Policy & Procedure Manual

October 2011

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Safety Concerns for Clients and Staff

1.1 COBC requires a parent/guardian be present, in the home, for the duration of all services provided by a COBC employee.

1.2 To maintain safety when performing services in the community, COBC employees are required to make their appointment calendars (client appointments and meetings with other agencies) easily accessible to COBC directors. Required information to be documented includes: Name of client/event, address and/or phone number, estimated duration of appointment.

1.3 In the event of a safety concern within a client's home environment the COBC employee will assess the severity of the event and declare it either non-life threatening or life threatening. When necessary the appropriate agencies will be contacted to report the event. All situations are to be documented in writing and become part of the client's file.

a. Non-Life Threatening: Contact client's parent/guardian or emergency contact as indicated by parent/guardian on the General Information form.
b. Life Threatening: Call 911 and inform the client's parent/guardian or emergency contact as indicated by parent/guardian on the General Information form.

1.4 If the COBC employee suspects child abuse or neglect, these concerns will be reported to the appropriate agencies or authorities in a timely manner.

Childhelp® USA National Child Abuse Hotline: 1-800-422-4453

1.5 In the event a COBC employee feels threatened within a client's home, the current session will be terminated and reported to the proper authorities when appropriate. All situations are to be documented in writing and become part of the client's file.

a. The continuation of on-going treatment is determined based on further discussion with the family. This meeting should occur in a timely manner following the situation. If no resolution can be achieved, services will be terminated or the appropriate referral will be made.

1.5 For the safety of all clients and staff, COBC employees do not transport clients or client's family members in staff member's vehicles.

Hazardous Materials & Bodily Fluids

2.1 If applicable, the parent/guardian is responsible for changing all wet or soiled diapers during a treatment session with COBC employees.

2.2 If the client engages in self-injurious behaviors or other aggressive behaviors that result in minor injury to the client, COBC employees will ask the parent/guardian to come into the area where treatment is being provided to administer basic first aid. The COBC employee is to assist in managing the client's behaviors to allow the parent/guardian to provide the required care. Basic first aid must be provided and any bodily fluids must be properly cleaned prior to the continuation of the treatment session.

2.3 Parent(s)/Guardian(s) are informed of these expectations when they receive COBC's Infectious Illness Policy (See Appendix A) and acknowledgment of this policy will be obtained through signature (See Appendix D).

Weather Concerns

3.1 All appointments will be kept whenever possible; however in the event an appointment needs to be cancelled due to inclement weather the COBC employee will make every effort to contact the parent/guardian. A message will be left through voicemail, text message and/or e-mail as applicable.

a. Final decisions to cancel will be made no later than 1 hour prior to the scheduled session.

b. Cancellation guidelines during a snow emergency:
Level 1 Snow Emergency = Cancellation is at the discretion of the COBC employee and/or the parent/guardian.

Level 2 Snow Emergency = Session Cancelled

Level 3 Snow Emergency = Session Cancelled

3.2 If weather affects the provision of services for prolonged periods of time all attempts will be made to contact the family (phone, voicemail, text message, e-mail) to inform them of these extended cancellations. When service can resume the family will be notified within 48 hours of the first day COBC will resume services. All attempts made to reschedule any missed appointments dependent on availability of family/client and COBC employee.

3.3 Parent(s)/Guardian(s) are informed of these expectations when they receive COBC's Severe Weather Policy (See Appendix B) and acknowledgment of this policy will be obtained through signature (See Appendix D).

Treatment Records

4.1 To the best of our ability COBC retains all records in hard copy (paper) and electronic format. A back up file of treatment records are created on a regular basis. If records are lost, stolen or destroyed COBC will immediately inform parents/guardians/clients of any lost, stolen or destroyed records upon discovery.

a. If the paper copy file has been affected, a new version will be reprinted.
b. If the electronic copy has been affected, a new version will be scanned.
c. If the electronic and paper copies have been affected, attempts will be made to retrieve the file(s) from our back-up system.
d. In the event that COBC has lost all copies through disaster, theft or accidental causes the parent/guardian or appropriate agency will be contacted in an attempt to recoup the files.

4.2 In order to maintain the confidentially and safety of each client's treatment record, information will kept on a password locked computer and/or locked file cabinet. Minimal identifies are used in visual filing systems.

4.3 Records are minimally transported by COBC employees. When it is necessary to transport treatment records, minimal documentation will be taken and will be kept with a staff member at all times or in a locked location. All identifiers will be shielded from view of persons not employed by COBC.

4.4 COBC employees have access to all records in both formats.

4.5 Parent(s)/Guardian(s) are informed of these expectations when they receive COBC's Treatment Records Policy (See Appendix C) and acknowledgment of this policy will be obtained through signature (See Appendix D).

Infection Control

5.1 The following will lead to cancellation of a session on behalf of the client or COBC employee. It is the responsibility of the parent/guardian or COBC employee to notify the appropriate person(s) as soon as they are aware the cancellation will need to take place but no less than 1 hour prior to the scheduled appointment time.

a. Fever or presence of infectious illness that has been treated by antibiotics for less than 24 hours.
b. Presence of vomiting, diarrhea or infectious illness that has been treated for less than 24 hours in a parent, sibling or anyone residing in the home of the client.
c. Presence of one or more of the infectious diseases as listed by the Ohio Department of Health that has not been properly treated to avoid the spread of that disease.

5.2 Continuation of sessions will be dependent upon consumption of antibiotics as prescribed by a physician or nurse practioner for 24 hours following diagnosis **and/or** fever free for 24 hours without assistance from a fever reducer.

5.3 To minimize the spread of infection, all COBC employees carry hand sanitizer, disposable gloves and practice proper hand washing techniques as outlined in the Nationwide Children's Hospital Helping Hands – Hand Hygiene handout (See Appendix X). COBC employees receive a copy of this handout upon hire.

5.4 Upon hire, COBC employees are required to read the "Universal Precautions: An Educational Training for Child Care Providers" as created by Jane Cotler, RN, MS and Chris Perreault, RN, BSN (See Appendix Y).

5.5 COBC employees are provided with a copy of the list of infectious diseases as listed by the Ohio Department of Health.

a. If upon entry into the client's home it is learned the client has one of the diseases listed by the Ohio Department of Health, the COBC employee will cancel that session and inform the local health department.
b. The Union County Health Department has agreed to share information with the appropriate county in the event the client does not live within Union County.

Number for Reporting: 937.642.2053

5.6 Parent(s)/Guardian(s) are informed of these expectations when they receive COBC's Infectious Illness Policy (See Appendix A) and acknowledgment of this policy will be obtained through signature (See Appendix D).

Management of Information

Sentinel Events

6.1 Following the occurrence of a sentinel event the following actions will be taken:

The event will be identified.
All precursors to the event will be documented.
Ways to prevent future occurrences of the event will be generated.
Those impacted by the event will be briefed on the information gathered and preventative strategies.
All appropriate agencies will be notified of the event and the findings.

6.2 Any sentinel events will be reported using the *Event Reporting* form (See Appendix E).

Continuum of Care

7.1 Population

COBC serves individuals ranging in age from 1-22 years old with an autism spectrum disorder, a suspected autism spectrum disorder or other developmental delay not combined with a major medical condition that would impact the effectiveness of ABA. If the individual has a diagnosis other than an autism spectrum disorder, service will be provided at the discretion of COBC directors.

7.2 Service Options

Our services include; In Home Consultation, Parent Training, Educational Advocacy and Social Skills Groups.

In Home Consultation involves a team that includes the client, a COBC consultant, parent(s)/guardian(s) and staff members (hired by the family) providing 1:1 behavior intervention in the home, school, and community to increase areas of skill deficit and reduce problem behaviors.

Parent training involves COBC consultants working with parents to give them the strategies needed to teach their child new skills and help reduce problem behaviors. This is provided as an essential piece of in home consultation or as an independent service in the absence of a team of staff members.

Educational Advocacy helps families navigate the educational system including RtI, 504, ETR, and IEP processes. COBC consultants work with the child's educational team to help improve the overall classroom learning experience.

Social Skills Groups provide participants with an opportunity to learn and practice social skills with similar age peers.

COBC also provides services as a contracted agency through a daycare, preschool or school system. These services often include additional educational opportunities for those staff.

7.3 Our Process

Initial Consultation

Following a referral from another agency or direct contact by the parent/guardian an initial consultation appointment is scheduled. Typically during this appointment services are discussed, questions are discussed, funding is reviewed, the intake appointment is scheduled and initial paperwork is completed (see below).

General Information Form (See Appendix F)
Electronic Consent (See Appendix G)
Authorization to Receive Information (See Appendix H)

Intake Appointment

The intake appointment is the first step in treatment delivery. This appointment often includes observation of the client and initial assessment(s) of the target behavior in addition to the review and completion of additional paperwork.

- HIPAA Privacy Notice (See Appendix I)
- Agreement to HIPAA Privacy Notice (See Appendix J)
- Marketing/Promotional Release (See Appendix K)
- Infectious Illness Policy (See Appendix A)
- Severe Weather Policy (See Appendix B)
- Treatment Records Policy (See Appendix C)
- Policy Signature Page (See Appendix D)
- Service Agreement (See Appendix L)
- Intake Form (See Appendix M)
- NIDA Quick Screen V1.0 (when client is over age 12) (See Appendix N)

During the intake appointment data collection will begin using a combination of the following:

- F.A.S.T (See Appendix O)
- ABC Logs (See Appendix P)
- Frequency count of the target behavior(s) (See Appendix Q)
- Preference Assessment (See Appendix R)
- Self Help Skills Inventory (See Appendix S)

Prior to the start of treatment COBC will request the most current treatment plan or evaluation for any current services the client is receiving (i.e. Occupational Therapy, Physical Therapy, Speech Therapy, Psychological Services) a copy of any formal school documentation (i.e. IEP, ETR) and/or a diagnostic evaluation.

<u>Service Agreement</u>

The service agreement outlines the following areas and is agreed upon by the parent/guardian prior to the start of service and training.

- Population and diagnoses to which COBC provides services
- Agreement to release necessary information to COBC
- Parent/Guardian request for COBC's services
- Parent/Guardian expectations during treatment
- Parent/Guardian agreement to follow recommendations made by COBC
- Hours required for service provision (minimum & recommended hours)
- Billing and Payment
- Cancellation Policy
- Termination of services

Intake Form

The intake form is completed by the COBC employee in an interview format with the parent/guardian and client when appropriate. The following types of information are gathered regarding the client during the completion of this interview.

- Client's diagnosis, presenting problems
- Living arrangement(s)
- Medical History (family, when appropriate)
- General Medical Concerns
- Developmental History
- Treatment History (family, when appropriate)
- Client's Strengths
- Challenging behaviors (including description & frequency)
- Language profile
- Adaptive functioning assessment
- Leisure activities
- Community involvement
- Skill building abilities
- School placement
- Goals for Treatment
- Current Funding
- Observations & Recommendations

7.4 Treatment Timeline

The goal of treatment for each client is to meet the goals set forth by the parent/guardian and consultant. In addition COBC strives for clients to be as independent as possible in all areas of functioning including life skills and social skills as well as to cope with common everyday stressors and challenges.

All goals are established through initial and on-going assessments of the client and information gathered through parents/guardians and/or other service providers involved in the client's case.

Following collection of data, a formal plan will be developed to address each of these goals. COBC consultant trains the parent(s)/guardian(s) and other service providers on the plan initially and on an on-going basis. Training with the intervention team will occur at minimum 1x/month.

Data will be collected on each goal by the parent(s)/guardian(s) and other staff. Data are reported to the COBC consultant for analysis. Decisions to continue, master or discontinue a current goal or introduce a new goal are based on the data.

These decisions will be made at minimum 1x per month during consultation meetings with the intervention team. During consultation meetings feedback on current implementation is essential as well as continued training on current and future goals.

7.5 Transition of Services

COBC consultant meets on a bi-annual basis with the family and client to discuss progress toward goals. If at that time it is determined by the family and consultant that services are no longer needed or are no longer appropriate because previously established treatment goals have been met, the client has met the age limit set by COBC or other services are deemed more appropriate, COBC will work with the family and client to determine the most appropriate services and referral agencies as well as set a timeline for transition. The parent/guardian and client, when appropriate, will sign a written transition summary (See Appendix T).

7.6 In the event records need to be released or transferred to another agency, COBC will first obtain consent from the client's parent/guardian (See Appendix U).

Human Resources

8.1 COBC directors will conduct annual evaluations reflecting the competency and performance of each staff member (See Appendix V) based upon the job description (See Appendix W).

8.2 COBC employees are expected to further their education by receiving on-going training. COBC employees are required to secure these training hours independently.

8.3 Upon hire, each COBC employee is required to provide a recent copy of their resume/vita, background checks and BCBA certificate.

8.4 COBC employees meet for weekly supervision to discuss client concerns. Each meeting is documented (See Appendix AA).

Complaints

9.1 Each parent/guardian and/or client has the right to share complaints regarding the service they are being provided by COBC and its employees.

Complaints regarding adherence to HIPAA can be sent to:

HIPAA Compliance Officer
PO Box 915
Marysville, OH 43040

9.2 Complaints regarding the conduct of a COBC employee can be directed to the Behavior Analyst Certification Board (BACB) by visiting their website, www.bacb.com or by sending complaints in writing to:

Behavior Analyst Certification Board, Inc
Disciplinary Matters
2888 Remington Green Lane, Suite C
Tallahassee, Florida 32308

Appendix A
Infectious Illness Policy

Infectious Illness Policy

The following will lead to cancellation of a session either by the parent/guardian or the COBC employee.

a. Fever or presence of infectious illness that has been treated by antibiotics for less than 24 hours.
b. Presence of vomiting, diarrhea or infectious illness that has been treated for less than 24 hours in a parent or sibling of the client.
c. Presence of one or more of the infectious diseases as listed by the Ohio Department of Health that has not been properly treated to avoid the spread of that disease.

It is the responsibility of the parent/guardian or COBC employee to notify the appropriate person(s) as soon as they are aware the cancellation will need to take place but no less than 1 hour prior to the scheduled appointment time.

Continuation of sessions will be dependent upon consumption of antibiotics as prescribed by a physician or nurse practioner for 24 hours following diagnosis **and/or** fever free for 24 hours without assistance from a fever reducer.

If the presence of an infectious disease is noted, COBC consultants are required to report it to the health department.

Universal Precautions
In the event bodily fluids become present during a session as the result of SIB, aggressions, illness or toileting needs the parent/guardian will be asked to attend to the situation. COBC consultants will assist in behavior management as appropriate.

