6. FACILITY SITE REVIEW

A. Facility Site Review and Medical Record Review Survey Requirements and Monitoring

APPLIES TO:

A. This policy applies to all Primary Care Providers (PCPs) who provide care and services to IEHP DualChoice Members.

POLICY:

A. Managed Care Plans (MCP) conduct Facility Site Review (FSR) and Medical Record Review (MRR) surveys on all PCP sites to ensure their capacity to support the safe and effective provision of primary care services (See Attachments, "DHCS MMCD Facility Site Review Standards (FSR) Standards" and "DHCS MMCD Medical Record Review (MRR) Standards" in Section 6).

DEFINITIONS:

A. Delegates – For the purpose of this policy, this is as health plan (e.g., Kaiser) delegated to perform activities outlined in this policy.

PROCEDURES:

IPA and Delegate Responsibilities

A. IPAs' and Delegates' credentialing responsibilities include obtaining evidence of current and valid site and medical record reviews for all PCPs, as applicable, in accordance with regulatory standards.

B. Delegates are responsible for conducting FSR/MRR for their PCPs.

C. IPAs and Delegates must have policies and procedures that document their review process, including a description of their site and medical records review requirements.

D. IEHP verifies IPA and Delegate compliance with the requirements listed above, during the annual review of their Quality Management Program Description, Evaluation and Work Plan, as well as during the Delegation Oversight Annual Audit. See Policies 25A2, "Delegation Oversight Audit" and 25D2, "Quality Management – IPA Quality Management Program Structure Requirements."

IEHP Responsibilities

A. All PCP sites in the IEHP network must pass their initial and subsequent site reviews, consisting of an FSR and MRR. For every new and continually contracted PCP site, IEHP ensures that:

   1. Each PCP site has passed an initial FSR prior to receiving assignment of Members.

   2. Each PCP site passes an initial MRR after the PCP is assigned Members.

3. Each PCP site passes periodic subsequent site reviews consisting of both a FSR and MRR at minimum, every three (3) years thereafter, unless it was determined that the PCP be placed on an annual review. No PCP or non-participating provider will be able to provide care and services at sites without completing a FSR/MRR.

B. An initial FSR and/or MRR may be waived if the PCP has documented proof that another MCP completed an FSR and/or MRR within the past three (3) years and the PCP received a passing score.

C. PCPs classified as No Assignment Primary Care Providers (NA PCPs), who do not have responsibilities as a PCP for preventive services, are not subject to a Facility Site Review/Medical Record Review (FSR/MRR). These PCPs would include but are not limited to:

1. Practitioners added to a Specialist Contract treating members for discharge services on behalf of the Specialist Group.
2. Practitioners contracted to admit patients (Admitters) on behalf of the IPA network.
3. Practitioners that function as PCPs but do not receive assignment because they have met capacity of IPA affiliations for the line of business.
4. Practitioners that function as a PCP but do not receive membership because they do not meet the sixteen (16) office hour requirement.

D. Scenarios that require an initial site review include, but are not limited to:

1. A new PCP site is added to the network;
2. A newly contracted Provider assumes a PCP site with a previous failing FSR and/or MRR score within the last three (3) years;
3. A PCP site is returning to the Medi-Cal managed care program and has not had a passing FSR in the last three (3) years;
4. There is a change of ownership of an existing Provider site; and
5. A PCP site relocates.
6. A new MCP is established or an existing MCP expands to a new service area. New MCPs and those that expand to a new area must complete an initial site review on a specified number of PCP sites.

E. IEHP and other local MCPs have collaboratively developed and maintained a standardized system of conducting FSRs and MRRs of shared PCPs that minimize duplication of review efforts. Each collaborative MCP determines whether to accept another MCP's FSR and/or MRR findings.

F. The FSR and MRR Survey is scheduled directly with the PCP office and the Providers are notified in advance of site reviews and whether the site review is conducted by DHCS or IEHP.

G. FSR and MRR are conducted by Certified Site Reviewers (CSRs) and/or Certified Master Trainers (CMTs). IEHP maintains (a) designated Physician(s), Nurse Practitioner(s), Physician Assistant(s) or registered nurse(s) as CMTs who are responsible for training and supervising CSRs. CMTs are also responsible for certifying, monitoring, and evaluating nurse and Physician reviewers for inter-rater reliability.

H. Residency Teaching Clinics, Federally Qualified Health Center (FQHC), and Rural Health Clinics are also subject to the FSR and MRR Survey. See Policies 6D, "Residency Teaching Clinics," and 6E, "Rural Health Clinics," for more detail.

Facility Site Review (FSR)

A. The FSR Survey is used to verify the following site and compliance information, and assign scores accordingly (see Attachment, "DHCS MMCD Facility Site Review Tool" in Section 6):

1. Access and Safety;
2. Personnel;
3. Office Management;
4. Clinical Services;
5. Preventive Services; and
6. Infection Control.

B. Critical elements related to the potential for adverse effect on patient health or safety and therefore, have a scored "weight" of two (2) points. All other survey criteria are weighted at one (1) point. Critical elements include the following fourteen (14) criteria:

1. Exit doors and aisles are unobstructed and egress (escape) accessible;
2. Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe, and Ambu (Artificial manual breathing unit) bag, appropriate to practice/ patient population is available on site;
3. Emergency medicine such as asthma, chest pain, hypoglycemia and anaphylactic reaction management: Epinephrine 1:1000 (injectable), and Benadryl 25 mg. (oral) or Benadryl 50 mg./ml. (injectable), Naloxone, chewable Aspirin 81 mg, Nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), and glucose. Appropriate sizes of ESIP needles/syringes and alcohol wipes;
4. Only qualified/trained personnel retrieve, prepare or administer medications;

5. Office practice procedures are utilized on-site that allow timely provision and tracking of physician review and follow-up of referrals, consultation reports and diagnostic test results;
6. Only lawfully authorized persons dispense drugs to patients;
7. Drugs and vaccines are prepared and drawn only prior to administration;
8. Personal protective equipment (PPE) for standard precautions is readily available for staff use;
9. Needle stick safety precautions are practiced on- site;
10. Blood, other potentially infectious materials (specimens) and regulated wastes (sharps/biohazardous non-sharps) are placed in appropriate leak-proof, labeled containers, for collection, handling, processing, storage, transport or shipping;
11. Staff demonstrate /verbalize necessary steps/process to ensure sterility and/or high-level disinfection to ensure sterility/disinfection of equipment;
12. Appropriate PPE is available, exposure control plan, medical safety data sheet (MSDS) and clean up instructions in the event of a cold chemical sterilant spill.
13. Spore testing of autoclave/steam sterilizer with documented results is completed (at least monthly), unless otherwise stated in the manufacturers guidelines, with documented results
14. Management of positive mechanical, chemical, and/or biological indicators of the sterilization process.

C. If deficiencies are found in any of the fourteen (14) critical elements during the survey, focused review survey, or monitoring visit the PCP must submit a Corrective Action Plan (CAP) and evidence of corrections within ten (10) calendar days of the survey date. The CSR or CMT must conduct a focused review to verify that CAPs for critical elements are completed within thirty (30) calendar days from the date of the FSR and/or MRR report.

D. Sites found deficient in any critical element during the survey are required to address 100% of the survey deficiencies, regardless of survey score.

E. Any PCP whose site review reveals significant quality of care issues any issue identified by the CMT or CSR that is not captured in the FSR is not eligible for participation in IEHP's network, pending the outcome of a review by IEHP's Peer Review Subcommittee.

F. All PCP sites are assessed for specific physical access requirements for Seniors and Persons with Disabilities initially and every three (3) years thereafter. Please see Policy 6B, "Physical Accessibility Review Survey" for more information.

Medical Record Review (MRR)

A. MRRs are performed at the time of the FSR if medical records are available.

1. MRRs are performed within ninety (90) calendar days of the PCP's effective date with IEHP.
2. An additional extension of ninety (90) calendar days may be allowed only if the new Provider does not have a sufficient number of Members assigned to complete a review of ten (10) medical records.
3. If there are still fewer than ten (10) assigned Members after six (6) months from the PCP's effective date, an MRR is completed on the total number of records available, and the scoring is adjusted according to the number of records reviewed.
4. The MRR score is based on a standard review of ten (10) randomly selected medical records per Provider, consisting of five (5) pediatric and five (5) adult or obstetric medical records. For PCP sites serving only pediatric or only adult patients, all ten (10) medical records must be reviewed using the appropriate preventive care criteria.

B. The MRR survey verifies the following medical record and compliance information (see Attachment, "DHCS MMCD Medical Record Review Tool" in Section 6):

1. Format;
2. Documentation;
3. Coordination/Continuity of Care;
4. Pediatric Preventive (as appropriate);
5. Adult Preventive (as appropriate); and
6. OB/CPSP (Comprehensive Perinatal Services Program) Preventive (when applicable).

C. During any MRR survey, IEHP has the option to request additional records for review if necessary. Medical records are selected randomly by using a Member Assignment List (Eligibility List).

D. Sites, where documentation of patient care by multiple PCPs occurs in the same record, are reviewed as a "shared" medical record system. Shared medical records are considered those that are not identifiable as "separate" records belonging to any specific PCP:

1. A minimum of ten (10) records are reviewed if two (2) to three (3) PCPs share records; and
2. Twenty (20) records are reviewed if four (4) to six (6) PCPs share records; and
3. Thirty (30) records are reviewed if seven (7) or more PCPs share records.

E. For group practices, where Physicians PCPs do not share charts, a minimum of ten (10) charts are reviewed for each PCP.

F. For group practices with mixed specialties, medical records are requested based on the different types of specialties in the office and DHCS regulations of the number of required adult Members and pediatric Members for review.

1. MRR Survey Addendum

a. All PCPs that provide obstetric (OB) services are required to undergo an audit specific to OB site and medical record requirements, utilizing the IEHP MRR Survey Addendum tool for PCP/OB/FP1/FP2. For OB/GYNs acting as PCPs, all medical records must be reviewed using preventive criteria for adults or pediatrics (pregnant under 21 years) and obstetrics. The medical record portion of the DHCS audit, OB/CPSP Preventative Preventive Criteria section verifies PCP-OB compliance with IEHP's policies and procedures regarding Perinatal OB/CPSP Preventive Care including:

1) Prenatal care assessments to include blood pressure (BP), fundal height, fetal heart tones and maternal complications;

2) Postpartum care assessments to include weight, BP, breast exam, abdomen or pelvic exam, depression and family planning.

Scoring

A. Compliance level categories for FSR and MRR score results are as follows:

	Exempted Pass	Conditional Pass	Fail (Not Pass)
FSR	• 90% and above without deficiencies in Critical Elements, pharmacy or infection control • CAP not required	• 90% and above with deficiencies in Critical Elements, pharmacy or infection control • 80% and above • CAP required	• Score below 80% • CAP required
MRR	• 90% and above with all individual section scores at 80% or above • CAP not required	• 90% and above with one or more individual section score below 80% • 80% and above • CAP required	• Score below 80% • CAP required
MCPs may require a CAP regardless of score for other findings identified during the survey that require correction.			

B. The FSR Survey contains a total of one hundred sixty-nine (169) points. Total MRR survey points will vary based on the number and type of charts reviewed (i.e., Peds vs Adults vs OB/CPSP).

C. PCP sites that successfully pass their FSR/MRR are issued a Certified Quality Provider Site certificate. The certificate is valid for up to three (3) years and affirms that a site has been deemed a DHCS Certified Quality Provider site.

D. PCPs with scores below 80% are placed on an annual review and will have their panels frozen to accept new Member assignments until corrections are verified and the CAP is closed.

E. A site that scores below 80% on their initial FSR and/or MRR Survey is considered a "failed site." Providers who do not pass the initial FSR after two (2) attempts may re-apply with IEHP after six (6) months. At the discretion of IEHP, additional training may be provided.

F. For existing sites that score below 80% on the FSR and/or MRR Survey, IEHP reserves the right to remove PCPs from the network and transfer Members to other PCPs as necessary to protect the health and safety of Members.

1. PCP sites that score below 80% in either FSR or MRR for two (2) consecutive reviews will receive a CAP notification letter and must score a minimum of 80% on their next annual FSR and MRR or the PCP will be terminated from the IEHP network.

    a. Should the PCP be allowed to remain in the network, survey deficiencies must be corrected by the PCP, then approved and verified and approved by IEHP.

    b. PCP sites that score below 80% in either FSR or MRR for three (3) consecutive reviews will be terminated from the IEHP network.

Corrective Action Plan (CAP)

A. The PCP receives a CAP notification letter at the time the survey is performed. Any deficiencies found during the FSR are noted on the form (See Attachment, "Corrective Action Plan Notification Tool" in Section 6). The CAP notes the PCP compliance status, timeframes for corrective action, and any other pertinent information.

1. CAPs for critical elements must be given at time of audit.

2. CAPs for all non-critical element deficiencies are issued within ten (10) calendar days of survey completion.

B. After passing the initial FSR, all CAPs must be closed prior to receiving assignment of Members.

C. New members will not be assigned to providers who do not correct site review deficiencies within the established CAP timelines.

D. Sites that receive an "Exempted Pass" are not required to complete a CAP unless determined necessary by the CSR. All sites that receive a "Conditional Pass" are required to submit a

CAP to IEHP to address 100% of cited deficiencies within thirty (30) calendar days from the date of the FSR/MRR report.

E. At the discretion of IEHP, a CAP may be requested regardless of FSR and/or MRR score.

CAP Verification Process

A. A CAP must be submitted for all FSR and MRR Survey scores of 80-89% or 90% and above with deficiencies in critical elements, pharmacy and/or infection control or individual medical record sections scoring below 80%. The MCP that completed the FSR/MRR is responsible for follow-up, closure of the CAPs, and interim reviews. CAP documentation must identify:

1. The specific deficiency;
2. Corrective actions needed;
3. Projected and actual dates of the deficiency correction;
4. Reevaluation of timelines and dates; and
5. Responsible persons.

B. CAPs for non-critical elements may be verified via document submission. CAPs for critical elements must be verified onsite.

C. Closed CAP documentation must include:

1. Documentation of problems in completing corrective actions (if any);
2. Resources and technical assistance provided by the MCP;
3. Evidence of the corrections;
4. Completion and closure dates; and
5. Name and title of the MCP reviewer.

D. IEHP, at its discretion, may continue to monitor PCP sites after it has met the threshold for Conditional Pass and the CAP response has been verified and approved.

E. The CSR or CMT is also responsible for reviewing the CAP with the PCP as well as finalizing, scoring, and signing the CAP.

F. At the CSR's discretion, if the CAP cannot be verified by the PCP's submission of definitive proof, then the CSR will go on site to obtain proof of CAP completion.

G. MCPs must follow the time below for CAP notification and completion:

CAP Timeline	CAP Action(s)
FSR and/or MRR Completion Day	The MCP must provide the PCP site a report containing: • The FSR and/or MRR scores;

6. FACILITY SITE REVIEW

A. Facility Site Review and Medical Record Review Survey Requirements and Monitoring

CAP Timeline	CAP Action(s)
	• Any critical element findings, if applicable; and • A formal written request for CAPs for all critical elements, if applicable.
Within ten (10) calendar days of the FSR and/or MRR	• The PCP site must submit a CAP and evidence of corrections to the MCP for all deficient critical elements, if applicable. • The MCP must provide a report to the PCP site containing FSR and/or MRR findings, along with a formal written request for CAPs for all non-critical element deficiencies. • The MCP must provide educational support and technical assistance to PCP sites as needed.
Within thirty (30) calendar days from the date of the FSR and/or MRR report	• The MCP must conduct a focused review to verify that CAPs for critical elements are completed. • The PCP site must submit a CAP for all non-critical element deficiencies to the MCP. • The MCP must provide educational support and technical assistance to PCP sites as needed.
Within sixty (60) calendar days from the date of the FSR and/or MRR report	• The MCP must review, approve, or request additional information on the submitted CAP(s) for non-critical findings. • The MCP must continue to provide educational support and technical assistance to PCP sites as needed.
Within ninety (90) calendar days from the date of the FSR and/or MRR report	• All CAPs must be closed. • Providers can request a definitive, time-specific extension period to complete the CAP(s), not to exceed 120 calendar days from the date of the initial report of FSR and/or MRR findings.

6. FACILITY SITE REVIEW

A. Facility Site Review and Medical Record Review Survey Requirements and Monitoring

CAP Timeline	CAP Action(s)
Beyond one hundred twenty (120) days from the date of the FSR and/or MRR report	• The MCP must request approval from DHCS to complete a CAP review for any extenuating circumstances that prevented completion of a CAP within the established timeline. • The MCP must conduct another FSR and/or MRR, as applicable, within twelve (12) months of the applicable FSR and/or MRR date(s).

Non-Compliant Provider

A. Any PCP who does not come into compliance with survey criteria within the established CAP timelines must be removed from the network and their Members will be appropriately reassigned to other network providers.

B. Any PCP that fails the FSR and/or MRR surveys, or is non-compliant with CAP timelines, will be reported to Medi-Cal MCP collaborative partners.

C. PCPs termed by IEHP for FSR and MRR Survey noncompliance may also be termed by all affiliated MCPs.

D. Members will not be assigned to PCPs who do not correct survey deficiencies within established CAP timeframes and until IEHP verifies that the PCP has corrected the deficiencies and the CAP is closed.

E. PCP sites that score 79% or below in either FSR or MRR for two (2) consecutive reviews will receive a non-compliance notification letter and must score a minimum of 80% on the next site review in both the FSR and MRR or the PCP will be administratively terminated from the IEHP network.

Provider Relocation

A. When a PCP site relocates, an initial FSR is completed within sixty (60) days of notification or discovery of the completed move. IEHP allows the PCP to continue to see their assigned Members however, the PCP site is not assigned new Members until they receive passing FSR and MRR scores.

B. Credentialed PCPs who move their offices to new locations are subject to the following:

1. If the new location is not currently an approved IEHP PCP site, the PCP is required to have an initial FSR and MRR within sixty (60) days of the effective date of the move or the date IEHP discovers that the PCP site has moved.

2. If the PCP relocating takes his/her medical records to the new location, a new MRR is not required if MRR was done within the past twelve (12) months and the PCP received a passing score. The PCP then retains the MRR score from the previous site.
    a. Current Members will remain assigned to the PCP.
    b. If the PCP does not notify IEHP, at least thirty (30) days prior to the move, then the PCP will be closed to auto-assignment for a minimum of sixty (60) days or until the site audit is completed.

C. PCPs applying for participation in IEHP's network, who join a currently approved IEHP PCP site, are subject to an MRR Survey specific to the new PCP. This is performed ninety (90) to one hundred eighty (180) calendar days after the PCP's eligibility date with IEHP unless records are shared.

D. Unless significant discrepancies are found, only one (1) site survey is performed in the three (3) year period following the most recent full audit for all PCP sites. Additional PCPs joining such sites receive an integrated facility score; however, a focused FSR may be required if the new PCP has a different specialty (i.e., Pediatrics vs Internal Medicine), as issues are identified and/or as requested by another department by IEHP.

On-Site Hours Requirements

A. PCPs must be physically on-site and available for patient care for a minimum of sixteen (16) hours per week per site location, as verified by IEHP. Please see Policy 6C, "PCP Sites Denied Participation or Removed from the IEHP Network". Exceptions to this requirement are:
    1. Residency Teaching Clinics - Refer to Policy 6D, "Residency Teaching Clinics." and
    2. Rural Health Clinics – Refer to Policy 6E, "Rural Clinics."

Monitoring

A. IEHP periodically monitors all PCP sites between each regularly scheduled FSR and MRR. Monitoring sites between audits includes the use of both internal quality management systems and external sources of information. The PCP's compliance with the fourteen (14) critical elements is monitored between full surveys through interim, and focused reviews. If deficiencies are identified through monitoring, IEHP will determine the appropriate course of action, such as conducting a site review or additional focused reviews, to educate and correct deficiencies according to established CAP timelines. Please see Policy 6H, "Interim FSR Monitoring for Primary Care Providers."

6. FACILITY SITE REVIEW

A. Facility Site Review and Medical Record Review Survey Requirements and Monitoring

B. Focused Reviews

1. A focused review is an audit used to investigate specific issues identified through quality monitoring, including Member complaints, referral from other internal departments, or to follow up on corrective actions. Reviewers may utilize the appropriate sections of the FSR and MRR tools for the focused review or other methods to investigate identified deficiencies or situations. All deficiencies found in a focused review require the completion and verification of a CAP according to established timelines.
2. As part of the DHCS' ongoing monitoring of IEHP's process, DHCS nurse auditors may conduct separate onsite site reviews of randomly chosen PCP sites to validate FSR and MRR processes and to monitor IEHP services. Prior notice to the PCP is not required.
3. IEHP can perform a focused review on any IEHP PCP site, at the discretion of the Plan.

C. Practitioner Office Site Quality visits

1. Practitioner Office Site Quality visits (includes PCPs) are conducted within sixty (60) days if a Practitioner office site quality complaint is received and the PCP has had a complaint within the past twelve (12) months or has had a minimum of three (3) substantiated complaints that could impact quality of care.
2. Practitioner office site quality complaints are issues related to physical accessibility, physical appearance, appearance-safety, adequacy of room space, referral process, availability of appointments, medical record keeping, and any other issue that could impact quality of care.
3. All complaints regarding appointment availability will be addressed by the Quality Management Department.
4. If the PCP's site does not meet the IEHP DHCS standards, the site will be issued a CAP request and will be monitored every six (6) months until all deficiencies are resolved.
5. If the PCP's site meets the IEHP DHCS standards, then the site will resume the regular scheduled audit timeframe.

D. DHCS Mandated Reporting:

1. IEHP reports its monitoring activities to DHCS semi-annually.
2. PCP site audit information is included in Quality Management reporting.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

6. FACILITY SITE REVIEW

B. Physical Accessibility Review Survey

APPLIES TO:

A. This policy applies to all contracted Primary Care Providers (PCPs), identified high volume Specialists, identified high volume Ancillary sites, Community-Based Adult Services (CBAS), and Urgent Care Center (UCC) Providers, who provide care and services to IEHP DualChoice Members.

POLICY:

A. All contracted PCP sites, identified high volume Specialists, identified high volume Ancillary sites, CBAS, and UCC Providers, must undergo the Physical Accessibility Review Survey (PARS) assessment.

PROCEDURES:

A. Physical Accessibility Review Survey

1. The PARS assessment is performed initially for all new sites and every three (3) years thereafter. For PCPs, the PARS assessment is performed as part of the Facility Site Review and Medical Record Review processes:
    a. For PCPs and Specialists, see Attachment "DHCS MMCD FSR Attachment C - Physical Accessibility Review Survey" in Section 6.
    b. For UCC Providers, Skill Nursing Facilities, and Non-Hospital Based Radiology Centers, see Attachment "DHCS MMCD FSR Attachment D – Ancillary Physical Accessibility Review Survey" in Section 6.
    c. For CBAS Providers, see Attachment "DHCS MMCD FSR Attachment E – CBAS Physical Accessibility Review Survey" in Section 6.
2. IEHP may review sites more frequently based upon request for review due to a significant site remodel or identified grievances related to physical accessibility. In addition, this would apply to all Providers adding or moving locations.
3. After concluding the PARS, the IEHP Reviewer will:
    a. Discuss the PARS findings with the Provider or Office Manager; and
    b. Enter the PARS findings into IEHP's designated database.
4. Results of the PARS assessment are shared with other Managed Care Plans as part of the collaboration process to minimize duplication of assessments.
5. IEHP makes PARS results available to Members on the IEHP website and Provider Directory noting the site as having Basic Access, Limited Access, Medical Equipment Access, as well as Accessibility Indicators such as the following (see Attachment "Physical Accessibility Review Survey" in Section 6).
    a. P= Parking;

b. EB= Exterior Building;

c. IB= Interior Building;

d. R= Restroom;

e. E= Exam Room; and

f. T= Exam Table/Scale.

6. The results of all the PARS assessments are informational and unlike the Facility Site Review (FSR) and Medical Record Review (MRR) Surveys, do not require a Corrective Action Plan (CAP) for any deficiencies.

B. Site Reviewer Requirements

1. Reviewer may be an IEHP clinical or non-clinical staff.
2. Reviewer will use the appropriate DHCS PARS tools and guidelines.
3. Reviewer will undergo PARS Training.

C. Provider Education

1. IEHP Nurse Educators will offer on-site PCP and staff education regarding PARS requirements in conjunction with the optional FSR/ MRR training that is offered to PCPs prior to review for all initial and periodic surveys, as necessary.

6. FACILITY SITE REVIEW

C. PCP Sites Denied Participation or Removed from the IEHP Network

APPLIES TO:

A. This policy applies to all IEHP DualChoice Providers.

POLICY:

A. IEHP conducts Facility Site Review (FSR) and Medical Record Review (MRR) surveys on all Primary Care Provider (PCP) sites to ensure their capacity to support the safe and effective provision of primary care services.[1]

B. IEHP reserves the right to remove PCPs from the network and transfer Members to other PCPs as necessary to protect the health and safety of Members.

PROCEDURES:

A. PCP sites may be removed, limited, or denied participation in the IEHP network under any of the following circumstances listed below:

1. FSR and MRR Surveys
    a. Sites that score:
        1) Below 80% on either the FSR or MRR;
        2) Below 80% on either the FSR or MRR, with a non-compliant Corrective Action Plan (CAP); and
        3) Below 80% on re-assessment of site or medical record review;
    b. Critical element deficiencies which are not corrected;
    c. PCP site does not come into compliance with survey criteria within established Corrective Action Plan (CAP) timeframes; and
    d. PCP site receives a failing score on either the FSR or MRR for two (2) consecutive site reviews and fails on its third consecutive attempt.
2. On-Site Hours
    a. IEHP requires a PCP to be on site at a minimum of sixteen (16) hours per week. If a PCP appears to be at the site less than sixteen (16) hours per week, the site is closed to new enrollment until IEHP can confirm the PCP meets this requirement.
    b. The PCP and/or IPA must submit a CAP signed by the PCP verifying that they are present at the site a minimum of sixteen (16) hours per week. Rural health clinics are exempt from this minimum on-site hours requirement. Please see Policy 6E, "Rural

[1] Medicare Managed Care Manual, "Chapter 6 – Relationships with Providers," Section 60.3

Health Clinics" for more details.

B. PCPs must complete a CAP within established timeframes. PCPs who fail to submit a CAP for on-site hours requirements will be referred to IEHP's Provider Relations team for further action, which may lead to the PCP being administratively removed from the IEHP network.

C. The following actions take place when a site is removed from the IEHP network:

1. The IPA, PCP and all participating Managed Care Plans are notified that the site is removed from the IEHP network.

2. All affected Members are mailed a notification letter informing them of the change and outlining their options. See Policy 18J, "IEHP Termination of PCPs, Specialists, Vision, and Behavioral Health Providers."

D. Pre-contracted providers who do not pass the initial FSR within two (2) attempts may reapply to IEHP six (6) months after being denied participation in the IEHP network.

E. PCPs who are administratively removed from or denied participation in the IEHP network for failing an FSR/MRR or failure to meet on-site hour requirements can apply through their IPA to be reconsidered for IEHP participation at either their original site or a new site. The re-application cannot be done until twelve (12) months after a site was terminated from or denied participation in the IEHP network**.** In either case, all conditions below must be met, as applicable:

1. For PCPs who failed an FSR/MRR:

   a. A repeat FSR and MRR Survey will be performed by IEHP within 12 months. The third consecutive attempt must result in a score of 80% or greater in both FSR and MRR. If the PCP site fails on its third consecutive attempt in the PCP site will be terminated from the IEHP network.

   b. Site surveys are scheduled by the Quality Management Department within sixty (60) days of notification from the Credentialing Department if a site has no record of a passing survey score in the past three (3) years.

2. For PCPs found not to be physically present at a site for a minimum of sixteen (16) hours per week and do not complete their CAP:

   a. PCPs can re-apply twelve (12) months after being denied participation in the IEHP network, either individually or through their IPA, to be reconsidered to become a participating PCP site.

   b. The PCP must submit directly to IEHP, or through their IPA if applicable, a schedule that covers the most recent six (6) month period (at minimum) and demonstrates that they are on-site at least sixteen (16) hours per week.

   c. The IPA must submit a letter signed by the PCP committing to this schedule and timeframe. PCPs may change the schedule in terms of days of the week (or

increasing on-site time); however, a minimum of sixteen (16) hours per week must be maintained. The IPA must provide IEHP with advance written notice of changes to the schedule.

d. IEHP Provider Relations or IEHP Quality Management team will confirm that the PCP is present according to the schedule by conducting telephone or unannounced in-person visits.

F. PCPs that voluntarily terminate their contract with IEHP may reapply if there are no quality issues involved.

G. If there is a change in ownership of an existing provider site, the site will need to undergo an initial site review.

H. PCPs denied participation or who have been removed twice from IEHP for any reason related to quality or compliance, are not allowed to reapply for participation with IEHP.

I. IEHP reserves the right to add additional requirements or perform specific additional monitoring as determined by IEHP.

INLAND EMPIRE HEALTH PLAN		
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6. FACILITY SITE REVIEW

D. Residency Teaching Clinics

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members and Providers.

POLICY:

A. All attending Physicians providing services to Members at residency clinics, as described in this policy, must be credentialed and approved by IEHP or the IPA, and open for enrollment through IEHP.

DEFINITIONS:

A. Residency Teaching Clinic – Clinics that operate full-time (Monday through Friday, approximately 8:00am to 5:00pm) as sites for the training of residents in a primary care discipline from an accredited residency training program.

PROCEDURES:

A. Except in cases specifically approved by the IEHP Chief Medical Officer or designee, IEHP may only assign Members to attending Physicians at residency teaching clinics. Members are not assigned to resident physicians.

B. IEHP Members who receive primary care services at a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) or Indian Health Facility (IHF) facilities are directly assigned to the clinic itself. See Policy 3E, "Primary Care Provider Assignment."

C. For attending Physicians to receive Member assignment as a Primary Care Provider (PCP), the following conditions must be met:

1. Residency teaching clinics must undergo and pass a Facility Site Review (FSR) and Medical Record Review (MRR) (See Policy 6A, "Facility Site Review and Medical Records Review Survey Requirements and Monitoring").

   a. The number of medical records reviewed depends on the number of Practitioners, and the following requirements apply to Practitioners on a shared medical record system:

Number of PCPs	**# of Medical Records reviewed**
One (1) to Three (3) PCPs	Ten (10) Records
Four (4) to Six (6) PCPs	Twenty (20) Records
Seven (7) or more PCPs	Thirty (30) Records

   Each attending Physician receives the same medical record score if they share medical records by specialty type as applicable.

2. The attending Physicians receiving Membership must be on-site a minimum of eight (8) hours per week.
3. There must always be an attending Physician available during clinic office hours.

D. The attending Physician shall serve in a supervisory capacity for residents, but the attending Physician need not examine every patient that is examined by a resident.

E. When possible, Members should be empaneled to one (1) resident physician to ensure continuity of care during the time of the physician's residency.

INLAND EMPIRE HEALTH PLAN		
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6. FACILITY SITE REVIEW

E. Rural Health Clinics

APPLIES TO:

A. This policy applies to all IEHP Providers (PCPs and Specialists) who treat IEHP DualChoice Members.

POLICY:

A. IEHP ensures access to primary care through Rural Health Clinics for Members that reside in designated rural area.

DEFINITIONS:

A. Rural Health Clinic - a clinic that is located in a designated by the Department of Health Care Services (DHCS) as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatment of mental conditions, and meets all other requirements.[1]

PROCEDURES:

A. For a Primary Care Provider (PCP) site to receive Member assignment as a rural health clinic, the following conditions must be met:[2]

   1. The clinic must be under the medical direction of a physician.
   2. The PCP must be available on-site a minimum of eight (8) hours per week.
   3. There must be a credentialed Advanced Practice Practitioner (APP) ((i.e., a Nurse Practitioner (NP) or Physician Assistant (PA), Certified Nurse Midwife (CNM)) or another credentialed PCP available on-site the remainder of the open clinic hours.
   4. The PCP must adhere to the appointment access standards, see Policy 9A, "Access Standards."
   5. Any APP seeing Members must be supervised by the Physician assigned to the Members and practice under specific protocols available at the clinic site and/or practice agreement available at the clinic site. See policy 6F, "Advanced Practice Practitioner Requirements."
   6. The PCP must be available during clinic hours to the APP via phone or pager and meet all after-hours access requirements.

B. At the discretion of IEHP Chief Medical Officer (CMO) or designee, NPs may be assigned membership if practicing in a designated rural area.

   1. Members are assigned to the rural health clinic, not the individual PCP practicing at the site, or the NP if so designated to act as the PCP. See Policy 18A1, "Primary Care Provider – IPA and Hospital Affiliations."

[1] Title 42 Code of Federal Regulations (CFR) § 491.2
[2] 42 CFR § 491.7

6. FACILITY SITE REVIEW

E. Rural Health Clinics

INLAND EMPIRE HEALTH PLAN		
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6. FACILITY SITE REVIEW

F. Advanced Practice Practitioner Requirements

APPLIES TO:

A. This policy applies to all IEHP DualChoice Advanced Practice Practitioners (APP).

POLICY:

A. IEHP ensures that the relationship between Advanced Practice Practitioners (APP) and their supervising physician is that of a shared and continuing responsibility to follow the progress of the Member in a manner which assures the APP's adherence to the limits of the specific professional practice established by law and regulations, while maximizing patient safety, health and well-being.[1]

DEFINITIONS:

A. Advanced Practice Practitioners (APP) –This includes Nurse Practitioners (NP), Physician Assistants (PAs), and Certified Nurse Midwives (CNMs) authorized to provide primary care under Physician supervision. These practitioners are otherwise known as non-physician medical practitioners or mid-level practitioners.

PROCEDURES:

General Requirements

A. The ratio of APP to the supervising Physician must not exceed the full-time equivalent (FTE) of one of the following:

1. Nurse Practitioners (NPs) 4:1 Physician
2. Physician Assistants (PAs) 4:1 Physician
3. Certified Nurse Midwives (CNMs) 4:1 Physician

Four (4) is the maximum number of APP to one (1) physician, in any combination of the above.

B. Each APP shall not exceed a full-time equivalent Provider-to-patient caseload of one (1) Provider per 1,000 patients.

C. A Primary Care Provider's (PCP) maximum enrollment may be increased if an APP is present at the site, see Policy 18A2, "Primary Care Provider - Enrollment Capacity."

D. APPs are not directly assigned Members and are not listed in the Provider Directory. At the discretion of the IEHP Chief Medical Officer or designee, NPs may be assigned Membership if practicing in a designated rural area. See Policy 6E, "Rural Health Clinics."

E. Requirements for APPs for licensure, education, training and experience must meet credentialing standards as set by the IPA and the health plan. See policies 5A1, "Credentialing

[1] Title 22, California Code of Regulations (CCR) § 51241

and Recredentialing – Credential Standards – Credentialing Policies," and 25B1, "Delegation Oversight - Credentialing Standards – Credentialing Policies."

F. APPs must identify themselves in all aspects of care as a non-physician Practitioner and staff must not use the terminology "doctor" to refer to APPs.[2]

G. APPs that prescribe controlled substances must have a valid and current Drug Enforcement Agency (DEA) registration number.

Physician Assistants (PA)

A. PAs must be practicing at a credentialed site assigned to their supervising Physician and have an onsite, site-specific "Practice Agreement of Physician Assistant" signed by one or more physicians and surgeons, or a physician and surgeon, who is authorized to approve the practice agreement on behalf of the staff of the physicians and surgeons.[3] All PAs act as the agent of the supervising Physician with whom they have an agreement.[4] This agreement must define specific services identified in practice protocols or specifically authorized by the supervising Physician.[5,6]

1. Both the Physician and PA must attest to, date and sign the agreement.[7]
2. An original or copy must be readily accessible and available at all practice sites in which the PA works.
3. The agreement must be reviewed, dated and signed whenever any changes occur within the practice agreement.

B. The Practice Agreement may authorize a PA to provide or perform activities if there is documentation evidencing the activity was actually performed.[8] Activities include, but are not limited to:

1. Physical examinations, including interscholastic athletic program examinations.[9]
2. Order durable medical equipment (DME) and make arrangements with regard to home health services or personal care services, as applicable. For home health and/or personal care services, after consultation with the supervising Physician, the PA may approve, sign, modify or add to the plan of treatment or care;[10]
3. Routine visual screening, which includes non-invasive, non-pharmacological, simple testing for visual acuity, visual field defects, color blindness and depth perception.

[2] 16 CCR § 1399.547
[3] California Business and Professions Code (Bus. & Prof. Code), § 3502
[4] 16 CCR § 1399.541
[5] 16 CCR § 1399.540
[6] CA Bus. & Prof. Code, § 3502
[7] 16 CCR § 1399.540
[8] CA Bus. & Prof. Code § 3502
[9] 16 CCR § 1399.541
[10] Ibid.

C. The Practice Agreement is assessed during the Facility Site Review (FSR) process that is conducted at a minimum of every three (3) years. A Practice Agreement will be accepted if signed and validated within the past twelve (12) months. Failure to maintain a current Practice Agreement may be grounds for disciplinary action by the Medical Board of California against a PA licensure.

D. All credentialed sites with a PA must have a current Practice Agreement with their supervising Physician in place and PAs must be practicing at a site assigned to their supervising Physician.

Nurse Practitioners (NP) and Certified Nurse Midwives (CNM)

A. NP/CNM's must be practicing at a site assigned to their supervising Physician.

B. The Medical Practice Act authorizes Physicians to diagnose mental and physical conditions, to use drugs in or upon human beings, to sever or penetrate the tissue of human beings and to use other methods in the treatment of diseases, injuries, deformities or other physical or mental conditions. The performance of any of these functions by a NP requires a standardized procedure.

C. All credentialed sites with a NP or CNM must have current on-site site-specific written standardized procedures for NPs and CNMs signed by the supervising Physician and NP and/or CNM.

D. The standardized procedures must include all eleven (11) elements jointly required by the Medical Board of California and the Board of Registered Nursing.[11] Standardized procedures must also include book (specify edition) or article title, page numbers and sections, and other written sources. Additionally, the standards of care established by the sources must be reviewed and authorized by the Nurse Practitioner, Physician, and administrator (as appropriate) in the practice setting.[12]

INLAND EMPIRE HEALTH PLAN		
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[11] 16 CCR § 1474
[12] Ibid.

6. FACILITY SITE REVIEW

G. Urgent Care Center Evaluation

APPLIES TO:

A. This policy applies to contracted Urgent Care centers serving IEHP DualChoice Members.

POLICY:

A. IEHP conducts an evaluation of all Urgent Care centers to ensure their capacity to support the safe and effective provision of urgent care services.

PROCEDURES:

A. IEHP performs an evaluation on contracted Urgent Care centers initially and at a minimum of every three (3) years thereafter (see Attachment, "IEHP Urgent Care Evaluation Tool" in Section 6).

B. When an Urgent Care center would like to be contracted with IEHP they are required to undergo the Medical Record Review (MRR) and an Urgent Care Center Evaluation. Five (5) medical records are evaluated against the IEHP Urgent Care Guidelines (See Attachment, "IEHP Urgent Care Center Evaluation Tool" in Section 6) where all the following minimum requirements must be met:

1. Physician is credentialed in accordance with IEHP's credentialing and re-credentialing guidelines. Physician must be Board-certified or eligible in the following specialties and/or subspecialties: Family Practice, Internal Medicine, Pediatrics, or Emergency Medicine. If the Provider does not have the above training qualifications, they will be subject to review for approval by IEHP's Credentialing Subcommittee.
2. If the Urgent Care also functions as a Primary Care Provider (PCP) site, hours may **not** be combined to meet the sixteen (16) hour requirement for PCP sites. Physicians or Non-Physicians Medical Practitioners (NPMP) are required to be onsite during hours of operation.
3. Urgent Care centers must maintain coverage for Members of all ages and genders during hours of operation, except for "pediatric only" Urgent Care centers, which must maintain coverage for Members of all genders and ages under 21 years old.
4. Triage and/or telephone advice is performed by appropriate licensed personnel: Doctor of Medicine (MD)/ Doctor of Osteopathic Medicine (DO), Nurse Practitioner (NP), Physician Assistant (PA) or Registered Nurse (RN). Licensed Vocational Nurses (LVNs) and non-licensed staff are not allowed to perform triage and/or provide telephone advice.
5. Laboratory Services: Urgent Care centers must maintain a current and valid California Laboratory Improvement Amendment (CLIA) waiver/certificate specific to the site location.[1] Members must have immediate access to a laboratory on-site, with ability to perform

[1] Title 42 of the Code of Federal Regulation (CFR) §493.37

all laboratory tests specified below as waived by CLIA and results available to the Member and PCP:

a. Urine human chorionic gonadotropin (HCG);

b. Hemoglobin or Hematocrit (*Note – an off-site laboratory that can provide stat H & H results within 1-hour is acceptable);

c. Blood Glucose;

d. Urine Dipstick;

e. Rapid Strep; and

f. Sexually Transmitted Infections (STI) collection materials.

6. Radiology Services: Urgent Care centers must maintain on-site or immediate access to diagnostic radiology services (plain film x-rays) with urgent results made available to Member and PCP. Urgent Care centers must demonstrate the ability to perform chest and limb x-rays at minimum.

7. Language Services: Members must have access to oral interpretation services, at no cost to the Member. Oral interpretation must be provided in all languages and is not limited to threshold or concentration standard languages. Interpretation can occur through the following language services;

   a. Telephonic: IEHP provides 24/7 access to telephonic interpreter services to Members and Providers. Members and Providers may contact Member Services at (800) 440877) 273-IEHP (4347) during business hours for these services. After business hours, Members and Providers can call the 24-Hours Nurse Advice Line at (888) 244-IEHP (4347) to access interpreter services.

   b. Video Remote Interpreting (American Sign Language (ASL) Only): IEHP provides 24/7 access to Video Remote Interpreting (VRI) services to Members and Providers. For set up and technical assistance, contact IEHP Provider Relations Team at (909) 890-2054. The Urgent Care center is responsible for the cost, maintenance, and connectivity (Wi-Fi, Cellular, LAN) of IEHP- approved VRI equipment.

8. Equipment: Members must always have access to the following equipment on site:

   a. Electrocardiogram (EKG) machine;

   b. Nebulizer;

   c. Splinting materials;

   d. Wound irrigation supplies;

   e. Eye and ear irrigation supplies;

   f. Eye Tray;

   g. Eye chart literate/illiterate and occluder for vision testing;

h. Suture kits and materials;

i. Dressing supplies;

j. Suction machine and catheters (Recommended);

k. Nasogastric (NG) tubes (Recommended);

l. Wood's Lamp (Recommended);

m. Oxygen;

n. Pulse Oximetry.

o. Ophthalmoscope;

p. Otoscope, and adult and pediatric ear speculums;

q. Basic exam equipment: percussion hammer, tongue blades, patient gowns;

r. Scales: standing and infant scales;

s. Thermometers: oral and/or tympanic/Thermoscan with a numeric reading;

t. Stethoscope and sphygmomanometer with various size cuffs (e.g. child, adult, obese/thigh); and

u. Exam table and lights in proper working order.

9. Medication: Providers must always have access to the following medication on- site:

   a. Albuterol for inhalation;

   b. Epinephrine 1:1,000 for anaphylaxis;

   c. Benadryl Intramuscular (IM) or Per Oral (PO);

   d. Burn Dressing;

   e. Tylenol and Motrin;

   f. Anti-nausea;

   g. Anti-diarrhea;

   h. Injectable Antibiotics;

   i. Tdap (Tetanus, Diphtheria, Pertussis);

   j. Xylocaine; and

   k. Fluorescein Strips.

10. Urgent Care centers must have an emergency transport policy/action plan.

11. Minimum Hours of Operation: Monday through Friday, 5 p.m. to 8 p.m. The Urgent Care center must be open at least four (4) hours on Saturday, Sunday and the major holidays listed below:

a. New Year's Day;

b. Memorial Day;

c. 4th of July;

d. Labor Day;

e. Thanksgiving Day; and

f. Christmas Day.

12. An Advanced Practice Practitioner (APP) (Nurse Practitioner or Physician Assistant) that evaluates Members during their visit at the Urgent Care center, when the Physician is not physically on site, is expected to practice only under specific and clearly written protocols approved by the supervising Physician.

    a. The supervising Physician providing the oversight and their APP must be credentialed and/or recredentialed according to IEHP standards.

    b. The supervising Physician must be able to display evidence of oversight through 10% medical record review of the APP within thirty (30) days of the visit.

    c. Supervising physician specialty must cover the population served.

C. These eight (8) critical elements, related to the potential for adverse effect on patient health or safety, have a scored "weight" of two (2) points. All other survey criteria are weighted at one (1) point.

1. Language services: Members must always have access to Telephonic and Video Remote Interpreting (ASL only);
2. Only qualified/trained personnel retrieve, prepare or administer medications;
3. Oxygen: Oxygen tank must be a minimum of ¾ full;
4. Appropriate sizes of Engineered Sharps Injury Protection (ESIP) needles/syringes;
5. Personal Protective Equipment (PPE) is readily available for staff use;
6. Needlestick safety precautions are practiced on site;
7. Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak proof, labeled containers for collection, handling processing, storage, transport, or shipping; and
8. Spore testing of autoclave/steam sterilizer with documented results (at least monthly).

D. Compliance level categories for the Urgent Care center evaluation are as follows:

1. Exempted Pass — 90% and above (without critical element deficiencies, or deficiencies in required medications and/or infection control)
2. Conditional Pass — 80-89% or 90% and above (with critical element deficiencies, or deficiencies in required medications and/or infection control)
3. Not- Pass — Below 80%

E. Urgent Care centers must receive a score of 80% or greater on the "IEHP Urgent Care Center Evaluation Tool" without any critical element deficiencies. Audits which score less than 90% collectively or less than 80% on any one section will require a Corrective Action Plan (CAP). Assignment of "Urgent Care" status will not be given until the CAP process is complete.

F. Corrective Action Plan (CAP) process

1. The CAP process addresses deficiencies found during the evaluation and provides guidance for the Urgent Care center to bring their facility into full compliance with IEHP standards.
2. The Urgent Care center receives a CAP notification letter at the time the evaluation is performed. Any deficiencies found during the evaluation are noted on the form. The CAP letter notes the timeframes for corrective action, and any other pertinent information.
3. The Urgent Care center must address all critical element deficiencies by submitting a CAP to IEHP within ten (10) working days of the evaluation date.
4. IEHP will verify correction of critical element deficiencies within thirty (30) business days of the evaluation date.
5. All Urgent Care centers are responsible for developing and submitting their non-critical element CAPs to IEHP within thirty (30) calendar days of the evaluation date.
6. IEHP has thirty (30) calendar days to review and accept the CAP and complete a CAP verification site visit (as needed).
7. If the site continues to have deficiencies at the time of verification, an additional thirty (30) calendar days will be allowed for the Urgent Care center to address all issues and IEHP to review and accept the CAP and perform a CAP verification site visit if needed.

G. CAP Verification Process

1. Once it has been demonstrated that a site has met IEHP's threshold of Conditional Pass and a CAP has been accepted and verified, no further follow-up is required. However, further monitoring may be done at IEHP's discretion.
2. IEHP verifies the Urgent Care center's continued compliance for implementing the submitted CAPs as follows:

a. At the Certified Site Reviewer's (CSR) discretion, a desk review of evidence of CAP; or

b. An onsite or virtual CAP verification.

3. All Urgent Care centers that receive a non-passing score (below 80%), does not submit a CAP, or does not address deficiencies will be presented to the IEHP Peer Review Subcommittee for further review and action(s) taken as appropriate.

INLAND EMPIRE HEALTH PLAN		
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6. FACILITY SITE REVIEW

H. Interim FSR Monitoring for Primary Care Providers

APPLIES TO:

A. This policy applies to all Primary Care Providers (PCPs), who provide care and services to IEHP DualChoice Members.

POLICY:

A. IEHP conducts Interim Facility Site Reviews (FSR) to monitor PCPs between site reviews to investigate problems identified through monitoring activities or follow-up on corrective actions.[1]

PROCEDURES:

A. A PCP Interim FSR is conducted between the initial and periodic FSR and MRR surveys, between sixteen (16) and twenty (20) months from the previous FSR and MRR surveys and is required at least once between the three (3) year review cycle.

B. The Interim FSR evaluates the following: fourteen (14) critical elements,[2] after- hours PCP access and emergency care instructions/telephone information made available to patients, the Initial Health Assessment (IHA), and/or any criteria on the DHCS FSR and MRR tool (See Attachment, "Interim Facility Site Review (Self-Assessment) Tool" in Section 6).

1. Interim FSR (Self-Assessment)
    a. PCP sites will complete the Interim FSR (Self-Assessment) if they have scored an 90% or above in their previous FSR & MRR survey.
    b. PCPs must submit their completed self-assessment via fax at (909) 890-5746 to IEHP Quality Management Department QM Coordinators with a signature of attestation within ten (10) business days of receiving assessment.
2. Interim FSR (On-Site)
    a. An Interim FSR (On-Site/virtual) will be performed if the PCP site scored below 90% in their previous FSR & MRR survey
    b. At the discretion of the health plan and Certified Site Reviewer (CSR), an interim self-assessment may be converted into an interim on-site review.
3. For all onsite/virtual Interim reviews, IEHP will conduct an interim onsite/virtual MRR a minimum of five (5) or available charts during the interim FSR.

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 20-006 Supersedes Policy Letter (PL) 14-004, "Site Reviews: Facility Site Review and Medical Record Review"
[2] Ibid.

6. FACILITY SITE REVIEW

H. Interim FSR Monitoring for Primary Care Providers

C. Corrective Action Plan (CAP)

1. PCP offices with identified deficiencies as a result of the Interim FSR (Self-Review form or On-Site/virtual) will be issued a request for CAP (See Attachment, "Corrective Action Plan Notification Tool" in Section 6). The CAP must be completed within the timeframes as discussed in policy 6A, "Facility Site Review and Medical Record Review Survey Requirements and Monitoring."
2. If the answer is "No" to any of the fourteen (14) critical elements, a CAP will be issued and the PCP must submit a completed CAP to IEHP within ten (10) calendar days of CAP request.

D. Monitoring and Oversight

1. IEHP systematically monitors all PCP sites between each regularly scheduled FSR and MRR Survey. Monitoring sites between audits includes internal quality management systems, and external sources of information.

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6. FACILITY SITE REVIEW

I. Behavioral Health Hospital Survey

APPLIES TO:

A. This policy applies to all psychiatric Hospitals who treat IEHP DualChoice Members.

POLICY:

A. IEHP conducts its Behavioral Health (BH) Hospital Survey on all contracted inpatient psychiatric Hospital surveys to ensure their capacity to support safe and effective provision of services.

PROCEDURES:

Behavioral Health Hospital Survey

A. IEHP utilizes the BH Hospital Survey Tool, as approved by the IEHP Quality Management (QM) Committee, to verify compliance with the following review criteria and assign scoring appropriately (see Attachment, "Behavioral Health Hospital Survey Tool" in Section 6). The Behavioral Health Hospital Survey Tool is based on Medicare Benefit Policy Manual (Chapter 2), Code of Federal Regulations (CFR), as well as the Joint Commission Accreditation Manual.

   1. Policies & Procedures Criteria
   2. Format Criteria
   3. Documentation Criteria
   4. Initial Assessment Criteria
   5. Treatment Planning Criteria
   6. Progress Notes Criteria
   7. Medication Management Criteria
   8. Coordination of Care Criteria
   9. Discharge and/or Transfer Criteria

B. Critical elements related to the potential for adverse effect on patient health or safety have a scored "weight" of two (2) points. All other survey criteria are weighted at one (1) point.

Initial and Ongoing BH Hospital Survey

A. IEHP schedules the BH Hospital Survey directly with the inpatient psychiatric Hospital to take place within twelve (12) months of the inpatient psychiatric Hospital's initial or renewed IEHP contract effective date and every three (3) years, thereafter.

B. Inpatient psychiatric Hospitals where documentation of patient care by multiple physician reviewers occurs in the same record are reviewed as a "shared" medical record system. Shared

medical records are considered those that are not identifiable as "separate" records belonging to any specific physician reviewer.

C. Utilizing the BH Hospital Survey Tool, IEHP reviews up to ten (10) randomly selected medical records. During the BH Hospital Survey, IEHP, at its discretion, may request additional medical records to review.

D. Categories for the BH survey score results are as follows:

1. The BH Hospital Survey contains a total of one hundred one (101) points, with the following compliance level categories:

Exempted Pass	Conditional Pass	Fail (Not Pass)
• 90% and above without deficiencies in critical elements • CAP not required	• 90% and above with deficiencies in critical elements • 80% and above • CAP required	• 79% or below • CAP required

2. Full points are given if the scored element meets the applicable criteria. Partial points are not given for any scored element that is considered only "partially" met. Zero (0) points are given if an element does not meet all criteria.

E. Inpatient psychiatric Hospitals that receive an Exempted Pass are not required to complete a Corrective Action Plan (CAP) unless determined necessary by IEHP.

F. CAP is required of inpatient psychiatric Hospitals in these scenarios to address 100% of cited deficiencies within thirty (30) calendar days of the survey date:

1. The Hospital receives a Conditional Pass; i.e., a score of 80-89% or 90% and above with one or more sections scoring below 80%; or

2. The Hospital receives a BH Hospital Survey score of 79% or below; or

3. The Hospital reveals significant quality of care issues during the BH survey.

G. An inpatient psychiatric Hospital that scores 79% or below on the BH Hospital Survey is considered a "failed site".

1. Failed sites will receive a CAP notification and must score a minimum of 80% on their next annual BH Hospital Survey.

2. IEHP reserves the right to take any or all of these actions against failed sites or those inpatient psychiatric hospitals that reveal significant quality of care issues during the BH survey.

a. Issue a request for CAP to correct identified deficiencies; and/or

b. Place the inpatient psychiatric Hospital on an annual review; and/or

c. Hold any new referral or transfer of Members until CAP is received, verified and closed; and/or

d. Escalate the issue to IEHP's Peer Review Subcommittee or designee for further action; and/or

e. Terminate the inpatient psychiatric Hospital from IEHP's network. If termination occurs, IEHP will notify County Behavioral Health.

Focused BH Hospital Survey

A. At the discretion of IEHP's Chief Medical Officer or designee, IEHP can perform a focused BH Hospital Survey on any inpatient psychiatric Hospital contracted with IEHP, with or without prior notification.

B. A focused survey is an audit used to investigate specific issues identified through quality monitoring, Member complaints, Potential Quality Incident (PQI), referral from other internal departments, or to follow up on corrective actions. All deficiencies found in a focused survey require the completion and verification of a CAP according to established CAP timelines.

C. Inpatient psychiatric hospitals that receive a Potential Quality Incident (PQI) and has had a minimum of three (3) substantiated Member complaints related to facility issues or record keeping will be surveyed within ninety (90) days of the third complaint or PQI.

1. If the inpatient psychiatric Hospital passes the review criteria, then the site will resume the regular scheduled audit timeframe (see Attachment, "Behavioral Health Hospital Survey Tool" in Section 6).

2. If the inpatient psychiatric Hospital does not pass the review criteria, it will be required to complete a CAP and be monitored every six (6) months until deficiencies are resolved. Monitoring will be done by reviewing Member complaints and/or through additional focused surveys.

D. IEHP may, at its discretion, add an addendum to the BH Hospital Survey to perform a focused audit.

Corrective Action Plan

A. IEHP issues a CAP notification letter at the time the BH Hospital Survey is performed. The CAP notification letter notes the inpatient psychiatric hospital's status, deficiencies found during the BH Hospital Survey, timeframes for corrective action, and any other pertinent information (see Attachment, "BH Hospital Survey – Corrective Action Plan Tool" in Section 6).

1. CAPs for critical elements are given at the time of survey.

2. CAPs for all non-critical element deficiencies are issued within ten (10) calendar days of survey completion.

B. Inpatient psychiatric Hospitals, wishing to appeal the results of their BH Hospital Survey must do so by writing to the IEHP Chief Medical Officer or designee within fourteen (14) business days of the date of the CAP notification.

1. Within thirty (30) days of receiving a written appeal, the IEHP Chief Medical Officer or designee responds in writing to the appealing inpatient psychiatric Hospital noting the status of the appeal.
2. If the appeal in whole or in part is not accepted by IEHP, the inpatient psychiatric hospital has thirty (30) calendar days to submit a CAP addressing all deficiencies noted in the BH Hospital Survey.

C. If deficiencies are found in any of the critical elements, the inpatient psychiatric Hospital must submit a CAP and evidence of corrections within ten (10) calendar days of the survey date.

D. Inpatient psychiatric hospitals that do not correct survey deficiencies within the established CAP timelines will not receive any new referrals or Member transfers until corrections are verified and the CAP is closed.

E. Any inpatient psychiatric Hospital that does not come into compliance with the review criteria within the established timelines may be referred to IEHP's Chief Medical Officer or designee for further action, including up to termination of the Hospital from IEHP's network.

CAP Verification Process

A. IEHP must perform its CAP verification within thirty (30) calendar days of receiving the inpatient psychiatric Hospital's CAP.

B. At IEHP's discretion, CAPs for critical or non-critical elements may be verified onsite or via document submission.

C. If a verification results in the identification of additional deficiencies, IEHP will require an additional CAP within the same CAP timeframes described above. A second CAP verification is therefore, performed within thirty (30) calendar days of accepting the second CAP.

D. Once IEHP verifies that the inpatient psychiatric Hospital has met IEHP's threshold of Conditional Pass and a CAP has been accepted and verified, no further follow-up is required. IEHP may however, continue monitoring the hospital at its discretion.

Monitoring

A. IEHP systematically monitors all psychiatric Hospitals between each regularly scheduled BH Hospital Survey. Monitoring sites between surveys include the use of both internal quality management systems and external sources of information, such as focused surveys, PQI referrals, and/or review of Member complaints. All deficiencies identified through the monitoring process require the completion of a CAP according to CAP timelines.

B. Information from BH Hospital Surveys are reported to the Quality Management Committee.

6. FACILITY SITE REVIEW

I. Behavioral Health Hospital Survey

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2021
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

6. FACILITY SITE REVIEW

Attachments

DESCRIPTION	POLICY CROSS REFERENCE
Behavioral Health Hospital Survey Tool	6I
Behavioral Health Hospital Survey – Correct Action Plan Tool	6I
Corrective Action Plan Notification Tool	6A, 6H
DHCS MMCD Facility Site Review (FSR) Standards	6A
DHCS MMCD Facility Site Review (FSR) Tool	6A
DHCS MMCD FSR Attachment C - Physical Accessibility Review Survey	6A, 6B
DHCS MMCD FSR Attachment D – Ancillary Physical Accessibility Review Survey	6B
DHCS MMCD FSR Attachment E – CBAS Physical Accessibility Review Survey	6B
DHCS MMCD Medical Record Review (MRR) Standards	6A
DHCS MMCD Medical Record Review (MRR) Tool	6A
IEHP Medical Record Review Survey Addendum	6A
IEHP Urgent Care Evaluation Tool	6G
Urgent Care CAP Complete Tool and Notification Letter	6G
Interim Facility Site Review (On-Site) Tool	6A, 6H, 7A
Interim Facility Site Review (Self-Assessment) Tool	6H, 7A

Behavioral Health Hospital Survey Corrective Action Plan (CAP) Notification

Date of Review:

Health Plan Performing Evaluation	**IEHP**		
Facility/Hospital Name:	Provider Name(s):		# of Provider(s) Reviewed: # of Charts Reviewed:
Address:		Contact Person and Title:	
Telephone:	Fax:	☐ Exempted Pass– No CAP Due	
BH Hospital Survey Score:	**Date Critical Element CAP Due:** Date BH Hospital Survey CAP Due:	**CAP Follow-up:** ☐ Mail/Fax ☐ Schedule Follow-up visit ☐ Critical Element ☐ BH Hospital Survey ☐ Follow-up visit scheduled date/time: _____	**CAP Closed Date:**
Reviewer's Name/Title (Print):		**Reviewer's signature/Title:**	

CAP Completion and Submission Requirements

Disclosure and Release

I have received and reviewed copies of the above listed site's evaluations and CAPs for the BH Hospital Survey. I agree to correct each identified deficiency by implementing any corrective action that may be required. **I understand that failure to correct any of the noted Critical Element deficiencies within the required 10 calendar days and any other noted deficiencies within the 30-day time period from the review date,** may result in the exclusion of this facility and the associated provider(s) from IEHP's network. **The completed CAP must include evidence of correction** {e.g. education sign sheets, forms used} **and dates completed.**

For assistance in completing the CAP, please call_____, RN, CSR at 909- _____.

I hereby authorize the above-mentioned health plan and any government agencies that have authority over the health plans, and authorized county entities in the State of California, to furnish to each other these reviews and CAPs of this facility.

_____	_____	_____
Facility Administrator/Designee Signature	**Printed Name and Title**	**Date**

Please Return Completed CAP via U.S. Mail or FAX to: **Attention: QM Coordinator** **Fax: 909-890-5545**	**Inland Empire Health Plan** **P.O. Box 1800,** **Rancho Cucamonga, CA 91729-1800**	**Facilities wishing to appeal the results of a BH Hospital Survey must do so in writing to the IEHP Chief Medical Officer or Designee, within 14 working days of the date of the notification letter.**	**P.O. Box listed to the left.** **CMO Fax: (909) 890-2019**

INSTRUCTIONS FOR USE

1st Column: (Health Plan Use Only) Health Plan verification and date – The Health Plans Certified Site Reviewer (CSR) will initial and date the deficiency that the site has addressed/corrected. The Facility's Corrective Action Plan will be verified by the CSR through a desk review by the Health Plan and/or a follow-up on site visit.

2nd Column: (Health Plan Use Only) Criteria – The Health Plan's CSR will check the criteria(s) that were found deficient during the site review and/or medical record review processes. The criteria(s) checked should be addressed/corrected by the hospital. A CAP for all critical element deficiencies, which are **bolded and underlined**, should be submitted to the Health Plan within 10 calendar days. A CAP for other criteria found deficient is due to the Health Plan within 30 days from the date of survey.

3rd Column: (Health Plan Use Only) Deficiency Cited/Reviewer Comments – This column is for the purpose of notifying the Facility and/or designated staff of the deficiency found and/or the CSR findings/comments.

4th Column: (Health Plan and Facility/Hospital Use) Recommended Corrective Action – The Health Plan's CSR will check and/or write comments for the facility/hospital in order to notify the facility and/or designated staff the documents and/or evidence needed in order to fulfill a deficiency.

5th Column: (Facility/Hospital Use Only) Correction Date – The facility/hospital will document the date that a deficiency has been addressed and/or corrected.

6th Column: (Facility/Hospital Use Only) Facility's Comments – The facility/hospital will document corrective actions taken to address/correct a deficiency, as well as provide appropriate documents to support corrective actions taken. If facility/hospital agrees with items checked in the 4th Column (Recommended Corrective Action) then the facility/hospital would write "agree with recommended corrective action," as well as submit supporting documents.

7th Column: (Facility/Hospital Use Only) Signature and Title of Facility Administrator or Designee – The facility/hospital staff who is responsible for maintaining compliance with a deficiency found during a site audit would put their name, title, and initial in this column.

NOTE: The Health Plan's Certified Site Reviewer (CSR) may conduct a follow-up on site review to verify corrective action within 30 days from the date of audit and/or request the CAP to be submitted to the Health Plan via mail and/or fax.

CAP COMPLETION SIGNATURE PAGE

I have completed the CAPs for the facility and medical record reviews performed on _____. I affirm each
(Enter Date of Review)

corrective action has been implemented as indicated on the attached Corrective Action Plan. I hereby authorize the reviewing health plan to furnish to all collaborative partner, any government agencies that have authority over the health plans, and authorized county entities in the State of California, the CAPs and related review tools for this facility.

_____	_____	_____
Facility Administrator/Designee Signature	**Printed Name and Title**	**Date**

Please Return Completed Corrective Action Plan and this signature sheet via U.S. Mail or FAX to:

Inland Empire Health Plan
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800
Attention: QM Coordinator
Fax: 909-890-5545

Behavioral Health Hospital Survey

I. Policies and Procedures Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	IA ☐	No evidence that staff competence was assessed initially and/or again once every three years.	☐ A copy of the staff competence assessment documentation ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	IB ☐	No evidence that the hospital has/follows a written policy addressing the control of medication between receipt by an individual health care provider and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage.	☐ A copy of a policy addressing the control of medication between receipt by an individual health care provider and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	IC ☐	No evidence that the hospital has/follows a written policy for as needed (PRN) orders: orders acted on based on the occurrence of a specific indication or symptom.	☐ A copy of policy for as needed (PRN) orders: orders acted on based on the occurrence of a specific indication or symptom ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	ID ☐	No evidence that the hospital has/follows a written policy for standing orders: A prewritten medication order and specific instructions from the licensed independent practitioner to administer a medication to a person in clearly defined circumstances.	☐ A copy of policy for standing orders: A prewritten medication order and specific instructions from the licensed independent practitioner to administer a medication to a person in clearly defined circumstances. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

I. Policies and Procedures Criteria						
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	IE ☐	No evidence that the hospital has/follows a written policy for titrating orders: orders in which the dose is either progressively increased or decreased in response to the patient's status.	☐ A copy of policy for titrating orders: orders in which the dose is either progressively increased or decreased in response to the patient's status ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	IF ☐	No evidence that the hospital has/follows a written policy for taper orders: orders in which the dose is decreased by a particular amount with each dosing interval.	☐ A copy of policy for taper orders: orders in which the dose is decreased by a particular amount with each dosing interval. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	IG ☐	No evidence that the hospital has/follows a written policy for orders for medications at discharge or transfer.	☐ A copy of policy for orders for medications at discharge or transfer. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	IH ☐	No evidence that the hospital has/follows a written policy that defines actions to take when medication orders are incomplete, illegible, or unclear.	☐ A copy of policy that defines actions to take when medication orders are incomplete, illegible, or unclear. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II ☐	No evidence that the hospital has/follows a written policy that defines actions to take and report for a sentinel event.	☐ A copy of policy that defines actions to take and report for a sentinel event. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

II. Format Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	II A ☐	Each Member did not have a separate record.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II B ☐	Each record did not have the Members address, employer or school, home and work telephone numbers documented.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II C ☐	Emergency "contact" was not identified.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the form is attached. ☐ Other:			
	II D ☐	Guardianship information was not identified.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the form is attached. ☐ Other:			
	II E ☐	Medical records were not maintained and organized.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II F ☐	Member's attending physician and/or rendering physician (PCP) was not identified.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the form is attached. ☐ Other:			

II. Format Criteria						
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	II G ☐	Primary language and interpreter service needs of non-or limited-English proficient (LEP) or hearing-impaired persons were not prominently noted.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II H ☐	Person or entity providing medical interpretation was not identified, as necessary.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II I ☐	No evidence of Signed Copy of the Notice of Privacy.	☐ A copy of the policy and procedure regarding Notice of Privacy is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

III. Documentation Criteria						
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	III A ☐	Allergies were not prominently noted.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	III B ☐	Chronic problems and/or significant conditions were not listed.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the chronic problem(s) and/or significant conditions form is attached. ☐ Other:			
	III C ☐	Current *continuous* medications were not listed.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the current continuous medications form is attached. ☐ Other:			
	III D ☐	No evidence that a Consent for Treatment or Informed Consent in the record was signed by the Member and/or legal guardian. For minors, the Consent for Treatment must be -signed by the Member's parent/caregiver/court officer (CFS worker or Probation Officer).	☐ A copy of the policy and procedure regarding Consent for Treatment or Informed Consent is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the Consent for Treatment/ Informed Consent form(s) is attached. ☐ Other:			

III. Documentation Criteria						
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	III E ☐	No evidence that the patient was given information to create psychiatric Advance Directives.	☐ A copy of the information is available regarding psychiatric Advanced Directive is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the psychiatric Advanced Directive is attached. ☐ Other:			
	III F ☐	No evidence that the patient was provided with referrals to peer support services.	☐ A copy of the policy and procedure regarding referrals to peer support services is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	III G ☐	No evidence that all entries in the record included the responsible service provider's name, professional degree and/or relevant identification number, if applicable, and were signed and dated (including electronic signature for EMR systems) where appropriate.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	III H ☐	No evidence that the service provider provided education to Member/family about service planning, discharge planning, supportive community services, behavioral health problems, and care options.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

III. Documentation Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	III I ☐	No evidence that the risks of noncompliance with treatment recommendations were discussed with the Member and/or family or legal guardian. For minors, discussions may also be made with the Member's parent/caregiver/ court officer (CFS worker or probation officer if appropriate)	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	III J ☐	No evidence that there was information that documents the course and result(s) of patient's care, treatment, and services.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	III K ☐	The record was not clearly legible.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	III L ☐	Errors were not corrected according to legal medical documentation standards.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

IV. Initial Assessment Criteria

Health Plan verification and date	CRITERI	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	IV A ☐	No evidence of a complete clinical case formulation documented in the record (e.g. primary diagnosis, medical conditions, psychosocial and environmental factors and functional impairments).	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV B ☐	No psychiatric evaluation completed within 24 hours of admission.	☐ A copy of the policy and procedure regarding psychiatric evaluation is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV C ☐	No evidence that a medical history and/or physical exam (appropriate to level of care) was in the record.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV D ☐	Current medical condition not identified.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

IV. Initial Assessment Criteria						
Health Plan verification and date	**CRITERI**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	IV D1 ☐	No evidence of documentation of communication/collaboration with the treating medical clinician for medical condition occurred.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV D2 ☐	No evidence of documentation that the patient/legal guardian refused consent for the release of information to the treating medical clinician. For minors, release of information may also be refused by the Member's parent/caregiver/court officer (CFS worker or Probation Officer).	☐ A copy of the policy and procedure regarding consent for the release of information is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV D3 ☐	No evidence of documentation that medical treatment history included the following information: known medical conditions, dates and providers of previous treatment, current treating clinicians, and current therapeutic interventions and responses.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV E ☐	No evidence of documentation of a complete mental status exam was in the record (patient's affect, speech, mood, thought content, judgement, insight, attention or concentration, memory, and impulse control) nor the frequency in which the mental status exam is completed.	☐ A copy of the policy and procedure regarding mental status exam/assessment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the mental status exam form is attached. ☐ Other:			

IV. Initial Assessment Criteria						
Health Plan verification and date	**CRITERI**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	IV F ☐	No evidence of documentation of patients' overall level of risk for suicidal/homicidal tendencies and/or the plan to mitigate the risk for suicide/homicide.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV G ☐	Behavioral health treatment history did not include the following information: dates and providers of previous treatment, and therapeutic interventions and responses.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV H ☐	No evidence of documentation of previous behavioral health hospitalization(s) were assessed and/or documented.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV I ☐	**No evidence of documentation of previous suicidal or homicidal/violent behaviors and risk, including dates, method, and lethality.**	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV J ☐	**No evidence of documentation of behavioral health history which includes an assessment of any abuse or psychological trauma the member has experienced or if the member has been the perpetrator of abuse.**	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

IV. Initial Assessment Criteria						
Health Plan verification and date	**CRITERI**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	IV K ☐	**If abuse was reported, there is no evidence that a report was completed to the appropriate authorities.**	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV L ☐	**No evidence of documentation of the patient's substance use history.**	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV M ☐	No evidence of documentation of spiritual and cultural variables that may impact treatment.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV N ☐	**No evidence of documentation of the patient's strengths**	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV O ☐	**No evidence of documentation of screening for metabolic disorders**	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

IV. Initial Assessment Criteria						
Health Plan verification and date	**CRITERI**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	IV P ☐	No evidence of documentation of presence or absence of relevant legal issues of the patient and/or family.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV Q ☐	No evidence of documentation that the patient was asked about community resources (support groups, social services, school based services, other social supports) that they are currently utilizing.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV R ☐	No evidence that the hospital obtained information on the medications the patient is currently taking when he/she is admitted to the hospital. This information was not documented in a list format that is useful to those who manage medications.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

V. Treatment Planning Criteria						
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	V A ☐	No evidence of documentation (a signed form) that the patient or legal guardian (based on each state's age of consent) had agreed to the treatment plan. For minors, the parent/caregiver/court officer (CFS worker or Probation Officer) may agree to the treatment plan.	☐ A copy of the policy and procedure regarding treatment plan is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V B ☐	No evidence that the hospital involved the patient in making decisions about his or her care, treatment, and services.	☐ A copy of the policy and procedure regarding treatment plan is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V C ☐	The treatment record did not indicate the family's involvement in the treatment process, including care decisions, when appropriate.	☐ A copy of the policy and procedure regarding treatment plan is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V D ☐	No evidence that services provided were under an individualized treatment or diagnostic plan.	☐ A copy of the policy and procedure regarding treatment plan is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

V. Treatment Planning Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	V E ☐	Services provided did not reasonably improve the patient's condition or were not for the purpose of diagnosis.	☐ A copy of the policy and procedure regarding services provided is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V F ☐	The treatment plan was not consistent with diagnosis and had no objective and no measurable short and long term goals.	☐ A copy of the policy and procedure regarding treatment plan is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V G ☐	Documentation was not adequate to justify the diagnosis and the treatment and rehabilitation activities carried out.	☐ A copy of the policy and procedure regarding treatment plan is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V H ☐	Based on the goals established in the patient's plan of care, staff did not evaluate the patient's needs. The frequency of evaluation was not documented.	☐ A copy of the policy and procedure regarding patient's plan of care/treatment plan is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

V. Treatment Planning Criteria						
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	V I ☐	The treatment plan did not include a safety plan when active risk issues were identified.	☐ A copy of the policy and procedure regarding treatment plan is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V J ☐	The treatment plan and goals for care were not revised based on the patient's needs.	☐ A copy of the policy and procedure regarding treatment plan is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V K ☐	The plan of care did not include the responsibilities of each member of the treatment team.	☐ A copy of the policy and procedure regarding plan of care is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V L ☐	No evidence that there was clear documentation of medication dispensing, as appropriate and necessary. For DETOX Services, there was no evidence of consistent documentation of vital signs throughout treatment in the record.	☐ A copy of the policy and procedure regarding medication dispensing is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

V. Treatment Planning Criteria						
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	V M ☐	No evidence of documentation of vital signs throughout treatment or inpatient stay.	☐ A copy of the policy and procedure regarding treatment plan is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V N ☐	**No evidence that tobacco use treatment was provided or offered.**	☐ A copy of the policy and procedure regarding providing or offering tobacco use treatment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V O ☐	**No evidence that there was clear documentation of physical restraint and/or seclusion and hours (if used).**	☐ A copy of the policy and procedure regarding documentation of physical restraint and/or seclusion and hours (if used is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V P ☐	No evidence that the hospital began the discharge planning process early in the patient's episode of care, treatment, and services.	☐ A copy of the policy and procedure regarding discharge planning process is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

VI. Progress Notes Criteria						
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VI A ☐	No evidence progress notes reflected reassessments when necessary.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	VI B ☐	On-going risk assessments are not documented in the progress notes (including but not limited to suicide and homicide) and monitoring of any at risk situations.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	VI C ☐	Progress notes do not indicate treatment given to the patient and do not indicate their reaction to it.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	VI D ☐	Progress notes written by Physicians do not document medical necessity and do not confirm patient is receiving treatment at the appropriate level of care.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	VI E ☐	No documentation of the dates of follow up appointments with their specialists, medical and/or behavioral health provider(s), as appropriate.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

VI. Progress Notes Criteria						
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VI F ☐	No documentation of any referrals made to other clinicians, agencies, and/or therapeutic services when indicated.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

VII. Medication Management Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	VII A ☐	No evidence of medication monitoring in the treatment record (physicians and nurses) for patients on medication	☐ A copy of the policy and procedure regarding medication management is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	VII B ☐	No evidence that the lab results were received and reviewed by the clinician, when lab work was ordered.	☐ A copy of the policy and procedure regarding medication management/ practitioner review of lab results is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	VII C ☐	No evidence of documentation that the prescribing clinician provided the patient with education about the risks, benefits, side effects, and alternatives of each medication.	☐ A copy of the policy and procedure regarding medication management is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	VII D ☐	No evidence that the prescriber coordinated care within 14 calendar days after initiation of a new medication upon discharge.	☐ A copy of the policy and procedure regarding medication management is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

VII. Medication Management Criteria						
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VII E ☐	No documentation that any referrals were made to other clinicians, agencies, and/or therapeutic services when indicated for medication management.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

VIII. Coordination of Care Criteria						
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VIII A ☐	No evidence that the patient was asked whether they are being seen by a medical physician (PCP).	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	VIII A1 ☐	Medical physician (PCP) was not documented.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	VIII A2 ☐	No evidence of documentation that communication/collaboration occurrence(s).	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	VIII B ☐	No documentation that the patient was asked whether they are being seen by multiple behavioral health clinician(s) - (e.g. psychiatrist and social worker, psychologist and substance/OTP/MAT counselors).	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

VIII. Coordination of Care Criteria						
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VIII B1 ☐	Behavioral health clinician(s) were not documented.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	VIII B2 ☐	No documentation of communication/collaboration occurrence(s) by other behavioral clinician(s).	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

IX. Discharge and/or Transfer Criteria						
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	IX A ☐	No evidence that the patient was transferred/ discharged to another program or hospital.	☐ A copy of the policy and procedure regarding transfer and/or discharge is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IX B ☐	No evidence that the patient was provided with written information on the medications that the patient should be taking when he or she is discharged from the hospital.	☐ A copy of the policy and procedure regarding transfer and/or discharge is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IX C ☐	No documentation of communication/collaboration occurred with receiving clinician/program when patient was transferred/discharge to another program or hospital.	☐ A copy of the policy and procedure regarding transfer and/or discharge is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IX D ☐	**No evidence that there was communication /collaboration with patient's aftercare providers if patient was discharged home.**	☐ A copy of the policy and procedure regarding transfer and/or discharge is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

IX. Discharge and/or Transfer Criteria						
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	IX E ☐	**No evidence that patients discharged on multiple antipsychotic medications have appropriate justification documented.**	☐ A copy of the policy and procedure regarding transfer and/or discharge is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IX F ☐	No evidence that the hospital arranged or assisted prior to discharge in arranging the services required by the patient after discharge in order to meet his or ongoing needs for care and services.	☐ A copy of the policy and procedure regarding transfer and/or discharge is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IX G ☐	**No evidence that tobacco use treatment is provided or offered at discharge**	☐ A copy of the policy and procedure regarding transfer and/or discharge is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IX H ☐	Clinical records were not completed within 30 days following discharge.	☐ A copy of the policy and procedure regarding transfer and/or discharge is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

Behavioral Health Hospital Survey

Date of Facility Review:

Facility Name:		**Facility Address:**	
Reviewer Name(s):			

Scoring Procedure

	Points possible per chart	Yes Pts. Given	No's Pts. Given	N/A's	Section Score %
I. Policies and Procedures	**9**				
II. Format	**9**				
III. Documentation	**12**				
IV. Initial Assessment	**27**				
V. Treatment Planning	**18**				
VI. Progress Notes	**6**				
VII. Medication Management	**5**				
VIII. Coordination of Care	**6**				
IX. Discharge and/or Transfer	**11**				
	Total (103) Points Possible	**Yes Pts. Given**	**No's**	**N/A's**	

Medical Record Scores

Scoring is based on up to 10 medical records.

1) Add points given in each section.
2) Add points given for all sections.
3) Subtract "N/A" points (if any) from total points possible to get "adjusted" total points possible.
4) Divide the total points given by "adjusted" total points possible.
5) Multiply by 100 to determine compliance rate as a percentage.

_____ ÷ _____ = _____ **x 100** = _____%
Points Given / Total/ Adjusted Pts. Poss. / Decimal Score / Compliance Rate

Compliance Rate

Note: Deficiency in any of the critical elements requires a CAP for the entire BH Hospital Survey, regardless of the Total Survey Score.

