

Appendix B  
**CALIFORNI HEALTH AND SAFETY CODE**  
**REFERENCE SECTIONS**

**DIVISION 1. ADMINISTRATION OF PUBLIC HEALTH**  
**PART 1.8. END-OF-LIFE CARE**

442. For the purposes of this part, the following definitions shall apply:

(a) "Actively dying" means the phase of terminal illness when death is imminent.

(b) "Disease-targeted treatment" means treatment directed at the underlying disease or condition that is intended to alter its natural history or progression, irrespective of whether or not a cure is a possibility.

(c) "Health care provider" means an attending physician and surgeon. It also means a nurse practitioner or physician assistant practicing in accordance with standardized procedures or protocols developed and approved by the supervising physician and surgeon and the nurse practitioner or physician assistant.

(d) "Hospice" means a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease, and provide supportive care to the primary caregiver and the family of the hospice patient, and that meets all of the criteria specified in subdivision (b) of Section 1746.

(e) "Palliative care" means medical treatment, interdisciplinary care, or consultation provided to a patient or family members, or both, that has as its primary purpose the prevention of, or relief from, suffering and the enhancement of the quality of life, rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life as described in subdivision (b) of Section 1339.31. In some cases, disease-targeted treatment may be used in palliative care.

(f) "Refusal or withdrawal of life-sustaining treatment" means forgoing treatment or medical procedures that replace or support an essential bodily function, including, but not limited to, cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis, and any other treatment or discontinuing any or all of those treatments after they have been used for a reasonable time.

442.5. When a health care provider makes a diagnosis that a patient has a terminal illness, the health care provider shall, upon the patient's request, provide the patient with comprehensive information and counseling regarding legal end-of-life care options pursuant to this section. When a terminally ill patient is in a health facility, as defined in Section 1250, the health care provider, or medical director of the health facility if the patient's health care provider is not available, may refer the patient to a hospice provider or private or public agencies and community-based organizations that specialize in end-of-life care case management and consultation to receive comprehensive information and counseling regarding legal end-of-life care options.

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(a) If the patient indicates a desire to receive the information and counseling, the comprehensive information shall include, but not be limited to, the following:

(1) Hospice care at home or in a health care setting.

(2) A prognosis with and without the continuation of disease-targeted treatment.

(3) The patient's right to refusal of or withdrawal from life-sustaining treatment.

(4) The patient's right to continue to pursue disease-targeted treatment, with or without concurrent palliative care.

(5) The patient's right to comprehensive pain and symptom management at the end of life, including, but not limited to, adequate pain medication, treatment of nausea, palliative chemotherapy, relief of shortness of breath and fatigue, and other clinical treatments useful when a patient is actively dying.

(6) The patient's right to give individual health care instruction pursuant to Section 4670 of the Probate Code, which provides the means by which a patient may provide written health care instruction, such as an advance health care directive, and the patient's right to appoint a legally recognized health care decisionmaker.

(b) The information described in subdivision (a) may, but is not required to, be in writing. Health care providers may utilize information from organizations specializing in end-of-life care that provide information on factsheets and Internet Web sites to convey the information described in subdivision (a).

(c) Counseling may include, but is not limited to, discussions about the outcomes for the patient and his or her family, based on the interest of the patient. Information and counseling, as described in subdivision (a), may occur over a series of meetings with the health care provider or others who may be providing the information and counseling based on the patient's needs.

(d) The information and counseling sessions may include a discussion of treatment options in a manner that the patient and his or her family can easily understand. If the patient requests information on the costs of treatment options, including the availability of insurance and eligibility of the patient for coverage, the patient shall be referred to the appropriate entity for that information.

442.7. If a health care provider does not wish to comply with his or her patient's request for information on end-of-life options, the health care provider shall do both of the following:

(a) Refer or transfer a patient to another health care provider that shall provide the requested information.

(b) Provide the patient with information on procedures to transfer to another health care provider that shall provide the requested information.

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**DIVISION 2. LICENSING PROVISIONS**  
**CHAPTER 2. HEALTH FACILITIES**  
**Article 1. General**

1253.5. (a) The State Department of Public Health, upon issuance and renewal of a license for a general acute care hospital as defined in subdivision (a) of Section 1250, an acute psychiatric hospital as defined in subdivision (b) of Section 1250, or a special hospital as defined in subdivision (f) of Section 1250, shall separately identify on the license each supplemental service, including the address of where each outpatient service is provided and the type of services provided at each outpatient location.

(b) On or before July 1, 2010, the department shall post and make available on its Web site a listing of all outpatient services of licensed hospitals identified on the hospital's license as a supplemental service pursuant to subdivision (a). The listing shall include the name and physical address of where the outpatient service is provided. The department's Web site shall include a disclaimer that the information contained in the listing is limited to the outpatient service information reported to the department by licensed hospitals.

(c) The department shall work with stakeholders to review, streamline, and revise the initial and renewal license application form prescribed and furnished by the department to any person, firm, association, partnership, or corporation desiring a license, a change in licensed beds or services, or renewing a license for a hospital, acute psychiatric hospital, or special hospital.

1254.4. (a) A general acute care hospital shall adopt a policy for providing family or next of kin with a reasonably brief period of accommodation, as described in subdivision (b), from the time that a patient is declared dead by reason of irreversible cessation of all functions of the entire brain, including the brain stem, in accordance with Section 7180, through discontinuation of cardiopulmonary support for the patient. During this reasonably brief period of accommodation, a hospital is required to continue only previously ordered cardiopulmonary support. No other medical intervention is required.

(b) For purposes of this section, a "reasonably brief period" means an amount of time afforded to gather family or next of kin at the patient's bedside.

(c) (1) A hospital subject to this section shall provide the patient's legally recognized health care decisionmaker, if any, or the patient's family or next of kin, if available, with a written statement of the policy described in subdivision (a), upon request, but no later than shortly after the treating physician has determined that the potential for brain death is imminent.

(2) If the patient's legally recognized health care decisionmaker, family, or next of kin voices any special religious or cultural practices and concerns of the patient or the patient's family surrounding the issue of death by reason of irreversible cessation of all functions of the entire brain of the patient, the hospital shall

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make reasonable efforts to accommodate those religious and cultural practices and concerns.

(d) For purposes of this section, in determining what is reasonable, a hospital shall consider the needs of other patients and prospective patients in urgent need of care.

(e) There shall be no private right of action to sue pursuant to this section.

