Capital BlueCross
FREESTANDING BIRTH CENTER 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
Emergency medical equipment/supplies available ☐ Yes ☐No
Written policy for checking the equipment/supplies ☐ Yes ☐No
Includes frequency of checks ☐ Yes ☐No
Average number of deliveries per month: _____
Maximum response time to page: _____
Maximum time for staff arrival after page: _____
Describe on-call availability for:

- Nurses: _____
- Nurse Midwives: _____
- Physicians: _____

Written criteria for transfer to acute care ☐ Yes ☐No
Written transfer agreement with acute care ☐ Yes ☐No
If **yes**, list facilities: _____

Written agreement for emergency transport services ☐ Yes ☐No
Reliance on 911 system ☐ 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 maintainance/retention of medical records ☐ 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: _____
List two current Quality Studies:
1. _____
2. _____

Written standards of care ☐ Yes ☐No
If **yes**, source of the standards: _____
Written infection control policies ☐ Yes ☐No

Patient Satisfaction

Patient Satisfaction Surveys utilized ☐ Yes ☐No
Annual return rate for surveys: _____ **%**
Results forwarded to PI committee ☐ Yes ☐No
Issues identified:
1. _____
2. _____

Written patient/family complaint process ☐ Yes ☐No

Clinical Management

Written policy on addressing advance directives ☐ Yes ☐No
Written policy for routine prenatal physician visit ☐ Yes ☐No
Written admission criteria ☐ Yes ☐No
Written discharge criteria ☐ Yes ☐No
Written discharge instruction provided to patients/family ☐ Yes ☐No
Transfer isolette available ☐ Yes ☐No
Written policy for transfer to physician care ☐ Yes ☐No
Criteria to identify high-risk cases ☐ Yes ☐No
48hr follow-up assessment postpartum ☐ Yes ☐No

Provider Name:

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

Incident reports ☐ Yes ☐No
Prenatal admissions ☐ Yes ☐No
Admissions during labor/delivery ☐ Yes ☐No
Newborns admitted to hospital ☐ Yes ☐No
Admissions within 14 days of delivery ☐ 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 all of the following for all clinical staff:

- Certification ☐ Yes ☐No
- Education ☐ Yes ☐No
- License ☐ 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: _____

Support Medical Staff

Director of Midwifery services ☐ Yes ☐No
Speciality: _____
Medical Director ☐ Yes ☐No
Board Certified ☐ Yes ☐No
Specialty: _____
Obstetricians ☐ Yes ☐No
If **yes**, number: _____
Number Board Certified: _____
Pediatricians ☐ Yes ☐No
If **yes**, number: _____
Number Board Certified: _____
Neonatologists ☐ Yes ☐No
If **yes**, number: _____
Number Board Certified: _____
If physician(s) not board certified, competency established through the facility's credentialing process ☐ Yes ☐No

Nursing Staff

_____ Number of Certified Nurse Midwives
_____ Number of RNs
Nurse Practitioners ***(list specialties below)*** ☐ Yes ☐No
_____
Written policy defining staff requiring CPR certification ☐ Yes ☐No
% Clinical staff CPR certified

SERVICES

Breast feeding classes ☐ Yes ☐No
Nutritional counseling ☐ Yes ☐No
Parenting classes ☐ Yes ☐No
Prenatal care ☐ Yes ☐No
Post-partum care ☐ Yes ☐No
Prenatal classes ☐ Yes ☐No
Other: _____

Laboratory

24hr – 7day/wk access ☐ Yes ☐No

Pharmacy

24hr – 7day/wk access ☐ 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 fire/disaster drills ☐ Yes ☐No
Results of drills documented ☐ Yes ☐No
Written policy for handling biohazardous materials ☐ Yes ☐No

Provider Name:

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:

Provider Name:

Phone: _____

Contact Person: _____

Counties Served: _____

Provider Name:

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 ☐	_____
	_____
	_____
	_____
	_____