Appendix B
Severe Weather Policy

Severe Weather Policy

All appointments will be kept whenever possible; however occasionally an appointment may need to be cancelled due to severe weather. Our consultants will make every attempt to inform the parent/guardian of a cancellation due to severe weather through phone call, text message and/or e-mail. We ask that you make your consultant aware of any severe weather conditions COBC may not be aware of due to your unique location conditions.

Our general guidelines are as follows:

Final decisions to cancel will be made no later than 1 hour prior to the scheduled session.

Cancellation guidelines during a snow emergency (applies to the county of residence for the client and the county of residence for the consultant):

Level 1 Snow Emergency = Cancellation is at the discretion of the COBC consultant and/or the parent/guardian

Level 2 Snow Emergency = Session Cancelled

Level 3 Snow Emergency = Session Cancelled

In the event severe weather impacts sessions taking place over more than 1 day, COBC and the parent/guardian will discuss a date for sessions to resume. COBC will make attempts to reschedule any missed appointments dependent on the availability of the family and the consultant.

Appendix C
Treatment Records Policy

Treatment Records Policy

To the best of our ability COBC retains all records in hard copy (paper) and electronic format. A back up file of treatment records are created on a regular basis. COBC maintains the confidentiality and safety of each client's treatment record by using minimal identifiers in the filing system(s), information is kept on a password locked computer and/or locked file cabinet and files will be minimally transported by COBC staff. COBC staff will have access to all records in both formats.

In the event treatment records are lost, stolen or destroyed COBC will immediately inform parents/guardians/clients upon discovery.

a. If the paper copy file has been affected, a new version will be reprinted.
b. If the electronic copy has been affected, a new version will be scanned.
c. If the electronic and paper copies have been affected, attempts will be made to retrieve the file(s) from our back-up system.
d. In the event that COBC has lost all copies through disaster, theft or accidental causes the parent/guardian or appropriate agency will be contacted in an attempt to recoup the files.

Appendix D
Policy Signature Page

Policy Signature Page

I have read and waive receipt of a paper copy of the following policies; however I may request a copy of each policy at any time.

	Infectious Illness Policy
	Severe Weather Policy
	Treatment Records Policy

I have read and received a paper copy of the following policies:

	Infectious Illness Policy
	Severe Weather Policy
	Treatment Records Policy

* All policies can be found on our website, www.cobcLLC.com.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date

Appendix E
Event Reporting

Event Reporting

Date Reported: _____ Date of Event: _____

Time Reported: _____ Time of Event: _____

Name of person completing report: _____

Name of person(s) involved in event: _____

_____

Event: _____

_____

_____

_____

Identified Precursors to Event: _____

_____

_____

_____

Potential Ways to Prevent Future Occurrences: _____

_____

_____

_____

Those involved were briefed on preventative strategies should a similar situation arise in the future (circle Yes or No): Yes No

Note any important reactions to these findings: _____

_____

_____

_____

Appropriate agencies were notified (circle Yes or No): Yes No

Indicate agencies contacted: _____

_____

_____

Appendix F
General Information Form

General Information Form

Client Information: Date: _____

Patient Name: _____
Last First Middle

Date of Birth: _____-_____-_____ Social Security #: _____-_____-___

Address: _____

City: _____ State: _____ Zip: _____

Gender: [ ] Male [ ] Female Home Phone: (____)_____-_____
May We Leave a Message [ ] Yes [ ] No

Cell Phone: (____)_____-_____
May We Leave a VM Message [ ] Yes [ ] No Other Phone: (____)_____-_____
May We Leave a Text Message [ ] Yes [ ] No May We Leave a Message [ ] Yes [ ] No

Primary Care Physician: _____ Phone: _____

Insurance Information:

Insured's Name: _____

Insured's place of employment: _____

Insured's Date of Birth: _____-_____-_____ Social Security #: _____-_____-_____

Insurance Carrier: _____ Plan Name/Plan #: _____

Group/Account: _____ ID: _____

If different from above:
Address: _____

City: _____ State: _____ Zip: _____

I have provided a copy of my insurance card: [ ] Yes [ ] No

In Case of Emergency, Contact:

Name: _____ Relationship: _____

Phone: (____)_____-_____

Who referred you to COBC? _____ *May We Thank Them [ ] Yes [ ] No*

Appendix G
Electronic Consent Form

Electronic Consent Form

I, _____, give permission to Central Ohio
(Name of Parent(s)/Guardian(s))

Behavioral Consulting, LLC to correspond with me regarding my child,

_____, through electronic mail.
(Child's name)

E-mail address(es):

_____

_____

By consenting to correspond through electronic mail, I also agree to the following:

- This form of communication can pose a risk of accidental dissemination of confidential information regarding my child.
- E-mails sent or received can be printed and included as part of my child's record.
- E-mails may be forwarded internally.
- Any change in e-mail address will be provided as soon as possible.
- Confirmation that I have received and read the email will be provided.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date

Additional Electronic Consent

I, _____, give permission to Central Ohio Behavioral Consulting, LLC
(Name of Parent(s)/Guardian(s))

to correspond with the following individuals regarding my child, _____,
(Child's name)

through electronic mail.

1. _____
(Individual name)

_____
(email address)

2. _____
(Individual name)

_____
(email address)

3. _____
(Individual name)

_____
(email address)

4. _____
(Individual name)

_____
(email address)

By consenting to correspond through electronic mail, I also agree to the following:

- This form of communication can pose a risk of accidental dissemination of confidential information regarding my child.
- E-mails sent or received can be printed and included as part of my child's record.
- E-mails may be forwarded internally.
- Any change in e-mail address will be provided as soon as possible.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date

Appendix H
Authorization to Receive Information

Authorization to Receive Information

Date: _____

I hereby authorize the following individuals and/or agencies to releaseand discuss information from the records of my child _____,

to Lindsay R. Sessor, M.A., BCBA and/or Leigh Ann M. Shepherd, M.A., BCBA, at Central Ohio Behavioral Consulting, LLC.

1. _____
(Individual/Agency)

_____
(Address) (Phone number)

2. _____
(Individual/Agency)

_____
(Address) (Phone number)

3. _____
(Individual/Agency)

_____
(Address) (Phone number)

4. _____
(Individual/Agency)

_____
(Address) (Phone number)

5. _____
(Individual/Agency)

_____
(Address) (Phone number)

Subject to the following limitations and exclusions:

_____
_____
_____
_____

I understand that I may revoke this consent at any time by informing the above parties in writing.

_____ _____
Client signature (ifappropriate) Date

_____ _____
Signatureof Parent or Guardian Date

_____ _____
Signatureof Parent or Guardian Date

_____ _____
Signature of Witness Date

This release of information remains in effect for one year from the date of signature unless otherwise notified.

Appendix I
HIPAA Privacy Notice

HIPAA Privacy Notice

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information. Protected Health Information (PHI) is information about you, including demographic information that could reasonably be used to identify you, and that relates to your past, present and future physical or mental health condition and related health care services. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 8/01/2011, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and provide the new Notice to you, and we will distribute it upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice.

Acknowledgement of Receipt of Notice: You will be asked to acknowledge, on our consent form, receipt of this Notice of Privacy Practices.

Your Authorization: In addition to our use of your health information for the following purposes, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. For example, we may disclose your health information regarding evaluations or progress made during treatment to your insurance company to arrange for payment of services.

To You Or Your Personal Representative: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to your personal representative, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care of your location, your general condition, or death. In the event of your absence or incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of COBC. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

Required by Law: We may use or disclose your health information when we are required to do so by law. You will be notified, as required by law, of any such uses or disclosure.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; for certain law enforcement purposes; to avert a serious threat to health or safety; and for certain judicial and administrative proceedings.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Your Rights Regarding Your Personal Health Information

Access to your records: All requests to copy and review your information must be in writing and signed by you or your legal representative. If there is a cost, we will inform you in advance. We may

charge for copying the information and for postage. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge a fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Central Ohio Behavioral Consulting
HIPAA Complaint Co-ordinator
PO Box 915
Marysville, OH 43040

Appendix J
Agreement to HIPAA Privacy Notice

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have read Central Ohio Behavioral
(Name of Parent/Guardian)

Consulting's Notice of Privacy Practices.

Print Name_____

Signature_____

Date_____

* You May Refuse to Sign This Acknowledgment*

_____

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- Other (Please

  Specify)_____

  _____

  _____

Appendix K
Marketing/Promotional Release

Marketing/Promotional Release

I, _____, give consent for
(Name of Parent(s)/Guardian(s))

Central Ohio Behavioral Consulting, LLC to use the following for use on their website or as part of any promotional materials. This consent applies to myself and my child _____. I understand that fictional names can be
(Child's name)

used for myself and my child at my request. I understand that my family will not receive monetary compensation for use of these items.

I give consent for the following materials to be used:

☐	Photographs	☐	Work Samples (written or art)
☐	Video Recordings	☐	Testimonial by Child
☐	Audio Recordings	☐	Testimonial by Parent/Guardian

☐ I do not give consent for COBC, LLC to use **my child's** information for marketing purposes.

☐ I do not give consent for COBC, LLC to use **my** information for marketing purposes.

This consent will remain in effect for one year from the date of signature **OR** until
_____ _____, 20_____
(Month) (Day)

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date

Appendix L
Service Agreement

Service Agreement

General Information

I hereby authorize the participation of my child, _____ , and myself in services offered by Central Ohio Behavioral Consulting, LLC (COBC, LLC).

I understand that services will be provided by COBC, LLC, namely Lindsay R. Sessor and/or Leigh Ann M. Shepherd who are Board Certified Behavior Analysts (BCBA).

I have requested these services for my child because he/she could benefit from additional support in the following areas and/or has been diagnosed with a developmental disability and displays developmental delays in one or more of the following areas:

- cognitive performance
- language development
- social skills
- self-help skills
- behavioral functioning

My child has not been diagnosed with any additional major medical conditions such as blindness, significant hearing loss, uncontrolled seizures, cerebral palsy, downs syndrome or severe delays in motor development.

I agree to release documents to inform COBC, LLC of my child's developmental, medical, and educational history as it pertains to my child's treatment. Necessary documents may include, but are not limited to, Individual Education Programs (IEP), Evaluation Team Reports (ETR), speech/language therapy, occupational therapy, physical therapy, psychology and/or neurology reports.

> Note: if contact with another service provider or agency is necessary, COBC, LLC will provide you with the appropriate release of information forms before the provider or agency is contacted.

I understand that all reports and records pertaining to my child and his/her participation in behavior intervention services with COBC, LLC will be kept on file in a confidential manner. COBC, LLC will protect all identifiable information to the limits of the law.

> Note: Information regarding suspected or actual abuse cannot be held in confidentiality.

Provision of Service

I understand that my child is being provided behavior intervention services. I am interested in applying behavioral principles and techniques I will learn to help teach my child. These strategies will be used to teach skills needed for my child to succeed at home, in school and community environments.

I understand that to ensure the quality of my child's program, it is necessary to follow the recommendations for behavior intervention provided by the consultant.

> These recommendations may include, but are not limited to:

- attendance at and participation in consultation meetings
- weekly 1:1 intervention hours
- appropriate intervention goals
- strategies for generalization of mastered skills

Note: failure to follow recommendations provided by COBC, LLC, without sufficient attempts to remedy the situation may result in termination of on-going services.

I understand that to maximize the success of my child's intervention program, I am expected to and agree to do the following to the best of my ability:

- attend and participate in all scheduled training sessions, consultation meetings, and school meetings
- have my child present during scheduled training sessions and consultation meetings as appropriate
- consistently implement recommended intervention strategies for skill building and/or reduction of problem behaviors
- maintain the organization of my child's intervention program, which may or may not include hiring individuals to serve as aides/tutors
- collect and/or generate materials necessary for the implementation of my child's programming and behavior plans in a timely fashion
- report and/or record data on my child's progress to the consultant to be analyzed and shared with the team as an integral part of the program decision making process
- receive feedback on the implementation of intervention procedures from the consultant
- provide feedback to the consultant and other members of the team
- seek supplemental services as needed

I understand that despite consistent short and long-term application of behavioral strategies recommended by COBC, LLC, my child may or may not benefit from this intervention. Though all efforts will be made to prevent, eliminate and minimize difficulties, I understand that my child may experience some distress during the initial implementation of any plan.

I understand that to remain a client with COBC, LLC I must maintain a minimum number of monthly contact hours with my consultant. All attempts need to be made to meet with my consultant for at least one hour per month. I understand that, unless sufficient documented attempts to schedule an appointment with the consultant have occurred, if I am unable to maintain one hour per month of service, I am still responsible for payment of one hour of service per month at a rate of $_____ per hour

Note: While one hour of contact per month is the minimum requirement, the consultant will recommend a range of monthly consultation hours that will best meet the needs of my child's intervention program.

I agree that to maximize the success of my child's intervention program, the consultant will need to provide services a minimum of _____ hours per month and up to _____ hours per month.

Note: services may include, but are not limited to, meetings with my child's team (this *must* include the consultant and parent(s) and may include the child, additional aides/tutors (hired by the family) or other necessary team members), parent training sessions, aide/tutor training sessions, meetings with school personnel, 1:1 sessions with my child, or observations of my child in the home, school, or community.

By agreeing to these terms, I understand that it is my responsibility to maintain contact with my consultant to assist in scheduling necessary appointments.

Note: In addition to regularly scheduled parent and/or consultation meetings, a bi-yearly progress evaluation meeting will be held to review intervention goals and progress made toward these goals. At this time, the consultant and I will determine the most appropriate course for continued intervention or determine that on-going intervention services will be terminated.

Billing and Payment

Invoices for services rendered will be mailed at the close of each week. I agree to pay the invoice in full upon receipt. Failure to make a payment within 60 days of the invoice date may result in the delay or termination of on-going services.

I understand that I am financially responsible for the full amount of the invoice issued for all services rendered, regardless of another agency's (e.g., school district, insurance company, third party funding source, etc.) agreement to pay for services.

Consultation Services

I agree to pay for behavior consultation services at a rate of $97.80 per hour, unless otherwise stated below. Consultation services may include:

- 1:1 sessions with the child
- Parent meetings/trainings
- Meetings/trainings with the behavior intervention team (i.e. parent(s) and aides/tutors)
- School visits or meetings, including ETR and IEP meetings
- Phone call and virtual meetings

Consultation rate: _____per hour as contracted by _____

I agree to pay for the following services at a rate of $48.90 per hour:

- Initial intake meeting
- Document generation

Note: contact with your consultant at COBC, LCC by phone and email is often a necessary component of an effective behavior intervention program.

Note: e-mail will not be billed as an additional service. However, the number, length, or content of emails may require that a consultation service be scheduled.

Note: phone calls within a single day that exceed 30 minutes will be billed at the contracted hourly rate or will necessitate the scheduling of a consultation meeting.