1255.25 (a) (1)

Not less than 30 days prior to closing a health facility, as defined in subdivision (a) or (b) of Section 1250, or eliminating a supplemental service, as defined in Section 70067 of Chapter 1 of Division 5 of Title 22 of the California **Code** of Regulations, the facility shall provide public notice of the proposed closure or elimination of the supplemental service, including a notice posted at the entrance to all affected facilities and a notice to the department and the board of supervisors of the county in which the health facility is located.

(2) Not less than 30 days prior to relocating the provision of supplemental services to a different campus, a health facility, as defined in subdivision (a) or (b) of Section 1250, shall provide public notice of the proposed relocation of supplemental services, including a notice posted at the entrance to all affected facilities and notice to the department and the board of supervisors of the county in which the health facility is located.

(b) The notice required by paragraph (1) or (2) of subdivision (a) shall include all of the following:

(1) A description of the proposed closure, elimination, or relocation. The description shall be limited to publicly available data, including the number of beds eliminated, if any, the probable decrease in the number of personnel, and a summary of any service that is being eliminated, if applicable.

(2) A description of the three nearest available comparable services in the community. If the health facility closing these services serves Medi-Cal or Medicare patients, this health facility shall specify if the providers of the nearest available comparable services serve these patients.

(3) A telephone number and address for each of the following, where interested parties may offer comments:

(A) The health facility.

(B) The parent entity, if any, or contracted company, if any, that acts as the corporate administrator of the health facility.

(C) The chief executive officer.

(c) Notwithstanding subdivisions (a) and (b), this section shall not apply to county facilities subject to Section 1442.5.

1255.8. (a) For purposes of this section, the following terms have the following meanings:

(1) "Colonized" means that a pathogen is present on the patient's body, but is not causing any signs or symptoms of an infection.

(2) "Committee" means the Healthcare Associated Infection Advisory Committee established pursuant to Section 1288.5.

(3) "Health facility" means a facility as defined in subdivision (a) of Section 1250.

(4) "Health-care-associated infection," "health-facility-acquired

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infection," or "HAI" means a health-care-associated infection as defined by the National Healthcare Safety Network of the federal Centers for Disease Control and Prevention, unless the department adopts a definition consistent with the recommendations of the committee or its successor.

(5) "MRSA" means Methicillin-resistant *Staphylococcus aureus*.

(b) (1) Each patient who is admitted to a health facility shall be tested for MRSA in the following cases, within 24 hours of admission:

(A) The patient is scheduled for inpatient surgery and has a documented medical condition making the patient susceptible to infection, based either upon federal Centers for Disease Control and Prevention findings or the recommendations of the committee or its successor.

(B) It has been documented that the patient has been previously discharged from a general acute care hospital within 30 days prior to the current hospital admission.

(C) The patient will be admitted to an intensive care unit or burn unit of the hospital.

(D) The patient receives inpatient dialysis treatment.

(E) The patient is being transferred from a skilled nursing facility.

(2) The department may interpret this subdivision to take into account the recommendations of the federal Centers for Disease Control and Prevention, or recommendations of the committee or its successor.

(3) If a patient tests positive for MRSA, the attending physician shall inform the patient or the patient's representative immediately or as soon as practically possible.

(4) A patient who tests positive for MRSA infection shall, prior to discharge, receive oral and written instruction regarding aftercare and precautions to prevent the spread of the infection to others.

(c) Commencing January 1, 2011, a patient tested in accordance with subdivision (b) and who shows evidence of increased risk of invasive MRSA shall again be tested for MRSA immediately prior to discharge from the facility. This subdivision shall not apply to a patient who has tested positive for MRSA infection or colonization upon entering the facility.

(d) A patient who is tested pursuant to subdivision (c) and who tests positive for MRSA infection shall receive oral and written instructions regarding aftercare and precautions to prevent the spread of the infection to others.

(e) The infection control policy required pursuant to Section 70739 of Title 22 of the California Code of Regulations, at a minimum, shall include all of the following:

(1) Procedures to reduce health care associated infections.

(2) Regular disinfection of all restrooms, countertops, furniture, televisions, telephones, bedding, office equipment, and surfaces in patient rooms, nursing stations, and storage units.

(3) Regular removal of accumulations of bodily fluids and intravenous substances, and cleaning and disinfection of all movable medical equipment, including point-of-care testing devices such as glucometers, and transportable medical devices.

(4) Regular cleaning and disinfection of all surfaces in common areas in the facility such as elevators, meeting rooms, and lounges.

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(f) Each facility shall designate an infection control officer who, in conjunction with the hospital infection control committee, shall ensure implementation of the testing and reporting provisions of this section and other hospital infection control efforts. The reports shall be presented to the appropriate committee within the facility for review. The name of the infection control officer shall be made publicly available, upon request.

(g) The department shall establish a health care acquired infection program pursuant to this section.

1257.7. (a) After July 1, 2010, all hospitals licensed pursuant to subdivisions (a), (b), and (f) of Section 1250 shall conduct, not less than annually, a security and safety assessment and, using the assessment, develop, and annually update based on the assessment, a security plan with measures to protect personnel, patients, and visitors from aggressive or violent behavior. The security and safety assessment shall examine trends of aggressive or violent behavior at the facility. These hospitals shall track incidents of aggressive or violent behavior as part of the quality assessment and improvement program and for the purposes of developing a security plan to deter and manage further aggressive or violent acts of a similar nature. The plan may include, but shall not be limited to, security considerations relating to all of the following:

- (1) Physical layout.
- (2) Staffing.
- (3) Security personnel availability.
- (4) Policy and training related to appropriate responses to violent acts.
- (5) Efforts to cooperate with local law enforcement regarding violent acts in the facility.

In developing this plan, the hospital shall consider guidelines or standards on violence in health care facilities issued by the department, the Division of Occupational Safety and Health, and the federal Occupational Safety and Health Administration. As part of the security plan, a hospital shall adopt security policies including, but not limited to, personnel training policies designed to protect personnel, patients, and visitors from aggressive or violent behavior. In developing the plan and the assessment, the hospital shall consult with affected employees, including the recognized collective bargaining agent or agents, if any, and members of the hospital medical staff organized pursuant to Section 2282 of the Business and Professions Code. This consultation may occur through hospital committees.

(b) The individual or members of a hospital committee responsible for developing the security plan shall be familiar with all of the following:

- (1) The role of security in hospital operations.
- (2) Hospital organization.
- (3) Protective measures, including alarms and access control.
- (4) The handling of disturbed patients, visitors, and employees.
- (5) Identification of aggressive and violent predicting factors.
- (6) Hospital safety and emergency preparedness.
- (7) The rudiments of documenting and reporting crimes, including, by way of example, not disturbing a crime scene.