___**Exempted Pass:** ≥ 90% without deficiencies in critical elements

___**Conditional Pass:** 80-89% or ≥ 90% with deficiencies in critical elements

___**Not Pass:** 79 % and Below
****

____ CAP Required

____ Other follow-up

Next Review Due: _____

Additional Comments/Notes:

I. Policies and Procedures Criteria

RN/MD/DO Review only:

Criteria met: Give one (1) point **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	**Score**	**Findings/Comments**
A. Staff competence is assessed initially and again, with documentation, once every three years.	**1**		
B. The hospital follows a written policy addressing the control of medication between receipt by an individual health care provider and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage.	**1**		
C. The hospital follows a written policy for as needed (PRN) orders: orders acted on based on the occurrence of a specific indication or symptom.	**1**		
D. The hospital follows a written policy for standing orders: A prewritten medication order and specific instructions from the licensed independent practitioner to administer a medication to a person in clearly defined circumstances.	**1**		
E. The hospital follows a written policy for titrating orders: orders in which the dose is either progressively increased or decreased in response to the patient's status.	**1**		
F. The hospital follows a written policy for taper orders: orders in which the dose is decreased by a particular amount with each dosing interval.	**1**		
G. The hospital follows a written policy for orders for medications at discharge or transfer.	**1**		
H. The hospital follows a written policy that defines actions to take when medication orders are incomplete, illegible, or unclear.	**1**		
I. The hospital follows a written policy that defines actions to take and report for a sentinel event.	**1**		
Total Points: 9	**Yes**		
Comments:	**No**		

II. Format Criteria

RN/MD/DO Review only

Criteria met: Give one (1) point **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Each Member has a separate record.	**1**											
B. Each record includes the Members address, employer or school, home and work telephone numbers.	**1**											
C. Emergency "contact" is identified.	**1**											
D. Guardianship information, as appropriate.	**1**											
E. Medical records are maintained and organized.	**1**											
F. Member's attending physician and/or rendering physician (PCP) is identified.	**1**											
G. Primary language and interpreter service needs of non-or limited-English proficient (LEP) or hearing/speech-impaired persons are prominently noted.	**1**											
H. Person or entity providing medical interpretation is identified, as necessary.	**1**											
I. Signed Copy of the Notice of Privacy.	**1**											
Total Points: 9	**Yes**											
Comments:	**No**											
	NA											

III. Documentation Criteria

RN/MD/DO Review only

Criteria met: Give one (1) point **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Allergies are prominently noted.	**1**											
B. Chronic problems and/or significant conditions are listed.	**1**											
C. Current *continuous* medications are listed.	**1**											
D. Evidence of a Consent for Treatment or Informed Consent in the record that is signed by the Member and/or legal guardian. For minors, the Consent for Treatment must be- signed by the Member's parent/caregiver/court officer (CFS worker or probation officer))	**1**											
E. The patient is given information to create psychiatric advance directives.	**1**											
F. The patient is provided with referrals to peer support services.	**1**											
G. All entries in the record include the responsible service provider's name, professional degree and/or relevant identification number, if applicable, and are signed and dated (including electronic signature for EMR systems) where appropriate.	**1**											
H. The service provider provides education to Member/family about service planning, discharge planning, supportive community services, behavioral health problems, and care options.	**1**											
I. Evidence that the risks of noncompliance with treatment recommendations are discussed with the Member and/or family or legal guardian. For minors, discussions may also be made with the Member's parent/caregiver/ court officer (CFS worker or probation officer if appropriate)	**1**											
J. There is information that documents the course and result(s) of patient's care, treatment, and services.	**1**											
K. The record is clearly legible.	**1**											
L. Errors are corrected according to legal medical documentation standards.	**1**											
Total Points: 12	**Yes**											
Comments:	**No**											
	N/A											

IV. Initial Assessment Criteria

RN/MD/DO Review only:

Criteria met: Give one (1) point or two (2) points (if a critical element) **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. A complete clinical case formulation is documented in the record (e.g. primary diagnosis, medical conditions, psychosocial and environmental factors and functional impairments).	**1**											
B. Psychiatric evaluation is complete within 24 hours of admission.	**1**											
C. A medical history and/or physical exam (appropriate to level of care) is in the record.	**1**											
D. Was a current medical condition identified?	**1**											
1. If a medical condition was identified, is there documentation that communication/collaboration with the treating medical clinician occurred?	**1**											
2. If a medical condition was identified, is there documentation that the patient/legal guardian refused consent for the release of information to the treating medical clinician? For minors, release of information may also be refused by the parent/caregiver/court (CFS worker or Probation Officer).	**1**											
3. The medical treatment history includes the following information: known medical conditions, dates and providers of previous treatment, current treating clinicians, and current therapeutic interventions and responses.	**1**											
E. A complete mental status exam is in the record, documenting the patient's affect, speech, mood, thought content, judgement, insight, attention or concentration, memory, and impulse control. Also documented is the frequency in which the mental status exam is completed.	**1**											

Criteria met: Give one (1) point or two (2) points (if a critical element) **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
F. There is documentation of patients' overall level of risk for suicidal/homicidal tendencies and the plan to mitigate the risk for suicide/homicide.	**1**											
G. The behavioral health treatment history includes the following information: dates and providers of previous treatment, and therapeutic interventions and responses.	**1**											
H. The record includes documentation of previous behavioral health hospitalization(s) are assessed and/or documented.	**1**											
I. **The record includes documentation of previous suicidal or homicidal/violent behaviors and risk, including dates, method, and lethality.**	**2**											
J. **The behavioral health history includes an assessment of any abuse or psychological trauma the member has experienced or if the member has been the perpetrator of abuse.**	**2**											
K. **If abuse was reported, there is documentation that a report was completed to the appropriate authorities.**	**2**											
L. **The assessment documents the patient's substance use history.**	**2**											
M. The assessment documents the spiritual and cultural variables that may impact treatment.	**1**											
N. **The assessment of the patient's strengths**	**2**											
O. **The record documents screening for metabolic disorders**	**2**											
P. The record documents the presence or absence of relevant legal issues of the patient and/or family.	**1**											
Q. There is documentation that the patient was asked about community resources (support groups, social services, school-based services, other social supports) that they are currently utilizing.	**1**											

Criteria met: Give one (1) point or two (2) points (if a critical element) **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
R. The hospital obtains information on the medications the patient is currently taking when he or she is admitted to the hospital. This information is documented in list format that is useful to those who manage medications.	**1**											
Total Points: 27	**Yes**											
	No											
	N/A											

Comments:

V. Treatment Planning Criteria

RN/MD/DO Review only:

Criteria met: Give one (1) point or two (2) points (if a Critical Element) **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. There is documentation (a signed form) that the patient or legal guardian (based on each state's age of consent) has agreed to the treatment plan. For minors, the parent/caregiver/court officer (CFS worker or Probation Officer) may agree to the treatment plan.	**1**											
B. The hospital involves the patient in making decisions about his or her care, treatment, and services.	**1**											
C. When appropriate, the treatment record indicates the family's involvement in the treatment process, including care decisions.	**1**											
D. Services provided are under an individualized treatment or diagnostic plan.	**1**											
E. Services provided are reasonably expected to improve the patient's condition or are for the purpose of diagnosis.	**1**											
F. The treatment plan is consistent with diagnosis and has objective and measurable short- and long-term goals.	**1**											
G. There is adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.	**1**											
H. Based on the goals established in the patient's plan of care, staff evaluate the patient's needs. The frequency of evaluation is also documented.	**1**											
I. The treatment plan includes a safety plan when active risk issues are identified.	**1**											
J. The treatment plan and goals for care are revised based on the patient's needs.	**1**											

Criteria met: Give one (1) point or two (2) points (if a Critical Element) **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
K. The plan of care includes the responsibilities of each member of the treatment team.	**1**											
L. There is clear documentation of medication dispensing, as appropriate and necessary. (NOTE: For DETOX Services, evidence of consistent documentation of vital signs throughout treatment in the record)	**1**											
M. There is evidence of documentation of vital signs throughout treatment or inpatient stay.	**1**											
N. **Tobacco use treatment was provided or offered**	**2**											
O. **There is clear documentation of physical restraint and/or seclusion and hours (if used)**	**2**											
P. The hospital begins the discharge planning process early in the patient's episode of care, treatment, and services.	**1**											
Total Points: 18	**Yes**											
Comments:	**No**											
	N/A											

VI. Progress Notes Criteria

RN/MD/DO Review only:

Criteria met: Give one (1) point **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. The progress notes reflect reassessments when necessary.	**1**											
B. The progress notes document on-going risk assessments (including but not limited to suicide and homicide) and monitoring of any at risk situations.	**1**											
C. The progress notes indicate treatment given to the patient and indicate their reaction to it.	**1**											
D. The progress notes written by Physicians, document medical necessity and confirm that level of care is appropriate for Member.	**1**											
E. The progress notes document the dates of follow up appointments with their specialists, medical and/or behavioral health provider(s), as appropriate.	**1**											
F. The progress notes document any referrals made to other clinicians, agencies, and/or therapeutic services when indicated.	**1**											
Total Points: 6	**Yes**											
	No											
	N/A											

Comments:

VII. Medication Management Criteria

RN/MD/DO Review only:

Criteria met: Give one (1) point **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. If the patient is on medication, there is evidence of medication monitoring in the treatment record. (physicians and nurses)	**1**											
B. When lab work is ordered, there is evidence the lab results were received and reviewed by the clinician.	**1**											
C. When the patient is on medications, the prescribing clinician documents that the patient was provided with education about the risks, benefits, side effects, and alternatives of each medication.	**1**											
D. When a primary care physician is identified, there is evidence the prescriber coordinated care within 14 calendar days after initiation of a new medication upon discharge.	**1**											
E. The progress notes document any referrals made to other clinicians, agencies, and/or therapeutic services when indicated.	**1**											
Total Points: 5	**Yes**											
Comments:	**No**											
	N/A											

VIII. Coordination of Care Criteria

RN/MD/DO Review only:

Criteria met: Give one (1) point **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. The record documents that the patient was asked whether they are being seen by a medical physician (PCP)?	**1**											
1. If yes, was the medical physician (PCP) documented?	**1**											
2. If the patient is being seen by a medical physician (PCP), there is documentation that communication/collaboration occurred.	**1**											
B. The record documents that the patient was asked whether they are being seen by multiple behavioral health clinician(s)? (e.g. psychiatrist and social worker, psychologist and substance/OTP/MAT counselors)	**1**											
1. If yes, were the behavioral health clinician(s) documented?	**1**											
2. If the patient is being seen by other behavioral health clinician(s), there is documentation that communication/collaboration occurred.	**1**											
Total Points: 6	**Yes**											
	No											
	N/A											

Comments:

IX. Discharge and/or Transfer Criteria

RN/MD/DO Review only:

Criteria met: Give one (1) point or two (2) points (if a Critical Element) **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Was the patient transferred/discharged to another program or hospital?	**1**											
B. Provide the patient with written information on the medications the patient should be taking when he or she is discharged from the hospital.	**1**											
C. If the patient was transferred/discharged to another program or hospital, there is documentation that communication/collaboration occurred with the receiving clinician/program.	**1**											
D. **If the patient discharged home, there is documentation that communication/collaboration occurred with aftercare providers.**	**2**											
E. **Patients discharged on multiple antipsychotic medications have appropriate justification documented.**	**2**											
F. Prior to discharge, the hospital arranges or assists in arranging the services required by the patient after discharge in order to meet his or her ongoing needs for care and services.	**1**											
G. **Tobacco use treatment provided or offered at discharge**	**2**											
H. Clinical records are completed within 30 days following discharge.	**1**											
Total Points: 11	**Yes**											
Comments:	**No**											

Criteria met: Give one (1) point or two (2) points (if a Critical Element) **Criteria not met: 0 points** **Criteria not applicable: N/A** **(NOTE: Any score of "0" or "N/A" must document a reason/rationale.)**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
	N/A											

PCP/Clinic Name:
Address:

QM Nurse:

CAP Notification

Date of Review:

PCP ID# _____

Health Plan Performing Evaluation	**IEHP**	**Molina**	**HealthNet**	**LA Care**	**Kaiser**	

Facility Name:	PCP Name(s):	# of PCPs Reviewed: # of Charts Reviewed:
Address:	Contact Person and Title:	
Telephone: / Fax:	☐ Exempted Pass for the Site Review Survey – No CAP Due ☐ Exempted Pass for the Medical Record Review Survey – No CAP Due	

Site Review Score:	**Date Critical Element CAP Due:** Date Site Review CAP Due:	**CAP Follow-up:** ☐ Mail/Fax ☐ Schedule Follow-up visit ☐ Critical Element ☐ Site Review ☐ Medical Records ☐ Follow-up visit scheduled date/time : _____	**CAP Closed Date:**
Medical Record Score:	Date Medical Record CAP Due:		

Reviewer's Name/Title (Print):	**Reviewer's signature/Title:**

Corrective Action Plan (CAP) Completion and Submission Requirements

The Health Plans have collaborated in establishing a process to facilitate compliance while limiting the intrusion into your facility. Participating Health Plans agree to accept evaluation findings of the other Health Plans upon the physician's signature of Disclosure and Release. The collaborative process does not supersede any contractual requirements, and participation is voluntary.

Disclosure and Release

I have received and reviewed copies of the above listed site's evaluations and corrective action plans for the facility and medical record reviews. I agree to correct each identified deficiency by implementing any corrective action that may be required. **I understand that failure to correct any of the noted Critical Element deficiencies within the required 10 business days and any other noted deficiencies within the 30-day time period from the review date,** may result in the exclusion of this facility and the associated provider(s) from the roster. **The completed CAP must include evidence of correction** {e.g. invoices, education sign sheets, forms used} **and dates completed.**

For assistance in completing the CAP, please call_____, QM RN, DHCS-CSR at 909- _____.

I hereby authorize the above mentioned health plans and any government agencies that have authority over the health plans, and authorized county entities in the State of California, to furnish to each other these reviews and corrective action plans of this facility.

Physician/Designee Signature	**Printed Name and Title**	**Date**

Please Return Completed CAP via U.S. Mail or FAX to: **Attention: QM Coordinator** **FAX 909-890-5746**	**Inland Empire Health Plan** **P.O. Box 1800,** **Rancho Cucamonga, CA 91729-1800**	**PCPs wishing to appeal the results of a Facility Site Review and Medical Record Review Survey must do so in writing, to Chief Medical Officer or Designee, within 14 working days of the date of the notification letter.**	**P.O. Box listed to the left. CMO Fax phone number: (909) 890-2019**

PCP/Clinic Name: QM Nurse:
Address:

INSTRUCTIONS FOR USE

1st Column: (Health Plan Use Only) Health Plan verification and date – The Health Plans Certified Site Reviewer (CSR) will initial and date the deficiency that the site has addressed/corrected. The Provider's Corrective Action Plan will be verified by the CSR through a desk review by the Health Plan and/or a follow-up on site visit.

2nd Column: (Health Plan Use Only) Criteria – The Health Plan's CSR will check the criteria(s) that were found deficient during the site review and/or medical record review processes. The criteria(s) checked should be addressed/corrected by the provider's office. A corrective action plan (CAP) for all critical element deficiencies, which are bolded and underlined, should be submitted to the Health Plan within 10 business days. A corrective action plan for other criteria found deficient is due to the Health Plan within 45 days from the date of audit.

3rd Column: (Health Plan Use Only) Deficiency Cited/Reviewer Comments – This column is for the purpose of notifying the provider and/or designated staff of the deficiency found and/or the CSR findings/comments.

4th Column: (Health Plan and Provider's Office Use) Recommended Corrective Action – The Health Plan's CSR will check and/or write comments for the Provider's office in order to notify the Provider and/or designated staff the documents and/or evidence needed in order to fulfill a deficiency.

5th Column: (Provider's Office Use Only) Correction Date – The provider's office will document the date that a deficiency has been addressed and/or corrected.

6th Column: (Provider's Office Use Only) Practitioners Comments – The provider's office will document corrective actions taken to address/correct a deficiency, as well as provide appropriate documents to support corrective actions taken. If provider's office agrees with items checked in the 4th Column (Recommended Corrective Action) then the provider's office would write "agree with recommended corrective action," as well as submit supporting documents.

7th Column: (Provider's Office Use Only) Signature and Title of Responsible Physician or Designee – The office staff who is responsible for maintaining compliance with a deficiency found during a site audit would put their name, title, and initial in this column.

NOTE: The Health Plan's Certified Site Reviewer (CSR) may conduct a follow-up on site review to verify corrective action within 45 days from the date of audit and/or request the corrective action plan (CAP) to be submitted to the Health Plan via mail and/or fax.

CAP COMPLETION SIGNATURE PAGE

I have completed the corrective action plans for the facility and medical record reviews performed on _____. I affirm each
(Enter Date of Review)

Corrective action has been implemented as indicated on the attached Corrective Action Plan. I hereby authorize the reviewing health plan to furnish to all collaborative health plans, any government agencies that have authority over the health plans, and authorized county entities in the State of California, the corrective action plans and related review tools for this facility.

_____	_____	_____
Physician/Designee Signature	**Printed Name and Title**	**Date**

Please Return Completed Corrective Action Plan and this signature sheet. via U.S. Mail or FAX to:

Inland Empire Health Plan
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800
Attention: QM Coordinator
FAX 909-890-5746

PCP/Clinic Name: QM Nurse:
Address:

Site Review Survey Critical Element CAP DATE DUE:
Signature Responsible Person:

NOTE: ALL CRITICAL ELEMENT CORRECTIVE ACTIONS MUST BE COMPLETED AND SUBMITTED TO THE AUDITING HEALTH PLAN WITHIN 10 BUSINESS DAYS OF THE SITE VISIT. THERE ARE NO EXCEPTIONS. Criteria that are **bolded** and underlined are considered critical elements.

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
I Access/Safety **Site Access/Safety Survey Criteria**						
C. Site is accessible and useable by individuals with physical disabilities ***3CCR 504; 24 CCR (CA Building Standards Code); 28 CFR 35 (American Disabilities Act of 1990, Title II, Title III)***						
	I AS C 4 ☐	**Exit doors and aisles are obstructed and egress (escape) is not accessible.**	☐ Exit doors and aisles have been cleared and egress (escape) is not impeded. ☐ A signed written explanation of corrective actions taken for exit doors and aisles to be unobstructed and egress accessible. ☐ Other:			
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week **22 CCR § 51056, §53216; 28 CCR §1300.67; 42 USC §139.5 (d) RN or MD Review Only**						
	I AS D 4 ☐	**Airway management: oxygen delivery system, bulb syringe nasal cannula or mask, Ambu bag are not available on site.**	☐ A copy of the receipt/invoice for the following: (Circle those that apply) portable oxygen tank, bulb syringe, nasal cannula or mask, ambu bag (adult/child) ☐ A copy of the receipt/work invoice for re-charging oxygen tank to at least ¾ full. ☐ A copy of the office policy and procedure regarding oxygen tank replacement or back up method is attached. ☐Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	I AS D 5 ☐	**Emergency medicine such as asthma, chest pain, hypoglycemia and anaphylactic reaction management: Epinephrine 1:1000 (injectable), and Benadryl 25 mg. (oral) or Benadryl 50 mg./ml. (injectable), Naloxone, chewable Aspirin 81 mg, Nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), and glucose. Appropriate sizes of ESIP needles/syringes and alcohol wipes.**	☐ A copy of the receipt/invoice for the following: (Circle those that apply) Naloxone, chewable Aspirin, Nitroglycerine spray/tablet, nebulizer, or metered dose inhaler and glucose. ☐ A copy of the office policy and procedure regarding emergency medications is attached. ☐ Other:			

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE

PCP/Clinic Name: QM Nurse:
Address:

II Personnel **Site Personnel Survey Criteria**						
C. Site personnel are qualified and trained for assigned responsibilities. ***CA Business & Professional (B&P) Code 2069. 16 CCR 1366, 22 CCR 75034, 75035***						
	IIP C 2 ☐	**No evidence that a qualified/trained personnel retrieve, prepare or administer medications**	☐ A copy of the office policy and procedure regarding qualified/trained personnel retrieve, prepare or administer medications is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
III Office Management **Office management survey Criteria**						
E. Procedures for timely referral/consultative services are established on site. **22CCR §53851: 28CCR § 1300.67 RN or MD Review Only**						
	III O M E 2 ☐	**Physician review and follow-up of referral/consultation reports and diagnostic test results is not evident.**	☐ A copy of the office policy and procedure regarding referrals to include the physician review and follow-up of referral/consultation reports and diagnostic test results is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the actual referral log utilized by the office is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
IV Clinical Services **Pharmaceutical Services Survey Criteria**						
C. Drugs are dispensed according to State and federal drug distribution laws and regulations. ***CA B&P Code 4024, 4076, 4170, 4171, 4173, 4174; 22 CCR 75032, 75033, 75036, 75037(a-g), 75038; 75039; 16 CCR 1718.1; 21 CFR 211.137, 42 USC 6A 300AA-26***						
	IV CS C 4 ☐	**Drugs are being dispensed to patients by other than lawfully authorized persons**	☐ A copy of the office policy and procedure regarding dispensing of medications is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A signed written explanation of the corrective action taken in regards to dispensing of medications. ☐ Other:			
	IV CS C5	**Personnel are unable to demonstrate or verbally explain procedures that vaccines are prepared and drawn only prior to administration.**	☐ A copy of the office policy and procedure regarding preparing and drawing up of medications is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A signed written explanation of the corrective action taken in regards to prepping of medications. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

VI Infection Control
Infection Control Survey Criteria

B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act.
8CCR 5193 (Cal OSHA Health Care Worker Needlestick Prevention Act, 1999); H&S Code, 117600-118360 (CA Medical Waste Management Act, 1997); 29 CFR 1910.1030.

	VI IC B 1 ☐	**Personal protective equipment is not readily available for staff use.**	☐ A copy of the receipt/invoice for the following is attached: (Circle those that apply) clothing barrier/gown, water repelling gloves, goggles/face shield, mask. ☐ A copy of the office policy and procedure regarding personal protective equipment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	VI IC B 2 ☐	**Blood, other potentially infectious material and regulated wastes are not placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport or shipping.**	☐ A copy of the receipt/invoice for the purchase of an appropriate biohazardous container is attached. ☐ A copy of the office policy and procedure regarding Biohazardous waste handling is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A signed written explanation of the corrective action taken in regards to regulated wastes. ☐ Other:			
	VI IC B 3 ☐	**Needle stick safety precautions are not practiced on site.**	☐ A copy of the receipt/invoice for the purchase of Engineered Sharps Injury Protection (ESIP) is attached. ☐ A copy of the office policy and procedure regarding needle stick safety precautions is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

D. Re-usable medical instruments are properly sterilized after each use. ***22CCR 53230, 53856; CA H&S Code, Chapter 6.1, 25090***						
	VI IC D 3a ☐	**Staff unable to demonstrate/verbalize necessary steps to ensure sterility and/or high-level disinfection to ensure sterility of equipment.**	☐ A copy of the office policy and procedure addressing steps to ensure sterility or disinfection. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	VI IC D 3c ☐	**Staff unable to demonstrate/verbalize an exposure control plan, Material Safety Data Sheets and procedure for cleaning up cold chemical sterilant spills.** **Site does not maintain appropriate PPE.**	☐ An invoice or receipt for appropriate PPE **plus:** ☐ A copy of the office policy and procedure addressing PPE requirements, exposure plan and clean up instructions. ☐ A copy of the Material Safety Data Sheets (MSDS) ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	VI IC D 4c ☐	**Spore testing of autoclave/steam sterilizer with documented results is not done at least monthly.**	☐ A copy of actual spore test results for the past _____ month(s) is attached. ☐ A copy of the office policy and procedure addressing positive spore test results is attached. ☐ A copy of the office policy and procedure and/or manufacturer's instructions regarding autoclave/steam sterilization is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	VI IC D 4d ☐	**Staff is unable to demonstrate/verbalize site protocols and/or manufacturer/product label for management of a positive spore test.**	☐ A copy of the office policy and procedure addressing positive spore test results is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Site Review Survey

1.

I. Access/Safety

Site Access/Safety Survey Criteria

A. Site is accessible and useable by individuals with physical disabilities
24 CCR (CA Building Standards Code); 28 CFR § 35 (American Disabilities Act of 1990, Title II, Title III)

ADA Regulations: Site must meet city, county and state building structure and access ordinances for persons with physical disabilities. A site/facility includes the building structure, walkways, parking lots, and equipment. All facilities designed, constructed; or altered by, on behalf of, or for the use of public entity must be readily accessible and usable by individuals with disabilities, if the construction or alteration was begun after January 26, 1992 (28 CFR 35. 151). Any alteration to a place of public accommodation or a commercials facility, after January 26, 1992, must be made to ensure that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs (28 CFR 36.402).

Sites must have the following safety accommodations for physically disabled persons:
Check only elements that have deficiencies in the criteria column

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	I AS A 1 ☐	There is not a clearly marked (blue) curb or sign designating disabled-parking space near an accessible primary entrance.	☐ A picture of parking space(s) for the disabled have been designated and are designated using reflectorized signs posted conspicuously. ☐ Signed written explanation of corrective action taken in regards to disabled parking space(s). ☐ Facility is located in residential area where designated parking is not permitted. ☐ A copy of the local ordinance is attached. ☐ A copy of the work invoice with completion date or receipts are attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	IASA 2 ☐	Pedestrian ramps do not have a level landing at the top and bottom of the ramp.	☐ A picture of a clear and level landing at the top and bottom of all ramps and on each side of the exit door has been provided**.** ☐ A copy of the work invoice with completion date or receipts are attached. ☐ Other:			
	IASA 3 ☐	Exit doorway openings do not allow for clear passage of a person in a wheelchair.	☐ All appropriate doorways have been remodeled to accommodate patients in wheelchairs. ☐ A 32 inch clearance for exit doorway-openings had been established. ☐ A copy of the completed and dated work invoice or receipts is attached. ☐ A copy of the building wavier is attached. ☐ Other:			
	IASA 4 ☐	There is not an accessible passenger elevator or reasonable alternative for multi-level floor accommodation.	☐ Elevator service has been provided for the facility. ☐ A copy of the completed and dated work invoice or receipts is attached. ☐ A freight elevator has been upgraded for general passenger use. ☐ A building waiver is in effect and is attached. ☐ Other:			
	IASA 5 ☐	Floor space for wheelchair in waiting area and exam room is not clear.	☐Waiting room and exam/treatment room have been rearranged to provide for a stationary adult wheelchair with appropriate room for turning. ☐An appropriate procedure is in place to accommodate a wheelchair. A copy of the procedure is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	I AS A 6 ☐	Restroom facilities are not wheelchair accessible and/or there was no reasonable alternative.	☐ Restroom facilities have been remodeled to accommodate wheelchair accessibility. ☐ A copy of the receipt and/or work invoice is attached. ☐ An alternative procedure is in place and the policy and procedure is attached. ☐ Other:			
	I AS A7 ☐	Hand washing facilities are not wheelchair accessible and/or there was no reasonable alternative.	☐ A sink has been modified to meet wheelchair access and safety requirements. ☐ A copy of the receipt and/or work invoice is attached. ☐ An alternative for hand washing facilities for wheelchair patients is in place and a copy of the policy and procedure is attached. ☐ Other:			
B. Site environment is maintained in a clean and sanitary condition *8 CCR §5193; 28 CCR §1300.80*						
	I AS B 1 ☐	All patient areas including floor/carpet, walls, and furniture are not neat, clean, and well maintained.	☐ The floors, carpets, walls, and furniture have been cleaned and/or repaired. ☐ A copy of the receipt and/or work invoice is attached. ☐ Other:			
	I AS B 2 ☐	Restrooms are not clean and/or do not contain appropriate sanitary supplies.	☐ Appropriate sanitary supplies have been obtained and placed in the restrooms. ☐ Circle which supply is needed: toilet tissue, hand washing soap, cloth/paper towels or antiseptic towelettes. ☐ A copy of the receipt and/or work invoice is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
C. Site environment is safe for all patients, personnel and visitors *8 CCR §3220; 22 CCR §53230; 24 CCR, §2, § 3, §9; 28 CCR §1300.80; 29 CFR §1910.301, §1926.34*						
Evidence that site staff has received training and/or information in the following:						
	I AS C 1 ☐	There is no evidence that site staff has received training and/or information in fire safety and prevention.	☐ Training has been provided to site personnel regarding fire prevention/safety. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office fire safety and prevention policy and procedure is attached. ☐ Other:			
	I AS C 2 ☐	There is no evidence that site staff has received training and/or information in emergency non-medical procedures (e.g. site evacuation, workplace violence, abusive patients)	☐ Training has been provided to site personnel regarding non-medical emergency procedures-site evacuation, workplace violence, and abusive patients. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office non-medical emergency policy and procedure is attached. ☐ Other:			
	I AS C 3 ☐	There is not adequate lighting in all areas to ensure safety.	☐ Lighting in working and walking areas has been installed. ☐ A copy of the receipt and/or work invoice is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	IASC 5 ☐	Exit doors are not clearly marked with "Exit" signs.	☐ "Exit" signs have been posted in the following areas: ☐ A copy of the receipt and/or work invoice is attached. ☐ Other:			
	IASC 6 ☐	There are no clearly diagramed "Evacuation Routes" for emergencies posted in a visible location.	☐ Clearly marked, easy-to-follow escape routes have been posted in visible areas. ☐ A copy of the office evacuation diagram posted is attached. ☐ Other:			
	IASC 7 ☐	Electrical cords and outlets are not in good working condition.	☐ Electrical cords have been replaced/repaired. ☐ Electrical outlets have been replaced/repaired. ☐ A copy of the receipt and/or work invoice is attached. ☐ Other:			
	IASC 8 ☐	There is not at least one type of fire-fighting/protection equipment that is accessible at all times.	☐ Smoke detector with intact, working batteries. ☐ Fire alarm device with code and reporting instructions posted conspicuously at phones and employee entrances. ☐ Automatic sprinkler system with sufficient clearance (10-in.) between sprinkler heads and stored materials. ☐ Fire extinguisher in an accessible location that displays readiness indicators or has an attached current dated inspection tag. A copy of the current dated inspection tag is attached. ☐ Other:			
	IASC9 ☐	There is no employee alarm system in place to warn employees of fire or other emergencies.	☐ Invoice or receipt for employee alarm system. ☐ Policy or procedure addressing employee notification of fire or other emergencies. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week ***22 CCR §51056, §53216; 28 CCR §1300.67*** **In order to be fully compliant with this section, please a written policy and procedure and documented evidence of staff training.**						
	I AS D 1 ☐	No evidence of personnel being trained in procedures/action plan to be carried out in case of a medical emergency on site.	☐ A copy of the office medical emergency policy and procedure is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	I AS D 2 ☐	Emergency equipment is not stored together in an easily accessible location.	☐ Emergency equipment is stored in an easily accessible location. ☐ Emergency equipment is appropriately sealed and is within the expiration dates posted on the label/seal. ☐ Other:			
	I AS D 3 ☐	There are no emergency phone number contacts posted.	☐ Emergency phone numbers are posted and are easily accessible to office staff. ☐ A copy of the emergency phone number list is attached. ☐ List should be dated, and updated annually. ☐ Other:			
Emergency medical equipment appropriate to practice/patient population is available on site:						
	I AS D 5 ☐	There is no evidence of anaphylactic reaction management supplies. Minimum supplies include Epinephrine 1:1000 (injectable), and Benadryl 25mg (oral) or Benadryl 50mg/ml (injectable), appropriate sizes of ESIP needles/ syringes and alcohol wipes.	☐ The following anaphylactic reaction management supply has been obtained: ☐ Epinephrine 1:1000 (injectable) ☐ Benadryl 25mg (oral) ☐ Benadryl 50mg/ml (injectable) ☐ Appropriate sizes of ESIP needles/syringes ☐ Alcohol wipes ☐ A copy of the receipt(s) is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	I AS D 6 ☐	Medication dosage chart (or other method for determining dosage) is not kept with emergency medications.	☐ A medication dosage chart has been included for each medication in the emergency kit. ☐ A copy of the following medication dosage chart is attached: ☐ Other:			
	I AS D 7 ☐	There is no documentation on checking of emergency equipment/supplies for expiration and operating status at least monthly.	☐ Emergency equipment/supplies are checked at least monthly for expiration and operating status. ☐ A copy of the office log is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	I AS D 8 ☐	No evidence that emergency equipment is replaced/re-stocked immediately after use.	☐ Emergency equipment is replaced/re-stocked immediately after use. ☐ A copy of the office policy and procedure is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

E. Medical and lab equipment used for patient care is properly maintained
CA Health & Safety Code § 111255; 28 CCR §1300.80, 21 CFR §800-1299
In order to be fully compliant with this section, please submit a written policy and procedure, a receipt for repairs and/or supplies, and documented evidence of staff training.

	I AS E 1 ☐	There is no evidence that medical equipment is clean.	☐ All specialized medical equipment is cleaned according to manufacturer's guidelines after use. ☐ A signed written explanation of corrective action taken in regards to cleaning of medical equipment. ☐ Other:			

Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	I AS E 2 ☐	There is no evidence of written documentation demonstrating the appropriate maintenance of all specialized medical equipment according to equipment manufacturer's guidelines.	☐ All medical equipment is serviced annually by a qualified technician or according to manufacturer's guidelines. ☐ A copy of the receipt and/or work invoice is attached. ☐ A copy of the calibration log for the following equipment: ☐ Glucometer ☐ Hemocue ☐ Other: ☐ Other:			

II. Personnel
Site Personnel Survey Criteria

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
A. Professional health care personnel have current California Licenses and Certifications. ***CA Business & Professional (B&P) Code §2050,* §2085, §2725, §2746, §2834, §3500, §4110; CCR, Title 16, §1355.4, §1399.547**						
	II P A 1 ☐	No evidence that all required Professional License(s) and Certification(s) issued from appropriate licensing/certification agencies are current.	☐ A copy of the following physician(s)/provider(s) license(s) or DEA certificate(s) is attached: ☐ Other:			
	II P A2 ☐	No evidence of Notification to Consumers for the licensed MD(s) and/or Physician Assistant(s).	☐ A copy of the Notification to Consumers for the licensed MD(s) and/or Physician Assistant(s) is attached: ☐ Other:			
B. Healthcare personnel are properly identified. ***CA B&P Code §680, AB 1439***						
	II P B 1 ☐	Healthcare personnel were not wearing identification badges/tags printed with name and title.	☐ A copy of identification badges/tags printed with name and title. ☐ Licenses and/or certificates are prominently displayed. ☐ A copy of the receipt/invoice is attached. ☐ Other:			
C. Site personnel are qualified and trained for assigned responsibilities. ***CA B&P Code §2069; 16 CCR §1366; 22 CCR §75034, §75035***						
	II P C 1 ☐	There is no documentation maintained on site showing education/training for non-licensed medical personnel.	☐ Diploma or certification from an accredited training program or a letter from current supervising physician certifying demonstrated proficiency of staff member to perform technical supportive services for the following staff is attached: ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	II P C 3 ☐	Site does not have a written policy or procedure documenting the process for confirming correct patient/medication/vaccine dosage prior to administration.	☐ A copy of the office policy and procedure is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II P C4 ☐	There was no evidence that qualified/trained personnel operate medical equipment.	☐ A copy of documentation of training for the following staff and medical equipment operated is attached:☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
D. Scope of practice for Non-Physician Medical Provider (NPMP) is clearly defined. ***16 CCR §1379, §1399.540, §1399.545, §1474, CA B&P Code §2725.1*** **In order to be fully compliant with this section, please submit a copy of the current Procedures, Agreements, or License**						
	II P D 1 ☐	There is no evidence of Standardized Procedures defining the scope of services provided for Nurse Practitioners (NP) and/or Certified Nurse Midwives (CNM).	☐ A copy of the currently signed and dated Standardized Procedures defining the scope of services provided for the Nurse Practitioner(s) (NP) and/or Certified Nurse Midwives (CNM) is attached: ☐ Other:			
	II P D 2 ☐	There is no evidence of a Practice Agreement defining the scope of services provided by Physician Assistants (PA) and Supervisory Guidelines defining the method of supervision by the Supervising Physician.	☐ A copy of the currently signed and dated Practice Agreement(s) is attached for the following physician assistant(s): ☐ A copy of the Practice Agreement(s) defining the method of supervision by the Supervising Physician is attached for the above PAs listed. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	II P D 3 ☐	There is no evidence that the Standardized Procedures, Practice Agreement and Supervisory Guidelines are revised updated and signed by the supervising physician and NPMP when changes in scope of services occur.	☐ Provide evidence of the Practice Agreements and Supervisory Guidelines for PAs as well as Standardized Procedures for NPs and CNMs are revised and signed by physician and mid-level practitioner when the scope of services changes. ☐ Other:			
	II P D 4 ☐	There is no evidence that the NPMP prescribing controlled substances has a valid DEA Registration Number.	☐ A current copy of the DEA Registration certificate for the following NPMP(s) is attached: ☐ Other:			
E. Non-physician medical providers (NPMP) are supervised according to established standards. ***B&P Code 3516(b); W&I Code 14132.966***						
	II P E 1 ☐	The ratio of the designated supervising physician on site and the number of NPMPs exceeds the established ratios in the following combination: a) 1:4 Nurse Practitioners b) 1:4 Certified Nurse Midwives c) 1: 4 Physicians Assistants	☐ A copy of the physicians on duty and the number of NPMP's supervised is attached along with the office policy and procedure on NPMP supervision. ☐ A signed written statement explaining the corrective action taken to establish proper ratios of the designated supervising physician(s) on site. ☐ Other:			
	II P E 2 ☐	There is no evidence the designated supervising or back-up physician is available in person or by electronic communication at all times when a NPMP is caring for patients.	☐ A copy of the policy and procedure for contacting the supervising or back up physician is attached. ☐ A signed written statement explaining the corrective action taken to communicate with the designated supervising or back-up physician. ☐ Other:			
	II P E3 ☐	Sites with Non-physician Medical Practitioners (NPMP) unable to provide evidence of physician supervision reviewing, countersigning, and dating a minimum sample of 5% of records.	☐ A copy of the policy and procedure for reviewing, countersigning, and dating a minimum of five percent sample of records of patients treated by NPMP. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
F. Site personnel receive safety training /information. ***8CCR §5193; CA H&S Code §117600; CA Penal Code §11164, §11168; 29CFR §1910.1030***						
	II P F 1 ☐	There is no evidence the site staff has received annual training and/or information regarding Infection Control / Universal Precautions.	☐ A copy of the office policy and procedure regarding Infection Control/Universal Precaution is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Annual staff training must be conducted regarding Infection Control/ Universal Precautions. ☐ Other:			
	II P F 2 ☐	There is no evidence the site staff has received annual training and /or information regarding Blood Borne Pathogens Exposure Prevention.	☐ A copy of the office policy and procedure regarding Blood Borne Pathogens Exposure Prevention is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Annual staff training must be conducted regarding office Blood Borne Pathogens Exposure Prevention Plan. ☐ Other:			
	II P F 3 ☐	There is no evidence the site staff has received annual training and/or information regarding Biohazardous Waste Handling.	☐ A copy of the office policy and procedure regarding Biohazardous Waste Handling is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Annual staff training must be conducted regarding Biohazardous Waste Handling. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
G. Site personnel receive training and/or information on member rights. ***22 CCR §51009, §51014.1, §51305.1, §53452, §53858; 28 CCR §1300.68***						

	II P G 1 ☐	There is no evidence that the staff has received training / information regarding Patient Confidentiality	☐ A copy of the office policy and procedure regarding Patient Confidentiality is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	II P G 2 ☐	There is no evidence that the staff has received training / information regarding Informed Consent, including Human Sterilization	☐ A copy of the office policy and procedure regarding Informed Consent, including Human Sterilization, is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	II P G 3 ☐	There is no evidence that the staff has received training / information regarding Prior Authorization Requests	☐ A copy of the office policy and procedure regarding Prior Authorization Requests is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II P G 4 ☐	There is no evidence that the staff has received training / information regarding Grievance/ Complaint Procedures	☐ A copy of the office policy and procedure regarding Grievances and/or Complaints is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II P G 5 ☐	There is no evidence the staff have specific knowledge of local reporting requirements, agencies, and procedures for Child/Elder/Domestic Violence Abuse reporting.	☐ A copy of the office policy and procedure regarding Child/Elder/Domestic Violence Abuse reporting is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	II P G 6 ☐	There is no evidence that the staff has received training / information regarding Sensitive Services/Minors' Rights	☐ A copy of the office policy and procedure regarding Sensitive Services/Minors' Rights is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II P G 7 ☐	There is no evidence that the staff has received training/information regarding Health Plan referral process/procedures/resources	☐ A copy of the office policy and procedure regarding Health Plan referrals is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form.log utilized is attached. ☐ Other:			
	II P G 8 ☐	There is no evidence that the staff has received training/information regarding Cultural and Linguistic Appropriate Services (CLAS).	☐ A copy of the office policy and procedure regarding Cultural and Linguistic appropriate services is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form.log utilized is attached. ☐ Other:			
	II P G 9 ☐	There is no evidence that the staff has received training/information regarding Disability Rights and Provider Obligations	☐ A copy of the office policy and procedure regarding disability Rights and Provider Obligations ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form.log utilized is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

III. Office Management
Office Management Survey Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
A. Physician coverage is available 24 hours a day, 7 days a week 22 CCR §56500, §53855 **The following are maintained current on site:**						
	III O M A 1 ☐	Clinic Office Hours are not posted or readily available upon request.	☐ The clinic office hours are now posted. ☐ The clinic office hours are readily available at the reception desk. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	III O M A 2 ☐	Provider office hour schedules are not available to staff.	☐ Provider office hours are available to staff. ☐ A copy of the provider office hours is attached. ☐ Other:			
	III O M A 3 ☐	Arrangement/schedule for after-hours, on-call, supervisory back-up physician coverage is not available to site staff.	☐ Arrangement/schedule for after-hours, on-call, supervisory back-up physician coverage is available to site staff. ☐ A copy of the arrangement/schedule for after-hours coverage is attached. ☐ Other:			
	III O M A 4 ☐	Contact information for off-site physician(s) is not available at all times during office hours	☐ Contact information for off-site physician(s) is available to staff. ☐ A copy of the contact information is attached. ☐ Other:			
	III O M A 5 ☐	Routine, urgent, and after-hours emergency care instructions/telephone information is not made available to patients..	☐ Routine, urgent, and after-hours emergency information is supplied to patients by the voice mail system and/or answering service. ☐ A copy of the policy and procedure and the script for provision of the information is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
B. **There are sufficient health care personnel to provide timely, appropriate health care services.** 22 CCR §53855; 28 CCR §1300.67.1, §1300.80						
	III OM B 1 ☐	Appropriate personnel do not handle emergent, urgent, and medical advice telephone calls.	☐ A copy of the office policy and procedure regarding Handling emergent, urgent, and medical advice telephone calls is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	III OM B 2 ☐	Telephone answering machine, voice mail system or answering service is not used whenever office staff does not directly answer phone calls.	☐ A telephone answering machine, voice mail system, and/or answering service has been put in place and a copy of the contract and/or invoice is attached. ☐ A signed written statement explaining the corrective action taken. ☐ Other:			
	III OM B 3 ☐	Telephone system, answering service, recorded telephone information, and recording device are not periodically checked and updated.	☐ A policy and procedure regarding periodically checking and updating the telephone system, answering service or recorded telephone information and related equipment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
C. **Health care services are readily available.** 22 CCR §56000 (2) **RN or MD review only.**						
	III O M C 1 ☐	Appointments are not scheduled according to patients stated clinical needs within the timeliness standards established for Plan members.	☐ A copy of the office policy and procedure regarding appointment scheduling is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	III O M C 2 ☐	Patients are not notified or reminded of scheduled routine and/or preventive screening appointments	☐ A copy of the office policy and procedure regarding notification of routine and/or preventive screening appointments is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	III O M C 3 ☐	There is no process in place to verify follow up on missed and canceled appointments	☐ A copy of the office policy and procedure and/or process regarding missed and/or cancelled appointments is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
D. **There is 24-hour access to interpreter services for limited-English proficient members.** 22 CCR §53851; 28 CCR 1300.67.04						
	III O M D 1 ☐	Interpreter services are not made available in identified threshold languages specified for location of the site.	☐ A copy of the office policy and procedure regarding interpretive services is attached. ☐ A signed written statement explaining the corrective action taken to provide interpretive services is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	III O M D 2 ☐	There is no evidence that persons providing language interpreter services on site are trained in medical interpretation.	☐ Documentation of training/assessment for the following personnel used for medical interpretation on site is attached: ☐ Other:			
E. **Procedures for timely referral/consultative services are established on site.** 22 CCR §53851; 28 CCR §1300.67 and §1300.80 **RN or MD Review Only** **Office practice procedures allow timely provision and tracking of:**						
	III O M E 1 ☐	There is no established system evident for processing internal and external referrals, consultant reports and diagnostic test results	☐ A copy of the office policy and procedure regarding processing internal and/or external referrals is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the referral log is attached. ☐ Other:			
F. **Member Grievance/Complaint processes are established on site** 22 CCR §53858, §56260						
	III O M F 1 ☐	Phone number(s) for filing grievances/complaints are not located on site	☐ The phone number(s) for filing grievances/complaints are located on site. ☐ A copy of the phone number(s) for filing grievances/complaints is attached. ☐ Other:			
	III O M F 2 ☐	Complaint forms and a copy of the grievance procedure(s) are not available on site.	☐ A copy of the office policy and procedure regarding grievances/complaints is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the complaint/grievance form utilized by the office is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
G. **Medical records are available for the practitioner at each scheduled patient encounter.** 22 CCR §75055; 28 CCR §1300.80						
	III O M G 1 ☐	Medical records are not readily retrievable for scheduled patient encounters.	☐ A copy of the office policy and procedure regarding medical record availability is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	III O M G2 ☐	Medical documents are not filed in a timely manner to ensure availability for patient encounters.	☐ A copy of the office policy and procedure regarding medical record accessibility and storage is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
H. Confidentiality of personal medical information is protected according to State and Federal guidelines. 22 CCR §51009, §53861, §75055; **§**28 CCR §1300.80; CA Civil Code §56.10 (Confidentiality of Medical Information Act) **RN or MD Review Only**						
	III O M H 1 ☐	Exam rooms and dressing areas do not safeguard patients' right to privacy.	☐ A signed written statement explaining the corrective action taken to provide patients' right to privacy is attached. ☐Other:			
	III O M H 2 ☐	Procedures are not followed to maintain the confidentiality of personal patient information.	☐ A copy of the office policy and procedure regarding confidentiality of medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Medical Record storage should be secured and/or inaccessible to unauthorized persons. ☐ A copy of the receipt and/or work order is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	III O M H 3 ☐	Medical record release procedures are not compliant with State and Federal guidelines.	☐ A copy of the office policy and procedure regarding medical record release is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the medical record release form utilized by the office is attached. ☐ Other:			
	III O M H 4 ☐	Storage and transmittal of medical records does not preserve confidentiality and security.	☐ A copy of the office policy and procedure regarding medical record storage and transmittal is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the receipt/invoice and/or contract with a medical record storage company is attached. ☐ Other:			
	III O M H 5 ☐	Medical records are not retained according to current State and DHS Standards.	☐ A copy of the office policy and procedure regarding retaining medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

IV. Clinical Services
Pharmaceutical Services Survey Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
A. Drugs and medication supplies are maintained secure to prevent unauthorized access. ***CA B&P Code* §4172; *22 CCR* §75037(a-g), §75039; *21 CFR* §1301.75, §1301.76, §1302.22; *16 CCR* §1356.3**						
	IV CS A 1 ☐	Drugs are not stored in specifically designated cupboards, cabinets, closets or drawers.	☐ Drugs have been placed in a designated space. ☐ The drug storage space is lockable and is not accessible by unauthorized person(s). ☐ A copy of the receipt is attached. ☐ The drug area is kept locked when authorized personnel are not in the immediate area. ☐ Other:			
	IV CS A 2 ☐	Prescription, sample and over-the-counter drugs, hypodermic needles/syringes, prescription pads are not securely stored in a lockable space (cabinet or room) within the office/clinic.	☐ Prescription, sample and over-the-counter drugs, hypodermic needles/syringes, prescription pads are stored in a lockable space. ☐The space is lockable and is not accessible by unauthorized person(s) for the following items: ☐ A copy of the receipt and/or work invoice is attached. ☐ Other:			
	IV CS A 3 ☐	Controlled drugs are not stored in a locked space accessible only to authorized personnel.	☐ Controlled drugs have been stored in a locked space accessible only to authorized personnel. ☐Controlled drug keys are with the authorized personnel only. (Physician must specify authorized personnel) ☐ A copy of the receipt and/or work invoice is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	IV CS A 4 ☐	A dose-by-dose controlled substance distribution log is not maintained.	☐ A copy of the controlled substance distribution log is attached and includes the following information: the Providers DEA Number, Name of medication, original quantity of drug, dose, date, name of patient receiving drug, name of authorized person dispensing drug, and number of remaining doses. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	IV CS A5 ☐	Sites does not have a written site-specific policy or procedure for the safe and effective distribution, control, storage, and use and disposition of drugs including samples.	☐ A copy of the office policy and procedure regarding the dispensing of sample drugs is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
B. Drugs are handled safely and stored appropriately. ***22 CCR §75037(a-g), §75039; 21 CFR §211.137; 21 USC §351***						
	IV CS B 1 ☐	Drugs are not prepared in a clean area, or "designated clean" area if prepared in a multipurpose room.	☐ There is a "designated clean" area established in the facility. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	IV CS B 2 ☐	Drugs for external use are not stored separately from drugs for internal use.	☐ Drugs have been separated for external and internal use. ☐ A signed written statement explaining the corrective action taken to separate external and internal drugs is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	IV CS B 3 ☐	Items other than medications are in refrigerator/freezer with drugs and are not in a separate compartment from the drugs.	☐ Medications are kept separate from food, lab specimens, cleaning supplies, and/or other items that may potentially cause contamination. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	IV CS B 4 ☐	Refrigerator thermometer temperature is not at 35° - 46° Fahrenheit or 2° - 8° Centigrade (at time of site visit) or there is no thermometer present.	☐ A thermometer with appropriate gradations has been purchased and is in the refrigerator. ☐ A copy of the receipt and/or invoice is attached. ☐ Other:			
	IV CS B 5 ☐	Freezer Thermometer temperature is not 5° Fahrenheit or -15° Centigrade, or lower at time of site visit or there is no thermometer present	☐ A thermometer with appropriate gradations has been purchased and is in the freezer. ☐ A copy of the receipt and/or invoice is attached. ☐ Other:			
	IV CS B6 ☐	Drug/vaccine storage units onsite do not maintain the required temperature. Dormitory-style or bar-style combined refrigerator/freezer units are not to be used for vaccine storage under any circumstances.	☐ An appropriate storage unit able to maintain required temperatures has been purchased. ☐ A copy of the receipt and/or invoice is attached. ☐ Other:			
	IV CS B 7 ☐	Daily temperature readings of medication refrigerator and freezer are not documented.	☐ A copy of the daily temperature log with separate daily readings of the refrigerator and/or freezer temperatures is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	IV CS B8 ☐	Sites does not have a written plan for vaccine protection in case of a power outage or refrigerator or freezer unit malfunction.	☐ A copy of the site's plan for protecting vaccines in the case of a power outage or refrigeration malfunction. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
Health Plan verification and date	CRITERI	**Deficiency Cited / Reviewer Comments**	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE

						PHYSICIAN OR DESIGNEE
	IV CS B 9 ☐	Drugs are not stored separately from test reagents, germicides, disinfectants, and other household substances.	☐ Drugs have been moved to a storage area away from test reagents, germicides, disinfectants and other household substances. ☐ A signed written statement explaining the corrective action taken regarding drug storage. ☐ Other:			
	IV CS B 10 ☐	Hazardous substances are not appropriately labeled.	☐ All hazardous substances now have labels indicating the substance in the container and the date prepared and/or appropriate symbol if needed. ☐ Other:			

Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	IV CS B 11 ☐	Site does not have method(s) in place for drug and hazardous substance disposal.	☐ A disposal method is in place for drug and hazardous substance disposal that is within county and city ordinances. ☐ A copy of the office procedure regarding drug and hazardous substance disposal is attached. ☐ A copy of an appropriate medical waste disposal contract. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
C. Drugs are dispensed according to State and federal drug distribution laws and regulations. ***CA B&P Code §4024, §4076, §4170, §4171, §4173, §4174; 22 CCR §75032, §75033, §75036, §75037(a-g), §75038, §75039; 16 CCR §1718.1; 21 CFR §211.137; 42 USC 6A §300AA-26***						
	IV CS C 1 ☐	Expired drugs were found on site.	☐ All expired drugs were removed and disposed of properly on site. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
Health Plan verification and date	**CRITERI**	**Deficiency Cited / Reviewer Comments**	Recommended Corrective Action	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE**

PCP/Clinic Name: QM Nurse:
Address:

						PHYSICIAN OR DESIGNEE
	IV CS C 2 ☐	The site has no procedure to check expiration date of all drugs (including vaccines and samples), and infant and therapeutic formulas.	☐ A copy of the office procedure regarding checking expiration dates of all drugs on site is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of a log utilized to document checking of expired drugs and supplies. ☐ Other:			
	IV CS C3 ☐	All stored and dispensed prescriptions drugs are not appropriately labeled.	☐ A copy of the office procedure regarding labeling of stored and dispensed prescription drugs is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of a sample label for dispensing medications is attached. ☐ Other:			

Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	IV CS C 6	Vaccine Information sheets (VIS) are not present on site, for distribution to patients.	☐ A copy of the in-service outline (agenda) and sign-in sheet are attached.			

	☐		☐ Attached are copies of VIS information is available according to patient population. ☐ Other:			
	IV CS C 7 ☐	Pharmacy on site, is not licensed by the CA state Board of Pharmacy.	☐ A copy of the current pharmacy license is attached. ☐ A copy of the office procedure regarding medication dispensing/storage is attached. ☐ A licensed pharmacist monitoring drug distribution and current CA license is attached. ☐ Other:			
	IV CS C8 ☐	Site does not utilize California Immunization Registry (CAIR) or most current version.	☐ A copy of the office procedure regarding entering dates of all immunizations given into CAIR is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
Laboratory Services Survey Criteria						
D. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations ***17 CCR §1050; 22 CCR §51211.2, §51137.2; B&P Code §1220; 42 USC 263a; Public Law 100-578***						
	IV CS D 1 ☐	Laboratory test procedures are not performed according to current site-specific CLIA Certificate.	☐ A copy of the current CLIA certificate is attached. ☐ A copy of the application/renewal for a CLIA certificate is attached. ☐ Other:			
	IV CS D 2 ☐	Testing personnel performing clinical lab procedures have not been trained.	☐ Documentation of training and/or certificate of training for the following procedure(s) is attached: ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**

	IV CS D 3 ☐	Lab supplies (e.g. vacutainers, vacutainer tubes, culture swabs, test solutions) are accessible to unauthorized persons. .	☐ A written explanation of the corrective action(s) taken for lab supplies to not be accessible to unauthorized persons. ☐ A copy of the receipt and/or invoice is attached. ☐ Other:			
	IV CS D 4 ☐	Lab test supplies are expired.	☐ Expired laboratory supplies were removed from the storage area. ☐ A copy of a log utilized to document checking of expired drugs and supplies. ☐ Other:			
	IV CS D 5 ☐	Site does not have a procedure to check expiration date and a method to dispose of expired lab test supplies.	☐ A copy of a log utilized to document checking of expired drugs and supplies. ☐ A copy of the office procedure regarding medication dispensing/storage is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
Radiology Services Survey Criteria						
E. Site meets CDPH Radiological inspection and safety regulations. ***17 CCR* §*30255,* §*30305,* §*30404,* §*30405***						
	IV CS E 1 ☐	The site does not have a current California Radiologic Health Branch Inspection Report and/or Proof of Registration, if there is radiological equipment on site.	☐ A copy of the current California Radiologic Health Branch Inspection Report is attached. ☐ A copy of the Inspection Report and short form sign-off sheet is attached. ☐ A copy of the Inspection Report and notice of violation form and approval letter for corrective action plan is attached. ☐ A copy of Proof of Registration is attached. ☐ Other:			

Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**

	IV CS E 2 ☐	The site does not have a current copy of Title 17 and/or a posted notice about availability of Title 17 and its location posted.	☐ A current copy of Title 17 is available in the office. ☐ A copy of the posted notice about available of Title 17 and its location is attached. ☐ A copy of the receipt and/or invoice is attached. ☐ Other:			
	IV CS E 3 ☐	The "Radiation Safety Operating Procedures" are not posted in a highly visible location.	☐ A copy of the office policy and procedure regarding "Radiation Safety Operating Procedures" is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the receipt and/or invoice is attached. ☐ Other:			
	IV CS E 4 ☐	A "Notice to Employees poster" is not posted in a highly visible location.	☐ A "Notice to Employees Poster" has been obtained and is posted in a highly visible location. ☐ A copy of the receipt and/or invoice is attached. ☐ Other:			
	IV CS E 5 ☐	A "Caution, X-Ray" sign is not posted on or next to door of each room that has X-Ray Equipment.	☐ A "Caution, X-Ray" sign is posted on or next to the door of each room that has X-Ray equipment. ☐ A copy of the receipt and/or invoice is attached. ☐ Other:			
	IV CS E 6 ☐	There is no Physician Supervisor/Operator Certificate posted and/or is not within current expiration date.	☐ A copy of the Physician Supervisor/ Operator Certificate has been posted. ☐ A copy of the current Supervisor/ Operator certificate is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	IV CS E 7 ☐	There is no Technologist certificate posted and/or is not within current expiration date .	☐ A copy of all technologist certificates are posted in the X-Ray Room and is attached. ☐ A current copy of the following technologist certificate is attached: ☐ Other:			
	IV CS E 8 ☐	There is no lead apron or lead shield to protect the equipment operator.	☐ A lead apron or shield for operator protection during operation of the X-Ray equipment has been obtained. ☐ A copy of the receipt and/or invoice is attached. ☐ Other:			
	IV CS E 9 ☐	There is no gonad shield for patient protection during procedures in which gonads are in direct beam.	☐ A gonad shield for patient protection during procedures has been obtained. ☐ A copy of the receipt and/or invoice is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

V. Preventive Services
Preventive Services Survey Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
A. Preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases. ***22CCR §53851, §56210; 28 CCR §1300.67***						
	V PS A 1 ☐	The exam tables are not in good repair. The exam lights are not in good repair.	☐ Each exam table has a protective barrier that is changed between patients. ☐ The exam table(s) has been repaired and is in good working order. ☐ The light(s) have been repaired and is in good working order. ☐ A copy of the receipt and/or product label is attached. ☐ Other:			
	V PS A 2 ☐	There is no stethoscope on site. There is no sphygmomanometer with various size cuffs on site.	☐A stethoscope(s) has been purchased and is kept on site. ☐ The purchase of a sphygmomanometer with the following size cuffs was purchased: child / adult / obese/thigh ☐ A copy of the receipt and/or product label is attached. ☐ Other:			
	V PS A 3 ☐	There is no thermometer with a numeric reading on site.	☐ A thermometer with a numeric reading has been purchased and is available on site. ☐ A copy of the receipt and/or product label is attached. ☐ Other:			
	V PS A 4 ☐	There is no percussion hammer on site, or the number is inadequate for the site. There are no tongue blades on site. There are no patient gowns on site, or inappropriate types for the site population.	☐ The following has been purchased and is available on site (circle those that apply): percussion hammer, tongue blades, patient gowns. ☐ A copy of the receipt and/or product label is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	V PS A 5 ☐	There is no balance scale or acceptable alternative scale on site. There is no infant scale on site.	☐ A balance scale or acceptable alternative scale has been purchased ☐ An infant scale has been purchased and is kept on site. ☐ A copy of the receipt and/or product label is attached. ☐ Other:			
	V PS A 6 ☐	There is no wall mounted right angle height measuring device. There is no right-angle infant length measuring unit on site. There is no acceptable tape measure on site for head circumference measurement.	☐A wall mounted right angle height-measuring device has been purchased and is available on site. ☐A right-angle infant length measuring unit has been purchased and is available on site. ☐An acceptable tape measure has been purchased and is available on site. ☐ A copy of the receipt and/or product label is attached. ☐ Other:			
	V PS A 7 ☐	There is no literate eye chart on site. There is no illiterate eye chart on site. There is no vision occluder for vision testing on site.	☐A literate and/or illiterate eye chart has been purchased and is kept on site. ☐A vision occluder or acceptable alternative has been purchased and is available on site. ☐ A copy of the receipt and/or product label is attached. ☐ Other:			
	V PS A 8 ☐	There is no ophthalmoscope on site or an inadequate number for the site.	☐ An ophthalmoscope(s) has been purchased and is available on site. ☐ A copy of the receipt and/or product label is attached. ☐ Other:			
	V PS A 9 ☐	There is no otoscope on site. There are no appropriate ear speculums on site.	☐ An otoscope(s) has been purchased and is available on site. ☐ Appropriate ear speculums have been purchased and are available on site. ☐ A copy of the receipt and/or product label is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	V PS A 10 ☐	There is no pure tone, air conduction audiometer on site, or acceptable alternative system. There is no quiet location for audiometer testing.	☐ A pure tone, air conduction audiometer has been purchased and is available on site. ☐ A quiet location for audiometer testing has been arranged and is in use. ☐ A copy of the receipt and/or product label is attached. ☐ Written explanation of process for acceptable alternative. ☐ Other:			
Health Education Survey Criteria						
B. Health Education services are available to Plan members. ***22CCR §53851; 28 CCR 1300.67***						
	V PS B 1 ☐	Health education materials are not readily accessible on site or are not made available in a timely manner upon request. Plan specific resource information is not readily accessible on site or is not made available in a timely manner upon request.	☐ Health education materials or a method of timely provision is in place. ☐ Health plan specific resource information or a method of timely provision is in place. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A signed written explanation of the corrective action taken. ☐ Other:			
	V PS B 2 ☐	Health education materials and plan-specific resource information is not applicable to the practice and population served by the site.	☐ Health education materials and plan specific resource information has been updated to the practice and population served by this site. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A signed written explanation of the corrective action taken. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	V PS B 3 ☐	Health Education materials and plan-specific resource information is not available in threshold languages identified for county and/or area of site location.	☐ Health Education materials and plan-specific resource information in appropriate threshold languages is available from the health plan. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A signed written explanation of the corrective action taken. ☐ Other:			
VI. Infection Control **Infection Control Survey Criteria**						
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
A. Infection control procedures for Standard/Universal precautions are followed. ***8 CCR §5193; 22 CCR §53230; 29 CFR §1910.1030; Federal Register 1989, §54:23042***						
	VI IC A 1 ☐	Antiseptic hand cleaner is not available in, or in reasonable proximity, to treatment areas for hand washing. Running water is not available in, or in reasonable proximity, to treatment areas for hand washing.	☐ Antiseptic hand cleaner is available on site in reasonable proximity to treatment areas. ☐ Running water is available on site in reasonable proximity to treatment areas. ☐ A copy of the receipt and/or work invoice is attached. ☐ A signed written statement of corrective action taken in regards to antiseptic hand cleaner and/or running water. ☐ Other:			
	VI IC A 2 ☐	A waste disposal container is not available in the exam, treatment and rest rooms.	☐ Waste disposal containers have been purchased and placed in the following area(s) ☐ A copy of the receipts/invoice is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	VI IC A 3 ☐	There is no site procedure for effectively isolating infectious patients with potential communicable conditions.	☐ A copy of the office policy and procedure regarding isolating infectious patients with potential communicable conditions is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. ***8 CCR §5193 (Cal OSHA Health Care Worker Needlestick Prevention Act, 1999); H&S Code, §117600-118360 (CA Medical Waste Management Act, 1997); 29 CFR §1910.1030.***						
	VI IC B 4 ☐	No Sharps Injury Log available on site. Sharp injury incidents are not documented.	☐ A copy of the sharps injury incidents form and log which describe the date, time, description of exposure incident, sharp type/brand, and follow-up care received within 14 days. ☐ A copy of the office policy and procedure regarding documentation of sharp injury incidents is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	VI IC B 5 ☐	Biohazardous (non-sharp) wastes are not contained separately from other trash/waste.	☐ Biohazardous wastes are contained separately from other trash/waste. ☐ A copy of the office policy and procedure regarding biohazardous wastes is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the receipt is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	**Deficiency Cited / Reviewer Comments**	Recommended Corrective Action	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VI IC B 6 ☐	Storage areas for regulated medical wastes are not maintained secure and inaccessible to unauthorized persons.	☐ Storage area for regulated medical waste has been created and is kept locked. ☐ A copy of the office policy and procedure regarding storage of regulated medical waste is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the receipt and/or work invoice is attached. ☐ Other:			
	VI IC B 7 ☐	Contaminated laundry is not laundered at the workplace or through a commercial laundry service. (This is not required if only disposable gowns/sheets, etc are used)	☐ A commercial laundry service is used for contaminated laundry and a copy of the contract is attached. ☐ ☐ A washer and dryer have been purchased and installed on site for use with contaminated laundry. A copy of the purchase and installation invoice or receipt is attached. ☐ Other:			
	VI IC B 8 ☐	Transportation of regulated medical wastes is not done by a registered hazardous waste hauler or by a person with an approved limited-quantity exemption.	☐ A copy of the contract and/or proof of service with a registered hazardous waste hauler is attached. ☐ A copy of a current approved limited-quantity exemption and medical waste tracking document is attached. ☐ Other:			
C. Contaminated surfaces are decontaminated according to Cal-OSHA Standards. ***8 CCR §5193; CA H&S Code §118275***						

	VI IC C 1 ☐	Equipment and work surfaces are not appropriately cleaned and decontaminated after contact with blood or other potentially infectious material.	☐ A copy of the office policy and procedure regarding decontamination of work surfaces and/or equipment after contact with blood or other potentially infectious material is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	☐ **VI IC C 2**	Routine cleaning and decontamination of equipment/work surfaces is not completed according to site-specific written schedule.	☐ A copy of the written routine cleaning schedule for all equipment and work surfaces is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VI IC C 3 ☐	Disinfectant solutions used on site are not approved by the Environmental Protection Agency (EPA).	☐ All non-approved disinfectant solutions have been removed and replaced with EPA approved solutions. ☐ A copy of the receipt and/or work invoice is attached. ☐ A copy of the product label. ☐ Other:			
	VI IC C 4 ☐	Disinfectant solutions used on site are not effective in killing TB/HIV/HB	☐ A copy of the office policy and procedure regarding disinfectant solutions is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the product label. ☐ A copy of the receipt and/or invoice is attached. ☐ Other:			
	VI IC C 5 ☐	Disinfectant solutions used on site are not used according to manufacturer instructions.	☐ A copy of the manufacturer instructions of the disinfectant solution used on site. ☐ If 10% Bleach solution is used it is changed/reconstituted every 24 hours and			

			the label must contain the reconstituted date and time. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
D. Re-usable medical instruments are properly sterilized after each use. ***22 CCR §53230, §53856***						
	VI IC D 1 ☐	Written site-specific policy/procedures or Manufacturer's Instructions for instrument/equipment sterilization are not available to staff.	☐ A copy of the site-specific policy and procedure or Manufacturer's instructions regarding autoclave/sterilization is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VI IC D 2 ☐	Cleaning reusable instruments/equipment is not done prior to sterilization.	☐ A copy of the site-specific policy and procedure or Manufacturer's instructions regarding cleaning reusable instruments and/or equipment prior to sterilization is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	VI IC D 3b ☐	There is no confirmation from manufacturer item(s) is/are heat-sensitive.	☐ A copy of the site-specific policy and procedure or Manufacturer's instructions regarding cold chemical sterilization is attached. ☐ A copy of the product label. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	VI IC D 4a ☐	Autoclave/steam sterilization. Staff cannot demonstrate or verbalize necessary steps/process to ensure sterility.	☐ A copy of the manufacturer's instructions and/or site-specific policy and procedure regarding autoclave/steam sterilization is attached. ☐ Written operating procedures for autoclave are available on site to staff.			

			☐ If instruments/equipment are transported off-site for sterilization, equipment handling and transport procedures are available on site to staff. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	VI IC D4 b ☐	Autoclave is not maintained and serviced according to manufacturer's guidelines.	☐ A copy of the manufacturer's guidelines for maintenance of the autoclave is attached. ☐ A copy of the service receipt/invoice from a qualified technician within the past 12 months is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VI IC D 4e ☐	Sterilized packages are not labeled with sterilization date and load identification information.	☐ Storage area(s) for sterilized packages are clean, dry and separated from non-sterile items by a functional barrier.			

			☐ Sterilized package labels include date of sterilization, load run identification information, and general contents. ☐ A copy of the office policy and procedure regarding routine evaluation of sterilized packages is attached. ☐ A copy of the sterilization log used in the office is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the log to check sterilized packages is attached. ☐ Other:			
	VI IC D 4f	Site does not maintain a storage area for keeping sterilized packages clean, dry, and separated from non-sterile items by a functional barrier. Staff unable to demonstrate or verbalize process for routine evaluation of sterilized packages	☐ A copy of the office policy and procedure addressing storage of sterilized packages. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

Medical Record Review Survey

NOTE: All criteria in this section were not documented in the medical record review.

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
I. Format Criteria						
	I A ☐	Member identification was not on each page.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	I B ☐	Individual personal biographical information was not documented.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	I C ☐	Emergency "contact" was not identified.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the form utilized is attached. ☐ Other:			
	I D ☐	Medical records on site were not consistently organized.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the form utilized is attached. ☐ Other:			
	I E ☐	Member's assigned primary care physician (PCP) was not identified.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	I F ☐	Primary language and linguistic service needs of non -or limited-English proficient (LEP) or hearing-impaired persons were not prominently noted.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	I G ☐	Person or entity providing medical interpretation is not identified in the record.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the form utilized is attached. ☐ Other:			
	I H ☐	Signed copy of the Notice of Privacy was not found in the record.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

II. Documentation Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	II A ☐	Allergies were not prominently noted.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II B ☐	Chronic problems and/or significant conditions were not listed.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the chronic problem(s) and/or significant conditions form is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	II C ☐	Current *continuous* medications were not listed.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the current continuous medications form is attached. ☐ Other:			
	II D1	Signed release of medical records was not present in the chart	☐ A copy of the policy and procedure regarding release of medical records. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the informed consent form(s) are attached as follows: ☐ Other:			
	II D2	Appropriate consent was not present for invasive procedures.	☐ A copy of the policy and procedure regarding informed consent is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the informed consent form(s) are attached as follows: ☐ Other:			
	II E ☐	Advance Health Care Directive information was not offered. (Only for: Adults, 18 years/older; emancipated minors)	☐ A copy of the information is available regarding Advance Health Care Directive is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

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	II F ☐	All entries were not signed, dated and legible	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II G ☐	Errors were not corrected according to legal medical documentation standards.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

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Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
III. Coordination/Continuity of Care Criteria						
	III A ☐	History of present illness was not documented.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	III B ☐	Working diagnoses were not consistent with findings.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	III C ☐	Treatment plans were not consistent with diagnoses.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	III D ☐	Instruction for follow-up care was not documented.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	III E ☐	Unresolved/continuing problems were not addressed in subsequent visit(s).	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	III F ☐	No evidence of practitioner review of consult/referral reports and diagnostic test results.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form and/or stamp utilized is attached. ☐ Other:			
	III G ☐	No evidence of follow up of specialty referrals made and results/reports of diagnostic tests.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form and/or stamp utilized is attached. ☐ Other:			
	III H ☐	Missed primary care appointments and outreach efforts/follow-up contacts are not documented.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form and/or stamp utilized is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
IV. Pediatric Preventive Criteria						
	IV A1 ☐	Initial Health Assessment (IHA): No evidence of History and Physical (H&P) performed within the first 120-days of enrollment in the health plan.	☐ A copy of the policy and procedure regarding IHA is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV A2 ☐	No evidence that an initial Individual Health Education Behavioral Assessment (IHEBA) was performed within the first 120-days of enrollment in the health plan.	☐ A copy of the policy and procedure regarding IHEBA/SHA is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV B1 ☐	Subsequent Comprehensive Health Assessment: Comprehensive History and Physical exam completed at age-appropriate frequency.	☐ A copy of the policy and procedure regarding Physical exam completed at age-appropriate frequency is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV B2 ☐	Individual Health Education Behavioral Assessment (IHEBA). Subsequent Periodic IHEBA.	☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C1 ☐	Well-Child Visit: Alcohol/Drug misuse: Screening and behavioral counseling.	☐ A copy of the policy and procedure regarding Alcohol/Drug misuse screening/counseling is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached.			

			☐ Other:			

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	IV C2 ☐	Well-Child Visit: Anemia Screening	☐ A copy of the policy and procedure regarding Anemia Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C3 ☐	Well-Child Visit: Anthropometric Measurements	☐ A copy of the policy and procedure regarding Anthropometric measurements is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C4 ☐	Well-Child Visit: Anticipatory Guidance	☐ A copy of the policy and procedure regarding Anticipatory Guidance is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C5 ☐	Well-Child Visit: Autism Spectrum Disorder Screening	☐ A copy of the policy and procedure regarding Autism Spectrum Disorder screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

	IV C6 ☐	Well-Child visit: Blood Lead Screening Test	☐ A copy of the policy and procedure regarding Blood Lead Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	IV C7 ☐	Well-Child Visit: Blood Pressure Screening	☐ A copy of the policy and procedure regarding Blood Pressure Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C8 ☐	Well-Child Visit: Dental/Oral Health Assessment	☐ A copy of the policy and procedure regarding Dental/Oral Health Assessment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 8a ☐	Well-Child Visit: Dental Assessment: Fluoride Supplements	☐ A copy of the policy and procedure regarding Fluoride supplementation is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 8b ☐	Well-Child Visit: Dental Assessment: Fluoride Varnish	☐ A copy of the policy and procedure regarding Fluoride Varnish is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached.			

			☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C9 ☐	Well Child Visit: Depression Screening	☐ A copy of the policy and procedure regarding Depression screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 9a ☐	Well Child Visit: Suicide-Risk Screening	☐ A copy of the policy and procedure regarding Suicide-Risk screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	IV C 9b ☐	Well-Child Visit: Maternal Depression Screening	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 10 ☐	Well-Child Visit: Developmental Disorder Screening	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

	IV C 11 ☐	Well-Child Visit: Developmental Surveillance	☐ A copy of the policy and procedure regarding Developmental Surveillance is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 12 ☐	Well-Check Visit: Drug Use Disorder Screening and Behavioral Counseling	☐ A copy of the policy and procedure regarding Drug Use Disorder Screening and Behavioral Counseling attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 13 ☐	Well-Child Visit: Dyslipidemia Screening	☐ A copy of the policy and procedure regarding Dyslipidemia Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	IV C 14 ☐	Well-Child Visit: Hearing Screening	☐ A copy of the policy and procedure regarding Hearing Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 15 ☐	Well-Child visit: Hepatitis B Screening	☐ A copy of the policy and procedure regarding Hepatitis B Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached.			

			☐ Other:			
	IV C 16 ☐	Well-Child visit: Hepatitis C Screening	☐ A copy of the policy and procedure regarding Hepatitis C Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 17 ☐	Well-Child visit: HIV Screening	☐ A copy of the policy and procedure regarding HIV is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 18 ☐	Well-Child Visit: Psychosocial/Behavioral Assessment	☐ A copy of the policy and procedure regarding Psychosocial/Behavioral Assessment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 19 ☐	Well-Child Visit: STI Screening and counseling	☐ A copy of the policy and procedure regarding STI Screening and counseling is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 20 ☐	Well-Child Visit: Sudden Cardiac Arrest and Sudden Cardiac Death Screening	☐ A copy of the policy and procedure regarding Sudden Cardiac Arrest and Sudden Cardiac Death Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached.			

			☐ Other:			
	IV C 21 ☐	Well-Child Visit: Tobacco products use, Screening and Prevention and Cessation Services	☐ A copy of the policy and procedure regarding Tobacco products use, Screening and Prevention and Cessation Services is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	IV C 22 ☐	Well-Child Visit: Tuberculosis screening	☐ A copy of the policy and procedure regarding TB risk Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 23 ☐	Well-Child Visit: Vision Screening	☐ A copy of the policy and procedure regarding Vision Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV D1 ☐	Childhood Immunizations: Given according to ACIP guidelines	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

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	IV D2 ☐	No evidence that documentation of immunization administration included manufacturer's name, lot number, site and initials.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV D3 ☐	No evidence that publication date of Vaccine Information Statement (VIS) was documented for each immunization administered.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

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Address:

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V. Adult Preventive Criteria						
	V A1 ☐	Initial Health Assessment (IHA): No evidence that History and Physical (H&P) was performed within the first 120-days of enrollment in the health plan.	☐ A copy of the policy and procedure regarding IHA is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	V A2 ☐	No evidence that an initial Individual Health Education Behavioral Assessment (IHEBA) was performed within the first 120-days of enrollment in the health plan.	☐ A copy of the policy and procedure regarding IHEBA/SHA is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	V B1 ☐	Periodic Health Evaluation according to most recent USPSTF Guidelines.	☐ A copy of the policy and procedure regarding adult periodic health evaluations is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	V B2 ☐	Subsequent Periodic IHEBA	☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	V C1 ☐	Adult Preventive Care Screenings: Abdominal Aneurysm Screening	☐ A copy of the policy and procedure regarding Abdominal Aneurysm screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached.			

			☐ Other:			
	V C2 ☐	Adult Preventive Care Screenings: Alcohol Misuse: Screening and Behavioral Counseling	☐ A copy of the policy and procedure regarding Alcohol Use Disorder Screening and Behavioral Counseling is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

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	V C3 ☐	Adult Preventive Care Screenings: Breast Cancer Screening	☐ A copy of the policy and procedure regarding Breast Cancer Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	V C4 ☐	Adult Preventive Care Screenings: Cervical Cancer Screening	☐ A copy of the policy and procedure regarding Cervical Cancer Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	V C5 ☐	Adult Preventive Care Screenings: Colorectal Cancer Screening	☐ A copy of the policy and procedure regarding Colorectal Cancer Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	V C6 ☐	Adult Preventive Care Screenings: Depression Screening	☐ A copy of the policy and procedure regarding Depression Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	V C7 ☐	Adult Preventive Care Screenings: Diabetic Screening	☐ A copy of the policy and procedure regarding Diabetic Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached.			

			☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VC 7a ☐	Adult Preventive Care Screenings: Diabetic Comprehensive Care	☐ A copy of the policy and procedure regarding Diabetic Comprehensive Care is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VC8 ☐	Adult Preventive Care Screenings: Drug Disorder Screening and Behavioral Counseling	☐ A copy of the policy and procedure regarding Drug Disorder Screening and Behavioral Counseling is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VC9 ☐	Adult Preventive Care Screenings: Dyslipidemia Screening	☐ A copy of the policy and procedure regarding Dyslipidemia Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VC 10 ☐	Adult Preventive Care Screenings: Folic Acid Supplementation	☐ A copy of the policy and procedure regarding Folic Acid Supplementation is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

	VC 11 ☐	Adult Preventive Care Screenings: Hepatitis B Screening	☐ A copy of the policy and procedure regarding Hepatitis B Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VC 12 ☐	Adult Preventive Care Screenings: Hepatitis C Screening	☐ A copy of the policy and procedure regarding Hepatitis C Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VC 13 ☐	Adult Preventive Care Screenings: High Blood Pressure Screening	☐ A copy of the policy and procedure regarding High Blood Pressure Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VC 14 ☐	Adult Preventive Care Screenings: HIV Screening	☐ A copy of the policy and procedure regarding HIV screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VC 15 ☐	Adult Preventive Care Screenings: Intimate Partner Violence Screening	☐ A copy of the policy and procedure regarding Intimate Partner Violence Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached.			

			☐ A copy of the office form utilized is attached. ☐ Other:			
	VC 16 ☐	Adult Preventive Care Screenings: Lung Cancer Screening	☐ A copy of the policy and procedure regarding Lung Cancer Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VC 17 ☐	Adult Preventive Care Screenings: Obesity Screening & Counseling	☐ A copy of the policy and procedure regarding Obesity Screening & Counseling is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VC 18 ☐	Adult Preventive Care Screenings: Osteoporosis Screening	☐ A copy of the policy and procedure regarding Osteoporosis Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VC 19 ☐	Adult Preventive Care Screenings: Sexually Transmitted Infection (STI) Screening & Counseling	☐ A copy of the policy and procedure regarding Sexually Transmitted Infection (STI) Screening & Counseling is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

	V C 20 ☐	Adult Preventive Care Screenings: Skin cancer Behavioral Counseling	☐ A copy of the policy and procedure regarding Skin cancer Behavioral Counseling is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	V C 21 ☐	Adult Preventive Care Screenings: Tobacco Use Counseling and Interventions	☐ A copy of the policy and procedure regarding Tobacco Use Counseling and Interventions is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	V C 22 ☐	Adult Preventive Care Screenings: Tuberculosis Screening	☐ A copy of the policy and procedure regarding Tuberculosis Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	V D1 ☐	Adult Immunizations: Given according to ACIP guidelines	☐ A copy of the policy and procedure regarding Adult Immunizations is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	V D2 ☐	Adult Immunizations: Vaccine administration documentation	☐ A copy of the policy and procedure regarding Vaccine administration documentation is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached.			

			☐ A copy of the office form utilized is attached. ☐ Other:			
	V D3 ☐	Adult Immunizations: Vaccine Information Statement (VIS) documentation	☐ A copy of the policy and procedure regarding Vaccine Information Statement (VIS) documentation is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
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VI. Perinatal Preventive Criteria						
	VI A1 ☐	No evidence of an Initial Comprehensive Prenatal Assessment (ICA) completed within 4 weeks of entry to prenatal care	☐ A copy of the policy and procedure regarding Initial prenatal visit is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI A2 ☐	Initial Comprehensive Prenatal Assessment (ICA): Obstetrical and Medical History	☐ A copy of the policy and procedure regarding Obstetrical and Medical History is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI A3 ☐	Initial Comprehensive Prenatal Assessment (ICA): Physical Exam	☐ A copy of the policy and procedure regarding Physical Exam is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI A4 ☐	Initial Comprehensive Prenatal Assessment (ICA): Dental Assessment	☐ A copy of the policy and procedure regarding Dental Assessment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI A5 ☐	Initial Comprehensive Prenatal Assessment (ICA): Healthy Weight Gain and Behavior Counseling	☐ A copy of the policy and procedure regarding Healthy Weight Gain and Behavior Counseling is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached.			

			☐ A copy of the office form utilized is attached. ☐ Other:			

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	VI A 6a ☐	Initial Comprehensive Prenatal Assessment (ICA), Lab Tests: Bacteriuria Screening	☐ A copy of the policy and procedure regarding Bacteriuria Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI A 6b ☐	Initial Comprehensive Prenatal Assessment (ICA), Lab Tests: Rh Incompatibility Screening	☐ A copy of the policy and procedure regarding Rh Incompatibility Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI A 6c ☐	Initial Comprehensive Prenatal Assessment (ICA), Lab Tests: Diabetes Screening	☐ A copy of the policy and procedure regarding Diabetes Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI A 6d ☐	Initial Comprehensive Prenatal Assessment (ICA), Lab Tests: Hepatitis B Virus Screening	☐ A copy of the policy and procedure regarding Hepatitis B Virus Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI A 6e ☐	Initial Comprehensive Prenatal Assessment (ICA), Lab Tests: Hepatitis C Virus Screening	☐ A copy of the policy and procedure regarding Hepatitis C Virus Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached.			

