BPHC BUREAU OF PRIMARY HEALTH CARE

POLICY INFORMATION NOTICE

94-7

DATE: February 7, 1994

Document Title: Migrant Health Voucher Program Guidance

To: Migrant Health Center/Migrant Health Program Grantees

Enclosed is the Migrant Health Voucher Program Guidance, which describes the Expectations of the Public Health Service for operational voucher projects which receive Section 329 funds to serve migrant and seasonal farmworkers. The document also serves as a guidebook to better prepare voucher projects to meet the needs of migrant and seasonal farmworkers and their families. The Bureau would like to acknowledge the work of Dr. Ben Duggar, with the Center for Health Policy Studies, and the numerous contributions of various voucher projects around the country in the development of this document.

If you have any questions about this guidance, please contact the Division of Community and Migrant Health, Migrant Health Branch, telephone (301) 594-4303.

Sincerely yours,

for Marilyn H. Gaston, M.D.
Assistant Surgeon General
Director

Enclosure

POLICY INFORMATION NOTICES (PINs)
Issued in FY 1994 as of February 7, 1994

PIN NUMBER	TITLE
94-1	Application Guidance State/Regional Primary Care Grants and Statewide Cooperative Agreements Including Competitive Improvement Packages
94-2	Funding Analysis Process for Community and Migrant Health Centers
94-3	Application Guidance for Demonstration Grants to States for Community Scholarship Programs for Fiscal Year 1994
94-4	Changes in Grants Administration for Bureau of Primary Health Care
94-5	Amendment to Policy Information Notice 93-17
94-6	Capital Improvement Projects (CIP) Application Review Process and Related Documents
94-7	Migrant Health Voucher Program Guidance

POLICY INFORMATION NOTICE 94- 7

DATE: February 7, 1994

MIGRANT HEALTH PROGRAM

MIGRANT HEALTH VOUCHER PROGRAM GUIDANCE

U.S. Department of Health and Human Services
Public Health Service
Health Resources and Services Administration
Bureau of Primary Health Care

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MIGRANT HEALTH VOUCHER PROGRAM GUIDANCE

I. PURPOSE

This guidance has been developed to share common expectations for voucher projects which receive Section 329 funds to serve migrant and seasonal farmworkers (MSFWs) and members of their families. It specifically communicates expectations about the concepts, programmatic content, administrative systems, and clinical systems for projects using referrals and "vouchers" as the principal means of assuring the provision of primary health care to eligible MSFWs.

Many of the technical assistance materials developed for community and migrant health centers (C/MHCs) are useful to voucher project managers. A bibliography is attached and referenced throughout this guidance. Project directors are urged to obtain the most recent list of publications available through the National Clearinghouse for Primary Care Information.[1]

There is no single model for a "voucher" project which meets the needs of all service areas. Innovative arrangements are encouraged, provided that minimum requirements are met with regard to:

- Governance[2]
- Medical Supervision[3]
- Administrative Systems[4]
- Clinical Systems[4]
- Financial Systems and Procedures[5]
- Marketing and Promotion of Services[6]

II. BACKGROUND

A voucher project may be warranted in areas where the numbers and/or density of MSFWs cannot justify the establishment of a migrant health center based on the traditional medical delivery system model, existing provider organizations cannot qualify or are unwilling to serve as grant recipients, and existing providers have the capacity to meet much of the primary health care needs of the MSFWs. These areas are generally characterized by limited agribusiness and/or short harvest and should be

identifiable as suitable for vouchering through a review of the State profiles.[7] Before selecting the voucher program option, all alternatives should first be evaluated and vouchers used as the last resort. The costs of establishing and staffing migrant health centers (MHCs) for short periods of time may render the medical model health center unfeasible. The reduced numbers of MSFWs can be more efficiently served by contracting with local health resources.

Voucher projects must be prepared to address the same special problems of migrants as those served by Migrant Health Centers (MHCs) (e.g., language and cultural barriers, environmental sanitation and occupational health hazards, poverty, limited transportation, etc.).[8] Because of the limited periods of time that migrants are in the area, it will be critical that the project have an organized outreach program to advise the migrants of the availability of services and to reassure them concerning ease of access. Projects should coordinate their activities fully with those of the established public health departments and the programs they offer (TB, diabetes, perinatal, crippled children, etc.), other programs serving migrants (e.g., Migrant Education, Migrant Head Start), WIC, Section 330 funded CHCs, local mental health and substance abuse programs, social service organizations, including child protective services, etc.[9]

Because the funding for migrant health has never been adequate to pay for all levels of care needed by all eligible beneficiaries, priority must be given to assuring access to primary care. Voucher projects are expected to meet all MHC regulations and directives, except as specifically waived or interpreted in this document. Section 329 grant recipients which operate as traditional medical model MHCs for part of the year and as voucher projects for another part of the year, or which operate medical model MHCs at one location and voucher projects at other locations, must meet all of the requirements which apply to the traditional medical model MHC.

Many of the expectations for traditional medical model MHCs are inappropriate for voucher projects. This document addresses the most important of these modified expectations. Voucher projects should discuss, with PHS Regional Office staff, opportunities to improve efficiency and effectiveness which would require waiving of specific requirements. Exceptions can be made on an individual project basis when clearly warranted.

III. MODELS OF VOUCHER PROGRAMS

Three prototypical types can be identified among those currently receiving MHP support:

- Services Coordinator Model
- Nurse Staffed Model
- Midlevel Practitioner Staffed Model

Any one of these types or combinations may be appropriate, depending on the needs, local resources and the type of organization administering the grant.

A. Services Coordinator Model

This is the most basic system model and is used when anticipated patient volume is very low. It is characterized by the absence of on-site medical personnel. Clients with health problems are referred to public health programs or private providers in the local community, and the voucher project provides needed outreach and other support services, such as transportation and translation services, for each referred encounter. Designated local providers are selected based upon their credentials, accessibility, and agreement to accept a fee schedule set by the project (often the Medicaid or other highly discounted rate). The key functions of this type project are:

Administrative Functions

- Determining farmworker eligibility status
- Establishing and maintaining a referral system, including establishing contractual arrangements for accepting referred patients and voucher payments when appropriate
- Maintaining a tracking system of clients served, which at a minimum includes chief complaint, referral destination, referral follow-through, and voucher reimbursement (services, charges, payments), if applicable

Clinical Functions

- Referring patients to appropriate providers
- Provision of support services to facilitate the clients' obtaining care and assisting clients in follow-up care required by providers

- Monitoring and facilitating patient compliance with the physician's instructions, including arranging for follow-up visits

- Establishing criteria for selecting physicians/dentists/nurse practitioners/physicians assistants to serve as referral providers and conduct utilization review functions for retention

Marketing/Promotion Functions

- Resource development, coordination with other local programs and providers

- Educating providers on MSFWs' lifestyles, health problems, and cultural considerations in providing treatment

- Marketing the availability of health care to MSFWs and their families to ensure a greater market penetration and timely receipt of necessary care

Financial

- Processing and paying bills (some programs may use the State Medicaid system)

- Monitoring and ensuring provider compliance with any contractual agreement, costs of care, etc.

- Internal fiscal management, including purchasing, payroll, cash management, etc.

B. Nurse Staffed Model

This system incorporates all the functions of the Services Coordinator model but also directly provides nursing care and case management services. A Public Health Nurse (PHN), or other licensed nurse with training and interests in dealing with community health problems, acts as the screening and referral agent for all or portions of the season. The nurse provides triage, monitors changing needs and ensures the efficient use of resources. Depending upon the nurse practice regulations of the State, the nurse may provide on-site selected health care treatments for minor complaints, health education, and preventive services. If treatment is provided on site, medical records for all treated patients must be maintained.[10] Each medical record will consist of the following components: history, vital

signs, problem list, medication list, treatment plan, lab and X-ray reports and medical consultation reports, as appropriate. The three key functions for the nurse staffed model, Administrative, Marketing/Promotion, and Financial and Marketing are similar to those described for the services coordinator model.

Clinical functions would include the following under this model:

Clinical Functions

- Direct provision of selected health care and preventive services according to protocols
- Screening, triage, and referring patients to appropriate providers
- Maintenance of a medical record system
- Provision of support services to facilitate the clients' obtaining care, and assisting clients in follow-up care needs required by providers
- Monitoring and facilitating patient compliance with the physician's instructions, including arranging for follow-up visits
- Providing limited nursing quality assurance and contract provider utilization review functions

C. Midlevel Provider Staffed Model

This system is similar to the Nurse Staffed Model except that a nurse practitioner or physician assistant provides triage and treatment on site, as directed by established treatment protocols approved by the supervising physician and permitted by State law. The key functions for this model are similar to those for the Nurse Staffed Model, but with the following additions:

Added Clinical Functions

- Triage and appropriate treatment as per protocols
- Provision of a comprehensive quality assurance program for services provided on-site, and a utilization review system for monitoring the appropriateness of services provided by contract providers receiving vouchers

Added Financial Functions

- Billing, credit and collection for services provided on site (in most states a midlevel provider will be able to bill Medicaid and some other third parties when providing covered benefits, such as EPSDT, to eligible patients)

These models represent three approaches to designing an entry point into the migrant health care system. In many cases the voucher project staff may operate out of county health departments, other federally funded clinics, satellite or free-standing clinics, or temporary quarters set up in the field expressly for short term use.

Program models may be combinations of the three presented above or may be different types at different times of the year. Flexibility in mandating procedures required by voucher projects is essential, within the constraints of setting certain minimal requirements to ensure achievement of legislative objectives and protecting MSFWs from substandard care.

IV. GOVERNANCE [2,4]

Consumer input will be dependent upon the model, complexity, and type of organization in which the voucher project is housed. A voucher project housed in a State health department would view consumer input different from one based in a federally-funded free standing clinic. Voucher projects serving migrants in areas without MHCs, and for which only small numbers of migrants reside for brief periods of time, may be excluded from the requirements in 42 CFR, Subpart F, 56.601 for governing board composition specified in 56.304. Qualifying grantees, referred to as "programs" rather than MHCs, may utilize MSFW representation on advisory councils as meeting requirements for consumer input.