(c) The hospital shall have sufficient personnel to provide security pursuant to the security plan developed pursuant to

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subdivision (a). Persons regularly assigned to provide security in a hospital setting shall be trained regarding the role of security in hospital operations, including the identification of aggressive and violent predicting factors and management of violent disturbances.

(d) Any act of assault, as defined in Section 240 of the Penal Code, or battery, as defined in Section 242 of the Penal Code, that results in injury or involves the use of a firearm or other dangerous weapon, against any on-duty hospital personnel shall be reported to the local law enforcement agency within 72 hours of the incident. Any other act of assault, as defined in Section 240 of the Penal Code, or battery, as defined in Section 242 of the Penal Code, against any on-duty hospital personnel may be reported to the local law enforcement agency within 72 hours of the incident. No health facility or employee of a health facility who reports a known or suspected instance of assault or battery pursuant to this section shall be civilly or criminally liable for any report required by this section. No health facility or employee of a health facility who reports a known or suspected instance of assault or battery that is authorized, but not required, by this section, shall be civilly or criminally liable for the report authorized by this section unless it can be proven that a false report was made and the health facility or its employee knew that the report was false or was made with reckless disregard of the truth or falsity of the report, and any health facility or employee of a health facility who makes a report known to be false or with reckless disregard of the truth or falsity of the report shall be liable for any damages caused. Any individual knowingly interfering with or obstructing the lawful reporting process shall be guilty of a misdemeanor. "Dangerous weapon," as used in this section, means any weapon the possession or concealed carrying of which is prohibited by Section 12020 of the Penal Code.

1262.5 (a) Each hospital shall have a written discharge planning policy and process.

(b) The policy required by subdivision (a) shall require that appropriate arrangements for posthospital care, including, but not limited to, care at home, in a skilled nursing or intermediate care facility, or from a hospice, are made prior to discharge for those patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning. If the hospital determines that the patient and family members or interested persons need to be counseled to prepare them for posthospital care, the hospital shall provide for that counseling.

(c) The process required by subdivision (a) shall require that the patient be informed, orally or in writing, of the continuing health care requirements following discharge from the hospital. The right to information regarding continuing health care requirements following discharge shall apply to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient, if the patient is unable to make those decisions for himself or herself. In addition, a patient may request that friends or family members be given this information, even if the patient is able to make his or her own decisions regarding medical care.

(d) (1) A transfer summary shall accompany the patient upon transfer to a skilled nursing or intermediate care facility or to the distinct part-skilled nursing or intermediate care service unit of

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the hospital. The transfer summary shall include essential information relative to the patient's diagnosis, hospital course, pain treatment and management, medications, treatments, dietary requirement, rehabilitation potential, known allergies, and treatment plan, and shall be signed by the physician.

(2) A copy of the transfer summary shall be given to the patient and the patient's legal representative, if any, prior to transfer to a skilled nursing or intermediate care facility.

(e) A hospital shall establish and implement a written policy to ensure that each patient receives, at the time of discharge, information regarding each medication dispensed, pursuant to Section 4074 of the Business and Professions Code.

(f) A hospital shall provide every patient anticipated to be in need of long-term care at the time of discharge with contact information for at least one public or nonprofit agency or organization dedicated to providing information or referral services relating to community-based long-term care options in the patient's county of residence and appropriate to the needs and characteristics of the patient. At a minimum, this information shall include contact information for the area agency on aging serving the patient's county of residence, local independent living centers, or other information appropriate to the needs and characteristics of the patient.

(g) A contract between a general acute care hospital and a health care service plan that is issued, amended, renewed, or delivered on or after January 1, 2002, may not contain a provision that prohibits or restricts any health care facility's compliance with the requirements of this section.

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**DIVISION 2. LICENSING PROVISIONS**

**CHAPTER 2. HEALTH FACILITIES**

**Article 2. Administration**

1265.4. (a) A licensed health facility, as defined in subdivision (a), (b), (c), (d), (f), or (k) of Section 1250, shall employ a full-time, part-time, or consulting dietitian. A health facility that employs a registered dietitian less than full time, shall also employ a full-time dietetic services supervisor who meets the requirements of subdivision (b) to supervise dietetic service operations. The dietetic services supervisor shall receive frequently scheduled consultation from a qualified dietitian.

(b) The dietetic services supervisor shall have completed at least one of the following educational requirements:

(1) A baccalaureate degree with major studies in food and nutrition, dietetics, or food management and has one year of experience in the dietetic service of a licensed health facility.

(2) A graduate of a dietetic technician training program approved by the American Dietetic Association, accredited by the Commission on Accreditation for Dietetics Education, or currently registered by the Commission on Dietetic Registration.

(3) A graduate of a dietetic assistant training program approved by the American Dietetic Association.

(4) Is a graduate of a dietetic services training program approved by the Dietary Managers Association and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California **Code** of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility.

(5) Is a graduate of a college degree program with major studies in food and nutrition, dietetics, food management, culinary arts, or hotel and restaurant management and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility.

(6) A graduate of a state approved program that provides 90 or more hours of classroom instruction in dietetic service supervision, or 90 hours or more of combined classroom instruction and instructor led interactive Web-based instruction in dietetic service supervision.

(7) Received training experience in food service supervision and management in the military equivalent in content to paragraph (2), (3), or (6).

(c) Pursuant to Section 1276, the State Department of Public Health may grant a program flexibility request to the facility to

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modify the requirements in subdivision (b) for any individual who has at least five years experience prior to January 1, 2009, as a dietetic services supervisor in a health facility specified in subdivision (a) to allow that individual to function as a dietetic services supervisor for a period not to exceed 18 months, as long as the individual is enrolled in a program that meets the requirements listed in subdivision (b). The department may extend the program flexibility request for a period not to exceed six months if the individual can demonstrate to the department that the coursework could not otherwise be completed within the original 18-month period. Program flexibility requests shall be submitted not later than December 31, 2009.

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**CHAPTER 2. HEALTH FACILITIES**  
**Article 3. Regulations**

1279.6. (a) A health facility, as defined in subdivision (a), (b), (c), or (f) of Section 1250, shall develop, implement, and comply with a patient safety plan for the purpose of improving the health and safety of patients and reducing preventable patient safety events. The patient safety plan shall be developed by the facility, in consultation with the facility's various health care professionals.

(b) The patient safety plan required pursuant to subdivision (a) shall, at a minimum, provide for the establishment of all of the following:

(1) A patient safety committee or equivalent committee in composition and function. The committee shall be composed of the facility's various health care professionals, including, but not limited to, physicians, nurses, pharmacists, and administrators. The committee shall do all of the following:

(A) Review and approve the patient safety plan.

