers.
- Contact the mothers per the Breastfeeding Peer Counselor Protocol for Contacting WIC Mothers in the WIC and Nutrition Manual.
- Provide counseling by telephone, home visit, clinic visit and/or hospital visit per the Breastfeeding Peer Counselor protocols and individual client's needs.
- Provide basic breastfeeding information and support such as the benefits of breastfeeding, overcoming common barriers, establishing breastfeeding, etc. Assists clients in preventing and handling common breastfeeding problems and concerns.
- Maintain and protect client confidentiality.
- Document all contacts made with clients via the Breastfeeding Peer Counselor Computer Program. If the system is down, the documentation will be made per Breastfeeding Peer Counselor protocol. When the system is live again, the contact information will be entered into the system per protocol.
- Operate within the Scope of Practice for a Breastfeeding Peer Counselor. See Scope of Practice for WIC Breastfeeding Peer Counselor in the Breastfeeding Peer Counselor Section of the WIC and Nutrition Manual.

- Refer identified breastfeeding problems or other health issues to appropriate health professional (e.g., IBCLC, DBE, CLC, LC, Registered Dietitian/Certified Nutritionist, nurse, etc. See the Guidelines for Referring/Yielding in the Breastfeeding Peer Counselor Section of the WIC and Nutrition Manual. Other referrals may be provided per Breastfeeding Peer Counselor protocols.
- Terminate clients from the Breastfeeding Peer Counselor Program after 3 documented unsuccessful attempts to contact once the client is no longer breastfeeding or the client wishes not to participate in the program. The Contact History must be printed and placed in the participant's medical record.
- Attend and assist with prenatal classes and breastfeeding support groups, as appropriate.
- Assist WIC staff in promoting breastfeeding peer counseling through special projects and duties, as assigned.
- Attend peer counselor meetings as directed by State Peer Counselor Coordinator. Attends other breastfeeding conferences/workshops, as appropriate.

The above information regarding a Breastfeeding Peer Counselor is reflected in the standard contract for Peer Counselors.

### **DUTIES OF WIC REGIONAL BREASTFEEDING COORDINATOR**

A Regional Breastfeeding Coordinator is a Registered Dietitian (RD) or Nurse (RN or LPN) with certification as a Certified Lactation Counselor (CLC), Certified Lactation Specialist (CLS), International Board-Certified Lactation Consultant (IBCLC) or DBE or State approved equivalent. The person designated in this position must be approved by the State WIC Agency. The Regional Breastfeeding Coordinator will provide breastfeeding education, promotion, and support in their local agency as well as other designated agencies and public and private community partners in their region. The region will be designated by the State WIC Agency.

### **RESPONSIBILITIES:**

- Develop programs, activities, and outreach that promote breastfeeding in the specified region. Work with the Breastfeeding Coordinators at the local agencies, in the specified region, in the development of a Breastfeeding Promotion Plan.
- Provide support, promotion, and education to public and private community partners such as other local agencies, hospitals, physicians, and community groups in the specified region.
- Develop and support breastfeeding coalitions and mother to mother support groups in the specified region.
- Serve as a committee chair and lead committee towards meeting the strategies in "The Strategic Plan for Improving Breastfeeding Rates in Kentucky."
- Attending Regional Breastfeeding Coordinator meetings, as designated by the State Office.
- In conjunction with the Local Agency Administrator, or authorized representative, ensure the agency's allotment of funds for 833 is appropriately expended in fiscal year.
- Maintain communication with State Breastfeeding Promotion Coordinator to assure continuous quality improvement in breastfeeding promotion and support in the specified region.
- Develop and evaluate an annual plan based upon the assessment of need of the public and private partners in the specified region and "The Strategic Plan for Increasing Breastfeeding Rates in Kentucky."
- Assist Breastfeeding Promotion Coordinators in specified region with breastfeeding training and promotion.

### **833 Cost Center-Breastfeeding (WIC)**

Only expenditures for designated Regional Breastfeeding Coordinators approved by the State WIC office, in specified agencies can be charged to this cost center. The expenditure will be for breastfeeding promotion activities to increase breastfeeding initiation and duration rates. This includes working with other LHDs and public and private community partners. Expenditures for direct one-on-one services cannot be coded to this cost center.