Travel Expenses

Travel charges are dependent on location of service and, if applicable, will be billed at the current IRS reimbursement rate.* All mileage expenses will be reflected on the weekly invoice.

Note: As of July 1st 2011, the current IRS reimbursement rate is 55.5 cents/mile.

Travel Rate: _____ per mile X _____miles per visit = _____

If significant travel necessitates one or more overnight stays, COBC, LLC will make all hotel reservations. I understand that I am responsible for payment of the consultant's overnight accommodations and those fees will be reflected on my weekly invoice.

Cancellation Policy

I agree to give notice of cancellation of any appointment within 24 hours of the scheduled appointment. I understand that if I give less than 24 hours notice I may still be charged for all or a portion of the scheduled appointment time.

I understand that cancellation of 3 scheduled appointments, even with 24 hours notice, within a 6 month period may result in termination of services.

Termination of On-going Services

I understand that I have the right to terminate on-going services for any reason.

I understand that COBC, LLC has the right to terminate on-going services for any reason.

I understand that to best meet the needs of my child, when on-going services are terminated, it is necessary to hold a termination meeting to discuss and document transition plans. I understand that this meeting will be billed at the standard consultation service rate of $_____ per hour.

Note: Termination meetings must be held within 30 days of notice of termination.

Complaints

Complaints regarding the conduct of a COBC employee can be directed to the Behavior Analyst Certification Board (BACB) by visiting their website: www.bacb.com
or by sending a written complaint to:

Behavior Analyst Certification Board, Inc
Disciplinary Matters
2888 Remington Green Lane Suite C
Tallahassee, FL 32308

Signature Page

Client's name: _____

I have read and understand the attached information fully and agree to the conditions described.

I will be provided with a copy of this consent form.

Signature (Guardian) _____ Date _____

Signature (Guardian) _____ Date _____

Signature (Witness) _____ Date _____

Appendix M
Intake Form

Intake Form

Date: _____

Parent/Guardian's Name: _____

Address: _____

_____

Phone Number(s): (H) _____

(C) _____

(W) _____

Child's Name _____

Date of Birth: _____

Diagnosis: _____

Members of household: _____

_____

Persons present for intake: _____

_____

Interviewer: _____

Family Life:

Custody Arrangement (if applicable):

Are there any spiritual, cultural, educational or legal issues that we should be aware of that may impact the course of treatment? Yes No

If Yes, please indicate:

Medical History:

Prenatal History:

Premature Full Term

Any complications during pregnancy and/or delivery? Yes No

If Yes, please indicate:

Developmental History:

Client displayed delays in the following areas (please indicate with a + or -):

Area of Development:		*+ or -*	*Notes:*
Fine Motor			
Gross Motor			
Language			
Play/Socialization			
Academic Concepts			

Treatment History:

Type of Treatment		*+ or -*	*Age*	*Referral*	*Notes*
Speech Therapy					
Occupational Therapy					
Physical Therapy					
Early Intervention					
Evaluation History					
Other					

Is there a family history of mental illness or developmental delay? Yes No

If yes, indicate type of diagnosis, age of diagnosis and relationship to client.

General Medical Concerns:

Are there any current medical concerns that could impact treatment? Yes No

If Yes, please indicate:

Indicate any known allergies:

Indicate any current illnesses:

Indicate any current medications (reason for Rx & dosage):

Strengths:

What does he/she enjoy doing during free time:

What is he/she is good at doing?

What does he/she like to do?

Behavior:

Type:	*Current Frequency:*	*Description of behavior:*
Aggression:	0x 1x/mth 1x/wk 1-2x/day 3-10x/day 10+/day	
SIB:	0x 1x/mth 1x/wk 1-2x/day 3-10x/day 10+/day	
Non-Compliance:	0x 1x/mth 1x/wk 1-2x/day 3-10x/day 10+/day	
Repetitive:	0x 1x/mth 1x/wk 1-2x/day 3-10x/day 10+/day	
Ritualistic:	0x 1x/mth 1x/wk 1-2x/day 3-10x/day 10+/day	

Additional Notes:

Language:

If different now from the past, how did that change/why did that change occur:

Functional use of language:

Requests for desired/needed items:

Use of gestures/signs:

Length of utterances:

Self Help Skills:

If different now from the past, how did that change/why did that change occur:

Feeding:

Toileting:

Dressing:

Sleep:

Lesire Skills:

If different now from the past, how did that change/why did that change occur:

Indoor/Outdoor Play:

Interests (ex: Books/Music/TV):

Independent activities:

Interactive activities:

Community:

As a family do you:

	Currently	Future Goal	Not a concern
Outings:			
Resturaunts:			
Sports:			
Family errands:			

Additional Notes:

Skill Building:

Current skills (Cognitive/Academic Skills):

How were current skills established? (School, 1:1, SLP, other interventions):

School:

Current school (include district):

Current teacher's name:

Current grade & progression through the grades:

School(s) attended:

Challenges:

Goals for Treatment (begin to prioritize goals - behavior, academics, self help, leisure skills & community:

Team intentions:

Hours/week, frequency of meetings:

Current Funding:

Insurance:

Scholarship:

County funds:

Waiver:

General Observations:

Recommendations:

* All information is provided by Parent/Guardians unless otherwise noted.

Appendix N
NIDA Quick Screen V1.0

NIDA Quick Screen V1.0[1]

Name: ..... **Sex ( ) F ( ) M Age**.....

Interviewer..... **Date** ...../...../.....

Introduction (Please read to patient)

Hi, I'm _____, nice to meet you. If it's okay with you, I'd like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I'll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.

Instructions: For each substance, mark in the appropriate column. For example, if the patient has used cocaine monthly in the past year, put a mark in the "Monthly" column in the "illegal drug" row.

NIDA *Quick Screen* Question: **In the past year, how often have you used the following?**	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol • **For men, 5 or more drinks a day** • **For women, 4 or more drinks a day**					
Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					

- If the patient says "**NO**" for all drugs in the Quick Screen, reinforce abstinence. **Screening is complete.**
- If the patient says "**Yes**" to **one or more days of heavy drinking**, *patient is an at-risk drinker*. Please see NIAAA website "How to Help Patients Who Drink Too Much: A Clinical Approach" http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm, for information to **Assess, Advise, Assist, and Arrange** help for at risk drinkers or patients with alcohol use disorders
- If patient says "**Yes**" to **use of tobacco**: *Any* current tobacco use places a patient at risk. Advise *all tobacco users to quit*. For more information on smoking cessation, please see "Helping Smokers Quit: A Guide for Clinicians" http://www.ahrq.gov/clinic/tobacco/clinhlpsmksqt.htm
- If the patient says "**Yes**" to **use of illegal drugs or prescription drugs for non-medical reasons**, proceed to **Question 1** of the NIDA-Modified ASSIST.

[1] *This guide is designed to assist clinicians serving adult patients in screening for drug use. The NIDA Quick Screen was adapted from the single-question screen for drug use in primary care by Smith et al. (available at http://archinte.ama-assn.org/cgi/reprint/170/13/1155) and the National Institute on Alcohol Abuse and Alcoholism's screening question on heavy drinking days (available at http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm). The NIDA-modified ASSIST was adapted from the World Health Organization (WHO) Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), Version 3.0, developed and published by WHO (available at http://www.who.int/substance_abuse/activities/assist_v3_english.pdf).*

Questions 1-8 of the NIDA-Modified ASSIST V2.0

Instructions: Patients may fill in the following form themselves but screening personnel should offer to read the questions aloud in a private setting and complete the form for the patient. To preserve confidentiality, a protective sheet should be placed on top of the questionnaire so it will not be seen by other patients after it is completed but before it is filed in the medical record.

Question 1 of 8, NIDA-Modified ASSIST **In your *LIFETIME*, which of the following substances have you ever used?** ***Note for Physicians: For prescription medications, please report nonmedical use only.***	**Yes**	**No**
a. Cannabis (marijuana, pot, grass, hash, etc.)		
b. Cocaine (coke, crack, etc.)		
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)		
d. Methamphetamine (speed, crystal meth, ice, etc.)		
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)		
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium,Rohypnol, GHB, etc.)		
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)		
h. Street opioids (heroin, opium, etc.)		
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)		
j. Other – specify:		

- Given the patient's response to the Quick Screen, the patient *should <u>not</u> indicate* "**NO**" for all drugs in Question 1. If they do, remind them that their answers to the Quick Screen indicated they used an illegal or prescription drug for nonmedical reasons within the past year and then **repeat Question 1**. If the patient indicates that the drug used is not listed, please mark **'Yes'** next to 'Other' and continue to **Question 2** of the NIDA-Modified ASSIST.
- If the patient says "**Yes**" to any of the drugs, proceed to **Question 2** of the NIDA-Modified ASSIST.

Question 2 of 8, NIDA-Modified ASSIST 2. In the past three months, how often have you used the substances you mentioned (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
• Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
• Cocaine (coke, crack, etc.)	0	2	3	4	6
• Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	2	3	4	6
• Methamphetamine (speed, crystal meth, ice, etc.)	0	2	3	4	6
• Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	2	3	4	6
• Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	2	3	4	6
• Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	2	3	4	6
• Street opioids (heroin, opium, etc.)	0	2	3	4	6
• Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	2	3	4	6
• Other – Specify:	0	2	3	4	6

- For patients who report "**Never**" having used any drug in the past 3 months: **Go to Questions 6-8.**
- For any recent **illicit or nonmedical prescription drug use**, go to **Question 3.**

3. In the past 3 months, how often have you had a strong desire or urge to use (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
b. Cocaine (coke, crack, etc.)	0	3	4	5	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	4	5	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	4	5	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	4	5	6
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	3	4	5	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	4	5	6
h. Street Opioids (heroin, opium, etc.)	0	3	4	5	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	4	5	6
j. Other – Specify:	0	3	4	5	6

4. During the past 3 months, how often has your use of (first drug, second drug, etc) led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
b. Cocaine (coke, crack, etc.)	0	4	5	6	7
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	4	5	6	7
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	4	5	6	7
e. Inhalants (nitrous oxide, glue, gas, pain thinner, etc.)	0	4	5	6	7
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	4	5	6	7
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	4	5	6	7
h. Street opioids (heroin, opium, etc.)	0	4	5	6	7
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	4	5	6	7
j. Other – Specify:	0	4	5	6	7

5. During the past 3 months, how often have you failed to do what was normally expected of you because of your use of (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
b. Cocaine (coke, crack, etc.)	0	5	6	7	8
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	5	6	7	8
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	5	6	7	8
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	5	6	7	8
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	5	6	7	8
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	5	6	7	8
h. Street Opioids (heroin, opium, etc.)	0	5	6	7	8
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	5	6	7	8
j. Other – Specify:	0	5	6	7	8

Instructions: Ask Questions 6 & 7 for all substances **ever used** (i.e., those endorsed in the Question 1).

6. Has a friend or relative or anyone else ever expressed concern about your use of (first drug, second drug, etc)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other – Specify:	0	3	6

7. Have you ever tried and failed to control, cut down or stop using (first drug, second drug, etc)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other – Specify:	0	3	6

Instructions: Ask Question 8 if the patient endorses any drug that might be injected, including those that might be listed in the other category (e.g., steroids). Circle appropriate response.

8. Have you ever used any drug by injection (NONMEDICAL USE ONLY)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months

- Recommend to patients reporting any prior or current intravenous drug use that they get tested for HIV and Hepatitis B/C.
- If patient reports using a drug by injection in the past three months, ask about their pattern of injecting during this period to determine their risk levels and the best course of intervention.
  - If patient responds that they inject once weekly or less OR fewer than 3 days in a row, provide a brief intervention including a discussions of the risks associated with injecting.
  - If patient responds that they inject more than once per week OR 3 or more days in a row, refer for further assessment.

Note: Recommend to patients reporting any current use of alcohol or illicit drugs that they get tested for HIV and other sexually transmitted diseases.

Tally Sheet for scoring the full NIDA-Modified ASSIST:

Instructions: For each substance (labeled a–j), add up the scores received for questions 2-7 above. This is the Substance Involvement (SI) score. Do not include the results from either the Q1 or Q8 (above) in your SI scores.

Substance Involvement Score	Total (SI SCORE)
a. Cannabis (marijuana, pot, grass, hash, etc.)	
b. Cocaine (coke, crack, etc.)	
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	
d. Methamphetamine (speed, crystal meth, ice, etc.)	
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	
h. Street Opioids (heroin, opium, etc.)	
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	
j. Other – Specify:	

Use the resultant Substance Involvement (SI) Score to identify patient's risk level.

To determine patient's risk level based on his or her SI score, see the table below:

Level of risk associated with different Substance Involvement Score ranges for Illicit or nonmedical prescription drug use	
0-3	Lower Risk
4-26	Moderate Risk
27+	High Risk

Appendix O
F.A.S.T.

FUNCTIONAL ANALYSIS SCREENING TOOL (F.A.S.T.)

Client: _____ Problem: _____
Informant: _____ Interviewer: _____ Date: _____

To the Interviewer: The FAST is designed to identify a number of factors that may influence the occurrence of behavior problems. It should be used only as an initial screening tool and as part of a comprehensive functional analysis of the behavior problem. The FAST should be administered to several individuals who interact with the client frequently. Results should then be used as the basis for conducting direct observations in several different contexts to verify likely behavioral functions, clarify ambiguous functions and identify other relevant factors that may not have been included in this instrument.

To the Informant: After completing the section on "Informant-Client Relationship," read each of the numbered items carefully. If a statement accurately describes the client's target behavior problem, circle "Yes." If not, circle "No." If the target problem consists of either self-injurious behavior (SIB) or "repetitive stereotyped mannerisms," begin with Part I. However, if the problem consists of aggression or some other form of socially disruptive behavior, such as property destruction or tantrums, complete only Part II.