(B) Receive and review reports of patient safety events as defined in subdivision (c).

(C) Monitor implementation of corrective actions for patient safety events.

(D) Make recommendations to eliminate future patient safety events.

(E) Review and revise the patient safety plan, at least once a year, but more often if necessary, to evaluate and update the plan, and to incorporate advancements in patient safety practices.

(2) A reporting system for patient safety events that allows anyone involved, including, but not limited to, health care practitioners, facility employees, patients, and visitors, to make a report of a patient safety event to the health facility.

(3) A process for a team of facility staff to conduct analyses, including, but not limited to, root cause analyses of patient safety events. The team shall be composed of the facility's various categories of health care professionals, with the appropriate competencies to conduct the required analyses.

(4) A reporting process that supports and encourages a culture of safety and reporting patient safety events.

(5) A process for providing ongoing patient safety training for facility personnel and health care practitioners.

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(c) For the purposes of this section, patient safety events shall be defined by the patient safety plan and shall include, but not be limited to, all adverse events or potential adverse events as described in Section 1279.1 that are determined to be preventable, and health-care-associated infections (HAI), as defined in the federal Centers for Disease Control and Prevention's National Healthcare Safety Network, or its successor, unless the department accepts the recommendation of the Healthcare Associated Infection Advisory Committee, or its successor, that are determined to be preventable.

1279.7. (a) A health facility, as defined in subdivision (a), (b), (c), or (f) of Section 1250, shall implement a facility-wide hand hygiene program.

(b) Commencing 36 months after the publication of a new design standard for connections for epidural applications by the International Organization for Standardization, or January 1, 2014, whichever occurs first, a health facility, as defined in subdivision (a), (b), (c), or (f) of Section 1250, is prohibited from using an epidural connection that would fit into a connection port other than the type it was intended for, unless an emergency or urgent situation exists and the prohibition would impair the ability to provide health care.

(c) Commencing 24 months after the publication of a new design standard for connections for intravenous or enteral applications by the International Organization for Standardization, or January 1, 2013, whichever occurs first, a health facility, as defined in subdivision (a), (b), (c), or (f) of Section 1250, is prohibited from using an intravenous connection or an enteral feeding connection that would fit into a connection port other than the type it was intended for, unless an emergency or urgent situation exists and the prohibition would impair the ability to provide health care.

(d) The Advanced Medical Technology Association shall, on January 1 of each year until the standards are developed, provide the Legislature with a report on the progress of the International Organization for Standardization in developing new design standards for connections for intravenous, epidural, or enteral applications.

(e) A health facility that is required to develop a patient safety plan pursuant to Section 1279.6 shall include in the patient safety plan measures to prevent adverse events associated with misconnecting intravenous, enteral feeding, and epidural lines. This subdivision shall become inoperative as to epidural connections upon the operative date of subdivision (b) and as to intravenous and enteral connections upon the operative date of subdivision (c).

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**CHAPTER 2. HEALTH FACILITIES**

**Article 3.5. Hospital Infectious Disease Control Program**

1288.45. For purposes of this article, the following definitions shall apply:

(a) "Advisory committee" or "HAI-AC" means the Healthcare Associated Infection Advisory Committee established pursuant to Section 1288.5.

(b) "Health-care-associated infection," "health facility acquired infection," or "HAI" means an infection defined by the National Health and Safety Network of the federal Centers for Disease Control and Prevention, unless the department adopts a definition consistent with the recommendations of the advisory committee or its successor.

(c) "Hospital" means a general acute care hospital as defined pursuant to subdivision (a) of Section 1250.

(d) "Infection prevention professional" means a registered nurse, medical technologist, or other salaried employee or consultant who, within two years of appointment, will meet the education and experience requirements for certification established by the national Certification Board for Infection Control and Epidemiology (CBIC), but does not include a physician who is appointed or receives a stipend as the infection prevention and control committee chairperson or hospital epidemiologist.

(e) "MRSA" means methicillin-resistant *Staphylococcus aureus*.

(f) "National Healthcare Safety Network" or "NHSN" means a secure, Internet-based system developed and managed by the federal Centers for Disease Control and Prevention (CDC) to collect, analyze, and report risk-adjusted HAI data related to the incidence of HAI and the process measures implemented to prevent these infections.

(g) "Program" means the health care infection surveillance, prevention, and control program within the department.

1288.5. (a) By July 1, 2007, the department shall appoint a Healthcare Associated Infection Advisory Committee (HAI-AC) that shall make recommendations related to methods of reporting cases of hospital acquired infections occurring in general acute care hospitals, and shall make recommendations on the use of national guidelines and the public reporting of process measures for preventing the spread of HAI that are reported to the department pursuant to subdivision (b) of Section 1288.8.

(b) The advisory committee shall include persons with expertise in the surveillance, prevention, and control of hospital-acquired infections, including department staff, local health department officials, health care infection control professionals, hospital

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administration professionals, health care providers, health care consumers, physicians with expertise in infectious disease and hospital epidemiology, and integrated health care systems experts or representatives.

(c) The advisory committee shall meet at least every quarter and shall serve without compensation, but shall be reimbursed for travel-related expenses that include transportation, lodging, and meals at the state per diem reimbursement rate.

(d) In addition to the responsibilities enumerated in subdivision (a), the advisory committee shall do all of the following:

(1) Review and evaluate federal and state legislation, regulations, and accreditation standards and communicate to the department how hospital infection prevention and control programs will be impacted.

(2) In accordance with subdivision (a) of Section 1288.6, recommend a method by which the number of infection prevention professionals would be assessed in each hospital.

(3) Recommend an educational curriculum by which health facility evaluator nurses and department consultants would be trained to survey for hospital infection surveillance, prevention, and control programs.

(4) Recommend a method by which hospitals are audited to determine the validity and reliability of data submitted to the NHSN and the department.

(5) Recommend a standardized method by which an HAI occurring after hospital discharge would be identified.

(6) Recommend a method by which risk-adjusted HAI data would be reported to the public, the Legislature, and the Governor.

(7) Recommend a standardized method by which department health facility evaluator nurses and consultants would evaluate health care workers for compliance with infection prevention procedures including, but not limited to, hand hygiene and environmental sanitation procedures.

(8) Recommend a method by which all hospital infection prevention professionals would be trained to use the NHSN HAI surveillance reporting system.

1288.55. (a) (1) Each health facility, as defined in paragraph (3) of subdivision (a) of Section 1255.8, shall quarterly report all cases of health-care-associated MRSA bloodstream infection, health-care-associated clostridium difficile infection, and health-care-associated Vancomycin-resistant enterococcal bloodstream infection, and the number of inpatient days.