The above exception notwithstanding, MSFW involvement in the design and operation of voucher programs is essential. An appropriate representation mechanism must be established. Advisory councils and consumer boards represent such mechanisms.

V. MANAGEMENT AND FINANCE [4,11]

Given the different options available, voucher program management structure should be determined by the complexity of the model, length of the time period during which services are provided, and the manner in which services are provided. Management should be

guided by the program's mission and goals.

A. Management and Financial Policy and Procedures:

A policy and procedure manual regarding administration, financial management, and marketing/promotion of services should include, at a minimum, the following elements:

1. Administration

- Process of establishing MSFW eligibility (who, when, where and how done)
- Mission statement of the program
- Organization chart which includes key positions and their relationships
- List of program committees, membership and meeting schedule
- Task inventory or job description for each individual assigned to the administrative section dealing with the voucher program
- Pertinent personnel policies governing hiring, performance evaluation, salary, vacation, sick leave, other fringe benefits, and procedures for disciplinary actions
- Hours of operation of the service site
- Patient/client flow chart
- Description of referral tracking system and related data collection. Appendix A to this guidance describes the use of referral and authorization forms and how they are used in a tracking system
- Procedures and documentation for authorization of reimbursable care (see Appendix A for descriptions of an acceptable system)

2. Financial Management

- Brief description of the program's accounting system, including payroll, purchasing, cash management and banking

- Description of billing processes (by contract providers to the program and by the program to patients and third party payers, if a midlevel provider is employed), and examples of forms and information which must accompany each bill (see Appendix A)

- Fee schedules for contract providers and for medical services delivered by a midlevel provider, if employed (to include copayment or sliding rate scale, if applicable)

- Systems and procedures for contract provider bill review and payment

- System for timely monitoring of obligations and payment amounts against the budget

- Agreement with State Medicaid agency or other fiscal agent, if either is used to process and pay bills

3. Marketing and Promotion of Services

- Plan for delivery of health education, both to promote use of the services and to improve the health practices of MSFWs

- Procedures for directly contacting migrants in camps, if applicable, to encourage their use of the services

- Procedures for providing growers with information about the services and how eligible MSFWs can access the voucher project services

- Materials for dissemination to crew leaders, camps, or distribution through other types of services providers, churches, posting in public places, public services announcement on local radio, etc., advising MSFWs of the services and how to access them

- Plan for coordination with other health and nutrition programs

- Plan for increasing the sensitivity of local providers to the health problems of migrants, increasing access to providers by migrants, and recruiting qualified providers

B. Reporting Requirements:

Voucher projects which do not directly deliver medical care may not have to comply with all of the Bureau of Primary Health Care Common Reporting Requirements (BCRR) which apply to MHCs.[14] The following minimum BCRR apply: Tables 1, 2-A, 3 and 8 must be fully completed. Table 6 lines 1 through 13, are also to be submitted. Voucher projects which employ or staff midlevel providers or physicians for delivery of care, even if only for several months out of the year, must submit full BCRR reports. Exceptions to certain of the reporting requirements may be approved by Regional Office staff, in consultation with the Central Office, for services coordinator and some nurse staff model voucher projects. Special circumstances and definitions for voucher project preparation of BCRR reports are described below:

- Generally, a multi-site MHC must "unduplicate" the users seen at its various satellite clinic sites before completing Tables 1 and 2A. When a voucher project's service sites are located far enough apart that a farmworker may work in the service area of first one and then another of the service sites, establishing a temporary residence in each site (e.g., migrates for purposes of engaging in seasonal farm work), the project need not unduplicate users across service sites when preparing Tables 1 and 2A. Note that in all cases the "within service site" user count must be unduplicated. This exception generally applies to: State-wide projects, but may also apply to other voucher projects serving large areas through multiple entry points

- Voucher projects which triage and refer a client to a contract physician may count the referral visit as an off-site, non-staff physician visit for purposes of Table III, regardless of whether the project pays for the visit, the physician bills Medicaid or other third-party payor, the patient pays the physician, or the physician sees the patient without charge. Provision of triage, support services (transportation and translation, for example) and follow-up services will be essentially the same, regardless of source of payment

- Note that delivery of services by several types of "other health" providers during a single visit to a voucher project service site can result in multiple "other health" encounters. See page III-6, of the BCRR Manual[14]. Because a major portion of the budget of

some voucher projects is allocated to "other health" providers, an accurate count of the encounters generated by these providers is essential.

- Although most service coordinator or nurse staffed voucher projects will have little or no information to enter in Table 7, it should be submitted. Voucher Programs may choose a subset of appropriate Migrant Health Clinical Measures after consulting with the Regional Office. For further information refer to the Clinical Measures Section of this document.

C. Medical Records [10]

A medical record is initiated on all new patients entering the system. All such records are to be filed and maintained according with accepted ambulatory health care standards.

For services coordinator models the client record will contain minimal medical information: the date(s) the client was seen, the chief complaint(s), disposition (referral destination, date of appointment, and follow-through information). A copy of the case summary and bill forwarded from the provider should be included in the record as soon as received. For the nurse and midlevel provider models the medical record will contain the same information as for the Services Coordinator Model, plus any information regarding symptoms, history, and vital signs. Any provisional diagnoses and treatment should also be recorded, together with the treatment plan for the patient, referral details, and follow-up schedule.

D. Reimbursement, Billing, Health Care Costs: [5,12]

MSFWs frequently are not eligible for Medicaid and cannot afford the costs of necessary medical care. Given the limited resources available, the voucher program must obtain maximum value for each dollar spent and can only serve as "last dollar coverage." This can be accomplished through:

- Full utilization of and coordination with other subsidized or low cost health related services providers (e.g., WIC, CHCs, local health department programs, etc.)

- Obtaining third party reimbursement when available and assisting those MSFWs who are eligible to apply for such coverage, including application for the maximum

allowable period of retroactive coverage

- Use of cost sharing based on ability to pay (e.g., sliding fee scale and, where appropriate, use of a nominal minimum fee)

- Obtaining the lowest possible fee rates from qualified providers used for referrals (some providers may accept a few patients at no cost, may accept the Medicaid reimbursement rates, or may accept all MSFW patients for a capitation or flat rate fee for all patients seen during designated "migrant clinics" held at the physician's office or the voucher project service site)

- Bills are forwarded directly to the project which processes them and pays the provider directly

- Bills are forwarded to the project which authorizes payment and then transmits them to the Medicaid or other fiscal agent

- Bills and a copy of the voucher authorization are sent directly by the provider to the Medicaid or other specified fiscal agent, with a copy of the billing information and case summary sent to the project

All bills or billing notices submitted to the project should be accompanied by a copy of the authorization form and a case or discharge summary. The case summary will include as a minimum the tentative or final diagnosis, treatment services, prescriptions, instructions to patient and any necessary follow-up requirements.

Voucher projects must have clearly defined parameters that govern reimbursement rates for all health care for which the project is liable. Only services specifically authorized through advance issuance of a voucher should be the responsibility of the project, and then only to the extent of negotiated reimbursement rates. It is recommended that vouchers contain wording indicating a cap on the maximum liability of the project for care provided to the referred patient. A 1992 review of several existing voucher projects disclosed payment caps ranging from $30 to $150 per user. To assist in cost containment, voucher projects should assist MSFWs to obtain Medicaid coverage when they are eligible. Contracts with providers receiving voucher payments should include a requirement that the provider bill Medicaid if retroactive eligibility is established. Voucher projects must monitor situations in which a patient is likely to become eligible for Medicaid and advise providers

who have rendered services within the retroactive coverage period. Virtually all pregnant MSFWs and young children will qualify for Medicaid eligibility, but if only present in the area for a few months, they may not be able to obtain eligibility before moving on. Projects should meet with officials administering the Medicaid eligibility system to determine if eligibility determinations can be expedited.

When MSFWs present at a voucher program site with a current Medicaid card from another State, referral providers can and should bill that State's Medicaid program. Although billing other State Medicaid programs is generally not a problem for hospitals, private practice physicians may be reluctant to do so because the costs of occasionally submitting a claim to a distant State may exceed the reimbursement rate. Voucher projects can facilitate interstate billing by identifying home base States from which most migrant patients come, and then obtaining descriptions of interstate procedures and billing forms which apply to each of these States. When referring a patient with out-of-state Medicaid eligibility to a local contract provider, send a copy of the billing procedure and forms together with the referral form.

E. Patient Eligibility, Fee Schedules, Collection: [5,12]

All patients must have their beneficiary status confirmed prior to authorization for reimbursed care or for receipt of direct care if the project employs a nurse or midlevel provider. Self declaration of agricultural worker, migratory status, and income level may be used, but the project has the option of requiring documentation when appropriate. Reasonable rules for "deeming" eligibility may be used (e.g., all those residing in a migrant farmworker camp may be deemed to be qualified migratory agricultural workers when it has previously been established that most do qualify). Bills for unauthorized care are not to be processed. All referrals must be logged and tracked by the administrative staff.

Voucher projects which provide direct health care services are required by regulation to have a fee schedule and a corresponding sliding schedule of discounts based on ability to pay. The full discount must apply to those whose income is below the most recent OMB Poverty Guidelines, although a nominal fee may be collected for specific services (e.g., each office visit, each prescription, etc.). Where feasible, it is recommended that a nominal minimum fee be collected in order to provide some income to the project, deter unnecessary care, and eliminate the stigma of "free care." At no time should the patient's ability or inability to pay be a barrier to the provision of care. The amount determined as a nominal fee for off site-visits should be in line with the economic capabilities of the service population.

Payment records and appropriate cash management practices must be maintained. All voucher projects should have a written credit and collection policy.