INFORMANT-CLIENT RELATIONSHIP

Indicate your relationship to the client: _____ Parent _____ Teacher/Instructor _____ Therapist _____Residential Staff

How long have you known the client? _____ Years _____ Months

Do you interact with the client on a daily basis? _____ Yes _____ No
If "Yes," how many hours per day? _____ If "No," how many days per week? _____

In what situations do you typically observe the client? (Mark all that apply)
_____ Self-care routines _____ Academic skills training _____ Meals _____ When the client has nothing to do
_____ Leisure activities _____ Work or vocational training _____ Evenings _____ Other: _____

Have you ever observed the client at length in an attempt to identify "causes" for the behavior? Yes No

PART I. SOCIAL INFLUENCES ON BEHAVIOR

1. The behavior usually occurs in your presence or in the presence of other clients	YES	NO
2. The behavior usually occurs soon after you or others interact with the client in some way, such as delivering an instruction or reprimand, walking away from (ignoring) the client, taking away a "preferred" item, requiring the client to change activities, talking to someone else in the client's presence, etc.	YES	NO
3. The behavior often is accompanied by other "emotional" responses, such as yelling or crying.	YES	NO

PART II. SOCIAL REINFORCEMENT

4. The behavior often occurs when the client has not received much attention.	YES	NO
5. When the behavior occurs, you or others usually respond by interacting with the client in some way (e.g., comforting statements, verbal correction or reprimand, response blocking, redirection).	YES	NO
6. The client often engages in <u>other</u> annoying behaviors that produce attention.	YES	NO
7. The client frequently approaches you (or others) and/or initiates social interaction.	YES	NO
8. The behavior rarely occurs when you give the client lots of attention.	YES	NO
9. The behavior often occurs when you take a particular item away from the client or you terminate a preferred leisure activity. (If "Yes," identify: _____)	YES	NO

10. The behavior often occurs when you inform the client that (s)he cannot have a certain item or cannot engage in a particular activity. (If "Yes," identify: _____) YES NO

11. When the behavior occurs, you often respond by giving the client a specific item, such as a favorite toy, food or some other item. (If "Yes," identify: _____) YES NO

12. The client often engages in <u>other</u> annoying behaviors that produce access to preferred items or activities. YES NO

13. The behavior rarely occurs when you give the client free access to preferred items or activities. YES NO

14. The behavior often occurs during training activities or when you place other types of demands on the client. (If "Yes," identify the activities: _____ self-care _____ academic _____ work other: _____) YES NO

15. The client often is noncompliant during training activities or when asked to complete tasks. YES NO

16. The behavior often occurs when the immediate environment is very noisy or crowded YES NO

17. When the behavior occurs, you often respond by giving the client a brief "break" from an ongoing task YES NO

18. The behavior rarely occurs when you place few demands on the client or when you leave the client alone. YES NO

PART III. NONSOCIAL (AUTOMATIC) REINFORCEMENT

19. The behavior occurs frequently when the client is alone or unoccupied. YES NO

20. The behavior occurs at relatively high rates regardless of what is going on in the client's immediate surrounding environment. YES NO

21. The client seems to have few known reinforcers or rarely engages in appropriate object manipulation or "play" behavior. YES NO

22. The client is generally unresponsive to social stimulation. YES NO

23. The client often engages in repetitive, stereotyped behaviors, such as body rocking, hand or finger waving, object twirling, mouthing, etc. YES NO

24. When the client engages in the behavior, you and others usually respond by doing nothing (i.e., you never or rarely attend to the behavior). YES NO

25. The behavior seems to occur in cycles. During a "high" cycle, the behavior occurs frequently and is extremely difficult to interrupt. During a "low" cycle, the behavior rarely occurs. YES NO

26. The behavior seems to occur more often when the client is ill. YES NO

27. The client has a history of recurrent illness (e.g., ear or sinus infections, allergies, dermatitis). YES NO

SCORING SUMMARY

Circle the items answered "Yes." If you completed only Part 2, also circle Items 1, 2 and 3.

<u>Items Circled "YES"</u>	<u>Likely Maintaining Variable:</u>
1 2 3 4 5 6 7 8	Social reinforcement (attention)
1 2 3 9 10 11 12 13	Social reinforcement (access to specific activities)
1 2 3 14 15 16 17 18	Social reinforcement (escape)
19 20 21 22 23 24	Automatic reinforcement (sensory stimulation)
19 20 24 25 26 27	Automatic reinforcement (pain attenuation)

Appendix P
ABC Logs

ABC Logs

Date/ Initials	Time	Antecedent	Behavior	Consequence	Child's response
		Asked to complete a task:____________ Asked to leave an activity: ___________ Removal of preferred item:___________ Request denied:____________________ Ignored by adult/sibling Playing alone Other: ___________________________			Continued with behavior Calmed Other: ______________
		Asked to complete a task:____________ Asked to leave an activity: ___________ Removal of preferred item:___________ Request denied:____________________ Ignored by adult/sibling Playing alone Other: ___________________________			Continued with behavior Calmed Other: ______________
		Asked to complete a task:____________ Asked to leave an activity: ___________ Removal of preferred item:___________ Request denied:____________________ Ignored by adult/sibling Playing alone Other: ___________________________			Continued with behavior Calmed Other: ______________
		Asked to complete a task:____________ Asked to leave an activity: ___________ Removal of preferred item:___________ Request denied:____________________ Ignored by adult/sibling Playing alone Other: ___________________________			Continued with behavior Calmed Other: ______________
		Asked to complete a task:____________ Asked to leave an activity: ___________ Removal of preferred item:___________ Request denied:____________________ Ignored by adult/sibling Playing alone Other: ___________________________			Continued with behavior Calmed Other: ______________

Appendix Q
Frequency Count of Target Behaviors

Frequency Count of Target Behaviors

CBC
central ohio behavioral consulting

	Behavior 1	Behavior 2	Behavior 3	Behavior 4	Behavior 5
Date: Initials: Session Time:					
Date: Initials: Session Time:					
Date: Initials: Session Time:					
Date: Initials: Session Time:					
Date: Initials: Session Time:					
Date: Initials: Session Time:					
Date: Initials: Session Time:					
Date: Initials: Session Time:					
Date: Initials: Session Time:					
Date: Initials: Session Time:					

Appendix R
Preference Assessment

Reinforcer Assessment Form

Date: _____
Child's Name: _____
Name of person completing form: _____

Dear parent/guardian:

The purpose of this structured interview is to get as much specific information as possible from you, the parent (or caregiver), as to what you believe would be useful reinforcers for your child. There are 10 total categories, and though I would like to have a list of 10 possible reinforcers, they do not all need to be from the same category. Therefore, this survey will ask questions about categories of reinforcers (e.g., visual, auditory, etc.).

1. Some individuals really enjoy looking at things such as a mirror, bright lights, shiny objects, spinning objects, TV, etc. What are the things you think your son/daughter most likes to watch?

_____

_____

_____

2. Some individuals really enjoy different sounds such as listening to music, car sounds, whistles, beeps, sirens, clapping, people singing, etc. What are the things you think your son/daughter most likes to listen to?

_____

_____

_____

_____

3. Some individuals really enjoy different smells such as perfume, flowers, coffee, pine trees, etc. What are things you think your son/daughter most likes to smell?

_____

_____

_____

_____

4. Some individuals really enjoy certain foods or snacks such as ice cream, pizza, juice, soda, coffee, candy, graham crackers, McDonald's hamburgers, etc. What are the things you think your son/daughter most likes to eat?

5. Some individuals really enjoy physical play or movement such as being tickled, wrestling, running, dancing, swinging, being pulled on a scooter board, etc. What activities like this do you think your son/daughter most enjoys?

6. Some individuals really enjoy touching things of different temperature, cold things like snow or an ice pack, or warm things like a hand warmer or a cup containing hot tea or coffee. What activities like this do you think your son/daughter most enjoys?

7. Some individuals really enjoy feeling different sensations such as splashing water in a sink, a vibrator against the skin, or the feel of air blown on the face from a fan. What activities like this do you think your son/daughter most enjoys?

8. Some individuals really enjoy it when others give them attention such as a hug, a pat on the back, clapping, saying “Good job”, etc. What forms of attention do you think your son/daughter most enjoys?

9. Some individuals really enjoy certain toys or objects such as puzzles, toy cars, balloons, comic books, flashlight, bubbles, play make-up, etc. What are your son/daughter’s favorite toys or objects?

10. What are some other items or activities that your son/daughter really enjoys?

Appendix S
Self Help Skills Inventory

Self Help Skills Inventory

Skill	Independently able to complete	Needs occasional prompting to complete	Needs full prompting to complete	
Dressing	Using numbers 1-6, rank order each category by current order of importance. 1 = first priority		Rank:	
Takes off shoes				
Takes off socks				
Takes off pants				
Takes off T-shirt				
Takes off sweatshirt/sweater				
Takes off jacket				
Takes off underwear				
Puts on shoes (with correct feet)				
Puts on socks				
Puts on pants				
Puts on T-Shirt				
Puts on sweatshirt/sweater				
Puts on jacket				
Puts on underwear				
Ties Shoes				
Puts clothes on in correct direction				
Manipulates Fasteners (buttons, snaps, zippers)				

Skill	Independently able to complete	Needs occasional prompting to complete	Needs full prompting to complete	
Toileting			Rank:	
Uses toilet (Urine)				
Uses toilet (BM)				
Self Care			Rank:	
Brushes teeth				
Washes hands				
Blows nose				
Uses a washcloth to clean self during bath/shower				
Washes hair during bath/shower				
Dries body following bath/shower				
Brushes hair				
Mealtime Skills			Rank:	
Drinks from an open cup				
Uses spoon/fork				
Prepares own drink				
Prepares simple snack				
Spreads/Cuts with a knife				
*Uses microwave				
*Uses stove/oven				

* Complete only if your child is 10+ years old

Skill	Independently able to complete	Needs occasional prompting to complete	Needs full prompting to complete	
***Household Chores**			Rank:	
Sets the table				
Clears the table				
Vacuums				
Dusts				
Cleans own room				
Cleans common areas				
Does laundry				
Mows grass				
Waters plants				
Gets the mail				
***Community Skills**			Rank:	
Pays cashier				
Orders at restaurant				
Makes change				
Practices appropriate safety during outings				
Locates needed items in a store				
Budgets money for desired items				

Name of Client: _____ Date: _____

Name of Person Completing: _____

Additional Comments:

Appendix T
Discharge/Treatment Summary

Transition Summary

-Confidential-

Client:
Date of Birth:
Age:
Parent/Guardian:
Address:

Consultant:
Date of Transition Meeting:
Participants:

I. Background Information

CHILD is a XX-year old BOY/GIRL who was diagnosed with DIAGNOSIS by DOCTOR of ORGANIZATION in LOCATION. (INCLUDE ANY OTHER MEDICAL CONDITIONS, MEDICATIONS, ETC.)

After diagnosis, his/her parents requested services through Central Ohio Behavioral Consulting, LLC. Services were initiated with an intake appointment conducted on DATE.

II. Service History

DESCRIBE COBC SERVICES RECIEVED
Include:

- Type of service received (In Home Consultation, Parent Training, Educational Advocacy, Social Skills Groups)
- Frequency of service provision
- Goals during service provision
    - Indicate progress towards goals (met, not met, challenges to accomplishing goals)

III. Reason for Termination/Transition of Services

DESCRIBE REASONS FOR TERMINATION & RATIONALE TRANSITION TO ALTERNATE SERVICES

- Indicate if prompted by Parent or COBC

IV. General Recommendations

The following recommendations are based on the progress that CHILD has made to date as well as progress that we would like to see CHILD make in the future.

EXAMPLES:

- CHILD should continue to receive direct instruction to help with the acquisition of new skills. In particular, his program should continue to work on increasing his language skills, self-help skills, and social/recreational skills as well as reducing negative behaviors.
- CHILD should continue to receive individual speech therapy on a weekly basis, or as recommended by his speech therapist.
- CHILD should attend school and group activities under supervision.
- CHILD should participate in structured programs outside of the residential setting, including school, work, and community activities.
- Efforts should be made to implement behavior management systems and schedules that have been effective with CHILD at school and in therapy sessions.
- CHILD's mother should be an active participant in meetings about his educational and living support to assist with making decisions for his future.
- CHILD's mother should contact us if further consultation is required.

PARENT/GUARDIAN Date

CLIENT (when appropriate) Date

NAME Date
Co-Director, Behavior Consultant
Central Ohio Behavioral Consulting, LLC

Appendix U
Authorization to Release COBC Records

Authorization to Release Information

Date: _____

Authorization for Use/Disclosure of Information: I voluntarily authorize Lindsay R. Sessor or Leigh Ann M. Shepherd at Central Ohio Behavioral Consulting, LLC to use or disclose information from my records during the term of this Authorization to the recipient(s) I have identified below.

Recipient(s):

1_____
(Individual/Agency)

_____
(Address) (Phone number)

2_____
(Individual/Agency)

_____
(Address) (Phone number)

3_____
(Individual/Agency)

_____
(Address) (Phone number)

4_____
(Individual/Agency)

_____
(Address) (Phone number)

5_____
(Individual/Agency)

_____
(Address) (Phone number)

Information to be disclosed: This authorization permits the above provider to disclose the following information:

- ❑ All of my treatment information that the provider has in her possession relating to any treatment received by me (i.e. consultation reports, progress notes, discharge summary, etc…).
- ❑ Only the following records or types of treatment information: (Insert dates of treatment, types of treatment or other designation) _____.

Term: This Authorization will remain in effect for one year from the date of this Authorization **OR** until _____ _____, 20_____.
(Month) (Day)

Redisclosure: I understand that once the provider listed above discloses my treatment information to the recipient(s) identified above, my provider cannot guarantee that the recipient(s) will not re-disclose my treatment information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my provider.

Revocation: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my provider at the following address: P.O. Box 915, Marysville, Ohio 43040.

The revocation will be effective immediately upon my provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my provider the receipt of my written notice of revocation.

_____

Client Printed Name

_____ _____

Client Signature Date

If individual is unable to sign this Authorization, please complete the information below:

_____ _____

Name of Parent/Legal Guardian Legal Relationship

_____ _____

Signature of Parent/Legal Guardian Date

_____

Signature of Witness

Appendix V
Annual Staff Evaluation

Annual Staff Evaluation

Employee Name:
Date of evaluation:
Evaluated by:

Responsibility	**Below Expectation**	**Meets Expectation**	**Exceeds Expectation**	**Comments**
Development of appropriate individualized behavior intervention programs based on the principles of applied behavior analysis (ABA).				
Supervision and training of in home staff and parents on behavior intervention strategies.				
Working collaboratively with teachers and other school staff and administrators to develop behavior strategies to be implemented in the school environment				
Regular communication with families and staff				
Preparation for meetings (consultation meetings and school meetings)				
Development of social skills curriculum				
Delivery of large group trainings covering topics related to autism spectrum disorders and behavior management strategies				
Communication with government agencies and funding sources				

Appendix W
Job Description

Central Ohio Behavioral Consulting, LLC

PO Box 915
Marysville, OH 43040

Job Description: Behavior Consultant

The behavior consultant is primarily responsible for independently developing, managing, and supervision behavior intervention programs in homes, schools and within the community using the principles of Applied Behavior Analysis (ABA).