			☐ A copy of the office form utilized is attached. ☐ Other:			
	VI A 6f ☐	Initial Comprehensive Prenatal Assessment (ICA), Lab Tests: Chlamydia Infection Screening	☐ A copy of the policy and procedure regarding Chlamydia Infection Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VI A 6g ☐	Initial Comprehensive Prenatal Assessment (ICA), Lab Tests: Syphilis Infection Screening	☐ A copy of the policy and procedure regarding Syphilis Infection Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI A 6h ☐	Initial Comprehensive Prenatal Assessment (ICA), Lab Tests: Gonorrhea Infection Screening	☐ A copy of the policy and procedure regarding Gonorrhea Infection Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI A 6i ☐	Initial Comprehensive Prenatal Assessment (ICA), Lab Tests: HIV Screening	☐ A copy of the policy and procedure regarding HIV Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

	VI B1 ☐	First Trimester Comprehensive Assessment: Individualized Care Plan (ICP)	☐ A copy of the policy and procedure regarding ICP is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI B2 ☐	First Trimester Comprehensive Assessment: Nutrition Assessment	☐ A copy of the policy and procedure regarding Nutrition Assessment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI B 3a ☐	Psychosocial Assessment: Maternal Mental Health Screening	☐ A copy of the policy and procedure regarding Maternal Mental Health Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VI B 3b ☐	Psychosocial Assessment: Social Needs Assessment	☐ A copy of the policy and procedure regarding Social Needs Assessment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI B 3c ☐	Psychosocial Assessment: Substance Use/Abuse Assessment	☐ A copy of the policy and procedure regarding Substance Use/Abuse Assessment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached.			

			☐ A copy of the office form utilized is attached. ☐ Other:			
	VI B4 ☐	First Trimester Comprehensive Assessment: Breast Feeding & Health Education Assessment	☐ A copy of the policy and procedure regarding Breast Feeding & Health Education Assessment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI B5 ☐	First Trimester Comprehensive Assessment: Preeclampsia Screening	☐ A copy of the policy and procedure regarding Preeclampsia Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI B6 ☐	First Trimester Comprehensive Assessment: Intimate Partner Violence Screening	☐ A copy of the policy and procedure regarding Intimate Partner Violence Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VI C1 ☐	Second Trimester Comprehensive Re-assessment: Individualized Care Plan Updated and follow up	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

	VI C2 ☐	Second Trimester Comprehensive Re-assessment: Nutrition Assessment	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI C 3a ☐	Second Trimester Comprehensive Psychosocial Assessment: Maternal Mental Health Screening	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI C 3b	Second Trimester Comprehensive Psychosocial Assessment: Social Needs Assessment	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI C 3c ☐	Second Trimester Comprehensive Psychosocial Assessment: Substance Use/Abuse Assessment	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VI C4	Second Trimester Comprehensive Assessment: Breast Feeding & other Health Education	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

	VI C5 ☐	Second Trimester Comprehensive Assessment: Preeclampsia Screening	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI C 5a ☐	Second Trimester Comprehensive Assessment: Preeclampsia Screening – Low does Aspirin	☐ A copy of the policy and procedure regarding Low does Aspirin is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI C6 ☐	Second Trimester Comprehensive Assessment: Intimate Partner Violence Screening	☐A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI C7 ☐	Second Trimester Comprehensive Assessment: Diabetes Screening	☐A copy of the policy and procedure regarding Diabetes Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI D1 ☐	Third Trimester Comprehensive Assessment: Individualized Care Plan	☐A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI D2 ☐	Third Trimester Comprehensive Assessment: Nutrition	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached.			

			☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VI D 3a ☐	Third Trimester Psychosocial Assessment: Maternal Mental Health Screening	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI D 3b ☐	Third Trimester Psychosocial Assessment: Social Needs Assessment	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI D 3c ☐	Third Trimester Psychosocial Assessment: Substance Use/Abuse Assessment	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI D4 ☐	Third Trimester Comprehensive Assessment: Breast Feeding & other Health Education	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

	VI D5 ☐	Third Trimester Comprehensive Assessment: Preeclampsia Screening	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI D 5a ☐	Third Trimester Comprehensive Assessment: Preeclampsia Screening – Low dose Aspirin	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI D6 ☐	Third Trimester Comprehensive Assessment: Intimate Partner Violence Screening	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI D7 ☐	Third Trimester Comprehensive Assessment: Diabetic Screening	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI D8 ☐	Third Trimester Comprehensive Assessment: Screening for Strep B	☐ A copy of the policy and procedure regarding Screening for Strep B is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI D8 ☐	Third Trimester Comprehensive Assessment: TDAP Immunization	☐ A copy of the policy and procedure regarding TDAP Immunization is attached.			

			☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI E ☐	Prenatal care visit periodicity according to most recent ACOG standards	☐ A copy of the policy and procedure regarding Prenatal care visit periodicity according to most recent ACOG standards is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI F ☐	Influenza Vaccine	☐ A copy of the policy and procedure regarding Influenza Vaccine is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI G ☐	COVID Vaccine	☐ A copy of the policy and procedure regarding Covid Vaccine is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VI H ☐	No evidence of a Referral to WIC and assessment of Infant Feeding status.	☐ A copy of the policy and procedure regarding Referral to WIC and assessment of Infant Feeding status.is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

	VI I ☐	No evidence that HIV-related services were *offered.*	☐ A copy of the policy and procedure regarding HIV-related services is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI J ☐	No evidence that AFP/Genetic screening was *offered.*	☐ A copy of the policy and procedure regarding AFP/Genetic screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI K ☐	No evidence of a Family Planning Evaluation.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI L1 ☐	Postpartum Comprehensive Assessment: Individualized Care Plan	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**

	VI L2 ☐	Postpartum Comprehensive Assessment: Nutrition Assessment	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI L 3a ☐	Postpartum Comprehensive Psychosocial Assessment: Maternal Mental Health /Postpartum depression screening	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI L 3b ☐	Postpartum Comprehensive Psychosocial Assessment: Social Needs Assessment	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI L 3c ☐	Postpartum Comprehensive Psychosocial Assessment: Substance Use/Abuse Assessment	☐ A copy of the policy and procedure regarding Substance Use/Abuse Assessment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**

	VI L4 ☐	Postpartum Comprehensive Health Education Assessment	☐ A copy of the policy and procedure regarding Postpartum Comprehensive Health Education Assessment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI L5 ☐	Postpartum Comprehensive Physical Exam	☐ A copy of the policy and procedure regarding Postpartum Comprehensive Physical Exam is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

California Department of Health Care Services
Managed Care Quality and Monitoring Division

July 1, 2022

Facility Site Review Standards

Purpose: The Facility Site Review Standards provide the instructions, rules, regulations, parameters, and indicators for conducting Facility Site Reviews using the Facility Site Review tool. The site reviewer must use these Standards for measuring, evaluating, assessing, and making decisions.

Scoring: Site reviews include on-site inspection and interviews with site personnel. Reviewers are expected to use reasonable evidence available during the review process to determine if practices and systems on site meet review criteria. Critical Elements have a weight of two (2) points each and non-Critical Elements have a weight of one (1) point on the site review tool. Compliance levels include:

1) Exempted Pass: 90% or above *without deficiencies* in Critical Elements, Pharmaceutical or Infection Control
2) Conditional Pass: 80-89%, or 90% and above with deficiencies in either Critical Elements, Pharmaceutical or Infection Control
3) Fail: 79% and below

A corrective action plan (CAP) is required for a total score less than 90%, *OR* for a total score of 90% or above if there are deficiencies in Critical Elements, Pharmaceutical Services or Infection Control. Compliance rates are based on 169 total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer. Reviewers are expected to determine how to ascertain information needed to complete the review. Review criteria that shall be reviewed *only* by a registered nurse (RN), nurse practitioner (NP), Certified Nurse Midwife (CNM), Licensed Midwife (LM), physician (MD), or physician assistant (PA) is labeled "  **RN/NP/CNM/LM/MD/PA".**

Directions: Score full point(s) if review item is met. Score zero (0) points if item is not met. Do not score partial points for any item. Explain all "N/A" and "No" (0 point) items in the comment section. Provide assistance/consultation as needed for CAPs and establish follow-up/verification timeline.

1) Add the points given in each section.
2) Add points given for all six (6) sections to determine total points given for the site.
3) Subtract all "N/A" items from 170 total possible points to determine the "adjusted" total possible points. If there are no "N/A" items, calculation of site score will be based on 170 points.
4) Divide the total points given by 170 or by the "adjusted" total. Multiply by 100 to calculate percentage rate.

Scoring Example:

Step 1: Add the points given in each section.

Step 2: Add points given for all six (6) sections.

Example: 31 (Access/Safety)
27 (Personnel)
25 (Office Management)
40 (Clinical Services)
13 (Preventive Services)
34 (Infection Control)
170 (POINTS GIVEN)

Step 3: Subtract "N/A" points from 170 total points possible.

170 (Total points possible)
- 5 (N/A points)
165 ("Adjusted" total points possible)

Step 4: Divide total points given by the "adjusted" points, then multiply by 100 to calculate percentage rate.

$$\frac{\text{Points given}}{\text{"Adjusted" total}} \quad \text{or} \quad \frac{140}{165} = 0.8485 \times 100 = \mathbf{85\%}$$

Criteria	I. Access/Safety Standards
A. Site is accessible and useable by individuals with physical disabilities.	**Sites must have the following safety accommodations for physically disabled persons:** **<u>Americans with Disabilities Act (ADA) Regulations</u>:** • Site must meet city, county, and state building structure and access ordinances for persons with physical disabilities. A site/facility includes the building structure, walkways, parking lots, and equipment. • All facilities designed, constructed; or altered by, on behalf of, or for the use of a public entity must be readily accessible and usable by individuals with disabilities, if the construction or alteration was begun after January 26, 1992.[1] • Any alteration to a place of public accommodation or a commercial facility, after January 26, 1992, must be made to ensure that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and useable by individuals with disabilities, including individuals who use wheelchairs.[2] **I.A.1) Clearly marked (blue) curb or sign designating disabled-parking space near accessible primary entrance.** **<u>Parking</u>:** • Parking spaces for persons with physical disabilities are located in close proximity to accessible building entrances. • Each parking space reserved for persons with disabilities is identified by a permanently affixed reflectorized sign posted in a conspicuous place. • If the provider has no control over availability of accessible parking within lot or nearby street spaces for persons with disabilities, the provider must have a plan in place for making program services available to persons with physical disabilities. **I.A.2) Pedestrian ramps have a level landing at the top and bottom of the ramp.** **<u>Ramps</u>:** • A clear and level landing is at the top and bottom of all ramps and on each side of an exit door. • Any path of travel is considered a ramp if its slope is greater than a 1-foot rise in 20 feet of horizontal run. • Ramps must be a minimum of 36-inches wide. Some areas require wider ramps.

[1] Title 28, Code of Federal Regulations (CFR), section 35.151. The CFR is searchable at: https://www.ecfr.gov/search.
[2] 28 CFR section 36.402.

Criteria	I. Access/Safety Standards
	• All edges must be protected to keep anyone from slipping off. • All ramps that are 5 feet long shall have a level top and bottom landings. • Ramps must have handrails on both sides if length is longer than 6 feet. **I.A.3) Exit and exam room doorway openings allow for clear passage of a person in a wheelchair.** **Exit Doors:** • All entrances and exterior and interior exit doors, regardless of the occupant load shall be made accessible to persons with disabilities. • Exam room and exit doorways have a minimum opening of 32 inches with the door open at 90 degrees that will allow for passage of wheelchairs. • Door hardware = operable with a single effort without requiring ability to grasp hardware. • Effort to operate doors = a maximum pressure of 5 pounds at interior doors. • Door hardware height = 30” – 44” above floor. • Exit doors include all doors required for access, circulation and use of the building and facilities, such as primary entrances and passageway doors. • Furniture and other items do not obstruct exit doorways or interfere with door swing pathway. **I.A.4) Accessible passenger elevator or reasonable alternative for multi-level floor accommodation.** **Elevators:** • If there is no elevator, a freight elevator may be used to achieve program accessibility if it is upgraded for general passenger use and if passageways leading to and from the elevator are well-lit, neat, and clean. **I.A.5) Clear floor space for wheelchair in waiting area and exam room.** **Clear Floor Space:** • Clear space in waiting/exam areas is sufficient (at least 30-in. x 48-in.) to accommodate a single, stationary adult wheelchair and occupant. • A minimum clear space of 60-inch diameter or square area is needed to turn a wheelchair. **Sanitary Facilities:** **I.A.6) Wheelchair accessible restroom facilities.** • A wheelchair accessible restroom stall allows sufficient space for a wheelchair to enter and permits the door to close.

Criteria	I. Access/Safety Standards
	• Sufficient knee clearance space underneath the sink allows wheelchair users to safely use a lavatory sink for hand washing. • If wheelchair-accessible restrooms are not available within the office site, reasonable alternative accommodation are provided such as a wheelchair-accessible restroom located within the building. Other reasonable alternatives may include, but is not limited to, urinal, bedpan, or bedside commode in a private area. **IA.7) Wheelchair accessible handwashing facilities or reasonable alternative.** • Restroom and hand washing facilities are accessible to able-bodied and physically disabled persons. • If wheelchair-accessible handwashing facilities are not available within the office site, reasonable alternative accommodation are provided such as sanitizers and wheelchair-accessible restroom located within the building. **Note:** • A public entity may not deny the benefits of its program, activities, and services to individuals with disabilities because its facilities are inaccessible.[3] • Every feature need not be accessible, if a reasonable portion of the facilities and accommodations provided is accessible.[4] • Reasonable Portion and/or Reasonable Alternatives are acceptable to achieve program accessibility. • Reasonable Portion applies to multi-storied structures and provides exceptions to the regulations requiring accessibility to all portions of a facility/site. • Reasonable Alternatives are methods other than site structural changes to achieve program accessibility, such as acquisition or redesign of equipment, assignment of assistants/aides to beneficiaries, provision of services at alternate accessible sites, and/or other site-specific alternatives to provide services.[5] • Points shall not be deducted if Reasonable Portion or Reasonable Alternative is made available on site.

[3] 28 CFR sections 35.149 – 35.150.
[4] Title 24, California Code of Regulations (CCR), sections 2-419, California Administrative Code, the State Building Code. CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index.
[5] Title II-5.2000 of the ADA Technical Assistance Manual, available at: https://www.ada.gov/taman2.html.

Criteria	I. Access/Safety Standards
	Specific measurements are provided strictly for "*reference only*" for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.
B. Site environment is maintained in a clean and sanitary condition.	**I.B.1) All patient areas including floor/carpet, walls, and furniture are neat, clean, and well maintained.** • The physical appearance of floors/carpets, walls, furniture, patient areas, and restrooms are clean and well maintained. **I.B.2) Restrooms are clean and contain appropriate sanitary supplies.** • Appropriate sanitary supplies, such as toilet tissue, hand washing soap, cloth/paper towels or antiseptic towelettes are made available for restroom use. • Environmental safety includes the "housekeeping" or hygienic condition of the site. • Clean means unsoiled, neat, tidy, and uncluttered. • "Well maintained" means being in good repair or condition.
C. Site environment is safe for all patients, visitors and personnel.	**<u>Ordinances</u>:** • Sites must meet city, county, and state fire safety and prevention ordinances. • Reviewers should be aware of applicable city and county ordinances in the areas in which they conduct reviews. **There is evidence staff has received safety training and/or has safety information available on the following:** **I.C.1) Fire safety and prevention.** **I.C.2) Emergency non-medical procedures (e.g. site evacuation, workplace violence).** **<u>Emergency Action Plans</u>:** • Non-medical emergencies include incidents of fire, natural disaster (e.g. earthquakes), workplace violence, etc. • Specific information for handling fire emergencies and evacuation procedures is available on site to staff. Personnel know ***where to locate*** information on site, and ***how to use*** information.[6]

[6] 29 CFR section 1910.38

Criteria	I. Access/Safety Standards
	I.C.3) Lighting is adequate in all areas to ensure safety. **Illumination:** Lighting is adequate in-patient flow working and walking areas such as corridors, walkways, waiting and exam rooms, and restrooms to allow for a safe path of travel. **I.C.4) (CE) Exit doors and aisles are unobstructed and egress (escape) accessible.** **Access Aisle:** • Accessible pedestrian paths of travel (ramps, corridors, walkways, lobbies, elevators, etc.) between elements (seats, tables, displays, equipment, parking spaces, etc.) provide a clear circulation path. • The minimum clear passage needed for a single wheelchair is 36 inches along an accessible route but may be reduced to a minimum of 32 inches at a doorway. • Means of egress (escape routes) are maintained free of obstructions or impediments to full instant use of the path of travel in case of fire or other type of emergency. • Building escape routes provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied. • Cords (including taped cords) or other items are not placed on or across walkway areas. **I.C.5) Exit doors are clearly marked with "Exit" signs.** **Exits:** Exit doorways are unobstructed and clearly marked by a readily visible "Exit" sign.[7] **I.C.6) Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location at all elevators, stairs and exits.** **Evacuation Routes**: • Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location at all elevators, stairs and exits.[8] **I.C.7) Electrical cords and outlets are in good working condition.** **Electrical Safety:** • Electrical cords are in good working condition with no exposed wires, frayed or cracked areas. Cords are not affixed to structures, placed in or across walkways, extended through walls, floors, and ceiling, or under doors or floor coverings.

[7] 29 CFR 1910.37
[8] 29 CFR 1910.33-39, 19 CCR 3.09 (a) (1) (B).

Criteria	I. Access/Safety Standards
	• Extension cords are not used as a substitute for permanent wiring. • All electrical outlets have an intact wall faceplate. • Sufficient clearance is maintained around lights and heating units to prevent combustible ignition. **I.C.8) Fire Fighting Equipment in accessible location.** **Firefighting equipment:** **There is firefighting equipment that must be in accessible locations on site. At least one of the following types of fire safety equipment is on site:** • **Fire Extinguisher:** The employer shall provide portable fire extinguishers and shall mount, locate, and identify them so that they are readily accessible. Fire extinguishers are maintained in a fully charged and operable condition and kept in their designated places at all times except during use.[9] • Smoke Detector with intact batteries. • Automatic Sprinkler System With a 10-inch clearance between sprinkler heads and stored materials. **I.C.9) An employee alarm system.** **Employee Alarm System:** • Employers must install and maintain an operable employee alarm system that has a distinctive signal to warn employees of fire or other emergencies, unless employees can promptly see or smell a fire or other hazard in time to provide adequate warning to them.[10] OSHA: For those employers with 10 or fewer employees in a workplace, direct voice communication is an acceptable procedure for sounding the alarm provided all employees can hear the alarm. Such workplaces do not need a back-up system. **Note:** Specific measurements are provided strictly for "*reference only"* for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.

[9] 29 CFR 1910.157
[10] 29 CFR 1910.37

Criteria	I. Access/Safety Standards
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week. **RN/NP/CNM/LM/MD/PA**	**I.D. 1) Personnel are trained in procedures/action plan to be carried out in case of medical emergency on site.** **Site Specific Emergency Procedures:** • Staff can describe site-specific actions or procedures for handling medical emergencies until the individual is stable or under care of local emergency medical services (EMS). • There is a written procedure for providing immediate emergent medical care on site until the local EMS is on the scene. Although site proximity to emergency care facilities may be considered when evaluating medical emergency procedures, the key factor is the ability to provide immediate care to patients *on site* until the patient is stable or EMS has taken over care/treatment. • When the physician or non-physician medical practitioner (NPMP) is not on site, staff/MA may call 911, and CPR-certified staff may initiate CPR if needed. • Non-CPR-certified staff may only call 911 and stay with the patient until help arrives. **I.D.2) Emergency equipment is stored together in easily accessible location and is ready to be used.** **Emergency Medical Equipment:** During business hours providers are prepared to provide emergency services for management of emergency medical conditions that occur on site ***until*** the emergent situation is stabilized and/or treatment is initiated by the local 911 Emergency Medical Service (EMS) system. Minimum emergency equipment is available on site to: ○ Establish and maintain a patent/open airway. ○ Manage emergency medical conditions. Emergency equipment and medication, appropriate to patient population served, are available in an accessible location and ready for use. • An accessible location is one that is reachable by personnel standing on the floor, or other permanent working area, without locating/retrieving step stool, ladder or other assistive devices. • For emergency “Crash” cart/kit, contents are appropriately sealed and are within the expiration dates posted on label/seal. • Site personnel are appropriately trained and can demonstrate knowledge and correct use of all medical equipment they are expected to operate within their scope of work. https://www.aafp.org/afp/2007/0601/p1679.html

Criteria	I. Access/Safety Standards
	I.D. 3) Emergency phone number contacts are posted, updated annually and as changes occur. **Emergency Phone Number list:** Posted in an accessible and prominent location(s) and includes: ○ Local emergency response services (e.g., fire, police/sheriff, ambulance). ○ Emergency contacts (e.g., responsible managers, supervisors). ○ Appropriate State, County, City, and local agencies (e.g., local poison control number). The list should be dated, and telephone numbers updated annually and as changes occur. **Emergency medical equipment appropriate to practice/patient population is available on site:** **I.D. 4) (CE) Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag:** Without the ability to adequately maintain the patient's airway, all other interventions are futile. Minimum airway control equipment with various sizes of airway devices appropriate to patient population within the practice and examples of oxygen delivery systems include: ○ Wall oxygen delivery system ○ Portable oxygen tank ○ Portable oxygen concentrator (POC) All oxygen delivery systems must be able to be regulated up to 6 liters of oxygen per minute, maintained for a minimum of 15 minutes. This flow rate establishes a minimum total oxygen delivery capacity of 90 liters for these devices:[11] ○ Nasal cannula or mask ○ Bulb syringe ○ Ambu bag as appropriate to patient population served. Mask should be replaced when they no longer make a solid seal.

[11] See the Food and Drug Administration (FDA) guidelines for oxygen generators and oxygen equipment for emergency use, available at: https://www.fda.gov/regulatory-information/search-fda-guidance-documents/review-guidelines-oxygen-generators-and-oxygen-equipment-emergency-use

	○ Portable oxygen tanks are maintained at least ¾ full. There is a method/system in place for oxygen tank replacement. If oxygen tanks are less than ¾ full at time of site visit, site has a back-up method for supplying oxygen if needed ***and*** a scheduled plan for tank replacement. ○ Oxygen tubing does not need be connected to oxygen tank, but must be kept in close proximity to tank. Oropharyngeal airways are no longer required. **I.D.5) (CE) Emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia:** Severe allergic reaction can cause urticaria (hives), hypotension, bronchospasm, wheezing, and pulmonary edema. Per the American Academy of Family Practice (AAFP), the minimum equipment to manage emergency anaphylactic reaction, asthma exacerbation, chest pain, opioid overdose, and hypoglycemia, based on the patient population served, shall include: ○ Epinephrine 1mg/mL (injectable) ○ Diphenhydramine 25 mg (oral) or 50 mg/ml (injectable) ○ Naloxone[12] ○ Chewable aspirin 81 mg[13] ○ Nitroglycerin spray/tablet[14] ○ Bronchodilator medication (solution for nebulizer or metered dose inhaler) ○ Glucose (any type of glucose containing at least 15 grams) ○ Appropriate sizes of ESIP needles/syringes[15] and alcohol wipes • The typical adult strength to address cardiac emergencies is 325 mg (four doses of 81 mg chewable aspirin or one dose of 325 non-enteric coated aspirin). • If the site is seeing adults, the reviewer shall assess whether the appropriate number of chewable aspirin tablets of 81 mg is available (at least four tablets). **I.D.6) Medication dosage chart for all medications included with emergency equipment (or other method for determining dosage) is kept with emergency medications.** • There is a current medication administration reference (e.g. medication dosage chart) available for readily identifying the correct medication dosages (e.g. adult, pediatric, infant, etc.). • Package inserts are not acceptable as dosage charts. • All emergency medications in the emergency kit/ crash cart must have dosage charts. Score should be either a **Yes or No only** **There is a process in place on site to:**

[12] In 2018, the U.S. Surgeon General issued an advisory emphasizing the importance of health care professionals having naloxone (an opioid antagonist) on hand and being trained in how to use it. The U.S. Surgeon General's advisory is available at: https://www.hhs.gov/surgeongeneral/priorities/opioids-and-addiction/naloxone-advisory/index.html. Also see the FDA's approval of Narcan to reverse opioid overdose: https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/narcan-naloxone-nasal-spray-approved-reverse-opioid-overdose, and articles regarding overdose preparedness for ambulatory clinics, available at: https://www.aafp.org/fpm/2021/0100/p17.html and https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5753997/.

[13] See the American Heart Association's article on Aspirin and Heart Disease, available at: https://www.heart.org/en/health-topics/heart-attack/treatment-of-a-heart-attack/aspirin-and-heart-disease.

[14] Pediatric offices only serving patients under 18 years old are not required to keep Nitroglycerin in their emergency kit. According to the FDA, "The safety and effectiveness of nitroglycerin in pediatric patients (under 18 years old) have not been established." Also see page 8 of an article on Nitrostat, available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2014/021134s007lbl.pdf.

[15] If the emergency kit or "crash cart" has only non-safety needles/syringes, score that deficiency in Section VI., Infection Control, criteria B.2. See Infection Control Standards.

Criteria	I. Access/Safety Standards
	I.D.7) Document checking of emergency equipment/supplies for expiration and operating status at least monthly. Documented evidence that emergency medication and equipment is checked at least monthly may include a log, checklist or other appropriate method(s). **I.D.8) Replace/re-stock emergency medication, equipment, and supplies immediately after use.** A receipt or documentation showing medication is ordered is acceptable for any medication shortage. **Note:** An "emergency medical condition" is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: 1) placing the health of the individual (or unborn child of a pregnant woman) in serious jeopardy 2) serious impairment to bodily functions 3) serious dysfunction of any bodily organ or part "Emergency services" means those services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death.
E. Medical and lab equipment used for patient care is properly maintained. **RN/NP/CNM/LM/MD/PA**	**I.E.1) Medical equipment is clean.** **Medical and Laboratory Equipment:** All equipment used to measure or assess patient health status/condition is clean. **I.E.2) Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines.** **Documentation:** • There is documented evidence that standard operating procedures have been followed for routine inspection/maintenance, calibration, repair of failure or malfunction, and testing and cleaning of all specialized equipment. • Appropriate written records include calibration or other written logs, work orders, service receipts, dated inspection sticker, etc.

Criteria	I. Access/Safety Standards
	• All equipment used to measure or assess patient health status/condition is functioning properly. All specialized equipment (e.g., ultrasonography equipment, electrocardiogram (EKG) machine, defibrillator, audiometer, hemoglobin meter, glucometer, scales, etc.) are adequately maintained according to the specified manufacturer's guidelines for the equipment or is serviced annually by a qualified technician. • Blood pressure cuffs, monitors, and other related equipment need not be calibrated unless required by the manufacturer. Manufacturer guidelines must be available on site, indicating that it is not necessary to calibrate the equipment. **Note:** The term monitor includes, but not limited to, glucometers, EKG, BP monitors, hemocues, and audiometers.

Criteria	II. Personnel Standards		
A.1. Professional health care personnel have current California licenses and certifications.	**Medical Professional**	**License/Certification**	**Issuing Agency**
	Certified Nurse Midwife (CNM)	RN License & Nurse-Midwife Certificate. Drug Enforcement Agency (DEA) Registration, *if appropriate*	CA Board of Registered Nursing DEA
	Certified Radiological Technologist (CRT)	CRT Certificate.	California Department of Public Health (CDPH), Radiologic Health Branch
	Doctor of Osteopathy (DO)	Physician's & Surgeon's Certificate DEA Registration	Osteopathic Medical Board of CA DEA
	Licensed Midwife (LM)	Licensed Midwife Certificate. Drug Enforcement Agency (DEA) Registration, *if appropriate*	Medical Board of CA DEA
	Licensed Vocational Nurse (LVN):	LVN License	CA Board of Vocational Nursing and Psychiatric Technicians
	Nurse Practitioner (NP)	RN License w/NP Certification & Furnishing Number DEA Registration, *if appropriate*	CA Board of Registered Nursing DEA
	Pharmacist (Pharm. D)	Pharmacist License	CA State Board of Pharmacy
	Physician/Surgeon (MD)	Physician's & Surgeon's Certificate DEA Registration	Medical Board of CA DEA
	Physicians' Assistant/ Associate (PA)	PA License DEA Registration, *if appropriate*	Physician Assistant Examining Committee/Medical Board of CA DEA
	Radiological Technician	Limited Permit	CDPH, Radiologic Health Branch

<table>
<tr><th>Criteria</th><th colspan="3">II. Personnel Standards</th></tr>
<tr><td></td><td>Registered Dietitian (RD)</td><td>RD Registration Card</td><td>Commission on Dietetic Registration</td></tr>
<tr><td></td><td>Registered Nurse (RN)</td><td>RN License</td><td>CA Board of Registered Nursing</td></tr>
<tr><td></td><td colspan="3">II.A.1) All required Professional Licenses and Certifications, issued from the appropriate licensing/certification agency, are current.
<u>Note</u>: All medical professional licenses and certifications must be current and issued from the appropriate agency for practice in California, and available on site. Although sites with centralized personnel departments are not required to keep documents or copies on site, copies and/or lists of currently certified or credentialed personnel must be readily available when requested by reviewers.</td></tr>
<tr><td rowspan="2">A.2. All required professional licenses and certifications, issued from the appropriate licensing/certification agency, are current.</td><td colspan="2"><u>Note</u>:
Effective June 27, 2010, MDs (does not apply to Osteopaths) shall provide notification to each patient that states the MD(s) on site is licensed and regulated by the Board, and includes the following:[16]

NOTICE
Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov.</td><td><u>Note</u>:
Effective August 11, 2011, PAs shall provide notification to each patient that states the PA(s) is licensed and regulated by the Physician Assistant Board , and includes the following:[17]

NOTIFICATION TO CONSUMERS
Physician Assistants are licensed and regulated by the Physician Assistant Board
(916) 561-8780
www.pab.ca.gov</td></tr>
<tr><td colspan="3">II.A.2) Notification is provided to each member that the MD(s) is licensed and regulated by the Medical Board, and that the Physician Assistant(s) is licensed and regulated by the Physician Assistant Board.

The notice to consumers above shall be provided by one of the following methods:</td></tr>
</table>

[16] 16 CCR 1355.4, as mandated by Business and Professions Code (BPC) section 138.
[17] 16 CCR 1399.547, as mandated by BPC section 138.

Criteria	II. Personnel Standards
	○ Prominently posted sign in an area visible to patients in at least 48-pt Arial font. ○ A written statement signed and dated by the patient (or patient's representative) and kept in the medical record, stating the patient understands that the MD is licensed and licensed and regulated by the board (for PA's, that the PA is licensed and regulated by the PA Board). ○ A statement on letterhead, discharge instructions or other document given to the patient (or patient's representative), where the notification is placed immediately above the signature line for the patient in at least 14-pt font.
B. Health care personnel are properly identified.	**II.B.1) Health care personnel wear identification badges/tags printed with name and title.** • Health care personnel shall disclose, while working, their name and title on a name tag at least 18-point type. • It is acceptable for health care personnel in a practice or an office, whose license is prominently displayed, to opt not to wear a nametag. **Note:** • In the interest of public safety and consumer awareness, it shall be unlawful for any person to use the title "nurse" in reference themselves, in any capacity, except for an individual who is a registered nurse, or a licensed vocational nurse. • "Health care practitioner" means any person who engages in acts that are the subject of licensure or regulation under Business and Professions Code (Sections 680-681). If a health care practitioner or licensed clinical social worker is working in a psychiatric setting or in a setting that is not licensed by the state, the employing entity or agency shall have the discretion to make an exception from the nametag requirement for the individual safety or therapeutic concerns.
C. Site personnel are qualified and trained for assigned responsibilities. **RN/NP/CNM/LM/MD/PA**	**Unlicensed Personnel:** Medical assistants (MAs) are unlicensed health personnel, at least 18 years of age, who perform basic administrative, clerical, and non-invasive routine technical supportive services under the supervision of a licensed physician, surgeon, or podiatrist in a medical office or clinic setting. • "Supervision" means the licensed physician must be physically present in the treatment facility during the performance of authorized procedures by the MA.

Criteria	II. Personnel Standards
	• Per Business and Professions Code Section 2069 (a) (1), a supervising physician and surgeon at a "community clinic" licensed under Health and Safety Code section 1204(a) may, at their discretion, in consultation with the nurse practitioner, nurse midwife, or physician assistant provide written instructions to be followed by a medical assistant in the performance of tasks or supportive services. • The written instructions may provide that the supervisory function for the medical assistant in performing these tasks or supportive services may be delegated to the nurse practitioner, nurse midwife, or physician assistant and that those tasks may be performed when the supervising physician and surgeon is not on site. **II.C.1) Documentation of education/training for non-licensed medical personnel is maintained on site.** • Training may be administered under a licensed physician; or under an RN, LVN, PA, or other qualified medical assistant acting under the direction of a licensed physician. The supervising physician is responsible for determining the training content and ascertaining proficiency of the MA. Training documentation maintained on site for the MA must include the following: • Diploma or certification from an accredited training program/school, or • Letter/statement from the current supervising physician that certifies in writing: date, location, content, and duration of training, demonstrated proficiency to perform current assigned scope of work, and signature. **II.C.2) (CE) Only qualified/trained personnel retrieve, prepare or administer medications.** Medication administration by an MA means the direct application of pre-measured medication orally, sublingually, topically, vaginally or rectally; or by providing a single dose to a patient for immediate self-administration by inhalation or by simple injection. • **All medications including vaccines must be verified with (shown to) a licensed person prior to administration.** • Unlicensed staff (e.g. MAs) have evidence of appropriate training and supervision in all medication administration methods performed within their scope of work. • To administer medications by subcutaneous or intramuscular injection, or to perform intradermal skin tests or venipunctures for withdrawing blood, an MA must have completed at least the minimum number of training-hours established in CCR, Title 16, Section 1366.1.

Criteria	II. Personnel Standards
	Note: • **MAs cannot administer anesthetics, including local anesthetic agents (such as Rocephin hydrated with Xylocaine).** [18] • MAs may not place an intravenous needle, start or disconnect the intravenous infusion tube, administer medications or injections into an intravenous line, or administer anesthesia. • The supervising physician must specifically authorize all medications administered by an MA. "Authorization" means a specific written or standing order prepared by the supervising physician. **II.C.3) Site has a procedure in place for confirming correct patient, correct medication/vaccine, correct dosage, and correct route prior to administration.** • To help reduce the risk of medication errors, staff shall follow procedures for confirming the correct patient, correct medication/vaccine, correct dosage, and correct route prior to administration. **II.C.4) Only qualified/trained personnel operate medical equipment.** **Medical Equipment:** • Provider and/or staff can demonstrate appropriate operation of medical equipment used in their scope of work. Not all staff is required to be proficient in use of all equipment but at any given time, a staff must be prepared to operate equipment that is not routinely needed by every patient such as patient lifts and accessible scales. Health care personnel at the site must demonstrate that they can turn on the oxygen tank and tell when an oxygen tank needs to be replaced and/or refilled. **Note:** • Personnel on site must be qualified for their responsibilities and adequately trained for their scope of work. • Site staff should have a general understanding of the systems/processes in place, appropriate supervision, and knowledge of the available sources of information on site.

[18] 16 CCR 1366.3(a) (1), also see information from the Medical Board of California on Medical Assistants, available at: https://www.mbc.ca.gov/Licensing/Physicians-and-Surgeons/Practice-Information/Medical-Assistants.aspx. https://www.mbc.ca.gov/FAQs/?cat=Licensees&topic=Medical%20Assistants

Criteria	II. Personnel Standards
	• Family members and personal care assistants, whether paid or unpaid, are not "unlicensed personnel" or otherwise captured within the scope of this tool.
D. Scope of practice for non-physician medical practitioners (NPMP) is clearly defined. 🗣 🗁 **RN/NP/CNM/LM/MD/PA**	**II.D.1) Standardized Procedures provided for NPs and/or CNMs.** • The scope of practice for NPs and CNMs is clearly defined including the delegation of the supervision of MAs when supervising physician is off premises. • Documents may be utilized to determine and/or clarify practice procedures and supervisory processes on site. • Reviewers are expected to verify that NP and/or CNM standardized procedures, and PA Practice Agreement and Supervision Physician's Responsibility documentation are present on site. • Reviewers are ***not*** expected to make in-depth evaluation of "appropriateness" of the NPMP's scope of practice. **NPs:** • NPs are prepared through education and experience to provide primary care and to perform advanced procedures. • The extent of required supervision must be specified in the Standardized Procedures. • Standardized procedures legally define the expanded scope of nursing practice that overlaps the practice of medicine. • Standardized Procedures should identify the furnishing of drugs or devices, extent of physician or surgeon supervision, method of periodic review of competence, including peer review, and review of provisions in the Standardized Procedures. **CNM:** • The certificate to practice nurse-midwifery authorizes the holder, under supervision of a licensed physician or surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family planning care for the mother, and immediate care for the newborn. • The supervising and back-up physician or surgeon for the CNM must be credentialed to perform obstetrical care in the same delivering facility in which the CNM has delivery privileges.

Criteria	II. Personnel Standards
	Note: CNMs and NPs operate under written Standardized Procedures that are collaboratively developed and approved by the supervising physician, the NP and administration within the organized health care facility/system in which standardized procedures will be used. **II.D.2) A Practice Agreement defines the scope of services provided by PAs and Supervisory Guidelines define the method of supervision by the Supervising Physician.** **PA:** • Practice Agreement: a) Defines specific procedures identified in practice protocols or specifically authorized by the supervising physician, and must be dated and signed by physician and PA. b) The delegation of the supervision of MAs when supervising physician is off premises. c) An original or copy must be readily accessible at all practice sites in which the PA works. d) Failure to maintain a Practice Agreement is a violation of the PA Regulations and is grounds for disciplinary action by the Medical Board of California against a physician assistant's licensure. • Supervising Physician's Responsibility for Supervision of PAs' Practice Agreement: Defines supervision responsibilities and methods required by Title 16, section 1399.545 of the Physician Assistant Regulations, and is signed by the physician. The following procedures must be identified: ○ Emergency transport of patients and back-up procedures (e.g., can call 911, name of hospital to transport patient included in Practice Agreement) for when the supervising physician is not on the premises. **Note:** • A Delegation of Services Agreement (DSA) in effect prior to January 1, 2020, shall be updated to meet the current requirements.[19] • DSAs that still reflect components that are no longer required by BPC section 3502.3 should be enforced since the DSA is the currently established agreement between the PA and the supervising physician. • The reviewer should assess the site's process for compliance with the DSA.

[19] BPC 3502.3

Criteria	II. Personnel Standards
	• Any deficiency shall result in a CAP requesting the site to adhere to the DSA components or establish a new Practice Agreement. **II.D.3) Standardized Procedures, Practice Agreements, and Supervisory Guidelines are revised, updated, and signed by the supervising physician and NPMP when changes in scope of services occur.** • Standardized Procedures, Practice Agreements shall undergo periodic review, with signed, dated revisions completed at each change in scope of work by supervising physician. • Frequency of the review to identify changes in scope of service shall be specified in writing. **II.D.4) Each NPMP that prescribes controlled substances has a valid DEA Registration Number.** **DEA:** Each NP, CNM, and PA that prescribes controlled substances is required to have a valid DEA Registration Number.

E. Non-physician medical practitioners (NPMP) are supervised according to established standards.
RN/NP/CNM/LM/MD/PA
	The designated supervising physician(s) on site:
	
	II.E.1) Ratio to number of NPMPs does not exceed established ratios in any combination.
	NPMPs:
	• The supervising physician holds ultimate responsibility for the practice of each supervised NPMP.
	• The maximum number of NPMPs who may be supervised by a single primary care physician (PCP) is limited to the following at any given time/shift in any of their locations:[20]
	  ○ 4 NPs with furnishing license (there is no limit to the number of NPs the physician may supervise if the NP does not hold a furnishing license);
	  ○ 4 CNMs; and
	  ○ 4 PAs.

[20] BPC 3516(b), Welfare and Institutions Code (WIC) section 14132.966

Criteria	II. Personnel Standards
	This ratio is based on each physician, not the number of offices. A PCP, an organized outpatient clinic, or a hospital outpatient department cannot utilize more NPMPs than can be supervised within these stated limits. Physician Assistant Board (PAB) is at https://www.pab.ca.gov/ or the PAB office at 916-561-8780. **II.E.2) The designated supervising or back-up physician is available in person or by electronic communication at all times when a NPMP is caring for patients.** **Supervising Physician**: • "Supervision" means that a licensed physician and surgeon oversee the activities of, and accept responsibility for, the medical services rendered by a PA. • Supervising or back-up physician is available in person or by electronic communication at all times when a NPMP is caring for patients. **II.E.3) Evidence of NPMP supervision.** **Evidence of NPMP Supervision:** • Standardized Procedures for NP or CNM should identify the furnishing of drugs or devices, extent of physician or surgeon supervision, method of periodic review of competence, including peer review, and review of provisions in the Standardized Procedures.[21] • Standardized Procedures shall undergo periodic review, with signed, dated revisions completed at each change in scope of work. • Evidence of supervision of NPMP(s) are verifiable through on-site observation of supervisory processes, documentation, or supervisor/NPMP's knowledge of the process.
F. Site personnel receive safety training. 🗁 **RN/NP/CNM/LM/MD/PA**	**II.F. There is evidence that site staff has received training on the following:** **1) Infection Control/Universal Precautions (annually)** **2) Bloodborne Pathogens Exposure Prevention (annually)** **3) Biohazardous Waste Handling (annually)** Training occurs ***prior to*** initial exposure to potentially infectious and/or biohazardous materials. Review and re-training sessions occur ***at least annually***. Training content is appropriate (language, educational level, etc.) to personnel on site.

[21] BPC 2834

Criteria	II. Personnel Standards
	Training *minimally* includes the following: o Universal/standard precautions o Use of personal protective equipment o Accessible copy of Bloodborne Pathogens Standard o Work practice controls/exposure prevention o Modes of transmitting bloodborne pathogens o Epidemiology/symptoms of HBV and HIV o Recognition of activities with exposure element o Handling and labeling of biohazardous waste(s) o Hepatitis B vaccination protocol and requirements o Explanation of emergency procedures o Post exposure reporting/evaluation/follow-up procedures o Decontamination of equipment/work areas o Site's written bloodborne pathogen exposure plan o Opportunity for discussion/questions Personnel must know ***where to locate*** information/resources on site about infection control, the Bloodborne Pathogens Exposure Plan, and ***how to use*** the information. Evidence of training must be verifiable. Evidence of training may include: o Informal in-services o New staff orientation o External training courses o Educational curriculum o Participation lists, etc. Training documentation must contain: 1) Employee's name 2) Job titles 3) Training date(s) 4) Type of training 5) Contents of training session 6) Names/qualifications of trainers Records must be kept for three (3) years.

Criteria	II. Personnel Standards
	Note: Site personnel treat all blood and other potentially infectious materials (OPIM) as if these *are* infectious. Site personnel who are reasonably anticipated to have eye, skin, mucous membranes and potential exposure to blood and/or OPIM receive training as required by the Bloodborne Pathogens Standard.[22]
G. Site personnel receive training on member rights. **RN/NP/CNM/LM/MD/PA**	**II.G. There is evidence that site staff has received information and/or training on the following:** **II.G.1) Patient Confidentiality** • Site personnel have received information and/or training about patient confidentiality and must be prepared to provide information on how patient confidentiality is protected at the site. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written patient confidentiality information on site and explain how to use information. **II.G.2) Informed Consent, including Human Sterilization** • Site personnel have received information and/or training on informed consent, including human sterilization. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written informed consent, including human sterilization information on site and explain how to use information. **II.G.3) Prior Authorization Requests** • Site personnel have received information and/or training on prior authorization requests.

[22] 8 CCR 5193

Criteria	II. Personnel Standards
	• Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written prior authorization requests information on site and explain how to use information. **II.G.4) II.F.4) Grievance/Complaint Procedure** • Site personnel have received information and/or training on grievance/complaint procedure. Staff must be prepared to provide information to patient when requested. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written grievance/complaint procedures information on site and explain how to use information. **II.G.5) Child/Elder/Domestic Violence Abuse Reporting**: Site personnel have specific knowledge of local reporting requirements, agencies, and procedures, and know *where to locat*e information on site and *how to use* information. **Note:** • Health practitioners (e.g., physicians, surgeons, licensed nurses, licensed social workers, paramedics) in a health facility, (e.g., clinic, physician's office, public health clinic) are legally mandated reporters of known or reasonably suspected cases of child abuse, elder abuse and domestic violence. • Legally mandated reporters must make telephone and written reports according to timeliness standards established by the designated local law enforcement agencies in each county. "Reasonably suspected" means having objectively reasonable suspicion based upon facts that could cause a reasonable person in a like position, drawing when appropriate on his or her training and experience, to suspect abuse (CA Penal Code 11164). • Failure to report by legally mandated reporters can result in criminal or civil prosecutions, punishable by monetary fines and/or county jail confinement.

Criteria	II. Personnel Standards
	Any person entering employment, which makes him/her a mandated reporter, must sign a statement, provided and retained by the employer, that the employee has knowledge of the Child Abuse reporting law and will comply with its provision.[23] **II.G.6) Sensitive Services/Minors' Rights** • Site personnel have received information and/or training on sensitive services/minors' rights. Sensitive Services include family planning, pregnancy, sexually transmitted infections, etc. • PCP sites must have basic information on sensitive services that are appropriate to their practice office and be prepared to provide information to patients when needed. • Minor's Rights: California Family Code provides that a minor may, without parental consent, receive a number of sensitive services including outpatient mental health treatment and counseling for children 12 years and older. **II.G.7) Health Plan Referral Process/Procedures/Resources** • Site personnel have received information and/or training on health plan referral process/procedures/resources. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written health plan referral process/procedures/resources information on site and explain how to use information. **II.G.8) Cultural and Linguistic Training** • Site personnel have received information and/or training on cultural and linguistic appropriate services. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written cultural and linguistic information on site and explain how to use information. Cultural and Linguistic

[23] Penal Code section 11166.5

Criteria	II. Personnel Standards
	Training- Culturally and Linguistically Appropriate Services (CLAS) mandates are Federal requirements for all recipients of Federal funds.[24] **II.G.9) Disability Rights and Provider Obligations** • Site personnel have received information and/or training on patient rights and provider obligations under the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and/or Section 1557 of the Affordable Care Act • Training content should include information about physical access, reasonable accommodations, policy modifications, and effective communication in healthcare settings. **https://www.hhs.gov/sites/default/files/ocr/civilrights/resources/factsheets/504.pdf** **https://www.hhs.gov/sites/default/files/section-1557-final-rule-faqs.pdf** **https://www.hhs.gov/sites/default/files/1557-fs-lep-508.pdf**

[24] See the National Standards on CLAS, available at: https://www.health.pa.gov/topics/Documents/Health%20Equity/CLAS%20Standards%20FactSheet.pdf.

Criteria	III. Office Management Standards
A. Physician coverage is available 24 hours a day, 7 days a week.	**III.A.1) Clinic office hours are posted or readily available upon request.** Current clinic office hours are posted within the office or readily available upon request. **III.A.2) Provider office hour schedules are available to staff.** **III.A.3) Arrangement/schedule for after-hours, on-call, supervisory back-up physician coverage is available to site staff and members after-hours.** Current site-specific resource information is available to site personnel and members about physician office hour schedule(s), local and/or Plan-specific systems for after-hours urgent care, emergent physician coverage available 24 hours a day, 7 days per week, and system for providing follow-up care. **III.A.4) Contact information for off-site physician(s) is available at all times during office hours.** When a physician is not on site during regular office hours, personnel are able to contact the physician (or covering physician) at all times by telephone, cell phone, pager, etc. **III.A.5) Routine, urgent and after-hours emergency care instructions/telephone information is made available to patients.** **Note:** One objective of effective clinic office management is to support the provision of appropriate, coordinated health care services. The review of clinic office management is to evaluate if effective systems are in place and whether site personnel appropriately follow established site-specific procedures.
B. There are sufficient health care personnel to provide timely, appropriate health Care services. **RN/NP/CNM/LM/MD/PA**	**III.B.1) Appropriate personnel handle emergent, urgent, and medical advice telephone calls.** • In addition to the physician, only appropriately licensed medical personnel such as a CNM, LM, NP, RN, or PA handles emergency, urgent, and medical advice/triage telephone calls.

Criteria	III. Office Management Standards
	• The California Board of Vocational Nursing and Psychiatric Technician Examiners has determined that the Licensed Vocational Nurse Practice Act does not permit the LVN to perform triage independently.[25] • The LVN may perform that part of the triage process that includes observation and data collection relative to basic physical assessment. • The LVN may not perform that part of the triage process that includes independent evaluation, interpretation of data, and determination of treatment priorities and levels of care. • Unlicensed personnel, such as medical assistants, may provide patient information or instructions only as authorized by the physician.[26] **Note:** Telephone triage is the system for managing telephone calls during ***and*** after office hours. **III.B.2) Telephone answering machine, voice mail system, or answering service is used whenever office staff does not directly answer phone calls.** • Telephone answering machine, voice mail system, or answering service is used whenever office staff does not directly answer phone calls. **III.B.3) Telephone system, answering service, recorded telephone information, and recording device are periodically checked and updated.** • Telephone system, answering service, recorded telephone information, and recording device are periodically checked and updated.
C. Health care services are readily available. **RN/NP/CNM/LM/MD/PA**	**III.C.1) Appointments are scheduled according to patients stated clinical needs within the timeliness standards established for Plan members.** **Note:** Medi-Cal Managed Care Health Plans *require* the following timeliness standards for access to appointments: ○ Urgent Care: 48 hours ○ Access to the first Prenatal Visit: 10 business days ○ Non-urgent (Routine) Care: 10 business days

[26] 16 CCR 1366(b)

Criteria	III. Office Management Standards
	III.C.2) Patients are notified of scheduled routine and/or preventive screening appointments. • The process established on site provides timely access to appointments for routine care, urgent care, prenatal care, pediatric periodic health assessments/immunizations, adult initial health assessments, specialty care, and emergency care. • Systems, practices, and procedures used for making services readily available to patients will vary from site to site. **III.C.3) There is a process in place verifying follow-up on missed and canceled appointments.** • An organized system must be evident (in use) for scheduling appointments appropriately, notifying, and reminding members of scheduled appointments, and following up on missed or canceled appointments. • Missed and/or canceled appointments and contact attempts must be documented in the patient's medical record.
D. There is 24-hour access to interpreter services for non- or limited-English proficient (LEP) members.	**III.D.1) Interpreter services are made available in identified threshold languages specified for location of site.** • Sites must provide 24-hour interpreter services for all members either through telephone language services or interpreters on site. **III.D.2) Persons providing language interpreter services, including sign language on site, are trained in medical interpretation.** • Site personnel used as interpreters have been assessed for their medical interpretation performance skills/capabilities. • Reviewer should ask for a written policy which includes the languages spoken by bilingual providers and staff. **Note:** https://www.lep.gov; 22 CCR 51309.5 • If bilingual staff are asked to interpret or translate, they should be qualified to do so. Assessment of ability, training on interpreter ethics and standards, and clear policies that delineate appropriate use of bilingual staff, staff or contract interpreters and translators, will help ensure quality and effective use of resources.

Criteria	III. Office Management Standards
	• Those utilizing the services of interpreters and translators should request information about certification, assessments taken, qualifications, experience, and training. Quality of interpretation should be a focus of concern for all recipients. • Family or friends should not be used as interpreters, unless specifically requested by the member's circumstances. Minors, under 18 years old, accompanying members shall not be used as interpreters. • The Affordable Care Act of 2010, Section 1557: prohibits from using low-quality video remote interpreting services or relying on unqualified staff, translators when providing language assistance services. • A request for or refusal of language/interpreter services must be documented in the member's medical record. Sign language interpreter services may be utilized for medically necessary health care services and related services such as: ○ Obtaining medical history and health assessments ○ Obtaining informed consents and permission for treatments ○ Medical procedures ○ Providing instructions regarding medications ○ Explaining diagnoses ○ Treatment and prognoses of an illness ○ Providing mental health assessment ○ Therapy or counseling
E. Procedures for timely referral/ consultative services are established on site. 💬 🗁 **RN/NP/CNM/LM/MD/PA**	**Office practice procedures allow timely provision and tracking of:** **III.E.1)Processing internal and external referrals, consultant reports, and diagnostic test results.** • An organized, timely referral system is evident for making and tracking referrals, reviewing reports, providing/scheduling follow-up care and filing reports in medical records. • Referral informational resources are readily available for use by site personnel. • Site staff can demonstrate (e.g., "walk through") the office referral process from beginning to end Systems, practices, and procedures used for handling referrals will vary from site-to-site.

Criteria	III. Office Management Standards
	III.E.2 (CE) Physician Review and follow-up of referral/consultation reports and diagnostic test results. • There is a documented process of the practitioner review of diagnostic tests/consultations and subsequent outreach to follow-up with the patient to communicate results and provide next steps. • Practitioner review is evidenced by date and signature/initials on the report of the reviewing practitioner.
F. Member grievance/ complaint processes are established on site.	**III.F.1) Phone number(s) for filing grievances/complaints are located on site.** • At least one telephone number for filing grievances is posted on site or is readily available upon request. **III.F.2) Complaint forms and a copy of the grievance procedure are available on site.** • Complaint forms and a copy of the grievance procedure are readily available on site and can be provided to members promptly upon request. • Includes The Department of Managed Health Care Help Center 1-888-466-2219 and Ombudsman 1-888-452-8609. **Note:** A "grievance" is defined as any written or oral expression of dissatisfaction and shall include any complaint, dispute, and request for reconsideration or appeal made by an enrollee or their representative to a Plan or entity with delegated authority to resolve grievances on behalf of the Plan.
G. Medical records are available for the practitioner at each scheduled patient encounter.	**III.G.1) Medical records are readily retrievable for scheduled patient encounters.** • The process/system established on site provides for the availability of medical records (paper and electronic), including outpatient, inpatient, referral services, and significant telephone consultations for patient encounters.

Criteria	III. Office Management Standards
	III.G.2) Medical documents are filed in a timely manner to ensure availability for patient encounters. • Medical records are filed in a timely manner that allows for ease of accessibility within the facility or in an appropriate health record storage facility if stored off-premises.[27]
H. Confidentiality of personal medical information is protected according to State and federal guidelines. **RN/NP/CNM/LM/MD/PA**	**III.H.1) Exam rooms and dressing areas safeguard patients' right to privacy.** **Privacy:** • Patients have the right to privacy for dressing/undressing, physical examination, and medical consultation. • Practices are in place to safeguard patient privacy. • Because dressing areas and examination room configurations vary greatly, reviewers will make site-specific determinations. **III.H.2) Procedures are followed to maintain the confidentiality of personal patient information.** **Confidentiality:** • Personnel follows site policy/procedures for maintaining confidentiality of individual patient information. • Individual patient conditions or information is not discussed in front of other patients or visitors, displayed or left unattended in reception and/or patient flow areas (this includes unattended electronic devices, patient registration sign-in sheets with more than one unique patient identifier). • There must be a confidentiality agreement between the provider and the cleaning service agency/persons if the medical records are kept in an open space and/or are unsecured. **Electronic Records:** • Electronic record-keeping system procedures have been established to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures, and maintain upkeep of computer systems.

[27] 22 CCR 75055

Criteria	III. Office Management Standards
	• Security protection includes an off-site backup storage system, an image mechanism with the ability to copy documents, a mechanism to ensure that recorded input is unalterable, and file recovery procedures. • Confidentiality protection may also include use of encryption, detailed user access controls, transaction logs, and blinded files. **III.H. 3) Medical record release procedures are compliant with State and federal guidelines.** **Record Release:** • Medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released. • The release terms, such as to whom records are released and for what purposes, and the expiration date of the consent to medical record release should also be described. • This does not prevent release of statistical or summary data, or exchange of individual identifiable medical information between individuals or institutions providing care, fiscal intermediaries, research entities and State or local official agencies.[28] **III.H.4) Storage and transmittal of medical records preserves confidentiality and security.** **Storage and transmittal:** • Health care services rendered under the Medi-Cal program or any other health care program administered by the department or its agents or contractors, shall confidentially and securely keep and maintain records of each service rendered under the Medi-Cal program or any other health care program administered by the department or its agents or contractors, the beneficiary or person to whom rendered, the date the service was rendered, and any additional information as the department may by regulation require. • FAX cover sheet shall have confidentiality statement. **III.H.5) Medical records are retained for a minimum of 10 years.** **Record Retention:** • Records required to be kept and maintained under this section (including minors under 18 years old) shall be retained by the provider for a period of 10 years from the final date of the contract

[28] 45 CFR 164.524

Criteria	III. Office Management Standards
	period between the plan and the provider, from the date of completion of any audit, or from the date the service was rendered, whichever is later, in accordance with 42 CFR 438.3(u).[29]

[29] WIC 14124.1

Criteria	IV. Clinical Services - Pharmaceutical Standards
A. Drugs and medication supplies are maintained secured to prevent unauthorized access.	**Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, disposition, etc.) must be addressed in a corrective action plan. **IV.A.1) Drugs are stored in specifically designated cupboards, cabinets, closets or drawers.** **Security**: • All drugs for dispensing are stored in an area that is secured at all times.[30] The Medical Board defines "area that is secure" to mean a locked storage area within a physician's office. • Keys to locked storage area are available only to staff authorized by the physician to have access.[31] • The Medical Board of California interprets "all drugs" to also include both sample and over-the-counter drugs.[32] **IV.A.2) Drugs, drug samples, and over-the-counter drugs, hypodermic needles/syringes, all medical sharp instruments, hazardous substances and prescription pads are securely stored in a lockable space (cabinet or room) within the office/clinic.** • All drugs (including sample and over the counter), medication supplies, hazardous substances and prescription pads are securely stored in a lockable space (room, closet, cabinet, drawer) within the office/clinic.[33] (CA B&P Code, 4051.3) • A secure area means that drugs and biologicals are stored in a manner to prevent unmonitored access by unauthorized individuals. Drugs and biologicals must not be stored in areas that are readily accessible to unauthorized persons. (42 CFR 482.13-CMS Manual System; 42 CFR Part 482.25) • Keys to the locked storage area are available only to staff authorized by the physician to have access.[34] (16 CCR, Chapter 2, Division 3, Section 1356.32) • During business hours, the lockable space may remain unlocked ONLY if there is no access to

[30] BPC 4172
[31] 16 CCR 1356.3
[32] 22 CCR 75032 and 75033
[33] BPC 4051.3
[34] 16 CCR 1356.32

Criteria	IV. Clinical Services - Pharmaceutical Standards
	this area by unauthorized persons and authorized clinic personnel remain in the immediate area at all times. At all other times, all drugs (including sample and over the counter), medication supplies, prescription pads and hazardous substances must be securely locked. **IV.A.3) Controlled drugs are stored in a locked space accessible only to authorized personnel.** **<u>Controlled substances</u>**: • Controlled substances are stored separately from other drugs in a securely locked, substantially constructed cabinet accessible only to authorized personnel.[35] **IV.A.4) A dose-by-dose controlled substance distribution log is maintained.** • Written records are maintained of controlled substances inventory list(s) that includes: 1) Provider's DEA number 2) Name of medication 3) Original quantity of drug 4) Dose 5) Date 6) Name of patient receiving drug 7) Name of authorized person dispensing drug and 8) Number of remaining doses • Control substances include all Schedule I, II, III, IV, and V substances listed in the CA Health and Safety Code, Sections 11053-11058, and do not need to be double locked. • Personnel with authorized access to controlled substances include physicians, dentists, podiatrists, PAs, licensed nurses, and pharmacists and specifically authorized employees.[36] **IV.A.5) Written site-specific policy/procedure for dispensing of sample drugs are available on site.** • A list of drugs available for use in the clinic shall be maintained. Site should have written site-specific policies and procedures (P&Ps) for use of sample medications including governing activities of pharmaceutical manufacturers' representatives American Society of hospital

[35] 21 CFR 1301.75
[36] 21 CFR 1301.72

Criteria	IV. Clinical Services - Pharmaceutical Standards
	pharmacist (ASHP) Guidelines: Minimum Standard for pharmaceutical services in ambulatory care).[37] • Each clinic, which provides drug distribution services, shall have written policy and procedures for the safe and effective distribution, control, storage, use and disposition of drugs. **Note:** During business hours, the drawer, cabinet or room containing drugs, medication supplies or hazardous substances may remain unlocked ***only*** if there is no access to area by unauthorized persons. Whenever drugs, medication supplies or hazardous substances are unlocked, authorized clinic personnel must ***always remain*** in the immediate area. At all other times, drugs, medication supplies, and hazardous substances must be securely locked. Controlled substances are ***always locked***.
B. Drugs are handled safely and stored appropriately. **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan (CAP). **IV.B.1) Drugs are prepared in a clean area or "designated clean" area if prepared in a multi-purpose room.** **Drug Preparation:** Drugs shall be drawn up in a designated clean medication preparation area that is not adjacent to potential sources of contamination, including sinks or other water sources. The drug preparation area should be cleaned and disinfected on a regular basis. CDC guidelines for drug preparation and safety: https://www.cdc.gov/injectionsafety/providers/provider_faqs_med-prep.html **IV.B.2) Drugs for external use are stored separately from drugs for internal use.** **Storage:** • Drugs shall be separated by route of administration, especially ophthalmic and otic preparations. • Vaccines and other drugs should be stored separately from food, lab specimens, human specimens, cleaning supplies, and other items that may potentially cause contamination.

[37] The ASHP Guidelines for Minimum Standard for Ambulatory Care Pharmacy Practice is available at: https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/anticoagulation/guidelines-minimum-standard-ambulatory-care-pharmacy.ashx?la=en&hash=ABF816352CAF1AB846B7C339A45AA74D80F820A6.

Criteria	IV. Clinical Services - Pharmaceutical Standards

	• The Center for Disease Control (CDC) recommends avoiding storing other medications and biological products such as lab specimens/human specimens in a vaccine storage unit.
	
	IV.B.3) Items other than medications in refrigerator/freezer are kept in a secured, separate compartment from drugs.
	• Storing food, other medications, and biological products with vaccines put vaccines at risk for temperature fluctuation, excessive light exposure, administration errors, and contamination.
	  ○ If food, other medications and biological products must be stored in the same refrigerator with vaccines, they must be in the sealed containers and stored below vaccines on the different shelves.
	• Drugs are stored under appropriate conditions of temperature, humidity, and light so that the identity, strength, quality, and purity of the drug product are not affected.[38]
	• Room temperature where drugs are stored does not exceed 30ºC (86ºF).[39]
	• A drug or device is considered "adulterated" if it contains any filthy, putrid, or decomposed substance, or if it has been prepared, packed or held under unsanitary conditions.[40]
	• A drug is considered contaminated if it has been held under unsanitary conditions that may have been contaminated with filth or rendered injurious to health.
	• Drugs that are unused are considered by the Environmental Protection Agency (EPA) to be toxic wastes and must be disposed in accordance with 40 CFR, part 261.
	
	American College of Physician guidelines state sound management procedures include:
	  ○ Routinely checking for expiration dates.
	  ○ Keeping medicines off the floor.
	  ○ Labeling the sample medicines or writing prescribing information directly on the sample package.
	  ○ Keeping a log of sample medicines given. In case of a recall, keeping a log allows to track down a patient to whom the recalled drug had been prescribed.
	  ○ When a medication sample is given to a patient, the name and strength of the medication, instructions for use and the quantity or duration of therapy is always documented in the patient's chart.

[38] 21 CFR 211.142
[39] 22 CCR 75037(d)
[40] Title 21, United States Code (USC), section 351. USC is searchable at: https://uscode.house.gov/search/criteria.shtml.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	ASHP guidelines for minimum standard for pharmaceutical services in ambulatory care: ○ Site should have written site-specific policies and procedures (P&Ps) for use of sample medications including governing activities of pharmaceutical manufacturers' representatives. ○ Each clinic, which provides drug distribution services, shall have written policy and procedures for the safe and effective distribution, control, storage, use and disposition of drugs.[41] **Immunobiologics:**[42] • Sites should have a written Vaccine Management Plan for routine and emergency vaccine management (required for Vaccines for Children (VFC) providers). • Vaccines are refrigerated immediately upon receipt on site and stored according to specific instructions on the package insert for each vaccine. • Diluent does not need refrigeration if vaccine is administered right after diluent is added. • Vaccines are not stored in the doors, floors, vegetable bins, or under or near cooling vents of a refrigerator or freezer. **IV.B.4) Refrigerator thermometer temperature is 36º-46º Fahrenheit or 2º-8º Centigrade (at time of site visit).** **Refrigerator:** Vaccines are kept in a refrigerator **maintained at 2-8ºC or 36-46ºF,** and include, but are not limited to, DTaP, Td, Tdap, Hepatitis A, Hepatitis B, IPV, Pneumococcal, Rotavirus, Hib, Influenza (inactivated and FluMist), MCV, HPV, recombinant Zoster, or any combinations of these listed vaccines.[43] **IV.B. 5) Freezer thermometer temperature is 5º Fahrenheit or –15º Centigrade, or lower (at time of site visit).**

[41] The ASHP Guidelines for Minimum Standard for Ambulatory Care Pharmacy Practice is available at: https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/anticoagulation/guidelines-minimum-standard-ambulatory-care-pharmacy.ashx?la=en&hash=ABF816352CAF1AB846B7C339A45AA74D80F820A6.
[42] See the FDA's webpage on Vaccines, available at: https://www.fda.gov/vaccines-blood-biologics/vaccines/questions-about-vaccines.
[43] See the CDC Vaccine Recommendation and Guidelines of the Advisory Committee on Immunization Practices, available at: https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/storage.html, and the CDC Vaccine Storage and Handling Toolkit, available at: https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	Freezer: Varicella and MMRV vaccines are stored in the **freezer at -15ºC or 5ºF, or lower,** and are always protected from light. o MMR may be stored in a refrigerator or freezer; VFC recommends MMR be stored in the freezer with MMRV. o Never freeze vaccine diluents. **IV.B. 6) Site utilizes drugs/vaccine storage units that are able to maintain required temperature.** CDC recommends for both temporary and long-term storage refrigerators and freezers using: o Purpose-built units designed to either refrigerate or freeze (can be compact, under-the counter style or large units). o Stand-alone household units. o Units dedicated to storage of biologics. Measures should be in place to ensure that vaccine storage units are not accidentally physically disconnected from the power supply, such as “Do Not Disconnect” labels and not plugging units into surge protectors with an on/off switch. **Do not store any vaccine in a dormitory-style or bar-style combined refrigerator/freezer unit under any circumstances.**[44] **IV.B. 7) Daily temperature readings of drugs/vaccines refrigerator and freezer are documented.** Refrigerator and freezer temperatures are documented at least once a day (required twice daily for VFC providers). CDC recommends use of a continuous temperature monitoring device (digital data loggers). o Digital data loggers (DDL) should have a minimum accuracy of +/- 1°F (0.5°C) o Equipped with buffered probe o Active temperature display outside of the unit o Capacity for continuous monitoring and recording where the data can be routinely downloaded o Calibrated at least every 2 years, to monitor vaccine storage unit temperatures

[44] See the CDC Vaccine & Immunization webpage, available at: https://www.cdc.gov/vaccines/.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	At least one back-up device should be readily available for emergency vaccine transport or when primary DDL is sent in for calibration. **IV.B. 8) Has a written plan for vaccine protection in case of power outage or malfunction of the refrigerator or freezer.** • A written plan for vaccine protection in case of power outage or malfunction of the refrigerator or freezer is required. www.cdc.gov https://www.cdc.gov/disasters/poweroutage/vaccinestorage.html • Site personnel must be able to verbalize the procedures in the plan used to promptly respond to OUT OF RANGE TEMPERATURES. • Quarantine vaccines until guidance is obtained. • Action is taken when temperatures are identified to be outside of the recommended range. • Contacting VFC (http://eziz.org/vfc/overview/) or manufacturer are acceptable procedures. • For VFC providers, follow program requirements for documentation and reporting. Consultation with CDC is available when necessary.[45] www.cdc.gov **IV.B. 9) Drugs and vaccines are stored separately from test reagents, germicides, disinfectants, and other household substances.** • As these items may potentially cause contamination to verify that drugs are stored separately from test reagents, germicides, disinfectants, and other household substances. **IV.B.10) Hazardous substances are appropriately labeled.** **IV.B.11) Site has method(s) in place for drug and hazardous substance disposal.** **Hazardous Substances Labeling and Disposal**: • Safety practices are followed in accordance with current/updated CAL-OSHA standards and 29 CFR 1910.1030.

[45] See the CDC General Best Practice Guidelines for Immunization: Best Practices Guidance of the ACIP, available at: https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/storage.html, the CDC Vaccine Storage and Handling Toolkit, available at: https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf, the FDA Questions about Vaccines, available at: https://www.fda.gov/vaccines-blood-biologics/vaccines/questions-about-vaccines, and the CDC webpage on Vaccines and Immunizations, available at: https://www.cdc.gov/vaccines/.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	• The manufacturer's label is not removed from a container (bag, bottle, box, can, cylinder, etc.) only if the hazardous material or residues of the material remain in the container. • Containers for biohazard waste shall comply with United States Department of Transportation requirements when prepared for transport offsite from the facility. • A hazardous waste transporter transporting medical waste shall maintain a completed tracking document and provide a copy of that document to the medical waste generator (clinic, etc.). All portable containers of hazardous chemicals and secondary containers into which hazardous substances are transferred or prepared require labeling. Labels must provide the following information: 1) Identity of hazardous substance 2) Description of hazard warning: can be words, pictures, symbols 3) Date of preparation or transfer **Exception**: Labeling is not required for portable containers into which hazardous chemicals are transferred from labeled containers, and which are intended only for the immediate use of the individual who performs the transfer. **Note:** The purpose of hazard communication is to convey information about hazardous substances used in the workplace. A hazardous substance is any substance that is a physical or health hazard.
C. Drugs are dispensed according to State and federal drug distribution laws and regulations. **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan. **IV.C.1) There are no expired drugs on site.** **Expiration Date:** • The manufacturer's expiration date must appear on the labeling of all drugs and formulas. • All prescription drugs not bearing the expiration date are deemed to have expired. • If a drug is to be reconstituted at the time of dispensing, its labeling must contain expiration information for both the reconstituted and unreconstituted drug. • Expired drugs may not be distributed or dispensed. • Per CDC – Medication Vials should be discarded whenever sterility is compromised or questionable.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	• Per CDC "If a multi-dose has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial". • Per VFC "For multi-dose vials that do not require reconstitution, doses that remain after withdrawal of a dose can be administered until the expiration date printed on the vial unless otherwise specified by the manufacturer (Polio, meningococcal polysaccharide vaccine (MPSV4), PPSV, TIV, IPV, and yellow fever that are available in multi-dose vials)".[46] Both CDC and VFC recommend to follow the manufacturer's product information. **IV.C.2) Site has a procedure to check expiration date of all drugs (including vaccines and samples), and infant and therapeutic formulas.** • Site has a procedure to check expiration date of all drugs (including vaccines and samples) and infant and therapeutic formula AT LEAST monthly. **IV.C.3) All stored and dispensed prescription drugs are appropriately labeled.** **Prescription Labeling**: • Labels shall be carefully preserved, and all medications shall be stored in their original containers. • Each prescription medication dispensed is in a container that is not cracked, soiled, or without secure closures.[47] • Each commercial container of a controlled substance shall have printed on the label the symbol designating the schedule in which such controlled substance is listed. • Drug container is labeled with the provider's name, patient's name, drug name, dose, frequency, route, quantity dispensed, and manufacturer's name and lot number. • California Pharmacy Law *does not* prohibit furnishing a limited quantity of sample drugs if dispensed to the patient in the package provided by the manufacturer, no charge is made to the patient, and appropriate documentation is made in the patient's medical record.[48]

[46] See the CDC Frequently Asked Questions regarding Multi-dose vials, available at: https://www.cdc.gov/injectionsafety/providers/provider_faqs_multivials.html, and the CDC Vaccine Storage and Handling Toolkit, available at: https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf.
[47] 22 CCR 75037(A)
[48] BPC 4170 and 4171

Criteria	IV. Clinical Services - Pharmaceutical Standards
	Drug Distribution: • Each clinic that provides drug distribution services has written policies and procedures for the safe and effective distribution control, storage, use and disposition of drugs. • In order to prevent inadvertent exposure to out-of-range temperatures, vaccines should never be re-distributed beyond the manufacturer/distributer-to-clinic distribution chain unless during an emergency. • In the event of necessary vaccine transport (emergency/power outage), vaccines must be packaged following CDC recommendations and include temperature monitoring devices during transport (approval is required for VFC providers prior to any vaccine transfer). **IV.C.4) (CE) Only lawfully authorized persons dispense drugs to patients.** **Drug Dispensing:** • Drug dispensing complies with all applicable State and federal laws and regulations. • Drugs are dispensed only by a physician, pharmacist, or other persons (e.g., NP, CNM, RN, PA) lawfully authorized to dispense medications upon the order of a licensed physician or surgeon. • Personnel such as MAs, office managers, and receptionists do not dispense drugs. • Drugs are not offered for sale, charged or billed to Medi-Cal members.[49] • A record of all drugs and formulas dispensed shall be entered in the patient's medical record. **Drug Administration:** • Basic safe practices for medication/vaccine administration, assess and document: 1) Patient's identity 2) Correct medication 3) Correct dose 4) Correct route 5) Appropriate time CMS Manual System;[50] • Proper preparation is critical for maintaining the integrity of the vaccine during transfer from the vial to the syringe.

[49] BPC 4193
[50] 42 CFR 482.23(c)

Criteria	IV. Clinical Services - Pharmaceutical Standards
	• Personnel can demonstrate or verbally explain procedure(s) used on site to confirm correct patient, medication/vaccine, dosage and route and vaccine are prepared and drawn only prior to administration. • Proper vaccine administration is critical to ensure that vaccination is safe and effective. • CDC recommends that all health care personnel who administer vaccines receive comprehensive, competency-based training on vaccine administration policies and procedures before administering vaccines. • Comprehensive, skills-based training should be integrated into existing staff education programs such as new staff orientation and annual education requirements. **IV.C.5) (CE) Drugs and Vaccines are prepared and drawn only prior to administration.** ACIP discourages the routine practice of providers' prefilling syringes. • Vaccines have a similar appearance after being drawn into a syringe, prefilling may result in administration errors. • Unused, provider prefilled syringes must be discarded if not used within the same day that they are filled. • Unused syringes that are prefilled by the manufacturer and activated (i.e., syringe cap removed, or needle attached) should be discarded at the end of the clinic day. In certain circumstances in which a single vaccine type is being used (e.g., in preparation for a community influenza vaccination campaign), filling a small number (10 or fewer) of syringes may be considered (*5*). The doses should be administered as soon as possible after filling, by the same person who filled the syringes. The Center for Biologics Evaluation and Research (CBER) at the FDA offers information concerning the storage and use of temperature-sensitive biological products that have been involved in a temporary electrical power failure or flood conditions.[51] **IV.C.6) Current Vaccine Information Sheets (VIS) for distribution to patients are present on site.** **Vaccine Immunization Statements**:

[51] See the CDC's Vaccine Recommendations and Guidelines of the ACIP, available at: https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/administration.html.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	• Since 1994, the National Childhood Vaccine Injury Act, Section 2126 of the Public Health Service Act, mandates that parents/guardians or adult patients be informed before vaccinations are administered. • Health care providers must present and offer a VIS to patients prior to any vaccine.[52] As of 2009, CDC allows providers to present a current VIS (such as a laminated copy in a binder, etc.) to the patient/parent/guardian and allow time for the patient to read and ask questions. Staff should also offer a copy each time.[53] • The date the VIS was given (or presented and offered) *and* the publication date of the VIS must be documented in the patient's medical record. • Federal law allows up to 6 months for a new VIS to be used. The most current VIS are available from state and local health departments or can be downloaded from the CDC web site at: http://www.cdc.gov/vaccines/pubs/vis/default.htm or by calling the CDC Immunization Hotline at (800) 232-2522. VFC contains current VIS and provider notifications at: http://www.eziz.org/ **IV.C.7) If there is a pharmacy on site, it is licensed by the CA State Board of Pharmacy.** **Pharmacy:** • If a pharmacy is located on site and owned by the clinic, the license issued by the CA State Board of Pharmacy must be present on site. • Every pharmacy that dispenses a controlled substance must be registered with the DEA and be licensed by the CA State Board of Pharmacy. • A licensed pharmacist monitors drug distribution and policies and procedures for medication dispensing and storage. **Note:** "Dispensing" of drugs means the furnishing of drugs or devices directly to a patient or upon a prescription from a physician, dentist, optometrist, podiatrist, veterinarian, or upon an order to furnish drugs or transmit a prescription from a certified nurse midwife, nurse practitioner, physician assistant or pharmacist acting within the scope of his or her practice. **IV.C.8) Site utilizes California Immunization Registry (CAIR) or the most current version.**

[52] 42 USC 300aa-26(D)(2)
[53] See the CDC's Facts about VIS, which is available at: https://www.cdc.gov/vaccines/hcp/vis/about/facts-vis.html.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	<u>Immunization Registry Utilization</u>: Scoring must be No or Yes. • DHCS requires documentation of immunizations in the California CAIR or the local registry. • If the clinic does not offer vaccines administration, the site staff shall be able to utilize the registry to access the member's immunization record. Contractor shall ensure that member-specific immunization information is periodically reported to an immunization registry (is) established in the Contractor's Service Area(s) as part of the Statewide Immunization Information System. Reports shall be made following the Member's initial health assessment and all other health care visits which result in an immunization being provided. Reporting shall be in accordance with all applicable State and Federal laws. DHCS Contract; CDC Recommendations at: www.cdc.gov/vaccines.

Criteria	IV. Clinical Services – Laboratory Review
D. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations.	**IV.D.1) Laboratory test procedures are performed according to current site-specific CLIA certificate.** **CLIA Certificates**: • All sites that perform laboratory testing for human health assessment, diagnosis, prevention, or treatment of disease has a current, unrevoked, unsuspended site-specific Clinical Laboratory Improvement Amendment (CLIA) certificate, or evidence of renewal. • Acceptable documentation such as the original certificate, copy of the original certificate, renewal receipt or other evidence of renewal submission is present on site or readily available upon request. The CLIA certificate or evidence of renewal should include the current site/clinic address. **Note:** Per 42 CFR, 493.35(b)(1-3), 493.43(b)(1-3) and 493.55(b)(1-3), laboratories must file a separate application for each laboratory location, with the following *exceptions*: 1) Laboratories that are not at a fixed location, that is, laboratories that move from testing site to testing site, such as mobile units providing laboratory testing, health screening fairs, or other temporary testing locations may be covered under the certificate of the designated primary site or home base, using its address. 2) Not-for-profit or Federal, State, or local government laboratories that engage in limited (not more than a combination of 15 moderately complex or waived tests per certificate) public health testing may file a single application, or 3) Laboratories within a hospital that are located at contiguous buildings on the same campus and under common direction may file a single application or multiple applications for laboratory sites within same physical location or street address. 4) A multi-site CLIA waiver can be used at all affiliated locations. A copy of the CLIA waiver must be at each individual location with the address of the main location on the waiver. A copy of the CLIA application must be reviewed by the CSR to verify the locations included for old and new locations. The CLIA Certificate on site includes one of the following: ○ Certificate of Waiver: Site can perform only exempt waived tests ○ Certificate for Provider-Performed Microscopy (PPM): Physicians, dentists, or NPMPs can perform PPM procedures and waived tests

Criteria	IV. Clinical Services – Laboratory Review
	○ Certificate of Registration: Allows moderate and/or high complexity lab testing to be conducted until compliance with CLIA regulations are determined by survey ○ Certificate of Compliance: Lab has been surveyed and found in compliance with all applicable CLIA requirements ○ Certificate of Accreditation: Lab is accredited by an accreditation organization approved by CMS **Waived Tests**: • If only waived tests are performed, site has a current CLIA Certificate of Waiver. • There are no specific CLIA regulations regarding the performance of waived tests. • Site personnel are expected to follow the test manufacturer's instructions. • Laboratories with certificates of waiver may not be routinely inspected by DHCS Laboratory Field Services Division but may be inspected as part of complaint investigations and on a random basis to determine whether only waived tests are being performed. **Moderate and High Complexity Tests:** Tests not listed as waived are divided into one of two categories, moderate complexity or high complexity, based on the complexity of the testing procedure. CLIA regulations for these categories list specific requirements for laboratory proficiency testing, patient test management, quality control, quality assurance, personnel, and inspections. **IV.D.2) Testing personnel performing clinical lab procedures have been trained.** **Personnel Training:** • Prior to testing biological specimens, personnel have been appropriately trained for the type and complexity of the laboratory services performed. • Personnel have demonstrated the ability to perform all testing operations reliably and to report results accurately. • Site personnel that perform CLIA waived tests have access to and can follow test manufacturer's instructions. • When requested, site personnel can provide a step-by-step verbal explanation or demonstration of test procedure and how to determine test results.

