Capital BlueCross
HOME INFUSION THERAPY SURVEY

Provider Name: ______________________________
CBC #: ______________ **Medicare #:** ______________ **Medicaid #:** ______________
Accrediting Organization: ______________ **Date of most recent accrediting survey:** ________
Person completing survey: ______________ **Phone:** __________ **Date:** __________
Contact person (if different than above): ______________________ **Phone:** __________

Directions: Please complete each line with appropriate information.
Where applicable please indicate with a check mark (☐).

ADMINISTRATION

24 Hr/Day -7 Day/Wk coverage ☐ Yes ☐No
Handicap access ☐ Yes ☐No
Written patient medical emergency plan ☐ Yes ☐No
Anaphylactic shock kit available ☐ Yes ☐No
Written on-call policy ☐ Yes ☐No
Written compliance program ☐ Yes ☐No
Compliance program officer ☐ Yes ☐No
Internal compliance audits ☐ Yes ☐No
Review of the Medicare/Medicaid sanction report ☐ Yes ☐No
Frequency of review: ______________
Written policy on patient confidentiality ☐ Yes ☐No
Written policy on medical record confidentiality ☐ Yes ☐No
Written policy for release of medical records ☐ Yes ☐No
Written policy for maintenance/retention of medical Records ☐ Yes ☐No
Maximum response time for delivery: ________
Written policy for delivery of supplies/pharmaceuticals ☐ Yes ☐No
Policy includes:
Method of delivery ☐ Yes ☐No
Frequency ☐ Yes ☐No
Quantity ☐ Yes ☐No
Written policy for handling narcotics ☐ Yes ☐No
Written policy on disposal of unused medications ☐ Yes ☐No
Written policy for retrieval of discontinued equipment/supplies ☐ Yes ☐No
Customer service/technical support toll-free number ☐ Yes ☐No

QUALITY MANAGEMENT

Quality Activities
Performance Improvement Program ☐ Yes ☐No
Performance Improvement Program includes utilization review ☐ Yes ☐No
Development of improvement activities based on identified issues ☐ Yes ☐No
Performance Improvement Committee ☐ Yes ☐No
Frequency of meetings: ______________
Quality Reports forwarded to the Board of Directors ☐ Yes ☐No
List two Current Quality Studies:
1. ______________
2. ______________
Written infection control policies ☐ Yes ☐No

Patient Satisfaction
Patient Satisfaction Surveys utilized ☐ Yes ☐No
Annual return rate for surveys: ________ **%**
Issues identified:
1. ______________
2. ______________
Results forwarded to PI committee ☐ Yes ☐No
Written patient/family complaint process ☐ Yes ☐No

Physician Satisfaction
Physician Satisfaction Survey utilized ☐ Yes ☐No
Annual return rate for surveys: ________ **%**

Clinical Management
Written policy on addressing advance directives ☐ Yes ☐No
Written policy for development of treatment plan ☐ Yes ☐No
Time frame to develop treatment plan: ________
Frequency of treatment plan updates: ________
Written discharge instruction provided to patients/family ☐ Yes ☐No

Provider Name:

Written policy for home safety assessment ☐ Yes ☐No

Written policy for follow-up evaluation of equipment function in the home ☐ Yes ☐No

Patient Education

Patient/Family education ☐ Yes ☐No

Documented in clinical record ☐ Yes ☐No

Services for hearing impaired ☐ Yes ☐No

Services for speech impaired ☐ Yes ☐No

Services for visually impaired ☐ Yes ☐No

Bilingual services ☐ Yes ☐No

Bilingual patient education materials ☐ Yes ☐No

Languages offered: ____________________

Data Collection

Most frequent admission diagnosis ☐ Yes ☐No

Incident reports ☐ Yes ☐No

Unexpected hospital admissions ☐ Yes ☐No

Infection rate ☐ Yes ☐No

Complications due to venous access devices ☐ Yes ☐No

Treatment discontinued prior to orders completed ☐ Yes ☐No

List other data: ____________________

CLINICAL STAFF

Written policy for clinical competency evaluation ☐ Yes ☐No

Evaluated during probationary period ☐ Yes ☐No

Evaluated annually ☐ Yes ☐No

Written policy for verification of the following for all clinical staff:

- Certification ☐ Yes ☐No
- Education ☐ Yes ☐No
- Licensure ☐ Yes ☐No

Number of mandatory educational programs staff is required to attend annually: __________

Written policy for routine testing of employees for infectious diseases ☐ Yes ☐No

Written policy for credentialing of Physicians ☐ Yes ☐No

Written policy for recredentialing of:

- Physicians ☐ Yes ☐No
- Clinical Staff ☐ Yes ☐No
- Frequency: ____________________

Medical Staff

Medical Director ☐ Yes ☐No

Name: ____________________

Specialty: ____________________

Board Certified ☐ Yes ☐No

If physician(s) not board certified, competency established through the facility's credentialing process ☐ Yes ☐No

Nursing Staff

__________ Number of RNs

__________ Number of LPNs

Written policy defining staff requiring CPR certification ☐ Yes ☐No

__________**%** Clinical staff CPR certified

Contracted staff utilized ☐ Yes ☐No

If **yes**, written policy for verification of the following for all contracted staff:

- Certification ☐ Yes ☐No
- Education ☐ Yes ☐No
- Licensure ☐ Yes ☐No

Written policy for evaluating contracted clinical staff's performance ☐ Yes ☐No

Certified in chemotherapy administration ☐ Yes ☐No

IV Nursing Society certified (IVNS) ☐ Yes ☐No

Certified in IV Therapy ☐ Yes ☐No

PICC Line ☐ Yes ☐No

Pediatric ☐ Yes ☐No

SERVICES

Primary Services

Blood and Blood Products ☐ Yes ☐No

Chemotherapy ☐ Yes ☐No

Phlebotomy ☐ Yes ☐No

TPN ☐ Yes ☐No

IV hydration ☐ Yes ☐No

Enteral ☐ Yes ☐No

Specialty Services

Immune Globulin administration ☐ Yes ☐No

Cardiac Ionotropes (dobutamine/dopamine) ☐ Yes ☐No

Other: ____________________

Laboratory

24hr access ☐ Yes ☐No

7day/wk coverage ☐ Yes ☐No

Provider Name:

Pharmacy

Number of Licensed Pharmacists: ____________

Number of Pharmacy Aides: ____________

24hr access ☐ Yes ☐No

7day/wk coverage ☐ Yes ☐No

FACILITIES & EQUIPMENT

Bioengineering specialist ☐ Yes ☐No

If **no**, person responsible for maintenance of biomedical equipment ☐ Yes ☐No

Written preventive maintenance plan ☐ Yes ☐No

Written plan for equipment failure ☐ Yes ☐No

Written emergency preparedness plan ☐ Yes ☐No

Plan includes:

- Fire ☐ Yes ☐No
- Loss of utilities ☐ Yes ☐No
- Inclement weather ☐ Yes ☐No

Written policy for handling contaminated equipment ☐ Yes ☐No

Written policy for handling biohazardous materials ☐ Yes ☐No

As a reminder, please be sure to include:

- ***Facility Information Sheet***
- ***Name sheet for branch offices***
- ***Affiliate or owned services***

COMMENTS

Provider Name:

Please complete the following based upon corporate ownership of off-site business initiatives and indicate specific services performed at the office site.

Branch Offices

Name: ______________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ________
Address: ______________________
City: ______________________
Phone: ______________________
Contact Person: ______________________
Counties Served: ______________________

Name: ______________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ________
Address: ______________________
City: ______________________
Phone: ______________________
Contact Person: ______________________
Counties Served: ______________________

Name: ______________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ________
Address: ______________________
City: ______________________
Phone: ______________________
Contact Person: ______________________
Counties Served: ______________________

Name: ______________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ________
Address: ______________________
City: ______________________
Phone: ______________________
Contact Person: ______________________
Counties Served: ______________________

Name: ______________________

Services Provided: ______________________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ________
Address: ______________________
City: ______________________
Phone: ______________________
Contact Person: ______________________
Counties Served: ______________________

Name: ______________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ________
Address: ______________________
City: ______________________
Phone: ______________________
Contact Person: ______________________
Counties Served: ______________________

Name: ______________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ________
Address: ______________________
City: ______________________
Phone: ______________________
Contact Person: ______________________
Counties Served: ______________________

Name: ______________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ________
Address: ______________________
City: ______________________
Phone: ______________________
Contact Person: ______________________
Counties Served: ______________________

HEALTHCARE FACILITY INFORMATION FORM

Provider Name:____

Parent:____

Affiliation:____

Affiliation:____

Number of Years in business:___________________________

Type of Control

☐**Voluntary Nonprofit**

☐**Proprietary** (Identify all individuals, members of partnership, major stockholders, etc. If 'Other' explain.)

- ☐ Individual ______________________
- ☐ Partnership______________________
- ☐ Corporation______________________
- ☐ Other______________________

☐ **Government**

- ☐ Federal
- ☐ State
- ☐ County
- ☐ Other, explain:______________________

Additional Information Requested

Has the facility, any corporate officer, employee or any agent acting on behalf of the facility been involved in or convicted of healthcare fraud or abuse in the last five (5) years?

☐Yes, explain:______________________

☐No

Have you or any of your affiliates, entered into a corporate integrity agreement with any state or federal agency?

☐Yes

☐No

If yes, provide a copy to Capital Blue Cross

Provide copies of the following:

- State Licensure certificate(s)
- List of Board of Directors
- Most recent accreditation letter
- Most recent DOH Report
- Evidence of current malpractice insurance
- Current organizational chart

COMMENTS: ____

Provider Name:

Please indicate the counties within your service area. If services are limited to only a portion of the county, please identify.

Adams ☐ ____________________
Berks ☐ ____________________
Centre ☐ ____________________
Columbia ☐ ____________________
Cumberland ☐ ____________________
Dauphin ☐ ____________________
Franklin ☐ ____________________
Fulton ☐ ____________________
Juniata ☐ ____________________
Lancaster ☐ ____________________
Lebanon ☐ ____________________
Lehigh ☐ ____________________
Mifflin ☐ ____________________
Montour ☐ ____________________
Northampton ☐ ____________________
Northumberland ☐ ____________________
Perry ☐ ____________________
Schuylkill ☐ ____________________
Snyder ☐ ____________________
Union ☐ ____________________
York ☐ ____________________

Other ☐ ____________________