Reports to Director(s)

Qualifications

- Master's Degree in Psychology, Special Education, Applied Behavior Analysis or related fields
- Board Certified Behavior Analyst (BCBA)
- Minimum of 2 years' experience developing and supervising behavior intervention program(s) and behavior plans based on the principles of Applied Behavior Analysis (ABA)
- Excellent understanding and utilization of the following treatment models:
    - Applied Behavior Analysis
    - Developmental psychology/human development
- Advanced knowledge of autism spectrum disorders
- Demonstrate superior knowledge of the function of behaviors and the use of FBAs for the development of program goals and intervention plans
- Demonstrate superior knowledge of funding sources rules and regulations and special education law for determining appropriate educational programming goals including effective instructional strategies to be implemented, placement, and behavior plan development
- Demonstrate ability to communicate with multiple funding sources and parents.

Responsibilities

- Develop individualized behavior intervention programs based on the principles of applied behavior analysis (ABA).
- Conduct all supervisory and program management responsibilities for families participating in the in-home consultation and parent training models of service delivery
- Supervise, shadow and train tutors/aides/therapists working directly with clients in participating in the in-home consultation model of service delivery.
- Provide education and training to parents participating in the parent training model of service delivery
- Work collaboratively with teachers and other school staff and administrators to develop behavior strategies to be implemented in the school environment
- Maintain regular contact with families and staff at appropriate times
- Ensure appropriate implementation and maintenance of individualized ABA programs
- Develop, monitor, and analyze individualized data measurement systems for each

intervention program
- Conduct team consultation meetings and prepare reports to update client intervention programs
- Follow up at regular intervals with families and staff to ensure successful implementation of interventions and instructional programs
- Help families prepare for school meetings (i.e. ETR, IEP) and attend these meeting with families
- Develop and teach curriculum for social skills groups and the corresponding parent components to social skills groups
- Lead large group trainings covering topics related to autism spectrum disorders and behavior management strategies

Clinical Skills & Procedures

- Functional behavior assessment (FBA) and/or analysis
- Skills assessments
- Preference assessments
- Behavior plans & protocols
- Writing and submitting reports to funding agencies and team members
- Data analysis, progress measurement, and treatment planning

Critical Functions (may include but are not necessarily limited to):

- Be able to lift 25-50 pounds
- Be able to run short distances, sit on the floor, bend down, squat and kneel
- Must have access to own vehicles for transportation to client homes or other locations throughout area of service delivery

Disclaimer

The above statements are intended to describe the general nature and level of work being performed by people assigned to this classification. They are not to be construed as an exhaustive list of all responsibilities, duties, and skills required of personnel so classified. All personnel may be required to perform duties outside of their normal responsibilities from time to time, as needed.

Appendix X
Helping Hands, Hand Hygiene

NATIONWIDE CHILDREN'S HOSPITAL℠

HELPING HAND™

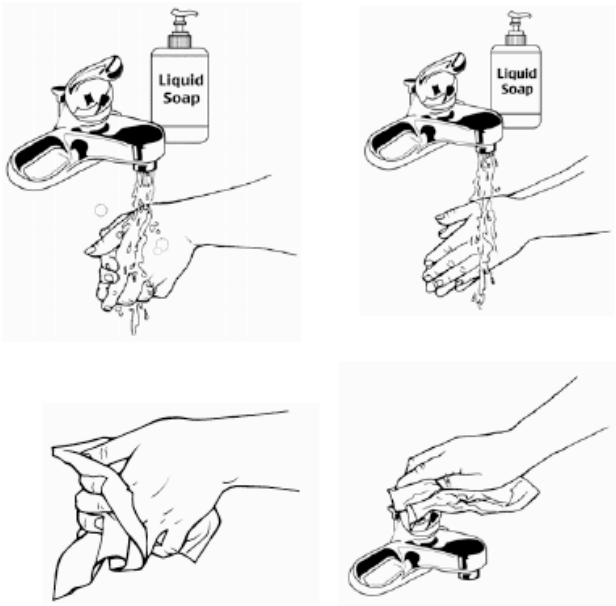
700 Children's Drive
Columbus, Ohio 43205-2696
nationwidechildrens.org

HAND HYGIENE

The best way to prevent the spread of germs (bacteria and viruses) and prevent infections is to remove or kill harmful bacteria and viruses by a process called "hand hygiene." Proper hand hygiene involves either washing hands with soap and water or decontaminating (killing germs on the hands) with an alcohol-based hand rub. When you clean your hands, you remove many germs. Germs are very small; you can't see them but they spread disease. Germs are everywhere. For example, they are on door handles, tables, phones, pencils, etc. Our hands constantly come into contact with them. That's why having clean hands will help keep you healthy.

HOW TO WASH YOUR HANDS

1. Wet your hands with warm, running water.
2. Apply soap.
3. Rub your hands together well for at least 15 seconds, making sure to clean between your fingers, under your nails, and on the back of your hands. You should be able to count to 15 slowly before you are finished rubbing your hands. If children are old enough, teach them to sing the ABC song while washing.
4. Rinse your hands well under the running water. This is because soap left on your hands may cause dry, chapped skin.
5. Dry your hands with a paper towel or clean washcloth.
6. Use the towel or washcloth to turn off the water. If you touch the water faucet after you wash your hands, you may get germs on your hands again.



It is important to use running water when washing your hands. Running water is an important part of washing away germs. Special Towelettes or hand wipes should only be used when running water is not nearby. Water basins should not be used instead of running water. Outbreaks of illnesses have been linked with sharing wash water and wash basins or sinks.

WHAT KIND OF SOAP TO USE WHEN WASHING HANDS

- Liquid soap works better than bar soap but using bar soap is fine.
- Anti-bacterial soap kills more germs than regular soap, but regular soap is okay most of the time.
- Use mild soaps to prevent chapped or dry hands.
- If your hands become dry, use hand lotion after washing your hands. If using lotions, use liquids or tubes that can be squirted so that your hands do not have to touch the spout of the container.

HH-IV-80 6/01, Revised 10/04

HOW TO USE THE WATERLESS ALCOHOL-BASED HAND RUB:

- Apply the rub to palm of hand.
- Rub hands together covering all surfaces of hands and fingers.
- Rub until hands are dry.

WHEN TO PERFORM HAND HYGIENE

Wash Hands with Soap and Water	Wash Hands with Soap and Water or Use a Waterless Alcohol-Based Hand Rub
▪ Before eating ▪ After using the bathroom ▪ After blowing or wiping your nose ▪ After coughing or sneezing into a tissue ▪ Any time your hands are dirty ▪ After changing diapers or helping a child use the potty ▪ After contact with body fluids like blood, urine or vomit	▪ When you get to school ▪ When you arrive home from school ▪ After petting animals ▪ After being in contact with a sick person

FINGERNAILS

Artificial nails* can hide dangerous bacteria and should be avoided, especially if you are doing dressing changes or caring for a child who has lowered immunity, a central IV line, or a feeding tube. It's best to use clear polish on natural nails or leave them unpolished.

* Includes bonding, tips, wrappings, tapes, inlays and overlays

OTHER HELPING HANDS

For more information on cleanliness and hygiene, ask your nurse for these Helping Hands: Dental: *Teeth and Gum Care,* HH-IV-4, *Personal Hygiene,* HH-IV-58, *Bathing Your Baby,* HH-IV-2, and *Lice: Treatment and Prevention,* HH-I-49.

Appendix Y
Universal Precautions:
An Educational Training for Childcare Providers

*** Created by Jane Cotler, RN, MS and Chris Perreault, RN, BSN*

UNIVERSAL PRECAUTIONS:
AN
EDUCATIONAL TRAINING

FOR
CHILD CARE PROVIDERS

Prepared by:
Jane Cotler, RN, MS
Child Health Consultant
Colorado Department of Public Health & Environment
4300 Cherry Creek Drive South
Denver, CO 80246

Chris Perreault, RN, BSN
Clinical Manager
The Children's Hospital School Health Program
1056 19th Avenue
Denver, CO 80218

1999

Dear Colleagues:

We are pleased to provide you with a copy of our new instructional manual, *Universal Precautions for Child Care Providers*. This manual is the result of a need to provide Universal Precautions educational training for child care providers. This instructional manual has been accepted by the Division of Child Care as a standard curriculum for Universal Precaution training.

We would like to acknowledge Sarah Scully, RD, MPH, Child Health Promotion Coordinator for testing this curriculum at the Boulder County Health Department.

A special thanks needs to be extended to the following agencies who so generously shared their materials with us:

Tri-County Health Department
The Children's Hospital School Health Program
Office of Occupational Safety and Health Administration, Division of US Department of Labor, Colorado Office

This curriculum was adapt from The Arizona Department of Health, Bloodborne Pathogens In The Early Childhood Setting

UNIVERSAL PRECAUTIONS

Additional statements of information/explanation to share are provided for you in *italics*.

Early childhood professionals need to be knowledgeable about infectious diseases that can be transmitted in the early childhood setting, including those spread through contact with blood and other potentially infectious body fluids.

OH #1: FOUR WAYS TO SPREAD GERMS

Communicable diseases are spread from person-to-person in four basic ways:

1. Airborne or the respiratory route

   These germs are spread when infected droplets from the nose, mouth, sinuses, throat, lungs or contaminated tissues or fabric are inhaled when we breathe.

   Examples of the **Airborne Route** of infection are: TB, Colds, Chicken pox

2. Direct contact route

   This type of germ contact occurs by directly touching an infected area or body fluid such as saliva, mucus, eye discharge, pus or spit.

   Examples of **Direct Contact** route are: Conjunctivitis, impetigo, lice, poison ivy, chicken pox

3. Fecal-oral route

   These germs enter the body from hands, food, mouthed toys, toilet, diapers, etc., that have been unintentionally infected with germs from stool.

   Examples of **Fecal-Oral** communicable route are: hand, foot, and mouth disease, Hepatitis A, rotavirus

4. Blood contact route

   Meaning that an individual must come into contact with the infected blood or infected body fluids or another in order to "catch" the disease.

   Examples of **Blood Contact** route are: HIV/AIDS, Hepatitis B, Hepatitis C

All communicable diseases are spread by one of these transmission routes. Some diseases

cause only mild illness, while others may be life-threatening. Understanding the route of transmission not only tells us how we spread disease, but also directs our efforts in preventing the spread of disease.

A pathogen is a disease-causing "germ". In the case of bloodborne pathogens, that are the focus of this activity, these germs are spread through the bloodborne route. The word pathogen means to cause suffering.

Bloodborne pathogens are disease-causing germs that are found in infected human blood and certain other body fluids, particularly semen and vaginal secretions.

1. These pathogens may be passed form person-to-person with any exposure to infected blood or inflected body fluid.

2. Pathogens of significance are Hepatitis B Virus (HBV), Hepatitis C and Human Immunodeficiency Virus (HIV).

The initials HIV and HBV are sometimes difficult for learners to distinguish between in an in-service or workshop setting. This is especially true when highlighting distinguishing characteristics of the diseases. It may be more helpful to use these terms: "HIV/AIDS", when referring to infection with the Human Immunodeficiency virus and Hepatitis B disease when referring to infection with Hepatitis B virus.

We are now going to take a look at bloodborne pathogens and young children. The number of children born with HIV infection is rapidly decreasing. Gains in medical knowledge and treatment are also resulting in longer life spans for these children.

As of December 1998, 688,200 Americans have been reported with AIDS. And at least 417,359 of them have died. Deaths among people with AIDS also declined for the first time in 1996, dropping 42%. From 1997-1998, there was a 20% decrease in the number of deaths from AIDS. If declines in AIDS cases continue, there will also be an increase in the number of people with HIV infection, pointing to an increased need for both prevention and treatment of services. It is estimated that at least 40,000 new HIV infections occur each year.

And each year an estimated 1,800 children are born with HIV infection. Over 80% of the children who are infected in this country were infected by their mothers during pregnancy or at the time of delivery. Between 1992 and 1996, the number of children with perinatally acquired AIDS dropped 43%. The majority of cases still occur among African-American and Hispanic children, indicating the need for intensified efforts to prevent infection among minority women and to reach women who are infected with early prenatal care and preventive treatment.

Most other children were infected through the transmission of infected blood. Transmission through breastmilk from an infected mother has also been documented.

It has been reported that the incidence of children with HIV infection is declining. For more up-to-date information, please contact the National AIDS Hotline is 1-800-342-AIDS. For Spanish speaking population, the National AIDS Hotline is 1-800-344-SIDA

Although the child care community is not yet overwhelmed by children with HIV infection, many programs have already come into contact with families affected by HIV and its most advanced state, Acquired Immune Deficiency Syndrome or AIDS. Some of these children are enrolled in child care, and many others are eligible to enroll.

> The *Centers for Disease Control and Prevention (CDC) has reported a dramatic decrease in pediatric AIDS due to the Public Health Service guidelines for zidovudine (ZDV or AZT) during pregnancy and the testing of pregnant women. The swiftness of the decline has suggested that the goal of eliminating perinatal transmission may be attainable.*

Hepatitis B Virus infection in children is being prevented through early detection of risks, and through immunization. HBV vaccine is now included in the routine childhood immunization series. Treatment of HBV infection discovered in early stages may prevent life-threatening complications.

> More than 1,000,000 Americans carry the Hepatitis B virus in their blood. Each year another 300,000 are infected. Some are infants born to mothers who carry the Hepatitis B virus.

OH #2: HIV/AIDS

HIV infection is caused by one of several related retro viruses that become incorporated in the host cell DNA and result in a wide range of clinical presentations varying from asymptomatic carrier states to severely debilitating and fatal disorders.

HIV infects a major subset of T cells defined as helper/inducer cells. Their function is to protect the immune system. These cells are systematically destroyed during the course of HIV disease, making the individual susceptible to a number of illnesses.

Most people infected with HIV develop detectable antibodies within 6-12 weeks after infection; occasionally, there is a delayed response. During this phase called "seroconverting" people are capable of transmitting the virus to others.

As of December 1999, there were a total of 22 children living with AIDS in Colorado under the age of 13 years.

Here are some considerations for children who are infected with HIV/AIDS:

1. Communicable diseases, e.g., the common cold, chicken pox and strep throat pose additional risks to the HIV-infected child. All parents must be alerted to the presence of infectious disease should it occur in the group setting.

2. If communicable diseases such as measles, chickenpox or whooping cough are identified in the group setting, temporary exclusion of the HIV-infected child may be recommended to protect the child from unwarranted health risks. This is done due to the decreased ability of the HIV-infected child to fight infection.

3. Disclosure of illness is parent driven. Parents normally disclose this illness to the director and the immediate care giver(s). This information is considered highly

confidential and the penalty for disclosure is severe. There is no need to share this information with other staff members. Ordinarily, most children are able to attend child care without restrictions.

4. A plan of care regarding the child's inclusion/exclusion needs to be in place before the child begins child care activities. This would involve exposure to communicable disease because the immune system may be compromised.

OH #3: HOW HIV INFECTION IS SPREAD

There are several ways that HIV is spread and those include:

1. From infected person to an uninfected person during unprotected anal, vaginal, or oral sexual intercourse;

2. Infected intravenous drug users when they share needles and syringes contaminated with their blood

All hypodermic needles and syringes must be considered as potential source of infection for bloodborne pathogens like HIV, Hepatitis B and C.