Criteria	IV. Clinical Services – Laboratory Review
	• The required training and certification are established by legislation for personnel performing moderate and high complexity tests.[54] Reviewers are not expected to complete an in-depth evaluation of personnel performing moderate and high complexity tests. **IV.D.3) Lab supplies (e.g. vacutainers, vacutainer tubes, culture swabs, test solutions) are inaccessible to unauthorized persons.** **IV.D.4) Lab test supplies are not expired.** Lab supplies are disposed of by manufacturer's expiration date. **IV.D.5) Site has a procedure to check expiration date and a method to dispose of expired lab test supplies.** **Note:** Any site that performs tests or examinations on human biological specimens derived from the human body is, by definition, "laboratories" under State and federal law, and includes locations such as nurses' stations within hospitals, clinics, surgical centers, physician offices, and health fairs. The current listing of waived tests may be obtained at www.cms.gov or www.fda.gov includes an evaluation every two years (or sooner of complaint driven) by CDPH of personnel licenses/training, laboratory site inspection and demonstration of testing proficiency for moderate and high-complexity test sites. **Contact CDPH Laboratory Field Services (510) 620-3800 or LFSrecep@cdph.ca.gov for CLIA certification, laboratory license, or personnel questions.**

[54] BPC 1200-1213

Criteria	IV. Clinical Services – Radiology Review
E. Site meets CDPH Radiological inspection and safety regulations	**IV.E.1) Site has current CA Radiologic Health Branch Inspection Report and Proof of Registration if there is radiological equipment on site.** **<u>CDPH Radiologic Health Branch (RHB) Inspection Report</u>**: If site has ***current*** documentation of one of the following, give the full 9 points and survey items 2-9 will not need to be surveyed. Acceptable documentation is: ○ Inspection Report and Proof of Registration, ***or*** ○ Inspection Report and Proof of Registration *and* Short Form Sign-off sheet, ***or*** ○ Inspection Report and Proof of Registration *and* Notice of Violation form *and* approval letter for corrective action plan from the CA RHB The Radiologic Inspection Report and Proof of Registration (receipt of payment or cancelled check), issued by the RHB, must be present if there is radiology equipment on site. If any violations are found, one of two documents are issued to the site: ○ "Short Form Sign-off sheet" is issued for minimal problems that are easily corrected. ○ "Notice of Violation" form, requiring a site corrective action plan, is issued if there are more violations that are serious. All "Notice of Violation" corrective action plans must be accompanied by an approval letter from the CA RHB. **If documents are not available on site, or if reviewer is uncertain about the "status of documents on site, proceed to score all items 1-9.** **The following documents are posted on site:** **IV.E.2) Current copy of Title 17 with a posted notice about availability of Title 17 and its location.** **IV.E.3) "Radiation Safety Operating Procedures" posted in highly visible location.** **IV.E.4) "Notice to Employees Poster" posted in highly visible location.** **IV.E.5) "Caution, X-ray" sign posted on or next to door of each room that has X-ray equipment.** **IV.E.6) Physician Supervisor/Operator certificate posted and within current expiration date.**

Criteria	IV. Clinical Services – Radiology Review
	IV.E.7) Technologist certificate posted and within current expiration date. **The following radiological protective equipment is present on site:** **IV.E.8) Operator protection devices: radiological equipment operator must use lead apron or lead shield.** **IV.E.9) Gonadal shield (0.5 mm or greater lead equivalent): for patient procedures in which gonads are in direct beam.** **<u>Radiological Equipment</u>:** Equipment inspection, based on a "priority" rating system, is established by legislation. https://blink.ucsd.edu/_files/safety-tab/rad/Title-17-CCR.pdf • Mammography equipment is inspected annually, and must have federal FDA Certification on site ***and*** CA Mammography X-ray Equipment and Facility Accreditation Certification posted on the machine.[55] • High Priority equipment (e.g. fluoroscopy, portable X-ray) is inspected every three years. • Medium Priority equipment is inspected every 4-5 years depending on the volume of patients, frequency of x-ray equipment uses, and likelihood of radiation exposure. If reviewer is uncertain about the "status of equipment inspection, call the RHB. **<u>Radiology Personnel</u>:** • All certificates/licenses are posted and show expiration dates. • If there are many technicians, a list of names, license numbers, and expiration dates may be substituted. • The Certified Radiological Technologist (CRT) certificate permits the technologist to perform all radiology films except mammography and fluoroscopy, which require separate certificates. • The "Limited Permit" restricts the technician to one of the ten-(10) x-ray categories specified on the limited certificate: Chest, Dental laboratory, Dermatology, Extremities, Gastrointestinal, Genitourinary, Leg-podiatric, Skull, Torso-skeletal, and X-ray bone densitometry.

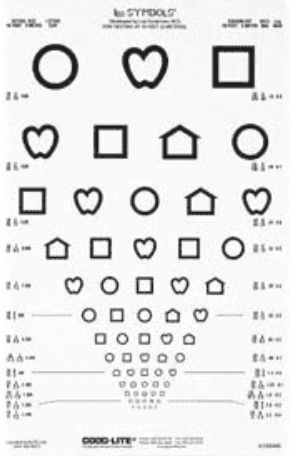
[55] 21 CFR 900

Criteria	IV. Clinical Services – Radiology Review
	Note: • Per RHB, dexascanners do not require lead aprons or gonadal shields, however, criteria 1-7 are still required. • RHB uses the ALARA (As Low As Reasonably Achievable) principle, which is the foundation of all radiation safety programs. The ALARA principle means to minimize exposure to radiation doses by employing all *reasonable* methods. • Dexascanners manufacturer guidelines do not require gonadal shielding or lead aprons due to very low radiation output, and potential for the shield to obscure the area being scanned, possibly rendering the scan non-diagnostic. With the focused beam, operators do not need aprons, the amount of exposure of "scattered" beams to an operator seated near the scanner is about the same level as that found in the natural environment. A traditional x-ray machine used for bone density testing, is not a dexascanner, and *may* require shielding/apron. **Note:** The RHB of the Food, Drug, and Radiation Safety Division of CDPH enforces the Radiation Control Laws and Regulations designed to protect both the public and employees against radiation hazards. Enforcement is carried out through licensing, registration and periodic inspection of sources of radiation, such as radiation machines. For questions regarding radiologic safety (e.g. expired or no inspection letters on site), call CDPH RHB at (916) 327-5106. For Radiation Emergency Assistance, call 1-800-*852*-7550. Ref: CCR, Title 17, Chapter 5, Subchapter 4 regulations at https://www.cdph.ca.gov/rhb

Criteria	V. Preventive Services Standards
A. Preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases.	**Examination equipment, appropriate for primary care services, is available on site:** **V.A.1) Exam tables and lights are in good repair.** **<u>Examination Table and Lights</u>:** • Lights and exam tables shall be in good repair. "Good repair" means clean and well maintained in proper working order. • Examination tables must have a protective barrier such as paper which is changed between patients, to cover the exam surface. **V.A.2) Stethoscope and sphygmomanometer with various size cuffs (e.g. child, adult, obese, thigh).** **V.A.3) Thermometer with a numeric reading.** **V.A.4) Basic exam equipment: in addition to items mentioned above, offices should have the following:** o Percussion hammer o Tongue blades o Patient gowns **V.A.5) Scales: Standing balance beam and infant scales.** **<u>Scales:</u>** • Infant scales are marked and accurate to increments of one (1) ounce or less and have a capacity of at least 35 pounds. • Standing floor scales are marked and accurate to increments of one-fourth (1/4) pound or less and have a capacity of at least 300 pounds. • Balance beam scales have an adjustment mechanism and zeroing weight to enable routine balancing at zero. • Electronic or digital scales have automatic zeroing and lock-in weight features. • Spring balance scales (e.g. bathroom scales) are unsatisfactory for clinical use as, over time, the spring counterbalance mechanism loses its accuracy.

Criteria	V. Preventive Services Standards
	V.A.6) Measuring devices for stature (height/length) measurement and head circumference measurement. **Measuring Devices:** Equipment on site for measuring stature (length/height) and head circumference includes: ○ Rigid 90º right angle headboard block that is perpendicular to the recumbent measurement surface. ○ Vertical to the wall-mounted standing measurement surface. ○ Flat, paper or plastic non-stretchable tape or yardstick, marked to one-eighth (1/8 in. or 1 mm) or less, attached to a firm, flat surface. The "0" of the tape is exactly at the base of the headboard for recumbent measurement, or exactly at foot level for standing measurement. ○ Moveable, non-flexible footboard at 90º right angle perpendicular to the recumbent measurement surface, or a flat floor surface for standing. ○ A non-stretchable tape measuring device marked to one-eighth (1/8 in. or 1 mm) or less for measuring head circumference (re-usable measuring device must be appropriately cleaned in between use). **V.A.7) Eye charts (literate and illiterate) and occluder for vision testing.** **Vision Testing:**[56] • Site has both literate (e.g., Snellen) and illiterate eye charts • The current preferred optotypes (figures or letters of different sizes) for patients who cannot distinguish letters are the LEA or HOTV symbols (see figures below)

[56] See the Procedures for the Evaluation of the Visual System by Pediatricians, available at: https://pediatrics.aappublications.org/content/137/1/e20153597. Also see the American Association for Pediatric Ophthalmology and Strabismus Vision Screening Committee's Pediatric Screening Guidance during the COVID-19 Pandemic, available at: https://aapos.org/education/allied-health/covid.

Criteria	V. Preventive Services Standards
	  • Wall mounted eye charts should be height adjustable and positioned at the eye-level of the patient • Examiners shall stand their patients with their heels to the line unless the eye chart that is being used to screen specifically instructs the patient to be positioned elsewhere. “Heel” lines are aligned with center of eye chart at 10 or 20-feet depending on whether the chart is for the 10-foot or 20-foot distance. • Eye charts are in an area with adequate lighting and at height(s) appropriate to use • Effective occlusion, such as with tape or an occlusive patch of the eye not being tested, is important to eliminate the possibility of peeking. **V.A.8) Ophthalmoscope.** Ophthalmoscope is in good working condition. **V.A.9) Otoscope with adult and pediatric ear speculums.** Otoscope with multi-size ear speculums appropriate to the population served. **V.A.10) A pure tone, air conduction audiometer is located in a quiet location for testing.**

Criteria	V. Preventive Services Standards

	Hearing Testing:[57]
	• The pure tone audiometer must have the minimum ability to:
	  ○ Produce intensities between 0 to 80 dB
	  ○ Have a headset with right and left earphones
	  ○ Be operated manually
	  ○ Produce frequencies at 1000, 2000, 3000, 4000, 6000, and 8000 Hz
	• Offices that provide pediatric preventive services should have a pure tone; air conduction audiometer available, audiometric testing is required at preventive health visits starting at 4 years of age.
	• PCP offices (such as Family Practitioners or General Practitioners) that refer all members to another provider for audiometric testing, must have a system in place that clearly demonstrates that the PCP office verifies that audiometric testing has been completed and that those results are returned to the PCP for review.

B. Health education services are available to Plan members.	**Health Education Services:** Services may include individual instruction, group classes, family counseling and/or other health educational programs and materials provided to members by the provider, health plan, or community sponsored programs. **Health education materials and Plan-specific resource information are:** **V.B.1) Readily accessible on site or are made available upon request.** **V.B.2) Applicable to the practice and population served on site.** **V.B.3) Available in threshold languages identified for county and/or area of site location.** **Health Education Materials:**

[57] See the American Speech-Language-Hearing Association's guidance on Audiograms, available at: https://www.asha.org/public/hearing/audiogram/.

Criteria	V. Preventive Services Standards
	• Must be available in the appropriate threshold languages and may be located in an accessible area on site (e.g., exam room, waiting room, health education room or area), or provided to members by clinic staff and/or by Plan upon request. • Must be available in accessible format which may include written information, audio and/or videotapes, computerized programs, and visual presentation aids for people with disabilities. • Should include general topics for health educational material such as: Immunizations, Pregnancy, Injury Prevention, Smoking Cessation, Dental Health, Nutrition, Physical Activity, STD/HIV Prevention, Family Planning, Asthma, Hypertension, and Diabetes. • Must meet the Medi-Cal Managed Care readability and suitability requirements for educational material distributed to Medi-Cal members.[58] **Plan-Specific Referral Information:** Plan-specific informing materials and/or resources are available on site in languages that are applicable to member population(s) primarily seen on site. ○ For example, if primarily English and Spanish-speaking members are seen on site, then Plan-specific informing materials are available on site in those languages. ○ Although a site may not stock informing materials in each threshold language identified for the county, site personnel has access to contact resource information for locating Plan-specific informing materials in threshold languages not typically seen on site. ○ Interpreter services are provided in all identified threshold and concentration standard languages. **Note:** Threshold languages are the primary languages spoken by Limited English Proficient (LEP) population groups residing in a county. A numeric threshold of 3,000 eligible LEP Medi-Cal beneficiaries or a concentration standard of 1,000 residing in a single ZIP code or 1,500 in two contiguous ZIP codes establishes the threshold languages identified by DHCS for each county.

[58] See All Plan Letter (APL) 18-016, "Readability and Suitability of Written Health Education Materials". APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

Criteria	VI. Infection Control Standards
A. Infection control procedures for Standard/Universal precautions are followed.  **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan (CAP). **Hand Washing Facilities:**[59] • Hand washing facilities are available in the exam room and/or utility room, and include an adequate supply of running potable water, soap and single use towels or hot air-drying machines. • Sinks with a standard faucet, foot-operated pedals, 4-6-inch wing-type handle, automatic shut-off systems or other types of water flow control mechanism are acceptable. • Staff can demonstrate infection control "barrier" methods used on site to prevent contamination of faucet handle, door handles and other surfaces until hand washing can be performed. • On occasions when running water is not readily available, an antiseptic hand cleanser, alcohol-based hand rub, or antiseptic towelettes is acceptable until running water is available.[60] **VI.A.1) Soap or antiseptic hand cleaner and running water are available in exam and/or treatment areas for hand washing.** **Soap or Antiseptic Hand Cleaner:** Hand washing prevents infection transmission by removing dirt, organic material and transient microorganisms from hands. ○ Hand washing with plain (non-antimicrobial) soap in any form (e.g., bar, leaflet, liquid, powder, granular) is acceptable for general patient care (Association for Professionals in Infection Control and Epidemiology, Inc., 1995). ○ Antimicrobial agents or alcohol-based antiseptic hand rubs are used for hand washing when indicated to remove debris and destroy transient microorganisms (e.g., before performing invasive procedures, after contact with potentially infectious materials). ○ Plain and antiseptic hand wash products are properly maintained and/or dispensed to prevent contamination.

[59] See the World Health Organization's Hand Hygiene guidelines, available at: https://www.who.int/gpsc/5may/Hand_Hygiene_Why_How_and_When_Brochure.pdf.
[60] 29 CFR 1919.1030

Criteria	VI. Infection Control Standards
	VI.A.2) A waste disposal container is available in exam rooms, procedure/treatment rooms, and restrooms. **Waste Disposal Container:**[61] • Contaminated wastes (e.g. dental drapes, band-aids, sanitary napkins, soiled disposable diapers) are disposed of in regular solid waste (trash) containers, and are maintained to prevent potential contamination of patient/staff areas and/or unsafe access by infants/children. • Closed containers are not required for regular, solid waste trash containers. **VI.A.3) Site has procedure for effectively isolating infectious patients with potential communicable conditions.** **Isolation Procedures**:[62] • Personnel can demonstrate or verbally explain procedure(s) used on site to isolate patients with potentially contagious conditions from other patients. • If personnel are unable to demonstrate or explain site-specific isolation procedures *and* cannot locate written isolation procedure instructions, site is considered deficient. • Isolation procedures may vary from site to site. **Note:** • Infection Control standards are practiced on site to minimize risk of disease transmission. • Site personnel are expected to apply the principles of "Standard Precautions" (CDC, 1996), used for all patients regardless of infection status. • Standard precautions apply to blood, all body fluids, non-intact skin, and mucous membranes, which are treated as potentially infectious for HIV, HBV or HCV, and other bloodborne pathogens. • "Universal precautions" refer to the OSHA mandated program that requires implementation of work practice controls, engineering controls, bloodborne pathogen orientation/education, and record keeping in healthcare facilities.

[61] HSC 118275-118320. Also see the OSHA Standards for Bloodborne Pathogens, available at: https://www.hercenter.org/rmw/osha-bps.php.
[62] See the CDC's Guidelines for Isolation Precautions, available at: https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html.

Criteria	VI. Infection Control Standards
B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. 🔍🗁 **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan. **VI.B.1) (CE) Personal Protective Equipment for Standard Precautions is readily available for staff use.** **Personal Protective Equipment (PPE):** PPE must be readily available.[63] PPE for protection against bloodborne pathogen hazards is available on site and must include: 1) Gloves 2) Water repellent clothing barrier/gown 3) Face/eye protection (e.g., goggles/face shield) 4) Respiratory infection protection (e.g., mask) PPE does not include general work clothes (e.g., uniforms, cloth lab coats) that will permit liquid to soak through. • The storage of PPE should be adequate to protect the PPE from contamination, loss, damage, water or sunlight. • Proper storage often requires a dry and clean place that is not subject to temperature extremes. **VI.B.2) (CE) Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport or shipping.** **Blood and Other Potentially Infectious Materials (OPIM):** • OPIM are all human body fluids, any unfixed tissue or organ (other than intact skin) from a human (living or dead), and HIV or HBV-containing blood, cells, tissue, organs, cultures, medium or solutions. • Containers for blood and OPIM are closable, leak proof, and labeled and/or color-coded. • Double bagging is required only if leakage is possible. **Labels:**

[63] 29 CFR 1910.1030

Criteria	VI. Infection Control Standards
	• A warning label is affixed to red-bagged regulated wastes, sharps containers, refrigerators/freezers containing blood or OPIM, containers used to store or transport blood or OPIM, and contaminated laundry or equipment for storage or transporting. • The international biohazard symbol with word "BIOHAZARD" *or* the words "Biohazardous Waste" label (fluorescent orange or red orange with contrasting lettering/symbols) is part of, or affixed to, the container. • Sharps containers are labeled with the words "Sharps Waste" or with the international biohazard symbol and the word "BIOHAZARD". • Individual containers of blood or OPIM are exempted from warning labels if placed inside a labeled secondary container for storage, transport, or disposal. • Alternative marking or color coding may be used to label contaminated laundry or specimen containers if the alternative marking permits employees on site to recognize that container requires compliance with Universal Precautions. **VI.B.3) (CE) Needlestick safety precautions are practiced on site.** **Needlestick Safety:**[64] • Contaminated sharps are discarded immediately. • Sharps containers are located close to the immediate area where sharps are used and are inaccessible to unauthorized persons. • Sharps are not bent, removed from a syringe, or recapped. Recapping, bending, or removing contaminated needles is permissible only if there is no feasible alternative or if such actions are required for a specific medical procedure. If recapping, bending, or removal is necessary, employers must ensure that workers use either a mechanical device or a one-handed technique. Needleless systems, needles with Engineered Sharps Injury Protection (ESIP) devices, and non-needle sharps are used (incl. in emergency kits), unless exemptions have been approved by Cal/OSHA.[65] • Security of portable containers in patient care areas is always maintained. • Any device capable of cutting or piercing (e.g. syringes, hypodermic needles, needleless devices, blades, broken glass, slides, vials) are placed in a closable, puncture-resistant, labeled,

[64] See the OSHA Needlestick Safety Frequently Asked Questions, available at: https://www.osha.gov/needlesticks/needlefaq.html, and the OSHA Standards for Bloodborne Pathogens, available at: https://www.hercenter.org/rmw/osha-bps.php.
[65] 8 CCR 5193

Criteria	VI. Infection Control Standards
	leak-proof container. If these requirements are met, containers made of various materials (e.g., cardboard, plastic) are acceptable. • Containers are not overfilled past the manufacturer's designated fill line, or more than ¾ full. • Supply of containers on hand is adequate to ensure routine change-out when filled. **VI.B.4) All sharp injury incidents are documented.** **Sharps Injury Documentation:**[66] • Site has a method in place to document sharps injuries. • The Sharps Injury Log must contain, at a minimum, information about the injury, the type and brand of device involved in the injury (if known), the department or work area where the exposure occurred, and an explanation of how the incident occurred. • The incident must be recorded in the log within 14 business days of the date the incident is reported to the employer and maintained in such a manner to protect the confidentiality of the injured employee (e.g., removal of personal identifiers) and follow-up care is documented within 14 days of injury incident. • Sites with 10 or fewer employees are exempt from OSHA recordkeeping requirements and are exempt from recording and maintaining a Sharps Injury Log, however, it is recommended to have a method in place to document sharps injuries regardless of the number of employees. **Regulated Waste Storage:** Regulated wastes include: ○ **Biohazardous wastes**, e.g., laboratory wastes, human specimens/tissue, blood/contaminated materials "known" to be infected with highly communicable diseases for humans and/or that require isolation. ○ **Medical wastes**, e.g., liquid/semi-liquid blood or OPIM, items caked with dry blood or OPIM and capable of releasing materials during handling, and contaminated sharps. **VI.B.5) Biohazardous (non-sharp) wastes are contained separate from other trash/waste.**

[66] See 8 CCR 5193, and the National Institute for Occupational Safety and Health's guidance on Preventing Needlesticks and Sharps Injuries, available at: https://www.cdc.gov/niosh/topics/bbp/sharps.html.

Criteria	VI. Infection Control Standards
	VI.B.6) Storage areas for regulated medical wastes are maintained secure and inaccessible to unauthorized persons.[67] • Regulated waste is contained separately from other wastes (e.g., contaminated wastes)* and placed in red biohazardous bags with Biohazard label and stored in a closed container that is not accessible to unauthorized persons. • If stored outside the office, a lock secures the entry door, gate or receptacle lid, and posted warning sign(s) in English and Spanish are visible for 25-feet: "CAUTION-BIOHAZARDOUS WASTE STORAGE AREA- UNAUTHORIZED PERSONS KEEP OUT" and CUIDADO-ZONA DE RESIDUOUS-BIOLOGICOS PELIGOROS-PROHIBIDA LE ENTRADA A PERSONAS NO AUTHORIZADAS". See HSC Sections 117915-117946, 49 CFR, Section 173.6; Core Infection Prevention and Control Practices -Centers for Disease Control and Prevention (CDC) The Healthcare Infection Control Advisory Committee (HICPAC), 2016. **VI.B.7) Contaminated laundry is laundered at the workplace or by a commercial laundry service.** **<u>Contaminated Laundry</u>:** • Contaminated laundry (soiled with blood/OPIM) is laundered by a commercial laundry service, or a washer and dryer on site. • Contaminated laundry should not contain sharps, and when transported, should have the appropriate warning label. • Manufacturer's guidelines are followed to decontaminate and launder reusable protective clothing. • Ensure that laundry areas have handwashing facilities and products and appropriate PPE available for staff. • Laundry requirements are "not applicable" if only disposable patient gowns and PPE are used on site.

[67] HSC 117600-118360, 29 CFR 1910.1030, CDC Guidelines for Isolating Precautions: Preventing Transmission of Infection Agents in Healthcare Settings, available at: https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html.

Criteria	VI. Infection Control Standards
	VI.B.8) Transportation of regulated medical wastes is only by a registered hazardous waste hauler or to a central location of accumulation in limited quantities (up to 35.2 pounds). **Medical Waste Disposal:** California adopted statutes into HSC affecting medical waste transporters in October 1993.[68] • Only medical waste transporters listed with CDPH can transport medical waste. • All medical waste transporters must carry paperwork issued by CDPH in each vehicle while transporting medical waste. • Medical wastes are hauled to a permitted offsite medical waste treatment facility, transfer station, or other registered generator by a registered hazardous waste transporter. • Limited-quantity exemption is not required for Small Quantity Generator (up to 35.2 pounds). However, a medical waste-tracking document that includes the name of the person transporting, number of waste containers (e.g., three sharps containers, or five biohazard bags), types of medical wastes, and date of transportation, is kept a minimum of 3 years for large waste generators and 2 years for small generators. For the CDPH list of current medical waste transporters, visit: https://www.cdph.ca.gov/Programs/CEH/DRSEM/CDPH%20Document%20Library/EMB/MedicalWaste/Haulist_012921.pdf For information on the United States Postal Service mailability standards for medical waste (including sharps) refer to the Domestic Mail Manual, section 601.10.17: https://pe.usps.com/Archive/HTML/DMMArchive20100607/601.htm CDPH Medical Waste Management Program: https://www.cdph.ca.gov/Programs/CEH/DRSEM/Pages/EMB/MedicalWaste/MedicalWaste.aspx CDPH Medical Waste Management Program Transporter Checklist: https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8660.pdf CDPH Medical Waste Transporter Annual Verification: https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8668.pdf

[68] HSC 117600-11836

Criteria	VI. Infection Control Standards
	CDPH Medical Waste Transfer Stations and Offsite Treatment Facilities: https://www.cdph.ca.gov/Programs/CEH/DRSEM/Pages/EMB/MedicalWaste/Transfer-and-Treatment.aspx CDPH Medical Waste Transporters Data Submission Protocol: https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8666.pdf Department of Toxic Substances Control-Managing Hazardous Waste Transporters Registration https://dtsc.ca.gov/transporters/ ***Note:** Contaminated wastes include materials soiled with blood during their use but are not within the scope of regulated wastes. Contaminated waste items need not be disposed as regulated waste in labeled red bags but can be discarded as solid waste in regular trash receptacle.
C. Contaminated surfaces are decontaminated according to Cal-OSHA standards. **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan (CAP). **VI.C.1) Equipment and work surfaces are appropriately cleaned and decontaminated after contact with blood or other potentially infectious material.** **Routine Decontamination:** ○ Contaminated work surfaces are decontaminated with an appropriate disinfectant.[69] ○ Written "housekeeping" schedules have been established and are followed for regular routine daily cleaning. ○ Staff can identify cleaning and disinfection of surfaces and equipment, the disinfectant used and responsible personnel in between patients use. **VI.C.2) Routine cleaning and decontamination of equipment/work surfaces is completed according to site-specific written schedule.** **The written schedule for cleaning and decontamination of the work site as follows:** ○ **Area cleaned/decontaminated**

[69] 29 CFR 1910.1030

Criteria	VI. Infection Control Standards
	○ **Frequency of cleaning/decontamination** ○ **Employee responsible for determining and implementing the written schedule** All equipment and environmental and work surfaces shall be cleaned and decontaminated after contact with blood or OPIM no later than at the end of the shift. Cleaning and decontamination of equipment and work surfaces is required more often as specified below: ○ Location within the facility ○ Type of surface or equipment to be treated ○ Type of soil or contamination present ○ Tasks or procedures being performed in the area Contaminated work surfaces shall be cleaned and decontaminated with an appropriate disinfectant immediately or as soon as feasible when: ○ Surfaces become overtly contaminated. ○ There is a spill of blood or OPIM. ○ Procedures are completed. ○ At the end of the work shift if the surface may have become contaminated since the last cleaning. **Spill Procedure:** Personnel can identify procedures for prompt decontamination of blood/body fluid spills, the disinfectant used, and the responsible person(s). **Disinfectant solutions used on site are:** **VI.C.3) Approved by the Environmental Protection Agency (EPA).** **VI.C.4) Effective in killing HIV/HBV/TB.** **VI.C.5) Follow manufacturer instructions.** **Disinfectant Products:** ○ Products used for decontamination have a current EPA-approved status. ○ Effectiveness in killing HIV/HBV/TB is stated on the manufacturer's product label. ○ Decontamination products are used according to manufacturer's guidelines for decontamination and contact times.

Criteria	VI. Infection Control Standards
	10% Bleach Solution: ○ 10% bleach solution that is EPA registered and effective against TB, is changed/reconstituted ***every*** 24 hours (due to instability of bleach once mixed with water). ○ Surface is cleaned prior to disinfecting (due to presence of organic matter (e.g., dirt, blood, excrement) inactivates active ingredient, sodium hypochlorite). ○ Surface is air-dried or allowed appropriate time (stated on label) before drying. ○ Manufacturer's directions, *specific* to every bleach product, are followed carefully. **Note:** "Contamination" means the presence or reasonably anticipated presence of blood or OPIM on any item or surface. "Decontamination" is the use of appropriate physical or chemical means to remove, inactivate or destroy bloodborne pathogens so that a surface or item is no longer capable of transmitting infectious particles and is rendered safe for handling, use or disposal.[70] Current EPA product lists and information is available from the EPA, Antimicrobial Division at (703) 305-1284, or at 29 CFR 1910.1030.
D. Reusable medical instruments are properly sterilized after each use. **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan (CAP). **VI.D.1) Written site-specific policy/procedures or manufacturer's instructions for instrument/equipment sterilization are available to staff.** If site uses an autoclave or cold chemical solution to achieve sterilization and/or high level disinfection (HLD) of instruments/equipment, site shall have specific policy/procedures or manufacturer's instructions addressing instrument/equipment pre-treatment, cleaning and preparation, the management of chemical solutions, autoclave loading and operation, safety guidelines and precautions, and other required processes, which are available to staff to follow. **Staff adheres to site-specific policy and/or manufacturer/product label directions for the following procedures:** **VI.D.2) Cleaning reusable instruments/equipment prior to sterilization.** **Cleaning Prior to Sterilization:**

[70] 8 CCR 5193. Also see CalOSHA's Best Practices Approach for Reducing Bloodborne Pathogen Exposure, available at: https://www.dir.ca.gov/dosh/dosh_publications/BBPBest1.pdf.

Criteria	VI. Infection Control Standards
	• Prior to undergoing the sterilization process, soiled instruments/equipment are thoroughly cleaned using enzymatic detergent, rinsed, dried, and inspected for the presence of dried blood or other debris. **Cold chemical sterilization/high level disinfection:** **VI.D.3a) (CE) Staff demonstrate /verbalize necessary steps/process to ensure sterility and/or high-level disinfection of equipment.** • Personnel can demonstrate or verbally explain procedure(s) used for cleaning prior to sterilization, and to locate written directions on site. • Product efficacy tests (i.e. test strips) shall be performed according to manufacturer's guidelines. **Cold Chemical Sterilization/High Level disinfection:** • Product manufacturer's directions are strictly followed for instrument pre-soaking treatment, solution preparation, solution exposure procedures, safety precautions (e.g., room temperature, area ventilation), and post-sterilization processes. • Sterilization and or high-level disinfection exposure times and solution expiration date and time are available to staff. • Written procedures for cold sterilization and/or high-level disinfection is available on site to staff. **VI.D.3b) Confirmation from manufacturer item(s) is/are heat sensitive.** • Per CDC,[71] the use of liquid chemical germicides to sterilize instruments ("cold sterilization") are limited. Sterility is not verified or assured with cold chemical sterilization. The first choice is always heat sterilization. The CDC refers to heat sterilization as "the method of choice when sterilizing instruments and devices. If an item is heat sensitive, it is preferable to use a heat-stable alternative or disposable item". • The use of a liquid chemical sterilant should be restricted to reprocessing devices that are heat-sensitive and incompatible with other sterilization methods. All other items should be heat sterilized or disposable.

[71] See the CDC Guidelines for Disinfection and Sterilization, available at: https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf. Also see the CDC's Guidelines on other sterilization methods, available at: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/sterilization/other-methods.html.

Criteria	VI. Infection Control Standards
	VI.D.3c) (CE) Appropriate PPE is available, exposure control plan, Material Safety Data Sheets (MSDS) and clean up instructions in the event of a cold chemical sterilant spill. Cold Chemical Sterilants Spillage: The OSHA Hazard Communication Standard requires manufacturers and importers of hazardous chemicals to develop MSDS for each chemical or mixture of chemicals.[72, 73] ○ Employers must have the data sheets for cold chemical sterilants readily available to employees who work with the products to which they could be exposed. ○ Staff should attend training classes in safety awareness about the use and exposure to cold chemical sterilants used on site. ○ Personnel are familiar with and can recognize signs and symptoms of exposure to cold chemical sterilants used on site. ○ Staff must be aware of the procedures for clean up in the event of spillage. ○ Staff can demonstrate or verbally explain procedure(s) used on site for chemical spill cleanup. ○ If personnel are unable to demonstrate or explain site-specific chemical spill cleanup procedures *and* cannot locate written chemical spill cleanup procedure instructions, site is considered deficient. ○ Cleanup procedures may vary from site to site depending on the cold chemical sterilants used. ○ The appropriate PPE for cold chemical sterilants clean up must be readily available. National Institute for Occupational Safety and Health (NIOSH) with the Centers for Disease Control and Prevention. Environmental Health and Safety guidelines for disinfectants and sterilization methods. MSDS for cold chemical sterilants. The American National Standard (ANSI)/Advancing Safety in Medical Technology (AAMI) ST58:2013. Control Methods and Work Practices: are in place to prevent or reduce exposure to the cold chemical sterilants. Cold chemical sterilants have toxic properties and are hazardous.

[72] 29 CFR 1910.1200, 1915.99, 1917.28, 1918.90, 1926.59, and 1928.21.
[73] See CDC guidelines on sterilizing heat sensitive dental instruments, available at: https://oshareview.com/2013/10/cdc-guidelines-sterilizing-heat-sensitive-dental-instruments-dental-infection-control/. 29 CFR 1910.1030(d)(3)(i), 29 CFR 1910.1030(d)(3)(ii), 29 CFR 1910.1030(d)(4)(ii)(A), 29 CFR 1910.1030(d)(4)(iii)(B), 29 CFR 1910.132, 29 CFR 1910.134. See the CDC Guidelines for Disinfection and Sterilization in Healthcare Facilities, available at: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/sterilization/index.html.

Criteria	VI. Infection Control Standards
	• Cold chemical sterilants must be used strictly in accordance with the manufacturer's directions. Always consult the manufacturer for safety precautions and MSDS information. • The appropriate PPE must be used to avoid inhalation or skin contact exposure to during the cold chemical sterilization/high level disinfection process. Examples of cold chemical sterilants include: ○ Glutaraldehyde (Cidex) ○ Peracetic acid ○ Hydrogen peroxide-based solutions Glutaraldehyde is a common cold chemical sterilants. Exposure to glutaraldehyde can cause the following health effects: throat and lung irritation, breathing difficulty, nose irritation, nosebleed, burning eyes and conjunctivitis, rash, hives, headaches, and nausea. Exposure to glutaraldehyde may be prevented or reduced by using the following control methods and work practices: ○ Use local exhaust ventilation. ○ Keep glutaraldehyde baths under a fume hood where possible.[74] ○ Avoid skin contact (use appropriate PPE-gloves and aprons made of nitrile or butyl rubber wear goggles and face shields). ○ Use only enough sterilants to perform the required sterilization procedure. ○ Seal or cover all containers holding the sterilants. ○ Attend training classes. **Autoclave/Steam Sterilization:** **VI.D.4a) Staff demonstrate/verbalize necessary steps/process to ensure sterility.** • Autoclave manufacturer's directions are strictly followed for instrument pre-cleaning, machine loading, operation safety precautions, minimum time-temperature criteria, and post sterilization processes. • Written operating procedures for autoclave are available on site to staff. • Documentation of sterilization loads include date, time and duration of run cycle, temperature, steam pressure, and operator of each run.

[74] For more information on glutaraldehyde exposure and safety tips, refer to the CDC guidance, available at: https://www.cdc.gov/niosh/docs/2001-115/default.html.

Criteria	VI. Infection Control Standards
	• If instruments/equipment are transported off-site for sterilization, equipment handling, and transport procedures are available on site to staff. • Documentation of instruments and personnel transporting must be maintained. **VI.D.4 b) Autoclave maintenance per manufacturer's guidelines.** **Autoclave Maintenance:** Autoclave is maintained and serviced according to manufacturer's guidelines. Documentation of maintenance should include: o Mechanical problems o Inspection dates o Results/outcome of routine servicing o Calibration o Repairs, etc. **Note:** If the manufacturer's guidelines are not present on site, then the autoclave is serviced annually by a qualified technician. A dated sticker on the autoclave or a service receipt is acceptable documentation of appropriate maintenance. **VI.D.4c) (CE) Spore testing of autoclave/steam sterilizer with documented results (at least monthly).** **Spore Testing:** • Autoclave spore testing is performed *at least monthly*, unless otherwise stated in manufacturer's guidelines. • Documentation of biological spore testing includes: o Date o Results o Types of spore test used o Person performing/documenting test results • Written procedures for performing routine spore testing and for handling positive spore test results are available on site to staff. • For positive spore tests, the autoclave is removed from service immediately until inspection is completed and a negative retest occurs. Procedures include: o ***Report*** problem o ***Repair*** autoclave o ***Retrieve*** all instruments sterilized since last negative spore test

Criteria	VI. Infection Control Standards
	○ ***Re-test*** autoclave ○ ***Re-sterilize*** retrieved instruments • Biologic spore test products vary and are designed for use based on specific autoclave type. Biologic control testing challenges the autoclave sterilization cycle with live, highly resistant, nonpathogenic spores. If spores are killed during processing, it is assumed that all other microorganisms are also killed and that the autoclave load is sterile. **Note: Documentation of monthly spore testing must be maintained onsite even for sterilization that is performed offsite.** **VI.D.4.d) (CE) Management of positive mechanical, chemical, and biological indicators of the sterilization process.** **Autoclave/Steam Sterilization Mechanical, Chemical, and Biological Indicators:[75]** • Sterilization failure can occur for reasons such as slight variation in the resistance of the spores, improper use of the sterilizer, and laboratory contamination during the culture. • Per CDC, the autoclave/steam sterilization procedure should be monitored routinely by using a combination of: ○ Mechanical Indicator: monitor sterilization process with a daily assessment of cycle time and temperature by examining the temperature record chart and an assessment of pressure via the pressure gauge (e.g., graphs, gauges, printouts) ○ Chemical Indicator: are usually either heat-or chemical-sensitive inks that change color when one or more sterilization parameters (e.g., steam-time, temperature, and/or saturated steam; ETO-time, temperature, relative humidity and/or ETO concentration) are present. ○ Biological: spore test – an indicator to evaluate the sterilizing conditions and indirectly the microbiologic status of the processed items Staff should adhere to site-specific protocol and/or manufacturer/product label for management of positive indicator(s).

[75] See the CDC Guidelines for Disinfection and Sterilization in Healthcare Facilities, available at: https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf.

Criteria	VI. Infection Control Standards

	VI.D.4.e) Sterilized packages are labeled with sterilization date and load identification information.
	Package and storage of sterilized items:
	• Following the sterilization process, medical and surgical devices must be handled using aseptic technique in order to prevent contamination.
	• Storage areas for sterilized packages are clean, dry and separated from non-sterile items by a functional barrier (e.g., shelf, cabinet door, and drawer).
	• Sterilized package labels include:
	  ○ Date of sterilization
	  ○ Load run identification information
	  ○ Initials of staff member
	  ○ General contents (e.g. suture set) each item in a sterile package need not be listed on the label if a master list of package contents is available elsewhere on site
	
	VI.D.4.f) Storage of sterilized packages.
	Storage of sterilized packages:[76]
	• Storage areas for sterilized packages are clean, dry and separated from non-sterile items by a functional barrier (e.g., shelf, cabinet door, and drawer).
	• Maintenance of sterility is event related, not time related.
	• Sterilized items are considered sterile until use, unless an event causes contamination.
	• Sterilized items are not considered sterile if package is opened, wet/moist, discolored or damaged, and should be kept removed from sterile package storage area.
	• Site has a process for routine evaluation of sterilized packages.

[76] See the CDC Summary of Recommendations regarding Disinfection and Sterilization, available at: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html, and the CDC Guidelines for Disinfection and Sterilization in Healthcare Facilities, available at: https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf.

Attachment C

Physical Accessibility Review Survey

California Department of Health Care Services
Medi-Cal Managed Care Division

Provider Name: □ PCP □ Specialist	Date of Review: Name of Reviewer:
Address: City:	Health Plan Name:
Phone: FAX:	Contact Person Name:

	Level of Access:
Basic Access: Demonstrates facility site access for the members with disabilities to parking, building, elevator, doctor's office, exam room and restroom. To meet Basic Access requirements, all (29) Critical Elements (CE) must be met.	☐ Basic Access
Limited Access: Demonstrates facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, doctor's office, exam room, and restroom. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.	☐ Limited Access
Medical Equipment Access: PCP site has height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus patient). This is noted in addition to level of Basic or Limited Access as appropriate.	☐ Medical Equipment is available

Below are the symbols that will be used in the provider directories to indicate areas of accessibility at a provider office/site. These should also be used in online directories. In order for a provider office to receive a symbol, the appropriate criteria must be met.

These symbols are in addition to identifying whether the provider office has Basic Access or Limited Access. A provider who has Basic Access will automatically meet the critical elements for the first six symbols (P, EB, IB, R, and E). And a provider who has Medical Equipment Access will meet the medical equipment elements for the last symbol (T).

Accessibility Indicator	Must Satisfy these Criteria	Yes	No	N/A	Comments
P = PARKING	Critical Elements (CE): 3, 7, 8, 11				
EB - EXTERIOR BUILDING	(CE): 14, 20, 22, 23 25, 27, 28, 31				
IB = INTERIOR BUILDING	(CE): 31, 34, 37 If lift include: 40 If elevators include: 53, 54, 55, 56, 57, 58				
R=RESTROOM	(CE): 65, 67, 68, 71, 75, 77				
E=EXAM ROOM	(CE): 80, 85				
T = EXAM TABLE/SCALE	Medical Equipment Elements (ME): 81, 82, 86				

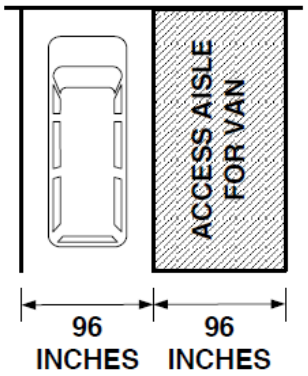
I certify that there have been no changes since the last physical accessibility review:

Name: _____ Signature: _____ Date: _____

I certify that there have been no changes since the last physical accessibility review:

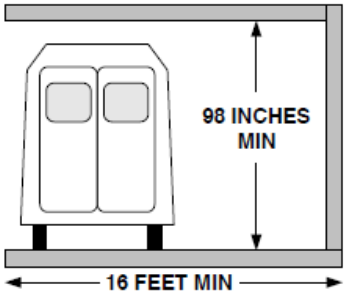
Name: _____ Signature: _____ Date: _____

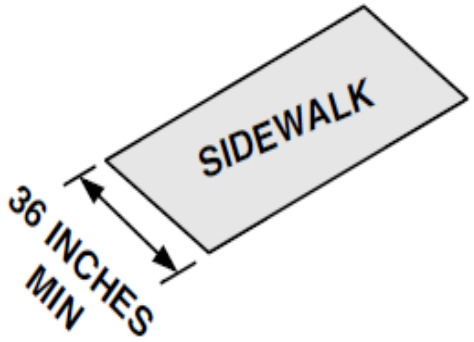
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
PARKING						
1	Is off-street public parking available?	Self explanatory.				
2	Are accessible parking spaces provided in off-street parking?	Self explanatory.				
3 (CE)	**Are the correct number of accessible parking spaces provided?** **1 to 25 total spaces – 1 required** **26 to 50 – 2 required** **51 to 75 – 3 required** **76 to 100 – 4 required** **101 to 150 – 5 required** **151 to 200 – 6 required** **201 to 300 – 7 required** **301 to 400 – 8 required**	If there are 25 total parking spaces or less, at least one accessible space is required. If there are between 26 and 50 total spaces, at least two accessible spaces are required, etc.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
4	Is the accessible parking space(s) closest to the main entrance?	The accessible parking space (s) should afford the shortest route of travel from adjacent parking to the accessible entrance.				
5	Is there an access aisle next to the accessible space(s)?	The access aisle is the space next to the accessible parking space where a person using the accessible space can load and unload from the vehicle. 				
6	Is the parking space(s) and access aisle(s) free of curb ramps that extend into the space and other obstructions?	If a curb ramp extends into the parking space(s) or access aisle, a person using that space and aisle would not have adequate level space to unload and load from the vehicle.				

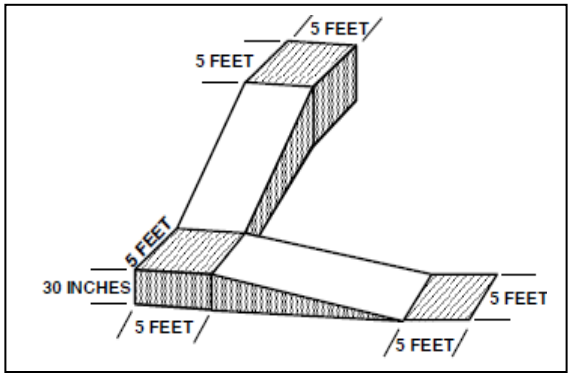
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
7 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the parking locations?**	Pathways should have curb ramps. Without curb ramps, wheelchair users may be required to travel in the street or behind parked cars where drivers cannot see them.				
8 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the drop off locations?**	See above Question # 7.				
9	Does every accessible parking space have a vertical sign posted with the International Symbol of Accessibility?	Symbol in the illustration depicts the International Symbol of Accessibility. 				

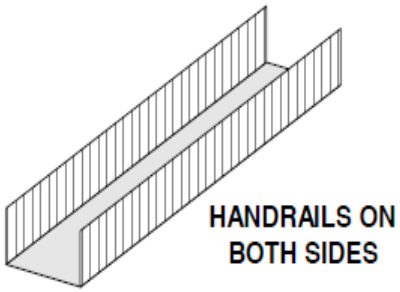
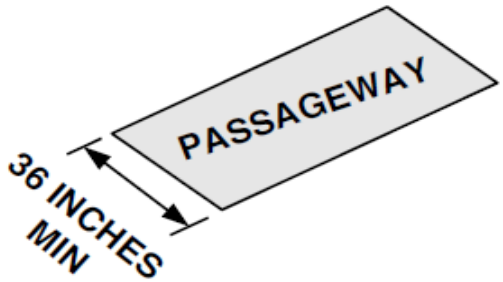
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
10	Are signs mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle?	Signs must be located so a vehicle parked in the space does not obscure them. (Van accessible spaces must be indicated with an additional sign)				
11 (CE)	**Is VAN accessible parking provided?**	1 van space for every 6 standard accessible spaces must be provided, but never less than one. For example, if there are 23 total spaces, at least one accessible space is required and it must be large enough (See Question # 5 for dimensions) to accommodate a van. If there are 201 total parking spaces, at least seven accessible spaces would be required and two of those would have to accommodate vans.				
12	Is VAN accessible parking signage provided?	Signs must be mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
13	If van accessible parking is provided in a parking garage, is there at least 8 feet 2 inches (98 inches total) vertical clearance available for full-sized, lift equipped vans?	If there is no parking garage, check NA. If designated accessible parking is located in a garage, the vertical clearance should be at a minimum 8 feet 2 inches (98 inches). Vertical clearance should be posted.  				
EXTERIOR ROUTE (FROM ACCESSIBLE PARKING, PUBLIC TRANSPORTATION, AND PUBLIC SIDEWALK TO THE ENTRANCE)						
14 (CE)	**For exterior routes, if the accessible route crosses a curb, is a curb ramp provided to the building entrance from the following: (Please mark NA for those that do not apply.)**	Self explanatory.				
	a. Parking?					
	b. Public transportation?					

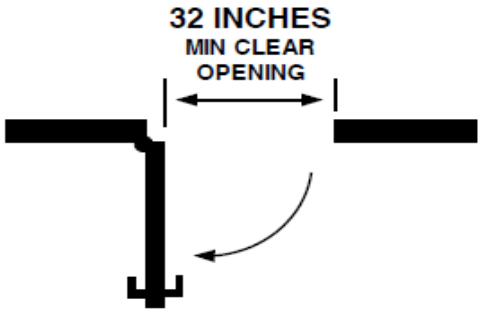
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	c. Public sidewalk?					
15	Is the accessible route to the building entrance at least 36 inches wide for exterior routes from the following: (Please mark NA for those that do not apply.)					
	a. Parking?					
	b. Public transportation?					
	c. Public sidewalk?					
16	Is the accessible route to the building entrance stable, firm, and slip resistant from the following: (Please mark NA for those that do not apply.)	An example of a stable surface is a floor or ground surface without loose elements like gravel or wood chips. Firm surfaces include solid concrete or pavement as opposed to a grassy, graveled or soft soil surface. Avoid glossy or slick surfaces such as ceramic tile.				
	a. Parking?					

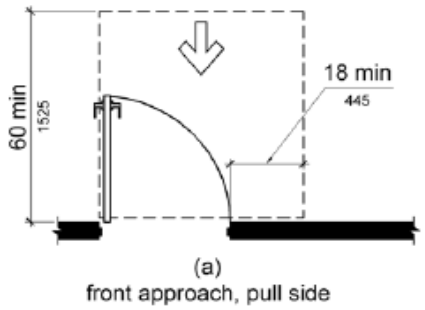
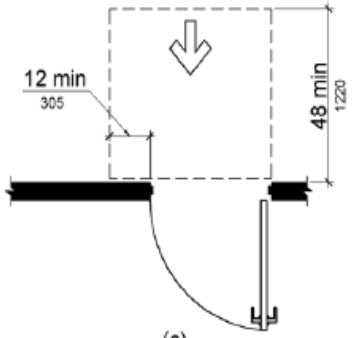
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	b. Public transportation?					
	c. Public sidewalk?					
17	Is there an accessible route that does not include stairs or steps?	Self explanatory.				
18	Is the route to the entrance from the accessible parking spaces, including transitions at curb ramps, free of grates, gaps, and openings that are both greater than ½ inch wide and over ¼ inch deep?	Self explanatory.				
RAMPS:						
19	Is an access ramp present?	If there is more than one ramp, select the one that appears to be the primary access ramp.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
20 (CE)	**Is each run (leg) of the ramp no longer than 30 feet between landings?**	**Each "run," shown in the white sections in the diagram below, must be no longer than 30 feet.** 				
21	Are 60 inches (5 feet) long, level landings provided at the top and bottom of each ramp run?	See Question 20 diagram above.				

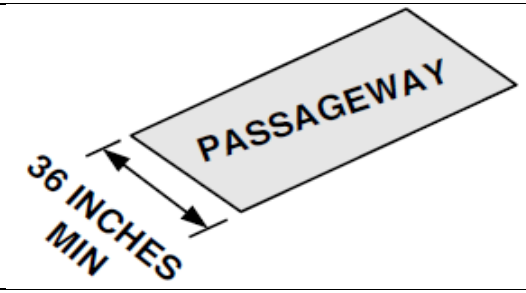
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
22 (CE)	**Are handrails provided on both sides of the ramp that are mounted between 34 and 38 inches above the ramp surface, if it is longer than 6 feet?**	If the ramp is not longer than 6 feet, check NA.  				
23 (CE)	**Are all ramps at least 36 inches wide?**	 				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
BUILDING ENTRANCE						
24	Is the main entrance accessible?	Self explanatory.				
25 (CE)	**If a main entrance is not accessible, is there another accessible entrance?**	Self explanatory.				
26	If a main entrance is not accessible, is there directional signage indicating the location of the accessible entrance?					

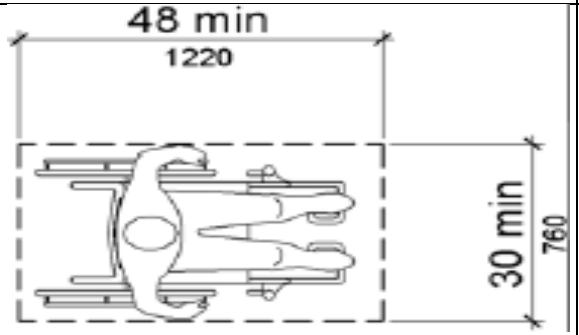
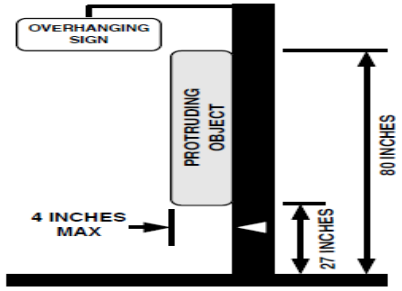
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
27 (CE)	**Do doors have an opening at least 32 inches wide (at the narrowest point below the opening hardware) when opened to 90°?**	When measuring double doors, measure the opening with one door open to 90°.  				
28 (CE)	**Is space available for a wheelchair user to approach, maneuver, and open the door?**	Appropriate space perpendicular and parallel to a doorway permits a wheelchair user, people using walkers and other mobility devices to open the door safely and independently. Following are two common examples of required minimum maneuvering clearances: 1. Approaching the door and pulling it toward you to open requires 60 inches of clear space perpendicular to the doorway and 18 inches parallel to the doorway. 2. Approaching the door and pushing it away from you to open requires 48 inches of clear space perpendicular to the doorway.				

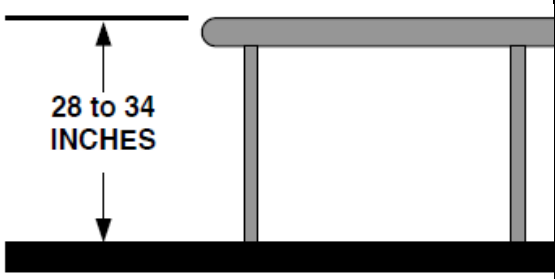
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
		 (a) front approach, pull side  (c) front approach, push side, door provided with both closer and latch				
29	Is the space required to open the door level and clear of movable objects (chairs, trash cans, etc.)?	If there are nonpermanent items such as trash cans, merchandise, etc., located in these areas, they must be removed or relocated.				

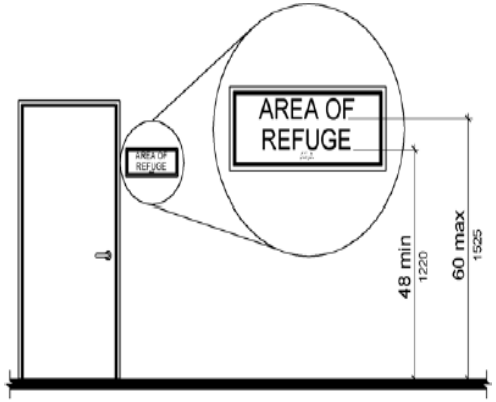
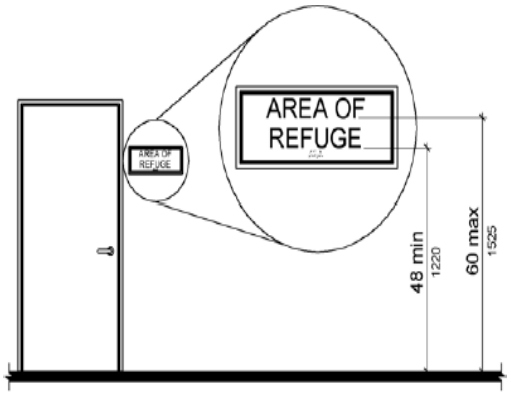
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
30	Are there automatic doors?	Self explanatory.				
31 (CE)	**Do entrance doors have handles that can be opened without grasping, pinching, or twisting of the wrist?**	Can the door be opened by someone with a closed fist or fully open hand? Door knobs, for example, cannot be used in this manner.				
INTERIOR ROUTE (FROM THE BUILDING ENTRANCE TO THE CLINIC/OFFICE ENTRANCE, TO THE REGISTRATION COUNTER/WINDOW, AND THROUGH THE CLINIC/OFFICE TO AREAS THAT PATIENTS COULD GO)						
32	Is there an interior route to the medical office?	Some medical offices are accessed directly from the street or parking lot rather than being located within a larger office building or complex, therefore they do not have interior routes.				
33	Is there an interior accessible route to the medical office that does not include stairs or steps?	Floors of a given story are level throughout the building, or connected by ramps, passenger elevators or access lifts.				

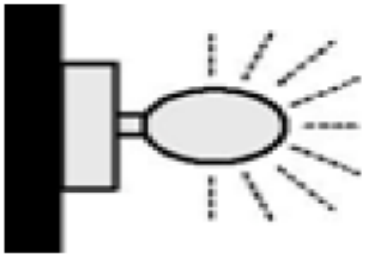
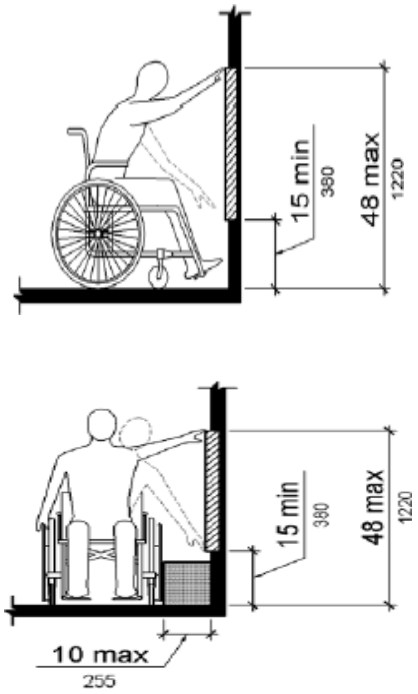
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
34 (CE)	**Are <u>ALL</u> interior paths of travel at least 36 inches wide?**					
35	Is the interior accessible route stable, firm, and slip resistant?	Avoid unsecured carpeting or other loose elements. It is easier for people using walkers, wheelchairs and other aids to walk or push on surfaces that have low pile carpeting without a pad underneath. Glossy or slick surfaces such as ceramic tile or marble can be slippery.				
36	Is the interior accessible route well lighted?	A brightly lit corridor will help avoid falls.				
37 (CE)	**If there are stairs on the accessible route, are there handrails on each side?**	If there are no stairs, check NA.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
38	If there are stairs, are all stairs risers closed that are on the accessible route?					
39	If there are stairs, are all stair treads marked by a stripe providing a clear visual contrast to assist people with visual impairments?	Contrast striping must be provided on the upper approach and lower tread for interior stairs and on the upper approach and all treads for exterior stairs. Stripes must be 2" to 4" wide placed parallel to and no more than 1" from the nose of the step or upper approach. The stripe must extend the full width of the step or upper approach and should be made of material that is at least as slip resistant as the other stair treads (a painted stripe is acceptable).				
40 (CE)	**If a platform lift is used, can it be used without assistance?**	If there is no platform lift, check NA. Lifts sometimes require a key for operation, thus preventing independent use.				

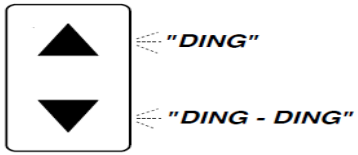
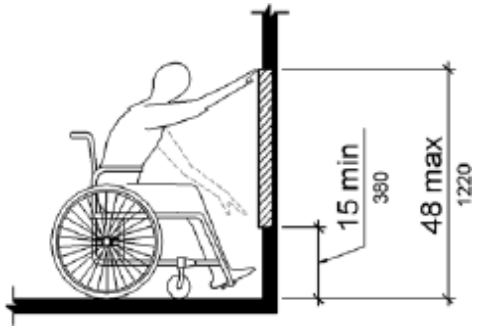
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
41	Does the interior door to the medical office require less than 5 pounds of pressure to open?	If interior door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
42	Is there a clear space 30 inches wide by 48 inches long in the waiting area(s) for a wheelchair or scooter user to park that is not in the path of travel?					
43	Is the path through the medical office free of any objects that stick out into the circulation path that a blind person might not detect with a cane?	If an object protrudes more than 4 inches and is located between 27 inches above the walking surface and below 80 inches, a blind person walking with a cane will not detect it. 				

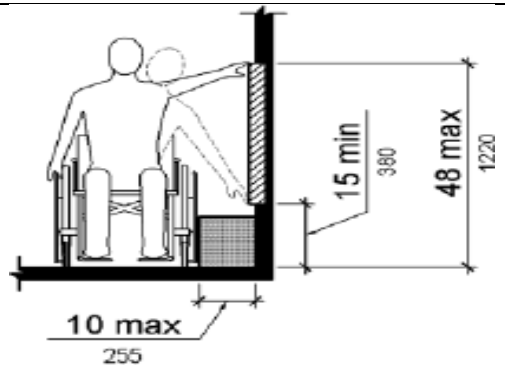
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
44	If floor mats are used, are the edges of floor mats stiff enough or secured so that they do not roll up?	If floor mats are not in use, check NA. Floor mats that are not secured to the floor can roll up or bunch up under walkers or wheelchair casters and cause a tripping hazard.				
45	Is a section of the sign-in/registration counter no more than 34 inches high and at least 36 inches wide and free of stored items.					
46	Does the office have a method, other than a lowered counter, by which people can sign in/register? (If yes, please note this method in comments.)	A medical office may use reasonable alternative methods to meet this need such as a clip board.				

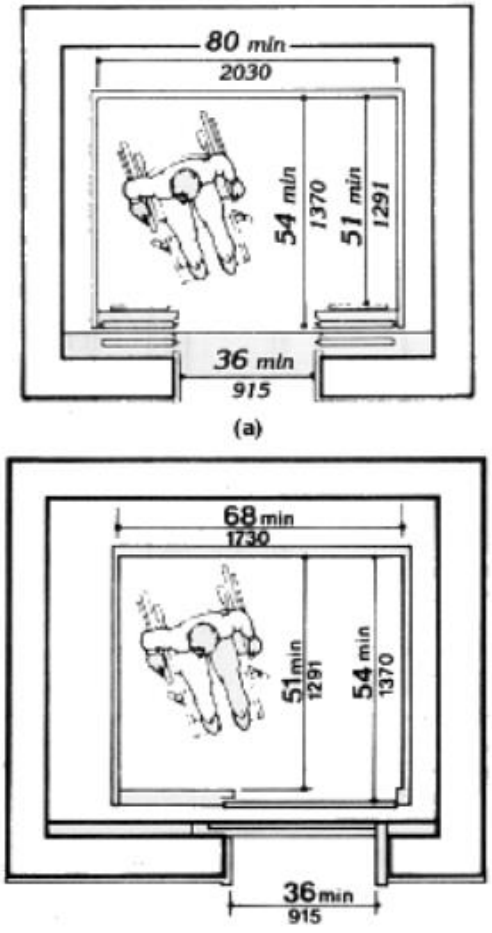
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
47	Do signs identifying permanent rooms and spaces include raised letters and Braille?					
48	Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor?	 Raised letters and Braille signs are either on the latch side of doors or on the face of doors and are mounted between 48 inches and 60 inches from the floor.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
49	If the building has a fire alarm system, are visual signals provided in each public space, including toilet rooms and each room where patients are seen?	If the building does not have a fire alarm system, check NA. 				
50	Are all patient-operated controls (call buttons, self-service literature, brochures, hand sanitizers, etc.) mounted or presented between 15 inches and 48 inches from the floor?					

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
51	Are all patient operated controls (e.g., call buttons, hand sanitizers) operable with one hand without grasping, pinching, or twisting to operate?	For example, a pump hand sanitizer that must be operated using two hands is inaccessible.				
ELEVATORS						
52	Is there an elevator?					
53 (CE)	**If needed, is the elevator available for public/patient use during business hours?**	Self explanatory.				

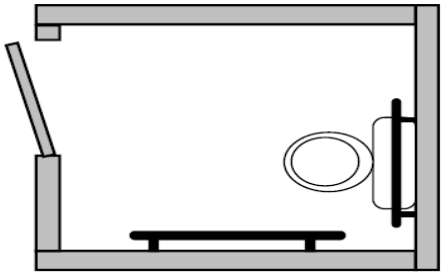
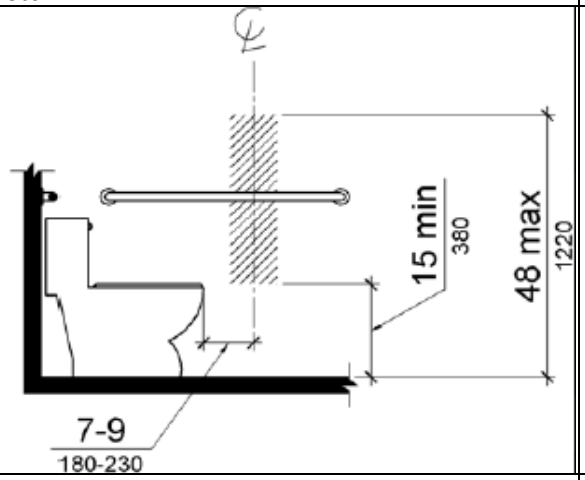
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
54 (CE)	**Is the elevator equipped with both visible and audible door opening/closing and floor indicators?**	A visible and audible signal is required at each elevator entrance to indicate which car is answering a call. An audible signal would be a "ding" or a verbal announcement. 				
55 (CE)	**Is there a raised letter and Braille sign on each side of each elevator jamb?**	These signs allow everyone to know which floor they are on before entering or exiting the elevator.				
56 (CE)	**Are the hall call buttons for the elevator no higher than 48 inches from the floor?**					

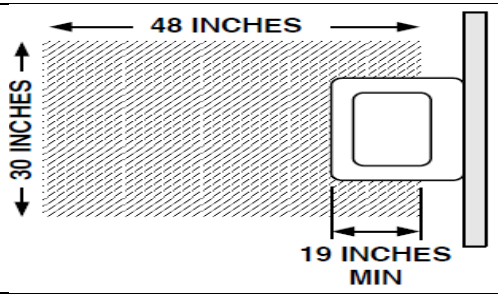
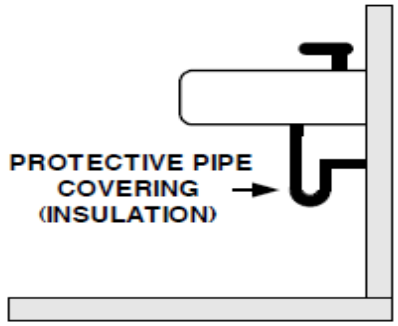
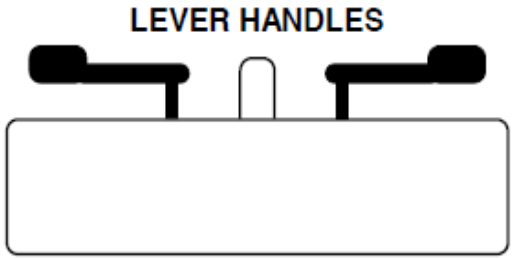
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
						

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
57 (CE)	**Is the elevator car large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit?**	The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide, depending on where the door is located.  				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
58 (CE)	**Do the buttons on the control panel inside the elevator have Braille and raised characters/symbols near the buttons?**	Self explanatory.				
59	Is there an emergency communication system in the elevator?	Self explanatory.				
60	Is the elevator emergency communication system usable without requiring voice communication?	It is essential that emergency communication not be dependent on voice communications alone because the safety of people with hearing or speech impairments could be jeopardized. Visible signal requirement could be satisfied with something as simple as a button that lights when the message is answered, indicating that help is on the way.				
61	Do raised letters and Braille identify the emergency intercom in the elevator?	Self explanatory.				

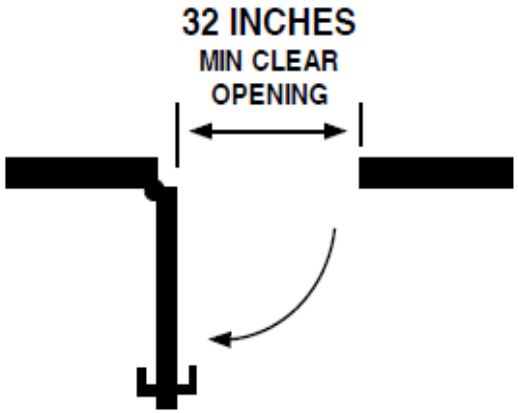
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
TOILET ROOMS (INCLUDING THOSE USED FOR SPECIMEN COLLECTION)						
ALL TOILET ROOMS:						
62	Is there an accessible toilet room?	Self explanatory.				
63	If there is an inaccessible toilet room, is there directional signage to an accessible toilet room?	Mark NA if there are no inaccessible toilet rooms. Self explanatory.				
64	Does the interior door to the restroom require less than 5 pounds of pressure to open?	If restroom door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
65 (CE)	**For all toilet rooms with and without stalls:**	Grab bars should be installed in a horizontal position between 33 and 36 inches above the				

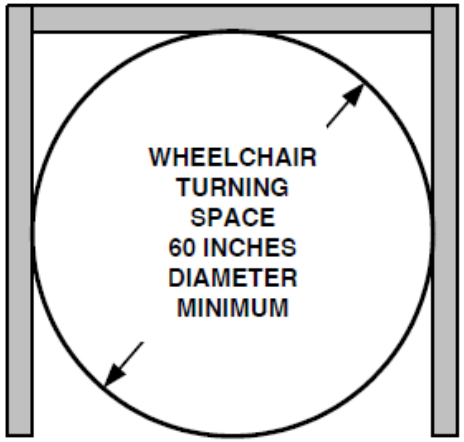
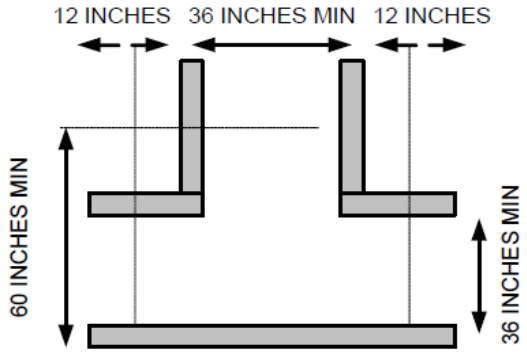
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	Are grab bars provided, one on the wall behind the toilet and one on the wall next to the toilet?	floor measured to the top of the gripping surface. 				
66	Are all objects mounted at least 12 inches above and 1½ inches below the grab bars?	This includes seat cover dispensers, toilet paper dispensers, sanitizers, trash containers, etc.				
67 (CE)	**Is the toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7 inches and 9 inches in front of the toilet, and at least 15 inches high?**					
68 (CE)	**Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair users to park in front of the sink?**	This space must extend at least 17 inches under the sink from the front edge, although it can extend up to 19 inches underneath.				

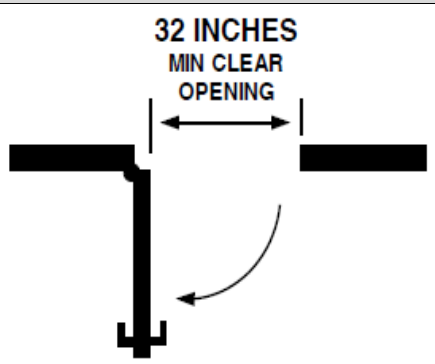
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
						
69	Is the space in front of the sink free of trash cans and other movable items?	Self explanatory.				
70	Are the pipes and water supply lines under the sink wrapped with a protective cover?					
71 (CE)	**Are faucet handles operable with one hand and without grasping, pinching, or twisting? (Check Yes if faucets are automatic.)**	A knob handle would not be accessible. 				

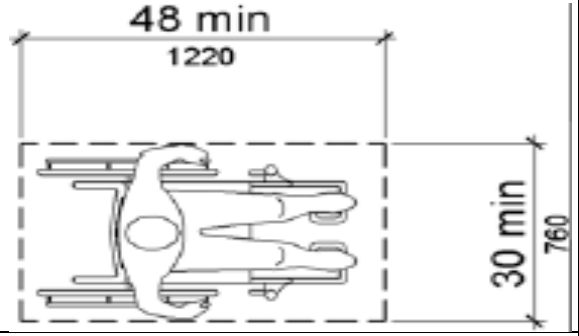
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
72	Are all dispensers mounted no higher than 40 inches from the floor?	Included are soap dispensers, paper towel dispensers, seat cover dispensers, hand dryers, etc.				
73	Are all dispensers (soap, paper towel, etc.) operable with one hand and without grasping, pinching, or twisting?	Self explanatory.				
74	If there is a pass-through door for specimen collection, is there a 30 inches by 48 inches space for a wheelchair or scooter user to park in front of it?	If there is no such door, check NA.				

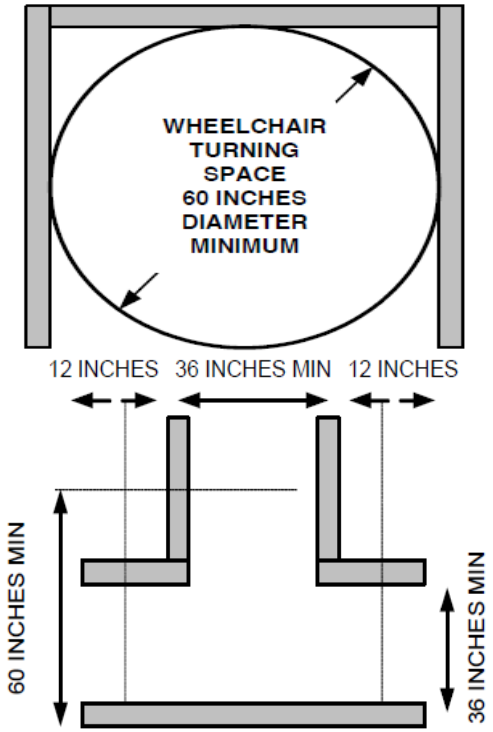
TOILET ROOM WITHOUT STALLS

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
75 (CE)	***Toilet room without stalls:*** **Do toilet room doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**	If there is no toilet room without stalls, check NA.  				
76	Is the space inside the toilet room without stalls clear, without trash cans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	TOILET ROOM WITH STALLS					
77 (CE)	***Toilet Room with stalls:*** **Is there a 60-inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space inside the toilet room with stalls to allow a turn around for wheelchair and scooter users?**	If there is no toilet room with stalls, check NA.   				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
78	Is the space inside the accessible stall clear, without trash cans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				
79	Can the hardware on the stall door be operated without grasping, pinching, or twisting of the wrist?	Handles, pulls, latches, locks, and other operating devices on accessible doors shall have a shape that is easy to grasp with one hand and does not require tight grasping, tight pinching, or twisting of the wrist to operate.				
EXAM/TREATMENT ROOMS/MEDICAL EQUIPMENT						
80 (CE)	**Do exam room doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**					

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
81 (ME)	**Is there a height adjustable exam table that lowers to between 17 inches and 19 inches from the floor to the top of the cushion?**	Self explanatory				
82 (ME)	**Is there space next to the height adjustable exam table for a wheelchair or scooter user to approach, park, and transfer or be assisted to transfer onto the table?**	9 				
83	Does the exam table provide elements to assist during a transfer (such as rails) and support a person while on the table? (If yes, please list in comments.)	Items that could help support a patient while on the table would be armrests, side rails, padded straps, cushions, wedges, etc.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
84	Is a lift available to assist staff with transfers (portable, overhead, or ceiling mounted)?	Self explanatory.				
85 (CE)	**Is there a 60 inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space so that a wheelchair or scooter user can make a 180° turn?**					

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
86 (ME)	**Is a weight scale available within the medical office with a platform to accommodate a wheelchair or scooter and the patient?**	Accessible scales are usable by all people including: wheelchair users, people with activity limitations, and larger people who may exceed a standard weight scale limit. This includes people with conditions that interfere with mobility, walking, climbing, using steps (joint pain, short stature, pregnancy, fatigue, respiratory and cardiac conditions, post surgical conditions, orthopedic injuries); and/or who use mobility devices (e.g. canes, crutches, walkers).				

References

2010 ADA Standards for Accessible Design
U.S Department of Justice
http://www.ada.gov/2010ADAstandards_index.htm

The revised regulations for Titles II and III of the Americans with Disabilities Act of 1990 (ADA) were published in the Federal Register on September 15, 2010. They provide the scoping and technical requirements for new construction and alterations resulting from the adoption of revised 2010 Standards in the final rules for Title II (28 CFR part 35) and Title III (28 CFR part 36). The 2010 ADA Standards go into effect March 15, 2012, but can be used now instead of the 1991 standards. The FSR Attachment C draws upon access requirements found in both the 1991 Americans with Disabilities Act Accessibility Guidelines and the 2010 ADA Standards. Some diagrams that appear in the FSR Attachment C are reproduced from these sources.

Two questions in the FSR Attachment C were drawn from Title 24, Part 2 of the California Building Standards Code. These are

1133B.4.4 – Striping for the visually impaired (Rev.1-1-2009), and 1115B-1 – Bathing and Toilet Facilities, placement of toilet paper dispensers. These standards can be found in:
2009 California Building Standards Code with California Errata and Amendments
State of California
Department of General Services
Division of the State Architect
Updated April 27, 2010
http://www.documents.dgs.ca.gov/dsa/pubs/access_manual_rev_04-27-10.pdf

Some diagrams are reprinted with permission from the Kentucky Department of Vocational Rehabilitation. These illustrations can also be found in:
"Health Care Usability Profile V3"

Oregon Health & Science University RRTC: Health & Wellness
Authors: Drum, C.E., Davis, C.E., Berardinelli, M., Cline, A., Laing, R., Horner-Johnson, W., & Krahn, G.
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Portland, OR 97239
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healthwellness.org

Attachment D

Ancillary Services Physical Accessibility Review Survey

California Department of Health Care Services
Managed Care Quality and Monitoring Division

For purposes of this tool, Ancillary Services refers to Diagnostic and Therapeutic services such as, but not limited to: Radiology, Imaging, Cardiac Testing, Kidney dialysis, Physical Therapy , Occupational therapy , Speech therapy ,Cardiac rehabilitation, Pulmonary testing.

Provider Name: _____ ☐ Radiology ☐ Infusion ☐ Physical Therapy ☐ Other _____	Date of Review: Name of Reviewer:
Address: City:	Health Plan Name:
Phone: FAX:	Contact Person Name:

	Level of Access:
Basic Access: Demonstrates ancillary facility site access for the members with disabilities to parking, building, elevator, restroom, diagnostic and treatment use. To meet Basic Access requirements, all (34) Critical Elements (CE) must be met.	☐ Basic Access
Limited Access: Demonstrates ancillary facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, restroom, diagnostic and treatment use. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.	☐ Limited Access
Medical Equipment: Diagnostic and treatment equipment meet accessibility features for use as indicated the "accessibility indicators". (assistance is available for the equipment used).	☐ Medical Equipment is available ☐ List of Equipment

Below are the symbols that will be used in the provider directories to indicate areas of accessibility at the ancillary site. These should also be used in online directories. In order for an ancillary site to receive a symbol, the appropriate criteria must be met.

These symbols are in addition to identifying whether the provider office has Basic Access or Limited Access. A provider who has Basic Access will automatically meet the critical elements for the first 5 symbols (P, EB, IB, R, PD).

Accessibility Indicator	Must Satisfy these Criteria	Yes	No	N/A	Comments
P = PARKING	**Critical Elements (CE): 3,7,8,11**				
EB = EXTERIOR BUILDING	**(CE): 14,20,21,22,25**				
IB = INTERIOR BUILDING	**(CE): 28,31,42,43,44,45,46,47**				
R =RESTROOM	**(CE): 53, 55,56,59,62,64**				
PD = PATIENT DIAGNOSTIC AND TREATMENT USE	**(CE): 66,67,70,76,78**				
T = MEDICAL EQUIPMENT	**(T): 72,73,74,77,80,81**				

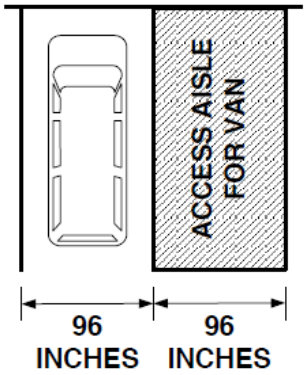
2nd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

Name: _____ Signature: _____ Date: _____

3rd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

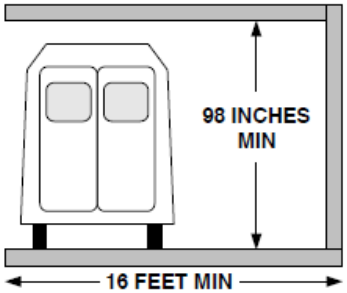
Name: _____ Signature: _____ Date: _____

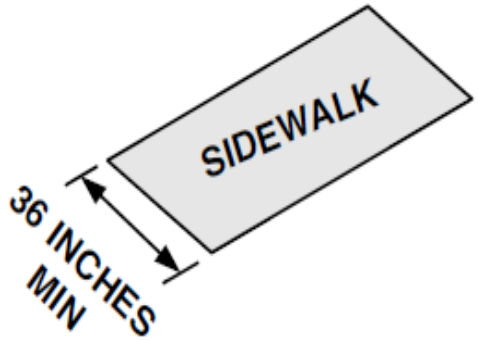
PARKING						
1	Is off-street public parking available?	Self explanatory.				
2	Are accessible parking spaces provided in off-street parking?	Self explanatory.				
3 (CE)	**Are the correct number of accessible parking spaces provided?** **1 to 25 total spaces – 1 required** **26 to 50 – 2 required** **51 to 75 – 3 required** **76 to 100 – 4 required** **101 to 150 – 5 required** **151 to 200 – 6 required** **201 to 300 – 7 required** **301 to 400 – 8 required**	**If there are 25 total parking spaces or less, at least one accessible space is required. If there are between 26 and 50 total spaces, at least two accessible spaces are required, etc.**				
4	Is the accessible parking space(s) closest to the main entrance?	The accessible parking space (s) should afford the shortest route of travel from adjacent parking to the accessible entrance.				

5	Is there an access aisle next to the accessible space(s)?	The access aisle is the space next to the accessible parking space where a person using the accessible space can load and unload from the vehicle.  				
6	Is the parking space(s) and access aisle(s) free of curb ramps that extend into the space and other obstructions?	If a curb ramp extends into the parking space(s) or access aisle, a person using that space and aisle would not have adequate level space to unload and load from the vehicle.				

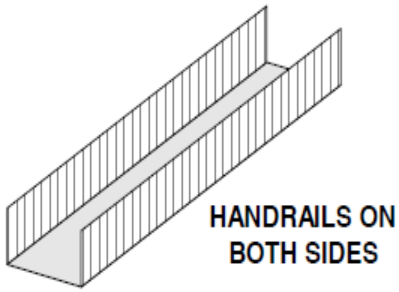
7 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the parking locations?**	**Pathways should have curb ramps. Without curb ramps, wheelchair users may be required to travel in the street or behind parked cars where drivers cannot see them.**				
8 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the drop off locations?**	**See above Question # 7.**				

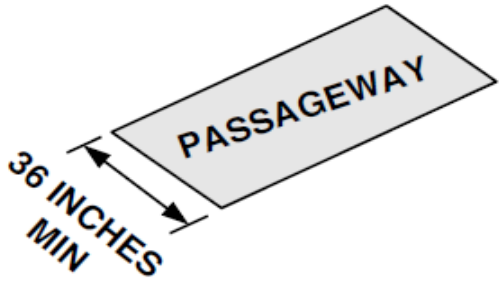
9	Does every accessible parking space have a vertical sign posted with the International Symbol of Accessibility?	Symbol in the illustration depicts the International Symbol of Accessibility. 				
10	Are signs mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle?	Signs must be located so a vehicle parked in the space does not obscure them. (Van accessible spaces must be indicated with an additional sign)				
	Is VAN accessible parking provided?	**1 van space for every 6 standard accessible spaces must be provided, but never less than one. For example, if there are 23 total spaces, at least one accessible space is required and it must be large enough (See Question # 5 for dimensions) to accommodate a van. If there are 201 total parking spaces, at least seven accessible spaces would be required and two of those would have to accommodate vans.**				
12	Is VAN accessible parking signage provided?	Signs must be mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle.				

