UC Riverside, School of Medicine Policies and Procedures
Policy Title: SOM Observers and Vendors in Clinical Areas
Policy Number: 950-02-008

Responsible Officer:	Chief Compliance & Privacy Officer
Responsible Office:	Compliance Advisory Services
Origination Date:	05/2013
Date of Revision:	11/2019; 06/2024; 08/2024
Scope:	UC Riverside School of Medicine

I. Policy Summary

This policy applies to observers, such as a biology student, who has requested to "shadow" a healthcare professional for educational purposes or to determine a career choice. The policy also applies to healthcare vendors who are present in clinical areas. This policy does not apply to observers who are themselves physicians, Allied Health professionals or foreign physicians requesting to observe medical and/or surgical techniques. The policy is intended to safeguard and protect the health and privacy of our patients.

II. Policy Text

A. UCR Health will ensure that visitors to clinical settings will be appropriately supervised. Vendors who are on-site performing services, such as maintenance, calibration, or product education are included. Other types of visitors, such as shadow students, may be present in the clinical setting, as observers. Observation of procedures and other patient care services falls under the UC Riverside School of Medicine mission of education. The patient has a right to know that a visitor, student, or other observer is not part of the UCR Health care delivery team. The patient is not obliged to agree to the presence of a visitor, student, or observer in their clinical encounter, and the patient will not be treated differently if they refuse.

1. Students may be permitted to shadow a physician or other health care worker provided that:
   a. The student is a UCR Student in a healthcare related educational program.
   b. Non-UCR students must be enrolled in a pre-med or science program.
2. All observers with access to patient care areas or areas where protected health information is maintained will be required to complete the following:
   a. Sign a Confidentiality Agreement For Non-Workforce Members (Attachment A).
   b. Complete the online UC Riverside Healthcare Privacy and Security training or complete a hard copy version of the training.
   c. Provide proof of health screening as detailed below.
   d. Sign a Statement of Casual Clinical Observer (Attachment B).
3. Observers must be accompanied by a supervising UCR Health staff member at all times except when in public areas. The sponsoring department must complete the Notification and Approval of an Observer in Clinical Areas (Attachment C).
   a. Patient permission must be obtained for an observer to be present during a patient care encounter, and the patient's consent must be documented in the patient's medical record.

b. No observers will be permitted who are known to be Foreign Nationals from the Specially Designated Nationals List maintained by the US Department of Treasury Office of Foreign Asset Center (specifically Cuba, Iran, North Korea, Sudan, Syria or Venezuela).
c. Vendors sign in on the Vendor Log at the front desk upon arrival and must have an appointment and prior approval of the treating physician before accessing patient areas.
d. If a student or vendor does not comply with the policy, the treating physician will be notified that the observer is not permitted to be present until the requirements are met.

III. Responsibilities

All UCR Health Faculty and Staff

IV. Procedures

A. A student observer:
1. Must be at least 18 years old and a high school graduate. High school graduates under the age of 18 will require additional approvals.
2. Interested in pursuing a medical career.

B. The Department hosting or sponsoring the observer must obtain approval from the Administrator responsible for the area where the observer will be present at least five days prior to the observer's start date in order to ensure adequate notification and preparation.

C. The Observer must register with the ambulatory practice site prior to scheduled observation date to provide proof of health screening to include the following:
1. PPD within the last 12 months.
2. MMR vaccination or titer, and Tdap.
3. Flu vaccination during flu season or completion of an "Informed Declination Form" declining the flu vaccination. See SOM Policies and Procedures, Influenza Immunization Requirement Policy.
4. Health insurance coverage.
5. If minor, under the age of 18 years of age, parental or guardian consent form and approval from the SOM Dean or an Associate Dean is required.

V. Forms/Instructions

Attachment A – 950-02-008-01 Confidentiality Agreement For Non-Workforce Members
Attachment B – 950-02-008-02 Statement of Casual Clinical Observer
Attachment C – 950-02-008-03 Notification and Approval of an Observer in Clinical Areas
Attachment D – 950-02-008-04 Waiver of Liability, Assumption of Risk, and Indemnity

VI. Related Information

Regulatory and Standards Analysis HIPAA Privacy and Security Regulations 45 CFR 164

VII. Revision History

Origination Date: 03/2016
Revision Date: 11/2019; 06/2024; 08/2024

Approvals:

COMPLIANCE COMMITTEE (09/03/2024)

Signed by:
Paul Hackman
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9/20/2024 | 10:59 PM PDT

PAUL HACKMAN, J.D., L.LM.
CHIEF COMPLIANCE AND PRIVACY OFFICER,
SCHOOL OF MEDICINE

DATE

Signed by:
Deborah Deas
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9/21/2024 | 4:45 PM PDT

DEBORAH DEAS, M.D., M.P.H
VICE CHANCELLOR, HEALTH SCIENCES
DEAN, SCHOOL OF MEDICINE

DATE

UCR HEALTH

ATTACHMENT A

CONFIDENTIALITY AGREEMENT FOR NON-WORKFORCE MEMBERS

The federal Health Insurance Portability and Accountability Act ("HIPAA") and its regulations, the California Confidentiality of Medical Information Act and other federal and state laws and regulations were established to protect the confidentiality of medical and personal information, and provide, generally, that patient information may not be disclosed except as permitted or required by law or unless authorized by the patient. In certain circumstances, HIPAA allows the disclosure of limited patient information in order to carryout treatment, education, research, public health, or health care operations activities without obtaining the patient or subject's authorization.