3. Women infected with HIV may pass the virus to their unborn child. As the virus may be passed through breast milk of the infected woman, breast feeding is not recommended for infants of infected mothers.

4. Blood-to-blood transmission can occur when the infected blood of an individual enters the bloodstream of another through blood transfusions, breaks in the skin, mucous membranes, or through needlesticks.

Nationwide screening of blood products for HIV began in 1985. Although receiving donated blood may have its risks, donating blood for transfusion to others remains a safe and vital act.

OH #4 and #5: Each one is titled, HOW YOU *CANNOT* GET HIV/AIDS:

Providing first aid for bleeding injuries poses a second concern for the possibility of a blood-to-blood contact. It is possible to become infected when infected blood (or bodily fluid containing visible blood) comes in contact with skin that is broken or open. Infected blood that comes in contact with mucous membranes, e.g., lining of the eyes, mouth, and nose, may also infect an individual.

HIV is not easily transmitted in average daily activities for adults or children. HIV is **NOT TRANSMITTED** by:

1. Casual contact with infected people;
2. Holding or hugging infected people;
3. Sharing food, utensils, clothing, bed linens, art equipment, e.g., play-dough, clay or water play;
4. Kissing on the lips or cheeks; or

5. Coming into contact with perspiration, tears, saliva, vomit, urine, or stool that does not contain visible blood;
6. Shaking hands;
7. Sharing restroom
8. Bathroom fixtures;
9. Drinking fountains;
10. Mosquitoes; and
11. Eating with carriers

Sharing personal articles contaminated with blood, e.g., toothbrushes and shaving razors, have been implicated in the transmission of HIV/AIDS.

OH #6: WRITTEN POLICIES

Childhood programs' written policies on HIV/AIDS should address:

1. Education and training for all staff and volunteers on a yearly basis.
2. Infection control measures, e.g., use of personal protective equipment, sanitation practices, bagging and disposal of items contaminated with visible blood or other body fluids.
3. Enrollment process: confidentiality vs. "need-to-know", enrollment interview with parents and staff involved in the child's care on an as needed basis and inclusion into program activities.
4. Record keeping/documentation that includes confidentiality, exposure to other communicable diseases and communication.
5. Ongoing support for staff, children and families.

In the early childhood setting the risks of becoming infected with HIV/AIDS are very low. Do keep in mind that the most common way individuals become infected with HIV/AIDS in through sexual relations with an infected partner, and sharing contaminated needles and syringes. These activities are not expected behaviors in an early childhood program.

OH #7: WHAT IS HEPATITIS B?

Hepatitis B infection occurs when the HBV virus enters the body, multiplies in the blood and infecting the liver.

Hepatitis A and Hepatitis B are easily confused because of the similarity of their names. Each of these diseases is caused by a separate and distinct virus. However, both viruses infect the liver and may show similar symptoms. ***Hepatitis A is spread through the stool-to-mouth or the fecal-oral route.*** *This infection is sometimes referred to as "infectious hepatitis".* ***Hepatitis B is spread through the bloodborne route and is sometimes called "serum hepatitis".*** Two hundred to three hundred million people throughout the world are chronic carriers of Hepatitis B and about half of these people do not have any symptoms of infection.

Hepatitis B can result in mild illness, chronic (long-lasting) infection or permanent liver damage.

Most individuals recover completely. However, death does occur in some cases due to liver failure. Hepatitis B infection is second only to tobacco among known human cancer-causing agents. Hepatitis B is the cause of up to 80% of liver cancer.

Hepatitis B can affect anyone. Each year in the United States, more than 200,000 people of all ages get hepatitis B and close to 5,000 die of sickness caused by HBV. Twenty-two thousand pregnant women are chronically infected. If you have had other forms of hepatitis, you can still get hepatitis B. If you wish to have more information, please log on to the Centers for Disease Control and Prevention website: http://www.cdc.gov/ncidod/disease/hepatitis/b/faqb.htm for information about hepatitis B and http://www.cdc.gov/nchstp/hiv_aids/pubs/facts/perinatl.htm

OH # 8: SYMPTOMS OF HEPATITIS B

Some signs and symptoms of Hepatitis B are: weakness, fatigue, loss of appetite, nausea, abdominal pain, fever and headache and occasionally yellowing of the skin and eyes which is called jaundice.

Hepatitis B infected individuals may show no symptoms of the illness, BUT they are capable of infecting others. They are referred to as "chronic carriers" and are at high risk for serious liver damage. They are 12-300 times more likely than the average person to develop liver cancer.

10% of infected individuals will become chronic carriers
30-50% of children infected between 1-5 years may become carriers
A high percentage of infants who acquire Hepatitis B from their mothers at birth will become chronic carriers

There is no cure for Hepatitis B.

OH # 9: WHAT IS HEPATITIS C

Hepatitis C (HCV) was first identified in the mid-1970's, but it wasn't until 1992 that a test specific for Hepatitis C became available. Hepatitis C Virus (HCV) infection is the most common chronic bloodborne infection in the United States. Approximately 3.9 million persons in the United States are infected with HCV. About 7% of these may have acquired their infection from a blood transfusion. There area bout 36,000 new infections each year. Chronic liver disease is the10th leading cause of death among adults in the United States. Studies indicate 40-60% of this disease is related to HCV, resulting in 8,000 to 10,000 deaths each year. Injecting drug use currently accounts for 60% of HCV infections in the U.S. Other modes of transmission include sexual exposure, shared cocaine straws, occupation, hemodialysis and perinatal.

HCV is not spread by sneezing, hugging, coughing, breast feeding, food or water, sharing eating utensils or drinking glasses, or casual contact. Tattooing and body piercing are not associated with HCV infection. There is no vaccine against hepatitis C.

For additional information you may contact: The Centers for Disease Control and Prevention, Hepatitis Branch (888) 443-7232 or www.cdc.gov. or the Hep C Connection, 1-800-522-HEPC or hepc-connection@worldnet.att.net. or The Hepatitis Foundation,

International 1-800-891-0707.

OH #10: HOW HEPATITIS IS SPREAD

Hepatitis is spread by:

1. Infected person to uninfected person during unprotected anal, vaginal or oral sexual intercourse;
2. Infected IV drug users when they share needles and syringes contaminated with their blood, through tattooing with unsterilized equipment;
3. HBV/HCV infected mothers passing the virus to their unborn child;
4. HBV/HCV infected mothers passing the virus through breastmilk;
5. Blood-to-blood transmission when the blood of an infected person enter the bloodstream of an unaffected person through blood transfusions, breaks in the skin or through mucous membranes; and

All early childhood programs should have written policies that address steps that must be taken when a child or adult is bitten by another, and that bite breaks the skin. These steps should include washing the bite with soap and water, placing a cool cloth on the bite, completing the "report" with a copy for the child's file and the parent and placing an immediate call to the parent to recommend the child's health care provider be contacted. If the bitten individual is an adult, the program's plan regarding significant exposure to bloodborne pathogens should be implemented.

a. Blood will not show positive for HBV or HCV during the incubation period of 1-12 weeks after exposure and only a blood test can distinguish between the different types of hepatitis. A positive test occurs 2-6 weeks after symptoms begin. The signs and symptoms of types of hepatitis are virtually the same.
b. Hepatitis B vaccine is now a routine immunization for children and is recommended for adults who:

    1) Routinely come in contact with blood or other potentially infected body fluids during their work day;
    2) Live in a household in which someone is infected;
    3) Are sexually active, especially with more than one partner
    4) Use needles to inject drugs.

OH #11: HOW ARE HBC, HCV and HIV SIMILAR AND HOW ARE THEY DIFFERENT

Now let's go over some bloodborne transmission risks and interventions in the early childhood classroom or home:

The infection control procedures for child care programs when a known HIV/AIDs or HBV/HCV infected individual is in your program are the same procedures that should **ALWAYS** be in place for the safety of all individuals, whether or not an HIV/AIDS or HBV/HCV infected person is in the program. Actually, having a child or children in your program with HIB or HBV/HCV infection may make the staff more conscious of using universal precautions.

OH # 12: UNIVERSAL PRECAUTIONS - COMPONENTS

The principles of infection control remain constant, whether HIV, HBV, HCV or other infectious agents are the cause for concern. The components of Universal Precautions include:

1. Personal protective equipment, e.g., wearing gloves, gowns, eye protection and other protective gear;
2. Handwashing,
3. Decontamination, e.g., appropriate cleaning methods to decontaminate surfaces, objects, etc.; and
4. Waste disposal, e.g., liquid or non-liquid form, double bagging and labeling.

OH # 13: TREAT ALL HUMAN BLOOD AND POTENTIALLY INFECTIOUS BODY FLUIDS AS CONTAGIOUS

1. Treat all human blood and potentially infectious body fluids as if they are known to contain bloodborne pathogens. Those potentially infectious body fluids are:

OH: #14: POTENTIALLY INFECTIOUS BODY FLUIDS

a. blood
b. vaginal secretions
c. semen
d. any body fluid that you can't identify
e. fluid that has visible blood present

2. Precaution should be taken when handling stool, urine, nasal secretions and vomitus.

Instructor's Note:
Before putting up the next 2 overheads, give the participants an opportunity to respond to the following two questions.)

What are some tasks in child care that may pose a risk to infection with bloodborne pathogens?

OH #15: EXPECTED RESPONSES

Expected Responses: Bleeding injuries, biting, loose tooth, changing band-aids or dressings, handling breast milk, any task that involves visible blood, and performing CPR.

The following is a note to assist in answering questions:

1. *Biting is not a common way of transmitting HIV. In fact, there are numerous reports of bites that did not result in HIV infection. This information is from the Center for Disease Control (CDC) fact sheet, HIV and It's Transmission, 1997.*

2. *Although Universal Precautions do not apply to human breast milk, gloves may be worn by health care workers in situations where exposure to breast milk might be frequent, e.g., in breast milk banking. CDC, May "95.*

3. *Saliva, tear and sweat: HIV has been found in saliva and tears in very low quantities from some AIDS patients. It is important to understand that finding a small amount of HIV in a body fluid does not necessarily mean that HIV can be transmitted by that body fluid. HIV may not be recovered from the sweat of HIV infected persons. Contact with saliva, tears or sweat has never been shown to result in transmission of HIV.*

What are some ways to protect yourselves while performing these tasks?

OH #16: EXPECTED RESPONSES

Expected Responses: Wearing gloves, washing hands, using bleach or other approved disinfecting solutions, using available resuscitation masks (CPR).

OH #17: HAND WASHING

The second component of Universal Precautions is Handwashing. Handwashing is one of the most important defense against the spread of infectious disease.

Children's hands and adult's hands should always be washed with soap and running water following contact with blood or other potentially infectious body secretions, as described above, even if gloves have been used for the task.

Do remember that handwashing is the most effective way to reduce the spread of disease.

Let's take a few minutes to review the method of handwashing:

Use soap. Liquid is best and warm running water.
Rub hands together vigorously for at least 30 seconds.
Remember all surfaces including thumbs, wrists, back of hands, between fingers and around and under nails.
Rinse hands well, letting water drain from wrists to fingers - don't turn off faucet.
Dry hands with paper towel, then use same towel to turn off faucet.
Discard towel.

Remember, the use of bar soap is discouraged as bacteria can grow on the bar and the soap dish.

Products such as moistened towelettes and antiseptic hand cleaners do not replace the need for handwashing as soon as possible following exposure. Antiseptic hand cleaners are effective alternatives if running water is not available, e.g., field trips.

OH #18: ALWAYS WASH HANDS

Remember: The times to always wash hands are:

When you arrive at the child care center
Before and after giving medications
Before beginning care/first aid
Before and after using the bathroom
In-between delivery of care/first aid
Before handling clean equipment and after handling dirty equipment
Before and after eating
Before handling food
Before leaving the building.

OH #19: PERSONAL HYGIENE

Personal hygiene as well as eating or drinking should not take place where there is a possibility of exposure. There should be no eating, drinking, smoking, applying make-up, handling contact lenses, etc, in areas in which first aid is provided.

OH #20: PERSONAL PROTECTIVE EQUIPMENT

This equipment always includes disposable latex or vinyl gloves that should be worn only once. Staff members allergic to latex gloves will have alternative gloves available for their use.

Additional protective equipment, e.g., masks, aprons, gowns, face shields may be required in a program serving special needs children whose care requires suctioning, catheter care, nasogastric or gastric feeding tubes. Gloves must be provided in each classroom and diaper changing area, with first aid supplies and on transportation vehicle(s). **Gloves must be discarded after one use. NEVER use gloves twice.** Hands must be washed each time gloves are discarded.

Instructor's Note: This is a good time to demonstrate how to remove gloves.

OH #21: SHARPS

All sharps must be disposed of in a container that is closeable, puncture resistant, leak proof on sides and bottom and labeled with a biohazard label or color-coded red. All needles, broken glass, etc, should be discarded into this container.

Needles or other contaminated sharps will not be bent, recapped, removed or purposely broken.

Sharps containers should be located in areas away form children's reach.

OH #22: BLEACH SOLUTIONS

All surfaces, especially those contaminated with visible blood or other potentially infectious body fluid should be washed and disinfected immediately with a solution consisting of 1 part bleach to 10 parts water. Wear gloves and use paper towels during this procedure.

The 1:10 bleach solution is the solution most often recommended for the decontamination of surfaces because it is effective, inexpensive and readily available.

Carpets contaminated with blood or other body fluids are satisfactorily decontaminated with standard carpet-cleaning chemicals.

OH #23: LAUNDRY PROCEDURES

Clothing and linens stained with blood should be handled with gloves and placed in a plastic bag and labeled and color-coded in accordance with OSHA regulations, until they can be laundered in hot, soapy water. Appropriate personal equipment should be worn when laundering contaminated laundry. Responsibility for laundering these items may vary, e.g., parents, program, or a professional laundry may do them.

1. The employer is responsible for cleaning employees contaminated clothing at no expense to the employee.

2. The child's clothing needs to be double plastic bagged and sent home.
3. Center items may be laundered at the center or at a laundromat.

Launder in hot water (165^0) for 25 minutes. If using cooler water, add bleach or other laundry disinfectant according to the instructions on the container.

WASTE DISPOSAL

Items that are visibly contaminated or are potentially infectious, must be disposed of in a separate sealed, double plastic bag before being discarded. The location of your program may determine the steps for appropriate waste disposal.