F. Fiscal: [5]

It is beyond the scope of this document to describe minimum requirements for acceptable accounting systems and financial management practices. Such requirements are described in detail in reference 5 of the bibliography, and are outlined in the current Bureau's Program Expectations for Community and Migrant Health Centers. However, it is emphasized that full financial accountability is expected for migrant health funded projects and that an accepted system by all referral providers is also warranted. To ensure accuracy in processing bills and to monitor obligations, projects should maintain a current file of all eligible providers and a log of outstanding referrals (those for which full and complete bills have not yet been paid). The referral log should also specify the name of the patient and the chief complaint. It is recommended that the project estimate each outstanding bill and regularly monitor estimated cumulative obligations against the available budget.

G. Marketing Health Services: [6]

MSFW populations generally do not seek health care as frequently as their level of need would indicate. There are a number of factors that contribute to this deficit, well documented elsewhere.[7,8] Enhancing the level of health care provided to this population requires projects to make a conscious effort to both market their services to the target population and to systematically remove deterrents to the

seeking of care by migrants. This often requires that project staff visit migrant camps and approach the target population directly concerning services. Distribution of information to growers, crew chiefs, and to other programs serving migrants (Migrant Education, WIC, JTPA, social service agencies, etc.) concerning the availability of services should also help maximize the demands for services. Coordination and sharing of outreach services with other migrant-related services is strongly encouraged.

H. Quality Assurance

Voucher programs are required to operate and maintain quality assurance programs in accordance with regulatory requirements. References found in Appendix C may be used to enable programs to address this issue.

VI. CLINICAL SERVICES

A. Arrangements for Clinical Care:

All contractual agreements or memoranda of understanding with local health providers must address provisions for authorization of services on a reimbursable basis, transmittal of billing and other information, and quality assurance, to specifically include the following points. See Appendix B for further discussion of the content of a provider contract or memorandum of understanding.

- Credentials of the provider and requirements that the provider notify the project if the license or other credential is suspended or otherwise discontinued
- Acceptance of the negotiated fee schedule or other rate See Section 4
- Manner and format of bills submitted to the project or fiscal agent
- Agreement to bill Medicaid if the patient is Medicaid eligible
- Normal hours and provisions for contact after hours
- Maintenance of medical records and the extent of information to be forwarded to the voucher project (beyond that required for billing)
- Manner in which medical information is to be

transferred among providers

- Manner in which outpatient tests or hospital inpatient care will be authorized

- Manner in which treatment follow-up and further referral will be provided

Any health provider utilized by the project must possess a valid license in the State where he/she is employed. To the extent feasible, contract providers should be board certified in their specialty and have admitting privileges at a local hospital(s).

It is critical that contracts or agreements with local providers include a provision that a case summary (to include as a minimum the tentative or final diagnosis, treatment services, prescriptions, instructions to patient and any necessary follow-up) and a copy of billing information be forwarded to the voucher project, even if the project does not directly process the bill.

In some cases it may be feasible to enter into more formal arrangements with a CHC to serve as a provider for MSFW clients drawn from a portion of the voucher project's service area. Generally, the voucher project would continue to provide outreach and various support services and operate the entry point through which eligible MSFWs access services. This should not, however, prevent MSFWs from directly accessing the CHC.

Financial arrangements between voucher projects and CHCs represent a potentially troublesome area since the CHC is obligated to see all patients, regardless of their ability to pay. However, the voucher project seeks special arrangements and priority in appointments for migrants referred to the CHC. It is therefore possible, although not desirable nor suggested, for a voucher project to reimburse the CHC for a portion of the costs, if the migrant patient does not have a third party payment source.

A possible arrangement would be for the voucher project to reimburse the CHC for the sliding fee schedule amount which the CHC would have charged the patient, up to the equivalent amount which the voucher project would have paid to private practice physicians. Since the voucher project will screen the migrant for eligibility and income, it will facilitate intake if the CHC merely accepts this information from the voucher project, bills the project for the applicable sliding fee, and sees the referred migrant on a priority

basis.

Given the limited resources available to voucher models, funds should be targeted to areas that do not benefit from a CHC presence.

B. Medical Supervision: [3,11]

Regardless of the model adopted, all voucher projects must have provision for medical input. For the services coordinator model where the organization does not directly employ any health professionals, arrangements with a physician to serve as medical director or advisor to the project may be sufficient. The principal responsibility of the medical advisor for a services coordinator project would be to supervise the selection process for referral providers (supervision of a structural quality assurance program) and to participate in the utilization review committee. If nurses or midlevel providers are employed by the project, an agreement for a "supervising" physician is essential. The supervising physician approves of protocols, supervises medical audits to assure compliance with protocols, participates in quality assurance and utilization review committees, and determines that the project staff is operating in compliance with State nursing and medical practice laws.

C. Clinical Policy and Procedures:

At a minimum, clinical policy and procedures for voucher programs should include the following:

- Standard procedures for handling medical emergencies (staff training in CPR, arrangements for transfer to a hospital, etc.)

- Criteria for determining when a referral is to be made, what type of referral is needed, together with the procedures and forms to use for local referrals, referrals to home base providers, and referrals to distant specialists unfamiliar with MSFWs' health problems and lifestyles

- Qualifications and criteria for selection of contract/agreement providers. Appendix B of this guidance outlines essential features of a provider contract or memorandum of understanding

- Procedures for clients or medical providers to contact staff on weekends and evenings

- Lists of referral providers, types of problems handled, hours of operation, language capabilities, etc.

- Quality assurance program (if a services coordinator program, the quality assurance program may be limited to a review of the qualifications of the referral providers and appropriateness of their utilization patterns, referral follow through, costs, and completeness of billing information). Appendix C of this guidance provides additional detail on quality assurance programs for different model voucher projects

If the program employs a licensed nurse, it must have, in addition to the above:

- Nursing protocols, both for on-site clinic visits and when services are provided at labor camps or in homes (to include screening and referral decisionmaking)

- Nursing formulary

- Charting procedures

- Medical record system description, to include secure storage, confidentiality provisions, maintenance program, and procedures for handling inquiries for medical record information (if the project is operated for less than 12 months of the year provision must be made for emergency access to records and for timely response to provider inquiries during the off season)

- Inventory of disposable supplies kept on hand

- Appointment and scheduling system

- Quality assurance program component for in-house services See Appendix C

If the project employs midlevel providers, it must also have:

- Screening, diagnosis and treatment protocols

- Emergency protocols for addressing the immediate needs for patients brought to the service site in dire distress, handling of ingestion of toxic substances, and other protocols for responding to other life threatening emergencies

- Procedures for exercise of medical supervision, including reviews to assure compliance with protocols

and for quality of care

- Current formulary, if appropriate
- Provider schedule if providers work on rotation or split shift, including backup physicians, if different

D. Appointments, Screening: [4,11]

All projects must maintain a scheduling and appointment system to organize and structure the delivery of care. However, allowance shall be made for acute walk-ins or other unscheduled needs. An appointment log should be maintained to document arrangements for translation, transportation, follow-up services and verify bills. Log entries should include the patient's name, date seen by the program, patient complaint, referral physician or destination, date and time of appointment(s), whether the referred encounter occurred, and any follow-up requirements.

In the nurse and midlevel provider models scheduling is more critical, since some level of care is to be provided on site. Voucher projects should arrange for some evening and weekend hours, both for operation of their access point, and by one or more of the contract providers who will see MSFW patients at those hours so that time away from work can be minimized. Office appointments made by community health workers or nursing staff during visits to the migrant camps should be coordinated with the office staff. All non-emergency care provided off site should be scheduled and logged in by the administrative staff, regardless of the voucher model.

A typical medical complaint would be treated as follows by a services coordinator model project. Appendix A provides additional information on the types of forms used and their information content:

1. Patient presents self and describes chief complaint to coordinator at entry point
2. Coordinator verifies beneficiary status and logs patient into program
3. Coordinator selects contract physician and calls office, describes complaint and makes appointment for the patient. Usually a family, general practice, internal medicine, pediatrician, or OB-Gyn physician will be used, unless the complaint can be handled by

other public health programs (county health department prenatal program, blood pressure screening, family planning), or the physician's office staff indicate that the complaint warrants immediate referral to a specialist (e.g., orthopedic problem). A referral form is then prepared which identifies the patient, the complaint, and any other relevant information which will facilitate the visit.

If the referral is to a provider with whom the program has an agreement for reimbursement and the patient does not have a third party payment source, the referral form will also serve as a voucher authorizing reimbursement for services. Reimbursement for a single office visit may be provided or, in some cases, the project may authorize continuing care with multiple visits, as needed, with notification to the program after each visit has occurred

4. Sufficient information is obtained to complete the referral and authorization form. An appointment slip is prepared and given to the patient, together with a copy of the referral and authorization form

5. Any support services needed to keep appointments and necessary to receive quality health services (examples are transportation or translation services) should be assessed, documented and arranged for

6. The service-site log is updated to include date and time of appointment, provider, complaint, and any special requirements (e.g., transportation, translator, etc.)

In cases where it is feasible, the initial contact with the client can be done at the migrant camp, in the client's home, or in the fields, in order to expedite treatment for any MSFW who has limited access to the entry point or no transportation.

For a voucher project which employs a nurse or midlevel provider, the above sequence would also include:

- A brief history and recording of vital signs in the medical record

- In the event of a referral, preparation of a referral and authorization envelope to be initiated if additional medical documentation is useful to the referral physician and is available. This might

include case history, vital signs, medications prescribed, previous laboratory and x-ray test results, and provisional nursing diagnosis by the on-site health provider

- Provider notification of the project by phone or written correspondence if he or she desires to follow the patient. The bill is sent, as specified in the contract, with a copy of the billing information and case summary forwarded to the voucher project service site for updating of the medical record and services log

- If additional follow-up care is needed scheduling a follow-up appointment with the appropriate health provider or, if the follow-up care can be provided by project staff, an appointment is made with project health staff for additional services.

E. Referral:

Although local systems for delivery of health care using vouchers will vary, certain information is necessary to consider when designing referral forms and reimbursement authorization. Appendix A describes a minimum data set necessary for such forms.