(2) Each health facility shall report quarterly to the department all central line associated bloodstream infections and the total central line days.

(3) Each health facility shall report quarterly to the department all health-care-associated surgical site infections of deep or organ space surgical sites, health-care-associated infections of orthopedic surgical sites, cardiac surgical sites, and gastrointestinal surgical sites designated as clean and clean-contaminated, and the number of surgeries involving deep or organ space, and orthopedic, cardiac, and gastrointestinal surgeries designated clean and clean-contaminated.

(b) The department's licensing and certification program shall do

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all of the following:

(1) Commencing January 1, 2011, post on the department's Web site information regarding the incidence rate of health-care-acquired central line associated bloodstream infections acquired at each health facility in California, including information on the number of inpatient days.

(2) Commencing January 1, 2012, post on the department's Web site information regarding the incidence rate of deep or organ space surgical site infections, orthopedic, cardiac, and gastrointestinal surgical procedures designated as clean and clean-contaminated, acquired at each health facility in California, including information on the number of inpatient days.

(3) No later than January 1, 2011, post on the department's Web site information regarding the incidence rate of health-care-associated MRSA bloodstream infection, health-care-associated clostridium difficile infection, and health-care-associated Vancomycin-resistant enterococcal bloodstream infection, at each health facility in California, including information on the number of inpatient days.

(c) Any information reported publicly as required under this section shall meet all of the following requirements:

(1) The department shall follow a risk adjustment process that is consistent with the federal Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN), or its successor, risk adjustment, and use its definitions, unless the department adopts, by regulation, a fair and equitable risk adjustment process that is consistent with the recommendations of the Healthcare Associated Infection Advisory Committee (HAI-AC), established pursuant to Section 1288.5, or its successor.

(2) For purposes of reporting, as required in subdivisions (a) and (b), an infection shall be reported using the NHSN definitions unless the department accepts the recommendation of the HAI-AC or its successor.

(3) If the federal Centers for Disease Control and Prevention do not use a public reporting model for specific health-care-acquired infections, then the department shall base its public reporting of incidence rate on the number of inpatient device days for infection reporting, or the number of specified device days for relevant device-related infections, and the number of specified surgeries conducted for surgical site infection reporting, unless the department adopts a public reporting model that is consistent with recommendations of the HAI-AC or its successor.

(d) Health facilities that report data pursuant to the system shall report this data to the NHSN and the department, as appropriate.

1288.6. (a) (1) Each general acute care hospital, in collaboration with infection prevention and control professionals, and with the participation of senior health care facility leadership shall, as a component of its strategic plan, at least once every three years, prepare a written report that examines the hospital's existing resources and evaluates the quality and effectiveness of the hospital's infection surveillance and prevention program.

(2) The report shall evaluate and include information on all of the following:

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(A) The risk and cost of the number of invasive patient procedures performed at the hospital.

(B) The number of intensive care beds.

(C) The number of emergency department visits to the hospital.

(D) The number of outpatient visits by departments.

(E) The number of licensed beds.

(F) Employee health and occupational health measures implemented at the hospital.

(G) Changing demographics of the community being served by the hospital.

(H) An estimate of the need and recommendations for additional resources for infection prevention and control programs necessary to address the findings of the plan.

(3) The report shall be updated annually, and shall be revised at regular intervals, if necessary, to accommodate technological advances and new information and findings contained in the triennial strategic plan with respect to improving disease surveillance and the prevention of HAI.

(b) Each general acute care hospital that uses central venous catheters (CVCs) shall implement policies and procedures to prevent occurrences of health care associated infection, as recommended by the Centers for Disease Control and Prevention intravascular bloodstream infection guidelines or other evidence-based national guidelines, as recommended by the advisory committee. A general acute care hospital that uses CVCs shall internally report CVC associated blood stream infection rates in intensive care units, utilizing device days to calculate the rate for each type of intensive care unit, to the appropriate medical staff committee of the hospital on a regular basis.

1288.7. By July 1, 2007, the department shall require that each general acute care hospital, in accordance with the Centers for Disease Control guidelines, take all of the following actions:

(a) Annually offer onsite influenza vaccinations, if available, to all hospital employees at no cost to the employee. Each general acute care hospital shall require its employees to be vaccinated, or if the employee elects not to be vaccinated, to declare in writing that he or she has declined the vaccination.

(b) Institute respiratory hygiene and cough etiquette protocols, develop and implement procedures for the isolation of patients with influenza, and adopt a seasonal influenza plan.

(c) Revise an existing or develop a new disaster plan that includes a pandemic influenza component. The plan shall also document any actual or recommended collaboration with local, regional, and state public health agencies or officials in the event of an influenza pandemic.

1288.8. (a) By January 1, 2008, the department shall take all of the following actions to protect against HAI in general acute care hospitals statewide:

(1) Implement an HAI surveillance and prevention program designed to assess the department's resource needs, educate health facility evaluator nurses in HAI, and educate department staff on methods of implementing recommendations for disease prevention.

(2) Revise existing and adopt new administrative regulations, as

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necessary, to incorporate current federal Centers for Disease Control and Prevention (CDC) guidelines and standards for HAI prevention.

(3) Require that general acute care hospitals develop a process for evaluating the judicious use of antibiotics, the results of which shall be monitored jointly by appropriate representatives and committees involved in quality improvement activities.

(b) On and after January 1, 2008, each general acute care hospital shall implement and annually report to the department on its implementation of infection surveillance and infection prevention process measures that have been recommended by the federal Centers for Disease Control and Prevention Healthcare Infection Control Practices Advisory Committee, as suitable for a mandatory public reporting program. Initially, these process measures shall include the CDC guidelines for central line insertion practices, surgical antimicrobial prophylaxis, and influenza vaccination of patients and healthcare personnel. In consultation with the advisory committee, the department shall make this information public no later than six months after receiving the data.

(c) The advisory committee shall make recommendations for phasing in the implementation and public reporting of additional process measures and outcome measures by January 1, 2008, and, in doing so, shall consider the measures recommended by the CDC.

(d) Each general acute care hospital shall also submit data on implemented process measures to the National Healthcare Safety Network of the CDC, or to any other scientifically valid national HAI reporting system based upon the recommendation of the federal Centers for Disease Control and Prevention Healthcare Infection Control Practices Advisory Committee or to another scientifically valid reporting database, as determined by the department based on the recommendations of the HAI-AC. Hospitals shall utilize the federal Centers for Disease Control and Prevention definitions and methodology for surveillance of HAI. Hospitals participating in the California Hospital Assessment and Reporting Task Force (CHART) shall publicly report those HAI measures as agreed to by all CHART hospitals.