Regulated (bio-hazardous) waste is defined as:

1. Liquid or semi-liquid blood or other potentially infectious material;

2. *Contaminated items that would release blood and other potentially infectious materials if compressed;*
3. *Items caked with dried blood or other potentially infectious material that are capable of releasing these materials during handling; and*
4. *Contaminated sharps (needles, broken glass contaminated with blood.)*

OH #24: TWO TYPES OF WASTE

There are two types of waste that need special attention. Early childhood programs usually generate an amount of "contaminated waste" that is not regulated.

1. Contaminated waste includes: diapers, sanitary napkins, used band-aid (not saturated with blood), discarded gloves or other personal protective equipment (not saturated with blood), vomit, etc.

Contaminated waste should be double-bagged in plastic, a disposed of in covered trash containers that are not accessible to children.

2. Regulated (bio-hazardous) waste includes items that are saturated with fluids containing blood, or items caked with dried blood. This waste must be placed in special containers, and handled by a hazardous waste disposal company.

In all cases, follow local regulations carefully concerning disposal procedures.

Now we are going to consider what happens following an exposure to blood or other potentially infectious materials.

All programs should have policies in place to provide guidance in the event significant exposure to potentially infected blood or body fluid has occurred to an adult or child. These policies should include the following:

Hepatitis B vaccination must be offered to an employee within 24 hours following a first aid incident in which blood or other body fluids were present. If the employee refuses, the employee must sign a form declining the offer of the Hepatitis B vaccine. (See sample Declination handout form).

OH #25: WHAT IS AN EXPOSURE INCIDENT

An Exposure Incident means a specific eye, mouth, other mucous membrane, non-intact skin or parental (needle or sharp object) with blood or other potentially infectious material that result from the performance of an employee's duties.

OH #26: AFTER EXPOSURE

Responsibilities and procedures after a significant exposure to blood or other potentially infectious materials include:

1. Wash the affected area and remove contaminated clothing;
2. Protect others from exposure (cleanup, decontaminate, and follow disposal procedures);
3. Report the event to your supervisor as soon as possible.
4. Seek medical care within 2 hours if the exposure warrants.
5. The physician/clinician will determine significance of the exposure as well as dictate follow-up medical care.
6. If consent for testing is obtained from the source of the exposure, only the physician and exposed worker are entitled to those results.
7. Confidentiality of the source and exposed worker must be maintained.
8. Document the exposure before the end of the day;

Documentation of the exposure must include: the name of the individual, date and time of the exposure, type of exposure, what happened and, if it is not prohibited by local or state regulations, the name of the person whose blood (body fluid) was the source of the exposure. Suggestions that might help to prevent a future accident of this kind should be documented at this time. (See sample Exposure handout).

9. Provide the healthcare professional with information and secure a confidential medical evaluation if necessary; and
10. Provide the health care professional's written opinion.

Confidentiality will be maintained. Medical records will be kept confidential.

Remember, in order for Universal Precautions to be effective, it must be practiced as a matter of routine, not only in particular situations. All staff must be instructed annually in the procedures used by their program, and monitored on their application on a regular basis.

OH #27 : OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

The Occupational Safety and Health Administration (OSHA) is a division of the US Department of Labor. OSHA regulates workplace health and safety standards. Bloodborne pathogen standards are included in OSHA regulation and early childhood staff are protected by these standards.

OSHA bloodborne pathogen standards include the requirement for training of all individuals who may have contact with blood and other potentially infectious materials during the course of their jobs.

OSHA does not specifically identify all occupations considered to be at risk for exposure. Risk determination is often left to the discretion of the employer.

Training is to be provided by the employer prior to the new employees first assignment and every year during work hours. The training is to familiarize staff with signs and symptoms of bloodborne diseases, e.g., HIV/AIDS and Hepatitis B and is to include review of site policies and procedures that address potential bloodborne pathogen exposure.

All programs should have an exposure control plan to guide them is an exposure to blood or other potentially infectious material occurs. This plan needs to be part of the training.

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Training records must include;

1. Dates of training sessions
2. Summary of training sessions
3. Names and qualifications of persons conducting trainings
4. Names and job titles of those attending trainings.
5. Records must be maintained for 3 years from the date of training

POST-EXPOSURE INCIDENT REPORT

Date of Report _____

Name: _____ Social Security No _____

Date of Exposure _____ **Time** _____

Describe Incident: Include what employee(s) task/activities performed at time of incident

_____

_____

_____

_____

Blood or other body fluids involved? Describe type and source.

_____

_____

Personal Protective Equipment used by those providing first aid?
___ gloves ____ mask ____ gown ____ other _____ ___ None used

Did an exposure incident occur? ____ Yes ____ No
(*An exposure incident means a specific eye, mouth, other mucous membrane, non-intact skin, or parental(needle or other sharp object) with blood or other potentially infectious material that result from the performance of an employee's duties).*

If yes, please describe:

Employee Previously Vaccinated Against Hepatitis B Virus: __ Yes __ No
DATE: (1) _____ (2) _____ (3) _____

If NO, was Hepatitis B Series Offered? _____ Yes _____ No

What steps could be taken to prevent this incident from happening again?

_____

_____

_____

Person completing this form: _____
Follow up: _____

BLOODBORNE FACTS

REPORTING EXPOSURE INCIDENTS

OSHA's new bloodborne pathogens standard provides for medical follow-up for workers who have an exposure incident. The most obvious exposure incident is a needlestick. But any specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials is considered an exposure incident and should be reported to the employer.

Exposure incidents can lead to infection from hepatitis B or human immunodeficiency virus which causes AIDS. Although few cases of AIDS are directly traceable to workplace exposure, every year about 8,700 health care workers contract hepatitis B from occupational exposures. Approximately 200 will die from this bloodborne infection. Some will become carriers, passing the infection on to others.

WHY REPORT?

Reporting right away permits immediate medical follow-up and early action is crucial. Immediate intervention can forestall the development of hepatitis B or enable the affected worker to track potential HIV infection. Prompt reporting also can help the worker avoid spreading bloodborne infections, enable the employer to evaluate the circumstances surrounding the exposure incident to try to find ways to prevent such a situation from occurring again.

Reporting is also important because part of the follow-up includes testing the blood of the source individual to determine HBV and HIV infectivity if this is unknown and if permission for testing can be obtained. The exposed employee must be informed of the results of these tests. Employers must tell the employee what to do if an exposure incident occurs.

MEDICAL EVALUATION AND FOLLOW-UP

Employers must provide free medical evaluation and treatment to employees who experience an exposure incident. They are to refer exposed employees to a licensed health care provider who will counsel the individual about what happened and how to prevent further spread of any potential infection. He/she will prescribe appropriate treatment in line with current U.S. Public Health Service recommendations. The licensed health care provider also will evaluate any reported illness to determine if the symptoms may be related to HIV or HBV development.

The first step is to test the blood of the exposed employee. Any employee who wants to participate in the medical evaluation program must agree to have blood drawn.

However, the employee has the option to give the blood sample but refuse permission for HIV testing at that time. The employer must maintain the employee's blood sample for 90 days in case the employee changes his/her mind about testing--should symptoms develop that might relate to HIV or HBV infection.

The health care provider will counsel the employee based on the test results. If the source individual was HBV positive or in a high risk category, the exposed employee may be given hepatitis B immune globulin and vaccination, as necessary. If there is not information on the source individual or the test is negative, and the employee has not been vaccinated or does not have immunity bases on her/his test, he/she may receive the vaccine. Further, the health care provider will discuss any other findings from the tests.

The standard requires that the employer make the hepatitis B vaccine available, at no cost to the employee, to all employees who have occupational exposure to blood and other potentially infectious materials. This requirement is in addition to post-exposure testing and treatment responsibilities.

WRITTEN OPINION

In addition to counseling the employee, the health care provider will provide a written report to the employer. This report simply identifies whether hepatitis B vaccine was recommended for the exposed employee and whether or not the employee received the vaccine. The health care provider also must note that the employee has been informed of the results of the evaluation and told of any medical conditions resulting from exposure to blood which require further evaluation or treatment. Any added findings must be kept confidential.

CONFIDENTIALITY

Medical records must remain confidential. They are not available to the employer. The employer must give specific written consent for anyone to see the records. Records must be maintained for the duration of employment plus 30 years in accordance with OSHA's standard on access to employee exposure and medical records.

US Department of Labor
Occupational Safety and Health Administration

BLOODBORNE FACTS

PERSONAL PROTECTIVE EQUIPMENT CUTS RISK

Wearing gloves, gowns and eye protection can significantly reduce health risks for workers exposed to blood and other potentially infectious materials. The new OSHA standard covering bloodborne disease requires employers to provide appropriate personal protective equipment (PPE) and clothing free of charge to employees.

Workers who have direct exposure to blood and other potentially infectious materials on their jobs run the risk of contracting bloodborne infections from hepatitis B virus (HBV), human immunodeficiency virus (HIV) which causes AIDS, and other pathogens. About 8,700 health care workers each year are infected with HBV, and 200 die from the infection. Although the risk of contracting AIDS through occupational exposure is much lower, wearing proper PPE can greatly reduce potential exposure to all bloodborne infections.

SELECTING PPE

Personal protective clothing and equipment must be suitable. This means the level of protection must fit the expected exposure. For example, gloves would be sufficient for a laboratory technician who is drawing blood, whereas a pathologist conducting an autopsy would need considerably more protective clothing.

Personal protective equipment may include gloves, gowns, laboratory coats, face shields or masks, eye protection, pocket masks, and other protective gear. The gear must be readily accessible to employees and available in appropriate sizes.

If an employee is expected to have hand contact with blood or other potentially infectious materials or contaminated surfaces, he/she must wear gloves. Single use gloves cannot be washed or decontaminated for reuse. Utility gloves may be decontaminated if they are not compromised. They should be replaced when they show signs of cracking, peeling, tearing, puncturing or deteriorating. If employees are allergic to standard gloves, the employer must provide hypoallergenic gloves or similar alternatives.

Routine gloving is not required for phlebotomy in voluntary blood donation centers, although it is necessary for all other phlebotomies. In any case, gloves must be available in voluntary blood donation centers for employees who want to use them. Workers in voluntary blood donation centers must use gloves (1) when they have cuts, scratches or other breaks in their skin; (2) while they are in training; and (3) when they believe contamination might occur.

Employees should wear eye and mouth protection such as goggles and masks, glasses with solid side shields, and masks or chin-length face shields when splashes, sprays, splatters or droplets of potentially infectious materials pose a hazard

AVOIDING CONTAMINATION

The key is that blood or other infectious materials must not reach an employee's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions for the duration of exposure.

Employers must provide the personal protective equipment and ensure that their workers wear it. This means that if a lab coat is considered personal protective equipment, it must be supplied by the employer rather than the employee. The employer also must clean or launder clothing and equipment and repair or replace it as necessary.

Additional protective measures such as using PPE in animal rooms and decontaminating PPE before laundering are essential in facilities that conduct research on HIV or HBV.

EXCEPTION

There is one exception to the requirement for protective gear. An employee may choose, temporarily and briefly, under rare and extraordinary circumstances, to forego the equipment. It must be the employee's professional judgement that using the personal protective equipment would prevent the delivery of health care or public safety service or would pose an increased hazard to the safety of the worker or co-worker. When one of these excepted situations occurs, employers are to investigate and document the circumstances to determine if there are ways to avoid it in the future. For example, if a firefighter's resuscitation device is damaged, perhaps another type of device should be used or the device should be carried in a different manner. Exceptions must be limited--this is not a blanket exemption.

DECONTAMINATING AND DISPOSING OF PPE

Employees must remove personal protective clothing and equipment before leaving the work area or when the PPE becomes contaminated. If a garment is penetrated, workers must remove it immediately or as soon as feasible. Used protective clothing and equipment must be placed in designated containers for storage, decontamination, or disposal.

OTHER PROTECTIVE PRACTICES

If an employee's skin or mucous membranes come into contact with blood, he or she is to wash with soap and water and flush eyes with water as soon as possible. In addition, workers must wash their hands immediately or as soon as feasible after removing protective equipment. If soap and water are not immediately available, employers may provide other handwashing measures such as moist towelettes. Employees still must wash with soap and water as soon as possible.

Employees must refrain from eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses in areas where they may be exposed to blood or other potentially infectious materials.

US Department of Labor
Occupational Safety and Health Administration

BLOODBORNE FACTS

HEPATITIS B VACCINATION -- PROTECTION FOR YOU

What is HBV?
Hepatitis B virus (HBV) is a potentially life-threatening bloodborne pathogen. Centers for Disease Control estimates there are approximately 280,000 HBV infections each year in the U.S.

Approximately 8,700 health care workers each year contract hepatitis B, and about 200 will die as a result. In addition, some who contract HBV will become carriers, passing the disease on to others. Carriers also face a significantly higher risk for other liver ailments which can be fatal, including cirrhosis of the liver and primary liver cancer.

HBV infection is transmitted through exposure to blood and other infectious body fluids and tissues. Anyone with occupational exposure to blood is at risk of contracting the infection.

Employers must provide engineering controls; workers must use work practices and protective clothing and equipment to prevent exposure to potentially infectious materials. However, the best defense against hepatitis B is vaccination.

WHO NEEDS VACCINATIONS?
The new OSHA standard covering bloodborne pathogens requires employers to offer the three-injection vaccination series free to all employees who are exposed to blood or other potentially infectious materials as part of their job duties. This includes health care workers, emergency responders, morticians, first-aid personnel, law enforcement officers, correctional facilities staff, launderers, as well as others.

The vaccination must be offered within 10 days of initial assignment to a job where exposure to blood or other potentially infectious materials can be "reasonably anticipated." The requirements for vaccinations of those already on the job take effect July 6, 1992.

WHAT DOES VACCINATION INVOLVE?
The hepatitis B Vaccination is a non-infectious, yeast-based vaccine given in three injections in the arm. It is prepared from recombinant yeast cultures, rather than human blood or plasma. Thus, there is no risk of contamination from other bloodborne pathogens nor is there any chance of developing HBV from the vaccine.

The second injection should be given one month after the first, and the third injection six months after the initial dose.

More than 90% of those vaccinated will develop immunity to the hepatitis B virus. To ensure immunity, it is important for individuals to receive all three injections. At this point it is unclear how long the immunity lasts, so booster shots may be required at some point in the future.

The vaccine causes no harm to those who are already immune or to those who may be HBV carriers. Although employees may opt to have their blood tested for antibodies to determine need for the vaccine, employers may not make antibody screening a condition of receiving vaccination nor are employers required to provide prescreening.

WHAT IF I DECLINE VACCINATION?
Workers who decide to decline vaccination must complete a declination form. Employers must keep these forms on file so that they know the vaccination status of everyone who is exposed to blood. At any time after a worker initially declines to receive the vaccine, he or she may opt to take it.