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### **WIC PROGRAM APPLICANT/PARTICIPANT FAIR HEARING PROCEDURES**

The following are policies that pertain to WIC applicants and participants only:

1. A WIC applicant/participant shall be provided with a copy of the Fair Hearing Procedures when:
  - Found ineligible;
  - Disqualified or suspended during a certification period; and
  - An action has resulted in a claim for repayment of improperly issued benefits.
2. Requests for fair hearings shall be honored unless:
  - The request for a hearing is not received by the state WIC Agency within sixty (60) days from the date of notice; or
  - The request is due to the tailoring of the WIC food package, which results in a reduction of supplemental foods.

The fair hearing will be in accordance with Administrative Regulation [902 KAR 18:040](#) and which meets the requirements of [KRS Chapter 13B](#). The fair hearing will be conducted by a Cabinet Hearing Officer.

Additionally, refer to the WIC Program Fair Hearing Procedures Poster and Fair Hearing Procedures Info Sheet in the [WIC and Nutrition Manual](#).

#### **The following policies pertain to WIC Vendors:**

1. A WIC Vendor shall be informed in writing of the right to a hearing and the method by which a hearing may be requested for the following adverse actions:
  - Denial of application to participate in the program.
  - Disqualification; or
  - Other adverse action which affects participation during the agreement performance period.
2. Refer to [902 KAR 18:081](#) for the actions that are not subject to appeal
3. The vendor's fair hearing will be in accordance with Administrative Regulation [902 KAR 18:081](#) and [KRS Chapter 13B](#).

#### **The following policies pertain to WIC local agencies:**

An appeal shall be granted if a local agency:

- Is denied application;
- Has participation in the program terminated; or
- Has any other adverse action affecting participation.

The appeal shall be to the Cabinet and shall be in accordance with the requirements of [KRS Chapter 13B](#), Administrative Regulation [902 KAR18:081](#) and the relevant federal and/or state regulations or laws.

Appealing the termination or suspension does not relieve the local agency from continued compliance with program requirements. Any adverse action will be postponed until a decision is reached in the hearing. A local agency cannot appeal the expiration of their services at the end of the service period.

### **Hearing Officials' Duties For The WIC Program**

Hearing procedures for the Cabinet for Health and Family Services and LHDs/agencies shall be governed by [KRS Chapter 13B](#) and Administrative Regulation [902 KAR1:400](#). WIC Program *hearing proceedings* for applicants, participants and vendors are governed by [KRS Chapter 13B](#) , and [902 KAR Chapter 18](#) (WIC Program) including [18:040](#) and [18:081](#).

WIC Program applicant/participant hearings shall be conducted or presided over by an impartial official or hearing body who does not have any personal stake or involvement in the decision, who was not directly involved in the determination of the adverse action being contested and who has no prior knowledge of the case under appeal.

The hearing official shall:

- Administer oaths or affirmations to persons who will be testifying on either the LHD's behalf or the requesting party's behalf;
- Ensure that a verbatim transcript or recording of the hearing proceedings is obtained;
- Ensure that all issues relevant to the case are considered;
- Request, receive, and make a part of the hearing record all evidence which has been determined to be necessary to decide the issues being raised;
- Regulate the conduct and the course of the hearing in a manner which is consistent with due process in order to ensure an orderly hearing;
- Order, only in cases involving a participant and only when necessary or relevant, an independent medical assessment or professional evaluation from a source mutually satisfactory to the appellant and LHD; and
- Render a hearing decision which will resolve the dispute. The written decision shall:
  - Summarize the facts of the case;
  - Specify the reasons for the decision;
  - Identify supporting evidence and pertinent regulations or policy;
  - Be based upon the application of appropriate Federal Law, regulations and policy as related to the facts of the case as established in the hearing record; and
  - Be a part of the record for the hearing.

### **Cross Reference: Rules for Conduct of Hearings**

Administrative Hearing Regulation [902 KAR1:400](#).