(e) In addition to the requirements in subdivision (a), the department shall establish an infection surveillance, prevention, and control program to do all of the following:

(1) Designate infection prevention professionals to serve as consultants to the licensing and certification program.

(2) Provide education and training to department health facility evaluator nurses and consultants to effectively survey hospitals for compliance with infection surveillance, prevention, and control recommendations, as well as state and federal statutes and regulations.

(3) By January 1, 2011, in consultation with the HAI-AC, develop a scientifically valid statewide electronic reporting system or utilize an existing scientifically valid database system capable of receiving electronically transmitted reports from hospitals related to HAI.

(4) Provide current infection prevention and control information to the public on the Internet.

(5) Beginning January 1, 2011, provide to the Governor, the Legislature, and the Chairs of the Senate Committee on Health and Assembly Committee on Health, and post on the department's Web site, an annual report of publicly reported HAI infection information

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received and reported pursuant to this article.

1288.9. By January 1, 2009, the department shall do all of the following:

(a) Require each general acute care hospital to develop, implement, and periodically evaluate compliance with policies and procedures to prevent secondary surgical site infections (SSI). The results of this evaluation shall be monitored by the infection prevention committee and reported to the surgical committee of the hospital.

(b) Require each general acute care hospital to develop policies and procedures to implement the current Centers for Disease Control and Prevention guidelines and Institute for Healthcare Improvement (IHI) process measures designed to prevent ventilator associated pneumonia.

(c) During surveys, evaluate the facility's compliance with existing policies and procedures to prevent HAI, including any externally or internally reported HAI process and outcome measures.

1288.95. (a) No later than January 1, 2010, a physician designated as a hospital epidemiologist or infection surveillance, prevention, and control committee chairperson shall participate in a continuing medical education (CME) training program offered by the federal Centers for Disease Control and Prevention (CDC) and the Society for Healthcare Epidemiologists of America, or other recognized professional organization. The CME program shall be specific to infection surveillance, prevention, and control. Documentation of attendance shall be placed in the physician's credentialing file.

(b) Beginning January 2010, all staff and contract physicians and all other licensed independent contractors, including, but not limited to, nurse practitioners and physician assistants, shall be trained in methods to prevent transmission of HAI, including, but not limited to, MRSA and Clostridium difficile infection.

(c) By January 2010, all permanent and temporary hospital employees and contractual staff, including students, shall be trained in hospital-specific infection prevention and control policies, including, but not limited to, hand hygiene, facility-specific isolation procedures, patient hygiene, and environmental sanitation procedures. The training shall be given annually and when new policies have been adopted by the infection surveillance, prevention, and control committee.

(d) Environmental services staff shall be trained by the hospital and shall be observed for compliance with hospital sanitation measures. The training shall be given at the start of employment, when new prevention measures have been adopted, and annually thereafter. Cultures of the environment may be randomly obtained by the hospital to determine compliance with hospital sanitation procedures.

**DIVISION 105. COMMUNICABLE DISEASE PREVENTION AND CONTROL**  
**PART 2. IMMUNIZATIONS**  
**CHAPTER 1.6. INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS**

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120392.9. Pursuant to its standardized procedures and if it has the vaccine in its possession, each year, commencing October 1 to the following April 1, inclusive, a general acute care hospital, as defined in subdivision (a) of Section 1250, shall offer, prior to discharge, immunizations for influenza and pneumococcal disease to inpatients, aged 65 years or older, based upon the adult immunization recommendations of the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention, and the recommendations of appropriate entities for the prevention, detection, and control of influenza outbreaks in California general acute care hospitals.

#### **DIVISION 107. STATEWIDE HEALTH PLANNING AND DEVELOPMENT**

##### **PART 2. HEALTH POLICY AND PLANNING**

##### **CHAPTER 2. HEALTH POLICY RESEARCH AND EVALUATION**

##### **Article 3. Hospital Fair Pricing Policies**

127400. As used in this article, the following terms have the following meanings:

(a) "Allowance for financially qualified patient" means, with respect to services rendered to a financially qualified patient, an allowance that is applied after the hospital's charges are imposed on the patient, due to the patient's determined financial inability to pay the charges.

(b) "Federal poverty level" means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

(c) "Financially qualified patient" means a patient who is both of the following:

(1) A patient who is a self-pay patient, as defined in subdivision (f) or a patient with high medical costs, as defined in subdivision (g).

(2) A patient who has a family income that does not exceed 350 percent of the federal poverty level.

(d) "Hospital" means a facility that is required to be licensed under subdivision (a), (b), or (f) of Section 1250, except a facility operated by the State Department of Mental Health or the Department of Corrections and Rehabilitation.

(e) "Office" means the Office of Statewide Health Planning and Development.

(f) "Self-pay patient" means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital. Self-pay patients may include charity care patients.

(g) "A patient with high medical costs" means a person whose family income does not exceed 350 percent of the federal poverty level, as defined in subdivision (b), if that individual does not receive a discounted rate from the hospital as a result of his or her third-party coverage. For these purposes, "high medical costs" means

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any of the following:

(1) Annual out-of-pocket costs incurred by the individual at the hospital that exceed 10 percent of the patient's family income in the prior 12 months.

(2) Annual out-of-pocket expenses that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

(3) A lower level determined by the hospital in accordance with the hospital's charity care policy.

(h) "Patient's family" means the following:

(1) For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family **Code**, and dependent children under 21 years of age, whether living at home or not.

(2) For persons under 18 years of age, parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

127401. Each general acute care hospital licensed pursuant to subdivision (a) of Section 1250 shall comply with the provisions of this article as a condition of licensure. The State Department of Health Services shall be responsible for the enforcement of these provisions.

127405. (a) (1) Each hospital shall maintain an understandable written policy regarding discount payments for financially qualified patients as well as an understandable written charity care policy. Uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level, as defined in subdivision (b) of Section 127400, shall be eligible to apply for participation under a hospital's charity care policy or discount payment policy. Notwithstanding any other provision of this article, a hospital may choose to grant eligibility for its discount payment policy or charity care policies to patients with incomes over 350 percent of the federal poverty level. Both the charity care policy and the discount payment policy shall state the process used by the hospital to determine whether a patient is eligible for charity care or discounted payment. In the event of a dispute, a patient may seek review from the business manager, chief financial officer, or other appropriate manager as designated in the charity care policy and the discount payment policy.

(2) Rural hospitals, as defined in Section 124840, may establish eligibility levels for financial assistance and charity care at less than 350 percent of the federal poverty level as appropriate to maintain their financial and operational integrity.