F. Follow-Up Care:

The voucher project is responsible for scheduling and/or confirming follow-up care with health providers. Upon completion of the authorized visit(s), if further follow-up care is required, the local physician either calls and notifies the project of the need or mails a notice to the program, allowing adequate time for scheduling. Voucher programs are encouraged to utilize the Migrant Health Center Directory to network with migrant health centers and other organizations receiving Section 329 funds. Directories can be obtained through the Clearinghouse for Primary Care Information, (703) 821-8955, extension 248.

Voucher projects should document in their grant applications that a review of client records and information from referral physicians indicate that on all occasions when a contract physician advised the project of a positive PAP smear, need for immunization, or diagnosis of hypertension, the project made an attempt to contact the client to arrange for follow-up care. If the client intake form indicates a customary source of primary care in his or her home base,

the project should make efforts to communicate findings and need to that provider if the migrant cannot be reached before departure from the project service area.

G. Emergency Care:

The project should address emergency care requirements and assure that at least one local hospital in the service area will accept MSFW emergency patients. A local physician with privileges at the hospital of choice should also be enlisted to act as the ER and admitting physician when the program seeks to expedite care.

H. Quality Assurance: [3,5,11]

Each voucher project must arrange for health care, financial and management quality assurance. Appendix C to this guidance provides additional details for health care quality assurance for different models of voucher projects. For medical quality assurance in nurse or midlevel staffed voucher projects the medical director/advisor will usually take the lead in designing a review process which covers the following items:

- Structure and maintenance of medical records. Medical records for voucher projects which employ nurse or midlevel providers must include:
  - intake (registration) and consent forms (both for treatment and for release of information)
  - progress notes, including complaint, diagnosis and treatment plan
  - vital signs for each illness related visit seen by a nurse or midlevel provider
  - history and physical (if indicated)
  - problem list
  - laboratory, X-ray, special study and consult reports (should be easily referenced and have been reviewed by the provider prior to inclusion into the record)
  - medication list
  - any drug sensitivity or life threatening medical condition will be clearly stamped and/or color coded on the front cover of the record
  - all records kept in accordance with the Privacy Act of 1974
  - all chart entries dated and signed to include the providers' professional discipline
- Selection process for local referral physicians or

other providers

- Utilization review of referral provider case summaries
- Nurse and midlevel provider adherence to protocols (treatment protocols will be on file for all midlevel providers), particularly for the use of pharmaceuticals, referrals, and follow-up
- Process for adherence to clinical indicators, outcome measurements, and medical audit procedures
- Compliance with all applicable State nursing and medical practice laws.

The project is also subject to external audits as deemed necessary by the Migrant Health Program. These reviews may be called with minimum advance notice and will focus on the following issues in depth:

- formulary content and drug utilization
- case management and follow-up
- provider credentials
- program utilization by patients
- any other areas impacting upon the project's ability to provide access to quality primary health services

Although service coordinator model voucher projects are not expected to perform clinical effectiveness studies or to determine compliance with clinical indicators, appropriateness of referrals and utilization review studies of contract service providers should be conducted at least annually by voucher project staff, with assistance of their medical advisor.

I. Clinical Measures

A set of clinical performance measures for migrant health centers has been developed. These measures are based on the concepts that developed the clinical measures for community health centers and include recommendations from a work group of migrant health center clinicians and Bureau of Primary Health Care clinicians. For detailed information on clinical measures for migrant voucher programs, refer to the Clinical Measures Workbook, Part II[15].

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APPENDIX A

REFERRAL AND AUTHORIZATION FORM

The following paragraphs describe the functions of a referral and authorization form and suggest a minimum data set necessary for performance of each. Also attached to this appendix is an example of a referral and authorization form designed by one of the voucher projects. The example is not necessarily the best for use at other projects, but did work well within the context of other information sources and the services delivery model used by the project which contributed this form.

1. Contents

Services Coordinator Model. Forms and procedures to support the referral process and the payment for services in a lay services coordinator staffed voucher project must capture all of the documentation needed for the following functions:

- Documenting the referral and facilitating the support process for a successful referral
- Facilitating patient intake and action by the referral provider
- Tracking of clients seen, complaints, disposition, and follow-through
- Fiscal control and payment by the voucher project
- Promoting continuity of care and facilitating follow-through and follow-up on provider instructions to the patient and recommendations for additional care
- Performance of quality assurance and utilization review
- Optimization of use of resources

Data elements which should be a part of the referral and authorization form, or collected on a registration form which can be linked to the referral form, in order to support the above functions in a services coordinator staffed voucher project are indicated below. Items which usually appear on a registration form rather than a medical provider referral form are indicated with an "*".

- Patient identification, contact information, and demographic characteristics
  - Name and local address
  - Arrangements to facilitate contact (name of crew leader, camp phone, directions for finding residence, other contact person, etc.)
  - Downstream or homebase address*
  - Downstream/homebase customary source of primary care*
  - Date of birth, sex, race and ethnicity

- Family structure and minimal information on each member*

- MSFW eligibility and third party coverage information
  - Seasonal farmwork as principal employment*
    Self
    Other family member
  - Migration for purpose of seasonal farmwork in past 24 months*
    Self
    Other family member
  - Former migrant farmworker who no longer engages in seasonal farmwork due to age or disability*
  - Family size and family income (for comparison with OMB poverty guidelines
  - Any current/recent Medicaid coverage (if so, in which state)
  - Information for determining eligibility for Medicaid in current state*
  - Any other third party coverage

(Note: collection of information regarding eligibility criteria for other programs serving migrants should be included when shared outreach or intake is contemplated, or in order to facilitate cross-referrals --- such information might include whether more than 50 percent of the patient's income was derived from seasonal farmwork, whether migration occurred across the school district boundary within the past 12 months, or past 5 years, etc., depending on the different definitions and criteria for eligibility used by the other programs)

- Current visit information
  - Date of encounter
  - Chief complaint or need
  - Other current problems/needs
  - Consent for treatment and consent for release of information (both by the voucher project to the referral provider and by the referral provider back to the project)

- Disposition
  - Referral provider and reason for referral
  - Appointment time and date, if applicable
  - Voucher information (control number, limitations on reimbursement, limitations on further care)
  - Authorized signature and date

- Special information helpful to referral provider and to project staff
  - Support needs of patient for transportation, translation, etc.
  - Environmental considerations (work, residence, pesticide exposure, etc. as likely to be relevant)
  - Other (previous recent encounters and referrals, etc.)

- Section for reporting by referral provider
  - Date and place of encounter
  - Diagnoses
  - Services (diagnostic, treatment) provided
  - Instructions to patient (include prescriptions)
  - Recommendations for followup care (include criteria for revisits)
  - Charge and request for payment, or indication of third party billing

- Section for administrative use by project
  - Appointment/referral completed
  - Follow-up requirements and plan, if any
  - Date feedback from referral provider received
  - Payment authorization/record (may also indicate amount)

Nurse Staffed Model. Functions for the nurse staffed voucher project include all of those listed above for the services coordinator staffed model, plus a formal patient assessment and care plan functions. It is recommended that nurses' notes follow a SOAP format (subjective, objective, assessment, and plan). Data elements necessary for the patient assessment and plan functions include:

- Subjective (elaborate on the chief complaint, symptoms, and history)
- Objective (vital signs, laboratory tests, and physical examination, etc.)
- Assessment (conclusions based on subjective and objective data)
- Plan (direct services, referral, and followup, as applicable)

Based on the assessment, the nurse will specify a plan. This may take the form of a decision to provide direct nursing care (apply a cold compress to a bruise, for example) and/or refer the patient to a contract provider. If referred to a contract provider, the plan must be modified after feedback is received from the provider to incorporate specified follow-up needs.

Midlevel Provider Staffed Project Model. The midlevel provider staffed project will perform all of the above functions, plus administer a sliding fee schedule and perform third-party billing for covered medical services delivered on-site. The information necessary for billing must then be collected. Insurance billing information generally consists of the following:

- Name and address of insured and relationship to patient
- Insurance group and policy number, Medicaid or Medicare number
- Employer, if Workers Compensation (WC) or if commercial insurance provided by an employer
- Name and address of carrier if WC or private insurance
- Diagnoses -- some insurance requires that diagnoses be coded according to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
- Date and place of service
- Procedures performed (carriers may require procedures coded, usually according to the latest edition of CPT-4 published by the American Medical Association, or the Health Care Financing Administration Common Procedures Coding System, HCPCS, for Medicare and Medicaid)
- Provider identification
- Charges (the amount charged may have no relationship to the amount "allowed" by the carrier)

2. Client or Patient Registration

The low volume of visits to some voucher projects may be such that it is appropriate to use the referral form also for patient registration. The registration information should include all of the identification, demographic, and contact information listed above under the services coordinator model information needs. The registration form, or supplementary family registration form, should include at least minimal information on all other family members.

When establishing Migrant Health Program eligibility, note that projects may accept self declaration of seasonal farmworker status, migratory status, and income.

Registration forms must capture information regarding customary source of primary care, if any, in the patient's home base area, as well as how to contact the migrant both during the present stay in the voucher project service area, and during the winter season.

Registration forms should also include collection of a signature authorizing the release of medical information necessary for medical care or processing of payments.

3. Documenting and Facilitating Referral

Each voucher project must conduct the following functions:

- Maintain a tracking system of clients seen, chief complaint, whether services provided on-site or, if referred off-site, referral destination, referral follow-through, and voucher reimbursement (services, charges, and payments).
- Provide the referral provider with information which facilitates the visit (relevant registration information, complaint and assessment, if available, and any special circumstances which may be relevant to the diagnosis and treatment decisions)
- Note the special needs of the client for support services, such as transportation and translation.
- Maintain a log of referrals outstanding (those for which full and complete bills have not yet been paid).