Special procedures apply for LHD Merit System employees and applicants for employment. (See LHD System Administrative Regulations [902 KAR 8:100](#); and [902 KAR 8:110](#).)

Special procedures may apply to programs with administrative regulations, such as the WIC Program's Administrative Regulation [902 KAR 18:040](#) and [902 KAR 18:081](#).

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**Kentucky Department for Public Health –  
Administrative Reference for LHDs**

**REFERENCES/CITATIONS:**

**Section: Abuse, Neglect, Violence**

Bureau of Justice Statistics. (2005). *Criminal Victimization*. Retrieved from [www.ojp.usdoj.gov](http://www.ojp.usdoj.gov).

Chang J, Berg C, Salzman L, & Herndon J. (2005). Homicide: A leading cause of injury deaths among pregnant and postpartum women in the United States, 1991-1999. *American Journal of Public Health*. 95-(3): 471-477.

Johnson, T.C. (2007). *Understanding children's sexual behaviors: What's natural and healthy*. San Diego: CA.

Silverman, J.G., Decker, M.R., Reed, E., & Raj, A. (2006). Intimate partner violence victimization prior to and during pregnancy among women residing in 26 u.s. states: Associations with maternal and neonatal health. *American Journal of Obstetrics and Gynecology*. 195(1): 140-148.

The National Child Abuse and Neglect Data System (2007). *Child Maltreatment*.

Section: Competencies Crosswalk-Public Health Nursing Competencies Narrative

Quad Council Coalition Competency Review Task Force. (2018). Community/Public Health Nursing Competencies

Public Health Foundation (PHF). Core Competencies for Public Health Professionals. [http://www.phf.org/resourcestools/Pages/Core\\_Public\\_Health\\_Competencies.aspx](http://www.phf.org/resourcestools/Pages/Core_Public_Health_Competencies.aspx)  
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**Section: Environmental Services**

Acknowledgements:

Information was gathered from the Centers for Disease Control and Prevention, National Resource Center for Health and Safety in Child Care and Early Education, Tacoma Pierce County Health Department, the Minnesota Department of Health and the Commonwealth of Massachusetts Department of Public Health websites.

**Section: Incident Reporting – [Tips for Reporting Incidents:](#)**

Reference: From the book, "*Charting Made Incredibly Easy*" by Springhouse Corporation.

**Section: Training Guidelines and Program Descriptions**

**Family Planning**

- Center for Disease Control and Prevention. (2021). Reproductive Health: Improving family planning. Retrieved from <https://www.cdc.gov/reproductivehealth/global/improving-family-planning.htm>
- Gavin, L., Moskosky, S., Carter, M., Curtis, K., Glass, E., et al. (2014). Providing quality family planning services: Recommendations of cdc and the u.s. office of population affairs. *MMWR. Morbidity and Mortality Weekly Report* 63(4).
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- Office of Population Affairs. (2021). Title X Statutes, Regulations, and Legislative Mandates. Retrieved from <https://opa.hhs.gov/grant-programs/title-x-service-grants/title-x-statutes-regulations-and-legislative-mandates>
- Office of Women’s Health. (2021). Preconception Health. Retrieved from <http://www.cdc.gov/preconception/hcp/index.html>
- Office of Women’s Health. (2021). Optimal Health Model. Retrieved from <https://opa.hhs.gov/adolescent-health/optimal-health>

## **Section: Medical Records Management**

### References:

CDC Publications  
Advisory Committee on Immunization Practices – ACIP  
Epidemiology and Prevention of Vaccine–Preventable Diseases (The Pink Book)  
1998 Guidelines for Treatment of Sexually Transmitted Diseases  
The Core Curriculum on TB  
Medical Acronyms, Eponyms & Abbreviations by Marilyn Fuller Delong  
Merck Manual  
Dorland’s Medical Dictionary  
Contraceptive Technology

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Review the [LHD Forms, Documents and Administrative Reference webpage](#) for forms and documents pertaining to:

### **Administrative Reference**

[Clinical Service Guide \(CSG\)](#)

[Clinic Health \(CH\) Forms](#)

[Environmental Health](#)

[LHD Security Requests](#)