(b) A hospital's discount payment policy shall clearly state eligibility criteria based upon income consistent with the application of the federal poverty level. The discount payment policy shall also include an extended payment plan to allow payment of the discounted price over time. The policy shall provide that the hospital and the patient may negotiate the terms of the payment plan.

(c) The charity care policy shall state clearly the eligibility criteria for charity care. In determining eligibility under its charity care policy, a hospital may consider income and monetary assets of the patient. For purposes of this determination, monetary

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assets shall not include retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans. Furthermore, the first ten thousand dollars (\$10,000) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars (\$10,000) be counted in determining eligibility.

(d) A hospital shall limit expected payment for services it provides to a patient at or below 350 percent of the federal poverty level, as defined in subdivision (b) of Section 124700, eligible under its discount payment policy to the amount of payment the hospital would expect, in good faith, to receive for providing services from Medicare, Medi-Cal, Healthy Families, or another government-sponsored health program of health benefits in which the hospital participates, whichever is greater. If the hospital provides a service for which there is no established payment by Medicare or any other government-sponsored program of health benefits in which the hospital participates, the hospital shall establish an appropriate discounted payment.

(e) A patient, or patient's legal representative, who requests a discounted payment, charity care, or other assistance in meeting his or her financial obligation to the hospital shall make every reasonable effort to provide the hospital with documentation of income and health benefits coverage. If the person requests charity care or a discounted payment and fails to provide information that is reasonable and necessary for the hospital to make a determination, the hospital may consider that failure in making its determination.

(1) For purposes of determining eligibility for discounted payment, documentation of income shall be limited to recent pay stubs or income tax returns.

(2) For purposes of determining eligibility for charity care, documentation of assets may include information on all monetary assets, but shall not include statements on retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans. A hospital may require waivers or releases from the patient or the patient's family, authorizing the hospital to obtain account information from financial or commercial institutions, or other entities that hold or maintain the monetary assets, to verify their value.

(3) Information obtained pursuant to paragraph (1) or (2) shall not be used for collections activities. This paragraph does not prohibit the use of information obtained by the hospital, collection agency, or assignee independently of the eligibility process for charity care or discounted payment.

(4) Eligibility for discounted payments or charity care may be determined at any time the hospital is in receipt of information specified in paragraph (1) or (2), respectively.

127410. (a) Each hospital shall provide patients with a written notice that shall contain information about availability of the hospital's discount payment and charity care policies, including information about eligibility, as well as contact information for a hospital employee or office from which the person may obtain further information about these policies. This written notice shall be provided in addition to the estimate provided pursuant to Section

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1339.585. The notice shall also be provided to patients who receive emergency or outpatient care and who may be billed for that care, but who were not admitted. The notice shall be provided in English, and in languages other than English. The languages to be provided shall be determined in a manner similar to that required pursuant to Section 12693.30 of the Insurance Code. Written correspondence to the patient required by this article shall also be in the language spoken by the patient, consistent with Section 12693.30 of the Insurance Code and applicable state and federal law.

(b) Notice of the hospital's policy for financially qualified and self-pay patients shall be clearly and conspicuously posted in locations that are visible to the public, including, but not limited to, all of the following:

- (1) Emergency department, if any.
- (2) Billing office.
- (3) Admissions office.
- (4) Other outpatient settings.

127420. (a) Each hospital shall make all reasonable efforts to obtain from the patient or his or her representative information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered by the hospital to a patient, including, but not limited to, any of the following:

- (1) Private health insurance.
- (2) Medicare.

(3) The Medi-Cal program, the Healthy Families Program, the California Childrens' Services Program, or other state-funded programs designed to provide health coverage.

(b) If a hospital bills a patient who has not provided proof of coverage by a third party at the time the care is provided or upon discharge, as a part of that billing, the hospital shall provide the patient with a clear and conspicuous notice that includes all of the following:

- (1) A statement of charges for services rendered by the hospital.
- (2) A request that the patient inform the hospital if the patient has health insurance coverage, Medicare, Healthy Families, Medi-Cal, or other coverage.
- (3) A statement that if the consumer does not have health insurance coverage, the consumer may be eligible for Medicare, Healthy Families, Medi-Cal, California Childrens' Services Program, or charity care.
- (4) A statement indicating how patients may obtain applications for the Medi-Cal program and the Healthy Families Program and that the hospital will provide these applications. If the patient does not indicate coverage by a third-party payer specified in subdivision (a), or requests a discounted price or charity care then the hospital shall provide an application for the Medi-Cal program, the Healthy Families Program or other governmental program to the patient. This application shall be provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient care.

(5) Information regarding the financially qualified patient and charity care application, including the following:

(A) A statement that indicates that if the patient lacks, or has inadequate, insurance, and meets certain low- and moderate-income requirements, the patient may qualify for discounted payment or

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charity care.

(B) The name and telephone number of a hospital employee or office from whom or which the patient may obtain information about the hospital's discount payment and charity care policies, and how to apply for that assistance.

127425. (a) Each hospital shall have a written policy about when and under whose authority patient debt is advanced for collection, whether the collection activity is conducted by the hospital, an affiliate or subsidiary of the hospital, or by an external collection agency.

(b) Each hospital shall establish a written policy defining standards and practices for the collection of debt, and shall obtain a written agreement from any agency that collects hospital receivables that it will adhere to the hospital's standards and scope of practices. The policy shall not conflict with other applicable laws and shall not be construed to create a joint venture between the hospital and the external entity, or otherwise to allow hospital governance of an external entity that collects hospital receivables. In determining the amount of a debt a hospital may seek to recover from patients who are eligible under the hospital's charity care policy or discount payment policy, the hospital may consider only income and monetary assets as limited by Section 127405.

(c) At time of billing, each hospital shall provide a written summary consistent with Section 127410, which includes the same information concerning services and charges provided to all other patients who receive care at the hospital.

(d) For a patient that lacks coverage, or for a patient that provides information that he or she may be a patient with high medical costs, as defined in this article, a hospital, any assignee of the hospital, or other owner of the patient debt, including a collection agency, shall not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 150 days after initial billing.

(e) If a patient is attempting to qualify for eligibility under the hospital's charity care or discount payment policy and is attempting in good faith to settle an outstanding bill with the hospital by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, the hospital shall not send the unpaid bill to any collection agency or other assignee, unless that entity has agreed to comply with this article.

(f) (1) The hospital or other assignee which is an affiliate or subsidiary of the hospital shall not, in dealing with patients eligible under the hospital's charity care or discount payment policies, use wage garnishments or liens on primary residences as a means of collecting unpaid hospital bills.