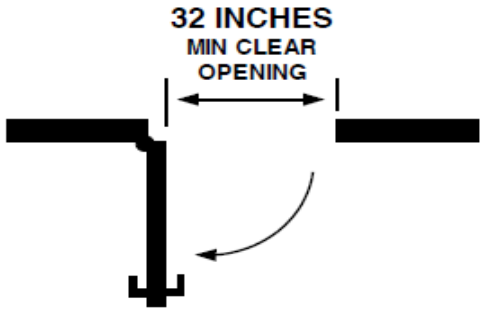
13	If van accessible parking is provided in a parking garage, is there at least 8 feet 2 inches (98 inches total) vertical clearance available for full-sized, lift equipped vans?	If there is no parking garage, check NA. If designated accessible parking is located in a garage, the vertical clearance should be at a minimum 8 feet 2 inches (98 inches). Vertical clearance should be posted.  				

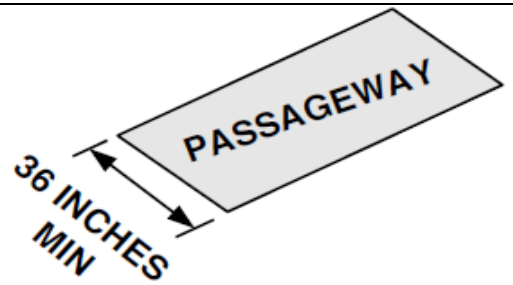
EXTERIOR ROUTE (FROM ACCESSIBLE PARKING, PUBLIC TRANSPORTATION, AND PUBLIC SIDEWALK TO THE ENTRANCE)						
14 (CE)	**For exterior routes, if the accessible route crosses a curb, is a curb ramp provided to the building entrance from the following: (Please mark NA for those that do not apply.)**	**Self explanatory.**				
	a. Parking?					
	b. Public transportation?					
	c. Public sidewalk?					
15	Is the accessible route to the building entrance at least 36 inches wide for exterior routes from the following:(Please mark NA for those that do not apply.)					

	a. Parking?					
	b. Public transportation?					
	c. Public sidewalk?					
16	Is the accessible route to the building entrance stable, firm, and slip resistant from the following: (Please mark NA for those that do not apply.)	An example of a stable surface is a floor or ground surface without loose elements like gravel or wood chips. Firm surfaces include solid concrete or pavement as opposed to a grassy, graveled or soft soil surface. Avoid glossy or slick surfaces such as ceramic tile.				
	a. Parking?					
	b. Public transportation?					
	c. Public sidewalk?					
17	Is there an accessible route that does not include stairs or steps?	Self explanatory.				

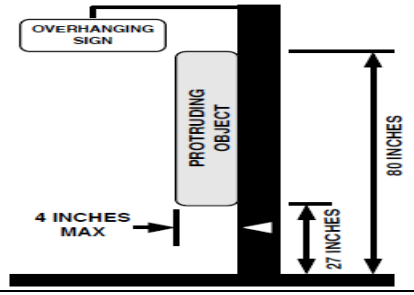
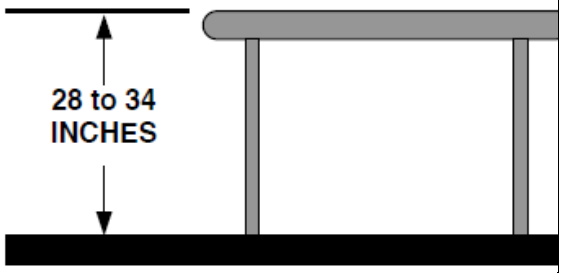
18	Is the route to the entrance from the accessible parking spaces, including transitions at curb ramps, free of grates, gaps, and openings that are both greater than ½ inch wide and over ¼ inch deep?	Self explanatory.				
RAMPS:						
19	Is an access ramp present?	If there is more than one ramp, select the one that appears to be the primary access ramp.				
20 (CE)	**Are handrails provided on both sides of the ramp that are mounted between 34 and 38 inches above the ramp surface, if it is longer than 6 feet?**	**If the ramp is not longer than 6 feet, check NA.**  				

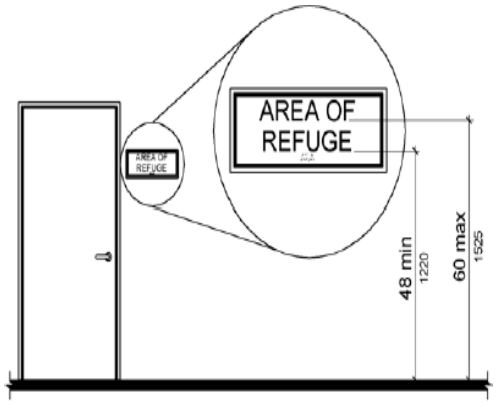
21 (CE)	**Are all ramps at least 36 inches wide?**					

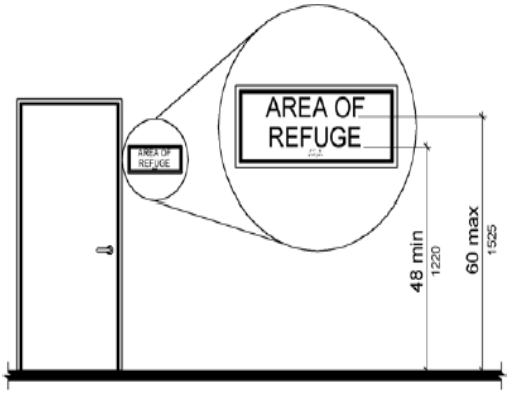
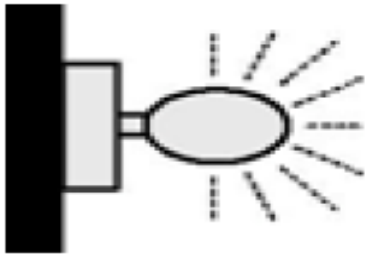
BUILDING ENTRANCE						
22 CE	**Is the main entrance accessible?**	**Self explanatory.**				
23	If a main entrance is not accessible, is there another accessible entrance?	Self explanatory.				
24	If a main entrance is not accessible, is there directional signage indicating the location of the accessible entrance?					
25 (CE)	**Do doors have an opening at least 32 inches wide (at the narrowest point below the opening hardware) when opened to 90°?**	**When measuring double doors, measure the opening with one door open to 90°.** 				

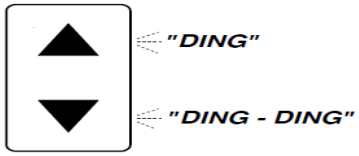
26	Are there automatic doors?	Self explanatory.				
INTERIOR ROUTE (FROM THE BUILDING ENTRANCE, TO THE REGISTRATION COUNTER/WINDOW, AND THROUGH TO THE PARTICIPANT AREAS						
27	Is there an interior route to the patient area?	Some patient areas are accessed directly from the street or drop off rather than being located within a larger building or complex, therefore they do not have interior routes.				
	Are <u>ALL</u> interior paths of travel at least 36 inches wide?					
29	Is the interior accessible route stable, firm, and slip resistant?	Avoid unsecured carpeting or other loose elements. It is easier for people using walkers, wheelchairs and other aids to walk or push on surfaces that have low pile carpeting without a pad underneath. Glossy or slick surfaces such as ceramic tile or marble can be slippery.				

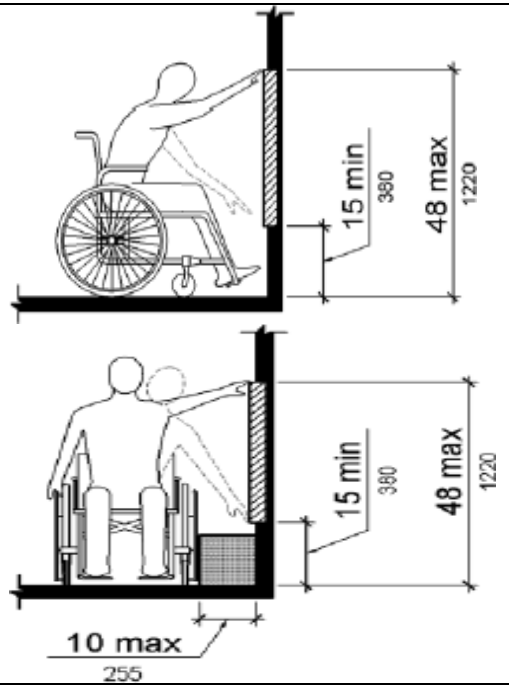
30	Is the interior accessible route well lighted?	A brightly lit corridor will help avoid falls.				
31 (CE)	**If there are stairs on the accessible route, are there handrails on each side?**	**If there are no stairs, check NA.**				
32	If there are stairs, are all stair risers closed that are on the accessible route?					
33	If there are stairs, are all stair treads marked by a stripe providing a clear visual contrast to assist people with visual impairments?	Contrast striping must be provided on the upper approach and lower tread for interior stairs and on the upper approach and all treads for exterior stairs. Stripes must be 2" to 4" wide placed parallel to and no more than 1" from the nose of the step or upper approach. The stripe must extend the full width of the step or upper approach and should be made of material that is at least as slip resistant as the other stair treads (a painted stripe is acceptable).				

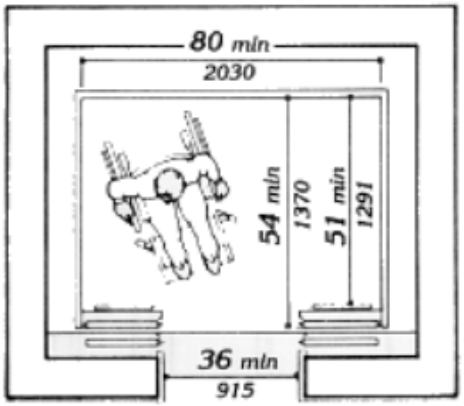
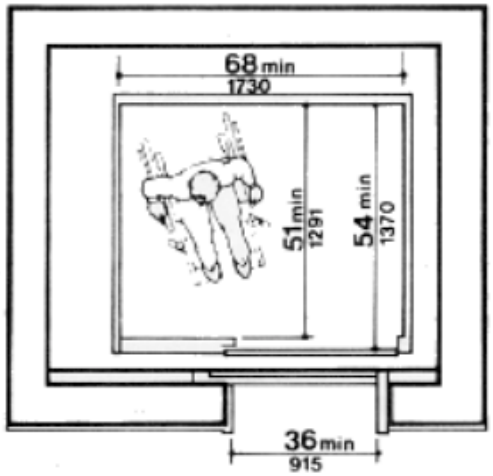
34	Is the path through the facility free of any objects that stick out into the circulation path that a blind person might not detect with a cane?	If an object protrudes more than 4 inches and is located between 27 inches above the walking surface and below 80 inches, a blind person walking with a cane will not detect it.  				
35	If floor mats are used, are the edges of floor mats stiff enough or secured so that they do not roll up?	If floor mats are not in use, check NA. Floor mats that are not secured to the floor can roll up or bunch up under walkers or wheelchair casters and cause a tripping hazard.				
36	Is a section of the sign-in/registration counter no more than 34 inches high and at least 36 inches wide and free of stored items?	 				

37	Does the office have a method, other than a lowered counter, by which people can sign in/register? (If yes, please note this method in comments.)	A medical office may use reasonable alternative methods to meet this need such as a clip board.				
38	Do signs identifying permanent rooms and spaces include raised letters and Braille?					

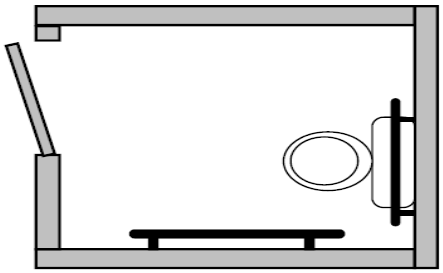
39	Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor?	 Raised letters and Braille signs are either on the latch side of doors or on the face of doors and are mounted between 48 inches and 60 inches from the floor.				
40	If the building has a fire alarm system, are visual signals provided in each public space, including toilet rooms and Participant Areas?	If the building does not have a fire alarm system, check NA. 				

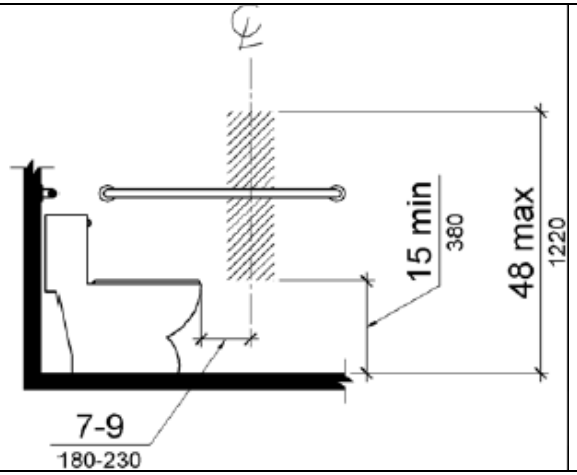
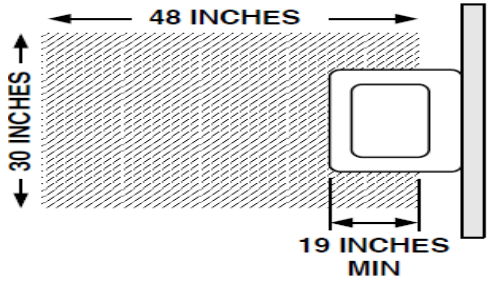
ELEVATORS						
41	Is there an elevator?	Self explanatory.				
42 (CE)	**If needed, is the elevator available for public/patient use during business hours?**	**Self explanatory.**				
43 (CE)	**Is the elevator equipped with both visible and audible door opening/closing and floor indicators?**	**A visible and audible signal is required at each elevator entrance to indicate which car is answering a call. An audible signal would be a "ding" or a verbal announcement.** 				
44 (CE)	**Is there a raised letter and Braille sign on each side of each elevator jamb?**	**These signs allow everyone to know which floor they are on before entering or exiting the elevator.**				

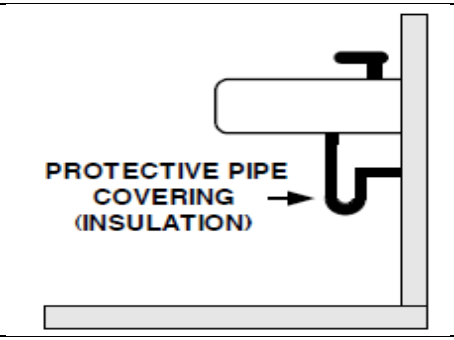
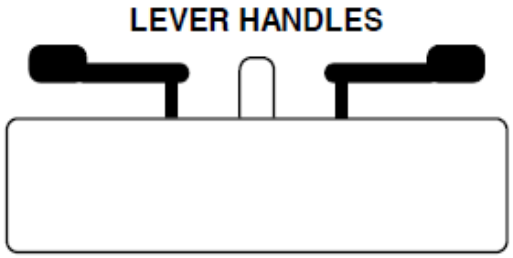
45 (CE)	**Are the hall call buttons for the elevator no higher than 48 inches from the floor?**					

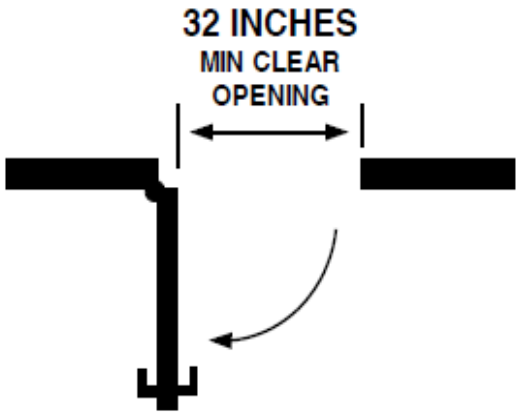
46 (CE)	**Is the elevator car large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit?**	**The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide, depending on where the door is located.**  (a)  				
	Do the buttons on the control panel inside the elevator have Braille and raised characters/symbols near the buttons?	**Self explanatory.**				

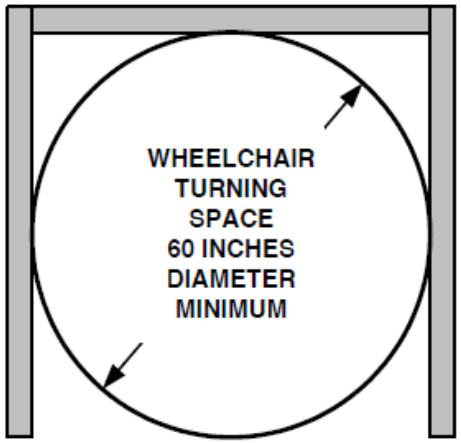
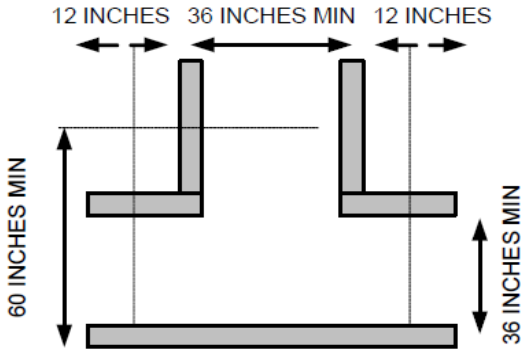
48	Is there an emergency communication system in the elevator?	Self explanatory.				
49	Is the elevator emergency communication system usable without requiring voice communication?	It is essential that emergency communication not be dependent on voice communications alone because the safety of people with hearing or speech impairments could be jeopardized. Visible signal requirement could be satisfied with something as simple as a button that lights when the message is answered, indicating that help is on the way.				
50	Do raised letters and Braille identify the emergency intercom in the elevator?	Self explanatory.				

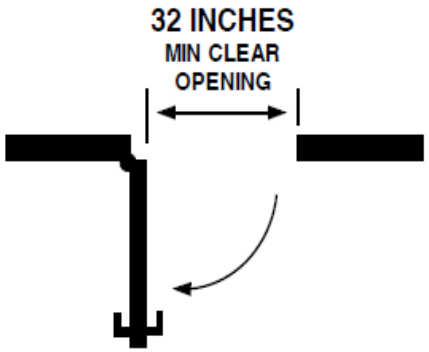
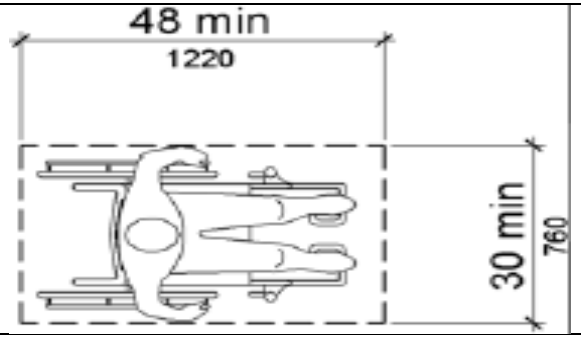
ALL RESTROOMS/TOILET ROOMS (WITH AND WITHOUT STALLS):						
51	Is there an accessible restroom/toilet room?	Self explanatory.				
52	Does the interior door to the restroom require less than 5 pounds of pressure to open?	If restroom door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
53 (CE)	**Are grab bars provided, one on the wall behind the toilet and one on the wall next to the toilet?**	**Grab bars should be installed in a horizontal position between 33 and 36 inches above the floor measured to the top of the gripping surface.** 				
54	Are all objects mounted at least 12 inches above and 1½ inches below the grab bars?	This includes seat cover dispensers, toilet paper dispensers, sanitizers, trash containers, etc.				

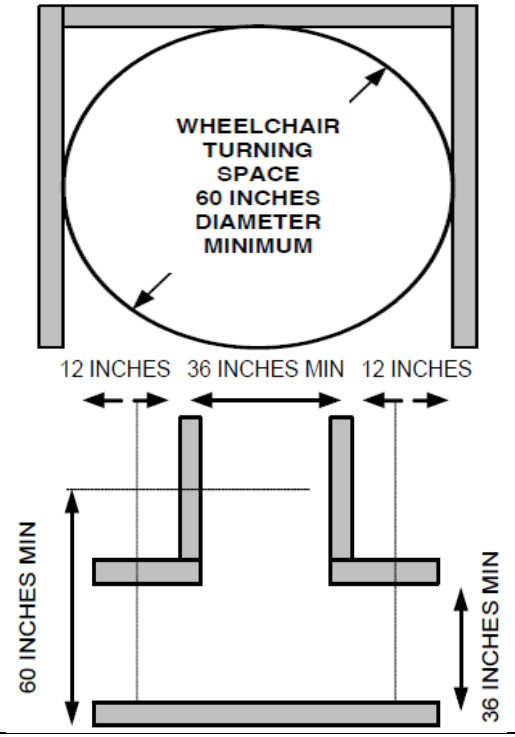
55 (CE)	**Is the toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7 inches and 9 inches in front of the toilet, and at least 15 inches high?**					
56 (CE)	**Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair users to park in front of the sink?**	**This space must extend at least 17 inches under the sink from the front edge, although it can extend up to 19 inches underneath.** 				
57	Is the space in front of the sink free of trashcans and other movable items?	Self explanatory.				

58	Are the pipes and water supply lines under the sink wrapped with a protective cover?					
59 (CE)	**Are faucet handles operable with one hand and without grasping, pinching, or twisting? (Check Yes if faucets are automatic.)**	**A knob handle would not be accessible.** 				
60	Are all dispensers mounted no higher than 40 inches from the floor?	Included are soap dispensers, paper towel dispensers, seat cover dispensers, hand dryers, etc.				
61	Are all dispensers (soap, paper towel, etc.) operable with one hand and without grasping, pinching, or twisting?	Self explanatory.				

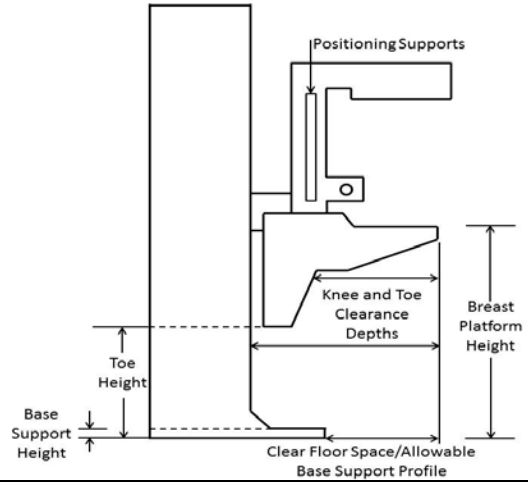
62 (CE)	**Do restroom doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**					
63	Is the space inside the restroom clear, without trashcans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				

64 (CE)	**Is there a 60-inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space inside the restroom to allow a turn around for wheelchair and scooter users?**	 				
65	Can the hardware on the stall door be operated without grasping, pinching, or twisting of the wrist?	Handles, pulls, latches, locks, and other operating devices on accessible doors shall have a shape that is easy to grasp with one hand and does not require tight grasping, tight pinching, or twisting of the wrist to operate.				

PATIENT AREAS (DIAGNOSTIC & TREATMENT, ROOMS)						
	Do doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?					
	Is there space next to the equipment for a wheelchair or scooter user to approach, park, and transfer or be assisted to transfer onto following?					
	a. Equipment (such as PT)?					
	b. Diagnostic apparatus?					
	c. Patient activity areas (such as OT, dining)?					
	d. Infusion (chairs, beds for chemo, dialysis)?					

68	Patient Dressing Rooms are accessible (all bullet points need to be present) • Doorways are at least 32 inches • Turning Radius is 60x60 inches • Seating 17-19 inches from the floor • Grab bars	If there are reasonable alternative for dressing room accommodations, this measure is met.				
69	In the diagnostic/treatment area, is there a 60 inch diameter turning circle or a 60 inch x 60 inch "T" shaped space so that a wheelchair or scooter user can make a 180° turn?					
70 (CE)	**If any diagnostic equipment or treatment tables/chairs are used, is there a patient pre-assessment process (i.e. phone, prior to appointment) to verify that the necessary services can be provided?**	Self explanatory.				

71	Does the Diagnostic Table have a weight limit?	Document weight limit : □ MRI _____ □ CT _____ □ Fluoroscopy_____ □ PET _____ □ Bone Density/Dexascan _____ □ Ultrasound _____ □ Nuclear Medicine_____ □ Xray_____ □ _____ □ _____				
72 (T)	**Is there height adjustable equipment (chairs and tables) that lowers between 17 inches and 19 inches from the floor to the top of the cushion?**	Score each appropriate equipment that do or do not lower 17 to 19 inches from the floor to the top of the cushion:				
	a. MRI					
	b. CT					
	c. Fluoroscopy					
	d. PET					
	e. Bone Density/Dexascan					
	f. Ultrasound					
	g. Nuclear Medicine					
	h. Xray					
	i. Physical Therapy Table					
	j. Dialysis Chair					
	k. Other					
	l. Other					
73 (T)	**Mammography machine can accommodate wheelchair users with knee and foot clearance under the breast plate allowing technologist to take quality**	The top of breast platform needs to go to 26 inches above the floor to accommodate an individual seated in a wheelchair.				

	images.					
74 (T)	**A Mammography chair is available for patients who must be seated.** ***Example:*** *persons with balance difficulties, or cannot stand for any length of time.*	The chair's footrests must accommodate and ride over the base support.				
75	Are transfer and positioning supports available?	Examples include: • Positioning supports while on the equipment as pillows, wedges, strapping, transfer supports Please list elements in comments.				
76 (CE)	**Does staff provide patient transfer assistance on and off of equipment (this includes use of lift equipment when needed).**	**Self Explanatory**				

77 (T)	**Is lift equipment available to assist staff with transfers (portable, overhead, or ceiling mounted)?**	**Self Explanatory**				
78 (CE)	**Is staff trained yearly on safe transfer techniques?**	**Self explanatory**				

WEIGHT MEASUREMENT						
79	Are patients normally weighed at this provider site?	Self explanatory				
80 (T)	**Is a weight scale available that can be used by a wheelchair or scooter user, obese patients whose weight exceeds the weight limits for standard scales, and for patients that cannot step onto a standard scale?**	**Accessible scale platform dimensions should be a minimum of 32x 36 inches**				
81 (T)	**If there is no accessible scale, are other methods to weigh the patient in place?**	**Examples of other methods to weigh the patient are: weight scales integrated into examination tables, chairs, stretchers, and lifts, or an accessible scale located in a nearby office, within the same building.**				

References

2010 ADA Standards for Accessible Design
U.S Department of Justice
http://www.ada.gov/2010ADAstandards_index.htm

The revised regulations for Titles II and III of the Americans with Disabilities Act of 1990 (ADA) were published in the Federal Register on September 15, 2010. They provide the scoping and technical requirements for new construction and alterations resulting from the adoption of revised 2010 Standards in the final rules for Title II (28 CFR part 35) and Title III (28 CFR part 36). The 2010 ADA Standards go into effect March 15, 2012, but can be used now instead of the 1991 standards. The FSR Attachment C draws upon access requirements found in both the 1991 Americans with Disabilities Act Accessibility Guidelines and the 2010 ADA Standards. Some diagrams that appear in the FSR Attachment C are reproduced from these sources.

Two questions in the FSR Attachment C were drawn from Title 24, Part 2 of the California Building Standards Code. These are 1133B.4.4 – Striping for the visually impaired (Rev.1-1-2009), and 1115B-1 – Bathing and Toilet Facilities, placement of toilet paper dispensers. These standards can be found in:

2009 California Building Standards Code with California Errata and Amendments
State of California
Department of General Services
Division of the State Architect
Updated April 27, 2010
http://www.documents.dgs.ca.gov/dsa/pubs/access_manual_rev_04-27-10.pdf

Some diagrams are reprinted with permission from the Kentucky Department of Vocational Rehabilitation. These illustrations can also be found in:

"Health Care Usability Profile V3"
© Copyright 2008
Oregon Health & Science University RRTC: Health & Wellness
Authors: Drum, C.E., Davis, C.E., Berardinelli, M., Cline, A., Laing, R., Horner-Johnson, W., & Krahn, G.
Oregon Institute on Disability and Development
Portland, OR 97239
rrtc@ohsu.edu
healthwellness.org

Attachment E

Community Based Adult Services (CBAS) Physical Accessibility Review Survey

California Department of Health Care Services
Managed Care Quality and Monitoring Division

Provider Name: □ CBAS □ Other	Date of Review: Name of Reviewer:
Address: City:	Health Plan Name:
Phone: FAX:	Contact Person Name:

	Level of Access:
Basic Access: Demonstrates facility site access for the members with disabilities to parking, building, elevator, Participant Areas, and restroom. To meet Basic Access requirements, all (24) Critical Elements (CE) must be met.	☐ Basic Access
Limited Access: Demonstrates facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, participant areas, and restroom. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.	☐ Limited Access

Below are the symbols that will be used in the provider directories to indicate areas of accessibility at a provider office/site. These should also be used in online directories. In order for a provider office to receive a symbol, the appropriate criteria must be met.

These symbols are in addition to identifying whether the provider office has Basic Access or Limited Access. A provider who has Basic Access will automatically meet the critical elements for the first six symbols (P, EB, IB, R, PA,). And a provider who has Medical Equipment Access will meet the medical equipment elements for the last symbol (T).

Accessibility Indicator	Must Satisfy these Criteria	Yes	No	N/A	Comments
P = PARKING	Critical Elements (CE): 6,7,8				
EB = EXTERIOR BUILDING	(CE): 9,15,16,17,20				
IB = INTERIOR BUILDING	(CE): 23,26,36,37,38,39,40,41				
R=RESTROOM	(CE): 47,49,50,53,56,58				
PA= PARTICIPANT AREAS	(CE): 60,61				

2nd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

Name: _____ Signature: _____ Date: _____

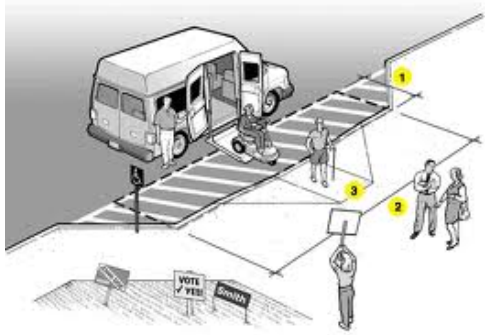
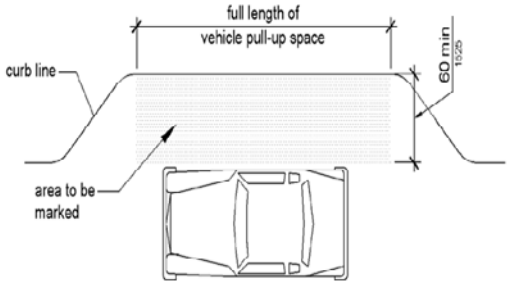
3rd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

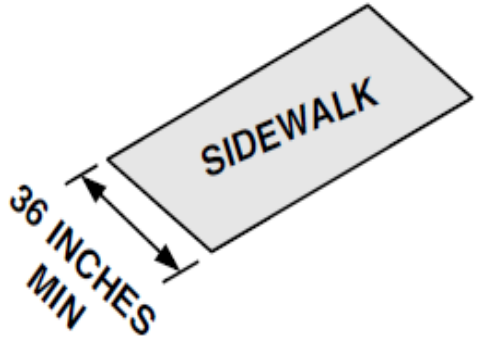
Name: _____ Signature: _____ Date: _____

PARKING						
1	Are accessible parking spaces provided in the designated parking area?	Self explanatory.				
2	Are the correct number of accessible parking spaces provided? 1 to 25 total spaces – 1 required 26 to 50 – 2 required 51 to 75 – 3 required 76 to 100 – 4 required 101 to 150 – 5 required 151 to 200 – 6 required 201 to 300 – 7 required 301 to 400 – 8 required	If there are 25 total parking spaces or less, at least one accessible space is required. If there are between 26 and 50 total spaces, at least two accessible spaces are required, etc.				
3	Is the accessible parking space(s) closest to the main entrance?	The accessible parking space (s) should afford the shortest route of travel from adjacent parking to the accessible entrance.				

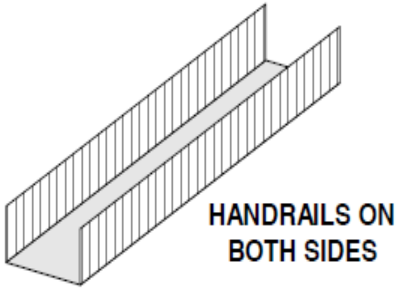
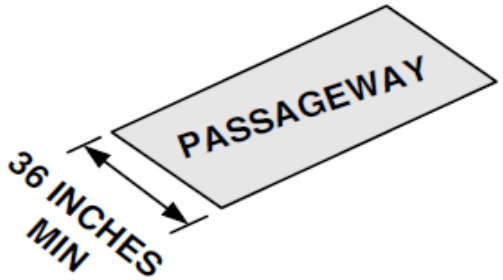
4	Does every accessible parking space have a vertical sign posted with the International Symbol of Accessibility?	Symbol in the illustration depicts the International Symbol of Accessibility. 				
5	Are signs mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle?	Signs must be located so a vehicle parked in the space does not obscure them. (Van accessible spaces must be indicated with an additional sign)				

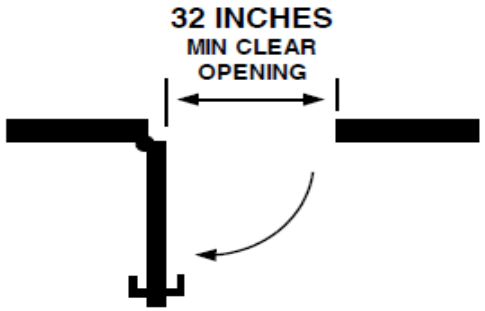
6 (CE)	**Is a passenger loading zone provided with a vehicular pull-up space.**	The vehicular pull-up space dimension is a minimum of 96 inches wide and 20 feet long				

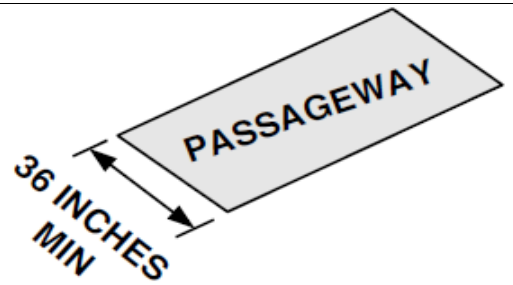
7 (CE)	**Is there an access aisle that adjoins an accessible route and does not overlap the Vehicular way /driveway?**	**Access aisles serving vehicle pull-up *spaces* shall be a minimum of 60 inches wide.**  				
8 (CE)	**Do curbs on the route have curb ramps at the drop off locations?**	**Pathways should have curb ramps. Without curb ramps, wheelchair users may be required to travel in the street or behind parked cars where drivers cannot see them.**				

EXTERIOR ROUTE (FROM DROP OFF AND PICK UP LOCATIONS TO THE ENTRANCE)						
9 (CE)	**For exterior routes, if the accessible route crosses a curb, is a curb ramp provided to the building entrance from the following: (Please mark NA for those that do not apply.)**	**Self explanatory.**				
	a. Public Transportation					
	b. Public sidewalk?					
	c. Drop off?					
10	Is the accessible route to the building entrance at least 36 inches wide for exterior routes from the following: (Please mark NA for those that do not apply.)					
	a. Public Transportation					
	b. Public sidewalk?					
	c. Drop off?					
11	Is the accessible route to the	An example of a stable surface is a floor or				

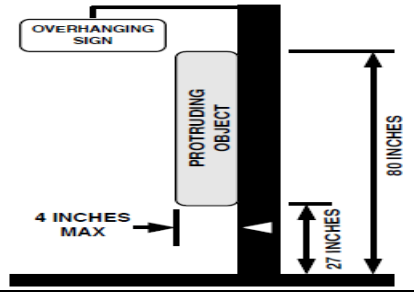
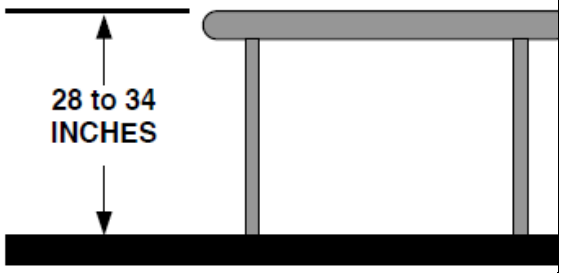
	building entrance stable, firm, and slip resistant from the following: (Please mark NA for those that do not apply.)	ground surface without loose elements like gravel or wood chips. Firm surfaces include solid concrete or pavement as opposed to a grassy, graveled or soft soil surface. Avoid glossy or slick surfaces such as ceramic tile.				
	a. Public Transportation					
	b. Public sidewalk?					
	c. Drop off?					
12	Is there an accessible route that does not include stairs or steps?	Self explanatory.				
13	Is the route to the entrance from drop off, free of grates, gaps, and openings that are both greater than ½ inch wide and over ¼ inch deep?	Self explanatory.				

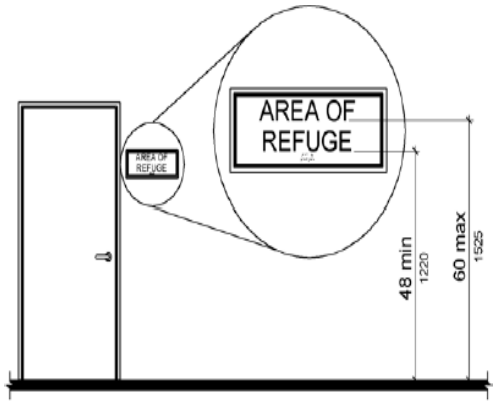
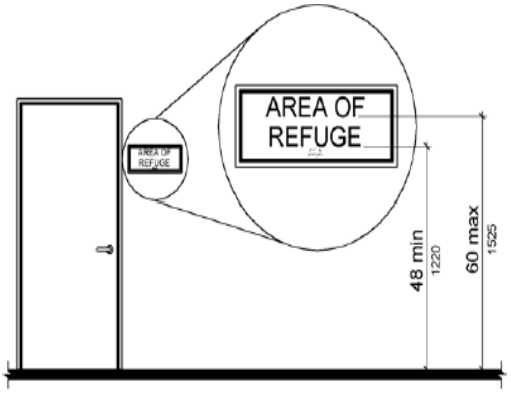
RAMPS:						
14	Is an access ramp present?	If there is more than one ramp, select the one that appears to be the primary access ramp.				
15 (CE)	**Are handrails provided on both sides of the ramp that are mounted between 34 and 38 inches above the ramp surface, if it is longer than 6 feet?**	**If the ramp is not longer than 6 feet, check N/A.** 				
16 (CE)	**Are all ramps at least 36 inches wide?**					

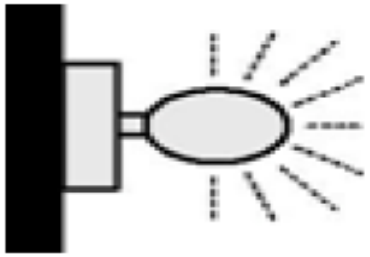
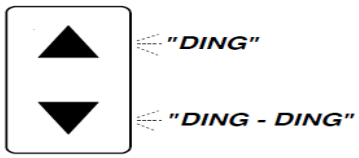
BUILDING ENTRANCE						
	Is the main entrance accessible?	**Self explanatory.**				
18	If a main entrance is not accessible, is there another accessible entrance?	Self explanatory.				
19	If a main entrance is not accessible, is there directional signage indicating the location of the accessible entrance?					
	Do doors have an opening at least 32 inches wide (at the narrowest point below the opening hardware) when opened to 90°?	**When measuring double doors, measure the opening with one door open to 90°.** 				

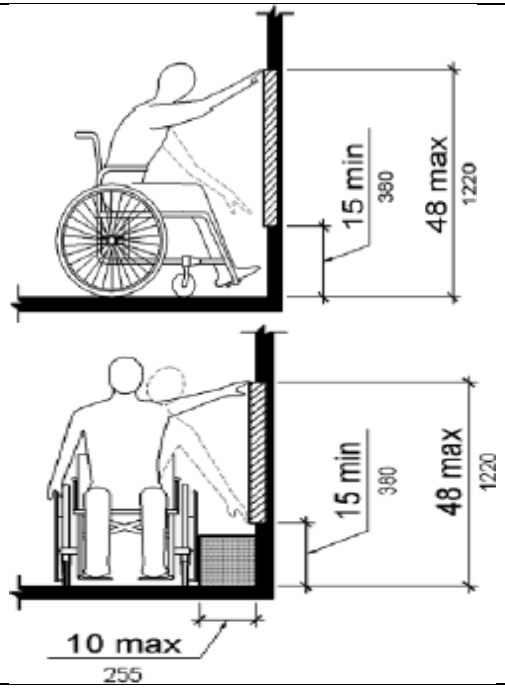
21	Are there automatic doors?	Self explanatory.				
INTERIOR ROUTE (FROM THE BUILDING ENTRANCE, TO THE REGISTRATION COUNTER/WINDOW, AND THROUGH TO THE PARTICIPANT AREAS						
22	Is there an interior route to the participant area?	Some participant areas are accessed directly from the street or drop off rather than being located within a larger building or complex, therefore they do not have interior routes.				
23 (CE)	**Are <u>ALL</u> interior paths of travel at least 36 inches wide?**					
24	Is the interior accessible route stable, firm, and slip resistant?	Avoid unsecured carpeting or other loose elements. It is easier for people using walkers, wheelchairs and other aids to walk or push on surfaces that have low pile carpeting without a pad underneath. Glossy or slick surfaces such as ceramic tile or marble can be slippery.				

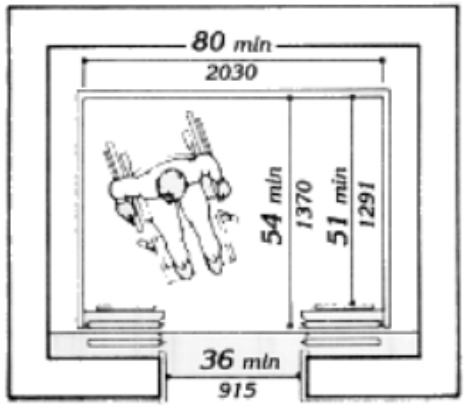
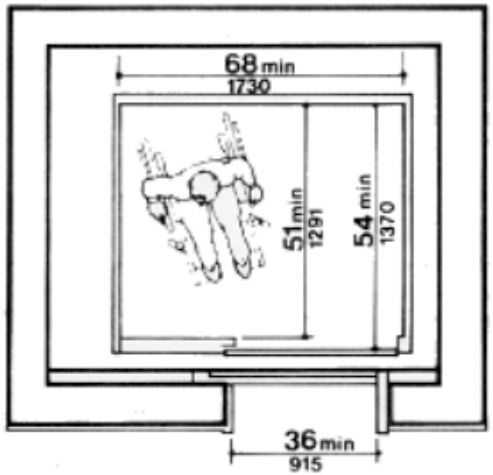
25	Is the interior accessible route well lighted?	A brightly lit corridor will help avoid falls.				
26 (CE)	**If there are stairs on the accessible route, are there handrails on each side?**	**If there are no stairs, check N/A.**				
27	If there are stairs, are all stair risers closed that are on the accessible route?					
28	If there are stairs, are all stair treads marked by a stripe providing a clear visual contrast to assist people with visual impairments?	Contrast striping must be provided on the upper approach and lower tread for interior stairs and on the upper approach and all treads for exterior stairs. Stripes must be 2" to 4" wide placed parallel to and no more than 1" from the nose of the step or upper approach. The stripe must extend the full width of the step or upper approach and should be made of material that is at least as slip resistant as the other stair treads (a painted stripe is acceptable).				

29	Is the path through the facility free of any objects that stick out into the circulation path that a blind person might not detect with a cane?	If an object protrudes more than 4 inches and is located between 27 inches above the walking surface and below 80 inches, a blind person walking with a cane will not detect it.  				
30	If floor mats are used, are the edges of floor mats stiff enough or secured so that they do not roll up?	If floor mats are not in use, check NA. Floor mats that are not secured to the floor can roll up or bunch up under walkers or wheelchair casters and cause a tripping hazard.				
31	Is a section of the sign-in/registration counter no more than 34 inches high and at least 36 inches wide and free of stored items.	 				

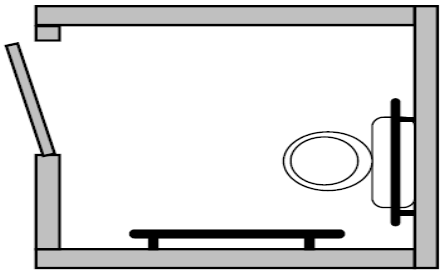
32	Do signs identifying permanent rooms and spaces include raised letters and Braille?					
33	Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor?	 Raised letters and Braille signs are either on the latch side of doors or on the face of doors and are mounted between 48 inches and 60 inches from the floor.				

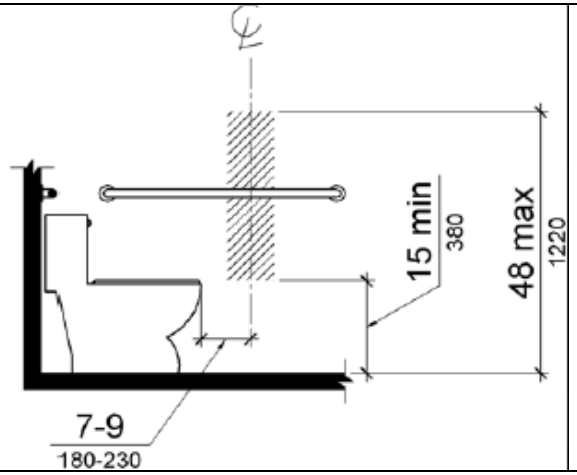
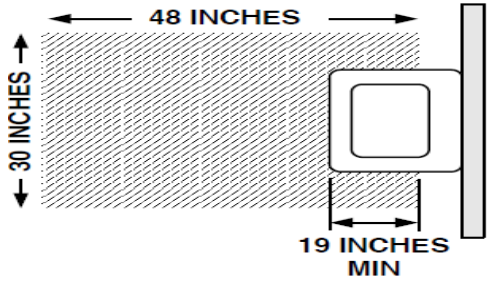
34	If the building has a fire alarm system, are visual signals provided in each public space, including toilet rooms and Participant Areas?	If the building does not have a fire alarm system, check NA. 				
ELEVATORS						
35	Is there an elevator?					
36 (CE)	**If needed, is the elevator available for public/patient use during business hours?**	**Self explanatory.**				
37 (CE)	**Is the elevator equipped with both visible and audible door opening/closing and floor indicators?**	**A visible and audible signal is required at each elevator entrance to indicate which car is answering a call. An audible signal would be a "ding" or a verbal announcement.** 				

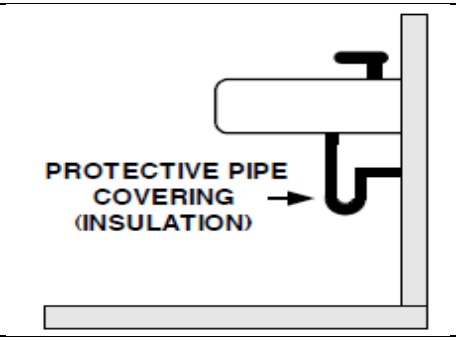
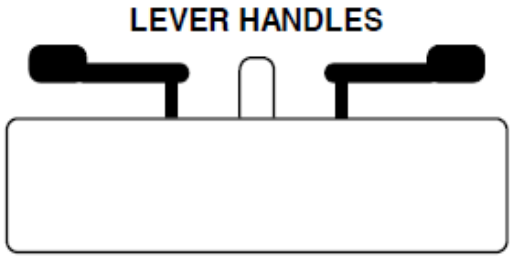
38 (CE)	**Are there raised letter and Braille sign on each side of each elevator jamb?**	**These signs allow everyone to know which floor they are on before entering or exiting the elevator.**				
39 (CE)	**Are the hall call buttons for the elevator no higher than 48 inches from the floor?**					

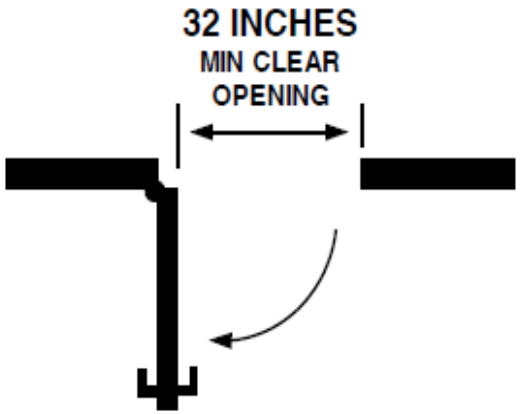
40 (CE)	**Is the elevator car large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit?**	**The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide, depending on where the door is located.**  (a)  				
41 (CE)	**Do the buttons on the control panel inside the elevator have Braille and raised characters/symbols near the buttons?**	**Self explanatory.**				

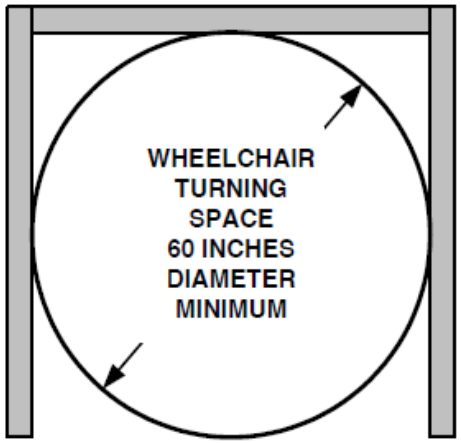
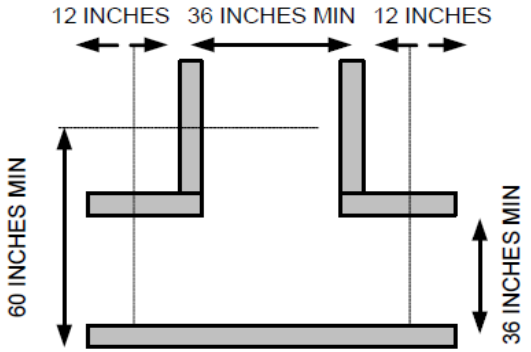
42	Is there an emergency communication system in the elevator?	Self explanatory.				
43	Is the elevator emergency communication system usable without requiring voice communication?	It is essential that emergency communication not be dependent on voice communications alone because the safety of people with hearing or speech impairments could be jeopardized. Visible signal requirement could be satisfied with something as simple as a button that lights when the message is answered, indicating that help is on the way.				
44	Do raised letters and Braille identify the emergency intercom in the elevator?	Self explanatory.				

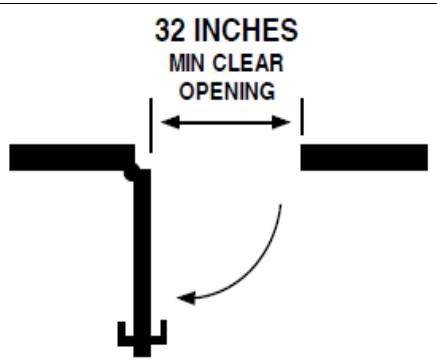
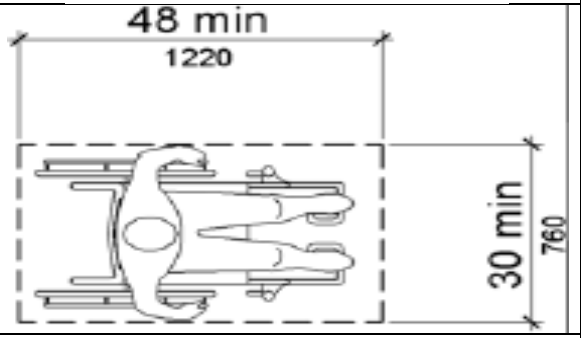
ALL RESTROOMS/TOILET ROOMS (WITH AND WITHOUT STALLS):						
45	Is there an accessible restroom/toilet room?	Self explanatory.				
46	Does the interior door to the restroom require less than 5 pounds of pressure to open?	If restroom door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
47 (CE)	**Are grab bars provided, one on the wall behind the toilet and one on the wall next to the toilet?**	**Grab bars should be installed in a horizontal position between 33 and 36 inches above the floor measured to the top of the gripping surface.** 				
48	Are all objects mounted at least 12 inches above and/or 1½ inches below the grab bars?	This includes seat cover dispensers, toilet paper dispensers, sanitizers, trash containers, etc.				

49 (CE)	**Is the toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7 inches and 9 inches in front of the toilet, and at least 15 inches high?**					
50 (CE)	**Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair users to park in front of the sink?**	**This space must extend at least 17 inches under the sink from the front edge, although it can extend up to 19 inches underneath.** 				
51	Is the space in front of the sink free of trashcans and other movable items?	Self explanatory.				

52	Are the pipes and water supply lines under the sink wrapped with a protective cover?					
53 (CE)	**Are faucet handles operable with one hand and without grasping, pinching, or twisting? (Check Yes if faucets are automatic.)**	**A knob handle would not be accessible.** 				
54	Are all dispensers mounted no higher than 40 inches from the floor?	Included are soap dispensers, paper towel dispensers, seat cover dispensers, hand dryers, etc.				
55	Are all dispensers (soap, paper towel, etc.) operable with one hand and without grasping, pinching, or twisting?	Self explanatory.				

56 (CE)	**Do restroom doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**					
57	Is the space inside the restroom clear, without trashcans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				

58 (CE)	**Is there a 60-inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space inside the restroom to allow a turn around for wheelchair and scooter users?**	 				
59	Can the hardware on the stall door be operated without grasping, pinching, or twisting of the wrist?	Handles, pulls, latches, locks, and other operating devices on accessible doors shall have a shape that is easy to grasp with one hand and does not require tight grasping, tight pinching, or twisting of the wrist to operate.				
PARTICIPANT AREAS (QUIET ROOM/THERAPY ROOM S-PT/OT, ACTIVITY AREA)						

60 (CE)	**Do doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**					
61 (CE)	**There is space in the following areas for a wheelchair or scooter user to approach and park for participation in activities or use of exercise equipment:**					
	a. Quiet room?					
	b. Physical Therapy Room {PT}?					
	c. Occupational Therapy {OT}?					
	d. Activity Area					

62	Is there a bed that is between 17 inches and 19 inches from the floor to the top of the cushion?	Self explanatory				

Medical Record Review Standards

Purpose: The Medical Record Review (MRR) Standards provide instructions, rules, regulations, parameters, and indicators for conducting medical record reviews using the MRR Tool. The site reviewer must use these Standards for measuring, evaluating, assessing, and making decisions.

Medical Record Selection: Medical records shall be randomly selected using methodology decided upon by the reviewer. Ten (10) medical records are reviewed for each primary care physician (PCP) site. For sites with *only* adult or *only* pediatric patient members, all ten records reviewed will be in *only* one preventive care criteria. For sites with adult and pediatric members, five (5) adults and five (5) pediatrics preventive criteria will be reviewed. For PCP sites where the OB-GYN providers both specialty and preventive services, based on the age of the patient, reviewer must review either adult or pediatric preventive criteria as well as OB Comprehensive Perinatal Services Program (CPSP) criteria.

PCP sites that document patient care performed by multiple PCPs in the same medical record are considered "shared." The MCP must consider shared medical records as those that are not identifiable as "separate" records belonging to any specific PCP. Scores calculated on shared medical records apply only to PCPs sharing the records. A minimum of ten shared records shall be reviewed for 2-3 PCPs, 20 records for 4-6 PCPs, and 30 records for 7 or more PCPs based on specialty and/or population served.

Example for determining the number of medical records to review:

> A site that has three (3) providers, two (2) providers see only adults and share records, and one (1) only see pediatrics and does not share records, 10 medical records on the two providers who share medical records and 10 medical records on the provider who does not share records will be conducted and scored separately. A total of 20 medical records shall be reviewed for this site. Two (2) scores will be reported for this site.

Reviewers are expected to determine the most appropriate method(s) on each site to ascertain information needed to complete the review. Review criteria that shall be reviewed *only* by a registered nurse (RN), nurse practitioner (NP), physician (MD), physician assistant (PA), Certified Nurse Midwife (CNM), or Licensed Midwife is labeled "**RN/NP/MD/PA/CNM/LM".**

Reviewers must ensure confidentiality on Protected Health Information (PHI) or Personally Identifiable Information (PII).

Scoring: The review score is based on a review standard of 10 records per individual primary care provider (PCP). Documented evidence found in the hard copy (paper) medical records and/or electronic medical records, including immunization registries, are used for review criteria determinations. Compliance levels are:
An Exempted Pass is 90%.
Conditional Pass is 80-89%.
Failure is below 79%.

The minimum passing score is 80%. A corrective action plan (CAP) is required for a total MRR score below 90%. Also, any section score of less than 80% requires a CAP for the entire MRR, regardless of the total MRR score.

Not Applicable (N/A) applies to any criterion that does not apply to the medical record being reviewed and must be explained in the comment section.

Directions: Score one point if criterion is met. Score zero points if criterion is not met. Do not score partial points for any criterion.

If 10 shared records are reviewed, score calculation shall be the same as for 10 records reviewed for a single PCP.
If 20 records are reviewed, divide total points given by the "adjusted" total points possible.
If 30 records are reviewed, divide total points given by the "adjusted" total points possible.
Multiply by 100 to calculate percentage rate.

Reviewers have the option to request additional records to review but must calculate scores accordingly.

Scoring Example:

Step 1: Add the points given in each section.
Step 2: Add the points given for all six sections.
(Format points given)
(Documentation points given)
(Coordination of Care points given)
(Pediatric Preventive points given)
(Adult Preventive points given)
+ (OB/CPSP Preventive points given)
= (Total points given)

Step 3: Subtract the “N/A” points from total points possible.

(Total points possible)
– (N/A points)
= (“Adjusted” total points possible)

Step 4: Divide total points given by the “adjusted” points possible, then multiply by 100 to calculate percentage rate.

$$\frac{\text{Total points given}}{\text{“Adjusted” total points possible}}$$

Example: $\frac{267}{305} = 0.875 \times 100 = 88\%$

Rationale: A well-organized medical record keeping system supports effective patient care, information confidentiality and quality review processes.

I. Format Criteria	
An individual medical record is established for each member.	Practitioners are able to readily identify each individual treated. A medical record is started upon the initial visit.[1] "Family charts" are not acceptable.
A. Member identification is on each Page.	• Member identification includes first and last name, and a unique identifier established for use on clinical site. • Electronically maintained records and printed records from electronic systems must contain member identification.
B. Individual personal biographical information is documented.	Personal biographical information includes: ○ Date of birth ○ Current address ○ Home/work phone numbers ○ Name of parent(s)/legal guardian if member is a minor If member refused to provide information, "refused" is documented in the medical record. Do not deduct points if member has refused to provide all personal information requested by the practitioner.
C. Emergency "contact" is identified.	The name and phone number of an "emergency contact" person is identified for all members. Listed emergency contacts may include: ○ Spouse, relative or friend, and must include at least one of the following: ○ Home, work, pager, cellular, or message phone number. • If the member is a minor, the primary (first) emergency contact person must be a parent or legal guardian and then other persons may be listed as additional emergency contacts. • Adults and emancipated minors may list anyone of their choosing. • If a member refuses to provide an emergency contact, "refused" is noted in the record. Do not deduct points if member has refused to provide personal information requested by the practitioner.

[1] See the U.S. Department of Health and Human Services Summary of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, available at: https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html.

I. Format Criteria	
	• Next of kin category is not considered as an emergency contact. The member's emergency contact may be different from the next of kin.
D. Medical records are maintained and organized	• Contents and format of printed and/or electronic records within the practice site are uniformly organized, securely fastened, attached or bound to prevent medical record loss. • Hard copy printed documents shall belong to the medical record established for each member (e.g., reusing the blank side of printed documents from another member is not acceptable and should be scored a "0"). • Medical Record information should be readily available.
E. Member's assigned and/or rendering PCP is identified.	• The assigned and/or rendering PCP is ***always*** identified when there is more than one PCP on site and/or when the member has selected health care from a non-physician medical practitioner. • Various methods can be used to identify the assigned PCP, reviewers must identify specific method(s) used at each individual site such as Health Plan ID Card, practitioner stamp, etc. • If there is only one PCP/Practitioner onsite and is not identified, reviewer may score "N/A".
F. Primary language and linguistic service needs of non-or of limited-English proficiency (LEP) or hearing/speech-impaired persons are prominently noted.	• The primary language is prominently documented at least once in the medical record. • Language documentation is not necessary, score "N/A," if English is the primary language. However, if "English" is documented, the point may be given. **Note:** Title VI of the Civil Rights Act of 1964 prohibits recipients of federal funds from providing services to LEP persons that are limited in scope or lower in quality than those provided to others. Since Medi-Cal is partially funded by federal funds, ***all*** Plans with Medi-Cal LEP members must ensure that these members have equal access to all health care services.[2]

[2] See All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language assistance Services, or any superseding APL. APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

I. Format Criteria	
G. Person or entity providing medical interpretation is identified.	• Requests for language and/or interpretation services by a non-or limited-English proficient member are documented. • Member refusal of interpreter services may be documented at least once and be accepted throughout the member's care unless otherwise specified. • If bilingual staff are asked to interpret or translate, they should be qualified to do so. Assessment of ability, training on interpreter ethics and standards, and clear policies that delineate appropriate use of bilingual staff, staff or contract interpreters and translators, will help ensure quality and effective use of resources. • Those utilizing the services of interpreters and translators should request information about certification, assessments taken, qualifications, experience, and training. Quality of interpretation should be a focus of concern for all recipients. • Family or friends should not be used as interpreters, unless specifically requested by the member and documented in the member's chart. • Minors (under 18 years old) accompanying member shall not be used as an interpreter. • The Affordable Care Act (ACA) 2010 section 1557: prohibits from using low-quality video remote interpreting services or relying on unqualified staff, translators when providing language assistance services. • Sign language interpreter services may be utilized for medically necessary health care services and related services such as obtaining medical history and health assessments, obtaining informed consents and permission for treatments, medical procedures, providing instructions regarding medications, explaining diagnoses, treatment and prognoses of an illness, providing mental health assessment, therapy or counseling. Various documents can be accepted to document linguistic service needs such as Individual Health Education Behavior Assessment (IHEBA)/Staying Healthy Assessment (SHA), intake form, demographic form, Electronic Medical Record (EMR) fields, consent forms, etc.

I. Format Criteria	
	Note: See Commonly Asked Questions and Answers Regarding LEP Individuals, available at: https://www.lep.gov/faq/faqs-rights-lep-individuals/commonly-asked-questions-and-answers-regarding-limited-english. See also Title 22 California Code of Regulations (CCR) Section 51309.5. The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index.
H. Signed Copy of the Notice of Privacy	The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The right to inspect, review and receive a copy of the medical records is covered by the Privacy Rule.[3]

[3] See the U.S. Department of Health and Human Services Understanding of Some of HIPAA's Permitted Uses and Disclosures, available at: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/permitted-uses/index.html.

Rationale: Well-documented records facilitate communication and coordination and promote efficiency and effectiveness of treatment.

RN/NP/MD/PA/CNM/LM

II. Documentation Criteria	
A. Allergies are prominently noted.	• Allergies and adverse reactions are listed in a prominent, easily identified, and consistent location in the medical record. • If member has no allergies or adverse reactions, "No Known Allergies" (NKA), "No known Drug Allergies" (NKDA), or ∅ is documented.[4]
B. Chronic problems and/or significant conditions are listed.	• Documentation may be on a separate "problem list," or a clearly identifiable problem list in the progress notes. • All chronic or significant problems are considered current if no "end date" is documented. **Note:** Chronic conditions are current long-term, on-going conditions with slow or little progress.[5]
C. Current continuous medications are listed.	• Documentation may be on a separate "medication list," or a clearly identifiable medication list in the progress notes. • List of current, on-going medications identifies the medication name, strength, dosage, route (if other than oral), and frequency. • Discontinued medications are noted on the medication list or in progress notes.[6]
D. Appropriate Consents are present.	1) Consent must be obtained prior to release of patient information.[7] 2) Adults, parents/legal guardians of a minor or emancipated minor may sign consent forms for operative and invasive procedures.[8] Persons under 18 years

[4] 22 CCR 70527 and 28 CCR 1300.80
[5] 22 CCR 70527 and 28 CCR 1300.80
[6] 22 CCR 70527 and 28 CCR 1300.80
[7] 22 CCR 73524, 22 CCR 51009, and Title 45, Code of Federal Regulations Section 164.524. The CFR is searchable at: https://www.ecfr.gov.
[8] An invasive procedure is a medical procedure that invades (enters) the body, usually by cutting or puncturing the skin or by inserting instruments into the body. Very minor procedures such as drawing blood testing, umbilical cord blood donations and a few other very specific

II. Documentation Criteria	
	of age are emancipated if they have entered into a valid marriage, are on military active duty, or have received a court declaration of emancipation under the CA Family Code, Section 7122.[9] **Note:** Human sterilization requires the Department of Health Care Services (DHCS) Consent Form PM 330 if services are performed at the site.
E. Advance Health Care Directive information is offered. (Adults 18 years of age or older; emancipated minors).	• Adult medical records include documentation of whether the member has been *offered* information or has executed an Advance Health Care Directive.[10] The Physician Orders for Life-Sustaining Treatment (POLST) form and Five Wishes are acceptable if appropriately completed and signed by necessary parties.[11] **Note:** Advance Health Care Directive Information is reviewed with the member at least every 5 years and as appropriate to the member's circumstance.
F. All entries are signed, dated and legible.	**Signature** includes: • First initial, last name, and title of health care personnel providing care, including Medical Assistants. • Initials and titles may be used only if signatures are specifically identified elsewhere in the medical record (e.g. signature page). • Stamped signatures are acceptable, but must be authenticated, meaning the stamped signature can be verified, validated, confirmed, and is countersigned or initialed. **Dated entries** include: • Month/day/year. • Entries are in reasonably consecutive order by date.

tests are not considered invasive and do not require a consent. Consent is implied by entering the provider's office or lab and allowing blood to be drawn. (Ref: National Institutes of Health; American Cancer Society)

[9] California Law is searchable at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml.

[10] See Probate Code, Section 4701, 42 CFR 422.128, 42 CFR 489.100, and APL 05-010.

[11] See AB 3000, Chapter 266, Statutes of 2008, available at: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=200720080AB3000.

II. Documentation Criteria	
	• Handwritten documentation does not contain skipped lines or empty spaces where information can be added. Entries are not backdated or inserted into spaces above previous entries. • Omissions are charted as a new entry. • Late entries are explained in the medical record, signed and dated. **Legibility** means the record entry is readable by a person other than the writer. Handwritten documentation, signatures, and initials are entered in ink that can be readily/clearly copied. Only standard abbreviations are used. All medical record documentation must be in English.[12] **Note:** • In EMR, methods to document signatures (and/or authenticate initials) will vary and must be individually evaluated. • Signature page may be in the member's medical record or available elsewhere onsite and all previous and current employees who document in medical records need to be included on the signature page. • Reviewers should assess the log-in process and may need to request printouts of entries. See the Centers for Medicare and Medicaid Services' (CMS) Guidance on Medicaid Documentation for Medical Office Staff, available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-officestaff-factsheet.pdf.
G. Errors are corrected according to legal medical documentation standards.	• The person that makes the documentation error corrects the error. Example correction methods: • Single line drawn through the error, with the writer's initial and date written above or near the lined-through entry. • Single line and initial.

[12] ACA Section 1557

II. Documentation Criteria	
	• The corrected information is written as a separate entry and includes date of the entry, signature (or initials), and title. There are no unexplained cross-outs, erased entries or use of correction fluid. Both the original entry and corrected entry are clearly preserved. **Note:** Reviewers must determine the method used for error corrections for EMR on a case by case basis. This should include the log-in process and whether the EMR allows for corrections to be made after entries are made.

Rationale: Medical records support coordination and continuity-of-care with documentation of past and present health status, medical treatment and future plans of care.

RN/NP/MD/PA/CNM/LM

III. Coordination Criteria	
A. History of present illness or reason for visit is documented.	Each focused visit (e.g., primary care, follow-up ER/urgent care, hospital discharge, etc.) includes a documented history of present illness or reason for visit.
B. Working diagnoses are consistent with findings.	Each visit has a documented "working" diagnosis/impression derived from a physical exam, and/or "Subjective" information such as chief complaint or reason for the visit as stated by member/parent. The documented "Objective" information (such as assessment, findings and conclusion) relate to the working diagnoses. **Note:** For scoring purposes, reviewers shall ***not make determinations*** about the "*rightfulness or wrongfulness"* of documented information but shall initiate the peer review process or internal investigation per health plan policy as appropriate.
C. Treatment plans are consistent with diagnoses.	A plan of treatment, care and/or education related to the stated diagnosis is documented for each diagnosis. **Note:** For scoring purposes, reviewers shall ***not make determinations*** about the "*rightfulness or wrongfulness"* of treatment rendered or care plan but shall initiate the peer review process or internal investigation per health plan policy as appropriate.
D. Instruction for follow-up care is documented.	• Specific follow-up instructions and a definite time for return visit or other follow-up care is documented. • Time period for return visits or other follow-up care is definitively stated in number of days, weeks, months, or PRN (as needed). • Every visit with the provider shall have follow-up instructions.
E. Unresolved continuing problems are addressed in subsequent visit(s).	• Previous complaints and unresolved or chronic problems are addressed in subsequent notes until problems are resolved or a diagnosis is made.

III. Coordination Criteria	
	• Each problem need not be addressed at every visit as long as the provider documents a reason for deferring the unresolved problem(s) for subsequent visits. • Documentation demonstrates that the practitioner follows up with members about treatment regimens, recommendations, and counseling.
F. There is evidence of practitioner review of specialty/consult/referral reports and diagnostic test results.	• There is documented evidence of practitioner review of records such as diagnostic studies, lab tests, X-ray reports, consultation summaries, inpatient/discharge records, emergency and urgent care reports, and all abnormal and/or "STAT" reports. • Evidence of review may include the practitioner's initials or signature on the report, notation in the progress notes, or other site-specific method of documenting practitioner review. **Note:** Electronically maintained medical reports must also show evidence of practitioner review and may differ from site to site. Evidence of practitioner review on any page of the report(s) or diagnostic result(s) that have multiple pages is acceptable.
G. There is evidence of follow-up of specialty/consult/referrals made, and results/reports of diagnostic tests, when appropriate.	Documentation includes: • Consultation reports and diagnostic test results for ordered requests. • Abnormal test results/diagnostic reports have explicit notation in the medical record or separate system, including attempts to contact the member/guardian, follow-up treatment, instructions, return office visits, referrals and/or other pertinent information. • Missed/broken appointments for diagnostic procedures, lab tests, specialty appointments and/or other referrals are noted, and include attempts to contact the member/parent and results of follow-up actions. If diagnostic appointments or referrals are documented in a separate system from medical records, they must be readily accessible and meet the medical retention requirements. **Note:**

III. Coordination Criteria	
	• Abnormal test results/diagnostic reports without follow-up documentation for specific pediatric or adult preventive screening criteria/diagnostic tests will be scored under this criterion. • If results are normal and there are no missing reports, then the reviewer may score "N/A" for this criterion. • If specific pediatric or adult preventive screenings are ordered and there is no documentation of normal results and/or follow-up, the reviewer shall score this under the appropriate preventive services criteria. • If the provider/staff does not follow up or attempt outreach to the member regarding a missed specialty referral, give a zero "0" score. Reviewer must assess the process of outreach efforts/follow-up contacts and documentation of attempts. The process must include at least one attempt for outreach/follow-up contact.
H. Missed primary care appointments and outreach efforts/follow-up contacts are documented.	Documentation includes: • Incidents of missed/broken appointments, cancellations or "No shows" with the PCP office. • Attempts to contact the member or parent/guardian and the results of follow-up actions. Missed and/or canceled appointments and contact attempts must be documented in the patient's medical record. **Note:** Reviewer must assess the process of outreach efforts/follow-up contacts and documentation of attempts. The process must include at least one attempt for outreach/follow-up contact.

Rationale: Pediatric preventive services are provided to members under 21 years of age in accordance with current American Academy of Pediatrics (AAP) bright future and US Preventive Task Force (USPSTF) recommendations. See the DHCS Boilerplate contract, available at: https://www.dhcs.ca.gov/provgovpart/Documents/2-Plan-Non-CCI-Boilerplate-Final-Rule-Amendment.pdf.

RN/NP/MD/PA/CNM/LM

IV. Pediatric Preventive Criteria	
A. Initial Health Assessment (IHA) includes H&P and IHEBA	**New Members** IHA must be completed within 120 days of plan enrollment or PCP effective date (whichever is more recent) or documented within the 12 months prior to Plan enrollment/PCP effective date. A complete IHA enables the PCP to assess current acute, chronic, and preventive needs and to identify those Members whose health needs require coordinated services with appropriate community resources/other agencies not covered by the Plan. References: Policy Letter (PL) 08-003 or current version and PL 13-001 or current version
1) Comprehensive History and Physical	**New members** The history must be comprehensive to assess and diagnose acute and chronic conditions it includes: ○ History of present illness ○ Past medical history ○ Social history ○ Review of Organ Systems (ROS) If an H&P is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented.
2) Individual Health Education Behavioral Assessment (IHEBA)	**New members** An age-appropriate IHEBA (“Staying Healthy” or other DHCS-approved tool such as AAP Bright Future is a screening tool that may assist in screening for risk factors for many preventive care criteria (e.g., alcohol misuse, STI, HIV, Tobacco, etc.) is completed by the member or parent/guardian within 120 days of the effective date of enrollment into the Plan or PCP effective date (whichever is more recent), or within the 12 months prior to Plan enrollment/PCP effective date. Staff may assist.

IV. Pediatric Preventive Criteria	
	The IHEBA shows evidence of practitioner review: ○ Printed name ○ Signature ○ Date ○ Interventions, which may be documented on the IHEBA form, in progress notes, or other areas of the paper or electronic medical record system. If an initial IHEBA is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented. • Give a point: 1) IHEBA is complete, reviewed, and signed by the provider. • Give a N/A: 2) The Provider documents patient refusal of IHEBA in Electronic Health Record chart notes. • Give a zero: 1) IHEBA was not reviewed/signed by the provider, 2) IHEBA is refused by the patient ("refused" box checked) and the provider has not signed the form. SHA Questionnaires are available at: http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx
B. Subsequent Comprehensive Health Assessment	**Existing/Current Members** The examination must be comprehensive, focus on specific assessments that are appropriate for the child's or adolescent's age, developmental phase, and needs building on the history gathered earlier. The physical examination provides opportunities to identify silent or subtle illnesses or conditions and time for the health care professional to educate children and their parents about the body and its growth and development. See the AAP/Bright Futures Recommendations for Preventive Pediatric Health Care, available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf
1) Comprehensive History and Physical Exam completed at age-appropriate frequency	• Health assessments containing age-appropriate requirements are provided per the most recent AAP periodicity schedule. • Assessments and identified problems are documented in the progress notes.

IV. Pediatric Preventive Criteria	
	• Follow-up care or referral is provided for identified physical health problems as appropriate. **Note:** The AAP periodicity exam schedule is more frequent than the Child Health and Disability Prevention Program (CHDP) periodicity examination schedule. The AAP scheduled visit must include all assessment components required by the CHDP program for the lower age nearest to the current age of the child.[13]
2) Subsequent Periodic IHEBA	• An age-appropriate IHEBA is re-administered when the member has reached the next specific age interval designated by DHCS' Managed Care Quality and Monitoring Division. • The PCP must review previously completed IHEBA questionnaires with parent, guardian, or adolescent annually before reaching the next age group. • Documentation requirements are the same as the initial IHEBA. The SHA Questionnaires are available at: http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx
C. Well-child Visit	The Bright Futures/AAP developed a set of comprehensive health guidelines for well-childcare, known as the "periodicity schedule."[14] It is a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence. **Screening** pertains to an assessment of the eligible population for presence of risk factors. • If the patient is positive for risk factors, (e.g., obesity, menstrual status, etc.) age and gender parameters of the criterion the provider shall offer and document appropriate follow-up intervention(s) (e.g., diagnostic testing, counseling, referral to specialist, documentation of patient refusal, etc.).

[13] See the AAP/Bright Futures Recommendations for Preventive Pediatric Health Care, available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

[14] The Bright Futures/AAP periodicity schedule is available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

IV. Pediatric Preventive Criteria	
	• Providers who fail to document the presence or absence of risk factors shall receive zero points since the patient's risk status could not be determined and the preventive care criterion was not addressed. • Evidence of risk assessments and screenings for other preventive care criteria may be found in the ***IHEBA,*** progress notes, comprehensive history forms, or elsewhere in the medical record. **Note:** The AAP does not approve nor endorse any specific tool for screening purposes. Examples of screening tools are available at: https://screeningtime.org/star-center/#/screening-tools https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx
1) **Alcohol Use Disorder Screening and Behavioral Counseling**	Per AAP recommendations, alcohol use disorder screening and behavioral counseling should begin at 11 years of age. If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s). Brief Assessment and Screening When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use is present. Validated assessment tools may be used without first using validated screening tools. The AAP recommended assessment tool is available at: http://crafft.org. Brief Interventions and Referral to Treatment When brief assessments reveal unhealthy alcohol use, brief misuse counseling with appropriate referral for additional evaluation and treatment options, referrals, or services must be offered. Brief interventions must include the following: • Providing feedback to the patient regarding screening and assessment results;

IV. Pediatric Preventive Criteria	
	• Discussing negative consequences that have occurred and the overall severity of the problem; • Supporting the patient in making behavioral changes; and • Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated. The AAP/Bright Futures periodicity schedule is available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf For details on Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment, refer to APL 21-014 or any superseding APL. Please refer to the link below to The Medi-Cal Provider Manual: https://www.dhcs.ca.gov/formsandpubs/publications/Pages/Manuals.aspx
2) Anemia Screening	Per AAP, perform risk assessment or screening at 4, 15, 18, 24, and 30 months, 3 years old, and then annually thereafter. Test serum hemoglobin at 12 months old. If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s). Acceptable evidence of anemia screening: evaluate patient's diet, nutrition supplement intake, menstrual status, medical history for chronic conditions, etc. Chronic conditions to assess that are associated with anemia: ○ A diet consistently low in iron, vitamin B-12 and folate ○ Heavy Menstruation. See link for signs of heavy menstrual bleeding: https://www.acog.org/womens-health/faqs/heavy-menstrual-bleeding ○ Pregnancy ○ Slow, chronic blood loss from an ulcer; Crohn's disease, celiac disease, cancer, kidney failure, diabetes, etc. The Bright Futures/AAP periodicity schedule is available at: https://www.aap.org/en-us/documents/periodicity_schedule.pdf.

IV. Pediatric Preventive Criteria	
	See the National Institutes of Health information on Anemia, available at: https://www.nhlbi.nih.gov/health-topics/anemia#:~:text=Some%20people%20are%20at%20a,such%20as%20chemotherapy%20for%20cancer. See the Center for Disease Control and Prevention's (CDC) information on heavy menstrual bleeding, available at: https://www.cdc.gov/ncbddd/blooddisorders/women/menorrhagia.html.
3) Anthropometric measurements	For each well exam: • Infants up to 24 months old: assess for length/height and head circumference (HC). Measurements are plotted in a World Health Organization (WHO) growth chart. • 2-21 years old: assess for height, weight, and body mass index (BMI) measurements are plotted in a CDC growth chart. • Provider should measure and track BMI to identify patient at risk for being overweight, obese, or underweight. Patients identified as overweight and/or obese are provided counseling for nutrition to promote healthy eating habits and regular physical activity. For additional information on anthropometric measurements, refer to the following link: https://www.dhcs.ca.gov/services/chdp/Documents/HAG/4AnthropometricMeasure.pdf **Note:** Site is deficient if anthropometric measurements are not plotted on the appropriate growth chart.[15]
4) Anticipatory Guidance	• Must be documented at each well child visit. • Is given by the health care provider to assist parents or guardians in the understanding of the expected growth and development of their children. • Specific to the age of the patient, includes information about the benefits of healthy lifestyles and practices that promote injury and disease prevention

[15] CDC growth charts are available at: https://www.cdc.gov/growthcharts/.

IV. Pediatric Preventive Criteria	
	https://brightfutures.aap.org/Bright%20Futures%20Documents/BF_PreventiveServices_Tipsheet.pdf#search=document%20anticipatory%20document
5) **Autism Spectrum Disorder (ASD) Screening**	ASD screening must be performed at 18 months and 24 months of age based on AAP periodicity "Bright Futures". If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s). ASD screening tools examples: ○ Ages and Stages Questionnaires (ASQ) ○ Communication and Symbolic Behavior Scales (CSBS) ○ Parents' Evaluation of Developmental Status (PEDS) ○ Modified Checklist for Autism in Toddlers (MCHAT) ○ Screening Tool for Autism in Toddlers and Young Children (STAT) ○ Survey of Well-being of Young Children (SWYC) screening tools (assess three domains of child functioning: developmental domain, emotional/behavioral domain, and family context) Refer to APL 19-014, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21, and APL 19-010, Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21, or any superseding APLs for more information on ASD. Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder" Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening", available at: https://pediatrics.aappublications.org/content/145/1/e20193449. See the AAP publication regarding Identification, Evaluation, and Management of Children with ASD, available at: https://pediatrics.aappublications.org/content/145/1/e20193447.

IV. Pediatric Preventive Criteria	
	See the Tufts Children's Hospital Survey of Well-being of Young Children, available at: https://www.tuftschildrenshospital.org/The-Survey-of-Wellbeing-of-Young-Children/Overview. See the AAP Screening Tools, available at: https://screeningtime.org/star-center/#/screening-tools
6) Blood Lead Screening	• Children receiving health services through publicly funded programs must receive anticipatory guidance on lead poisoning prevention at each periodic health assessment, starting at 6 months of age and continuing until 72 months of age. • Provider shall offer and document appropriate follow-up intervention(s) for patient whose screen reveals elevated Blood Lead Levels. Medi-Cal managed care health plans (MCPs) must ensure that the providers provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child member that, at a minimum, includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age. Childhood Lead Poisoning Prevention Branch (CLPPB) anticipatory guidance includes information about other common sources of lead exposure for children.[16] Spanish version: https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/CDPH%20Document%20Library/CLPPB-antguid(S).pdf. Order or perform blood lead screening tests on all child members in accordance with the following: • At 12 months and at 24 months of age. • When the network provider performing a PHA becomes aware that a child member who is 12 to 24 months of age has no documented evidence of a blood lead screening test taken at 12 months of age or thereafter.