To control the paperwork it will be helpful if the referral form and voucher authorization are a single form. If a multipart form

is used, a copy of the referral form containing the above information and retained by the voucher project service site can serve as a voucher log, a system for tracking whether appointments were followed through, and for tracking obligations. Prenumbered forms with the clinic copy filed sequentially in a suspense folder are often used by voucher projects to accomplish these functions. The referral provider can complete the form after the visit, send one copy back to the project and insert the other copy into a medical record as a substitute for registration and encounter reports.

4. Fiscal Control

Fiscal control in a voucher project requires a system to ensure that:

- Payment is made only for authorized referrals and services
- Payment is made only for Migrant Health Program (MHP) beneficiaries
- Third party payment sources are used instead of MHP funds whenever possible
- A sliding schedule of discounts based on ability to pay is used to obtain full or partial payments from patients
- Payment amounts to providers are in accordance with negotiated fee schedules
- Duplicate payment for the same service is prevented
- Obligations for authorized referral services not yet reimbursed are monitored against the remaining budget

The necessary data elements to be included on the referral and voucher form in order to perform the above functions include:

- Information collected or entered by project intake/referral staff
  - Signature of person authorized to make the referral
  - Specification of what services are authorized
  - Name, beneficiary status, and ID number, if applicable, of patient
  - Source of payment (other third party or voucher program)
  - Financial classification, if applicable (for sliding fee schedule)

- A sequentially assigned unique referral or billing number

- Information collected or entered by contract provider
  - Date and location of encounter
  - Services provided
  - Charges

- Information entered by project financial or administrative staff
  - Date all information required for reimbursement received
  - Amount of reimbursement by project allowed for authorized services
  - Date sent to payments office

The system should include maintaining a copy of the referral/voucher form in a suspense file until the bill is received, matching the bill with the correct voucher authorization and removing it from the suspense file, checking the voucher for correct authorization, comparing the billed services against what was authorized, checking the amount to be reimbursed against the fee schedule, and insuring that the patient does not have a third party payment source. Note that a patient hospitalized may often receive retroactive Medicaid eligibility dating back 90 days. Contracts with providers should therefore include agreement that they will bill Medicaid, or other third party payment sources, when and if eligibility is discovered or determined retroactively (if they have already received payment from the voucher program, they must issue a credit).

Handling of sliding fee discounts varies among voucher projects. Some apply the schedule at time of issuing the voucher form, collecting a token or discounted fee. Still others may negotiate with the provider for a reimbursement level that anticipates collection of a minimum fee at the time the vouchered service is delivered.

5. Continuity of Care

Assuring continuity of care may be problematic at the services coordinator staffed project, since there may be no staff person with health or social services training. Thus, a lay person may serve as the care coordinator, or case manager, and may not be well equipped to perform the coordination and communications functions among different medical care providers. For a nurse or midlevel staffed voucher project, the nurse or midlevel provider performs triage, directly provides some care on-site, serves as a gatekeeper to referral providers, authorizes additional services

and revisits, and coordinates subsequent referrals to specialists or hospitalization.

The voucher program guidance includes a variety of requirements which will contribute to continuity of care, including: 1) roles for nurses in a nurse/voucher system, 2) contract physician or other provider information flow, and 3) information retention by the migrant health project. Specific requirements for nurse or midlevel provider staffed voucher projects are:

- Voucher projects will forward with the referral form pertinent information from the medical record to facilitate diagnosis and treatment.

- Referral log entries will include whether or not the physician encounter occurred and, if appropriate, follow-up requirements.

- Agreements with providers should require that the physician notify the project by phone or written correspondence if he or she desires to follow the referred patient, regardless of subsequent payment source.

- The nurse will assist clients in follow-up care needs prescribed by providers.

- Voucher project staff will monitor patient compliance with follow-up visits and treatment programs.

- Contractual agreements with local health providers must include a provision that a case summary containing the diagnosis, treatment, prescriptions, patient instructions, and any requirements for follow-up will be forwarded to the project with the bill.

- A copy of the case summary and bill forwarded by the provider should be included in the medical record maintained by the voucher project as soon as received. Case summaries should be reviewed to be sure that if continuing care is required, a treatment plan is given, including referral details and follow-up schedule. If additional follow-up care is needed which is beyond the capabilities of the project, the project should schedule follow-up appointments with appropriate health providers.

The data elements included on the referral form should assist and guide providers and nursing personnel in meeting the above requirements. The necessary data elements for these functions

were outlined in Section 1, above. Similarly, the provider's case summary must be sufficiently complete so that the nurse can communicate what was done, and why, to any subsequent provider. Timeliness is critical to this communication process.

6. Quality Assurance and Utilization Review

Appendix C to this guidance describes minimum requirements for quality assurance and utilization review functions in voucher projects. The discussion in the following paragraphs is limited to the requirements on the referral and authorization form for information to support performance of quality assurance and utilization review.

The first action which is subject to quality assurance program (QAP) review is that of the decision whether or not to make a referral to a contract provider and, if so, to which provider. Even services coordinator staffed entry points will require that a reason for the referral be documented. For nurse or midlevel provider staffed voucher projects, documentation must be sufficiently complete to assess adherence to protocols for conduct of triage, referral, and for direct provision of services when appropriate.

The second component for review is that of the utilization by the referral provider. If the voucher project reimburses additionally for diagnostic tests and procedures, the appropriateness of each, given the complaint and symptom of the patient can be screened using utilization review (UR) criteria. A SOAP visit record and case summary must be reasonably complete to serve as the basis for UR.

The third component for QAP review is that of the follow-through by the voucher project staff. Timely receipt of information from the contract provider are required for appropriate follow-through actions by project staff to take place.

7. Resource Use Optimization

The optimization of the use of resources refers to the allocation of functions between nursing or midlevel provider staff and referral providers, and the selection from among referral providers to make the most appropriate referral. Optimization will therefore depend upon:

- The needs of the patient
- What is permissible under the State Nurse Practice Act or applicable laws for other midlevel providers

- Ability of the referral provider or the voucher project to offer the complement of support services to assure that MSFWs follow-through with the treatment requirements

- Ability and willingness of the voucher project staff to take the responsibility for follow-up care

Resource optimization decisions are subject to utilization review, and continuous monitoring or periodic retrospective reviews should be performed in order to improve decisionmaking.

8. Examples of Referral/Authorization Forms

One of the combined nurse and voucher projects which come close to meeting the full array of information needs for the referral form and bill submission system, is that used by the former Illinois Migrant Health Project operated by the Illinois Migrant Council (this project is now operated by the Community Health Partnership of Illinois). Copies of the two sides of the form used by IMC appear in Exhibits 1 and 2. A four part form was used with one copy filed at the IMC clinic in a suspense folder. The other three copies go with the client to the contract physician's office. After the physician sees the patient and completes the form, one copy was sent to the IMC clinic immediately, one copy was retained for the physician's records, and one copy was sent with the periodic billing to the IMC clinic for processing.

Although an excellent form it does lack a space for inserting information on the special support needs of the migrant patient and doesn't prompt the nurse to supply relevant medical history information. The form also lacks information on third party payment and beneficiary status. However, the system within which the form was used provided positive tracking of each referral, assurance that the referral was accomplished and authorization.

In addition to the information contained on the form used by IMC, projects should consider additions in Section I which prompt the nurse to provide: 1) special support service needs, and 2) pertinent medical history or other information from the medical record which will facilitate diagnosis and treatment. Section II should have a prompt added for "patient instructions." We also recommend addition of a line in the administrative section for noting beneficiary status and third party payment information.

Although expensive to print, four part pre-numbered forms are worth the price. The distribution of the form copies should be the same as applied to IMC's forms. The voucher project staff should "approve" vouchers for payment <u>after</u> receiving the case

summary from the provider. Clinic sites should maintain a suspense file of referrals outstanding, and provide periodic reports to the Project Director as to the extent of obligations.

EXHIBIT 1

Health Project

CLIENT VOUCHER and REFERRAL FORM

*CLINIC ADDRESS + PHONE STAMPED (PRINTED) HERE

№ 3001

Referred To: _____ Client _____

Street _____ Client I.D. No. _____ Sex _____

City _____ Zip _____ Address _____

Phone _____ Birth Date _____ Phone _____

Appt. Date _____ Time _____ Head of House _____

SECTION I

Present Complaints: (S)

Nursing Assessment (O) BP _____ Temp _____ Pulse _____ Other _____

Signature _____ Date _____ Time _____

SECTION II

Doctor's Findings: (O) BP _____ Temp _____ Pulse _____ Other _____

Diagnosis (A)

SAMPLE

Treatment Provided: (P)

Follow-up you would like provided by IMC staff:

Signature _____ Date _____ Time _____

ATTENTION PROVIDER this voucher is valid for one (1) client visit for which the charges are $30.00 or less and is void 15 days after issue.

AUTHORIZATION FOR MEDICAL and DENTAL CARE: I hereby authorize any medical or dental care considered by the staff of the Illinois Migrant Health Project and/or their contracted physicians/dentists to be in my or members of my family's best interest and authorize the release of any information acquired in the course of my registration, examination or treatment.

AUTORIZACION PARA ATENCION MEDICA Y DENTAL: Autorizo cualquier atencion medica o dental considerada por el Illinois Migrant Health Project o por sus medicos/dentistas contratados en el mejor interes de mi familia o mio, y autorizo prestar cualquier informacion obtenida durante mi registracion, examinacion o tratamiento.

Client's Signature _____ VOID _____ Date of Issue _____

Voucher Issued by _____ Date of Issue _____

PLEASE SEE REVERSE SIDE FOR DETAILED INSTRUCTIONS, COPY DISTRIBUTION and HEALTH STAFF FOLLOW-UP

EXHIBIT 2

GENERAL INSTRUCTIONS

1. This Client Voucher and Referral Form authorizes services for which the charges are $30.00 or less and is void 15 days after issue. Please contact the Illinois Migrant Health Project at the phone number indicated on the face for approval of charges in excess of $30.00.
2. The Illinois Migrant Health Project has no funding for hospitalization or extensive diagnostic testing and, therefore, will not be responsible for these costs. Clients in need of extended health services should be referred back to the Illinois Migrant Council for assistance in securing benefits from other agencies such as Public Aid. A notation for recommended follow-up care should be made under Section II on the face of this Voucher and Referral Form.