(2) A collection agency or other assignee that is not a subsidiary or affiliate of the hospital shall not, in dealing with any patient under the hospital's charity care or discount payment policies, use as a means of collecting unpaid hospital bills, any of the following:

(A) A wage garnishment, except by order of the court upon noticed motion, supported by a declaration filed by the movant identifying the basis for which it believes that the patient has the ability to make payments on the judgment under the wage garnishment, which the court shall consider in light of the size of the judgment and additional information provided by the patient prior to, or at, the

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hearing concerning the patient's ability to pay, including information about probable future medical expenses based on the current condition of the patient and other obligations of the patient.

(B) Notice or conduct a sale of the patient's primary residence during the life of the patient or his or her spouse, or during the period a child of the patient is a minor, or a child of the patient who has attained the age of majority is unable to take care of himself or herself and resides in the dwelling as his or her primary residence. In the event a person protected by this paragraph owns more than one dwelling, the primary residence shall be the dwelling that is the patient's current homestead, as defined in Section 704.710 of the Code of Civil Procedure or was the patient's homestead at the time of the death of a person other than the patient who is asserting the protections of this paragraph.

(3) This requirement does not preclude a hospital, collection agency, or other assignee from pursuing reimbursement and any enforcement remedy or remedies from third-party liability settlements, tortfeasors, or other legally responsible parties.

(g) Any extended payment plans offered by a hospital to assist patients eligible under the hospital's charity care policy, discount payment policy, or any other policy adopted by the hospital for assisting low-income patients with no insurance or high medical costs in settling outstanding past due hospital bills, shall be interest free. The hospital extended payment plan may be declared no longer operative after the patient's failure to make all consecutive payments due during a 90-day period. Before declaring the hospital extended payment plan no longer operative, the hospital, collection agency, or assignee shall make a reasonable attempt to contact the patient by phone and, to give notice in writing, that the extended payment plan may become inoperative, and of the opportunity to renegotiate the extended payment plan. Prior to the hospital extended payment plan being declared inoperative, the hospital, collection agency, or assignee shall attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient. The hospital, collection agency, or assignee shall not report adverse information to a consumer credit reporting agency or commence a civil action against the patient or responsible party for nonpayment prior to the time the extended payment plan is declared to be no longer operative. For purposes of this section, the notice and phone call to the patient may be made to the last known phone number and address of the patient.

(h) Nothing in this section shall be construed to diminish or eliminate any protections consumers have under existing federal and state debt collection laws, or any other consumer protections available under state or federal law. If the patient fails to make all consecutive payments for 90 days and fails to renegotiate a payment plan, this subdivision does not limit or alter the obligation of the patient to make payments on the obligation owing to the hospital pursuant to any contract or applicable statute from the date that the extended payment plan is declared no longer operative, as set forth in subdivision (g).

127430. (a) Prior to commencing collection activities against a patient, the hospital, any assignee of the hospital, or other owner of the patient debt, including a collection agency, shall provide the

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patient with a clear and conspicuous written notice containing both of the following:

(1) A plain language summary of the patient's rights pursuant to this article, the Rosenthal Fair Debt Collection Practices Act (Title 1.6C (commencing with Section 1788) of Part 4 of Division 3 of the Civil Code), and the federal Fair Debt Collection Practices Act (Subchapter V (commencing with Section 1692) of Chapter 41 of Title 15 of the United States Code). The summary shall include a statement that the Federal Trade Commission enforces the federal act.

The summary shall be sufficient if it appears in substantially the following form: "State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (382-4357) or online at [www.ftc.gov](http://www.ftc.gov)."

(2) A statement that nonprofit credit counseling services may be available in the area.

(b) The notice required by subdivision (a) shall also accompany any document indicating that the commencement of collection activities may occur.

(c) The requirements of this section shall apply to the entity engaged in the collection activities. If a hospital assigns or sells the debt to another entity, the obligations shall apply to the entity, including a collection agency, engaged in the debt collection activity.

127435. Each hospital shall provide to the office a copy of its discount payment policy, charity care policy, eligibility procedures for those policies, review process, and the application for charity care or discounted payment programs. The office may determine whether the information is to be provided electronically or in some other manner. The information shall be provided at least biennially on January 1, or when a significant change is made. If no significant change has been made by the hospital since the information was previously provided, notifying the office of the lack of change shall meet the requirements of this section. The office shall make this information available to the public.

127440. The hospital shall reimburse the patient or patients any amount actually paid in excess of the amount due under this article, including interest. Interest owed by the hospital to the patient shall accrue at the rate set forth in Section 685.010 of the **Code** of Civil Procedure, beginning on the date payment by the patient is received by the hospital. However, a hospital is not required to reimburse the patient or pay interest if the amount due is less than five dollars (\$5.00). The hospital shall give the patient a credit for the amount due for at least 60 days from the date the amount is due.

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127443. The rights, remedies, and penalties established by this article are cumulative, and shall not supersede the rights, remedies, or penalties established under other laws.

127444. Nothing in this article shall be construed to prohibit a hospital from uniformly imposing charges from its established charge schedule or published rates, nor shall this article preclude the recognition of a hospital's established charge schedule or published rates for purposes of applying any payment limit, interim payment amount, or other payment calculation based upon a hospital's rates or charges under the Medi-Cal program, the Medicare Program, workers' compensation, or other federal, state, or local public program of health benefits. No health care service plan, insurer, or any other person shall reduce the amount it would otherwise reimburse a claim for hospital services because a hospital has waived, or will waive, collection of all or a portion of a patient's bill for hospital services in accordance with the hospital's charity care or discount payment policy, notwithstanding any contractual provision.

127445. Notwithstanding any other provision of law, the amounts paid by parties for services resulting from reduced or waived charges under a hospital's discounted payment or charity care policy shall not constitute a hospital's uniform, published, prevailing, or customary charges, its usual fees to the general public, or its charges to non-Medi-Cal purchasers under comparable circumstances, and shall not be used to calculate a hospital's median non-Medicare or Medi-Cal charges, for purposes of any payment limit under the federal Medicare Program, the Medi-Cal program, or any other federal or state-financed health care program.

127446. To the extent that any requirement of Section 127400, 127401, or 127405 results in a federal determination that a hospital's established charge schedule or published rates are not the hospital's customary or prevailing charges for services, the requirement in question shall be inoperative for all general acute care hospitals, including, but not limited to, a hospital that is licensed to and operated by a county or a hospital authority established pursuant to Section 101850. The State Department of Public Health shall seek federal guidance regarding modifications to the requirement in question. All other requirements of this article shall remain in effect.