[16] The CLPPB Guidance is available at: https://vchca.org/images/public_health/VCCHDP/Chapter6.pdf.

IV. Pediatric Preventive Criteria	
	• When the network provider performing a PHA becomes aware that a child member who is 24 to 72 months of age has no documented evidence of a blood lead screening test taken. • At any time, a change in circumstances has, in the professional judgement of the network provider, put the child member at risk. • If requested by the parent or guardian. Follow the CDC Recommendations for Post-Arrival Lead Screening of Refugees contained in the CLPPB issued guidelines.[17] **Note:** Network providers are not required to perform a blood lead screening test if either of the following applies: • In the professional judgment of the network provider, the risk of screening poses a greater risk to the child member's health than the risk of lead poisoning. • If a parent, guardian, or other person with legal authority to withhold consent for the child refuses to consent to the screening. Evidence of provider compliance of blood lead screening test if not performed: • The provider must document the reason(s) for not performing the blood lead screening test in the child member's medical record. • In cases where consent has been withheld, the provider must obtain a signed statement of voluntary refusal by parent or guardian. If the provider is unable to obtain a signed statement of voluntary refusal because the party that withheld consent, refuses or declines to sign it, or is unable to sign it (e.g., when services are provided via telehealth modality), it is acceptable for the provider to document the refusal. See APL 20-016, Blood Lead Screening of Young Children, or any superseding APL for more information.

[17] The CDC Recommendations are available at: https://www.cdc.gov/immigrantrefugeehealth/guidelines/lead-guidelines.html.

IV. Pediatric Preventive Criteria	
	Please refer to California Department of Public Health (CDPH) CLPPB and the CDC for recommended actions based on BLL levels: • Information on how to report blood lead screening test results to CLPPB can be found at: https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/report_results.aspx. • Health care providers using a point-of-care device are considered laboratories and must report.[18] • See the CDC Guidance on Childhood Lead Poisoning Prevention, available at: https://www.cdc.gov/nceh/lead. • See the California Management Guidelines on Childhood Lead Poisoning for Health Care Providers publication, available at: https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/prov.aspx • For children at risk of lead exposure, see "Prevention of Childhood Lead Toxicity", available at: http://pediatrics.aappublicatons.org/content/138/1/e20161493, and "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention", available at: https://www.cdc.gov/nceh/lead/acclpp/final_document_030712.pdf
7) **Blood Pressure Screening**	• Per AAP, blood pressure screening starts at 3 years old. • In infants and children with specific risk conditions, blood pressure measurements should be performed at visits before age 3 years. • Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveals elevated blood pressure.

[18] See Health and Safety Code Section 124130. State law is searchable at: https://leginfo.legislature.ca.gov/faces/home.xhtml.

IV. Pediatric Preventive Criteria	
	In persons aged 3-18 years, the prevalence of hypertension is 3.6 %. Evidence suggests that elevated blood pressure in childhood increases the risk for adult Hypertension and Metabolic Syndrome. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents", available at: http://pediatrics.aappublications.org/content/140/3/e20171904 See the Bright Futures Medical Screening Reference Table, available at: https://brightfutures.aap.org/Bright%20Futures%20Documents/MSRTable_InfancyVisits_BF4.pdf. See the AAP guidance on Clinical Practice Guidelines for Screening and Management of High Blood Pressure in Children and Adolescents, available at: https://publications.aap.org/pediatrics/article/140/3/e20171904/38358/Clinical-Practice-Guideline-for-Screening-and
8) Dental/Oral Health Assessment	• Per DHCS contracts, the provider is responsible for ensuring that dental screening/oral health assessment for all members are included as part of the IHA.[19] • Inspection of the mouth, teeth, and gums is performed at every health assessment visit and refer to a dentist if a dental problem is detected or suspected. • Per AAP, referral to a dental home begins at 12 months. If patients do not have an established dental home after 12 months, continue performing an oral health risk assessment and refer to a dental home.[20] • Documentation of "HEENT" is acceptable. See the Caries-risk Assessment and Management for Infants, Children, and Adolescents, available at: https://www.aapd.org/media/Policies_Guidelines/BP_CariesRiskAssessment.pdf See the AAP guidance on Fluoride Use in Caries Prevention in the Primary Care Setting, available at: http://pediatrics.aappublications.org/content/134/3/626.

[19] For additional information, see the MCP Contract, Exhibit A, Attachment 11, Provision 15.
[20] See the AAP Oral Health Practice Tools, available at: https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/.

IV. Pediatric Preventive Criteria	
a. Fluoride Supplementation	• The AAP and USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride. • Parents or legal guardian should be encouraged to check with local water utility agency if water has fluoride. • If local water does not contain fluoride, provider may recommend the purchase of fluoridated water or give prescription for fluoride drops or tablets. • Per AAP, fluoride supplementation for all children ages 6 months until their fifth-year birthday (age range according to the most current AAP periodicity schedule) whose daily exposure to systemic fluoride is deficient. For the fluoridation status of a community water supply, contact the local water department or the link for "My Water's Fluoride", available at: https://nccd.cdc.gov/doh_mwf/default/default.aspx See the AAP's guidance on Maintaining and Improving the Oral Health of Young Children, available at: http://pediatrics.aappublications.org/content/134/6/1224. See the USPSTF guidance on Dental Caries in Children Younger Than 5 Years, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1 Comment: USPSTF changed their recommendation as of 12/7/21 which is what AAP is referencing in the AAP periodicity schedule footnote 35 and 36. See guidance on fluoride supplementation, available at: https://publichealth.nc.gov/oralhealth/library/includes/IMBresources/2020-FluorideSupplementation.pdf#:~:text=Pediatric%20Dentistry%20%28AAPD%29%20recommend%20the%20daily%20administration%20of,years%20of%20age%20to%20provide%20the%20maximum%20benefits.

IV. Pediatric Preventive Criteria	
b. Fluoride Varnish	• Fluoride varnish is a dental treatment that can help prevent tooth decay, slow it down, or stop it from getting worse by strengthening the tooth enamel (outer coating on teeth). • AAP recommends that fluoride varnish be applied to the teeth of infants and children starting at tooth eruption until their fifth-year birthdate (age range according to the most current AAP periodicity schedule). All children in this category should receive fluoride varnish application at least once every 3-6 months in the primary care or dental office. **Note:** Documentation of "seeing a dentist" without specific notation that fluoride varnish was applied at the dentist office does not meet the criterion. Not all dentists routinely apply fluoride varnish during routine dental visits. See the USPSTF guidance on Dental Caries in Children Younger Than age 5 Years, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1. See APL 19-010, Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21, for additional guidance on fluoride varnish. See the AAP publication on Maintaining and Improving the Oral Health of Young Children, available at: https://publications.aap.org/pediatrics/article/134/6/1224/33112/Maintaining-and-Improving-the-Oral-Health-of-Young.
9) Depression Screening	• AAP recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 20 years. • Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up if screening is positive and a follow up plan is documented.

IV. Pediatric Preventive Criteria	
	• Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening is positive for depression. • Depression screening must be done using a validated screening tool. Per AAP, screen using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit, and available at: https://downloads.aap.org/AAP/PDF/Mental_Health_Tools_for_Pediatrics.pdf and https://screeningtime.org/star-center/#/screening-tools.
a) Suicide Risk Screening	• Pending AAP guidance
b) Maternal Depression Screening	• Maternal mental health condition is defined as a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression. • Maternal depression screen at 1-, 2-, 4-, and 6-month visits. • Maternal depression screening must be done using a validated screening tool, such as the Edinburgh Postnatal Depression Scale (EPDS), Postpartum Depression Screening Scale, or Patient Health Questionnaire (PHQ) 9.[21] • As with any screening test, results should be interpreted within the clinical context and when appropriate referral to the PCP and/or to mental health care providers for follow up.[22] • Provider shall offer and document appropriate follow-up intervention(s) for women whose screening is positive for maternal depression. Assembly Bill (AB) 2193 requires provider who provides prenatal or postpartum care for a patient to offer to screen or appropriately screen a mother for maternal mental health conditions.[23] It also requires interpregnancy care providers to do the same when the patient has experienced a stillbirth or miscarriage. (Health and Safety Code, section 123640 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1236

[21] See the American College of Obstetricians and Gynecologists (ACOG) guidance on Screening for Perinatal Depression, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/11/screening-for-perinatal-depression.
[22] For additional resources on perinatal depression, see: http://www.acog.org/More-Info/PerinatalDepression.
[23] AB 2193 (Chapter 755, Statutes of 2018) is available at: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB2193.

IV. Pediatric Preventive Criteria	
	40.&lawCode=HSC), with the most recent version effective 1/1/2022, as amended by AB 1477. Per AAP, "screening should occur per 'Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice', available at: https://pediatrics.aappublications.org/content/143/1/e20183259 See the ACOG Frequently Asked Questions on Postpartum Depression, available at: https://www.acog.org/Patients/FAQs/Postpartum-Depression. See the USPSTF recommendation on Screening Depression in Adults, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening1 See the U.S. Department of Health and Human Services guidance on Postpartum Depression, available at: https://www.womenshealth.gov/mental-health/mental-health-conditions/postpartum-depression.
10) Developmental Disorder Screening	• Screen for developmental disorders at the 9th, 18th, and 30th month visits. • 30th month screening can be done at 24 months. • Providers must use an AAP validated screening tool that must also be a global, not domain specific, consistent with criteria set forth in the CMS Technical Specifications. • Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening is positive for developmental disorder. • The CMS Technical Specifications are consistent with age recommendations and use of a validated screening tool; however, tech spec excludes MCHAT tool which AAP allows. CMS determined that the ASQ: SE and M-CHAT screening tools were too specific because they screen for a domain-specific condition (social emotional development or autism, respectively), rather than a full, general assessment of developmental delays.

IV. Pediatric Preventive Criteria	
	For detailed information on the CMS Technical Specifications please refer to the link: https://www.medicaid.gov/license/form/6466/4391. The developmental screening measure starts on page 65. Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children with Developmental Disorders Through Developmental Surveillance and Screening", available at: https://pediatrics.aappublications.org/content/145/1/e20193449.
11) Developmental Surveillance	Developmental surveillance is a component of every well care visit. If the patient is positive for potential delays, provider shall offer and document appropriate follow-up intervention(s).
12) Drug Use Disorder Screening and Behavioral Counseling	Per AAP recommendations, drug use screening and behavioral counseling should begin at 11 years of age. Provider shall offer and document appropriate follow-up interventions for patient whose screening reveals unhealthy drug use. Brief Assessment and Screening When a screening is positive, validated assessment tools should be used to determine if unhealthy drug use is present. Validated drug assessment tools may be used without first using validated screening tools. The AAP recommended assessment tool is available at: http://crafft.org. Brief Interventions and Referral to Treatment When brief assessments reveal unhealthy drug use, brief misuse counseling with appropriate referral for additional evaluation and treatment options, referrals, or services must be offered. Brief interventions must include the following: • Providing feedback to the patient regarding screening and assessment results; • Discussing negative consequences that have occurred and the overall severity of the problem; • Supporting the patient in making behavioral changes; and • Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated.

IV. Pediatric Preventive Criteria	
	See APL 21-014 or any superseding APL for details on Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment. See the AAP guidance on Substance Use Screening, Brief Intervention, and Referral to Treatment, available at: https://pediatrics.aappublications.org/content/138/1/e20161211.
13) Dyslipidemia Screening	Family history of obesity, diabetes, hypertension, and heart disease is commonly associated with a combined dyslipidemia. Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveals dyslipidemia. Per AAP perform a risk assessment at: ○ 2, 4, 6, and 8 years old, then annually thereafter. ○ Order one lipid panel between 9 and 11. ○ Perform again between 17 and 21 years old to identify children with genetic dyslipidemia or more lifestyle-related dyslipidemia. For more information see "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents", available at: https://www.nhlbi.nih.gov/health-topics/integrated-guidelines-for-cardiovascular-health-and-risk-reduction-in-children-and-adolescents For more information on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents, see: https://www.nhlbi.nih.gov/node/80308 https://brightfutures.aap.org/Pages/default.aspx
14) Hearing Screening	Per AAP audiometric screenings are performed at: ○ Birth to 2 months old, 4, 5, 8, and 10 years old ○ Once between 11-14 years old ○ Once between 15-17 years old ○ Once between 18-21 years old Per AAP, clinicians must confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position

IV. Pediatric Preventive Criteria	
	Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs", available at: http://pediatrics.aappublications.org/content/120/4/898.full. A failed audiometric screening is followed-up with a repeat screening at least two weeks and no later than 6 weeks after the initial screening. If the second screening also fails, the primary care provider must make a referral to a specialist. • Non-audiometric assessments shall be performed at each health assessment visit until the child reaches 21 years old and includes an assessment of birth/family history (hearing loss in the family), history of ear infection and the signs and symptoms of hearing loss (i.e. does not startle at loud noises, does not turn to the source of a sound after 6 months of age, speech is delayed and unclear, often says, "Huh?", turns the TV volume up too high, etc.). • Audiometric testing is performed using a newborn hearing screening test (e.g. Automated Auditory Brainstem Response [AABR] or Otoacoustic Emission [OAE] technology) at the birth hospital or specialty facility; or a Behavioral Audiometry Evaluation with an audiometer at the primary care facility starting at 4 years old and includes follow-up care as appropriate. See the AAP periodicity schedule, available at: www.aap.org/periodicityschedule. See the CDC recommendations and guidelines on Hearing Loss in Children, available at: https://www.cdc.gov/ncbddd/hearingloss/recommendations.html. See the CDC guidance on Hearing Screenings for Children, available at: https://www.cdc.gov/ncbddd/hearingloss/screening.html. For more information on Hearing Loss in Children, see: https://www.cdc.gov/ncbddd/hearingloss/facts.html.
15) Hepatitis B Virus Infection Screening	• Pending guidance from AAP
	• Per AAP, all individuals 18 and older should be assessed for risk of hepatitis C virus (HCV) infection.

IV. Pediatric Preventive Criteria	
16) Hepatitis C Virus Infection Screening	• Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveal potential for Hepatitis C Virus infection. • Per USPSTF and CDC, test at least once between the ages of 18 and 79. Persons with increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually.[24] . For more information refer to Hepatitis C Virus Infection in Adolescents and Adults: Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening.
17) Human Immunodeficiency Virus (HIV) Infection Screening	• Per AAP, risk assessment for HIV shall be completed at each well child visit starting at 11 years old. • Adolescents should be tested for HIV according to the USPSTF recommendations once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent.[25] • Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually. If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s). Recommendations for STD screening are listed in Box 3 at: https://www.cdc.gov/mmwr/volumes/68/rr/rr6805a1.htm#B3_down. Additional information on screening recommendations is available at: https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm; https://stacks.cdc.gov/view/cdc/82088. The CDC Recommendations for Providing Quality STD Clinical Services is available at: https://www.cdc.gov/mmwr/volumes/68/rr/rr6805a1.htm.

[24] See the USPSTF recommendations on HCV screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening, and the CDC recommendations on HCV screening, available at: https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm.
[25] See the USPSTF recommendation on HIV screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening

IV. Pediatric Preventive Criteria	
	For additional information on clinical considerations for risk assessment, screening intervals, treatment, and prevention, see: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening The AAP periodicity schedule is available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf For those at risk, look for documented evidence that pre-exposure prophylaxis (PrEP) was offered.
18) Psychosocial/Behavioral Assessment	• Psychosocial/Behavior Assessment should be done at each well child visit. • This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. • • **Note: Social Determinants Of Health (SDOH)** • Per AAP, social determinants of health (SDOH) are the web of interpersonal and community relationships experienced by children, parents, and families. • Per CDC, social determinants of health (SDOH) are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality of life risks and outcomes. https://brightfutures.aap.org/Bright%20Futures%20Documents/BF_IntegrateSDoH_Tipsheet.pdf https://www.cdc.gov/socialdeterminants/about.html See the AAP publication titled “Promoting Optimal Development: Screening for Behavioral and Emotional Problems”, available at: http://pediatrics.aappublications.org/content/135/2/384. See the AAP publication titled “Poverty and Child Health in the United States”, available at: http://pediatrics.aappublications.org/content/137/4/e20160339 https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

IV. Pediatric Preventive Criteria	
19) Sexually Transmitted Infection (STI) Screening and Counseling	Per AAP, adolescents should be screened for STIs per recommendations in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases. • Sexual activity shall be assessed at every well child visit starting at 11 years old. • If adolescents are identified as sexually active (by report or on the IHEBA form), the provider shall offer and provide contraceptive care with the goals of helping teens reduce risks and negative health consequences associated with adolescent sexual behaviors, including unintended pregnancies and STIs. • For adolescents that have been pregnant, provider should engage in a discussion of counseling on inter-pregnancy intervals and contraceptive care, such as moderately and most effective contraceptive options. Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveals STI.AAP refers to CDC for full list of STIs, available at: https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/California-STI-Treatment-Guidelines.aspx • **Risk assessments for Adolescents and 24 years and younger:** Annual chlamydia and gonorrhea screenings should be done for sexually active women under age 25 as well as older women who are at risk. Screening for syphilis, HIV, chlamydia, and Hepatitis B should be given to all pregnant women, and gonorrhea screening for all pregnant women.[26] • **Men Who Have Sex with Men** (MSM): These men have higher rates of STIs, such as HIV and syphilis and should be tested for these as well as chlamydia, and gonorrhea. • **Men Who Have Sex with Women**: There is insufficient evidence for screening among heterosexual men who are at low risk for infection, however, screening young men can be considered in high prevalence clinical settings (adolescent clinics, correctional facilities, and STI/sexual health clinic).

[26] See the AAP guidance on Screening and Nonviral STIs in Adolescents and Young Adults: https://publications.aap.org/pediatrics/article/134/1/e302/62344/Screening-for-Nonviral-Sexually-Transmitted, the AAP periodicity schedule, available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf, and the AAP guidance on Adolescent Sexual Health, available at: https://www.aap.org/en/patient-care/adolescent-sexual-health/.

- **Sex Workers**: This population is at higher risk for HIV and other STIs than others, and should be tested at least annually for HIV.
- **Transgender and Gender Diverse Persons**: Screening recommendations should be adapted based on anatomy, (i.e., annual, routine screening for Chlamydia in cis-gender women < 25 years old should be extended to all transgender men and gender diverse people with a cervix. Consider screening at the rectal site based on reported sexual behaviors and exposure. **Persons with HIV**: For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter. More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology.

Syphilis

- People who are pregnant
- Male adolescents and young adults in settings with high prevalence rates (e.g. jails or juvenile correction facilities)
- MSM at least annually (every 3 to 6 months if high risk because of multiple or anonymous partners, sex in conjunction with illicit drug use, or having sex partners who participated in these activities)

See the AAP guidance on Adolescent Sexual Health, available at: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/adolescent-sexual-health/Pages/default.aspx

See the DHCS webpage on the Staying Healthy Assessment, available at: https://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx.
For information on chlamydia and gonorrhea screening. see: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/chlamydia-and-gonorrhea-screening.

For USPSTF information on syphilis screening, see: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/syphilis-infection-in-nonpregnant-adults-and-adolescents.

Senate Bill (SB) 306 (Pan, Chapter 486, Statutes of 2021)
https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB306

IV. Pediatric Preventive Criteria	
	https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=120685&lawCode=HSC
20) Sudden Cardiac Arrest and Sudden Cardiac Death Screening	Pending guidance from AAP
21) Tobacco Use Screening, Prevention, and Cessation Services	Tobacco Use Screening, Prevention, and Cessation Services • Screen all children 11 years and older at each well child visit for tobacco products use. • Tobacco products include but not limited to smoked cigarettes, chewed tobacco, electronic cigarette, and vaping products use, and/or exposure to secondhand smoke. • If patient answered “yes” to the smoke/tobacco questions in the IHEBA or at any time the PCP identifies a potential tobacco use problem, then the provider shall document prevention and/or cessation services to potential/active tobacco users. • Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveal tobacco use. Tobacco cessation services must be documented in the patient’s medical record as follows: 1) Initial and annual assessment of tobacco (e-cigarette, vaping products, and/or secondhand smoke) use for each adolescent (11-21 years of age). 2) FDA-approved tobacco cessation medications (for non-pregnant adults of any age). 3) Individual, group, and telephone counseling for members of any age who use tobacco products. 4) Services for pregnant tobacco users. 5) Prevention of tobacco use in children and adolescents (including counseling and pharmacotherapy). For information on comprehensive tobacco prevention and cessation services for Medi-Cal beneficiaries is available at, see APL 16-014, Comprehensive Tobacco

IV. Pediatric Preventive Criteria	
	Prevention and Cessation Services for Medi-Cal Beneficiaries, or any superseding APL. Smoking status can be assessed through the use of the SHA, which is DHCS's IHEBA. The AAP recommended assessment tool is available at: http://crafft.org.
22)Tuberculosis Screening	• Per AAP, Committee on Infectious Diseases, published in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases, testing should be performed on recognition of high-risk factors. • All children are assessed for risk of exposure to tuberculosis (TB) at 1, 6, and 12-months old and annually thereafter. • Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveals positive risk factors for TB. • Two tests that are used to detect TB bacteria in the body: the TB skin test (TST) (Mantoux) and TB blood tests QuantiFERON-TB Gold Plus. A positive TB skin test or TB blood test only tells that a person has been infected with TB bacteria. TB infection screening test is administered to children *identified at risk,* if there has not been a test in the previous year. The Mantoux is not given if a previously positive Mantoux is documented. Documentation of a positive test includes follow-up care (e.g. further medical evaluation, chest x-ray, diagnostic laboratory studies and/or referral to specialist). • Providers are required to follow current CDC and American Thoracic Society guidelines for TB diagnosis and treatment. The California Pediatric Tuberculosis Risk Assessment tool is available at: https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-Pediatric-TB-Risk-Assessment.pdf. CDC guidance on TB testing and diagnosis is available at: https://www.cdc.gov/tb/topic/testing/default.htm.
23)Vision Screening	• Age-appropriate visual screening occurs at each health assessment visit, with referral to optometrist/ophthalmologist as appropriate.

IV. Pediatric Preventive Criteria	

	• Per AAP, visual acuity screenings using optotypes (figures or letters of different sizes used for vision screening) are to be performed at ages 3 (if cooperative), 4, 5, 6, 8, 10, 12, and 15 years old.
	• Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age.
	• Documentation of "PERRLA" is acceptable for children below the age of 3 years.
	• If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s).
	•
	• AAP recommended eye charts are:
	  ○ LEA Symbols (3-5 years old)
	  ○ HOTV Chart (3-5 years old)
	  ○ Sloan Letters (preferred) or Snellen Letters (over 5 years old)
	
	See the AAP publications titled "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" available at: http://pediatrics.aappublications.org/content/137/1/e20153596 and "Procedures for the Evaluation of the Visual System by Pediatricians", available at: http://pediatrics.aappublications.org/content/137/1/e20153597.
	
	Note: Although specific screening details are not generally documented in the medical record, screening for infants and children (birth to 3 years) may consist of evaluations Such as external eye inspection, ophthalmoscopy red reflex examination, or corneal penlight evaluation. Visual acuity screening usually begins at age 3 years. AAP guidance on Visual System Assessment in Infants, Children, and Young Adults by Pediatricians is available at: https://pediatrics.aappublications.org/content/137/1/e20153596.

D) Childhood Immunizations	Every visit should be an opportunity to update and complete a child's immunizations. Childhood Immunizations Schedules, per the AAP Committee on Infectious Diseases, are available at: https://redbook.solutions.aap.org/SS/immunization_Schedules.aspx.

IV. Pediatric Preventive Criteria	
	For reference, see the CDC's ACIP webpage, available at: https://www.cdc.gov/vaccines/acip/index.html, also see APL 18-004, Immunization Requirements, or any superseding APL For details on Immunization Requirements.
1) **Given according to ACIP guidelines**	Immunization status is assessed at each health assessment visit. Practitioners are required to ensure the provision of immunizations according to CDC's most recent ACIP guidelines, unless medically contraindicated, vaccine shortage or refused by the parent. Refer to the following link for more information on ACIP Vaccine Recommendations and Guidelines: https://www.cdc.gov/vaccines/hcp/acip-recs/index.html.
2) **Vaccine administration documentation**	The name, manufacturer, date of administration, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries, in accordance with the National Childhood Vaccine Injury Act. For additional details on the National Childhood Vaccine Injury Act, refer to: https://www.congress.gov/bill/99th-congress/house-bill/5546
3) **Vaccine Information Statement (VIS) documentation**	• VISs are information sheets produced by the CDC that explain both the benefits and risks of a vaccine to the vaccine recipients. • Federal law requires that healthcare staff provide a VIS to a patient, parent, or legal representative before each dose of certain vaccines. VIS documentation in the medical/electronic record, medication logs, or immunization registries include the date the VIS was given or presented/offered *and* the VIS publication date. Refer to the following link from the CDC for the current VISs: https://www.cdc.gov/vaccines/hcp/vis/current-vis.html. **Note:** Federal law allows up to 6 months for the updated VIS to be distributed.

Rationale: Current Guide to Clinical Preventive Services, U.S. Preventive Services Task Force (USPSTF) Report is the minimum standard for adult preventive health services.

RN/NP/MD/PA/CNM/LM

V. Adult Preventive Criteria	
A. Initial Health Assessment (IHA): Includes H&P and IHEBA	**New Members:** The IHA (comprehensive history and IHEBA "Staying Healthy Assessment" or other DHCS-approved tool) enables the PCP to assess current acute, chronic, and preventive needs *and* to identify those Members whose health needs require coordinated services with appropriate community resources/other agencies not covered by the Plan. IHA must be completed within 120 days of plan enrollment or PCP effective date (whichever is more recent) or documented within the 12 months prior to Plan enrollment/PCP effective date. Reference: PLs 08–003 and 13-001, or any superseding APL.
1) Comprehensive History and Physical	**New members**: The history must be comprehensive to assess and diagnose acute and chronic conditions it includes: o History of present illness o Past medical history o Social history o Review of Organ Systems (ROS) including dental assessment Referrals for any abnormal findings must be documented. If an H&P is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented. A review of the organ systems that include documentation of "inspection of the mouth" or "seeing dentist" meets the criteria for dental assessment during a comprehensive history and physical.
	New members: An age-appropriate IHEBA ("Staying Healthy" or other DHCS-approved tool) is completed by the member within 120 days of the effective date of

V. Adult Preventive Criteria	
2) **Individual Health Education Behavioral Assessment (IHEBA)**	enrollment into the Plan or PCP effective date (whichever is more recent), or within the 12 months prior to Plan enrollment/PCP effective date. Staff may assist. The IHEBA has evidence of practitioner review: ○ Printed name ○ Signature ○ Date ○ Interventions, which may be documented on the IHEBA form, in progress notes, or other areas of the paper or electronic medical record system. If an initial IHEBA is not found in the medical record, the reasons (e.g., member's refusal, missed appointment) and contact attempts to reschedule are documented. SHA Questionnaires are available at: http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx
B. Periodic Health Evaluation according to most recent USPSTF guidelines	The type, quantity, and frequency of preventive services is based on the most recent USPSTF recommendations.
1) **Comprehensive History and Physical Exam completed at age-appropriate frequency.**	• Periodic health evaluations occur in accordance with the frequency that is appropriate for individual risk factors. • In addition to USPSTF recommendations, periodic health evaluations are scheduled as indicated by the member's needs and according to the clinical judgment of the practitioner. Example: A patient with elevated cholesterol levels and other risk factors for coronary heart disease (CHD) may be evaluated more frequently than other persons of the same age without similar risk factors.
2) **Subsequent Periodic IHEBA**	• The adult or senior assessment must be re-administered every 3 to 5 years, at a minimum. • The PCP must review previously completed SHA questionnaires with the patient every year, except years when the assessment is re-administered.

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Documentation requirements are the same as the initial IHEBA.
For subsequent annual reviews, PCP must sign, print name, and date “SHA Annual Review” section (last page) to verify the annual review was conducted and discussed with the patient.

SHA Questionnaires are available at:
http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx
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<tr><td>C. Adult Preventive Care Screenings</td><td>
The following adult preventive care screenings are based on USPTSF Grade A and B recommendations.

If the patient falls within the eligible condition (e.g. obesity, post-menopausal, etc.), age and gender parameters of the criterion, the provider shall assess for risk factors.
The IHEBA screening tool may assist in screening for risk factors for many preventive care criteria (i.e. Alcohol misuse, STI, HIV, Tobacco, etc.).
Evidence of risk assessments and screenings for other preventive care criteria may be found elsewhere in the medical record if the IHEBA was completed, reviewed, and signed by the provider, and the patient is negative for risk, the provider may be given a point.
If the patient is positive for risk factors, the provider shall offer and document follow-up intervention(s).
Providers who fail to document the presence or absence of risk factors shall receive zero (0) points.
An “NA” score is warranted if the patient falls outside of the eligible condition, age and gender parameters of the specific criterion.

If specific preventive care screening tests are ordered, but results are not found in the member’s record, and no documentation of follow-up is documented, these deficiencies will be cited under the appropriate preventive care criteria. The Follow-up of Specialty Referrals criteria pertain to referrals/lab tests that are not specified under preventive care criteria (i.e. ophthalmology, nephrology, etc.).

Use the following scoring methodology under adult preventive care screenings:

If ordered and result found, score as 1.

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V. Adult Preventive Criteria	
	○ If ordered and patient refused, score as 1. ○ If ordered and no result found, but outreach efforts are documented, score as 1. ○ If ordered but no result or outreach efforts documented, score as 0.
1) Abdominal Aneurysm Screening	Assess all individuals during well adult visits for past and current tobacco use. USPSTF recommends that medical providers should perform a one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked 100 or more cigarettes in their lifetime. Indirect evidence shows that smoking is the strongest predictor of Abdominal Aortic Aneurysm (AAA) prevalence, growth, and rupture rates.[27] There is a dose-response relationship, as greater smoking exposure is associated with an increased risk for AAA. The USPSTF Grade A and B Recommendations are available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations.
2) Alcohol Use Disorder Screening and Behavioral Counseling	Assess all adults at each well visit for alcohol misuse. If at any time the PCP identifies a potential alcohol misuse problem (e.g., patient answered "yes" to the alcohol questions in the IHEBA), the provider shall: • Refer any member identified with possible alcohol use disorders to the alcohol and drug program in the county where the member resides for evaluation and treatment. • Use the Alcohol Use Disorder Identification Test (AUDIT) or Alcohol Use Disorder Identification Test-Consumption (AUDIT-C). • Complete at least one expanded screening, using a validated screening tool every year and additional screenings can be provided in a calendar year if medical necessity is documented by the member's provider. • Offer behavioral counseling intervention(s) to those members that a provider identifies as having risky or hazardous alcohol use. 1) A member responds affirmatively to the alcohol questions in the IHEBA.

[27] See the USPSTF recommendation on AAA Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/abdominal-aortic-aneurysm-screening.

2) Member provides responses on the expanded screening that indicate hazardous use, or when otherwise identified.

When a member responds affirmatively to the alcohol questions in the IHEBA, provides responses on the expanded screening that indicate hazardous use, or when otherwise identified.

Behavioral counseling intervention(s) typically include one to three sessions, 15 minutes in duration per session, offered in-person, by telephone, or by telehealth modalities.

See the NIH guidance on Screening Tests, available at: https://pubs.niaaa.nih.gov/publications/arh28-2/78-79.htm

See APL 21-014, Alcohol and Drug Screenings, Assessment, Brief Interventions and Referral to Treatment, or any superseding APL, for additional information.

The USPSTF uses the term “unhealthy alcohol use” to define a spectrum of behaviors, from risky drinking to alcohol use disorder (AUD) (e.g., harmful alcohol use, abuse, or dependence). Risky or hazardous alcohol use means drinking more than the recommended daily, weekly, or per-occasion amounts, resulting in increased risk for adverse health consequences but not meeting criteria for AUD (e.g. the National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines “risky use” as exceeding the recommended limits of 4 drinks per day (56 g/d based on the US standard of 14 g/drink) or 14 drinks per week (196 g/d) for healthy adult men aged 21 to 64 years or 3 drinks per day or 7 drinks per week (42 g/d or 98 g/week) for all adult women of any age and men 65 years or older).

Screening

Unhealthy alcohol use screening must be done with validated screening tools. The US Surgeon General, NIAAA, CDC, and ASAM recommend routinely screening adult patients for unhealthy alcohol use and providing them with appropriate interventions, https://www.niaaa.nih.gov/guide

Brief Assessment

When a screen is positive, providers should use validated assessment tools to determine if an alcohol use disorder is present. Validated alcohol assessment tools may be used without first using validated screening tools. Validated assessment tools include, but are not limited to:

- CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble)
- NIDA-modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST)
- Alcohol Use Disorders Identification Test (AUDIT)

Brief Interventions and Referral to Treatment

For recipients with brief assessments revealing alcohol misuse, brief misuse counseling should be offered. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment (MAT), should be offered to recipients whose brief assessment demonstrates probable alcohol use disorder. Alcohol brief interventions includes alcohol misuse counseling and counseling a member regarding additional treatment options, referrals, or services. Brief interventions must include the following:

- Providing feedback to the patient regarding screening and assessment results.
- Discussing negative consequences that have occurred and the overall severity of the problem.
- Supporting the patient in making behavioral changes.
- Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated.

Documentation Requirements

Member medical records must include the following:

- The service provided, for example: screen and brief intervention.
- The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record).
- The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record).
- If and where a referral to an alcohol or substance use disorder program was made.

V. Adult Preventive Criteria	
	A recommended substance abuse assessment tool is available at http://crafft.org. Please refer to the following link to The Medi-Cal Provider Manual: https://www.dhcs.ca.gov/formsandpubs/publications/Pages/Manuals.aspx.
3) **Breast Cancer Screening**	A routine screening mammography for breast cancer is completed every 1-2 years on all women starting at age 50, concluding at age 75 unless pathology has been demonstrated.[28]
4) Cervical Cancer Screening	• Screen for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years. • Women ages 30 to 65 years who want to lengthen the screening interval, screen with a combination of cytology and human papillomavirus (HPV) co-testing every 5 years OR with high-risk human papillomavirus (hrHPV) testing alone every 5 years. • Follow-up of abnormal test results are documented. Routine Pap testing may not be required for the following: • Women who have undergone hysterectomy in which the cervix is removed (TAH - Total Abdominal Hysterectomy), unless the hysterectomy was performed because of invasive cancer. • Women 66 years and older who have had regular previous screening in which the Pap result have been consistently normal. The USPSTF recommendation on Cervical Cancer Screening is available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening.
5) Colorectal Cancer Screening	All adults are screened for colorectal cancer beginning at age 45 years old and concluding at age 75 years to include: • High sensitivity gFOBT or FIT every year • sDNA-FIT every 1 to 3 years

[28] See the USPSTF recommendation on Breast Cancer Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening.

V. Adult Preventive Criteria	
	• CT colonography every 5 years • Flexible sigmoidoscopy every 5 years • Flexible sigmoidoscopy every 10 years + FIT every year • Colonoscopy screening every 10 years. When abnormal results are found on flexible sigmoidoscopy or CT colonography, follow-up with colonoscopy is needed for further evaluation. Rates of colorectal cancer incidence are higher in Black adults and American Indian and Alaskan Native adults, persons with a family history of colorectal cancer (even in the absence of any known inherited syndrome such as Lynch syndrome or familial adenomatous polyposis), men, and persons with other risk factors (such as obesity, diabetes, long-term smoking, and unhealthy alcohol use. The decision to screen for colorectal cancer in adults **aged 76 to 85 years** should be an individual one,taking into account the patient's overall health and prior screening history. The USPSTF recommendation on Colorectal Cancer Screening is available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening.
6) Depression Screening	• Per USPSTF, screen for depression in the general adult population, including pregnant and postpartum women. • Screening should be implemented at each well visit with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. • Providers should screen all adults who have not been previously screened using a validated screening tool. If the depression screening is positive, a follow up plan must be documented. • Providers should use clinical judgment in consideration of risk factors, comorbid conditions, and life events to determine if additional screening of high-risk patients is warranted. Recommended screening tools include: ○ Patient Health Questionnaire (PHQ) in various forms ○ Hospital Anxiety and Depression Scales in adults ○ Geriatric Depression Scale in older adults

V. Adult Preventive Criteria	
	○ The Edinburgh Postnatal Depression Scale (EPDS) pregnant and postpartum IHEBA forms when used solely for depression screening do not have psychometric properties and may not be reliable screening tools for depression. The USPSTF Grade A and B Recommendations are available at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations. The USPSTF recommendation on Screening for Depression in Adults is available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-adults-screening.
7) Diabetic Screening and Comprehensive Care	• Per USPSTF, screen for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 35 to 70 years who are overweight or obese. • Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity. • Glucose abnormalities can be detected by measuring HbA1c or fasting plasma glucose or with an oral glucose tolerance test. • Hemoglobin A1C (HbA1c) is a measure of long-term blood glucose concentration and is not affected by acute changes in glucose levels due to stress or illness. HbA1c measurements do not require fasting, they are more convenient than using a fasting plasma glucose or oral glucose tolerance test. The oral glucose tolerance test is done in the morning in a fasting state; blood glucose concentration is measured 2 hours after ingestion of a 75-g oral glucose load. • The diagnosis of IFG, IGT, or type 2 diabetes should be confirmed; repeated testing with the same test on a different day is the preferred method of confirmation. See the USPSTF recommendation on Prediabetes and Type 2 Diabetes Screening, available at:

V. Adult Preventive Criteria	
	https://uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-prediabetes-and-type-2-diabetes. See APL 18-018, Diabetes Prevention Program, or any superseding APL for additional information. • When reviewing medical records of patients with a diagnosis of Diabetes, the reviewer should score based on documented routine comprehensive diabetic care/screening: retinal exams, podiatry, nephrology, etc. • Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life. With support from health care providers, patients can manage their diabetes with self-care, taking medications as instructed, eating a healthy diet, being physically active, and quitting smoking. See the National Community for Quality Assurance guidance on Comprehensive Diabetes Care, available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. See the USPSTF recommendation on Prediabetes and Type 2 Diabetes Screening, available at: https://uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-prediabetes-and-type-2-diabetes.
8) Drug Use Disorder Screening and Behavioral Counseling	Assess all adults at each well visit for drug misuse. If at any time the PCP identifies a potential drug use problem (e.g., patient answered “yes” to the drug use questions in the IHEBA), the provider shall: • Refer any member identified with possible drug use disorders to the drug treatment program in the county where the member resides for evaluation and treatment. • Complete at least one expanded screening, using a validated screening tool, every year and additional screenings can be provided in a calendar year if medical necessity is documented by the member’s provider. • Offer behavioral counseling intervention(s) to those members that a provider identified as having as having risky or hazardous drug use.

1) A member responds affirmatively to the drug use questions in the IHEBA.
2) Member provides responses on the expanded screening that indicate hazardous use, or when otherwise identified.

When a member responds affirmatively to the drug use questions in the IHEBA, provides responses on the expanded screening that indicate hazardous use, or when otherwise identified.

Behavioral counseling intervention(s) typically include one to three sessions, 15 minutes in duration per session, offered in-person, by telephone, or by telehealth modalities.

See APL 21-014, Alcohol and Drug Screenings, Assessment, Brief Interventions and Referral to Treatment, or any superseding APL, for additional information.

The term “unhealthy drug use” is defined as the use of illegally obtained substances, excluding alcohol and tobacco, or the use of nonmedical prescription medications that differ than the parameters for which they were prescribed such as duration, frequency, and amount.

Brief Assessment

When a screen is positive, providers should use validated assessment tools to determine if a drug use disorder is present. Validated drug assessment tools may be used without first using validated screening tools. Validated assessment tools include, but are not limited to:

- CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble)
- NIDA-modified Alcohol, Smoking, and Substance Involvement Screening Test (NM-ASSIST)
- Drug Abuse Screening Test (DAST-20)

Brief Interventions and Referral to Treatment

For recipients with brief assessments revealing drug misuse, brief misuse counseling should be offered. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment (MAT), should be offered to

<table>
<tr><th colspan="2">V. Adult Preventive Criteria</th></tr>
<tr><td></td><td>recipients whose brief assessment demonstrates probable substance use disorder. Drug brief interventions includes misuse counseling and counseling a member regarding additional treatment options, referrals, or services. Brief interventions must include the following:
• Providing feedback to the patient regarding screening and assessment of results.
• Discussing negative consequences that have occurred and the overall severity of the problem.
• Supporting the patient in making behavioral changes.
• Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated.

<u>Documentation Requirements</u>
Member medical records must include the following:
• The service provided, for example: screen and brief intervention.
• The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electric health record).
• The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record).
• If and where a referral to an alcohol or substance use disorder program was made.

A recommended substance abuse assessment tool is available at: http://crafft.org.

Please refer to the following link to the Medi-Cal Provider Manual: https://www.dhcs.ca.gov/formsandpubs/publications/Pages/Manuals.aspx.</td></tr>
<tr><td>9) Dyslipidemia Screening</td><td>USPSTF recommends that adults without a history of cardiovascular disease (CVD) (e.g., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all the following criteria are met:
1) They are aged 40 to 75 years;
2) They have one or more CVD risk factors (e.g., dyslipidemia, diabetes, hypertension, or smoking); and</td></tr>
</table>

V. Adult Preventive Criteria	
	3) They have a calculated 10-year risk of a cardiovascular event of 10% or greater. Screen universal lipids at every well visit for those with increased risk of heart disease and at least every 6 years for healthy adults. The USPSTF Grade A and B Recommendations are available at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.
10) Folic Acid Supplementation	• The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.[29] • USPSTF and WHO categorize women in the age range of 12-49 years as "women who are capable of becoming pregnant".
11) Hepatitis B Virus Screening	Assess all adults for risk of acquiring Hepatitis B Virus (HBV) at each well visit. Screening those at risk should include testing to three HBV screening seromarkers (HBsAg, antibody to HBsAg [anti-HBs], and antibody to hepatitis B core antigen [anti-HBc]) so that persons can be classified into the appropriate hepatitis B category and properly recommended to receive vaccination, counseling, and linkage to care and treatment. Important risk groups for HBV infection with a prevalence of ≥2% that should be screened include: • Persons born in countries and regions with a high prevalence of HBV infection (≥2%), such as sub-Saharan Africa and Central and Southeast Asia (Egypt, Algeria, Morocco, Libya, Afghanistan, Vietnam, Cambodia, Thailand, Philippines, Malaysia, Indonesia, Singapore, etc.). • U.S.-born persons not vaccinated as infants whose parents were born in regions with a very high prevalence of HBV infection (≥8%).

[29] See the USPSTF recommendation on Folic Acid to Prevent Neural Tube Defects, available at: https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/folic-acid-to-prevent-neural-tube-defects-preventive-medication.

V. Adult Preventive Criteria	
	• HIV-positive persons • Injection drug users • MSM • Household contacts or sexual partners of persons with HBV infection See the CDC guidance on Viral Hepatitis, available at: https://www.cdc.gov/hepatitis/hbv/hbvfaq.htm
12) Hepatitis C Virus Screening	• All adults 18 to 79 years old shall be assessed for risk of Hepatitis C Virus (HCV) exposure at each well visits. • Testing should be initiated with anti-HCV. For those with reactive test results, the anti-HCV test should be followed with an HCV RNA. Persons for whom HCV Testing is recommended: • All Adults ages 18 to 79 years should be tested once. • Currently, or had history of, ever injecting drugs. • Medical Conditions: Long term hemodialysis, persons who received clotting factor concentrates produced before 1987; HIV infection; Persistent abnormal alanine aminotransferase levels (ALT). • Prior recipients of transfusions or organ transplant before July 1992 or donor who later tested positive for HCV infection. Persons with continued risk for HCV infection (e.g., injection drug users) should be screened periodically. There is limited information about the specific screening interval that should occur in persons who continue to be at risk for new HCV infection or how pregnancy changes the need for additional screening. See the USPSTF recommendation on Screening for HCV in Adolescents and Adults Practice Considerations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening#bootstrap-panel--6. See the CDC Recommendations for Hepatitis C Screening Among Adults in the United States, available at: https://www.cdc.gov/hepatitis/hcv/guidelinesc.htm.

V. Adult Preventive Criteria	
	See the USPSTF Grade A and B Recommendations, available at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.
13) High Blood Pressure Screening	• All adults including those without known hypertension are screened. • A blood pressure (B/P) measurement for the normotensive adult is documented at least once every 2 years if the last systolic reading was below 120 mmHg and the diastolic reading was below 80 mmHg. • B/P is measured annually if the last systolic reading was 120 to 139 mmHg and the diastolic reading was 80 to 89 mmHg. See the USPSTF Grade A and B Recommendation, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hypertension-in-adults-screening.
14) HIV Screening	USPSTF recommends risk assessment shall be completed at each well visit for patients 65 years old and younger: • Those at high risk (regardless of age) i.e., having intercourse without a condom or with more than one sexual partner whose HIV status is unknown. • IV drug users. • MSM. All shall be tested for HIV and offered pre-exposure prophylaxis (PrEP). [30] Lab results are documented. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening
	• Per the USPSTF, clinicians shall screen for Intimate Partner Violence (IPV) on asymptomatic women of reproductive age, which is defined across studies as

[30] See the USPSTF recommendation on Prevention of HIV Infection, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis.

V. Adult Preventive Criteria	
15) Intimate Partner Violence Screening for Women of Reproductive Age	ranging from 12 to 49 years, with most research focusing on women age 18 years or older. • Provide or refer those who screen positive to ongoing support services. The SHA is an incomplete tool to screen for IPV, however, per USPSTF the following instruments accurately detect IPV in the past year among adult women: ○ Humiliation, Afraid, Rape, Kick (HARK) ○ Hurt, Insult, Threaten, Scream (HITS) ○ Extended–Hurt, Insult, Threaten, Scream (E-HITS) ○ Partner Violence Screen (PVS) ○ Woman Abuse Screening Tool (WAST) The USPSTF A and B recommendations are the minimum that is required by DHCS. The term “intimate partner violence” describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy. See the CDC guidance on IPV, available at: https://www.cdc.gov/violenceprevention/intimatepartnerviolence/
16) Lung Cancer Screening	• Assess all individuals during well adult visits for past and current tobacco use. • Per USPSTF, screen annually for lung cancer with low-dose computed tomography in adults ages 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. • Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. See the USPSTF recommendation on Lung Cancer Screening, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/lung-cancer-screening.

V. Adult Preventive Criteria	
17) Obesity Screening and Counseling	• USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. • Documentation shall include weight and BMI • There is fair to good evidence that high-intensity counseling—about diet, exercise, or both—together with behavioral interventions aimed at skill development, motivation, and support strategies produces modest, sustained weight loss (typically 3-5 kg for 1 year or more) in adults who are obese (as defined by BMI ≥ 30 kg/m2). Although the USPSTF did not find direct evidence that behavioral interventions lower mortality or morbidity from obesity, the USPSTF concluded that changes in intermediate outcomes, such as improved glucose metabolism, lipid levels, and blood pressure, from modest weight loss provide indirect evidence of health benefits. See the USPSTF recommendation on Screening and Counseling for Obesity in Adults, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/obesity-in-adults-screening-and-counseling-2003.
18) Osteoporosis Screening	Assess all postmenopausal women during well adult visits for risk of osteoporosis. USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, or who have at least one risk factor, as determined by a formal clinical risk assessment tool.[31] These risk factors include: • Parental history of hip fracture • Smoking • Excessive alcohol consumption • Low body weight.

[31] See the USPSTF recommendations on Screening for Osteoporosis to Prevent Fractures, available at: https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/osteoporosis-screening.

V. Adult Preventive Criteria	
	USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older. For postmenopausal women younger than 65 years who have at least 1 risk factor, a reasonable approach to determine who should be screened with bone measurement testing is to use a clinical risk assessment tool.
19) Sexually Transmitted Infection (STI) Screening and Counseling	Assess all individuals during well adult visits for risk of STI.[32] Chlamydia & Gonorrhea: • Test all sexually active women under 25 years old • Older women who have new or multiple sex partners • MSM regardless of condom use or persons with HIV shall be tested at least annually Syphilis: • MSM or persons with HIV shall be screened at least annually Trichomonas: • Sexually active women seeking care for vaginal discharge • Women who are IV drug users • Exchanging sex for payment • HIV+, have History of STD, etc. Herpes: • Men and women requesting STI evaluation who have multiple sex partners shall be tested. • HIV+ • MSM w/ undiagnosed genital tract infection.

[32] See the USPSTF recommendation on STIs: Behavioral Counseling, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/sexually-transmitted-infections-behavioral-counseling.

V. Adult Preventive Criteria	
	Intensive behavioral counseling for adults who are at increased risk for STIs includes counseling on use of appropriate protection and lifestyle.
20) Skin Cancer Behavioral Counseling	USPSTF recommends that young adults and parents of young children should be counseled to minimize exposure to Ultraviolet (UV) radiation for persons aged 6 months to 24 years to reduce their risk of skin cancer.[33]
21)Tobacco Use: Screening, Counseling, and Intervention	• Assess all individuals during well adult visits for tobacco use and document prevention and/or counseling services to potential/active tobacco users. • If the PCP identifies tobacco use (e.g. Patient answered "Yes" on IHEBA). ○ Per USPSTF, providers can document any combination of the following since not all may apply especially to pregnant tobacco users: tobacco cessation services, behavioral counseling and/or pharmacotherapy. See APL 16-014, Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries, or any superseding APL, for additional information. If the PCP identifies tobacco use (i.e., Patient answered "Yes" on IHEBA), documentation that the provider offered tobacco cessation services, behavioral counseling, and/or pharmacotherapy to include any or a combination of the following must be in the patient's medical record: • FDA-approved tobacco cessation medications (for non-pregnant adults of any age). • Individual, group, and telephone counseling for members of any age who use tobacco's products. • Services for pregnant tobacco users. See APL 16-014, Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries, or any superseding APL, for additional information.
22) Tuberculosis Screening	• Adults are assessed for TB risk factors or symptomatic assessments upon enrollment and at periodic physical evaluations.

[33] See the USPSTF Grade A and B Recommendations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/skin-cancer-counseling.

	• The Mantoux skin test, or other approved TB infection screening test,[34] is administered to all asymptomatic persons at increased risk of developing TB irrespective of age or periodicity if they had not had a test in the previous year. • Adults already known to have HIV or who are significantly immunosuppressed require annual TB testing. The Mantoux is not given if a previously positive Mantoux is documented. Documentation of a positive test includes follow-up care, for example: ○ Further medical evaluation ○ Chest x-ray ○ Diagnostic laboratory studies ○ Referral to specialist Practitioners are required to follow current CDC and American Thoracic Society guidelines for TB diagnosis and treatment. See the CDPH guidance on California Adult TB Risk Assessment, available at: https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-TB-Risk-Assessment-and-Fact-Sheet.pdf. See the USPSTF recommendation on Latent TB Infection Screening, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/latent-tuberculosis-infection-screening. See the CDC publications on TB, available at: www.cdc.gov/tb/publications//.
D) Adult Immunizations	

[34] Per June 25, 2010, CDC MMWR, the FDA approved IGRA serum TB tests, such as QuantiFERON®-TB Gold (QFT-G and QFT-GIT) and T-SPOT®.TB (T-Spot).

V. Adult Preventive Criteria	
1) Given according to ACIP guidelines	Immunization status is assessed at periodic health evaluations. Practitioners are required to ensure the provision of immunizations according to CDC's most recent ACIP guidelines, unless medically contraindicated or refused by the member.[35] Vaccination status must be assessed for the following: ○ Td/Tdap (every 10 years) ○ Flu (annually) ○ Pneumococcal (ages 65 and older; or anyone with underlying conditions) ○ Zoster (starting at age 50) ○ Varicella and MMR Documented evidence of immunity (i.e. titers, childhood acquired infection) in the medical record meets the criteria for Varicella and MMR. The name of the vaccines and date the member received the vaccines must be documented as part of the assessment. See APL 18-004, Immunization Requirements, or any superseding APL for additional information.
2) Vaccine administration documentation	The name, manufacturer, date of administration, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries, in accordance with the National Childhood Vaccine Injury Act.
3) Vaccine Information Statement (VIS) documentation	The date the VIS was given (or presented and offered) and the VIS publication date are documented in the medical record.

[35] See the CDC ACIP Guidance on Immunization Schedules, available at: https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html.

Rationale: Perinatal assessments are provided according to the current American College of Obstetrics and Gynecologists (ACOG) standards and Comprehensive Perinatal Services Program (CPSP) Guidelines.[36] Reviewers please note, if the OB-GYN provider is also acting as the member's PCP and the member is/was pregnant during the review period (e.g. the last three years), the appropriate preventive services criteria, based on the members' age, i.e. Pediatric or Adult shall ALSO be reviewed and scored.

RN/NP/MD/PA/CNM/LM

VI. OB/CPSP Preventive Criteria	
A. Initial Comprehensive Prenatal Assessment (ICA)	**Initial Prenatal Visit - First entry to OB Care:** During the initial Comprehensive assessment, provider gathers baseline information on the pregnant woman, such as: ○ Obstetric and medical history, including medical documentation from prior visits with other providers. ○ Nutrition status ○ Health education ○ Psychosocial needs Based on the information gathered, the provider and the pregnant woman develop an individualized care plan (ICP) to meet her unique needs. Documentation of ICP services received, or reasons why not received, must be provided. See VI, B, below, for the First Trimester Comprehensive Assessment, which may be completed over more than one visit during the trimester. See the CDPH CPSP Provider Handbook, available at: https://custom.cvent.com/C506006261F8428CB7CCB91AAA9A05B4/files/8a01c5b0dd744c0aa06f0dece9dec3f1.pdf.
1) Initial Prenatal Visit	Documentation of initial prenatal visit completed within four weeks of entry to prenatal care. Optimally within the first trimester.
2) Obstetrical and Medical History	**Obstetric/medical:** The H&P exam must be consistent with the most recent ACOG Guidelines for Perinatal Care.[37]

[36] See the CDPH webpage on CPSP, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx
[37] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.

VI. OB/CPSP Preventive Criteria	
3) Physical Exam	Physical exam: includes breast and pelvic exam and calculation of estimated date of delivery. https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx
4) Dental Assessment	Dental Screening and referral as indicated must be documented. Oral health problems are associated with other diseases including heart disease, diabetes, and respiratory infections.[38]
5) Healthy Weight Gain and Behavior Counseling	The USPSTF recommends that clinicians offer pregnant women effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.[39] Effective behavioral counseling interventions promotes healthy weight gain and decreases risk of gestational diabetes mellitus, emergency cesarean delivery, infant macrosomia, and LGA infants.
6) Lab tests	
a) Bacteriuria Screening	USPSTF recommends screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at their first prenatal visit, if later.[40]

[38] See the ACOG guidance on Oral Health Care During Pregnancy and Through the Lifespan, available at: https://www.acog.org/en/Clinical/Clinical%20Guidance/Committee%20Opinion/Articles/2013/08/Oral%20Health%20Care%20During%20Pregnancy%20and%20Through%20the%20Lifespan

[39] See the USPSTF recommendation on Healthy Weight and Weight Gain in Pregnancy, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/healthy-weight-and-weight-gain-during-pregnancy-behavioral-counseling-interventions

[40] See the USPSTF recommendation on Screening for Asymptomatic Bacteria in Adults, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/asymptomatic-bacteriuria-in-adults-screening.

VI. OB/CPSP Preventive Criteria	
	Urine culture is recommended for bacteriuria screening in pregnancy and is the method for diagnosis. Pregnant women with asymptomatic bacteriuria usually receive antibiotic therapy, based on urine culture results and follow-up monitoring.
b) Rh Incompatibility Screening	• Rh incompatibility screening: 24-28 weeks gestation.[41] • Rh incompatibility is a condition that occurs during pregnancy if a woman has Rh-negative blood and her baby has Rh-positive blood.
c) Diabetes Screening	USPSTF recommends screening for gestational diabetes mellitus **(**GDM**)** in asymptomatic pregnant women after 24 weeks of gestation.[42] • In the two-step approach: the 50-g OGCT is performed between 24 and 28 weeks of gestation. A diagnosis of GDM is made when two or more glucose values fall at or above the specified glucose thresholds. • One-step approach: a 75-g glucose load is administered after fasting and plasma glucose levels are evaluated after 1 and 2 hours. Gestational diabetes is diagnosed if 1 glucose value falls at or above the specified glucose threshold. Self-monitoring of blood glucose can be a useful tool in the management of pregnant woman with pre-existing and with gestational diabetes.
d) Hepatitis B Virus Screening	All pregnant women are screened for Hepatitis B during their first trimester or prenatal visit, whichever comes first.[43] The screening tests for detecting maternal HBV infection is the serologic identification of HBsAg. Screening should be performed in each pregnancy, regardless of previous HBV vaccination or previous negative HBsAg test results.

[41] See the USPSTF recommendation on Rh(D) Incompatibility Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/rh-d-incompatibility-screening, and the NIH guidance on Rh Incompatibility, available at: https://www.nhlbi.nih.gov/health-topics/rh-incompatibility.
[42] See the USPSTF recommendation on Gestational Diabetes Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/gestational-diabetes-screening.
[43] See the USPSTF recommendation on HBV Infection in Pregnant Women, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-in-pregnant-women-screening.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2864180/

VI. OB/CPSP Preventive Criteria	
	Following referral required for women with positive HBV: • Case management during pregnancy • HBV DNA viral load testing • Referral to specialty care for counseling and medical management of HBV infection. See Hepatitis B information on the CDC website, available at: https://www.cdc.gov/hepatitis/hbv/index.htm.
e) Hepatitis C Virus Screening	Per ACOG all pregnant women should receive Hepatitis C screening with blood assessment during the first prenatal visit. Pregnant woman with newly diagnosed HCV infection and abnormal serum aminotransferase and/or platelet levels should be referred for further medical assessment to rule out liver fibrosis or injury and so antiviral treatment can be initiated at the appropriate time. Providers should report HCV infection in a pregnant person to infant's health care provider so that follow-up HCV testing can be conducted at the recommended time, and to the local health department so that ongoing risk factors can be assessed and relevant contacts can receive hepatitis A and hepatitis B testing and vaccination, as indicated, and can be linked, as appropriate, to preventive services. https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2021/05/routine-hepatitis-c-virus-screening-in-pregnant-individuals
f) Chlamydia Infection Screening	Per CDC, All pregnant women under 25 years old and older women with increased risk such as new or multiple sex partners, or a sex partner who has an STD, should be tested for chlamydia at their first prenatal visit pregnant women with chlamydial infection should have a test-of-cure four weeks after treatment and be retested within three months. Retest during the 3rd trimester for women under 25 years of age or at risk.

VI. OB/CPSP Preventive Criteria	
	See the CDC guidance on Chlamydia, available at: https://www.cdc.gov/std/chlamydia. See the CDC guidance on STD Tests, available at: https://www.cdc.gov/std/prevention/screeningreccs.htm. See the USPSTF recommendation on Chlamydia and Gonorrhea Screening, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/chlamydia-and-gonorrhea-screening.
g) Syphilis Infection Screening	Per CDC, all pregnant women should be tested for syphilis at the first prenatal visit.[44] High risk women need to be tested again during the third trimester (28 weeks gestation) and at delivery. This includes women who live in areas of high syphilis morbidity, are previously untested, had a positive screening test in the first trimester, or are at higher risk for syphilis (i.e., multiple sex partners, drug use, transactional sex, late entry into prenatal care or no prenatal care, meth or heroin use, incarceration themselves or of sex partners, unstable housing, or homelessness).
h) Gonorrhea Infection Screening	All pregnant women under 25 years old, and older pregnant women who are at increased risk, are screened for gonorrhea during their first prenatal visit.[45] Specific microbiologic diagnosis of *N. gonorrhea* infection should be performed for all women at risk for or suspected of having gonorrhea. See the CDC guidance on Gonococcal Infections Among Adolescents and Adults, available at: https://www.cdc.gov/std/treatment-guidelines/gonorrhea-adults.htm.

[44] See the CDC information on syphilis, available at: https://www.cdc.gov/std/syphilis/stdfact-syphilis-detailed.htm.
[45] See the CDC guidance on Gonococcal Infections Among Adolescents and Adults, available at: https://www.cdc.gov/std/treatment-guidelines/gonorrhea-adults.htm, and the USPSTF recommendation on Chlamydia and Gonorrhea Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/chlamydia-and-gonorrhea-screening.

VI. OB/CPSP Preventive Criteria	
i) Human Immunodeficiency Virus (HIV) Screening	Per ACOG, all pregnant women should be informed that HIV test is part of the routine panel of the prenatal tests.[46] If woman declines HIV testing this should be documented in the medical record. Repeat testing in the third trimester is recommended for woman known to be at high risk of acquiring HIV infection, and women who declined testing earlier in pregnancy.
B. First Trimester Comprehensive Assessment	A Comprehensive Perinatal Assessment must be completed each trimester and during the postpartum period. A Comprehensive Assessment tool must be used and updated every trimester and during the 12-month post-pregnancy period. The assessment tool must be consistent with CDPH's template tool, as confirmed by the local county or city Perinatal Health Coordinator.[47] See the CPSP Integrated Initial 1, 2, and 3 Trimester Assessments and ICP, available link bottom of the page.
1) Individualized Care Plan (ICP)	ICP documentation includes specific obstetric, nutrition, psychosocial, and health education risk problems/conditions, interventions, and referrals. **ICP must be developed based on the comprehensive assessment in each trimester and during the 12-month post-pregnancy period. The ICP must be updated based on the Comprehensive Assessments in each trimester, during the 12-month post-pregnancy period, and more frequently as needed. Documentation must be provided of the services offered and whether received.**
2) Nutrition Assessment	A complete initial nutrition assessment should be performed at the initial visit or within four weeks thereafter and should be documented in the

[46] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx, and the USPSTF recommendation on HIV Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening

[47] See the CDPH CPSP webpage, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx, and the Title 22 CPSP regulations, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-Title22CPSPRegulations.pdf

VI. OB/CPSP Preventive Criteria	
	pregnant woman medical record: • anthropometric data • biochemical data • clinical data • dietary data
3) Psychosocial Assessment	The psychosocial screening should be performed on a regular basis and documented in the woman's prenatal record.[48] The assessment should include the following: ○ Depression assessment ○ Social and mental history ○ Substance use Disorder including alcohol and tobacco ○ Unintended pregnancy ○ Support systems ○ Documentation of referral as appropriate. See the proposed changes for the 20202 Prenatal and Postpartum care HEDIS measures, available at: https://www.ncqa.org/wp-content/uploads/2019/02/20190208_08_Perinatal_Depression.pdf.
a) Maternal Mental Health Screening	Screening for maternal mental health conditions must be part of the Comprehensive Assessments at each trimester. Identified needs must be incorporated into the Individualized Care Plan and follow up services documented. *Health and Safety Code (HSC) Section 123640: and* AB-1477 Maternal mental *health: Licensed health care practitioner who provides prenatal, postpartum or interpregnancy care for a patient shall ensure that the mother is offered screening or is appropriately screened for maternal mental health conditions.* Counselling, referrals, or any interventions is documented.

[48] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx, and the CDPH CPSP Provider Handbook, available at: https://custom.cvent.com/C506006261F8428CB7CCB91AAA9A05B4/files/8a01c5b0dd744c0aa06f0dece9dec3f1.pdf.

"Maternal mental health condition" means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

- USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women.
- CMS Technical Specifications include screening using validated tools and documentation of a follow-up plan if the depression screening is positive that aligns with USPSTF's referral and documentation of counseling or interventions with those found at risk for perinatal depression.
- Patient is screened for depression on the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen.

Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record.

- Edinburgh Postnatal Depression Scale (EPDS),
- Patient Health Questionnaire (PHQ) 9

Follow-Up Plan – Documented follow-up for a positive depression screening must include one or more of the following:

- Additional evaluation or assessment for depression
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

Additional information on CMS Technical Specifications, is available at: https://www.medicaid.gov/license/form/6466/4391.

VI. OB/CPSP Preventive Criteria	
	See the USPSTF Grade A and B Recommendations, available at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.
b) Social Needs Assessment	The comprehensive Assessments in each trimester must also provide social needs assessment includes housing, food, transportation, unintended pregnancy, support system available.[49] Identified needs must be incorporated into the Individualized Care Plan, and follow up services documented
c) Substance Use Disorder Assessment	• All pregnant women should be routinely asked about their use of alcohol, tobacco and drug, including prescription opioids and other medications used for nonmedical reasons. • If the woman acknowledges the use of alcohol, cocaine, opioids, amphetamines, or other mood-altering drugs or if chemical dependence is suspected, she should be counseled about the perinatal implications of their use during pregnancy and offered referral to an appropriate treatment program. See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx.
3) Breastfeeding and other Health Education Assessment	• Health Education including breast feeding, preparation to breastfeed, language, cultural competence. And education needs must be assessed at least once during each trimester and more frequently as needed. Identified needs must be incorporated into the Individualized Care Plan, and follow up services documented. • Materials must be available in the appropriate threshold languages and must meet readability and suitability requirements for educational material distributed to Medi-Cal members.[50]

[49] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx.
[50] See APL 18-016, Readability and Suitability of Written Health Education Materials, or any superseding APL.

VI. OB/CPSP Preventive Criteria	
4) Preeclampsia Screening	USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.[51]
5) Intimate Partner Violence Screening	• USPSTF recommends that clinicians screen IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services.[52] • Provision of a Domestic Violence Screening is documented. • Assessment checklists, body diagrams and/or documentation in progress notes are acceptable. Domestic violence screening includes: • Medical screening • Documentation of physical injuries • Documentation of illnesses attributable to spousal/partner abuse • Referral to appropriate community service agencies[53]
C. Second Trimester Comprehensive Assessment	See the CDPH CPSP webpage, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx. See the Title 22 CPSP Regulations, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-Title22CPSPRegulations.pdf.
1) Individualized Care Plan (ICP)	ICP documentation includes specific obstetric, nutrition, psychosocial, and health education risk problems/conditions, interventions, and referrals. ICP must be updated every trimester and more frequently as needed

[51] See the USPSTF recommendation on Preeclampsia Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/preeclampsia-screening.
[52] See the USPSTF recommendation on IPV, Elder Abuse, and Abuse of Vulnerable Adults Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening.
[53] HSC 1233.5

VI. OB/CPSP Preventive Criteria	
2) Nutrition Assessment	A nutrition reassessment using updated information should be offered to each client at least once every trimester and the individualized care plan should be revised accordingly. Nutrition ICP component should address: • The prevention and/or resolution of nutrition problems. • The support and maintenance of strengths and habits oriented toward optimal nutritional status • Dispensing, as medically necessary, prenatal vitamin/mineral supplement to each pregnant woman. • Treatment and intervention directed toward helping the patient understand the importance of, and maintain good nutrition during pregnancy and lactation, with referrals as appropriate.
3) Psychosocial Assessment	The psychosocial screening should be performed on a regular basis and documented in the woman's prenatal record. The assessment should include the following: ○ Depression assessment ○ Social and mental history ○ Substance use/abuse including alcohol and tobacco ○ Unintended pregnancy ○ Support systems ○ Documentation of referrals as appropriate. See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx. https://www.ncqa.org/wp-content/uploads/2019/02/20190208_08_Perinatal_Depression.pdf
a) Maternal Mental Health Screening	Screening for maternal mental health conditions must be part of the Comprehensive Assessments at each trimester. Identified needs must be incorporated into the Individualized Care Plan and follow up services documented.

VI. OB/CPSP Preventive Criteria	
	Health and Safety Code (HSC) Section 123640 and AB-1477 Maternal Mental Health: Licensed health care practitioner who provides prenatal, postpartum or interpregnancy care for a patient shall ensure that the mother is offered screening or is appropriately screened for maternal mental health conditions. Counseling, referrals or any interventions is documented. *"Maternal mental health condition" means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.* • USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. • CMS Technical Specifications includes screening using validated tools and documentation of a follow-up plan if the depression screening is positive that aligns with USPSTF's referral and documentation of counseling or interventions with those found at risk for perinatal depression. • Patient screened for depression on the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen. • Edinburgh Postnatal Depression Scale (EPDS), • Patient Health Questionnaire (PHQ) 9 Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. Follow-Up Plan – Documented follow-up for a positive depression screening must include one or more of the following: ○ Additional evaluation or assessment for depression • Suicide Risk Assessment • Referral to a practitioner who is qualified to diagnose and treat depression • Pharmacological interventions

VI. OB/CPSP Preventive Criteria	
	• Other interventions or follow-up for the diagnosis or treatment of depression For additional information on CMS Technical Specifications, see: https://www.medicaid.gov/license/form/6466/4391. See the USPSTF Grade A and B recommendations, available at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.
b) Social Needs Assessment	Social needs assessment including housing, food, transportation, unintended pregnancy, support system available.[54]
c) Substance Use Disorder Assessment	• All pregnant women should be routinely asked about their use of alcohol, tobacco, and drugs, including prescription opioids and other medications used for nonmedical reasons. • If the woman acknowledges the use of alcohol, cocaine, opioids, amphetamines, or other mood-altering drugs or if chemical dependence is suspected, she should be counseled about the perinatal implications of their use during pregnancy and offered referral to an appropriate treatment program. See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx See the USPSTF Grade A and B Recommendations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations.
4) Breastfeeding and Other Health Education Assessment	• Health Education including breast feeding, language, cultural competence, and education needs must be assessed.

[54] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx.

VI. OB/CPSP Preventive Criteria	
	• Materials must be available in the appropriate threshold languages and must meet readability and suitability requirements for educational material distributed to Medi-Cal members.[55]
5) Preeclampsia Screening	USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.[56]
a) Low Dose Aspirin	The Provider should advise on the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.[57]
6) Intimate Partner Violence Screening	• USPSTF recommends that clinicians screen for IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services.[58] • Provision of a Domestic Violence Screening is documented. • Assessment checklists, body diagrams and/or documentation in progress notes are acceptable. Domestic violence screening includes: • Medical screening. • Documentation of physical injuries or illnesses attributable to spousal/partner abuse. • Referral to appropriate community service agencies.[59]

[55] See APL 18-106, Readability and Suitability of Written Health Education Materials, or any superseding APL.
[56] See the USPSTF recommendation on Preeclampsia Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/preeclampsia-screening.
[57] See the USPSTF Grande A and B recommendations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations.
[58] See the USPSTF recommendation on IPV, Elder Abuse, and Abuse of Vulnerable Adults Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening.
[59] HSC 1233.5

VI. OB/CPSP Preventive Criteria	
7) Diabetes Screening	The **USPSTF** recommends screening for **gestational diabetes** mellitus **(GDM)** in asymptomatic pregnant women after 24 and 28 weeks of gestation.[60] • In the 2-step approach, the 50-g OGCT is performed between 24 and 28 weeks of gestation in a non-fasting state. If the screening threshold is met or exceeded, patients receive the oral glucose tolerance test (OGTT). A diagnosis of GDM is made when 2 or more glucose values fall at or above the specified glucose thresholds. • 1-step approach, a 75-g glucose load is administered after fasting and plasma glucose levels are evaluated after one and two hours. Gestational diabetes is diagnosed if 1 glucose value falls at or above the specified glucose threshold.
D. Third Trimester Comprehensive Assessment	See the CDPH CPSP webpage, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx. See the Title 22 CPSP Regulations, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-Title22CPSPRegulations.pdf.
1) Individualized Care Plan (ICP) Update and Follow Up	ICP documentation includes specific obstetric, nutrition, psychosocial and health education risk problems/conditions, interventions, and referrals. See the CPSP Integrated Initial 1, 2, and 3 Trimester Assessments and ICP, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-CombinedInitialandTrimesterAssessmentandCarePlan.pdf. See the CPCP Postpartum Assessment and ICP, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-PostpartumAssessmentandCarePlan.pdf.

[60] See the USPSTF recommendation on Gestational Diabetes Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/gestational-diabetes-screening.

VI. OB/CPSP Preventive Criteria	
2) Nutrition Assessment	A nutrition reassessment using updated information should be offered to each client at least once every trimester and the individualized care plan should be revised accordingly. Nutrition ICP component should address: • The prevention and/or resolution of nutrition problems. • The support and maintenance of strengths and habits oriented toward optimal nutritional status. • Dispensing, as medically necessary, prenatal vitamin/mineral supplement to each pregnant woman. • Treatment and intervention directed toward helping the patient understand the importance of, and maintain good nutrition during pregnancy and lactation, with referrals as appropriate. https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-Title22CPSPRegulations.pdf
3) Psychosocial Assessment	Psychosocial assessment must be performed on a regular basis and documented in the woman's prenatal record. The assessment should include the following: • Depression Assessment • Social and Mental History • Substance use/abuse including alcohol and tobacco; unintended pregnancy • Support systems • Documentation of referrals as appropriate See the CDPH CPSP Provider Handbook, available at: https://custom.cvent.com/C506006261F8428CB7CCB91AAA9A05B4/files/8a01c5b0dd744c0aa06f0dece9dec3f1.pdf. See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx
	Practitioner who provides prenatal, interpregnancy, or postpartum care for a patient shall ensure that the mother is offered screening or is appropriately screened for

VI. OB/CPSP Preventive Criteria	
a) Maternal Mental Health Screening	*maternal mental health conditions.* Counselling, referrals or any interventions is documented. *"Maternal mental health condition" means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.*[61] • USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. • CMS Technical Specifications includes screening using validated tools and documentation of a follow-up plan if the depression screening is positive that aligns with USPSTF's referral and documentation of counseling or interventions with those found at risk for perinatal depression. • Patient screened for depression on the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen. Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. • Edinburgh Postnatal Depression Scale (EPDS), • Patient Health Questionnaire (PHQ) 9 Follow-Up Plan – Documented follow-up for a positive depression screening must include one or more of the following: • Additional evaluation or assessment for depression • Suicide Risk Assessment • Referral to a practitioner who is qualified to diagnose and treat depression • Pharmacological interventions • Other interventions or follow-up for the diagnosis or treatment of depression

[61] HSC 123640

VI. OB/CPSP Preventive Criteria	
	For additional information on CMS Technical Specifications, see: https://www.medicaid.gov/license/form/6466/4391. See the USPSTF recommendation on Screening Depression in Adults, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-adults-screening. The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.[62]
b) Social Needs Assessment	The comprehensive assessments in each trimester must also provide social needs assessment including housing, food, transportation, unintended pregnancy, support system available.[63] Identified needs must be incorporated into the Individualized Care Plan, and follow up services documented
c) Substance Use Disorder Assessment	• All pregnant women should be routinely asked about their use of alcohol, tobacco and drug, including prescription opioids and other medications used for nonmedical reasons. • If the woman acknowledges the use of alcohol, cocaine, opioids, amphetamines, or other mood-altering drugs or if chemical dependence is suspected, she should be counseled about the perinatal implications of their use during pregnancy and offered referral to an appropriate treatment program. The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.

[62] See the USPSTF recommendation on Perinatal Depression, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/perinatal-depression-preventive-interventions.
[63] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx.

VI. OB/CPSP Preventive Criteria	
	See APL 21-014, Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment, or any superseding APL for additional information. The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco.[64] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx. See the USPSTF Grade A and B Recommendations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations.
4) Breastfeeding and other Health Education Assessment	• Health Education including breast feeding, preparation to breastfeed, language, cultural competence, and education needs must be assessed at least once during each trimester and more frequently as needed. Identified needs must be incorporated into the Individualized Care Plan and follow up services documented. • Materials must be available in the appropriate threshold languages and must meet readability and suitability requirements for educational material distributed to Medi-Cal members.[65]
5) Preeclampsia Screening	USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.[66]

[64] See the USPSTF recommendation on Tobacco Smoking Cessation in Adults, Including Pregnant Persons, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions.
[65] See APL 18-016, Readability and Suitability of Written Health Education Materials, or any superseding APL.
[66] See the ACIP recommendations on Routine Vaccination of Infants, Children, Adolescents, Pregnant Women, and Adults, available at: https://www.cdc.gov/vaccines/vpd/dtap-tdap-td/hcp/recommendations.html.

VI. OB/CPSP Preventive Criteria	
a) Low-Dose Aspirin	USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.[67]
6) Intimate Partner Violence Screening	• USPSTF recommends that clinicians screen for IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services.[68] • Provision of a Domestic Violence Screening is documented. • Assessment checklists, body diagrams and/or documentation in progress notes are acceptable. Domestic violence screening includes: • Medical screening. • Documentation of physical injuries or illnesses attributable to spousal/partner abuse. • Referral to appropriate community service agencies.[69]
7) Diabetic Screening	The **USPSTF** recommends screening for **gestational diabetes** mellitus **(GDM)** in asymptomatic pregnant women after 24 and 28 weeks of gestation.[70] • In the 2-step approach, the 50-g OGCT is performed between 24 and 28 weeks of gestation in a non-fasting state. If the screening threshold is met or exceeded, patients receive the oral glucose tolerance test (OGTT). A diagnosis of GDM is made when 2 or more glucose values fall at or above the specified glucose thresholds.

[67] See the USPSTF recommendation on Aspirin Use to Prevent Preeclampsia and Related Morbidity and Mortality, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/low-dose-aspirin-use-for-the-prevention-of-morbidity-and-mortality-from-preeclampsia-preventive-medication.
[68] See the USPSTF recommendation on IPV, Elder Abuse, and Abuse of Vulnerable Adults Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening.
[69] HSC 1233.5
[70] See the USPSTF recommendation on Screening for Gestational Diabetes, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/gestational-diabetes-screening.

VI. OB/CPSP Preventive Criteria	
	• 1-step approach, a 75-g glucose load is administered after fasting and plasma glucose levels are evaluated after one and two hours. Gestational diabetes is diagnosed if 1 glucose value falls at or above the specified glucose threshold. • Self-monitoring of blood glucose can be a useful tool in the management of pregnant woman with pre-existing and with gestational diabetes.
8) Screening for Strep B	All pregnant women are screened for Group B Streptococcus (GBS) between their 35th and 37th week of pregnancy. Vaginal or rectal swab cultures at 36 – 37 weeks of gestation are positive for GBS, they should receive appropriate intrapartum antibiotic prophylaxis unless a prelabor cesarean birth is performed in the setting of intact membranes. Please refer to the following link for ACOG Frequently Asked Questions on Group B Streptococcus and pregnancy: https://www.acog.org/womens-health/faqs/group-b-strep-and-pregnancy. See the ACOG guidance on Prevention of Group B Streptococcal Early-Onset Disease in Newborns, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/02/prevention-of-group-b-streptococcal-early-onset-disease-in-newborns?utm_source=vanity&utm_medium=web&utm_campaign=clinical.
9) Screening for Syphilis	Pregnant women with high risk for syphilis and women who live in areas with high syphilis morbidity should be re-tested for syphilis between 28 and 32 weeks and at delivery. Stat RPR should be performed at delivery for women with no prenatal care. https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/CS_Eval_Management_pregnant%20women.pdf
10) Tdap Immunization	• Pregnant women should receive a single dose of Tdap during every pregnancy, preferably at 27 through 36 weeks gestation.

VI. OB/CPSP Preventive Criteria	
	• Tdap is recommended only in the immediate postpartum period before discharge from the hospital or birthing center for new mothers who have never received Tdap before or whose vaccination status is unknown. • Practitioners are required to ensure the provision of immunizations according to CDC's most recent ACIP guidelines, unless medically contraindicated or refused by the member. See the CDC's ACIP recommendations on Routine Vaccination of Infants, Children, Adolescents, Pregnant Women, and Adults, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/preeclampsia-screening1. See the CDC's ACIP guidelines on vaccines, available at: https://www.cdc.gov/vaccines/hcp/acip-recs/index.html. Please note-the administration of pertussis is eligible for the Valued Based Payment (VBP) program. Please consult with the MCP for details.
E. Prenatal care visit periodicity according to most recent ACOG Standards	ACOG's *Guidelines for Perinatal Care* recommend the following prenatal schedule for a 40-week uncomplicated pregnancy: 1) First visit by 6-8th week 2) Approximately every 4 weeks for the first 28 weeks of pregnancy 3) Every 2-3 weeks until 36 weeks gestation 4) Weekly thereafter until delivery If the recommended ACOG schedule is not met, documentation shows missed appointments, attempts to contact member and/or outreach activities. Refer the following link to ACOG for further details: https://www.acog.org/clinical
F. Influenza Vaccine	CDC and ACIP recommend that pregnant women gets vaccinated during any trimester of their pregnancy. Refer to the following link for further information on vaccination schedules:

VI. OB/CPSP Preventive Criteria	
	https://www.cdc.gov/vaccines/pregnancy/hcp-toolkit/guidelines.html https://www.cdc.gov/vaccines/hcp/acip-recs/rec-vac-preg.html See CDC guidance on pregnancy and vaccination, available at: https://www.cdc.gov/vaccines/pregnancy/pregnant-women/index.html See APL 18-004, Immunization Requirements, or any superseding APL for additional information.
G. COVID Vaccine	The American College of Obstetricians and Gynecologists (ACOG) recommends that all eligible persons greater than age 12 years, including pregnant and lactating individuals, receive a COVID-19 vaccine or vaccine series. Provider should document the discussion in the medical record if pregnant woman refused to receive the vaccine. During the subsequent office visits, obstetrician–gynecologists should address ongoing questions and concerns and offer vaccination again. https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2020/12/covid-19-vaccination-considerations-for-obstetric-gynecologic-care
H. Referral to Special Supplemental Nutrition Program for Women, Infants, and Children (**WIC) and assessment of Infant Feeding Status**	Pregnant and breastfeeding mothers must be referred to WIC.[71] • Referral to WIC is documented in the medical record.[72] • Infant feeding plans are documented during the prenatal period. • Infant feeding/breastfeeding status is documented during the postpartum period.[73] Refer to the following link for information on the WIC program: https://m.wic.ca.gov/

[71] Public Law 103-448, Section 203(e)
[72] 42 CFR 431.635
[73] PL 98-010, Breastfeeding Promotion

VI. OB/CPSP Preventive Criteria	
	Note: Although WIC determines eligibility for program participation, nearly all Medi-Cal beneficiaries are income eligible for WIC. Federal regulations specify that pregnant and breastfeeding women are given the highest priority for WIC Program enrollment.
I. HIV-related services *offered*	Per ACOG, repeat testing in the third trimester is recommended for women known to be at high risk of acquiring HIV infection, and women who declined testing earlier in pregnancy. • The ***offering*** of prenatal HIV information, counseling, and HIV antibody testing is documented.[74] • Practitioners are ***not required*** to document that the HIV test was given or disclose (except to the member) the results (positive or negative) of an HIV test. • Offering a prenatal HIV test is not required if a positive HIV test is already documented in the patient's record or if the patient has AIDS diagnosed by a physician. See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx. See the CDC STI Screening Recommendations, available at: https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm. See the ACOG guidance on Prenatal and Perinatal HIV Testing, available at: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Prenatal-and-Perinatal-Human-Immunodeficiency-Virus-Testing?IsMobileSet=false. See the USPSTF recommendation on HIV Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening.