Confidential Patient Information includes: Any individually identifiable information in possession or derived from a provider of health care regarding a patient's medical history, mental or physical condition or treatment, as well as the patients and/or their family members records, test results, conversations, research records and financial information. (Note this information is defined in the Privacy Rule as "protected health information.")

Examples include but are not limited to:

- Physical medical and psychiatric records including paper, photo, video, diagnostic and therapeutic reports, laboratory and pathology samples
- Patient insurance and billing records
- Computerized patient data
- Visual observation of patients receiving medical care or accessing services; and
- Verbal information provided by or about a patient.

I understand and agree that this document establishes a Confidentiality Agreement between _____ [*insert name of Individual*] a representative of UC Riverside School of Medicine and the UC Riverside School of Medicine and sets forth the understanding regarding the protection of any confidential information that Individual may have access to while performing services at the UC Riverside School of Medicine with the following purpose:

1. I understand that I will be granted access to, or otherwise become acquainted with, the following information ("Information") relating to UCR School of Medicine patients:
   - Clinical/medical information
   - Insurance and Billing information
   - Scheduling information
   - Visual observation of patients receiving medical care or accessing services
   - Other (describe)_____

It is understood and agreed that except as required by law, I will use and hold all Information in strict trust and confidence and will use such information only for the purposes contemplated herein, and not for any other purpose.

2. I acknowledge that it my responsibility to respect the privacy and confidentiality of Information received from the UC Riverside School of Medicine. I will not access, use or disclose patient or other confidential information unless I am authorized or permitted to do so by law or as authorized by the patient, I

further understand that I am required to immediately report any information about unauthorized access, use or disclosure of confidential patient information to the UCR School of Medicine.

3. I agree to not disclose the Information to any other individuals.

4. Neither the release of any Information hereunder or the act of disclosure shall constitute a grant of any license under a trademark, patent, or copyright or application of the same.

5. I understand and acknowledge that, should I breach any provision of this Confidentiality Statement, I may be subject to civil or criminal liability.

Signature **Date**

Print Name

ATTACHMENT B

STATEMENT OF CASUAL CLINICAL OBSERVER

I, _____(*Print Observer's Name)*, acknowledge that as a Casual Observer:

I understand that I must be accompanied by a UCR Health Staff member at <u>all times when in a Clinical area.</u>

Signature **Date**

Print Name

UCR HEALTH

ATTACHMENT C

NOTIFICATION AND APPROVAL OF AN OBSERVER IN CLINICAL AREA

Name of Observer: _____

Name of Sponsoring Faculty Member/Staff Member: _____

Staff who will be supervising the observer (list all):

Sponsoring Department: _____ Division: _____

Clinical Area where Observer will be Present: _____

Proposed Start Date: End Date:

Observer is:

- ☐ UCR Student in a related educational program
- ☐ Non-UCR student in a pre-med or science program
- ☐ Other: _____

Purpose:

The undersigned accepts responsibility for the observer and confirms that the observer has submitted the required documentation.

Supervising Physician: _____

Name of Sponsoring Faculty Member/Staff Member: _____

UCR HEALTH

ATTACHMENT D

Participant's Name:_____

UNIVERSITY OF CALIFORNIA AT RIVERSIDE SCHOOL OF MEDICINE

Waiver of Liability, Assumption of Risk, and Indemnity Agreement

Waiver: In consideration of being permitted to participate in any way in

Description of Shadowing Program or Activity including date(s):

hereinafter called "The Activity", I, for myself, my heirs, personal representatives or assigns, **do hereby release, waive, discharge, and covenant not to sue** The Regents of the University of California, its officers, employees, and agents from liability **from any and all claims including the negligence of The Regents of the University of California, its officers, employees and agents,** resulting in personal injury, accidents or illnesses (including death), and property loss arising from, but not limited to, participation in The Activity.

Signature of Parent/Guardian of Minor	Date	Signature of Participant	Date

Assumption of Risks: Participation in The Activity carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. The specific risks vary from one activity to another, but the risks range from 1) minor injuries such as scratches, bruises, and sprains 2) major injuries such as eye injury or loss of sight, joint or back injuries, heart attacks, and concussions to 3) catastrophic injuries including paralysis and death.

I have read the previous paragraphs and I know, understand, and appreciate these and other risks that are inherent in The Activity. I hereby assert that my participation is voluntary and that I knowingly assume all such risks.

Indemnification and Hold Harmless: I also agree to INDEMNIFY AND HOLD The Regents of the University of California HARMLESS from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees brought as a result of my involvement in The Activity and to reimburse them for any such expenses incurred.

Severability: The undersigned further expressly agrees that the foregoing waiver and assumption of risks agreement is intended to be as broad and inclusive as is permitted by the law of the State of California and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

Acknowledgment of Understanding: I have read this waiver of liability, assumption of risk, and indemnity agreement, fully understand its terms, and **understand that I am giving up substantial rights, including my right to sue**. I acknowledge that I am signing the agreement freely and voluntarily, and **intend by my signature to be a complete and unconditional release of all liability** to the greatest extent allowed by law.

Signature of Parent/Guardian of Minor	Date	Signature of Participant	Date

Participant's Age (if minor)_____