COPY DISTRIBUTION

1. The top three (3) copies of the Client Voucher and Referral Form are taken by the client to the health provider's office (white, yellow and pink copies).
2. Please complete Section II and return the white copy immediately to the Illinois Migrant Health Project.
3. Retain the yellow copy for your records.
4. Attach the pink copy to your standard billing when submitting vouchers for payment. (See Billing Instructions.)

BILLING INSTRUCTIONS

1. Please submit the pink copy of this Voucher and Referral Form along with your standard billing to the "Bill to" address on the face of this Client Voucher and Referral Form on a monthly basis by the 10th of the following month, (e.g., for services rendered in July, bills must be submitted by August 10th).
2. Before payment can be received, Section II "Doctor's Findings," of this Client Voucher must be completed.
3. Payment cannot be guaranteed for bills submitted more than 45 days after the date of issue on the Client Voucher and Referral Form.

SECTION III

Follow-up provided by IMC staff:

Signature _____ Date _____ Time _____

APPENDIX B

PROVIDER CONTRACTS AND MEMORANDA OF UNDERSTANDING

It is vital that details of how referrals will be made, information and communications flow, billing procedures and reimbursement rates, and other expectations between a voucher project and each local health care provider to which the project will refer patients be produced as a written document. This document can then be used as an attachment to, or the wording incorporated into, a contract or memorandum of understanding between the project and provider. In some communities verbal agreements and a hand shake may commonly be used, but such agreements are subject to misinterpretations, lack continuity if either party leaves the community or expires, and are cumbersome to communicate to other staff of either party's organization.

This appendix outlines the recommended features of a complete agreement between a voucher project and a local provider. The recommended set of items to be covered should include the following areas which should be incorporated within or as an attachment to the formal document.

- Legal name/description of the parties to the agreement
- Certifications and representations
- Purpose (intent of agreement)
- Period of time during which the agreement shall apply
- What the voucher project will do for provider in regard to:
  - making appointments for referred patients
  - transmitting patient information to the provider demographic and contact information complaint and relevant background, including special needs
  - third party billing information, if applicable forms for reporting outcomes, followup, and for billing project
  - consent for treatment and for release of information
  - providing support services (such as a translator)
  - reimbursing the provider for authorized services at an agreed upon rate
  - facilitating patient application for Medicaid and other payment sources

- Expectations by the project of the provider:
  - Maintain a current valid license and authorize credentials verification
  - Advise on a timely basis if license/credential is suspended or discontinued
  - Accept referred patients on a timely basis
  - Provide project with a case summary on a timely basis detailing diagnoses, treatments, patient instructions, and followup care needs
  - Bill third party, including Medicaid for services rendered during period of retroactive eligibility -- credit project for such recoveries
  - Accept negotiated reimbursement rates and limitations
  - If an institution (CHC, hospital, local health department), the institution will operate a quality assurance program in accordance with state, Federal, or JCAHO requirements -- advise the project if the institution's quality assurance program is determined to be inadequate by the licensing, certification, or funding organization.
  - Facilitate inpatient or specialist referrals necessary for referred patients

- Termination of agreement. Events which cause an automatic termination. Advance notice for voluntary termination

- How modifications to this agreement may be made

- Relationship of provider to project (independent contractor or provider, not as employee of the project)

- Procedures for emergency contacts during evenings and weekends

- Maintenance of records and participation in utilization review process

- Representatives for each party (who and how to contact)

- Other requirements (any clauses which the project is required to include in contracts, such as nondiscrimination, etc)

- Date and signatures of the parties

Exhibits 3 and 4 represent examples of formats for a memorandum of understanding and a contract used by current voucher projects. These documents can be made very compact by referring to an

attached detailed description of forms, information flow, patient flow and billing expectations. Exhibit 3 is a memorandum of understanding between PROTEUS, a statewide voucher project, and local contract providers. This document includes most, but not all of the items listed above. It is supplemented by giving the provider an instruction manual for use of the referral and voucher authorization form and a description of PROTEUS' migrant health project other systems and procedures. Exhibit 4 is an agreement (contract) between Northwest Michigan Health Services, Inc. (NMHSI) and a local pharmacy (the pharmacy name, owner, address, and phone number have been deleted from the copy). Contents of the pharmacy contract include most of the relevant items listed above, plus an indemnification clause which protects NMHSI from liability claims resulting from activities of the pharmacy.

Indemnification clauses, or clauses which specify that the relationship of the provider is that of independent contractor and not as employee or agent of the voucher project, will not protect the project against being sued if a patient is injured by acts or omissions of the contract provider. However, they provide defense and a basis for apportioning any subsequent settlement or judgement to the provider rather than the project if there is no contributory negligence by the project.

Because of the diversity of arrangements which exist, we have not attempted to provide a draft idealized provider contract. A wide variety of other formats for contracts and memorandums of understanding are in use by current voucher projects. It is recommended that each voucher project consult their attorney regarding proposed draft contracts before signing them.

EXHIBIT 3

MEMORANDUM OF UNDERSTANDING

This document constitutes a Memorandum of Understanding between

PROTEUS EMPLOYMENT OPPORTUNITIES, INC.

and

_____
_____
_____
_____

A. PURPOSE

The parties identified above enter into this Memorandum of Understanding for purposes of carrying out the mission and provisions of the Iowa Migrant Health Project.

B. LIMITATIONS

1. Both parties shall undertake the performance described herein abiding by their respective corporate bylaws and policies and complying with all applicable local, state, and federal laws.

C. DURATION

The Memorandum of Understanding shall be in effect for the period starting February 1, 1992, and ending January 31, 1993. The period of operation may be modified upon mutual, written consent.

D. TERMINATION

If either party desires to terminate this Memorandum of Understanding, it may do so upon 10 days written notice to the other party.

E. MODIFICATIONS

Each party reserves the right to modify this agreement at any time. Modifications shall become addenda to the original Memorandum of Understanding and shall bear signatures of the two parties.

F. REPRESENTATIVES

1. Each party shall provide a primary contact person acting on behalf of their principals in the performance of this agreement.

a. For Proteus, the primary contact person will be Ruben Garza, Director of Migrant Health, or Terry Y. Meek, Executive Director.

b. For _____, the primary contact person will be _____.

2. Proteus will provide a list of project staff who will be assigned to carry out Project task.

G. STATEMENT OF WORK

Proteus shall do the following:

1. Provide information about the Migrant Health Project to employees, officials, or contractors, affiliated with _____. Information may be conveyed through meetings, posters, brochures, or other means deemed suitable.

2. Outreach and determine eligibility of migrant and seasonal farmworkers (MSFWs).

3. Conduct an initial assessment of the MSFW to determine health needs and appropriateness of referral.

4. Follow prearranged system for referral of MSFWs to the community health program.

5. Arrange and/or provide transportation of MSFWs as necessary.

6. Arrange and/or provide translation services for the MSFW for any and all appointments scheduled.

7. Provided follow - up with the MSFW to assure understanding and follow through of instructions, care and/or medications.

8. Reimburse _____ for costs charged at Title XIX rates as authorized through a Proteus voucher up to a maximum of $60 per calendar year per MSFW.

9. Assist the farmworker to facilitate additional means of payment for necessary medical costs.

10. Shall refer significant treatment and emergencies to a hospital emergency room.

_____ shall do the following:

1. Work with Proteus Migrant Health Project Staff to develop a referral system.

2. Make a good faith effort to serve MSFWs in a timely manner as they are referred by Proteus.

3. Provide Proteus with necessary follow-up documentation on referred MSFWs.

4. Work with Proteus staff in the coordination of linkages to other community health resources which might also serve the MSFW population.

5. Submit timely statements to Proteus based on the prearranged sliding fee schedule, available insurance, Proteus' voucher allowance, etc.

Ruben Garza, Director of Migrant Health Proteus	Date
Signature and Title Provider	Date

EXHIBIT 4

COPY

NORTHWEST MICHIGAN HEALTH SERVICES, INC.
PHARMACEUTICAL SERVICE AGREEMENT

This Agreement is between Northwest Michigan Health Services, Inc. (hereinafter referred to as NMHSI) and

PHARMACY

(hereinafter referred to as Participating Pharmacy).

WHEREAS, NMHSI, a Michigan non-profit corporation, has been organized to make comprehensive primary health care services available to migratory farm workers and their dependents as provided by Section 329 of the Public Health Services Act;

WHEREAS, NMHSI has included, as a part of its health care services, certain outpatient pharmaceutical services rendered to Clients through participating pharmacies;

WHEREAS, NMHSI desires to arrange for the dispensing of outpatient prescription medications and pharmaceutical services to Clients through participating pharmacies;

WHEREAS, NMHSI and Participating Pharmacy desire to promote high standards of phamaceutical care on a cost effective basis;

WHEREAS, Participating Pharmacy desires to dispense such outpatient prescription medications and provide pharmaceutical services to NMHSI Clients subject to the terms and conditions hereafter set forth in this Agreement;

WHEREAS, this document, entitled NMHSI Pharmaceutical Service Agreement, will be recognized as an offering of participation up to the time of execution by both parties, at which time it will become a legal and binding contract;

Now, therefore, in consideration of the mutual covenants herein contained, the parties do hereby agree as follows:

1.0 OBLIGATIONS OF THE PARTICIPATING PHARMACY

1.1 Participating Pharmacy agrees to:

a. Provide pharmaceutical services to NMHSI Clients when ordered by a written or verbal prescription from an NMHSI employed Physician and a completed NMHSI "PHARMACY REFERRAL" form. An NMHSI "PHARMACY REFERRAL" form is included as a part of this agreement and is incorporated into this agreement by reference. Participating Pharmacy attention is specifically directed to the ATTENTION PHARMACIST: notes at the bottom of the NMHSI "PHARMACY REFERRAL" form.