[74] HSC 125107

VI. OB/CPSP Preventive Criteria	
J. AFP/Genetic Screening *offered*	The offering of blood screening tests prior to 20 weeks gestation counting from the first day of the last normal menstrual period is documented.[75] Genetic screening documentation includes: • Family history • Triple marker screening tests: Alpha Fetoprotein (AF), unconjugated estriol (UE), human chorionic gonadotropin (HCG) • Member's consent or refusal to participate For information on the Alpha-Fetoprotein Test, see: https://americanpregnancy.org/prenatal-testing/alpha-fetoprotein-test **Note:** Member's participation is voluntary. Testing occurs through CDPH Expanded AFP Program, and only laboratories designated by CDPH may be used for testing.
K. Family Planning Evaluation	• Women should be counseled about the risks and benefits of repeat pregnancy sooner than 18 months which have been associated with adverse perinatal outcomes, including preterm birth, low birth weight, and small size of gestational age, as well as adverse maternal outcomes. • All postpartum women can be considered at risk for unintended pregnancy for that period of time. Family Planning counseling, including counseling of interpregnancy intervals, contraceptive care, referral or provision of services is documented.[76] Prenatal discussions should include the woman's reproductive life plans, including the desire for and timing of any future pregnancies. See the HHS guidance on Contraceptive Care Measures, available at: https://opa.hhs.gov/research-evaluation/title-x-services-research/contraceptive-care-measures

[75] 17 CCR 6521-6532
[76] See PL 98-011, Family Planning Services in Medi-Cal Managed Care, or any superseding APL for additional information.

<table>
<tr><th colspan="2">VI. OB/CPSP Preventive Criteria</th></tr>
<tr><td></td><td>See DHCS' Office of Family Planning webpage, available at: https://www.dhcs.ca.gov/services/ofp/Pages/OfficeofFamilyPlanning.aspx

See APL 18-019, Family Planning Services Policy for Self-Administered Hormonal Contraceptives, or any superseding APL for additional information.</td></tr>
<tr><td>L. Comprehensive Postpartum Assessment</td><td>The weeks following birth are a critical period for a woman and her infant, setting the stage for long-term health and well-being. To optimize the health of women and infants, postpartum care should become an ongoing process, rather than a single encounter, with services and support tailored to each woman's individual needs.
As of April 1, 2022, Medi-Cal's postpartum period is extended from 60 to 365 days, regardless of how the pregnancy ends.

• Per ACOG, women should contact their OB-GYN or other obstetric care providers within the first three weeks postpartum.
• The comprehensive postpartum visit should be scheduled between four weeks and six weeks after delivery.
• This initial postpartum assessment should be followed up with ongoing care as needed throughout the 12 month postpartum period, including with a comprehensive postpartum visit no later than 12 weeks after birth.

The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being, including the following domains:
○ Mood and emotional well-being
○ Infant care and feeding
○ Sexuality
○ Contraception
○ Birth spacing
○ Sleep and fatigue
○ Physical recovery from birth
○ Chronic disease management
○ Health maintenance</td></tr>
</table>

VI. OB/CPSP Preventive Criteria	
	Women with chronic medical conditions such as hypertensive disorders, obesity, diabetes, thyroid disorders, renal disease, and mood disorders should be counseled regarding the importance of timely follow-up with their OB-GYN or primary care providers for ongoing coordination of care. During the postpartum period, the woman and her OB-GYN or other obstetric care provider should identify the health care provider who will assume primary responsibility for her ongoing care in her primary medical home. See the ACOG guidance on Optimizing Postpartum Care, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care. See the ACOG guidance on Postpartum Care, available at: https://www.acog.org/news/news-releases/2018/04/acog-redesigns-postpartum-care See the CDPH CPSP Postpartum Assessment and ICP, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-PostpartumAssessmentandCarePlan.pdf. https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/I21-13.pdf#:~:text=Individuals%20in%20Medi-Cal%20with%20a%20SOC%20may%20be,for%20the%20rest%20of%20pregnancy%20and%20postpartum%20period. See PL 12-003, Obstetrical Care-Perinatal Services, or any superseding APL for additional information. See ACOG information on Optimizing Postpartum Care, available at: https://www.acog.org/More-Info/OptimizingPostpartumCare. **Note:** Postpartum care is eligible for the VBP program. Please consult with the MCP for details.

VI. OB/CPSP Preventive Criteria	
	For screening: If the postpartum assessment visit is not documented a point will not be given. A point can be given if there is documentation in the medical record of missed appointments and attempts to contact member and/or outreach activities. If appointments are documented in a separate system from medical records, they must be readily accessible and meet the medical retention requirements.
1) Individualized Care Plan (ICP)	ICP documentation includes specific obstetric, nutrition, psychosocial and health education risk problems/conditions, interventions, and referrals. **ICP must be developed based on the comprehensive assessment in each trimester and post-partum.** See the CDPH CPSP Integrated Initial 1st, 2nd, and 3rd Trimester Assessments and ICP, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-CombinedInitialandTrimesterAssessmentandCarePlan.pdf. See the CDPH CPSP Postpartum Assessment and ICP, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-PostpartumAssessmentandCarePlan.pdf.
2) Nutrition Assessment	• USPSTF recommends providing interventions during pregnancy and after birth to support breastfeeding. Nutrition Assessment should include mother and infant including support for breast feeding.[77] • Any needed interventions must be noted. • Documentation of referrals as indicated. Infant feeding/breastfeeding status is documented during the postpartum period.[78] See the ACOG guidance on Optimizing Support for Breastfeeding as Part of Obstetric Practice, available at: https://www.acog.org/Clinical-Guidance-and-

[77] See the USPSTF recommendation on Breastfeeding: Primary Care Interventions, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breastfeeding-primary-care-interventions.
[78] See PL 98-010, Breastfeeding Promotion, or any superseding APL for additional information.

VI. OB/CPSP Preventive Criteria	
	Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Support-for-Breastfeeding-as-Part-of-Obstetric-Practice?IsMobileSet=false. https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-PostpartumAssessmentandCarePlan.pdf
3) Psychosocial Assessment	Psychosocial Assessment includes mood and emotional wellbeing; sleep and fatigue.[79] See the ACOG guidance on Optimizing Postpartum Care, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care.
a) Maternal Mental Health Screening/Postpartum Depression screening	*Practitioner who provides prenatal or postpartum care for a patient shall ensure that the mother is offered screening or is appropriately screened for maternal mental health conditions.* Counselling and intervention must be documented. • USPSTF recommends that clinicians provide or refer postpartum persons who are at increased risk of postpartum depression to counseling interventions.[80] • CMS Technical Specifications includes screening using validated tools and documentation of a follow-up plan if the depression screening is positive that aligns with USPSTF's referral and documentation of counseling or interventions with those found at risk for postpartum depression. • Patient screened for depression on the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen. Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record.

[79] See the ACOG guidance on Optimizing Postpartum Care, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care?utm_source=redirect&utm_medium=web&utm_campaign=otn.
[80] See the USPSTF recommendation on Perinatal Depression, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/abdominal-aortic-aneurysm-screening.

VI. OB/CPSP Preventive Criteria	
	Follow-Up Plan – Documented follow-up for a positive depression screening must include one or more of the following: ○ Additional evaluation or assessment for depression ○ Suicide Risk Assessment ○ Referral to a practitioner who is qualified to diagnose and treat depression ○ Pharmacological interventions ○ Other interventions or follow-up for the diagnosis or treatment of depression For additional information on CMS Technical Specifications, see: https://www.medicaid.gov/license/form/6466/4391. Edinburgh Postnatal Depression Scale (EPDS) is most commonly used and has been translated in 50 different languages.[81]
b) Social Needs Assessment	Social and Mental History (past and current). Follow up on pre-existing mental health disorders and social care needs such as housing, food, and transportation refer as appropriate.
c) Substance Use Disorder Assessment	Screen for tobacco and alcohol use and provide counseling; Screen for substance use disorder and refer as indicated. USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.[82] See APL 21-014, Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment, or any superseding APL for additional information.

[81] HSC 123640
[82] See the USPSTF recommendation on Unhealthy Alcohol Use in Adolescents and Adults, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions.

VI. OB/CPSP Preventive Criteria	
	USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco.[83]
4) Breastfeeding and other Health Education Assessment	• Health Education on infant care and feeding including breast feeding, contraception, and birth spacing. • Materials must be in threshold language and must meet readability and suitability requirements for educational material distributed to Medi-Cal members.[84] See the USPSTF recommendation on Breastfeeding, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breastfeeding-primary-care-interventions. See APL 18-019, Family Planning Services Policy for Self-Administered Hormonal Contraceptives, or any superseding APL for additional information.
5) Comprehensive Physical Exam	The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being, including the following domains: • Mood and emotional well-being • Infant care and feeding • Sexuality • Contraception • Birth spacing • Sleep and fatigue • Physical recovery from birth • Chronic disease management • Health maintenance

[83] See the USPSTF recommendation on Tobacco Smoking Cessation in Adults, Including Pregnant Persons, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions

[84] See APL 18-016, Readability and Suitability of Written Health Education Materials, or any superseding APL for additional information.

VI. OB/CPSP Preventive Criteria	
	Women with chronic medical conditions such as hypertensive disorders, obesity, diabetes, thyroid disorders, renal disease, and mood disorders should be counseled regarding the importance of timely follow-up with their OB-GYN or primary care providers for ongoing coordination of care. During the postpartum period, the woman and her OB-GYN or other obstetric care provider should identify the health care provider who will assume primary responsibility for her ongoing care in her primary medical home. It is recommended that all women have contact with their OB-GYN or other obstetric care providers within the first three weeks postpartum. This initial assessment should be followed up with ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth. See the ACOG guidance on Optimizing Postpartum Care, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care

California Department of Health Care Services
Managed Care Quality and Monitoring Division

July 1, 2022

Medical Record Review Tool

Health Plan: _____

Site ID: _____ **Site NPI:** _____

Address: _____

City and Zip Code: _____

Phone: _____ **Fax:** _____

No. of Physicians: _____

Review Date: _____

Reviewer name/title: _____

Reviewer name/title: _____

Reviewer name/title: _____

Reviewer name/title: _____

Collaborating MCP(s): **1.** _____

2. _____

Contact person/title: _____

Provider Name	Credentials (MD, NP, PA, CNM, LM)	NPI

Electronic Medical Record (EMR): Yes ___ No __

Paper/Hard Copy Medical Records: Yes ___ No___ Shared Medical Records: Yes_____ No_____ Number of Records Reviewed: _____

Visit Purpose		Site-Specific Certification(s)		Provider Type		Clinic Type	
_____Initial Full Scope	_____Monitoring	_____ AAAHC	_____ JC	_____ Family Practice	_____ Internal Medicine	_____ Primary Care	_____ Community
_____Periodic Full Scope	_____Follow-up	_____ CHDP	_____ NCQA	_____ General Practice	_____ Pediatrics	_____ Hospital	_____ FQHC
_____Focused Review	_____Technical	_____CPSP	_____ None	_____OB/GYN as PCP		_____ Rural Health	_____ Solo

Assistance ____Other_____ (type)	_____ Other _____	_____Certified Nurse Midwife _____ Licensed Midwife	_____ Group _____ Staff/Teaching _____ Other (Type)_____

Medical Record Scores

Note: When scoring for OB/CPSP Preventive, score the Adult or Pediatric Preventive criteria for the same record.

	Points possible	Yes Pts. Given	No's	N/A's	Section Score %
I. Format	**(8) x 10 = 80**				
II. Documentation	**(8) x 10 = 90**				
III. Coordination of Care	**(8) x 10 = 80**				
IV. Pediatric Preventive	**(34) x # of records**				
V. Adult Preventive	**(30) x # of records**				
VI. OB/CPSP Preventive	**(59) x # of records**				
	Points Possible	**Yes Pts. Given**	**No's**	**N/A's**	

Scoring Procedure

Scoring is based on 10 medical records.

1) Add points given in each section.
2) Add points given for all six (6) sections.
3) Subtract "N/A" points (if any) from total points possible to get "adjusted" total points possible.
4) Divide total points given by "adjusted" total points possible.
5) Multiply by 100 to determine compliance rate as a percentage.

_____ ÷ _____ = _____ **x 100 =** _____**%**

Points Given | Total/ Adjusted Pts. Poss. | Decimal Score | Compliance Rate

Note:
Since Preventive Criteria have different points possible per type (Ped-34, Adult-30, OB/CPSP-59, the total points possible will differ from site to site, depending on the number of *types* of records that are selected. The "No's" column *may* be used to help double-check math. The far-right Section Score % column may be used to determine if section is <80%.

Compliance Rate

Note: Any section score of < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

____ **Exempted Pass: 90% or above:**
(Total score is ≥ 90% ***and*** all section scores are 80% or above)

____ **Conditional Pass: 80-89%:**
(Total MRR is 80-89% ***OR*** *Any* section(s) score is < 80%)

____ **Fail: 79% and Below**

____ CAP Required

____ Other follow-up

Next Review Due: _____

Medical Records Reference:

Medical Record	CIN	Age Year/Month	Gender	Member's MCP Enrollment Date	PCP's MCP Effective Date	On Site (x)	Remote Access (x)
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

I. Format Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point Criteria not met: 0 points Criteria not applicable: N/A	Wt.	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
Individual Medical Record is established for each member.												
A. Member identification is on each page.	**1**											
B. Individual personal biographical information is documented.	**1**											
C. Emergency "contact" is identified.	**1**											
D. Medical records are maintained and organized.	**1**											
E. Member's assigned and/or rendering primary care physician (PCP) is identified.	**1**											
F. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing/speech-impaired persons are prominently noted.	**1**											
G. Person or entity providing medical interpretation is identified.	**1**											
H. Signed Copy of the Notice of Privacy.	**1**											
Comments:	**Yes**											
	No											
	NA											

II. Documentation Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point **Criteria not met: 0 points** **Criteria not applicable: N/A**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Allergies are prominently noted.	**1**											
B. Chronic problems and/or significant conditions are listed.	**1**											
C. Current *continuous* medications are listed.	**1**											
D. Appropriate consents are present:												
1) Release of Medical Records	**1**											
2) Informed Consent for invasive procedures	**1**											
E. Advance Health Care Directive Information is offered.	**1**											
F. All entries are signed, dated, and legible.	**1**											
G. Errors are corrected according to legal medical documentation standards.	**1**											
Comments:	**Yes**											
	No											
	N/A											

III. Coordination of Care Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point Criteria not met: 0 points Criteria not applicable: N/A	Wt.	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
A. History of present illness or reason for visit is documented.	1											
B. Working diagnoses are consistent with findings.	1											
C. Treatment plans are consistent with diagnoses.	1											
D. Instruction for follow-up care is documented.	1											
E. Unresolved/continuing problems are addressed in subsequent visit(s).	1											
F. There is evidence of practitioner *review* of specialty/consult/referral reports and diagnostic test results.	1											
G. There is evidence of *follow-up* of specialty consult/referrals made, and results/reports of diagnostic tests, when appropriate.	1											
H. Missed primary care appointments and outreach efforts/follow-up contacts are documented.	1											
Comments:	Yes											
	No											
	N/A											

IV. Pediatric Preventive Criteria **NOTE: * denotes** Pending AAP guidance.

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point **Criteria not met: 0 points** **Criteria not applicable: N/A**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Initial Health Assessment (IHA) Includes H&P and Individual Health Education Behavioral Assessment (IHEBA)												
1) Comprehensive History and Physical	**1**											
2) IHEBA	**1**											
B. Subsequent Comprehensive Health Assessment												
1) Comprehensive History and Physical exam completed at age-appropriate frequency	**1**											
2) Subsequent Periodic IHEBA	**1**											
C. Well-child visit												
1) Alcohol Use Disorder Screening and Behavioral Counseling	**1**											
2) Anemia Screening	**1**											
3) Anthropometric Measurements	**1**											
4) Anticipatory Guidance	**1**											
5) Autism Spectrum Disorder Screening	**1**											
6) Blood Lead Screening	**1**											
7) Blood Pressure Screening	**1**											
8) Dental/Oral Health Assessment	**1**											
a) Fluoride Supplementation	**1**											
b) Fluoride Varnish	**1**											
9) Depression Screening	**1**											

IV. Pediatric Preventive Criteria **NOTE: * denotes** Pending AAP guidance.

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point Criteria not met: 0 points Criteria not applicable: N/A	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
a) Suicide-Risk Screening*	**1**											
b) Maternal Depression Screening	**1**											
10) Developmental Disorder Screening	**1**											
11) Developmental Surveillance	**1**											
12) Drug Use Disorder Screening and Behavioral Counseling	**1**											
13) Dyslipidemia Screening	**1**											
14) Hearing Screening	**1**											
15) Hepatitis B Virus Infection Screening*	**1**											
16) Hepatitis C Virus Infection Screening	**1**											
17) Human Immunodeficiency Virus (HIV) Infection Screening	**1**											
18) Psychosocial/Behavioral Assessment	**1**											
19) Sexually Transmitted Infections (STIs) Screening and Counseling	**1**											
20) Sudden Cardiac Arrest and Sudden Cardiac Death Screening*	**1**											
21) Tobacco Use Screening, Prevention, and Cessation Services	**1**											
22) Tuberculosis Screening	**1**											
23) Vision Screening	**1**											
D. Childhood Immunizations												
1) Given according to Advisory Committee on Immunization Practices (ACIP) guidelines	**1**											
2) Vaccine administration documentation	**1**											

IV. Pediatric Preventive Criteria **NOTE: * denotes** Pending AAP guidance.

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point **Criteria not met: 0 points** **Criteria not applicable: N/A**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
3) Vaccine Information Statement (VIS) documentation	**1**											
Comments:	**Yes**											
	No											
	N/A											

V. Adult Preventive Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point Criteria not met: 0 points Criteria not applicable: N/A	Wt.	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
A. Initial Health Assessment (IHA): Includes H&P and Individual Health Education Behavioral Assessment (IHEBA)												
1) Comprehensive History and Physical	**1**											
2) IHEBA	**1**											
B. Periodic Health Evaluation according to most recent United States Preventive Services Taskforce (USPSTF) Guidelines												
1) Comprehensive History and Physical Exam completed at age-appropriate frequency	**1**											
2) **Subsequent** Periodic IHEBA	**1**											
C. Adult Preventive Care Screenings												
1) Abdominal Aneurysm Screening	**1**											
2) Alcohol Use Disorder Screening and Behavioral Counseling	**1**											
3) Breast Cancer Screening	**1**											
4) Cervical Cancer Screening	**1**											
5) Colorectal Cancer Screening	**1**											
6) Depression Screening	**1**											
7) Diabetic Screening	**1**											
a) Comprehensive Diabetic Care	**1**											
8) Drug Disorder Screening and Behavioral Counseling	**1**											
9) Dyslipidemia Screening	**1**											
10) Folic Acid Supplementation	**1**											
11) Hepatitis B Virus Screening	**1**											

V. Adult Preventive Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point Criteria not met: 0 points Criteria not applicable: N/A	Wt.	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
12) Hepatitis C Virus Screening	1											
13) High Blood Pressure Screening	1											
14) HIV Screening	1											
15) Intimate Partner Violence Screening for Women of Reproductive Age	1											
16) Lung Cancer Screening	1											
17) Obesity Screening and Counseling	1											
18) Osteoporosis Screening	1											
19) Sexually Transmitted Infection (STI) Screening and Counseling	1											
20) Skin Cancer Behavioral Counseling	1											
21) Tobacco Use Screening, Counseling, and Intervention	1											
22) Tuberculosis Screening	1											
D. Adult Immunizations												
1) Given according to ACIP guidelines	1											
2) Vaccine administration documentation	1											
3) Vaccine Information Statement (VIS) documentation	1											

Comments:

	Yes											
	No											
	N/A											

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point Criteria not met: 0 points Criteria not applicable: N/A	Wt.	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
A. Initial Comprehensive Prenatal Assessment (ICA)												
1) Initial prenatal visit	**1**											
2) Obstetrical and Medical History	**1**											
3) Physical Exam	**1**											
4) Dental Assessment	**1**											
5) Healthy Weight Gain and Behavior Counseling	**1**											
6) Lab tests												
a) Bacteriuria Screening	**1**											
b) Rh Incompatibility Screening	**1**											
c) Diabetes Screening	**1**											
d) Hepatitis B Virus Screening	**1**											
e) Hepatitis C Virus Screening	**1**											
f) Chlamydia Infection Screening	**1**											
g) Syphilis Infection Screening	**1**											
h) Gonorrhea Infection Screening	**1**											
i) Human Immunodeficiency Virus (HIV) Screening	**1**											
B. First Trimester Comprehensive Assessment												
1) Individualized Care Plan (ICP)	**1**											
2) Nutrition Assessment	**1**											

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point Criteria not met: 0 points Criteria not applicable: N/A	Wt.	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
3) Psychosocial Assessment												
a) Maternal Mental Health Screening	**1**											
b) Social Needs Assessment	**1**											
c) Substance Use Disorder	**1**											
4) Breast Feeding and other Health Education Assessment	**1**											
5) Preeclampsia Screening	**1**											
6) Intimate Partner Violence Screening	**1**											
C. Second Trimester Comprehensive assessment												
1) ICP	**1**											
2) Nutrition Assessment	**1**											
3) Psychosocial Assessment												
a) Maternal Mental Health Screening	**1**											
b) Social Needs Assessment	**1**											
c) Substance Use Disorder Assessment	**1**											
4) Breast Feeding and other Health Education Assessment	**1**											
5) Preeclampsia Screening	**1**											
a) Low Dose Aspirin	**1**											
6) Intimate Partner Violence Screening	**1**											
7) Diabetes Screening	**1**											

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point Criteria not met: 0 points Criteria not applicable: N/A	Wt.	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
D. Third Trimester Comprehensive assessment												
1) ICP Update and Follow Up	**1**											
2) Nutrition Assessment	**1**											
3) Psychosocial Assessment												
a) Maternal Mental Health Screening	**1**											
b) Social Needs Assessment	**1**											
c) Substance Use Disorder Assessment	**1**											
4) Breastfeeding and other Health Education Assessment	**1**											
5) Preeclampsia Screening	**1**											
a) Low Dose Aspirin	**1**											
6) Intimate Partner Violence Screening	**1**											
7) Diabetic Screening	**1**											
8) Screening for Strep B	**1**											
9) Screening for Syphilis	**1**											
10) Tdap Immunization	**1**											
E. Prenatal care visit periodicity according to most recent American College of Obstetricians and Gynecologists (ACOG) standards	**1**											
F. Influenza Vaccine	**1**											
G. COVID Vaccine	**1**											

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point Criteria not met: 0 points Criteria not applicable: N/A	Wt.	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
H. Referral to Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and assessment of Infant Feeding Status	1											
I. HIV-related services *offered*	1											
J. AFP/Genetic Screening offered	1											
K. Family Planning Evaluation	1											
L. Comprehensive Postpartum Assessment												
1) ICP	1											
2) Nutrition Assessment	1											
3) Psychosocial Assessment												
a) Maternal Mental Health Screening/Postpartum Depression screening	1											
b) Social Needs Assessment	1											
c) Substance Use Disorder Assessment	1											
4) Breastfeeding and other Health Education Assessment	1											
5) Comprehensive Physical Exam	1											
Comments:	Yes											
	No											
	N/A											

IEHP MEDICAL RECORD REVIEW SURVEY ADDENDUM
PCP/OB, FP1, FP2
This Addendum has no scoring value, however, findings may require corrective action.

		1.	**CPSP (For PCP/ OB, FP1, FP2)**			
			A. Is the office CPSP Certified?			
			B Is the office using IEHP forms? (1)			
			C. Who in the office is assigned to perform CPSP services?			
			D. Interventions: **(For CPSP Certified & Non-CPSP Certified Providers)**			
			1. How is the member referred to the following:			
			a. Nutrition (1)			
			b. Social Worker (1)			
			c. Health Education (1)			
		2.	**OB REFERRAL (For FP1 and FP2 Providers)**			
			A. What OB does the office refer to?			
			B. Is there a letter from OB acknowledging the relationship? (1)			
			C. When are Members transferred to OB for delivery? (1)			
			D. When are records transferred? (1) **(PCP/OB & OB Specialist)**			
		3.	**POLICY AND PROCEDURES (FOR FP1 & FP2 PROVIDERS)**			
			A. Is there a policy for High Risk OB Referrals (1)			
			B. Is there a policy for OB Referral Process for Routine Deliveries (1)			

		4.	**ULTRASOUND (For PCP/OB, FP1 & FP2 Providers)**			
			A. Trained Staff (1)			

IEHP MEDICAL RECORD REVIEW SURVEY ADDENDUM
PCP/OB, FP1, FP2
This Addendum has no scoring value, however, findings may require corrective action.

			B. Written policies and procedures re: safety, confidentiality, and operating procedures. (1)			
			C. Equipment maintenance and calibration performed on all equipment (1)			
			D. Provide a setting for ultrasound exam that allows for patient safety and comfort. (1)			
			E. There is documentation done for each exam. (1)			
		5.	**REQUIRED EQUIPMENT FOR OB SERVICES (For PCP/OB, FP1 & FP2 Providers)**			
			A. Examination equipment			
			1. Nitrazine paper.			
			2. Keto (urine) sticks.			
			3. Doppler			

Inland Empire Health Plan

Urgent Care Center Evaluation Tool

Review Date: _____ **Reviewer Name: _____** **Reviewer Signature_____**

Provider Name/Address: _____ **Phone:_____** **Fax:_____**

_____ **Contact Person/Title:_____**

_____

No. of staff on site: ____ Physician ____ NP ____ CNM ____ PA ____ RN ____ LVN ____ MA ____Clerical ____Other

Hours of Operation: Evening Hrs

S	M	T	W	Th	F	Sat

Saturday Hrs._____ Sunday Hrs. _____ Holiday Hrs. _____

Visit Purpose	**Site-Specific Certification(s)**
_____Initial Full Scope _____Monitoring _____Follow Up _____Ed/TA _____Focused Review _____Other _____ (type)	Population Served: ___0-20yrs ___21-54yrs ___55 and above Special Services List:

Site Scores	Scoring Procedures	**Compliance Rate**
I. Access/Safety ___/10 **II. Personnel ___/14** **III. Office Management ___/7** **IV. Clinical Services ___/25** **V. Required Equipment ___/25** **VI. Required Medications ___/15** **VII. Infection Control ___/11** **VIII. Medical Record Review ___/35** **Total ___/142**	1.) Add points given in each section. 2.) Add total points given for all six sections 3.) Adjust score for "N/A" criteria (if needed). 4.) Subtract "N/A" points from total points possible. 5.) Divide total points given by 100 or by "adjusted" total points 6.) Multiply by 100 to get the compliance (percent) rate	**_____Exempted Pass:** 90% or above (w/o) CE, Pharm, and/or IC deficit **_____Conditional Pass:** 80-89%, or 90% or above (w/CE, Pharm, and/or IC deficit **_____Not Pass:** Below 80% **_____CAP required** **_____Other follow-up** **Next review date: _____**

I. Access / Safety

Site Access/Safety Survey Criteria

	YES	NO	N/A	Wt.	Site Score
1. Waiting area is clean and adequate for patient volume				1	
2. Adequate fire safety- at least one type of fire fighting/protection equipment is accessible at all times				1	
3. Wheelchair access to building and office				1	
4. Office hours posted/visible from outside building				1	
5. Evacuation plan posted; exit signs clearly marked for emergency exit				1	
6. Emergency kit checked at least monthly and after each use. O2 system, Ambu-bag, oral airways, bulb syringe, and emergency meds (Benadryl, epinephrine) required.				1	
7. Medical equipment is clean, functioning properly, and maintained in operational condition with documentation to demonstrate appropriate maintenance according to manufacturer's guidelines				1	
8. Exam rooms are clean and safe and provide physical and auditory privacy for patients.				1	
9. Language services: members must have access to the following language service at all times (Telephonic and Video Remote Interpreting CASL only).				**2**	
Comments: Write comments for all "No" (0 points) and "N/A" scores **TOTALS**					

II. Personnel

Site Personnel Survey Criteria

	YES	NO	N/A	Wt.	Site Score
1. A Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), or Nurse Practitioner (NP) is on site during hours of operation.				1	
2. MDs, DOs, PAs, and/or PAs must be credentialed with IEHP.				1	
3. NPs and/or PAs that prescribe controlled substances possess current and valid DEA registration number.				1	
4. All required Professional Licenses and Certifications are issued from the appropriate licensing/certification body.				1	
5. The scope of practice for NPs is defined and there are standardized procedures signed and dated by both the supervising physician and NP.				1	
6. There is a practice agreement signed by both the Physician's Assistant (PA) and supervising Physician that includes all provisions as described in SB 697 Section 5 (Section 3502.3 of Business and Professions Code)				1	
7. The proper ratio of physician to mid-level practitioners supervised is maintained at 1:4 NP, 1:3 CNM, 1:4 PA-C.				1	
8. Oversight of NP is evidenced by a minimum of 10% medical record review by supervising physician.				1	
9. Supervision of PA is included in the practice agreement.				1	
10. Oversight of PA is evidenced by a minimum of 10% medical record review by supervising physician.				1	
11. Supervising physician specialty must cover populations served.				1	

12. All health care personnel wear identification badges/tags printed with name & title.				1	
13. Personnel are trained in procedures/action plans to be carried out in case of medical & non-medical emergencies.				1	
14. Physician credentialed with IEHP or delegated contractor with the stated specialties (Family Practice, Internal Medicine or Pediatrics) is available for mid-level practitioners to contact for consultation during all hours of operation.				1	
Comments: Write comments for all "No" (0 points) and "N/A" scores **TOTALS**					

III. Office Management

RN/MD Review Only (#B)

Office Management Survey Criteria					
	YES	NO	N/A	Wt.	Site Score
1. Policy/Procedure: Patient triage. Only licensed medical personnel shall triage and handle phone triage/ advice (MD, DO, NP, RN, PA)				1	
2. Policy/Procedure: Transport of emergency patients to appropriate facility.				1	
3. Policy/Procedure: Patient confidentiality. Confidentiality is maintained according to HIPAA guidelines				1	
4. Policy/Procedure: Handling & disposing of biohazardous waste & blood borne pathogen exposure (Evidence of Staff Training)				1	
5. Patient rights posted. Evidence of system for handling complaints and grievances.				1	
6. Child/Elder/Domestic abuse reporting mandate, training and hotline numbers available.				1	
7. Interpreter services are in identified threshold languages; interpreter services phone numbers available to staff				1	
Comments: Write comments for all "No" (0 points) and "N/A" scores **TOTALS**					

IV.

V. Clinical Services

A. Clinical Services Survey Criteria

	YES	NO	N/A	Wt.	Site Score
1. Refrigerator daily temperature logs maintained appropriately.				1	
2. Only qualified/trained personnel retrieve, prepare or administer medications.				**2**	
3. All medications, including samples and needles/syringes and prescription pads are secured & inaccessible to patients				1	
4. Controlled drugs are stored separately in a locked space. A dose-by-dose distribution log is kept.				1	
5. There are no expired drugs on site.				1	
6. Drugs are prepared in a clean area or "Designated clean" area if prepared in a multipurpose room.				1	
Comments: Write comments for all "No" (0 points) and "N/A" scores **TOTALS**					

B. Laboratory Services Survey Criteria

	YES	NO	N/A	Wt.	Site Score
1. Laboratory test procedures are performed according to current site-specific CLIA certificate.				1	
2. Laboratory services must be available on-site with ability to perform all minimum required tests.				1	
3. Minimum tests performed on site include: Urine HCG, hemoglobin or hematocrit, blood glucose & urine dipstick, Rapid Strep, STI collection materials. *off-site laboratory that can provide stat H & H results within 1-hour is acceptable				1	
4. Personnel performing clinical lab procedures have been trained.				1	
5. Lab supplies are inaccessible to unauthorized persons.				1	
6. Lab test supplies (e.g. vacutainers, culture swabs, test solutions) are not expired.				1	
7. Site has a procedure to dispose of expired lab supplies.				1	
Comments: Write comments for all "No" (0 points) and "N/A" scores **TOTALS**					

C. Radiology Services Survey Criteria

	YES	NO	N/A	Wt.	Site Score
1. Site has current CA Radiologic Health Branch Inspection Report, if there is radiological equipment on site.				1	
2. If no radiological equipment on site, immediate access to diagnostic radiology services (plain film x-rays) with urgent results made available to member and PCP a. Chest and Limb x-rays				1	
3. Current copy of Title 17 with a posted notice about availability of Title 17 and its location. (document must be posted on site.)				1	
4. "Radiation Safety Operating Procedures" posted in highly visible location.				1	
5. "Notice to Employees Poster" posted in highly visible location.				1	
6. "Caution, X-ray" sign posted on or next to door of each room that has X-ray equipment.				1	
7. Physician Supervisor/Operator certificate posted and within current expiration date.				1	
8. Technologist certificate posted *and* within current expiration date.				1	
The following radiological protective equipment is present on site: 9. Operator protection devices: radiological equipment operator must use lead apron or lead shield.				1	
10. Gonadal shield (0.5 mm or greater lead equivalent): for patient procedures in which gonads are in direct beam				1	
11. Urgent x-ray results are made available to the Member and PCP				1	
Comments: Write comments for all "No" (0 points) and "N/A" scores **TOTALS**					

VI. Minimum Required Equipment

Equipment Survey Criteria

	YES	NO	N/A	Wt.	Site Score
1. Exam table and lights in proper working order				1	
2. Stethoscope and sphygmomanometer with various size cuffs (e.g. child, adult, obese/thigh).				1	
3. Thermometers: oral and/or tympanic/thermoscan with a numeric reading				1	
4. Scales: standing and infant scales.				1	
5. Basic exam equipment: percussion hammer, tongue blades, patient gowns.				1	
6. Ophthalmoscope				1	
7. Otoscope and adult and pediatric ear speculums				1	
8. EKG machine				1	
9. Nebulizer				1	
10. Splinting materials				1	
11. Suction machine and catheters (Recommended)				1	
12. NG tubes (Recommended)				1	
13. Wound irrigation supplies				1	
14. Eye and Ear irrigation supplies				1	
15. Eye tray				1	
16. Wood's lamp for dermatologic diagnosis (Recommended)				1	
17. Suture kits and materials				1	
18. Dressing supplies				1	
19. Eye charts literate and illiterate, and occluder for vision testing				1	
20. Pulse Oximetry				1	
21. Oxygen (Oxygen tank must be a minimum of ¾ full)				**2**	
22. Appropriate sizes of ESIP needles/syringes				**2**	
23. Alcohol wipes				1	
Comments: Write comments for all "No" (0 points) and "N/A" scores **TOTALS**					

VII. Minimum Required Medications

Medication Survey Criteria

	YES	NO	N/A	Wt.	Site Score
1. Albuterol for inhalation or Nebulizer or metered dose inhaler				1	
2. Epinephrine 1:1,000 (Injectable) for anaphylaxis				1	
3. Benadryl 50 mg (injectable) or Benadryl 25 mg (oral)				1	
4. Burn dressing, i.e. Silvadene				1	
5. Tylenol & Motrin				1	
6. Anti-nausea medication				1	
7. Anti-diarrhea medication				1	
8. Injectable Antibiotics				1	
9. Tdap				1	
10. Xylocaine				1	
11. Fluorescein Strips				1	
12. Naloxone				1	
13. Chewable Aspirin				1	
14. Nitroglycerine spray/tablet				1	
15. Glucose				1	

Comments: Write comments for all “No” (0 points) and “N/A” scores **TOTALS**					

VIII.

IX. Infection Control

Infection Control Survey Criteria

	YES	NO	N/A	Wt.	Site Score
1. Personal Protective Equipment is readily available for staff use.				**2**	
2. Needlestick safety precautions are practiced on site.				**2**	
3. Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate *leak proof, labeled* containers for collection, handling, processing, storage, transport or shipping.				**2**	
4. Spore testing of autoclave/steam sterilizer with documented results (at least monthly).				**2**	
5. Cold chemical sterilization solutions used according to manufacturer's recommendations.				1	
6. Equipment and work surfaces are appropriately cleaned and decontaminated after contact with blood or other potentially infectious material with an EPA approved disinfectant.				1	
7. Autoclave/steam sterilization performed by trained personnel.				1	
Comments: Write comments for all "No" (0 points) and "N/A" scores **TOTALS**					

X. Medical Record Review

Medical Record Survey Criteria

	#1	#2	#3	#4	#5
1. Files are legible, organized, contents are securely fastened and maintained in a secure area					
2. Each page is dated and contains the patient's name.					
3. Medication allergies (or NKA) are noted.					
4. There is a signed consent for treatments/procedures.					
5. Documentation of a targeted physical assessment with vital signs.					
6. Documentation of after-care instructions acknowledged.					
7. Notification to primary care physician.					
Comments: Write comments for all "No" (0 points) and "N/A" scores **Combined totals: _____**	Total:	Total:	Total:	Total:	Total:

Urgent Care Site Review

Access / Safety	Personnel	Office Management	Clinical Services	Required Equipment	Required Medications	Infection Control	Medical Records	Total
10	**14**	**7**	**25**	**25**	**15**	**11**	**35**	**Exempted Pass: 90-100%** (w/o critical element, pharmacy and/or infection control deficiencies) **Conditional Pass: 80-89%, or 90% & above** (w/ critical element, pharmacy and/or infection control deficiencies) **Not Pass: Below 80%**

Access/Safety
Personnel
Office Management
Medical Records
Clinical Services
Required Equipment
Required Medication
Infection Control

Interim Facility Site Review Tool

PCP/Clinic Name:	**Phone:**	**Fax/Email:**	
Site Address:	**Office Contact:**		**County**: Riverside
Last Full Scope FSR: **MRR**: **FSR Score:** **MRR Score:**	**Health Plan:** IEHP	**Reviewer:** Aileen Concemino, RN	

Please have the physician or designee complete the form below and return within ten (10) business days. If the completed form is not received within the allotted time frame, an Onsite Interim Review maybe performed. If the answer is "No" to any of the questions, a Corrective Action Plan (CAP) must be submitted to the Health Plan.

Please send completed form and documents to: IEHP QM Coordinator Leonardo-K@iehp.org or (909) 890-5746 (fax).

Check the appropriate Yes/No/NA response below & include any comments. Please note, this form has 2 pages

Physician Coverage is available 24 hours a day, 7 days a week	Compliant	Non-Compliant	N/A	Comments
1. After-hours emergency care instructions/telephone information is made available to patients	Yes ☐	No ☐		After Hours Access Method: (i.e. phone services/exchange)
CRITICAL ELEMENT	Compliant	Non-Compliant	N/A	Comments
1. Exit doors & aisles are unobstructed and egress (escape) accessible • Accessible pedestrian paths of travel provide a clear circulation path. • Escape routes are maintained free of obstructions or impediments to full instant use of the path of travel in case of fire or other emergency. • Building escape routes provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied. • Cords or other items are not placed on or across walkway areas.	Yes ☐	No ☐		
2. Airway Management • Must have a wall oxygen delivery system or portable oxygen tank that is maintained at least ¾ full. Portable oxygen tank must have a flow meter attached. • There is a method/system in place for oxygen tank replacement. • There are various sizes of oral oropharyngeal airways devices appropriate to patient population available on site. • There is a nasal cannula or mask available and various sizes of ambu-bags appropriate to patient population available on site.	Yes ☐	No ☐		Name of person checking supplies:
3. Emergency medicine • Emergency medicine such as asthma, chest pain, hypoglycemia and anaphylactic reaction management: Epinephrine 1:1000 (injectable), and Benadryl 25 mg. (oral) or Benadryl 50 mg./ml. (injectable), Naloxone, chewable Aspirin, Nitroglycerine spray/tablet, nebulizer or metered dose inhaler and glucose. • Appropriate sizes of ESIP needles/syringes and alcohol wipes. All emergency medication in the Emergency kit/ Crash cart must have dosage charts. Package inserts ARE NOT acceptable.	Yes ☐	No ☐		Name of person checking supplies:
4. Qualified personnel prepare/administer medication • There must be a licensed physician physically present in the treatment facility during the performance of authorized procedures by the Medical Assistant(MA). • There must be a process in place and verbalized by the MA(s), at the time of survey, that the pre-labeled medication container and prepared dose are shown to the licensed person prior to administration. The supervising physician must specifically authorize all medications administered by an MA.	Yes ☐	No ☐	N/A ☐	Name of *MD/NURSE ONLY* checking MA administered meds:
5. Timely review & follow-up of referral/consultation reports & test results • Site staff can demonstrate the office referral process from beginning to end. • Referral process must include physician review (e.g. x-ray, labs, specialist notes). • A process for follow-up of referral/consultation reports and diagnostic test results is in place	Yes ☐	No ☐		*Please provide referral logs for past 3 months.* Name of person tracking referrals:
6. Authorized persons dispense medications • Drug dispensing is in compliance with all applicable State and Federal laws and regulations. • Drugs are dispensed only by a physician, pharmacist or other persons lawfully authorized to dispense medications upon the order of a licensed physician or surgeon.	Yes ☐	No ☐		Name of *MD/NURSE* dispensing drugs:
7. Drugs and Vaccines are prepared and drawn only prior to administration. • Personnel are able to demonstrate or verbally explain procedure(s) used on site to confirm correct patient/dosage and vaccine are prepared and drawn only prior to administration. ACIP discourages routine practice of prefilling syringes	Yes ☐	No ☐		
8. Personal protective equipment • PPE is available for staff use on site & includes water repelling gloves, water-resistant gowns, face/eye protection (e.g. face shield or goggles), & respiratory infection protection (e.g. mask).	Yes ☐	No ☐		

Interim Facility Site Review Tool

CRITICAL ELEMENT	Compliant	Non-Compliant	N/A	Comments
9. Needle stick precautions are practiced on site • Engineered Sharps Injury Protection (ESIP) devices are used on site • Contaminated sharps are discarded immediately. • Sharps containers are: 1) located close to the immediate area where sharps are used; 2) inaccessible to unauthorized persons; 3) secured (locked) in patient care areas at all times; and 4) not overfilled past manufacturer's designated fill line or more than ¾ full.	Yes ☐	No ☐		*Please provide proof of purchase of ESIP (Engineered Sharps Injury Protection) devices/ Safety Needles used onsite.*
10. Blood and other infectious materials storage and handling • Containers for blood and other potentially infectious materials (OPIM) are closable, leak proof, and labeled and/or color-coded (e.g. red bags). • Double bagging is required only if leakage is possible.	Yes ☐	No ☐		
CE 11-14 Please mark NA if no Cold Sterilization or Autoclave onsite	Compliant	Non-Compliant	N/A	Comments
11. Staff demonstrate/verbalize necessary steps/process to ensure sterility and/or high-level disinfection to ensure sterility/disinfection of equipment. • Product manufacturer's directions are strictly followed for instrument pre-soaking treatment, solution preparation, solution exposure procedures, safety precautions (e.g., room temperature, area ventilation), and post-sterilization processes. • Sterility is not verified or assured with cold chemical sterilization and/or high-level disinfection. The first choice is always heat sterilization. • The CDC refers to heat sterilization as "the method of choice when sterilizing instruments and devices. If an item is heat sensitive, it is preferable to use a heat-stable alternative or disposable item." • The use of liquid chemical sterilant should be restricted to reprocessing devices that are heat-sensitive and incompatible with other sterilization methods. All other items should be heat sterilized or disposable.	Yes ☐	No ☐	NA ☐	
12. Appropriate PPE is available, exposure control plan, MSDS and clean up instructions in the event of a cold chemical sterilant spill. • Always consult the manufacturer for safety precautions and MSDS information. The appropriate PPE must be used to avoid inhalation or skin contact exposure during the cold chemical sterilization/high level disinfection process.	Yes ☐	No ☐	NA ☐	
13. Spore testing of autoclave/steam sterilizer with documented results (at least monthly). • Autoclave spore testing is performed at least monthly.	Yes ☐	No ☐	NA ☐	*Please provide spore test results for the last 3 months.* Date of last spore test:
14. Management of positive mechanical, chemical, and/or biological indicators of the sterilization process. • Sterilization failure can occur for reasons such as slight variation in the resistance of the spores, improper use of the sterilizer, and laboratory contamination during the culture. • Sterility is not verified or assured with cold chemical sterilization. • Written procedures for performing routine spore testing and for handling positive spore test results are available on site to staff. • For positive spore tests, the autoclave is removed from service immediately until inspection is completed and a negative retest occurs. • Procedures include: report problem, repair autoclave, retrieve all instruments sterilized since last negative spore test, re-test autoclave and re-sterilize retrieved instruments.	Yes ☐	No ☐	NA ☐	
Initial Health Assessment (IHA) • Reviewed the Initial Health Assessment attached criteria, including how to locate my newly assigned membership on the IEHP website.	Yes ☐	No ☐		

Attestation: I hereby affirm, the information indicated on this form and any documents thereto is true, current, correct and complete to the best of my knowledge, belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges or physician participation agreement

PCP/Representative Signature & Title: _____ Date: _____

Print Name & Title: _____

MEDICAL GROUP OR HEALTH PLAN USE ONLY		
Interim Review Approved: ☐ Yes ☐ No	Follow-up Required: ☐ Yes ☐ No	Date CAP Due:
Nurse Comments:		
Nurse Reviewer Signature:		Date:

Interim Facility Site Review Tool - On Site

PCP/Clinic Name:		Phone: Fax/Email:	
Site Address:		Office Contact:	County: Riverside
Last Full Scope FSR: MRR: FSR Score: MRR Score:		Health Plan: IEHP	Reviewer: Aileen Concemino, RN

Physician Coverage is available 24 hours a day, 7 days a week	Compliant	Non-Compliant	N/A	Comments
1. After-hours emergency care instructions/telephone information is made available to patients	Yes ☐	No ☐		After Hours Access Method: (i.e. phone services/exchange)
CRITICAL ELEMENT	**Compliant**	**Non-Compliant**	**N/A**	**Comments**
1. Exit doors & aisles are unobstructed and egress (escape) accessible • Accessible pedestrian paths of travel provide a clear circulation path. • Escape routes are maintained free of obstructions or impediments to full instant use of the path of travel in case of fire or other emergency. • Building escape routes provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied. • Cords or other items are not placed on or across walkway areas.	Yes ☐	No ☐		
2. Airway Management • Must have a wall oxygen delivery system or portable oxygen tank that is maintained at least ¾ full. Portable oxygen tank must have a flow meter attached. • There is a method/system in place for oxygen tank replacement. • There are various sizes of oral oropharyngeal airways devices appropriate to patient population available on site. • There is a nasal cannula or mask available and various sizes of ambu-bags appropriate to patient population available on site.	Yes ☐	No ☐		Name of person checking supplies:
3. Emergency medicine • Emergency medicine such as asthma, chest pain, hypoglycemia and anaphylactic reaction management: Epinephrine 1:1000 (injectable), and Benadryl 25 mg. (oral) or Benadryl 50 mg./ml. (injectable), Naloxone, chewable Aspirin, Nitroglycerine spray/tablet, nebulizer or metered dose inhaler and glucose. • Appropriate sizes of ESIP needles/syringes and alcohol wipes. All emergency medication in the Emergency kit/ Crash cart must have dosage charts. Package inserts ARE NOT acceptable.	Yes ☐	No ☐		Name of person checking supplies:
4. Qualified personnel prepare/administer medication • There must be a licensed physician physically present in the treatment facility during the performance of authorized procedures by the Medical Assistant(MA). • There must be a process in place and verbalized by the MA(s), at the time of survey, that the pre-labeled medication container and prepared dose are shown to the licensed person prior to administration. The supervising physician must specifically authorize all medications administered by an MA.	Yes ☐	No ☐	N/A ☐	Name of *MD/NURSE ONLY* checking MA administered meds:
5. Timely review & follow-up of referral/consultation reports & test results • Site staff can demonstrate the office referral process from beginning to end. • Referral process must include physician review (e.g. x-ray, labs, specialist notes). • A process for follow-up of referral/consultation reports and diagnostic test results is in place	Yes ☐	No ☐		*Please provide referral logs for past 3 months.* Name of person tracking referrals:
6. Authorized persons dispense medications • Drug dispensing is in compliance with all applicable State and Federal laws and regulations. • Drugs are dispensed only by a physician, pharmacist or other persons lawfully authorized to dispense medications upon the order of a licensed physician or surgeon.	Yes ☐	No ☐		Name of *MD/NURSE* dispensing drugs:
7. Drugs and Vaccines are prepared and drawn only prior to administration. • Personnel are able to demonstrate or verbally explain procedure(s) used on site to confirm correct patient/dosage and vaccine are prepared and drawn only prior to administration. ACIP discourages routine practice of prefilling syringes	Yes ☐	No ☐		
8. Personal protective equipment • PPE is available for staff use on site & includes water repelling gloves, water-resistant gowns, face/eye protection (e.g. face shield or goggles), & respiratory infection protection (e.g. mask).	Yes ☐	No ☐		

Interim Facility Site Review Tool

CRITICAL ELEMENT	Compliant	Non-Compliant	N/A	Comments
9. Needle stick precautions are practiced on site • Engineered Sharps Injury Protection (ESIP) devices are used on site • Contaminated sharps are discarded immediately. • Sharps containers are: 1) located close to the immediate area where sharps are used; 2) inaccessible to unauthorized persons; 3) secured (locked) in patient care areas at all times; and 4) not overfilled past manufacturer's designated fill line or more than ¾ full.	Yes ☐	No ☐		*Please provide proof of purchase of ESIP (Engineered Sharps Injury Protection) devices/ Safety Needles used onsite.*
10. Blood and other infectious materials storage and handling • Containers for blood and other potentially infectious materials (OPIM) are closable, leak proof, and labeled and/or color-coded (e.g. red bags). • Double bagging is required only if leakage is possible.	Yes ☐	No ☐		
CE 11-14 Please mark NA if no Cold Sterilization or Autoclave onsite	**Compliant**	**Non-Compliant**	**N/A**	**Comments**
11. Staff demonstrate/verbalize necessary steps/process to ensure sterility and/or high-level disinfection to ensure sterility/disinfection of equipment. • Product manufacturer's directions are strictly followed for instrument pre-soaking treatment, solution preparation, solution exposure procedures, safety precautions (e.g., room temperature, area ventilation), and post-sterilization processes. • Sterility is not verified or assured with cold chemical sterilization and/or high-level disinfection. The first choice is always heat sterilization. • The CDC refers to heat sterilization as "the method of choice when sterilizing instruments and devices. If an item is heat sensitive, it is preferable to use a heat-stable alternative or disposable item." • The use of liquid chemical sterilant should be restricted to reprocessing devices that are heat-sensitive and incompatible with other sterilization methods. All other items should be heat sterilized or disposable.	Yes ☐	No ☐	NA ☐	
12. Appropriate PPE is available, exposure control plan, MSDS and clean up instructions in the event of a cold chemical sterilant spill. • Always consult the manufacturer for safety precautions and MSDS information. The appropriate PPE must be used to avoid inhalation or skin contact exposure during the cold chemical sterilization/high level disinfection process.	Yes ☐	No ☐	NA ☐	
13. Spore testing of autoclave/steam sterilizer with documented results (at least monthly). • Autoclave spore testing is performed at least monthly.	Yes ☐	No ☐	NA ☐	*Please provide spore test results for the last 3 months.* Date of last spore test:
14. Management of positive mechanical, chemical, and/or biological indicators of the sterilization process. • Sterilization failure can occur for reasons such as slight variation in the resistance of the spores, improper use of the sterilizer, and laboratory contamination during the culture. • Sterility is not verified or assured with cold chemical sterilization. • Written procedures for performing routine spore testing and for handling positive spore test results are available on site to staff. • For positive spore tests, the autoclave is removed from service immediately until inspection is completed and a negative retest occurs. • Procedures include: report problem, repair autoclave, retrieve all instruments sterilized since last negative spore test, re-test autoclave and re-sterilize retrieved instruments.	Yes ☐	No ☐	NA ☐	
Initial Health Assessment (IHA) • Reviewed the Initial Health Assessment attached criteria, including how to locate my newly assigned membership on the IEHP website.	Yes ☐	No ☐		

MEDICAL GROUP OR HEALTH PLAN USE ONLY		
Interim Review Approved: ☐ Yes ☐ No	Follow-up Required: ☐ Yes ☐ No	Date CAP Due:
Nurse Comments:		
Nurse Reviewer Signature:		Date:

Date of Review:

Urgent Care 1st CAP Notification Letter

Health Plan Performing Evaluation:					
Reviewer's Name/Title (Print):		**Reviewer's signature/Title**			
Facility Name:	PCP Name(s):			# UC Charts Reviewed	
Address:		Contact Person and Title:			
Telephone:	Fax:				
Urgent Care Score:	**Date CAP Due:**		**Date Critical Element CAP Due:**		
			Date CAP Follow up:		

Corrective Action Plan (CAP) Completion and Submission Requirements

Disclosure and Release

I have received and reviewed copies of the above listed site's evaluations and corrective action plans for the urgent care review. I agree to correct each identified deficiency by implementing any corrective action that may be required. **I understand that failure to correct any of the noted Critical Element deficiencies within the required 10 business days and any other noted deficiencies within the 45-day time period from the review date,** may result in the exclusion of this facility and the associated provider(s) from the roster. **The completed CAP must include evidence of correction** {e.g. invoices, education sign sheets, forms used} **and dates completed**.

For assistance in completing the CAP, please call _____ _____ at_____.

_____ _____ _____

Physician/Designee Signature **Printed Name and Title** **Date**

Please Return Completed CAP via U.S. Mail or FAX to:

Inland Empire Health Plan
Quality Management Department
P.O. Box 1800, Rancho Cucamonga, CA 91729-1800
Fax: (909) 890-5545 Attention: QM Coordinator

Urgent Care Center Review Survey Corrective Action Plan

NOTE: Criteria that are **bolded** and underlined are considered critical elements.

I. Access/Safety
Site Access/Safety Survey Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited/Reviewer Comments	Corrective Action	CORRECTION DATE AND /OR PRACTITIONERS COMMENTS.	Responsible MD or Designee at Site
	I AS 1 ☐	All patient areas including floor/carpet, walls, and furniture are not neat, clean and well maintained. (Clean means unsoiled, neat, tidy, and uncluttered. Well-maintained means being in good repair or condition.)	The floors, carpets, walls, and furniture have been cleaned and/or repaired. ☐Copies of completed and dated work invoices and/or receipts are attached.		
	I AS 2 ☐	There is not at least one type of fire fighting/protection equipment that is accessible at all times. An accessible location is reachable by personnel standing on the floor, or other permanent working area, without the need to locate/retrieve a step stool, ladder of other assistive devices.	The below indicated firefighting/protection equipment has been obtained and is in place in an accessible location on site at all times: ☐ Smoke detector with intact, working batteries; ☐ Fire alarm device with code and reporting instructions posted conspicuously at phones and employee entrances; ☐ Automatic sprinkler system with sufficient clearance (10-in.) between sprinkler heads and stored materials. ☐ Fire extinguisher in an accessible location that displays readiness indicators or has an attached current dated inspection tag. ☐ Copies of receipts attached.		

Health Plan verification and date	CRITERIA	Deficiency Cited/Reviewer Comments	Corrective Action	CORRECTION DATE AND /OR PRACTITIONERS COMMENTS.	Responsible MD or Designee at Site
	IAS 3 ☐	Exit doorway openings do not allow for clear passage of a person in a wheelchair. At least 32 inches for exit doorway-opening clearance is required for a wheelchair. (Exit doors include all doors required for access, circulation and use of the building and facilities, such as primary entrances and passageway doors.)	All appropriate doorways have been remodeled to accommodate patients in wheelchairs. ☐A copy of the completed and dated work invoice or receipts is attached. ☐ If facility is under building waiver a copy is attached.		
	IAS 4 ☐	Clinic Office Hours are not posted or readily available upon request.	☐ The clinic office hours are now posted or readily available at the reception desk.		
	IAS 5 ☐	There are no clearly diagramed "Evacuation Routes" for emergencies posted in a visible location.	☐ Clearly marked, easy-to-follow escape routes have been posted in visible areas, such as hallways, exam rooms and patient waiting areas.		
	IAS 6 ☐	Emergency equipment is not checked monthly- including O2, Ambu-bag, oral airways, bulb syringe and emergency medications (Benadryl & Epinephrine).	Emergency equipment is now checked monthly, including meds. ☐ Appropriate completed and dated logs are attached.		
	IAS 7 ☐	Medical equipment is not being maintained properly and/or according to manufacturer's standards.	All equipment is now clean and properly maintained. ☐ Cleaning logs, calibration receipts and/or maintenance receipts attached.		

Health Plan verification and date	CRITERIA	Deficiency Cited/Reviewer Comments	Corrective Action	CORRECTION DATE AND /OR PRACTITIONERS COMMENTS.	Responsible MD or Designee at Site
	IAS 8 ☐	The exam rooms are not clean and safe, nor do they provide privacy for the patient.	☐ The exam rooms are now clean and safe. The exam rooms now provide both auditory and physical privacy**.**		
	IAS 9 ☐	**Language Services: members must have access to the following language services at all times – Telephonic and Video Remote Interpreting (ASL Only).**	☐ **Must have both at all times: Telephonic and Video Remote Interpreting (ASL only).**	**MUST BE COMPLETED WITHIN 10 DAYS OF SITE REVIEW (SEE CE CAP TOOL)**	

II. Personnel
Site Personnel Survey Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited/Reviewer Comments	Corrective Action	CORRECTION DATE AND /OR PRACTITIONERS COMMENTS.	Responsible MD or Designee at Site
	II P 1 ☐	MD, DO, NP or PA not on site at all times during hours of operation.	MD or DO is on site at all times during hours of operation. ☐ Copy of MD's or DO's schedule is attached.		
	II P 2 ☐	No evidence that MDs, DOs, PAs, and/or NPs are credentialed with IEHP.	☐ Office will confirm with IEHP credentialing department and show proof that providers are credentialed or is in the process.		
	II P 3 ☐	No evidence that NPs and/or PAs that prescribe controlled substances possess current and valid DEA registration number.	Current DEA registration is on site at all times. ☐ Copy of DEA registration is attached.		
	II P 4 ☐	There is no evidence that all required Professional License(s) and Certification(s) issued from appropriate licensing/certification agencies is current	Maintain current professional license(s) and certification(s) on site at all times. ☐ Copy of license(s)/certification(s) is attached.		
	II P 5 ☐	No evidence the scope of practice for NPs is defined and there are standardized procedures signed and dated by both the supervising physician and NP annually	There is a Standards of Practice signed and kept on site at all times. ☐ Copy of Standards of Practice is attached.		

Health Plan verification and date	CRITERIA	Deficiency Cited/Reviewer Comments	Corrective Action	CORRECTION DATE AND /OR PRACTITIONERS COMMENTS.	Responsible MD or Designee at Site
	II P 6 ☐	There is no evidence of a practice agreement signed annually by both the Physician's Assistant (PA) and supervising Physician that includes all provisions as described in SB 697 Section 5 is present. (Section 3502.3 of Business and Professions Code)	There is a signed copy of the Physicians Agreement on site at all times. ☐ Copy of Practice Agreement is attached.		
	II P 7 ☐	The proper ratio of physician to mid-level practitioners supervised is not maintained at 1:4 NP, 1:3 CNM, 1:4 PA-C.	Proof of the provider schedule if more than one Urgent Care is supervised by the same physician to ensure the proper ratio. ☐ Copy of Provider and Mid-level practitioner schedule attached.		
	II P 8 ☐	Oversight of NP is not evidenced by a minimum of 10% medical record review by supervising physician	Proof of Provider oversight of NP. ☐ Copy of medical record documentation co-signed by Provider.		
	II P 9 ☐	Supervision of PA is not included in the practice agreement.	There is evidence of supervision of PA in Practice Agreement. ☐ Copy of Practice Agreement is attached.		
	II P 10 ☐	Oversight of PA is not evidenced by a minimum of 10% medical record review by supervising physician	Proof of Provider oversight of PA. ☐ Copy of medical record documentation co-signed by Provider.		

Health Plan verification and date	CRITERIA	Deficiency Cited/Reviewer Comments	Corrective Action	CORRECTION DATE AND /OR PRACTITIONERS COMMENTS.	Responsible MD or Designee at Site
	II P 11 ☐	Supervising physician/ specialty is unable to cover populations served.	There evidence that Supervising Physician/Specialty is able to cover population served. ☐ Copy of Supervising Physician's license is attached.		
	II P 12 ☐	Healthcare staff not wearing identification badges/tags.	Healthcare staff now has and are wearing identification badges with name and title. ☐ A copy of badges attached.		
	II P 13 ☐	There is no evidence that personnel are trained in procedures for medical and/or non-medical emergencies.	Personnel are now trained in procedures to handle medical and/or non-medical emergencies. ☐ Copies of the policy & procedure for emergencies and the training in-service and sign-in sheet are attached.		
	II P 14 ☐	Physician credentialed with IEHP or delegated contractor with the stated specialties (Family Practice, Internal Medicine or Pediatrics) is not available for Midlevel practitioners to contact for consultation during all hours of operation.	Proof that credentialed Physician/Specialist is available for mid-level to contact for consultation during all hours of operation. ☐ Copy of policy and procedure for supervising Physician/Specialist to be available during all hours of operation attached.		

III. Office Management
Office Management Survey Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited/Reviewer Comments	Corrective Action	CORRECTION DATE AND /OR PRACTITIONERS COMMENTS.	Responsible MD or Designee at Site
	III O 1 ☐	Non-Qualified personnel handles emergent, urgent and medical advice telephone calls (Patient Triage).	Non-Qualified personnel has been educated on Policy and Procedure regarding appropriate handling of emergent, urgent and medical advice telephone calls according to the attached office procedure. ☐ Copy of policy & procedure attached.		
	III O 2 ☐	There is no policy in place for transfer of emergency patients to an appropriate facility.	A policy and procedure for the transfer of emergency patients to an appropriate facility has been written and staff educated. ☐ A copy of the policy & procedure is attached, as well as the in-service class outline and sign-in sheet.		
	III O 3 ☐	There is no evidence that the staff has received training/information regarding Patient Confidentiality	Staff has been trained regarding Patient Confidentiality and the location of reference information in the office. ☐ A copy of the office policy & procedure is attached, as well as the in-service class outline and sign-in sheet.		
	III O 4 ☐	There is no evidence that staff has received training on the handling/disposal of Biohazardous waste, and/or Blood Borne Pathogen Exposure.	Staff has been trained on the handling and disposal of Biohazardous waste, and/or Blood Borne Pathogen Exposure. ☐ A copy of the office policies & procedures is attached, as well as the in-service class outline and sign-in sheet.		

Health Plan verification and date	CRITERIA	Deficiency Cited/Reviewer Comments	Corrective Action	CORRECTION DATE AND /OR PRACTITIONERS COMMENTS.	Responsible MD or Designee at Site
	III O 5 ☐	Patient Rights not posted. There is no system for complaints/grievances noted.	Patient Rights now posted. A system has been implemented for handling complaints/grievances. ☐ A copy of the office policy & procedure is attached.		
	III O 6 ☐	No documentation that staff has been trained on Child/Elder/Domestic Abuse.	Staff now trained on requirements of Child/Elder/Domestic Abuse reporting. ☐ A copy of the office policies & procedures is attached, as well as the in-service class outline and sign-in sheet.		
	III O 7 ☐	No evidence that staff is knowledgeable about interpreter services.	Staff has had training regarding interpreter services. ☐ A copy of the in-service class outline and sign-in sheet is attached.		

IV. Clinical Services
A. Clinical Services Survey Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited/Reviewer Comments	Corrective Action	CORRECTION DATE AND /OR PRACTITIONERS COMMENTS.	Responsible MD or Designee at Site
	IV CS A1 ☐	Daily temperature reading of the medication refrigerator is not documented.	A log with daily readings of the refrigerator temperature has been implemented. ☐ A copy of the log is attached.		
	IV CS A2 ☐	**No evidence that only lawfully authorized persons prepare, administer and dispense drugs to patients.**	Drugs now dispensed only by lawfully authorized personnel. ☐ A copy of the policy & procedure is attached.	**MUST BE COMPLETED WITHIN 10 DAYS OF SITE REVIEW (SEE CE CAP TOOL)**	
	IV CS A3 ☐	Medications, syringes, etc, not properly stored in a secure place that is inaccessible to patients.	☐ Medications, syringes, etc., are now stored in a secure, inaccessible place.		
	IV CS A4 ☐	Controlled drugs are not stored in a separate, locked space. No dose-by-dose log is maintained.	Controlled drugs have been stored separately from others, in an area that is kept locked at all times, with the keys controlled by authorized clinic personnel. A dose-by-dose log is now being kept. ☐ A copy of the log is attached		
	IV CS A5 ☐	Expired drugs were found on site.	All drugs have current expiration dates on containers. Expired drugs have been removed from dispensing area and are disposed of using the drug and hazardous substance disposal procedure. ☐ A copy of the policy & procedure is attached		
	IV CS A6 ☐	There is no designated "clean" area in which to prepare medication.	☐ A "clean" area for medication preparation has now been clearly designated and labeled.		

IV. Clinical Services
B. Laboratory Services Survey Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited/Reviewer Comments	Corrective Action	CORRECTION DATE AND /OR PRACTITIONERS COMMENTS.	Responsible MD or Designee at Site
	IV CS B1 ☐	There is no CLIA certificate or waiver on site.	A CLIA waiver or certificate has now been obtained. ☐ A copy is attached.		
	IV CS B2 ☐	There is no evidence that laboratory services are available on-site or off-site for H&H with stat results available within 1-hour.	Laboratory services are now available on-site or off-site for H&H with stat results within 1-hour. ☐ Copy of policy and procedure attached.		
	IV CS B3 ☐	There is no evidence that all required minimum lab tests are performed on site	Minimal lab tests, including, HCG, hemoglobin or hematocrit, blood glucose, urine dipstick, rapid strep and STD collection are now performed on site. ☐ Copy of receipts attached.		
	IV CS B4 ☐	There is no evidence that personnel performing lab tests have been trained.	Personnel have been appropriately trained. ☐ A copy of the office policies & procedures is attached, as well as the in-service class outline and sign-in sheet.		
	IV CS B5 ☐	Lab test supplies are accessible to unauthorized persons.	☐ Lab supplies have now been moved to a secure location that is inaccessible to unauthorized persons.		
	IV CS B6 ☐	There are expired lab supplies on site.	☐ Site has now disposed of all expired lab supplies.		
	IV CS B7 ☐	Site has no policy & procedure to dispose of expired lab supplies.	There is now a policy & procedure in place to address the disposal of unused lab supplies. ☐A copy of the policy & procedure is attached.		

IV. Clinical Services
C. Radiology Services Survey Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited/Reviewer Comments	Corrective Action	CORRECTION DATE AND /OR PRACTITIONERS COMMENTS.	Responsible MD or Designee at Site
	IV CS C1 ☐	There is no current CA Radiologic Health Branch Inspection Report on site.	A current Radiologic Inspection Report has now been obtained. ☐ A copy of the report is attached.		
	IV CS C2 ☐	No radiological equipment on site and member has no immediate access to diagnostic radiology services (plain film x-rays) and with urgent results not made available to member and PCP a. Chest and Limb x-rays	☐ Copy of Policy and Procedure regarding immediate radiology equipment access and with urgent results available to member and Provider.		
	IV CS C3 ☐	There is no Title 17 on site and no notice regarding Title 17 is posted.	☐ The site now has a current copy of Title 17 on site and a notice of availability is posted.		
	IV CS C4 ☐	Radiation Safety Operation Procedures are not posted.	☐ A copy of the Radiation Safety Operation Procedures has now been posted in a visible location.		
	IV CS C5 ☐	There is no, “Notice to Employees”, poster.	☐ The, “Notice to Employees”, poster has been obtained and posted in a visible location.		

Health Plan verification and date	CRITERIA	Deficiency Cited/Reviewer Comments	Corrective Action	CORRECTION DATE AND /OR PRACTITIONERS COMMENTS.	Responsible MD or Designee at Site
	IV CS C6 ☐	There is no "Caution X-ray", sign.	☐ A, "Caution X-ray", sign has been obtained and posted in a visible location.		
	IV CS C7 ☐	No posted Physician Supervisor/Operator certificate is posted, or certificate has expired.	A current Physician Supervisor/Operator certificate has been obtained and is posted in a visible location. ☐ A copy of the certificate is attached.		
	IV CS C8 ☐	No technologist certificate is posted or certificate has expired.	A current technologist certificate has been obtained and is now posted. ☐ A copy of the certificate is attached.		
	IV CS C9 ☐	No operator protective devices available on site.	Protective devices (lead apron or shield) have now been obtained. ☐ A copy of the receipt is attached.		
	IV CS C1 10 ☐	No gonadal shield is available on site. (0.5mm or greater lead equivalent)	A gonadal shield has now been obtained. ☐ A copy of the receipt is attached.		
	IV CS C 11 ☐	There is no evidence that urgent x-ray results are made available to the Member and PCP	Urgent x-ray results are now available to the Member and PCP ☐ Copy of policy and procedure attached		

V. Minimum Required Equipment
Equipment Survey Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited/Reviewer Comments	Corrective Action	CORRECTION DATE AND /OR PRACTITIONERS COMMENTS.	Responsible MD or Designee at Site
	VME 1 ☐	Exam tables and lights are not in good repair.	Each exam table has a protective barrier that is changed between patients. ☐ The exam table(s) has been repaired and is in good working order. A copy of the repair invoice is attached. ☐ The light(s) has been repaired. A copy of the repair or replacement invoice is attached.		
	VME 2 ☐	Stethoscopes and sphygmomanometer with various size cuffs are not available.	Stethoscopes and blood pressure units with adult/pediatric /extra large and/or thigh cuffs have been obtained. ☐ A copy of the receipt is attached.		
	VME 3 ☐	No thermometers (oral or tympanic) on site.	Thermometers have been purchased and are kept on site. ☐ A copy of the receipt is attached.		
	VME 4 ☐	No adult balance scale and/or infant scale on site.	Scale has been purchased. ☐ A copy of the receipt is attached.		
	VME 5 ☐	No basic exam equipment: percussion hammer, tongue blades, patient gowns are available on site.	Basic exam equipment has been purchased and is available on site. ☐ A copy of the receipt(s) is attached.		

Health Plan verification and date	CRITERIA	Deficiency Cited/Reviewer Comments	Corrective Action	CORRECTION DATE AND /OR PRACTITIONERS COMMENTS.	Responsible MD or Designee at Site
	VME 6 ☐	No ophthalmoscope available on site.	Ophthalmoscope has been purchased. ☐ A copy of the receipt is attached.		
	VME 7 ☐	No otoscope with adult and pediatric speculums available on site	Otoscope and speculums have been purchased. ☐ A copy of the receipt is attached.		
	VME 8 ☐	No EKG machine available on site.	EKG machine has been purchased. ☐ Copy of receipt is attached.		
	VME 9 ☐	No nebulizer available on site.	Nebulizer has been purchased. ☐ Copy of receipt attached.		
	VME 10 ☐	No splinting materials available on site.	Splinting materials have been purchased. ☐ Copy of receipt attached.		
	VME 13 ☐	No wound irrigation supplies available on site.	Wound irrigation supplies have been purchased. ☐ Copy of receipt attached.		
	VME 14	No eye or ear irrigation supplies available on site.	Eye irrigation supplies have been purchased. Ear irrigation supplies have been purchased.		

	☐		☐ Copy of receipt attached.		
Health Plan verification and date	**CRITERIA**	**Deficiency Cited/Reviewer Comments**	**Corrective Action**	**CORRECTION DATE AND /OR PRACTITIONERS COMMENTS.**	**Responsible MD or Designee at Site**
	V ME 15 ☐	No eye tray available on site.	Eye Tray has been purchased. ☐ Copy of receipt attached.		
	V ME 17 ☐	No suture kits and/or materials on site.	Suture kits and materials have been purchased. ☐ Copy of receipt attached.		
	V ME 18 ☐	No dressing supplies available on site.	Dressing supplies have been purchased. ☐ Copy of receipt attached.		
	V ME 19 ☐	No eye chart (literate or illiterate) and/or occluder for vision testing on site	Eye chart has been purchased occluder has been obtained. ☐ Copy of receipt attached.		
	V ME 20 ☐	Pulse Oximetry	Pulse Oximetry has been purchased. ☐ Copy of receipt attached.		
	V ME 21 ☐	**Oxygen (Oxygen tank was not the required minimum of ¾ full)**	Oxygen tank is a required criterion ☐ Copy of receipt attached.	**MUST BE COMPLETED WITHIN 10 DAYS OF SITE REVIEW (SEE CE CAP TOOL)**	

Health Plan verification and date	CRITERIA	Deficiency Cited/Reviewer Comments	Corrective Action	CORRECTION DATE AND /OR PRACTITIONERS COMMENTS.	Responsible MD or Designee at Site
	V ME 22 ☐	**Appropriate sizes of ESIP needles/syringes**	Proof of appropriate size safety needles. ☐ Copy of receipt attached.	**MUST BE COMPLETED WITHIN 10 DAYS OF SITE REVIEW (SEE CE CAP TOOL)**	
	V ME 23 ☐	Alcohol wipes not present	Proof of alcohol wipes. ☐ Copy of receipt attached.		
VI. Minimum Required Medications Medication Survey Criteria					
	VI MM 1 ☐	No Albuterol for inhalation available on site.	Albuterol has been purchased. ☐ Copy of receipt attached.		
	VI MM 2 ☐	No Epinephrine 1:1000 for anaphylaxis is available on site.	Epinephrine 1:1000 has been purchased. ☐ Copy of receipt attached.		
	VI MM 3 ☐	No Benadryl IM or PO available on site.	Benadryl IM or PO has been purchased. ☐ Copy of receipt attached.		

Health Plan verification and date	CRITERIA	Deficiency Cited/Reviewer Comments	Corrective Action	CORRECTION DATE AND /OR PRACTITIONERS COMMENTS.	Responsible MD or Designee at Site
	VIMM 4 ☐	No Burn Dressing available on site.	Burn Dressing has been purchased. ☐ Copy of receipt attached.		
	VIMM 5 ☐	No Tylenol and Motrin available on site.	Tylenol and Motrin have been purchased. ☐ Copy of receipt attached.		
	VIMM 6 ☐	No anti-nausea medication available on site.	Anti-nausea medication has been purchased. ☐ Copy of receipt attached.		
	VIMM 7 ☐	No anti-diarrheal medication available on site.	Anti-diarrheal medication has been purchased. ☐ Copy of receipt attached.		
	VIMM 8 ☐	No injectable Antibiotics available on site.	Injectable Antibiotics have been purchased. ☐ Copy of receipt attached.		
	VIMM 9 ☐	No Tdap available on site.	Tdap has been purchased. ☐ Copy of receipt attached.		

Health Plan verification and date	CRITERIA	Deficiency Cited/Reviewer Comments	Corrective Action	CORRECTION DATE AND /OR PRACTITIONERS COMMENTS.	Responsible MD or Designee at Site
	VI MM 10 ☐	No Xylocaine available on site.	Xylocaine has been purchased. ☐ Copy of receipt attached.		
	VI MM 11 ☐	No Fluorescein drops or strips available on site.	Fluorescein has been purchased. ☐ Copy of receipt attached.		
	VI MM 12 ☐	No Naloxone available on site.	Naloxone has been purchased. ☐ Copy of receipt attached.		
	VI MM 13 ☐	No chewable Aspirin available on site.	Chewable Aspirin has been purchased ☐ Copy of receipt attached.		
	VI MM 14 ☐	No Nitroglycerine spray/ tablet available on site.	Nitroglycerine spray / tablet has been purchased. ☐ Copy of receipt attached.		
	VI MM 15 ☐	No glucose available on site.	Glucose has been purchased. ☐ Copy of receipt attached.		

VII. Infection Control
Infection Control Survey Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited/Reviewer Comments	Corrective Action	CORRECTION DATE AND /OR PRACTITIONERS COMMENTS.	Responsible MD or Designee at Site
	VII IC 1 ☐	**Personal protective equipment is not readily available for staff use.**	A Blood Borne Pathogen Protection kit has been purchased and is available for use. This kit provides a spill clean-up pack and a protective apparel pack. ☐ A copy of the receipt is attached.	**MUST BE COMPLETED WITHIN 10 DAYS OF SITE REVIEW (SEE CE CAP TOOL)**	
	VII IC 2 ☐	**Needle stick safety precautions are not practiced on site.**	Needle stick precautions have been implemented, sharps containers are located close to immediate area where sharps are used and are inaccessible to unauthorized persons. Needleless systems, needle devices and non-needle sharps have been purchased. ☐ A copy of the receipt is attached.	**MUST BE COMPLETED WITHIN 10 DAYS OF SITE REVIEW (SEE CE CAP TOOL)**	
	VII IC 3 ☐	**Blood and other potentially infectious material and regulated wastes are not placed in appropriate *leak proof, labeled* containers for collection, handling, processing, storage, transport or shipping.**	☐ Blood and other potentially infectious materials and regulated wastes are now placed in leak proof, labeled containers.	**MUST BE COMPLETED WITHIN 10 DAYS OF SITE REVIEW (SEE CE CAP TOOL)**	

Health Plan verification and date	CRITERIA	Deficiency Cited/Reviewer Comments	Corrective Action	CORRECTION DATE AND /OR PRACTITIONERS COMMENTS.	Responsible MD or Designee at Site
	VII IC 4 ☐	**Spore testing of autoclave/steam sterilizer with documented results is not done monthly.**	Monthly spore testing of the autoclave/steam sterilizer has been implemented. ☐ Copies of the autoclave service and spore testing results are attached.	**MUST BE COMPLETED WITHIN 10 DAYS OF SITE REVIEW (SEE CE CAP TOOL)**	
	VII IC 5 ☐	Manufacturer's recommendations are not strictly followed for proper cold chemical sterilization of instruments/equipment.	Strict following of manufacturer's recommendations has been reinforced to the staff. ☐ A copy of the in-service class outline and sign-in sheet are attached.		
	VII IC 6 ☐	Equipment and work surfaces are not appropriately cleaned and decontaminated after contact with blood or other potentially infectious material.	Equipment and work surfaces are cleaned immediately and decontaminated with appropriate solutions. ☐ A copy of the procedure is attached. ☐ A copy of the office in-service outline and sign-in sheet are attached.		
	VII IC 7 ☐	Autoclave/steam sterilization process manufacturer's directions are not strictly followed for instrument pre-clean, machine loading and operation of the autoclave or not performed by trained personnel.	Strict following of manufacturer's directions for the pre-cleaning of instruments and equipment, machine loading and operation has been reinforced to the staff. An in-service was conducted. ☐ A copy of the class outline and sign-in sheet is attached. ☐ The manufacturer's instructions have been prominently posted in the autoclave area for immediate reference by all staff.		

VIII. Medical Records
Medical Records Survey Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited/Reviewer Comments	Corrective Action	CORRECTION DATE AND /OR PRACTITIONERS COMMENTS.	Responsible MD or Designee at Site
	VIII MR 1 ☐	The medical records are not legible, organized with the contents securely fastened, nor maintained in a secure area.	☐ All entries are legible. The records have been organized with the documents securely fastened and are stored in a secure area.		
	VIII MR 2 ☐	Encounter date and/or patient name is not evident on each page.	☐ Each page now contains the date and the patient's name.		
	VIII MR 3 ☐	There is no notation of medication allergies/adverse reactions, or NKA.	☐ All charts now have medication allergies/adverse reactions, or NKA prominently noted.		
	VIII MR 4 ☐	No consents are evident for either general treatment or procedures.	A policy has been put in place to obtain patient consent for treatment/procedures. ☐ A copy of the office policy& procedure is attached.		
	VIII MR 5	There is no evidence of a targeted physical assessment, including vital signs.	☐ Targeted physical assessments are now being performed, including vital signs.		

	☐				
Health Plan verification and date	**CRITERIA**	**Deficiency Cited/Reviewer Comments**	**Corrective Action**	**CORRECTION DATE AND /OR PRACTITIONERS COMMENTS.**	**Responsible MD or Designee at Site**
	VIII MR 6 ☐	There is no documentation of acknowledgement of aftercare instructions being given to patients.	A system has now been put in place to assure that Patients will acknowledge understanding of appropriate aftercare instructions received. ☐ A copy of the office policy & procedure is attached.		
	VIII MR 7 ☐	There is no documentation that the patient's primary care physician was notified of the patient's urgent care visit.	A policy & procedure has now been put in place to notify PCPs of patient visits to the urgent care center. ☐ A copy of the office policy & procedure is attached.		

CAP COMPLETION SIGNATURE PAGE.

I have completed the corrective action plan for the Urgent Care Facility review performed on _____. I affirm each
(Enter Date of Review)

Corrective action has been implemented as indicated on the attached Corrective Action Plan.