WHAT IF I AM EXPOSED BUT HAVE NOT YET BEEN VACCINATED?
If a worker experiences an exposure incident, such as a needlestick or a blood splash in the eye, he/she must receive confidential medical evaluation from a licensed health care professional with appropriate follow-up. To the extent possible by law, the employer is to determine the source individual for HBV as well as HIV infectivity. The worker's blood will also be screened if he or she agree.

The healthcare professional is to follow the guidelines of the U.S. Public Health Service in providing treatment. This would include hepatitis B vaccination. The health care professional must give a written opinion on whether the employee received it. Employee medical records must remain confidential. HIV or HBV status must NOT be reported to the employer.

U.S. Department of Labor
Occupational Safety and Health Administration

BLOODBORNE FACTS

Holding the Line on Contamination

Keeping work areas in a clean and sanitary condition reduces employee's risk of exposure to bloodborne pathogens. Each year about 8,700 health care workers are infected with hepatitis B virus, and 200 die from contracting hepatitis B through their work. The chance of contracting human immunodeficiency virus (HIV), the bloodborne pathogen which causes AIDS, from occupational exposure is small, yet a good housekeeping program can minimize this risk as well.

DECONTAMINATION

Every employer whose employees are exposed to blood or other potentially infectious materials must develop a written schedule for cleaning each area where exposures occur. The methods of decontaminating different surfaces must be specific, determined by the type of surface to be cleaned, the soil present and the tasks or procedures that occur in that area.

For example, different cleaning and decontamination measures would be used for surgical operatory and a patient room. Similarly, hard surfaced flooring and carpeting require separate cleaning methods. More extensive efforts will be necessary for gross contamination than for minor spattering. Likewise, such varied tasks as laboratory analyses and normal patient care would require different techniques for clean-up.

Employees must decontaminate working surfaces and equipment with an appropriate disinfectant after completing procedures involving exposure to blood. Many laboratory procedures are performed on a continual basis throughout a shift. Except as discussed below, it is not necessary to clean and decontaminate between procedures. However, if the employee leaves the area for a period of time, for a break or lunch, then contaminated work surfaces must be cleaned.

Employees also must clean (1) when surfaces become obviously contaminated; (2) after any spill of blood or other potentially infectious materials; and (3) at the end of the work shift is contamination might have occurred. thus, employees need not decontaminate the work area after each patient care procedure, but only after those that actually result in contamination.

If surfaces or equipment are draped with protective coverings such as plastic wrap or aluminum foil, these coverings should be removed or replaced if they become obviously contaminated. Reusable receptacles such as bins, pails and cans that are likely to become contaminated must be inspected and decontaminated on a regular basis. If contamination is visible, workers must clean and decontaminate the item immediately, or as soon as feasible.

Should glassware that may be potentially contaminated break, workers need to use mechanical means such as a brush and dustpan or tongs or forceps to pick up the broken glass - never by hand, even when wearing gloves.

Before any equipment is serviced or shipped for repairing or cleaning, it must be decontaminated to the extent possible. the equipment must be labeled, indicating which portions are still contaminated. This enables employees and those who service the equipment to take appropriate precautions to prevent exposure.

REGULATED WASTE

In addition to effective decontamination of work areas, proper handling of regulated waste is essential to prevent unnecessary exposure to blood and other potentially infectious materials. Regulated waste must be handled with great care, e.g., liquid or semi-liquid blood and other potentially infectious materials, items caked with these materials, items that would release blood or other potentially infected materials if compressed, pathological or microbiological wastes containing them and contaminated sharps

Containers used to store regulated waste must be closeable and suitable to contain the contents and prevent leakage of fluids. Containers designed for sharps also must be puncture resistant. They must be labeled or color-coded to ensure that employees are award of the potential hazards. Such containers must be closed before removal to prevent the contents from spilling. If the outside of a container becomes contaminated, it must be placed within a second suitable container.

Regulated waste must be disposed of in accordance with applicable state and local laws.

LAUNDRY

Laundry workers must wear gloves and handle contaminated laundry as little as possible, with a minimum of agitation. Contaminated laundry should be bagged or placed in containers at the location where it is used, but not sorted or rinsed there.

Laundry must be transported within the establishment or to outside laundries in labeled or red color-coded bags. If the facility uses Universal Precautions for handling all soiled laundry, then alternate labeling or color coding that can be recognized the employees may be used. If laundry is wet and it might soak through laundry bags, the workers must use bags that prevent leakage to transport it.

RESEARCH FACILITIES

More stringent decontamination requirements apply to research laboratories and production facilities that work with concentrated strains of HIV and HBV.

US Department of Labor
Occupational Safety and Health Administration

	HEPATITIS B (HBV)	HEPATITIS C (HCV)	HIV/AIDS
VIRUS	Stable	Stable	Fragile
INCIDENCE	World-Wide	World-Wide	World-Wide
HIGH-RISK	IV Drug Users Homosexual Heterosexual & Multiple Partners	IV Drug Users, Alcoholics Anyone who has had a blood transfusion before 1992 Multiple sex partners	IV Drug Users Homosexual Heterosexual & Multiple Partners
COMMUNICABILITY	15 x Greater than AIDS	Highly communicable - 10th leading cause of death	
COMPLICATIONS	Cirrhosis Predisposition to liver cancer Jaundice Death	Liver Inflammation Cirrhosis Cancer	Persistent cold/flu like symptoms Opportunistic diseases Death
TRANSMISSION	Blood/Blood Products Semen, vaginal secretions	Blood/Blood Products **NOT** easily spread through sex	
INCUBATION	2-6 Months 1/3 = no symptoms - carriers virus shed in 6 mos. 1/3 = some symptoms - carriers 1/3 = full-blown disease develops	2-25 weeks. Average 7 to 9 weeks	3-6 Months HIV Positive (8-15 yrs) AIDS
SYMPTOMS	Fever Anorexia Rash Joint Pain	Same as HBV	Mono-like symptoms Anorexia Night sweats Fatigue
COMPLICATIONS	Cirrhosis Predisposition to liver cancer Jaundice Death	Liver Inflammation Cirrhosis Cancer	Persistent cold/flu like symptoms Opportunistic diseases Death
VACCINE	Yes	No	No
PRECAUTIONS	Environmental safeguards Education Personal Protective Equipment Universal Precautions Vaccine	Safe sex Environmental safeguards Education Personal Protective Equipment Universal Precautions	Environmental safeguards Education Personal Protective Equipment Universal Precautions

OH #15

Appendix Z
Infectious Disease List

***Provided by the Ohio Department of Health*

Know Your ABCs: A Quick Guide to Reportable Infectious Diseases in Ohio

from the Ohio Administrative Code Chapter 3701-3; Effective January 1, 2009

Class A ***Diseases of major public health concern because of the severity of disease or potential for epidemic spread - report by telephone immediately upon recognition that a case, a suspected case, or a positive laboratory result exists***

- Anthrax
- Botulism, foodborne
- Cholera
- Diphtheria
- Influenza A - novel virus
- Measles
- Meningococcal disease
- Plague
- Rabies, human
- Rubella (not congenital)
- Severe acute respiratory syndrome (SARS)
- Smallpox
- Tularemia
- Viral hemorrhagic fever (VHF)
- Yellow fever

Any unexpected pattern of cases, suspected cases, deaths or increased incidence of any other disease of major public health concern, because of the severity of disease or potential for epidemic spread, which may indicate a newly recognized infectious agent, outbreak, epidemic, related public health hazard or act of bioterrorism.

Class B ***(1) Diseases of public health concern needing timely response because of potential for epidemic spread - report by the end of the next business day after the existence of a case, a suspected case, or a positive laboratory result is known***

- Arboviral neuroinvasive and non-neuroinvasive disease:
  - Eastern equine encephalitis virus disease
  - LaCrosse virus disease (other California serogroup virus disease)
  - Powassan virus disease
  - St. Louis encephalitis virus disease
  - West Nile virus infection
  - Western equine encephalitis virus disease
  - Other arthropod-borne disease
- Chancroid
- Coccidioidomycosis
- Cyclosporiasis
- Dengue
- *E. coli* O157:H7 and other enterohemorrhagic (Shiga toxin-producing) *E. coli*
- Granuloma inguinale
- *Haemophilus influenzae* (invasive disease)
- Hantavirus
- Hemolytic uremic syndrome (HUS)
- Hepatitis A
- Hepatitis B, perinatal
- Influenza-associated pediatric mortality
- Legionnaires' disease
- Listeriosis
- Malaria
- Meningitis, aseptic (viral)
- Meningitis, bacterial
- Mumps
- Pertussis
- Poliomyelitis (including vaccine-associated cases)
- Psittacosis
- Q fever
- Rubella (congenital)
- Salmonellosis
- Shigellosis
- *Staphylococcus aureus,* with resistance or intermediate resistance to vancomycin (VRSA, VISA)
- Syphilis
- Tetanus
- Tuberculosis, including multi-drug resistant tuberculosis (MDR-TB)
- Typhoid fever

Class B ***(2) Diseases of significant public health concern - report by the end of the work week after the existence of a case, a suspected case, or a positive laboratory result is known***

- Amebiasis
- Botulism, infant
- Botulism, wound
- Brucellosis
- Campylobacteriosis
- Chlamydia infections (urethritis, epididymitis, cervicitis, pelvic inflammatory disease, neonatal conjunctivitis, pneumonia, and lymphogranuloma venereum (LGV))
- Creutzfeldt-Jakob disease (CJD)
- Cryptosporidiosis
- Cytomegalovirus (CMV) (congenital)
- Ehrlichiosis/Anaplasmosis
- Giardiasis
- Gonococcal infections (urethritis, cervicitis, pelvic inflammatory disease, pharyngitis, arthritis, endocarditis, meningitis, and neonatal conjunctivitis)
- Hepatitis B, non-perinatal
- Hepatitis C
- Hepatitis D (delta hepatitis)
- Hepatitis E
- Herpes (congenital)
- Influenza-associated hospitalization
- Leprosy (Hansen disease)
- Leptospirosis
- Lyme disease
- Mycobacterial disease, other than tuberculosis (MOTT)
- Rocky Mountain spotted fever (RMSF)
- Streptococcal disease, group A, invasive (IGAS)
- Streptococcal disease, group B, in newborn
- Streptococcal toxic shock syndrome (STSS)
- *Streptococcus pneumoniae,* invasive disease (ISP)
- Toxic shock syndrome (TSS)
- Trichinosis
- Typhus fever
- Varicella
- Vibriosis
- Yersiniosis

Class C ***Report an outbreak, unusual incidence, or epidemic (e.g., histoplasmosis, pediculosis, scabies, staphylococcal infections) by the end of the next business day***

Outbreaks:

- Community
- Foodborne
- Healthcare-associated
- Institutional
- Waterborne
- Zoonotic

NOTE: Cases of AIDS (acquired immune deficiency syndrome), AIDS-related conditions, HIV (human immunodeficiency virus) infection, perinatal exposure to HIV, and CD4 T-lymphocytes counts <200 or 14% must be reported on forms and in a manner prescribed by the Director.

Know Your ABCs (Alphabetical Order) Effective January 1, 2009

Name	Class
Amebiasis	B2
Anthrax	A
Arboviral neuroinvasive and non-neuroinvasive disease	B1
Botulism, foodborne	A
Botulism, infant	B2
Botulism, wound	B2
Brucellosis	B2
Campylobacteriosis	B2
Chancroid	B1
Chlamydia infections (urethritis, epididymitis, cervicitis, pelvic inflammatory disease, neonatal conjunctivitis, pneumonia, and lymphogranuloma venereum (LGV))	B2
Cholera	A
Coccidioidomycosis	B1
Creutzfeldt-Jakob disease (CJD)	B2
Cryptosporidiosis	B2
Cyclosporiasis	B1
Cytomegalovirus (CMV) (congenital)	B2
Dengue	B1
Diphtheria	A
E. coli O157:H7 and other enterohemorrhagic (Shiga toxin-producing) *E. coli*	B1
Eastern equine encephalitis virus disease	B1
Ehrlichiosis/Anaplasmosis	B2
Giardiasis	B2
Gonococcal infections (urethritis, cervicitis, pelvic inflammatory disease, pharyngitis, arthritis, endocarditis, meningitis, and neonatal conjunctivitis)	B2
Granuloma inguinale	B1
Haemophilus influenzae (invasive disease)	B1
Hantavirus	B1
Hemolytic uremic syndrome (HUS)	B1
Hepatitis A	B1
Hepatitis B, non-perinatal	B2
Hepatitis B, perinatal	B1
Hepatitis C	B2
Hepatitis D (delta hepatitis)	B2
Hepatitis E	B2
Herpes (congenital)	B2
Influenza A – novel virus	A
Influenza-associated hospitalization	B2
Influenza-associated pediatric mortality	B1
LaCrosse virus disease (other California serogroup virus disease)	B1
Legionnaires' disease	B1
Leprosy (Hansen disease)	B2
Leptospirosis	B2
Listeriosis	B1
Lyme disease	B2
Malaria	B1
Measles	A
Meningitis, aseptic (viral)	B1
Meningitis, bacterial	B1
Meningococcal disease	A
Mumps	B1
Mycobacterial disease, other than tuberculosis (MOTT)	B2
Other arthropod-borne disease	B1
Outbreaks: Community, Foodborne, Healthcare-associated, Institutional, Waterborne, and Zoonotic	C
Pertussis	B1
Plague	A
Poliomyelitis (including vaccine-associated cases)	B1
Powassan virus disease	B1
Psittacosis	B1
Q fever	B1
Rabies, human	A
Rocky Mountain spotted fever (RMSF)	B2
Rubella (congenital)	B1
Rubella (not congenital)	A
Salmonellosis	B1
Severe acute respiratory syndrome (SARS)	A
Shigellosis	B1
Smallpox	A
St. Louis encephalitis virus disease	B1
Staphylococcus aureus, with resistance or intermediate resistance to vancomycin (VRSA, VISA)	B1
Streptococcal disease, group A, invasive (IGAS)	B2
Streptococcal disease, group B, in newborn	B2
Streptococcal toxic shock syndrome (STSS)	B2
Streptococcus pneumoniae, invasive disease (ISP)	B2
Syphilis	B1
Tetanus	B1
Toxic shock syndrome (TSS)	B2
Trichinosis	B2
Tuberculosis, including multi-drug resistant tuberculosis (MDR-TB)	B1
Tularemia	A
Typhoid fever	B1
Typhus fever	B2
Varicella	B2
Vibriosis	B2
Viral hemorrhagic fever (VHF)	A
West Nile virus infection	B1
Western equine encephalitis virus disease	B1
Yellow fever	A
Yersiniosis	B2

Appendix AA
Supervision Documentation Spreadsheet

Supervision Documentation Spreadsheet

Date	Participants	Supervision Topic(s)