b. Bill NMHSI by returning the pink copy of all NMHSI "PHARMACY REFERRAL" forms received from NMHSI Clients together with the

Participating Pharmacy's standard itemized bill to the address provided at the top of the referral forms. If referral forms having different addresses are received, a separate billing is to be sent to each address. Bills are to be provided to NMHSI monthly or more often. Payment will not be rendered for pharmaceutical services which have not been authorized through the issuance of an NMHSI "PHARMACY REFERRAL" form, i.e., billings must be accompanied by the pink copy of NMHSI's referral form.

c. The price billed for each prescription is to be equal to the acquisition cost of the medication dispensed plus a professional dispensing fee. The medication acquisition cost shall be calculated by Participating Pharmacy based upon average wholesale price (AWP) less 10%. Average wholesale price for purposes of this agreement shall mean the prevailing medication price charged to Participating Pharmacy by the medication wholesaler, not to exceed AWP as reported by the American Druggist Redbook. The professional dispensing fee shall be $3.75 for each prescription order or refill thereof.

d. The Participating Pharmacy shall look solely to NMHSI for payment of covered services and will accept reimbursement from NMHSI as payment in full for covered services provided by Participating Pharmacy to NMHSI Clients. Participating Pharmacy will not bill NMHSI Clients for any covered services. No copayment is requested or allowed.

e. Acknowledge that nothing herein shall be construed to require a Participating Pharmacy to dispense any prescription medication if, in the pharmacist's professional judgement, such medication should not be dispensed.

f. Allow a duly authorized NMHSI agent, upon reasonable notice or request, free access during regular business hours to the books, invoices, and prescription files of the Participating Pharmacy as may be reasonably necessary for verification of information relevant to the performance and administration of this Agreement, including a complete audit of the records of the Participating Pharmacy if deemed necessary by NMHSI. Verification may be made at any time during the term of this Agreement, and up to one (1) year following its termination.

2.0 <u>OBLIGATIONS OF NORTHWEST MICHIGAN HEALTH SERVICES, INC.</u>

2.1 NMHSI agrees to:

a. Work cooperatively with the Participating Pharmacy to resolve issues which may arise from time to time concerning the rendering of pharmacy services to NMHSI Clients under the terms of this agreement.

b. Within 21 days of the receipt of a properly completed and submitted bill, render payment to the Participating Pharmacy. To be considered complete, a billing must consist of the

Participating Pharmacy's standard itemized billing statment and the pink copies of all NMHSI "PHARMACY REFERRAL" forms authorizing the the dispensing of medications being billed on the statement.

3.0 SYMBOLS AND TRADEMARKS

3.1 A Participating Pharmacy shall have the right to designate and make public reference to its status as a participating NMHSI provider provided, however, that the Participating Pharmacy shall not use the NMHSI name or its trademark for any service promotion or advertising unless first approved in writing in advance by NMHSI.

3.2 NMHSI shall have the right to designate and make oral and published reference to Participating Pharmacy as a participating provider for NMHSI, provided, however, that NMHSI shall not otherwise use the name of Participating Pharmacy in any other way unless first approved in writing in advance by the Participating Pharmacy.

4.0 TERMINATION:

a. This Agreement may be terminated by either party without cause by giving thirty (30) days written notice to the other party. During such thirty (30) day notice period, the Participating Pharmacy shall be required to perform its obligations in compliance with the NMHSI Pharmaceutical Service Agreement.

b. Each party acknowledges the right of the other to inform NMHSI Clients of termination of this Agreement.

5.0 MISCELLANEOUS:

5.1 Except as hereinafter provided, this Agreement shall insure to the benefit and be binding upon the successors and assignees of each party hereto.

5.2 Participating Pharmacy shall indemnify and hold NMHSI harmless against and from any and all liability, losses, damages, claims or costs due to or arising out of any personal injury or death or property damaged caused by or resulting from the activities and operations of Participating Pharmacy; except that the provisions of this paragraph shall not apply with respect to any liability, suits, claims, demands or costs arising from any willful or negligent act or omission of NMHSI or any agent, contractor, or employee of NMHSI, other than Participating Pharmacy.

5.3 Any notice required to be given pursuant to the terms or provisions of this Agreement shall be in writing and sent by certified mail, return receipt requested, postage prepaid, to:

NMHSI:

Dale Reimer, Executive Director
Northwest Michigan Health Services, Inc.
10767 Traverse Highway, Suite B
Traverse City, MI 49684
Phone: (616) 947-1112

Participating Pharmacy: Owner/Operator

Pharmacy

Phone: (616) 49455

6.0 ACCEPTANCE OF NMHSI PHARMACEUTICAL SERVICE AGREEMENT

6.1 The inclusive dates during which this agreement shall be in effect are April 1, 1992 through March 31, 1993.

6.2 The undersigned parties being duly authorized to enter into contracts for their respective entities, do hereby agree to the terms and conditions of this contract.

FOR NMHSI:

WITNESS our hands and seals, this _____ day of _____ ,1992

Signed, Sealed and Delivered in Presence of,

_____

_____

_____

its_____

FOR PARTICIPATING PHARMACY:

WITNESS our hands and seals, this _____ day of _____ ,1992

Signed, Sealed and Delivered in Presence of,

_____

_____

_____

its_____

(PROWRITE\FILES\PHARMCON.92)

PHARMACY REFERRAL

NORTHWEST MICHIGAN HEALTH SERVICES, INC.
10767 Traverse Highway, Suite B
Traverse City, Michigan 49684
947-0351

Copy distribution
Wht. - Kept by Clinic
Yel. - Kept by Pharmacy
Pink - Returned with Pharmacy Bill

Pharmacy _____ Date _____ Void after _____

Patient's Name _____ I.D. Number _____

Medication(s)			No. of Refills Remaining		
1. _____	Rx #	_____	_____	X	Cost $ _____
2. _____	Rx #	_____	_____	X	Cost $ _____
3. _____	Rx #	_____	_____	X	Cost $ _____

ATTENTION PHARMACIST:

- Please use generic drugs unless contraindicated by physician.
- Each form is valid for no more than 3 prescriptions. Do not add prescriptions beyond those listed by N.M.H.S.I. staff.
- Do not dispense more than a 1-month supply of any medication unless authorized by N.M.H.S.I. staff.
- Please complete this form and return it along with an itemized statement to the above address.

JB

_____
Issuer's Signature

APPENDIX C

QUALITY ASSURANCE AND UTILIZATION REVIEW PROGRAMS FOR VOUCHER PROJECTS

The comprehensiveness and detail of health care quality assurance programs appropriate for voucher projects vary with the services delivery model. Statewide voucher projects which concurrently operate geographically distant service sites which differ in delivery models may need to design separate quality assurance programs (QAPs) for each such site. This appendix to the Migrant Health Voucher Program Guidance outlines the required components of QAPs designed for each of the three prototypical delivery system models currently in use by voucher projects, and describes methods which may be used to implement these QAPs. It is not intended that these examples deter any project which may wish to undertake a more rigorous QAP, or to exploit unique local circumstances which offer an opportunity to provide exceptionally detailed quality control. The examples described here represent minimum requirements for an acceptable QAP, given the services delivery model employed.

Services Coordinator Staffed Delivery Model

Because the services coordinator staffed voucher project does not directly deliver health services, quality assurance depends primarily on selecting and contracting with competent and qualified medical and dental providers. There will be a need for services coordinator staffed projects to include the following components in their QAP:

- A plan for assuring that the credentials of physicians and dentists selected as contract providers meet federal requirements

- Assuring that other types of providers utilized are in compliance with state and local licensing requirements

- Provision of written protocols for making referrals, and a system for assuring that decisions to refer clients to contract providers are consistent with these protocols

- A plan for conducting utilization review of services for which voucher payments are made

- A plan for obtaining feedback from the MSFWs served by the project (generally through representation on the governing or consumer advisory board, and through

periodic formal assessment of client satisfaction)

It is recommended that each voucher project establish a Quality Assurance Committee to take responsibility for developing and implementing the QAP. Membership on the QAP should include the Medical Director and other appropriate clinicians.

The QAC for a project which is in operation only 4 months or less each year should meet early in the season, sample and audit records for compliance with QAP guidelines, provide corrective feedback, and schedule the monitoring of effectiveness of the corrective actions. At the conclusion of the season, the committee should meet again, conduct the QAP audit, then review and revise the QAP, policy and procedures, etc., as appropriate, to lay foundations for quality improvements in the subsequent season. Projects in operation for more than 4 months should also schedule a meeting early in the season, another within at least 3 months after the first meeting, and again after the conclusion of the season. Year round voucher projects should schedule quality assurance committee meetings at least quarterly. The QAC should present its findings to the full Board of Directors at least annually.

Provider Credentials

All contract physicians and dentists must have a valid license to practice in those state(s) in which they will provide services to referred clients of the voucher project. It is vital that the project also learn on a timely basis if a provider's license is suspended or terminated. Agreements with physicians and dentists should include a clause in which the provider attests that he or she is currently licensed in specified states, and that he or she will immediately notify the project if the license is suspended or terminated.

For providers that have privileges at the local hospital, the hospital must also perform credential reviews and may be willing to share these findings with the project.

Institutional providers, such as the local hospital, federally-funded CHC, or county health department, have their own internal quality assurance programs required by regulatory agencies, funding agencies, and third party payors such as Medicare. Having the institutional providers attest to their Medicare/Medicaid provider status, licensure, etc., and agreeing to notify the voucher project if any such status is revoked or suspended, will suffice for project QAP applied to these providers.

Client Assessment and Referral Protocols

It is not intended that lay services coordinators make medical decisions regarding the care of a migrant that requests services. However, such staff must be able to triage clients, and either make decisions about emergency, urgent, or deferrable care, or know how to obtain help with such decisions. This process should be documented in the policy and procedures manual for the project. Moreover, at least annually client encounter records should be sampled and reviewed for adherence to the protocols for assessment and referral.

Clients and potential clients should be advised that the voucher project does not provide emergency care, and migrants and those working with migrants provided with instructions on how to call for an ambulance, and directions to hospital emergency rooms in the area. This information should be widely disseminated so that valuable time is not lost when a true medical emergency arises. It is advisable that the services coordinator have received training in CPR and at least the basic Red Cross course in first aid, or equivalent. Examples of medical emergencies include the following (this is not an exhaustive list):

Bleeding which cannot be stopped
Difficulty breathing
Convulsions
Compound fractures
Eye injuries
Fever of 104 degrees or more
Heat stroke
Possible miscarriage or imminent delivery
Vomiting of blood
Loss of consciousness
Severe abdominal or chest pain

Once a medical emergency has been ruled out, the procedure for client assessment should be completed, a provider appropriate to the assessment findings selected, and the provider contacted to arrange an appointment.

Protocols should govern selection of the appropriate provider type as well as the urgency of the appointment. Presenting complaints, selection of referral provider, timing of appointment, and subsequent diagnosis and treatment should be audited against the assessment and referral protocols to identify service coordinator needs for additional training. It is recommended that a random sample of at least 20 client encounters be included in each record audit.

Utilization Review

Because of the potential costs to the project when a contract provider recommends that a referred patient receive a diagnostic test not included in the office visit reimbursement rate, requests that the patient be recalled in a few days, or when the contract provider recommends sending the referred patient to a specialist, there is a need for utilization review (UR). Each voucher project's service coordinators will perform both concurrent (continuous) UR through the process of arranging followup care, issuing vouchers, and approving vouchers for payment, and should arrange for retroactive UR at least annually (usually at the end of the peak season).

However, retroactive UR at the end of the season should involve the Medical Director or Advisor and should be developed to include the following steps:

1. Select records for review only from those patients for which two or more vouchers were paid for services provided within a prescribed time of one another (no more than 30 days). A sample of 20 such patients' patterns of care should be examined for the audit.

2. Under the supervision of the Medical Director or Advisor, screen the sample records and identify any for which the utilization patterns do not follow explicit parameters considered to be routine (e.g., patients with a diagnosis of diabetes should have blood sugar measured). The Medical Director would then review those which do not meet the explicit screens.

3. If the Medical Director identifies questionable or potential problems, a meeting with the contract provider for each such case should be arranged. Often the outcome of such a case review will be the identification of poor documentation by the provider. However, questionable recalls, or suspect re-referrals or tests, may be identified.

Consumer Satisfaction

Representation of the MSFW users on the governing board or consumer advisory board provides a mechanism for users of the project to give feedback regarding their satisfaction with services. It is also recommended that either a continuous or periodical survey of user satisfaction be conducted.

Exhibit 5 is an example of a consumer survey questionnaire (this survey is administered annually to at least 20 clients of each of the service sites operated by Proteus Employment Opportunities,

Inc., the statewide voucher project grantee in Iowa).

Nurse Staffed Delivery Model

Voucher project service sites which are staffed by a nurse (LPN or RN) will perform all of the functions of the services coordinator model, plus provide some nursing services directly. Consequently, the QAP for a nurse staffed voucher project must include all of the above described components, plus the review of nursing services against nursing protocols. The periodic nursing audits (at least annual) should be used to identify opportunities for improving both the performance of nursing services and the documentation of these services in patient medical records.

Voucher project grantees which are state health departments will be subject to the nursing service audits performed by the health department. The description of the quality assurance program developed for all health department nurses should be incorporated into the project policy and procedures manual. Exhibit 6 is an example of a nursing protocol used by Proteus for patients presenting with a complaint of back pain. Exhibit 7 is an example of the quality review worksheet used by Proteus when auditing nursing services.

EXHIBIT 5

PROTEUS MIGRANT HEALTH PROJECT

CLIENT SATISFACTION SURVEY
ENCUESTA de SATISFACCION de los CLIENTES

Site/Localidad_____ Date/Fecha de Hoy_____
Date of Birth/Fecha de Nacimiento_____ Sex/Sexo_____

Please share your opinion about this Health Program by circling the word that comes closest to how you feel. Do not write your name on this form unless you want us to know who you are. These surveys will remain confidential. Thank you for your time.

Favor de darnos su opinion de este Programa de Salud circulando la palabra que mas corresponde a su opinion. No ponga su nombre en esta forma a menos que Ud. quiere que se sepa. Estas encuestas se guardaran en confianza. Gracias por su valioso tiempo.

N/A = doesn't apply to your experience
N/A = no corresponde a su experiencia

1. Time spent waiting to see the Migrant Health Nurse or Health Aide.
   Too long Reasonable Short N/A

   Tiemp pasado esperando ver a la enfermera del Proteus Migrant Health.
   Desmasiado Razonable Poco N/A

2. Time spent waiting to see the doctor in his/her office.
   Too long Reasonable Short N/A

   Tiempo pasado esperando ver al (la) doctor(a) en su oficina.
   Desmasiado Razonable Poco N/A

3. Time spent waiting to get an appointment with the doctor.
   Too long Reasonable Short N/A

   Tiemp pasado esperando una cita con el (la) doctor (a).
   Desmasiado Razonable Poco N/A

4. The care and instructions given to you by the Migrant Health Nurse or Health Aide.
   Unsatisfactory Satisfactory Very Good N/A

   La atencion y las instrucciones que le dio la enfermera del Proteus Migrant Health.
   Insatisfactorias Satisfactorias Muy buena N/A

Client Satisfaction Survey - Page Two

5. The care given to you by the doctor.
   Unsatisfactory Satisfactory Very Good N/A

   La atencion medica que le dio el (la) doctor (a).
   Insatisfactoria Satisfactoria Muy buena N/A

6. The assistance given to you by the Proteus Migrant Health Staff.
   Unsatisfactory Satisfactory Very Good N/A

   La ayuda que le dio la asistenta de la enfermera.
   Insatisfactoria Satisfactoria Muy buena N/A

7. Proteus Migrant Health Project office hours:
   Inconvenient Acceptable Convenient N/A

   Horas de oficina del Programa de Salud del Proteus Migrant Health Project:
   Inconvenientes Aceptables Convenientes N/A

8. Assistance you received from our staff with other health problems. (Public Aid, WIC, referrals, etc.)
   Unsatisfactory Satisfactory Very Good N/A

   Ayuda que Ud. recibio de nuestro personal con otros problemas de salud (Asistencia Publica, los cupones de la leche, etc.).
   Insatisfactoria Satisfactoria Muy buena N/A

Please place an X next to the five services you and your family need most.

Favor de poner una X al lado de los cinco servicios que mas necesita Ud y su familia.

____ Doctor visits/Visitas con el (la) doctor(a).

____ Medication/Medicinas

____ Birth Control (Family Planning)/Control de la natalidad

____ Medical Care during Pregnancy/Atencion medica durante el embarazo

____ Dental Care/Atencion dental

____ Nutrition Information and WIC/Informacion sobre la comida y "los cupones de la leche"

Client Satisfaction Survey - Page Three

____ Someone to talk to about personal and family problems/Con quien hablar de los problemas personales y familiares

____ Translation Services/Servicios de interprete

____ Transporation Services/Servicios de transporte

____ Home/Camp visits/Visitas en casa y al campo

____ Eye glasses/Lentes O Anteojos

____ Other/Otro (be specific/explique)_____

_____

Please use the rest of this form for any comments you think will help us improve our services.

Favor de usar el resto de esta forma para otros comentarios que nos ayudaran a mejorar nuestros servicios.

_____

_____

_____

_____

_____

_____

EXHIBIT 6

PROTEUS EMPLOYMENT OPPORTUNITIES, INC.

P.S.P. Section	P.S.P. No.	Page 11
NURSING PROTOCOLS	13.11	of 13
Subject	Date Effective	Cross-Reference
BACK PAIN	4/1/91	

13.11.1 SUBJECTIVE:

1. Client verbal history of cause, onset, and duration and type of symptoms
   a. If work related, send to employer for Workmen's Compensation
2. Client management of symptoms
3. Predisposing factors (arthritis, congenital or systemic disease)
4. Numbness and/or weakness
5. Trauma

13.11.2 OBJECTIVE:

1. Assess range of motion, gait, and posture
2. Assess for flank pain; check temperature

13.11.3 NURSING ASSESSMENT (DIAGNOSIS)

13.11.4 REFER TO CONTRACTED PROVIDER

13.11.5 CLIENT EDUCATION AND FOLLOW-UP

1. Restrict activities as ordered
2. Bedrest as ordered; use of bed board; position for comfort
3. Instruct client on proper body mechanics
4. Take medication as ordered; explain side-effects
5. Back exercises and prevention measures as ordered
6. Refer back to physician if pain becomes worse or condition does not improve in 3-4 days.
7. Follow-up at home/office or by telephone

EXHIBIT 7

QUALITY ASSURANCE MIGRANT RN REVIEW SHEET

Site_____
R.N._____

Date of Encounter_____ B.D._____ Sex_____ Age___

Date of Audit_____ Presenting problem(s) being assessed:_____

_____

_____

Nursing Care
Presenting nursing problem and/or diagnosis documented on referral and/or narrative

	YES	NO	N/A
Nursing assessment completed Comment:	___	___	___
Nursing assessment (diagnosis) consistent with subjective and objective data Comment:	___	___	___
Follow-up appropriate Comment:	___	___	___
Referral to contracted provider consistent with protocol for nursing diagnosis Comment:	___	___	___
Client education documented Comment:	___	___	___
Client education consistent with Nursing protocol Comment:	___	___	___
Minimum health maintenance schedule completed Comment:	___	___	___
Individual client checklist utilized	___	___	___

Comment:

Page 2-Quality Assurance Migrant Review Sheet

Individual care plan utilized for chronic conditions Comment:	___	___	___
Appropriate log(s) used Comment:	___	___	___
SOAP utilized Comment:	___	___	___