_____	_____	_____
Physician/Designee Signature	**Printed Name and Title**	**Date**

Please Return Completed CAP
And this signature sheet. via U.S. Mail or FAX to:

Inland Empire Health Plan
Quality Management Department
P.O. Box 1800, Rancho Cucamonga, CA 91729-1800
Fax: (909) 890-5545 Attention: QM Coordinator

California Department of Health Care Services
Managed Care Quality and Monitoring Division

July 1, 2022

Facility Site Review Tool

Date: _____ **Health Plan Name or Code:** _____ **IPA:** _____

Last Review Date: _____ **Site ID:** _____ **Site NPI:** _____

Reviewer name/title: _____ **Provider Address:** _____

Reviewer name/title: _____ **City and Zip Code:** _____

Reviewer name/title: _____ **Phone:** _____ **Fax:** _____ **Current Fire Clearance:** _____

Contact person/title: _____

No. of staff on site: _____ **Physician** _____ **NP** _____ **CNM** _____ **LM** _____ **PA** _____ **RN** _____ **LVN** _____ **MA** _____ **Clerical** _____ **other**

Visit Purpose	Site-Specific Certification(s)	Provider Type	Clinic Type
_____ Initial Full Scope _____ Monitoring _____ Periodic Full Scope _____ Follow-up _____ Focused _____ Ed/TA _____Other _____ (type)	_____ AAAHC _____ JC _____ CHDP _____ NCQA _____ CPSP _____ None _____ PCMH _____ Other_____	_____ Family Practice _____ Internal Medicine _____ Pediatrics _____ OB/GYN _____General Practice _____ Specialist)	_____ Primary Care _____ Community _____ Hospital _____ FQHC _____ Rural Health _____ Solo _____ Medical Group _____ Staff/Teaching _____ Other _____ (type)

Site Scores

	Total Points Poss.	Points Given	No Points	N/As	CE*
I. Access/Safety	**31**				
II. Personnel	**27**				
III. Office Management	**25**				
IV. Clinical Services	**40**				
V. Preventive Services	**13**				
VI. Infection Control	**34**				
Totals	**170**				

*CE = Critical Elements. Indicate any CEs for easy reference to generate a CAP.

Scoring Procedure

1) Add points given in each section.
2) Add total points given for all six sections.
3) Adjust score for "N/A" criteria (if needed), by subtracting N/A points from 169 total points possible.
4) Divide total points given by "adjusted" total points.
5) Multiply by 100 to get the compliance (percent) rate.

__170__ - _____ = _____
N/A Points **Adjusted Points**

_____ ÷ _____ = _____ X 100 = _____%
Points Given **Total / Adjusted Points** **Decimal Compliance Score** **Rate**

Compliance Rate

_____ **Exempted Pass: 90% or above** (without deficiencies in Critical Elements, Pharmaceutical Services, or Infection Control)

_____ **Conditional Pass: 80-89%, or 90% and above** with deficiencies in Critical Elements, Pharmaceutical Services, or Infection Control

_____ **Fail: 79% and Below**

_____ CAP Required

_____ Other follow-up

Next Site Review Due: _____

I. Access/Safety Criteria	Yes	No	N/A	Wt.	Site Score
A. Site is accessible and useable by individuals with physical disabilities. Title 24, California Code of Regulations (CCR) (CA Building Standards Code); Title 28 Code of Federal Regulations (CFR) §35 (American Disabilities Act of 1990, Title II, Title III) All facilities designed, altered, or constructed after January 26, 1992, for the use of public entity must be readily accessible and usable by persons with disabilities. Sites must have the following safety accommodations for physically disabled persons:					
1) Clearly marked (blue) curb or sign designating disabled-parking space near accessible primary entrance.	1)	1)	1)	1	
2) Pedestrian ramps have a level landing at the top and bottom of the ramp.	2)	2)	2)	1	
3) Exit and exam room doorway openings allow for clear passage of a person in a wheelchair.	3)	3)	3)	1	
4) Accessible passenger elevator or reasonable alternative for multi-level floor accommodation.	4)	4)	4)	1	
5) Clear floor space for wheelchair in waiting area and exam room.	5)	5)	5)	1	
6) Wheelchair accessible restroom facilities.	6)	6)	6)	1	
7) Wheelchair accessible handwashing facilities or reasonable alternative.	7)	7)	7)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

I. Access/Safety Criteria, continued	Yes	No	N/A	Wt.	Site Score
B. Site environment is maintained in a clean and sanitary condition. 28 CCR §1300.80; 22 CCR §75062					
1) All patient areas including floor/carpet, walls, and furniture are neat, clean, and well maintained.	1)	1)	1)	1	
2) Restrooms are clean and contain appropriate sanitary supplies.	2)	2)	2)	1	
C. Site environment is safe for all patients, visitors, and personnel. 8 CCR §3220, §2299-2989; 22 CCR §53230; 24 CCR, §2, §3, §9; 28 CCR §1300.80; 29 CFR §1910.37, §1910.38, §1910.157, §1910.301, §1926.34 There is evidence staff has received safety training and/or has safety information available on the following:					
1) Fire safety and prevention.	1)	1)	1)	1	
2) Emergency non-medical procedures (e.g. site evacuation, workplace violence).	2)	2)	2)	1	
3) Lighting is adequate in all areas to ensure safety.	3)	3)	3)	1	
4) <u>Exit doors and aisles are unobstructed and egress (escape) accessible.</u>	**4)**	**4)**	**4)**	**2**	
5) Exit doors are clearly marked with “Exit” signs.	5)	5)	5)	1	
6) Clearly diagramed “Evacuation Routes” for emergencies are posted in a visible location at all elevators, stairs and exits.	6)	6)	6)	1	
7) Electrical cords and outlets are in good working condition.	7)	7)	7)	1	
8) Fire Fighting Equipment in accessible location	8)	8)	8)	1	
9) An employee alarm system.	9)	9)	9)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

RN/NP/CNM/LM/ MD/PA only

I. Access/Safety Criteria, continued	Yes	No	N/A	Wt.	Site Score
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week. 8 CCR §3220; 22 CCR §51056, §53216, §75031; 28 CCR §1300.67, §1300.80; American Academy of Family Practice (AAFP)					
1) Personnel are trained in procedures/action plan to be carried out in case of medical emergency on site.	1)	1)	1)	1	
2) Emergency equipment is stored together in easily accessible location and is ready to be used.	2)	2)	2)	1	
3) Emergency phone number contacts are posted, updated annually, and as changes occur.	3)	3)	3)	1	
Emergency medical equipment appropriate to practice/patient population is available on site:					
4) **Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag.**	**4)**	**4)**	**4)**	**2**	
5) Emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia. Epinephrine 1mg/ml (injectable) and Diphenhydramine (Benadryl) 25 mg (oral) or Diphenhydramine (Benadryl) 50 mg/ml (injectable), Naloxone, chewable Aspirin 81 mg, Nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), and glucose (any type of glucose containing at least 15 grams). Appropriate sizes of ESIP needles/syringes and alcohol wipes.	**5)**	**5)**	**5)**	**2**	
6) Medication dosage chart for all medications included with emergency equipment (or other method for determining dosage) is kept with emergency medications.	6)	6)	6)	1	
There is a process in place on site to:					
7) Document checking of emergency medication, equipment and supplies for expiration and operating status at least monthly.	7)	7)	7)	1	
8) Replace/re-stock emergency medication, equipment and supplies immediately after use.	8)	8)	8)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

RN/NP/CNM/LM/MD/PA only

I. Access/Safety Criteria, continued	Yes	No	N/A	Wt.	Site Score
E. Medical and lab equipment used for patient care is properly maintained. 28 CCR §1300.80; 21 CFR §800-1299; 22 CCR §75062; §53230					
1) Medical equipment is clean.	1)	1)	1)	1	
2) Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines.	2)	2)	2)	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **TOTALS**					

RN/NP/CNM/LM/MD/PA only

II. Personnel Criteria	Yes	No	N/A	Wt.	Site Score
A. Professional health care personnel have current California licenses and certifications. CA Business & Professional Code (BPC) §2050, §2099.5, §2506**,** §2725, §2746, §2835, §3500, §4110; CCR, Title 16, §1355.4, §1399.547					
1) All required Professional Licenses and Certifications, issued from the appropriate licensing/certification agency, are current.	1)	1)	1)	1	
2) Notification is provided to each member that the MD(s) is licensed and regulated by the Medical Board, and that the Physician Assistant(s) is licensed and regulated by the Physician Assistant Committee.	2)	2)	2)	1	
B. Health care personnel are properly identified. BPC §680					
1) Health care personnel wear identification badges/tags printed with name and title.	1)	1)	1)	1	
C. Site personnel are qualified and trained for assigned responsibilities. BPC §2069; 16 CCR §1366 - 1366.4					
1) Documentation of education/training for non-licensed medical personnel is maintained on site.	1)	1)	1)	1	
2) Only qualified/trained personnel retrieve, prepare, or administer medications.	**2)**	**2)**	**2)**	**2**	
3) Site has a procedure in place for confirming correct patient/medication/vaccine dosage and route prior to administration.	3)	3)	3)	1	
4) Only qualified/trained personnel operate medical equipment.	4)	4)	4)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

RN/NP/CNM/LM/MD/PA only

II. Personnel Criteria, continued	Yes	No	N/A	Wt.	Site Score
D. Scope of practice for non-physician medical practitioners (NPMP) is clearly defined. 16 CCR §1379, §1399.540, §1399.545, §1474; BPC §2725, §2746.5, §2746.51, §2836.1					
1) Standardized Procedures provided for Nurse Practitioners (NP) and/or Certified Nurse Midwives (CNM).	1)	1)	1)	1	
2) A Practice Agreement defines the scope of services provided by Physician Assistants (PA) and Supervisory Guidelines define the method of supervision by the Supervising Physician.	2)	2)	2)	1	
3) Standardized Procedures, Practice Agreements and Supervisory Guidelines are revised, updated and signed by the supervising physician and NPMP when changes in scope of services occur.	3)	3)	3)	1	
4) Each NPMP that prescribes controlled substances has a valid Drug Enforcement Administration Registration Number.	4)	4)	4)	1	
E. NPMPs are supervised according to established standards. BPC §3516(b); Welfare and Institutions Code (WIC) 14132.966; 16 CCR §1379; §1399.545					
The designated supervising physician(s) on site: 1) Ratio to number of NPMPs does not exceed established ratios in any combination. a) 1:4 NPs b) 1:4 CNMs c) 1:4 PAs	1)	1)	1)	1	
2) The designated supervising or back-up physician is available in person or by electronic communication at all times when a NPMP is caring for patients.	2)	2)	2)	1	
3) Evidence of NPMP supervision.	3)	3)	3)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

RN/NP/CNM/LM/MD/PA only

II. Personnel Criteria, continued	Yes	No	N/A	Wt.	Site Score
F. Site personnel receive safety training annually 8 CCR §5193; CA Health and Safety Code (HSC) §117600; CA Penal Code §11164, §11168; 29 CFR §1910.1030, 8 CCR §3342					
There is evidence that site staff has received **annual** training on the following: 1) Infection Control/Universal Precautions (annually)	1)	1)	1)	1	
2) Blood Borne Pathogens Exposure Prevention (annually)	2)	2)	2)	1	
3) Biohazardous Waste Handling (annually)	3)	3)	3)	1	
G. Site personnel receive training on member rights. 22 CCR §51009, §51305.1, §53452, §53858; 28 CCR §1300.68; 42 CFR §438.206 (6); 42 CFR §438.224; 42 CFR §438.10 (g); HSC 124260, 1374.16; CA Penal Code §11164, §1166.5, §11168, Family Code 6920, 6924, 6930; National Youth law					
There is evidence that site staff has received training on the following: 1) Patient confidentiality	1)	1)	1)	1	
2) Informed Consent, including human sterilization	2)	2)	2)	1	
3) Prior Authorization requests	3)	3)	3)	1	
4) Grievance/Complaint Procedure	4)	4)	4)	1	
5) Child/Elder/Domestic Violence Abuse	5)	5)	5)	1	
6) Sensitive Services/Minors' Rights	6)	6)	6)	1	
7) Health Plan referral process/procedures/resources	7)	7)	7)	1	
8) Cultural and linguistics	8)	8)	8)	1	
9) Disability Rights and Provider Obligations	9)	9)	9)	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **TOTALS**					

III. Office Management Criteria	Yes	No	N/A	Wt.	Site Score
A. Physician coverage is available 24 hours a day, 7 days a week. 22 CCR §56500, §53855 The following are maintained current on site:					
1) Clinic office hours are posted or readily available upon request.	1)	1)	1)	1	
2) Provider office hour schedules are available to staff.	2)	2)	2)	1	
3) Arrangement/schedule for after-hours, on-call, supervisory back-up physician coverage is available to site staff.	3)	3)	3)	1	
4) Contact information for off-site physician(s) is available at all times during office hours.	4)	4)	4)	1	
5) Routine, urgent and after-hours emergency care instructions/telephone information is made available to patients.	5)	5)	5)	1	
B. There are sufficient health care personnel to provide timely, appropriate health care services. 22 CCR §53855; 28 CCR §1300.67.1, §1300.80					
1) Appropriate personnel handle emergent, urgent, and medical advice telephone calls.	1)	1)	1)	1	
2) Telephone answering machine, voice mail system, or answering service is used whenever office staff does not directly answer phone calls.	2)	2)	2)	1	
3) Telephone system, answering service, recorded telephone information, and recording device are periodically checked and updated.	3)	3)	3)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

RN/NP/CNM/LM/MD/PA only

III. Office Management Criteria, continued	Yes	No	N/A	Wt.	Site Score
C. Health care services are readily available. 22 CCR §56000(2); 28 CCR §1300.67.2.2					
1) Appointments are scheduled according to patients stated clinical needs within the timeliness standards established for Plan members.	1)	1)	1)	1	
2) Patients are notified of scheduled routine and/or preventive screening appointments.	2)	2)	2)	1	
3) There is a process in place verifying follow-up on missed and canceled appointments.	3)	3)	3)	1	
D. There is 24-hour access to interpreter services for non- or limited-English proficient (LEP) members. 22 CCR §53851; 28 CCR 1300.67.04					
1) Interpreter services are made available in identified threshold languages specified for location of site.	1)	1)	1)	1	
2) Persons providing language interpreter services, including sign language on site, are trained in medical interpretation.	2)	2)	2)	1	
E. Procedures for timely referral/consultative services are established on site. 22 CCR §53851; 28 CCR §1300.67, §1300.80					
Office practice procedures allow timely provision and tracking of:					
1) Processing internal and external referrals, consultant reports, and diagnostic test results.	1)	1)	1)	1	
2) **Physician Review and follow-up of referral/consultation reports and diagnostic test results.**	**2)**	**2)**	**2)**	**2**	
F. Member Grievance/Complaint processes are established on site. 22 CCR §53858, §56260					
1) Phone number(s) for filing grievances/complaints are located on site.	1)	1)	1)	1	
2) Complaint forms and a copy of the grievance procedure are available on site.	2)	2)	2)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

III. Office Management Criteria, continued	Yes	No	N/A	Wt.	Site Score
G. Medical records are available for the practitioner at each scheduled patient encounter. 22 CCR §75055; 28 CCR §1300.80					
1) Medical records are readily retrievable for scheduled patient encounters.	1)	1)	1)	1	
2) Medical documents are filed in a timely manner to ensure availability for patient encounters.	2)	2)	2)	1	
H. Confidentiality of personal medical information is protected according to State and federal guidelines.					
1) Exam rooms and dressing areas safeguard patients' right to privacy.	1)	1)	1)	1	
2) Procedures are followed to maintain the confidentiality of personal patient information.	2)	2)	2)	1	
3) Medical record release procedures are compliant with State and federal guidelines.	3)	3)	3)	1	
4) Storage and transmittal of medical records preserves confidentiality and security.	4)	4)	4)	1	
5) Medical records are retained for a minimum of 10 years.	5)	5)	5)	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **TOTALS**					

IV. Clinical Services: Pharmaceutical Services Criteria	Yes	No	N/A	Wt.	Site Score
A. Drugs and medication supplies are maintained secure to prevent unauthorized access. BPC §4172; 22 CCR §75032, §75033, §75037(a-g), §75039; 21 CFR §1301.72, §1301.75, §1301.76, §1302; 16 CCR §1356.3; HSC §11053-11058					
1) Drugs are stored in specifically designated cupboards, cabinets, closets or drawers.	1)	1)	1)	1	
2) Prescription drug samples, and over-the-counter drugs, hypodermic needles/syringes, all medical sharp instruments, hazardous substances, and prescription pads are securely stored in a lockable space (cabinet or room) within the office/clinic.	2)	2)	2)	1	
3) Controlled drugs are stored in a locked space accessible only to authorized personnel.	3)	3)	3)	1	
4) A dose-by-dose controlled substance distribution log is maintained.	4)	4)	4)	1	
5) Written site-specific policy/procedure for dispensing of sample drugs are available on site.	5)	5)	5)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

RN/NP/CNM/LM/MD/PA only

IV. Clinical Services: Pharmaceutical Services Criteria, continued	Yes	No	N/A	Wt.	Site Score
B. Drugs are handled safely and stored appropriately. 22 CCR §75037(a-g), §75039; 21 CFR §211.137; 21 USC §351; HSC §117600-118360; 40 CFR, part 261; Current CDC Recommendations					
1) Drugs are prepared in a clean area or "designated clean" area if prepared in a multi-purpose room.	1)	1)	1)	1	
2) Drugs for external use are stored separately from drugs for internal use.	2)	2)	2)	1	
3) Items other than medications in refrigerator/freezer are kept in a secured, separate compartment from drugs.	3)	3)	3)	1	
4) Refrigerator thermometer temperature is 36º-46º Fahrenheit or 2º-8º Centigrade (at time of site visit).	4)	4)	4)	1	
5) Freezer thermometer temperature is 5º Fahrenheit or –15º Centigrade, or lower (at time of site visit).	5)	5)	5)	1	
6) Site utilizes drugs/vaccine storage units that are able to maintain required temperature.	6)	6)	6)	1	
7) Daily temperature readings of drugs/vaccines refrigerator and freezer are documented.	7)	7)	7)	1	
8) Has a written plan for vaccine protection in case of power outage or malfunction of the refrigerator or freezer.	8)	8)	8)	1	
9) Drugs and vaccines are stored separately from test reagents, germicides, disinfectants, and other household substances.	9)	9)	9)	1	
10) Hazardous substances are appropriately labeled.	10)	10)	10)	1	
11) Site has method(s) in place for drug and hazardous substance disposal.	11)	11)	11)	1	

Comments: (Write comments for all "No" (0 points) and "N/A" scores.)

RN/NP/CNM/LM/MD/PA only

IV. Clinical Services: Pharmaceutical Services Criteria, continued	Yes	No	N/A	Wt.	Site Score
C. Drugs are dispensed according to State and federal drug distribution laws and regulations. BPC §4024, §4076, §4170, §4171, §4173, §4174; 22 CCR §75032, §75033, §75036, §75037(a-g), §75038, §75039; 16 CCR §1718.1; 21 CFR §211.137; 42 USC 6A §300AA-26; CDC Recommendations; DHCS Contract; All Plan Letter 18-004; BPC §4000 et seq (Pharmacy Law); §4170; HSC §11000-11651 (Uniform Controlled Substances Act)					
1) There are no expired drugs on site.	1)	1)	1)	1	
2) Site has a procedure to check expiration date of all drugs (including vaccines and samples), and infant and therapeutic formulas.	2)	2)	2)	1	
3) All stored and dispensed prescription drugs are appropriately labeled.	3)	3)	3)	1	
4) **Only lawfully authorized persons dispense drugs to patients.**	**4)**	**4)**	**4)**	**2**	
5) **Drugs and Vaccines are prepared and drawn only prior to administration.**	**5)**	**5)**	**5)**	**2**	
6) Current Vaccine Information Sheets (VIS) for distribution to patients are present on site.	6)	6)	6)	1	
7) If there is a pharmacy on site, it is licensed by the CA State Board of Pharmacy.	7)	7)	7)	1	
8) Site utilizes California Immunization Registry (CAIR) or the most current version.	8)	8)	8)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

IV. Clinical Services: Laboratory Services Criteria	Yes	No	N/A	Wt.	Site Score
D. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations. 22 CCR §51211.2, §51137.2; BPC §1200-1214, §1229, §1220; 42 USC 263a; Public Law 100-578; www.cms.gov; www.fda.gov					
1) Laboratory test procedures are performed according to current site-specific CLIA certificate.	1)	1)	1)	1	
2) Testing personnel performing clinical lab procedures have been trained.	2)	2)	2)	1	
3) Lab supplies (e.g. vacutainers, vacutainer tubes, culture swabs, test solutions) are inaccessible to unauthorized persons.	3)	3)	3)	1	
4) Lab test supplies are not expired.	4)	4)	4)	1	
5) Site has a procedure to check expiration date and a method to dispose of expired lab test supplies.	5)	5)	5)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

IV. Clinical Services: **Radiology Services Criteria**	**Yes**	**No**	**N/A**	**Wt.**	**Site Score**
E. Site meets CDPH Radiological inspection and safety regulations. 17 CCR §30110, §30111, §30255, §30305, §30404, §30405; https://www.cdph.ca.gov/rhb or (916) 327-5106					
1) Site has current CA Radiologic Health Branch Inspection Report and Proof of Registration if there is radiological equipment on site.	1)	1)	1)	1	
The following documents are <u>posted</u> on site: 2) Current copy of Title 17 with a posted notice about availability of Title 17 and its location.	2)	2)	2)	1	
3) "Radiation Safety Operating Procedures" posted in highly visible location.	3)	3)	3)	1	
4) "Notice to Employees Poster" posted in highly visible location.	4)	4)	4)	1	
5) "Caution, X-ray" sign posted on or next to door of each room that has X-ray equipment.	5)	5)	5)	1	
6) Physician Supervisor/Operator certificate posted *and* within current expiration date.	6)	6)	6)	1	
7) Technologist certificate posted *and* within current expiration date.	7)	7)	7)	1	
The following radiological protective equipment is present on site: 8) Operator protection devices: radiological equipment operator must use lead apron or lead shield.	8)	8)	8)	1	
9) Gonadal shield (0.5 mm or greater lead equivalent): for patient procedures in which gonads are in direct beam.	9)	9)	9)	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **TOTALS**					

V. Preventive Services	Yes	No	N/A	Wt.	Site Score
A. Preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases. 22 CCR §53851; 28 CCR §1300.67 Examination equipment, appropriate for primary care services, is available on site:					
1) Exam tables and lights are in good repair.	1)	1)	1)	1	
2) Stethoscope and sphygmomanometer with various size cuffs (e.g. child, adult, obese/thigh).	2)	2)	2)	1	
3) Thermometer with a numeric reading**.**	3)	3)	3)	1	
4) Basic exam equipment: percussion hammer, tongue blades, patient gowns.	4)	4)	4)	1	
5) Scales: standing balance beam and infant scales.	5)	5)	5)	1	
6) Measuring devices for stature (height/length) measurement and head circumference measurement.	6)	6)	6)	1	
7) Eye charts (literate and illiterate) and occluder for vision testing.	7)	7)	7)	1	
8) Ophthalmoscope.	8)	8)	8)	1	
9) Otoscope with multi-size ear speculums appropriate to the population served.	9)	9)	9)	1	
10) A pure tone, air conduction audiometer is located in a quiet location for testing.	10)	10)	10)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

V. Preventive Services: Health Education Criteria	Yes	No	N/A	Wt.	Site Score
B. Health education services are available to Plan members. 22 CCR §53851; 28 CCR 1300.67					
Health education materials and Plan-specific resource information are: 1) Readily accessible on site or are made available upon request.	1)	1)	1)	1	
2) Applicable to the practice and population served on site.	2)	2)	2)	1	
3) Available in threshold languages identified for county and/or area of site location.	3)	3)	3)	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **TOTALS**					

RN/NP/CNM/LM/MD/PA only

VI. Infection Control Criteria	Yes	No	N/A	Wt.	Site Score
A. Infection control procedures for Standard/Universal precautions are followed. 8 CCR §5193; 22 CCR §53230; 29 CFR §1910.1030; Federal Register 1989, §54:23042					
1) Soap or antiseptic hand cleaner and running water are available in exam and/or treatment areas for hand washing.	1)	1)	1)	1	
2) A waste disposal container is available in exam rooms, procedure/treatment rooms, and restrooms.	2)	2)	2)	1	
3) Site has procedure for effectively isolating infectious patients with potential communicable conditions.	3)	3)	3)	1	
B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. 8 CCR §5193 (Cal OSHA Health Care Worker Needlestick Prevention Act, 1999); HSC, §117600-118360 (CA Medical Waste Management Act, 1997, updated January 2017); 29 CFR §1910.1030; 49 CCR §173.6; 49 CFR, Section 173.6; CDC Core Infection Prevention and Control Practices -Centers for Disease Control and Prevention (CDC) The Healthcare Infection Control Advisory Committee (HICPAC), 2016; 2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare settings.					
1) **Personal Protective Equipment (PPE) for Standard Precautions is readily available for staff use.**	**1)**	**1)**	**1)**	**2**	
2) Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport or shipping.	**2)**	**2)**	**2)**	**2**	
3) **Needlestick safety precautions are practiced on site.**	**3)**	**3)**	**3)**	**2**	
4) All sharp injury incidents are documented.	4)	4)	4)	1	
5) Biohazardous (non-sharp) wastes are contained separate from other trash/waste.	5)	5)	5)	1	
6) Storage areas for regulated medical wastes are maintained secure and inaccessible to unauthorized persons.	6)	6)	6)	1	
7) Contaminated laundry is laundered at the workplace or by a commercial laundry service.	7)	7)	7)	1	
8) Transportation of regulated medical wastes is only by a registered hazardous waste hauler or to a central location of accumulation in limited quantities (up to 35.2 pounds).	8)	8)	8)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

RN/NP/CNM/LM/MD/PA only

VI. Infection Control Criteria, continued	Yes	No	N/A	Wt.	Site Score
C. Contaminated surfaces are decontaminated according to Cal-OSHA Standards. 8 CCR §5193; HSC §118275					
1) Equipment and work surfaces are appropriately cleaned and decontaminated after contact with blood or other potentially infectious material.	1)	1)	1)	1	
2) Routine cleaning and decontamination of equipment/work surfaces is completed according to site-specific written schedule.	2)	2)	2)	1	
Disinfectant solutions used on site are: 3) Approved by the Environmental Protection Agency (EPA).	3)	3)	3)	1	
4) Effective in killing HIV/HBV/TB.	4)	4)	4)	1	
5) Follow manufacturer instructions.	5)	5)	5)	1	

Comments: (Write comments for all “No” (0 points) and “N/A” scores.)

RN/NP/CNM/LM/MD/PA only

VI. Infection Control Criteria, continued	Yes	No	N/A	Wt.	Site Score
D.Reusable medical instruments are properly sterilized after each use. 22 CCR §53230, §53856; CDC guideline for disinfection and sterilization; Food and Drug Administration: Reprocessing medical equipment in health care setting.					
1) Written site-specific policy/procedures or manufacturer's instructions for instrument/equipment sterilization are available to staff.	1)	1)	1)	1	
Staff adheres to site-specific policy and/or manufacturer/product label directions for the following procedures:					
2) Cleaning reusable instruments/equipment prior to sterilization.	2)	2)	2)	1	
3) Cold chemical sterilization/high level disinfection:					
a) Staff demonstrate/verbalize necessary steps/process to ensure sterility and/or high-level disinfection of equipment.	**3a)**	**3a)**	**3a)**	**2**	
b) Confirmation from manufacturer item(s) is/are heat sensitive.	3b)	3b)	3b)	1	
c) Appropriate PPE is available, exposure control plan, Material Safety Data Sheets and clean up instructions in the event of a cold chemical sterilant spill.	**3c)**	**3c)**	**3c)**	**2**	
4) Autoclave/steam sterilization.					
a) Staff demonstrate/verbalize necessary steps/process to ensure sterility.	4a)	4a)	4a)	1	
b) Autoclave maintenance per manufacturer's guidelines.	4b)	4b)	4b)	1	
c) **Spore testing of autoclave/steam sterilizer with documented results (at least monthly).**	**4c)**	**4c)**	**4c)**	**2**	
d) **Management of positive mechanical, chemical, and biological indicators of the sterilization process.**	**4d)**	**4d)**	**4d)**	**2**	
e) Sterilized packages are labeled with sterilization date and load identification information.	4e)	4e)	4e)	1	
f) Storage of sterilized packages.	4f)	4f)	4f)	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **TOTALS**					

California Department of Health Care Services
Managed Care Quality and Monitoring Division

July 1, 2022

Medical Record Review Standards

Purpose: The Medical Record Review (MRR) Standards provide instructions, rules, regulations, parameters, and indicators for conducting medical record reviews using the MRR Tool. The site reviewer must use these Standards for measuring, evaluating, assessing, and making decisions.

Medical Record Selection: Medical records shall be randomly selected using methodology decided upon by the reviewer. Ten (10) medical records are reviewed for each primary care physician (PCP) site. For sites with *only* adult or *only* pediatric patient members, all ten records reviewed will be in *only* one preventive care criteria. For sites with adult and pediatric members, five (5) adults and five (5) pediatrics preventive criteria will be reviewed. For PCP sites where the OB-GYN providers both specialty and preventive services, based on the age of the patient, reviewer must review either adult or pediatric preventive criteria as well as OB Comprehensive Perinatal Services Program (CPSP) criteria.

PCP sites that document patient care performed by multiple PCPs in the same medical record are considered "shared." The MCP must consider shared medical records as those that are not identifiable as "separate" records belonging to any specific PCP. Scores calculated on shared medical records apply only to PCPs sharing the records. A minimum of ten shared records shall be reviewed for 2-3 PCPs, 20 records for 4-6 PCPs, and 30 records for 7 or more PCPs based on specialty and/or population served.

Example for determining the number of medical records to review:

> A site that has three (3) providers, two (2) providers see only adults and share records, and one (1) only see pediatrics and does not share records, 10 medical records on the two providers who share medical records and 10 medical records on the provider who does not share records will be conducted and scored separately. A total of 20 medical records shall be reviewed for this site. Two (2) scores will be reported for this site.

Reviewers are expected to determine the most appropriate method(s) on each site to ascertain information needed to complete the review. Review criteria that shall be reviewed *only* by a registered nurse (RN), nurse practitioner (NP), physician (MD), physician assistant (PA), Certified Nurse Midwife (CNM), or Licensed Midwife is labeled "**RN/NP/MD/PA/CNM/LM".**

Reviewers must ensure confidentiality on Protected Health Information (PHI) or Personally Identifiable Information (PII).

Scoring: The review score is based on a review standard of 10 records per individual primary care provider (PCP). Documented evidence found in the hard copy (paper) medical records and/or electronic medical records, including immunization registries, are used for review criteria determinations. Compliance levels are:
An Exempted Pass is 90%.
Conditional Pass is 80-89%.
Failure is below 80%.

The minimum passing score is 80%. A corrective action plan (CAP) is required for a total MRR score below 90%. Also, any section score of less than 80% requires a CAP for the entire MRR, regardless of the total MRR score.

Not Applicable (N/A) applies to any criterion that does not apply to the medical record being reviewed and must be explained in the comment section.

Directions: Score one point if criterion is met. Score zero points if criterion is not met. Do not score partial points for any criterion.

If 10 shared records are reviewed, score calculation shall be the same as for 10 records reviewed for a single PCP.
If 20 records are reviewed, divide total points given by the "adjusted" total points possible.
If 30 records are reviewed, divide total points given by the "adjusted" total points possible.
Multiply by 100 to calculate percentage rate.

Reviewers have the option to request additional records to review but must calculate scores accordingly.

Scoring Example:

Step 1: Add the points given in each section.
Step 2: Add the points given for all six sections.
(Format points given)
(Documentation points given)
(Coordination of Care points given)
(Pediatric Preventive points given)
(Adult Preventive points given)
+ (OB/CPSP Preventive points given)

= (Total points given)

Step 3: Subtract the "N/A" points from total points possible.

(Total points possible)
– (N/A points)
= ("Adjusted" total points possible)

Step 4: Divide total points given by the "adjusted" points possible, then multiply by 100 to calculate percentage rate.

Total points given
"Adjusted" total points possible

Example: 267
305 = 0.875 X 100 = 88%

Rationale: A well-organized medical record keeping system supports effective patient care, information confidentiality and quality review processes.

I. Format Criteria	
An individual medical record is established for each member.	Practitioners are able to readily identify each individual treated. A medical record is started upon the initial visit.[1] "Family charts" are not acceptable.
A. Member identification is on each Page.	• Member identification includes first and last name, and a unique identifier established for use on clinical site. • Electronically maintained records and printed records from electronic systems must contain member identification.
B. Individual personal biographical information is documented.	Personal biographical information includes: ○ Date of birth ○ Current address ○ Home/work phone numbers ○ Name of parent(s)/legal guardian if member is a minor If member refused to provide information, "refused" is documented in the medical record. Do not deduct points if member has refused to provide all personal information requested by the practitioner.
C. Emergency "contact" is identified.	The name and phone number of an "emergency contact" person is identified for all members. Listed emergency contacts may include: ○ Spouse, relative or friend, and must include at least one of the following: ○ Home, work, pager, cellular, or message phone number. • If the member is a minor, the primary (first) emergency contact person must be a parent or legal guardian and then other persons may be listed as additional emergency contacts. • Adults and emancipated minors may list anyone of their choosing.

[1] See the U.S. Department of Health and Human Services Summary of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, available at: https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html.

I. Format Criteria	
	• If a member refuses to provide an emergency contact, "refused" is noted in the record. Do not deduct points if member has refused to provide personal information requested by the practitioner. • Next of kin category is not considered as an emergency contact. The member's emergency contact may be different from the next of kin.
D. Medical records are maintained and organized	• Contents and format of printed and/or electronic records within the practice site are uniformly organized, securely fastened, attached or bound to prevent medical record loss. • Hard copy printed documents shall belong to the medical record established for each member (e.g., reusing the blank side of printed documents from another member is not acceptable and should be scored a "0"). • Medical Record information should be readily available.
E. Member's assigned and/or rendering PCP is identified.	• The assigned and/or rendering PCP is ***always*** identified when there is more than one PCP on site and/or when the member has selected health care from a non-physician medical practitioner. • Various methods can be used to identify the assigned PCP, reviewers must identify specific method(s) used at each individual site such as Health Plan ID Card, practitioner stamp, etc. • If there is only one PCP/Practitioner onsite and is not identified, reviewer may score "N/A".
F. Primary language and linguistic service needs of non-or of limited-English proficiency (LEP) or hearing/speech-impaired persons are prominently noted.	• The primary language is prominently documented at least once in the medical record. • Language documentation is not necessary, score "N/A," if English is the primary language. However, if "English" is documented, the point may be given. **Note:** Title VI of the Civil Rights Act of 1964 prohibits recipients of federal funds from providing services to LEP persons that are limited in scope or lower in quality than those provided to others. Since Medi-Cal is partially funded by federal funds,

I. Format Criteria	
	all Plans with Medi-Cal LEP members must ensure that these members have equal access to all health care services.[2]
G. Person or entity providing medical interpretation is identified.	• Requests for language and/or interpretation services by a non-or limited-English proficient member are documented. • Member refusal of interpreter services may be documented at least once and be accepted throughout the member's care unless otherwise specified. • If bilingual staff are asked to interpret or translate, they should be qualified to do so. Assessment of ability, training on interpreter ethics and standards, and clear policies that delineate appropriate use of bilingual staff, staff or contract interpreters and translators, will help ensure quality and effective use of resources. • Those utilizing the services of interpreters and translators should request information about certification, assessments taken, qualifications, experience, and training. Quality of interpretation should be a focus of concern for all recipients. • Family or friends should not be used as interpreters, unless specifically requested by the member and documented in the member's chart. • Minors (under 18 years old) accompanying member shall not be used as an interpreter. • The Affordable Care Act (ACA) 2010 section 1557: prohibits from using low-quality video remote interpreting services or relying on unqualified staff, translators when providing language assistance services. • Sign language interpreter services may be utilized for medically necessary health care services and related services such as obtaining medical history and health assessments, obtaining informed consents and permission for treatments, medical procedures, providing instructions regarding medications, explaining

[2] See All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language assistance Services, or any superseding APL. APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

I. Format Criteria	
	diagnoses, treatment and prognoses of an illness, providing mental health assessment, therapy or counseling. Various documents can be accepted to document linguistic service needs such as Individual Health Education Behavior Assessment (IHEBA)/Staying Healthy Assessment (SHA), intake form, demographic form, Electronic Medical Record (EMR) fields, consent forms, etc. **Note:** See Commonly Asked Questions and Answers Regarding LEP Individuals, available at: https://www.lep.gov/faq/faqs-rights-lep-individuals/commonly-asked-questions-and-answers-regarding-limited-english. See also Title 22 California Code of Regulations (CCR) Section 51309.5. The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index.
H. Signed Copy of the Notice of Privacy	The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The right to inspect, review and receive a copy of the medical records is covered by the Privacy Rule.[3]

[3] See the U.S. Department of Health and Human Services Understanding of Some of HIPAA's Permitted Uses and Disclosures, available at: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/permitted-uses/index.html.

Rationale: Well-documented records facilitate communication and coordination and promote efficiency and effectiveness of treatment.

RN/NP/MD/PA/CNM/LM

II. Documentation Criteria	
A. Allergies are prominently noted.	• Allergies and adverse reactions are listed in a prominent, easily identified, and consistent location in the medical record. • If member has no allergies or adverse reactions, "No Known Allergies" (NKA), "No known Drug Allergies" (NKDA), or ∅ is documented.[4]
B. Chronic problems and/or significant conditions are listed.	• Documentation may be on a separate "problem list," or a clearly identifiable problem list in the progress notes. • All chronic or significant problems are considered current if no "end date" is documented. **Note:** Chronic conditions are current long-term, on-going conditions with slow or little progress.[5]
C. Current continuous medications are listed.	• Documentation may be on a separate "medication list," or a clearly identifiable medication list in the progress notes. • List of current, on-going medications identifies the medication name, strength, dosage, route (if other than oral), and frequency. • Discontinued medications are noted on the medication list or in progress notes.[6]
D. Appropriate Consents are present.	1) Consent must be obtained prior to release of patient information.[7]

[4] 22 CCR 70527 and 28 CCR 1300.80
[5] 22 CCR 70527 and 28 CCR 1300.80
[6] 22 CCR 70527 and 28 CCR 1300.80
[7] 22 CCR 73524, 22 CCR 51009, and Title 45, Code of Federal Regulations Section 164.524. The CFR is searchable at: https://www.ecfr.gov.

II. Documentation Criteria	
	2) Adults, parents/legal guardians of a minor or emancipated minor may sign consent forms for operative and invasive procedures.[8] Persons under 18 years of age are emancipated if they have entered into a valid marriage, are on military active duty, or have received a court declaration of emancipation under the CA Family Code, Section 7122.[9] **Note:** Human sterilization requires the Department of Health Care Services (DHCS) Consent Form PM 330 if services are performed at the site.
E. Advance Health Care Directive information is offered. (Adults 18 years of age or older; emancipated minors).	• Adult medical records include documentation of whether the member has been *offered* information or has executed an Advance Health Care Directive.[10] The Physician Orders for Life-Sustaining Treatment (POLST) form and Five Wishes are acceptable if appropriately completed and signed by necessary parties.[11] **Note:** Advance Health Care Directive Information is reviewed with the member at least every 5 years and as appropriate to the member's circumstance.
F. All entries are signed, dated and legible.	**Signature** includes: • First initial, last name, and title of health care personnel providing care, including Medical Assistants. • Initials and titles may be used only if signatures are specifically identified elsewhere in the medical record (e.g. signature page).

[8] An invasive procedure is a medical procedure that invades (enters) the body, usually by cutting or puncturing the skin or by inserting instruments into the body. Very minor procedures such as drawing blood testing, umbilical cord blood donations and a few other very specific tests are not considered invasive and do not require a consent. Consent is implied by entering the provider's office or lab and allowing blood to be drawn. (Ref: National Institutes of Health; American Cancer Society)
[9] California Law is searchable at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml.
[10] See Probate Code, Section 4701, 42 CFR 422.128, 42 CFR 489.100, and APL 05-010.
[11] See AB 3000, Chapter 266, Statutes of 2008, available at: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=200720080AB3000.

II. Documentation Criteria	
	• Stamped signatures are acceptable, but must be authenticated, meaning the stamped signature can be verified, validated, confirmed, and is countersigned or initialed. **Dated entries** include: • Month/day/year. • Entries are in reasonably consecutive order by date. • Handwritten documentation does not contain skipped lines or empty spaces where information can be added. Entries are not backdated or inserted into spaces above previous entries. • Omissions are charted as a new entry. • Late entries are explained in the medical record, signed and dated. **Legibility** means the record entry is readable by a person other than the writer. Handwritten documentation, signatures, and initials are entered in ink that can be readily/clearly copied. Only standard abbreviations are used. All medical record documentation must be in English.[12] **Note:** • In EMR, methods to document signatures (and/or authenticate initials) will vary and must be individually evaluated. • Signature page may be in the member's medical record or available elsewhere onsite and all previous and current employees who document in medical records need to be included on the signature page. • Reviewers should assess the log-in process and may need to request printouts of entries. See the Centers for Medicare and Medicaid Services' (CMS) Guidance on Medicaid Documentation for Medical Office Staff, available at: https://www.cms.gov/Medicare-

[12] ACA Section 1557

II. Documentation Criteria	
	Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-officestaff-factsheet.pdf.
G. Errors are corrected according to legal medical documentation standards.	• The person that makes the documentation error corrects the error. Example correction methods: • Single line drawn through the error, with the writer's initial and date written above or near the lined-through entry. • Single line and initial. • The corrected information is written as a separate entry and includes date of the entry, signature (or initials), and title. There are no unexplained cross-outs, erased entries or use of correction fluid. Both the original entry and corrected entry are clearly preserved. **Note:** Reviewers must determine the method used for error corrections for EMR on a case by case basis. This should include the log-in process and whether the EMR allows for corrections to be made after entries are made.

Rationale: Medical records support coordination and continuity-of-care with documentation of past and present health status, medical treatment and future plans of care.

RN/NP/MD/PA/CNM/LM

III. Coordination Criteria	
A. History of present illness or reason for visit is documented.	Each focused visit (e.g., primary care, follow-up ER/urgent care, hospital discharge, etc.) includes a documented history of present illness or reason for visit.
B. Working diagnoses are consistent with findings.	Each visit has a documented "working" diagnosis/impression derived from a physical exam, and/or "Subjective" information such as chief complaint or reason for the visit as stated by member/parent. The documented "Objective" information (such as assessment, findings and conclusion) relate to the working diagnoses. **Note:** For scoring purposes, reviewers shall ***not make determinations*** about the "*rightfulness or wrongfulness"* of documented information but shall initiate the peer review process or internal investigation per health plan policy as appropriate.
C. Treatment plans are consistent with diagnoses.	A plan of treatment, care and/or education related to the stated diagnosis is documented for each diagnosis. **Note:** For scoring purposes, reviewers shall ***not make determinations*** about the "*rightfulness or wrongfulness"* of treatment rendered or care plan but shall initiate the peer review process or internal investigation per health plan policy as appropriate.
D. Instruction for follow-up care is documented.	• Specific follow-up instructions and a definite time for return visit or other follow-up care is documented. • Time period for return visits or other follow-up care is definitively stated in number of days, weeks, months, or PRN (as needed). • Every visit with the provider shall have follow-up instructions.
E. Unresolved continuing problems are addressed in subsequent visit(s).	• Previous complaints and unresolved or chronic problems are addressed in subsequent notes until problems are resolved or a diagnosis is made.

III. Coordination Criteria	
	• Each problem need not be addressed at every visit as long as the provider documents a reason for deferring the unresolved problem(s) for subsequent visits. • Documentation demonstrates that the practitioner follows up with members about treatment regimens, recommendations, and counseling.
F. There is evidence of practitioner review of specialty/consult/referral reports and diagnostic test results.	• There is documented evidence of practitioner review of records such as diagnostic studies, lab tests, X-ray reports, consultation summaries, inpatient/discharge records, emergency and urgent care reports, and all abnormal and/or "STAT" reports. • Evidence of review may include the practitioner's initials or signature on the report, notation in the progress notes, or other site-specific method of documenting practitioner review. **Note:** Electronically maintained medical reports must also show evidence of practitioner review and may differ from site to site. Evidence of practitioner review on any page of the report(s) or diagnostic result(s) that have multiple pages is acceptable.
G. There is evidence of follow-up of specialty/consult/referrals made, and results/reports of diagnostic tests, when appropriate.	Documentation includes: • Consultation reports and diagnostic test results for ordered requests. • Abnormal test results/diagnostic reports have explicit notation in the medical record or separate system, including attempts to contact the member/guardian, follow-up treatment, instructions, return office visits, referrals and/or other pertinent information. • Missed/broken appointments for diagnostic procedures, lab tests, specialty appointments and/or other referrals are noted, and include attempts to contact the member/parent and results of follow-up actions. If diagnostic appointments or referrals are documented in a separate system from medical records, they must be readily accessible and meet the medical retention requirements. **Note:**

III. Coordination Criteria	
	• Abnormal test results/diagnostic reports without follow-up documentation for specific pediatric or adult preventive screening criteria/diagnostic tests will be scored under this criterion. • If results are normal and there are no missing reports, then the reviewer may score "N/A" for this criterion. • If specific pediatric or adult preventive screenings are ordered and there is no documentation of normal results and/or follow-up, the reviewer shall score this under the appropriate preventive services criteria. • If the provider/staff does not follow up or attempt outreach to the member regarding a missed specialty referral, give a zero "0" score. Reviewer must assess the process of outreach efforts/follow-up contacts and documentation of attempts. The process must include at least one attempt for outreach/follow-up contact.
H. Missed primary care appointments and outreach efforts/follow-up contacts are documented.	Documentation includes: • Incidents of missed/broken appointments, cancellations or "No shows" with the PCP office. • Attempts to contact the member or parent/guardian and the results of follow-up actions. Missed and/or canceled appointments and contact attempts must be documented in the patient's medical record. **Note:** Reviewer must assess the process of outreach efforts/follow-up contacts and documentation of attempts. The process must include at least one attempt for outreach/follow-up contact.

Rationale: Pediatric preventive services are provided to members under 21 years of age in accordance with current American Academy of Pediatrics (AAP) bright future and US Preventive Task Force (USPSTF) recommendations. See the DHCS Boilerplate contract, available at: https://www.dhcs.ca.gov/provgovpart/Documents/2-Plan-Non-CCI-Boilerplate-Final-Rule-Amendment.pdf.

RN/NP/MD/PA/CNM/LM

IV. Pediatric Preventive Criteria	
A. Initial Health Assessment (IHA) includes H&P and IHEBA	**New Members** IHA must be completed within 120 days of plan enrollment or PCP effective date (whichever is more recent) or documented within the 12 months prior to Plan enrollment/PCP effective date. A complete IHA enables the PCP to assess current acute, chronic, and preventive needs and to identify those Members whose health needs require coordinated services with appropriate community resources/other agencies not covered by the Plan. References: Policy Letter (PL) 08-003 or current version and PL 13-001 or current version
1) Comprehensive History and Physical	**New members** The history must be comprehensive to assess and diagnose acute and chronic conditions it includes: ○ History of present illness ○ Past medical history ○ Social history ○ Review of Organ Systems (ROS) If an H&P is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented.
2) Individual Health Education Behavioral Assessment (IHEBA)	**New members** An age-appropriate IHEBA (“Staying Healthy” or other DHCS-approved tool such as AAP Bright Future is a screening tool that may assist in screening for risk factors for many preventive care criteria (e.g., alcohol misuse, STI, HIV, Tobacco, etc.) is completed by the member or parent/guardian within 120 days of the effective date of enrollment into the Plan or PCP effective date (whichever is more

IV. Pediatric Preventive Criteria	
	recent), or within the 12 months prior to Plan enrollment/PCP effective date. Staff may assist. The IHEBA shows evidence of practitioner review: ○ Printed name ○ Signature ○ Date ○ Interventions, which may be documented on the IHEBA form, in progress notes, or other areas of the paper or electronic medical record system. If an initial IHEBA is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented. • Give a point: 1) IHEBA is complete, reviewed, and signed by the provider. • Give a N/A: 2) The Provider documents patient refusal of IHEBA in Electronic Health Record chart notes. • Give a zero: 1) IHEBA was not reviewed/signed by the provider, 2) IHEBA is refused by the patient ("refused" box checked) and the provider has not signed the form. SHA Questionnaires are available at: http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx
B. Subsequent Comprehensive Health Assessment	**Existing/Current Members** The examination must be comprehensive, focus on specific assessments that are appropriate for the child's or adolescent's age, developmental phase, and needs building on the history gathered earlier. The physical examination provides opportunities to identify silent or subtle illnesses or conditions and time for the health care professional to educate children and their parents about the body and its growth and development. See the AAP/Bright Futures Recommendations for Preventive Pediatric Health Care, available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

IV. Pediatric Preventive Criteria	
1) Comprehensive History and Physical Exam completed at age-appropriate frequency	• Health assessments containing age-appropriate requirements are provided per the most recent AAP periodicity schedule. • Assessments and identified problems are documented in the progress notes. • Follow-up care or referral is provided for identified physical health problems as appropriate. **Note:** The AAP periodicity exam schedule is more frequent than the Child Health and Disability Prevention Program (CHDP) periodicity examination schedule. The AAP scheduled visit must include all assessment components required by the CHDP program for the lower age nearest to the current age of the child.[13]
2) Subsequent Periodic IHEBA	• An age-appropriate IHEBA is re-administered when the member has reached the next specific age interval designated by DHCS' Managed Care Quality and Monitoring Division. • The PCP must review previously completed IHEBA questionnaires with parent, guardian, or adolescent annually before reaching the next age group. • Documentation requirements are the same as the initial IHEBA. The SHA Questionnaires are available at: http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx
c. Well-child Visit	The Bright Futures/AAP developed a set of comprehensive health guidelines for well-childcare, known as the "periodicity schedule."[14] It is a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence. **Screening** pertains to an assessment of the eligible population for presence of risk factors. • If the patient is positive for risk factors, (e.g., obesity, menstrual status, etc.) age and gender parameters of the criterion the provider shall offer and document

[13] See the AAP/Bright Futures Recommendations for Preventive Pediatric Health Care, available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

[14] The Bright Futures/AAP periodicity schedule is available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

IV. Pediatric Preventive Criteria	
	appropriate follow-up intervention(s) (e.g., diagnostic testing, counseling, referral to specialist, documentation of patient refusal, etc.). • Providers who fail to document the presence or absence of risk factors shall receive zero points since the patient's risk status could not be determined and the preventive care criterion was not addressed. • Evidence of risk assessments and screenings for other preventive care criteria may be found in the ***IHEBA,*** progress notes, comprehensive history forms, or elsewhere in the medical record. **Note:** The AAP does not approve nor endorse any specific tool for screening purposes. Examples of screening tools are available at: https://screeningtime.org/star-center/#/screening-tools https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx
1) **Alcohol Use Disorder Screening and Behavioral Counseling**	Per AAP recommendations, alcohol use disorder screening and behavioral counseling should begin at 11 years of age. If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s). Brief Assessment and Screening When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use is present. Validated assessment tools may be used without first using validated screening tools. The AAP recommended assessment tool is available at: http://crafft.org. Brief Interventions and Referral to Treatment When brief assessments reveal unhealthy alcohol use, brief misuse counseling with appropriate referral for additional evaluation and treatment options, referrals, or services must be offered.

IV. Pediatric Preventive Criteria	
	Brief interventions must include the following: • Providing feedback to the patient regarding screening and assessment results; • Discussing negative consequences that have occurred and the overall severity of the problem; • Supporting the patient in making behavioral changes; and • Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated. The AAP/Bright Futures periodicity schedule is available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf For details on Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment, refer to APL 21-014 or any superseding APL. Please refer to the link below to The Medi-Cal Provider Manual: https://www.dhcs.ca.gov/formsandpubs/publications/Pages/Manuals.aspx
2) Anemia Screening	Per AAP, perform risk assessment or screening at 4, 15, 18, 24, and 30 months, 3 years old, and then annually thereafter. Test serum hemoglobin at 12 months old. If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s). Acceptable evidence of anemia screening: evaluate patient's diet, nutrition supplement intake, menstrual status, medical history for chronic conditions, etc. Chronic conditions to assess that are associated with anemia: ○ A diet consistently low in iron, vitamin B-12 and folate ○ Heavy Menstruation. See link for signs of heavy menstrual bleeding: https://www.acog.org/womens-health/faqs/heavy-menstrual-bleeding ○ Pregnancy ○ Slow, chronic blood loss from an ulcer; Crohn's disease, celiac disease, cancer, kidney failure, diabetes, etc.

IV. Pediatric Preventive Criteria	
	The Bright Futures/AAP periodicity schedule is available at: https://www.aap.org/en-us/documents/periodicity_schedule.pdf. See the National Institutes of Health information on Anemia, available at: https://www.nhlbi.nih.gov/health-topics/anemia#:~:text=Some%20people%20are%20at%20a,such%20as%20chemotherapy%20for%20cancer. See the Center for Disease Control and Prevention's (CDC) information on heavy menstrual bleeding, available at: https://www.cdc.gov/ncbddd/blooddisorders/women/menorrhagia.html.
3) Anthropometric measurements	For each well exam: • Infants up to 24 months old: assess for length/height and head circumference (HC). Measurements are plotted in a World Health Organization (WHO) growth chart. • 2-21 years old: assess for height, weight, and body mass index (BMI) measurements are plotted in a CDC growth chart. • Provider should measure and track BMI to identify patient at risk for being overweight, obese, or underweight. Patients identified as overweight and/or obese are provided counseling for nutrition to promote healthy eating habits and regular physical activity. For additional information on anthropometric measurements, refer to the following link: https://www.dhcs.ca.gov/services/chdp/Documents/HAG/4AnthropometricMeasure.pdf **Note:** Site is deficient if anthropometric measurements are not plotted on the appropriate growth chart.[15]
4) Anticipatory Guidance	• Must be documented at each well child visit.

[15] CDC growth charts are available at: https://www.cdc.gov/growthcharts/.

IV. Pediatric Preventive Criteria	
	• Is given by the health care provider to assist parents or guardians in the understanding of the expected growth and development of their children. • Specific to the age of the patient, includes information about the benefits of healthy lifestyles and practices that promote injury and disease prevention https://brightfutures.aap.org/Bright%20Futures%20Documents/BF_PreventiveServices_Tipsheet.pdf#search=document%20anticipatory%20document
5) Autism Spectrum Disorder (ASD) Screening	ASD screening must be performed at 18 months and 24 months of age based on AAP periodicity "Bright Futures". If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s). ASD screening tools examples: ○ Ages and Stages Questionnaires (ASQ) ○ Communication and Symbolic Behavior Scales (CSBS) ○ Parents' Evaluation of Developmental Status (PEDS) ○ Modified Checklist for Autism in Toddlers (MCHAT) ○ Screening Tool for Autism in Toddlers and Young Children (STAT) ○ Survey of Well-being of Young Children (SWYC) screening tools (assess three domains of child functioning: developmental domain, emotional/behavioral domain, and family context) Refer to APL 19-014, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21, and APL 19-010, Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21, or any superseding APLs for more information on ASD. Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder" Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening", available at: https://pediatrics.aappublications.org/content/145/1/e20193449.

IV. Pediatric Preventive Criteria	
	See the AAP publication regarding Identification, Evaluation, and Management of Children with ASD, available at: https://pediatrics.aappublications.org/content/145/1/e20193447. See the Tufts Children's Hospital Survey of Well-being of Young Children, available at: https://www.tuftschildrenshospital.org/The-Survey-of-Wellbeing-of-Young-Children/Overview. See the AAP Screening Tools, available at: https://screeningtime.org/star-center/#/screening-tools
6) Blood Lead Screening	• Children receiving health services through publicly funded programs must receive anticipatory guidance on lead poisoning prevention at each periodic health assessment, starting at 6 months of age and continuing until 72 months of age. • Provider shall offer and document appropriate follow-up intervention(s) for patient whose screen reveals elevated Blood Lead Levels. Medi-Cal managed care health plans (MCPs) must ensure that the providers provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child member that, at a minimum, includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age. Childhood Lead Poisoning Prevention Branch (CLPPB) anticipatory guidance includes information about other common sources of lead exposure for children.[16] Spanish version: https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/CDPH%20Document%20Library/CLPPB-antguid(S).pdf. Order or perform blood lead screening tests on all child members in accordance with the following:

[16] The CLPPB Guidance is available at: https://vchca.org/images/public_health/VCCHDP/Chapter6.pdf.

IV. Pediatric Preventive Criteria	
	• At 12 months and at 24 months of age. • When the network provider performing a PHA becomes aware that a child member who is 12 to 24 months of age has no documented evidence of a blood lead screening test taken at 12 months of age or thereafter. • When the network provider performing a PHA becomes aware that a child member who is 24 to 72 months of age has no documented evidence of a blood lead screening test taken. • At any time, a change in circumstances has, in the professional judgement of the network provider, put the child member at risk. • If requested by the parent or guardian. Follow the CDC Recommendations for Post-Arrival Lead Screening of Refugees contained in the CLPPB issued guidelines.[17] **Note:** Network providers are not required to perform a blood lead screening test if either of the following applies: • In the professional judgment of the network provider, the risk of screening poses a greater risk to the child member's health than the risk of lead poisoning. • If a parent, guardian, or other person with legal authority to withhold consent for the child refuses to consent to the screening. Evidence of provider compliance of blood lead screening test if not performed: • The provider must document the reason(s) for not performing the blood lead screening test in the child member's medical record. • In cases where consent has been withheld, the provider must obtain a signed statement of voluntary refusal by parent or guardian. If the provider is unable to obtain a signed statement of voluntary refusal because the party that withheld consent, refuses or declines to sign it, or is unable to sign it (e.g., when services are provided via telehealth modality), it is acceptable for the provider to document the refusal.

[17] The CDC Recommendations are available at: https://www.cdc.gov/immigrantrefugeehealth/guidelines/lead-guidelines.html.

IV. Pediatric Preventive Criteria	
	See APL 20-016, Blood Lead Screening of Young Children, or any superseding APL for more information. Please refer to California Department of Public Health (CDPH) CLPPB and the CDC for recommended actions based on BLL levels: • Information on how to report blood lead screening test results to CLPPB can be found at: https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/report_results.aspx. • Health care providers using a point-of-care device are considered laboratories and must report.[18] • See the CDC Guidance on Childhood Lead Poisoning Prevention, available at: https://www.cdc.gov/nceh/lead. • See the California Management Guidelines on Childhood Lead Poisoning for Health Care Providers publication, available at: https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/prov.aspx • For children at risk of lead exposure, see "Prevention of Childhood Lead Toxicity", available at: http://pediatrics.aappublicatons.org/content/138/1/e20161493, and "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention", available at: https://www.cdc.gov/nceh/lead/acclpp/final_document_030712.pdf
7) **Blood Pressure Screening**	• Per AAP, blood pressure screening starts at 3 years old. • In infants and children with specific risk conditions, blood pressure measurements should be performed at visits before age 3 years.

[18] See Health and Safety Code Section 124130. State law is searchable at: https://leginfo.legislature.ca.gov/faces/home.xhtml.

IV. Pediatric Preventive Criteria	
	• Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveals elevated blood pressure. In persons aged 3-18 years, the prevalence of hypertension is 3.6 %. Evidence suggests that elevated blood pressure in childhood increases the risk for adult Hypertension and Metabolic Syndrome. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents", available at: http://pediatrics.aappublications.org/content/140/3/e20171904 See the Bright Futures Medical Screening Reference Table, available at: https://brightfutures.aap.org/Bright%20Futures%20Documents/MSRTable_InfancyVisits_BF4.pdf. See the AAP guidance on Clinical Practice Guidelines for Screening and Management of High Blood Pressure in Children and Adolescents, available at: https://publications.aap.org/pediatrics/article/140/3/e20171904/38358/Clinical-Practice-Guideline-for-Screening-and
8) Dental/Oral Health Assessment	• Per DHCS contracts, the provider is responsible for ensuring that dental screening/oral health assessment for all members are included as part of the IHA.[19] • Inspection of the mouth, teeth, and gums is performed at every health assessment visit and refer to a dentist if a dental problem is detected or suspected. • Per AAP, referral to a dental home begins at 12 months. If patients do not have an established dental home after 12 months, continue performing an oral health risk assessment and refer to a dental home.[20] • Documentation of "HEENT" is acceptable.

[19] For additional information, see the MCP Contract, Exhibit A, Attachment 11, Provision 15.
[20] See the AAP Oral Health Practice Tools, available at: https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/.

IV. Pediatric Preventive Criteria	
	See the Caries-risk Assessment and Management for Infants, Children, and Adolescents, available at: https://www.aapd.org/media/Policies_Guidelines/BP_CariesRiskAssessment.pdf See the AAP guidance on Fluoride Use in Caries Prevention in the Primary Care Setting, available at: http://pediatrics.aappublications.org/content/134/3/626.
a. Fluoride Supplementation	• The AAP and USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride. • Parents or legal guardian should be encouraged to check with local water utility agency if water has fluoride. • If local water does not contain fluoride, provider may recommend the purchase of fluoridated water or give prescription for fluoride drops or tablets. • Per AAP, fluoride supplementation for all children ages 6 months until their fifth-year birthday (age range according to the most current AAP periodicity schedule) whose daily exposure to systemic fluoride is deficient. For the fluoridation status of a community water supply, contact the local water department or the link for “My Water’s Fluoride”, available at: https://nccd.cdc.gov/doh_mwf/default/default.aspx See the AAP’s guidance on Maintaining and Improving the Oral Health of Young Children, available at: http://pediatrics.aappublications.org/content/134/6/1224. See the USPSTF guidance on Dental Caries in Children Younger Than 5 Years, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1 Comment: USPSTF changed their recommendation as of 12/7/21 which is what AAP is referencing in the AAP periodicity schedule footnote 35 and 36.

IV. Pediatric Preventive Criteria	
	See guidance on fluoride supplementation, available at: https://publichealth.nc.gov/oralhealth/library/includes/IMBresources/2020-FluorideSupplementation.pdf#:~:text=Pediatric%20Dentistry%20%28AAPD%29%20recommend%20the%20daily%20administration%20of,years%20of%20age%20to%20provide%20the%20maximum%20benefits.
b. Fluoride Varnish	• Fluoride varnish is a dental treatment that can help prevent tooth decay, slow it down, or stop it from getting worse by strengthening the tooth enamel (outer coating on teeth). • AAP recommends that fluoride varnish be applied to the teeth of infants and children starting at tooth eruption until their fifth-year birthdate (age range according to the most current AAP periodicity schedule). All children in this category should receive fluoride varnish application at least once every 3-6 months in the primary care or dental office. **Note:** Documentation of "seeing a dentist" without specific notation that fluoride varnish was applied at the dentist office does not meet the criterion. Not all dentists routinely apply fluoride varnish during routine dental visits. See the USPSTF guidance on Dental Caries in Children Younger Than age 5 Years, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1. See APL 19-010, Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21, for additional guidance on fluoride varnish. See the AAP publication on Maintaining and Improving the Oral Health of Young Children, available at: https://publications.aap.org/pediatrics/article/134/6/1224/33112/Maintaining-and-Improving-the-Oral-Health-of-Young.

IV. Pediatric Preventive Criteria	
9) Depression Screening	• AAP recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 20 years. • Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up if screening is positive and a follow up plan is documented. • Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening is positive for depression. • Depression screening must be done using a validated screening tool. Per AAP, screen using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit, and available at: https://downloads.aap.org/AAP/PDF/Mental_Health_Tools_for_Pediatrics.pdf and https://screeningtime.org/star-center/#/screening-tools.
a) Suicide Risk Screening	• Pending AAP guidance
b) Maternal Depression Screening	• Maternal mental health condition is defined as a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression. • Maternal depression screen at 1-, 2-, 4-, and 6-month visits. • Maternal depression screening must be done using a validated screening tool, such as the Edinburgh Postnatal Depression Scale (EPDS), Postpartum Depression Screening Scale, or Patient Health Questionnaire (PHQ) 9.[21] • As with any screening test, results should be interpreted within the clinical context and when appropriate referral to the PCP and/or to mental health care providers for follow up.[22] • Provider shall offer and document appropriate follow-up intervention(s) for women whose screening is positive for maternal depression.

[21] See the American College of Obstetricians and Gynecologists (ACOG) guidance on Screening for Perinatal Depression, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/11/screening-for-perinatal-depression.
[22] For additional resources on perinatal depression, see: http://www.acog.org/More-Info/PerinatalDepression.

IV. Pediatric Preventive Criteria	
	Assembly Bill (AB) 2193 requires provider who provides prenatal or postpartum care for a patient to offer to screen or appropriately screen a mother for maternal mental health conditions.[23] It also requires interpregnancy care providers to do the same when the patient has experienced a stillbirth or miscarriage. (Health and Safety Code, section 123640 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=123640.&lawCode=HSC), with the most recent version effective 1/1/2022, as amended by AB 1477. Per AAP, "screening should occur per 'Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice', available at: https://pediatrics.aappublications.org/content/143/1/e20183259 See the ACOG Frequently Asked Questions on Postpartum Depression, available at: https://www.acog.org/Patients/FAQs/Postpartum-Depression. See the USPSTF recommendation on Screening Depression in Adults, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening1 See the U.S. Department of Health and Human Services guidance on Postpartum Depression, available at: https://www.womenshealth.gov/mental-health/mental-health-conditions/postpartum-depression.
10) Developmental Disorder Screening	• Screen for developmental disorders at the 9th, 18th, and 30th month visits. • 30th month screening can be done at 24 months. • Providers must use an AAP validated screening tool that must also be a global, not domain specific, consistent with criteria set forth in the CMS Technical Specifications. • Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening is positive for developmental disorder.

[23] AB 2193 (Chapter 755, Statutes of 2018) is available at: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB2193.

IV. Pediatric Preventive Criteria	
	• The CMS Technical Specifications are consistent with age recommendations and use of a validated screening tool; however, tech spec excludes MCHAT tool which AAP allows. CMS determined that the ASQ: SE and M-CHAT screening tools were too specific because they screen for a domain-specific condition (social emotional development or autism, respectively), rather than a full, general assessment of developmental delays. For detailed information on the CMS Technical Specifications please refer to the link: https://www.medicaid.gov/license/form/6466/4391. The developmental screening measure starts on page 65. Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children with Developmental Disorders Through Developmental Surveillance and Screening", available at: https://pediatrics.aappublications.org/content/145/1/e20193449.
11) Developmental Surveillance	Developmental surveillance is a component of every well care visit. If the patient is positive for potential delays, provider shall offer and document appropriate follow-up intervention(s).
12) Drug Use Disorder Screening and Behavioral Counseling	Per AAP recommendations, drug use screening and behavioral counseling should begin at 11 years of age. Provider shall offer and document appropriate follow-up interventions for patient whose screening reveals unhealthy drug use. Brief Assessment and Screening When a screening is positive, validated assessment tools should be used to determine if unhealthy drug use is present. Validated drug assessment tools may be used without first using validated screening tools. The AAP recommended assessment tool is available at: http://crafft.org. Brief Interventions and Referral to Treatment

IV. Pediatric Preventive Criteria	
	When brief assessments reveal unhealthy drug use, brief misuse counseling with appropriate referral for additional evaluation and treatment options, referrals, or services must be offered. Brief interventions must include the following: • Providing feedback to the patient regarding screening and assessment results; • Discussing negative consequences that have occurred and the overall severity of the problem; • Supporting the patient in making behavioral changes; and • Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated. See APL 21-014 or any superseding APL for details on Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment. See the AAP guidance on Substance Use Screening, Brief Intervention, and Referral to Treatment, available at: https://pediatrics.aappublications.org/content/138/1/e20161211.
13) Dyslipidemia Screening	Family history of obesity, diabetes, hypertension, and heart disease is commonly associated with a combined dyslipidemia. Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveals dyslipidemia. Per AAP perform a risk assessment at: ○ 2, 4, 6, and 8 years old, then annually thereafter. ○ Order one lipid panel between 9 and 11. ○ Perform again between 17 and 21 years old to identify children with genetic dyslipidemia or more lifestyle-related dyslipidemia. For more information see “Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents”, available at: https://www.nhlbi.nih.gov/health-topics/integrated-guidelines-for-cardiovascular-health-and-risk-reduction-in-children-and-adolescents

IV. Pediatric Preventive Criteria	
	For more information on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents, see: https://www.nhlbi.nih.gov/node/80308 https://brightfutures.aap.org/Pages/default.aspx
14) Hearing Screening	Per AAP audiometric screenings are performed at: ○ Birth to 2 months old, 4, 5, 8, and 10 years old ○ Once between 11-14 years old ○ Once between 15-17 years old ○ Once between 18-21 years old Per AAP, clinicians must confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs", available at: http://pediatrics.aappublications.org/content/120/4/898.full. A failed audiometric screening is followed-up with a repeat screening at least two weeks and no later than 6 weeks after the initial screening. If the second screening also fails, the primary care provider must make a referral to a specialist. • Non-audiometric assessments shall be performed at each health assessment visit until the child reaches 21 years old and includes an assessment of birth/family history (hearing loss in the family), history of ear infection and the signs and symptoms of hearing loss (i.e. does not startle at loud noises, does not turn to the source of a sound after 6 months of age, speech is delayed and unclear, often says, "Huh?", turns the TV volume up too high, etc.). • Audiometric testing is performed using a newborn hearing screening test (e.g. Automated Auditory Brainstem Response [AABR] or Otoacoustic Emission [OAE] technology) at the birth hospital or specialty facility; or a Behavioral Audiometry Evaluation with an audiometer at the primary care facility starting at 4 years old and includes follow-up care as appropriate. See the AAP periodicity schedule, available at: www.aap.org/periodicityschedule.

IV. Pediatric Preventive Criteria	
	See the CDC recommendations and guidelines on Hearing Loss in Children, available at: https://www.cdc.gov/ncbddd/hearingloss/recommendations.html. See the CDC guidance on Hearing Screenings for Children, available at: https://www.cdc.gov/ncbddd/hearingloss/screening.html. For more information on Hearing Loss in Children, see: https://www.cdc.gov/ncbddd/hearingloss/facts.html.
15) Hepatitis B Virus Infection Screening	• Pending guidance from AAP
16) Hepatitis C Virus Infection Screening	• Per AAP, all individuals 18 and older should be assessed for risk of hepatitis C virus (HCV) infection. • Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveal potential for Hepatitis C Virus infection. • Per USPSTF and CDC, test at least once between the ages of 18 and 79. Persons with increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually.[24] . For more information refer to Hepatitis C Virus Infection in Adolescents and Adults: Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening.
17) Human Immunodeficiency Virus (HIV) Infection Screening	• Per AAP, risk assessment for HIV shall be completed at each well child visit starting at 11 years old.

[24] See the USPSTF recommendations on HCV screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening, and the CDC recommendations on HCV screening, available at: https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm.

IV. Pediatric Preventive Criteria	
	• Adolescents should be tested for HIV according to the USPSTF recommendations once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent.[25] • Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually. If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s). Recommendations for STD screening are listed in Box 3 at: https://www.cdc.gov/mmwr/volumes/68/rr/rr6805a1.htm#B3_down. Additional information on screening recommendations is available at: https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm; https://stacks.cdc.gov/view/cdc/82088. The CDC Recommendations for Providing Quality STD Clinical Services is available at: https://www.cdc.gov/mmwr/volumes/68/rr/rr6805a1.htm. For additional information on clinical considerations for risk assessment, screening intervals, treatment, and prevention, see: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening The AAP periodicity schedule is available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf For those at risk, look for documented evidence that pre-exposure prophylaxis (PrEP) was offered.
18) Psychosocial/Behavioral Assessment	• Psychosocial/Behavior Assessment should be done at each well child visit. • This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health.

[25] See the USPSTF recommendation on HIV screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening

IV. Pediatric Preventive Criteria	
	• • **Note: Social Determinants Of Health (SDOH)** • Per AAP, social determinants of health (SDOH) are the web of interpersonal and community relationships experienced by children, parents, and families. • Per CDC, social determinants of health (SDOH) are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality of life risks and outcomes. https://brightfutures.aap.org/Bright%20Futures%20Documents/BF_IntegrateSDoH_Tipsheet.pdf https://www.cdc.gov/socialdeterminants/about.html See the AAP publication titled "Promoting Optimal Development: Screening for Behavioral and Emotional Problems", available at: http://pediatrics.aappublications.org/content/135/2/384. See the AAP publication titled "Poverty and Child Health in the United States", available at: http://pediatrics.aappublications.org/content/137/4/e20160339 https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.
19) Sexually Transmitted Infection (STI) Screening and Counseling	Per AAP, adolescents should be screened for STIs per recommendations in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases. • Sexual activity shall be assessed at every well child visit starting at 11 years old. • If adolescents are identified as sexually active (by report or on the IHEBA form), the provider shall offer and provide contraceptive care with the goals of helping teens reduce risks and negative health consequences associated with adolescent sexual behaviors, including unintended pregnancies and STIs. • For adolescents that have been pregnant, provider should engage in a discussion of counseling on inter-pregnancy intervals and contraceptive care, such as moderately and most effective contraceptive options. Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveals STI.AAP refers to CDC for full list of STIs, available at:

IV. Pediatric Preventive Criteria	
	https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/California-STI-Treatment-Guidelines.aspx • **Risk assessments for Adolescents and 24 years and younger:** Annual chlamydia and gonorrhea screenings should be done for sexually active women under age 25 as well as older women who are at risk. Screening for syphilis, HIV, chlamydia, and Hepatitis B should be given to all pregnant women, and gonorrhea screening for all pregnant women.[26] • **Men Who Have Sex with Men** (MSM): These men have higher rates of STIs, such as HIV and syphilis and should be tested for these as well as chlamydia, and gonorrhea. • **Men Who Have Sex with Women**: There is insufficient evidence for screening among heterosexual men who are at low risk for infection, however, screening young men can be considered in high prevalence clinical settings (adolescent clinics, correctional facilities, and STI/sexual health clinic). • **Sex Workers**: This population is at higher risk for HIV and other STIs than others, and should be tested at least annually for HIV. • **Transgender and Gender Diverse Persons**: Screening recommendations should be adapted based on anatomy, (i.e., annual, routine screening for Chlamydia in cis-gender women < 25 years old should be extended to all transgender men and gender diverse people with a cervix. Consider screening at the rectal site based on reported sexual behaviors and exposure. **Persons with HIV**: For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter. More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology. **Syphilis** • People who are pregnant

[26] See the AAP guidance on Screening and Nonviral STIs in Adolescents and Young Adults: https://publications.aap.org/pediatrics/article/134/1/e302/62344/Screening-for-Nonviral-Sexually-Transmitted, the AAP periodicity schedule, available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf, and the AAP guidance on Adolescent Sexual Health, available at: https://www.aap.org/en/patient-care/adolescent-sexual-health/.

IV. Pediatric Preventive Criteria	
	• Male adolescents and young adults in settings with high prevalence rates (e.g. jails or juvenile correction facilities) • MSM at least annually (every 3 to 6 months if high risk because of multiple or anonymous partners, sex in conjunction with illicit drug use, or having sex partners who participated in these activities) See the AAP guidance on Adolescent Sexual Health, available at: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/adolescent-sexual-health/Pages/default.aspx See the DHCS webpage on the Staying Healthy Assessment, available at: https://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx. For information on chlamydia and gonorrhea screening. see: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/chlamydia-and-gonorrhea-screening. For USPSTF information on syphilis screening, see: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/syphilis-infection-in-nonpregnant-adults-and-adolescents. Senate Bill (SB) 306 (Pan, Chapter 486, Statutes of 2021) https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB306 https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=120685&lawCode=HSC
20) Sudden Cardiac Arrest and Sudden Cardiac Death Screening	Pending guidance from AAP
21) Tobacco Use Screening, Prevention, and Cessation Services	Tobacco Use Screening, Prevention, and Cessation Services • Screen all children 11 years and older at each well child visit for tobacco products use.

IV. Pediatric Preventive Criteria	
	• Tobacco products include but not limited to smoked cigarettes, chewed tobacco, electronic cigarette, and vaping products use, and/or exposure to secondhand smoke. • If patient answered "yes" to the smoke/tobacco questions in the IHEBA or at any time the PCP identifies a potential tobacco use problem, then the provider shall document prevention and/or cessation services to potential/active tobacco users. • Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveal tobacco use. Tobacco cessation services must be documented in the patient's medical record as follows: 1) Initial and annual assessment of tobacco (e-cigarette, vaping products, and/or secondhand smoke) use for each adolescent (11-21 years of age). 2) FDA-approved tobacco cessation medications (for non-pregnant adults of any age). 3) Individual, group, and telephone counseling for members of any age who use tobacco products. 4) Services for pregnant tobacco users. 5) Prevention of tobacco use in children and adolescents (including counseling and pharmacotherapy). For information on comprehensive tobacco prevention and cessation services for Medi-Cal beneficiaries is available at, see APL 16-014, Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries, or any superseding APL. Smoking status can be assessed through the use of the SHA, which is DHCS's IHEBA. The AAP recommended assessment tool is available at: http://crafft.org.
22)Tuberculosis Screening	• Per AAP, Committee on Infectious Diseases, published in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases, testing should be performed on recognition of high-risk factors.

IV. Pediatric Preventive Criteria	
	• All children are assessed for risk of exposure to tuberculosis (TB) at 1, 6, and 12-months old and annually thereafter. • Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveals positive risk factors for TB. • Two tests that are used to detect TB bacteria in the body: the TB skin test (TST) (Mantoux) and TB blood tests QuantiFERON-TB Gold Plus. A positive TB skin test or TB blood test only tells that a person has been infected with TB bacteria. TB infection screening test is administered to children *identified at risk,* if there has not been a test in the previous year. The Mantoux is not given if a previously positive Mantoux is documented. Documentation of a positive test includes follow-up care (e.g. further medical evaluation, chest x-ray, diagnostic laboratory studies and/or referral to specialist). • Providers are required to follow current CDC and American Thoracic Society guidelines for TB diagnosis and treatment. The California Pediatric Tuberculosis Risk Assessment tool is available at: https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-Pediatric-TB-Risk-Assessment.pdf. CDC guidance on TB testing and diagnosis is available at: https://www.cdc.gov/tb/topic/testing/default.htm.
23)Vision Screening	• Age-appropriate visual screening occurs at each health assessment visit, with referral to optometrist/ophthalmologist as appropriate. • Per AAP, visual acuity screenings using optotypes (figures or letters of different sizes used for vision screening) are to be performed at ages 3 (if cooperative), 4, 5, 6, 8, 10, 12, and 15 years old. • Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. • Documentation of “PERRLA” is acceptable for children below the age of 3 years. • If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s).

IV. Pediatric Preventive Criteria	

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	• AAP recommended eye charts are:
	  ○ LEA Symbols (3-5 years old)
	  ○ HOTV Chart (3-5 years old)
	  ○ Sloan Letters (preferred) or Snellen Letters (over 5 years old)
	
	See the AAP publications titled "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" available at: http://pediatrics.aappublications.org/content/137/1/e20153596 and "Procedures for the Evaluation of the Visual System by Pediatricians", available at: http://pediatrics.aappublications.org/content/137/1/e20153597.
	
	Note: Although specific screening details are not generally documented in the medical record, screening for infants and children (birth to 3 years) may consist of evaluations Such as external eye inspection, ophthalmoscopy red reflex examination, or corneal penlight evaluation. Visual acuity screening usually begins at age 3 years. AAP guidance on Visual System Assessment in Infants, Children, and Young Adults by Pediatricians is available at: https://pediatrics.aappublications.org/content/137/1/e20153596.

D) Childhood Immunizations	Every visit should be an opportunity to update and complete a child's immunizations. Childhood Immunizations Schedules, per the AAP Committee on Infectious Diseases, are available at: https://redbook.solutions.aap.org/SS/immunization_Schedules.aspx. For reference, see the CDC's ACIP webpage, available at: https://www.cdc.gov/vaccines/acip/index.html, also see APL 18-004, Immunization Requirements, or any superseding APL For details on Immunization Requirements.
1) Given according to ACIP guidelines	Immunization status is assessed at each health assessment visit. Practitioners are required to ensure the provision of immunizations according to CDC's most recent ACIP guidelines, unless medically contraindicated, vaccine shortage or refused by the parent.

IV. Pediatric Preventive Criteria	
	Refer to the following link for more information on ACIP Vaccine Recommendations and Guidelines: https://www.cdc.gov/vaccines/hcp/acip-recs/index.html.
2) **Vaccine administration documentation**	The name, manufacturer, date of administration, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries, in accordance with the National Childhood Vaccine Injury Act. For additional details on the National Childhood Vaccine Injury Act, refer to: https://www.congress.gov/bill/99th-congress/house-bill/5546
3) **Vaccine Information Statement (VIS) documentation**	• VISs are information sheets produced by the CDC that explain both the benefits and risks of a vaccine to the vaccine recipients. • Federal law requires that healthcare staff provide a VIS to a patient, parent, or legal representative before each dose of certain vaccines. VIS documentation in the medical/electronic record, medication logs, or immunization registries include the date the VIS was given or presented/offered *and* the VIS publication date. Refer to the following link from the CDC for the current VISs: https://www.cdc.gov/vaccines/hcp/vis/current-vis.html. **Note:** Federal law allows up to 6 months for the updated VIS to be distributed.

Rationale: Current Guide to Clinical Preventive Services, U.S. Preventive Services Task Force (USPSTF) Report is the minimum standard for adult preventive health services.

RN/NP/MD/PA/CNM/LM

V. Adult Preventive Criteria	
A. Initial Health Assessment (IHA): Includes H&P and IHEBA	**New Members:** The IHA (comprehensive history and IHEBA "Staying Healthy Assessment" or other DHCS-approved tool) enables the PCP to assess current acute, chronic, and preventive needs *and* to identify those Members whose health needs require coordinated services with appropriate community resources/other agencies not covered by the Plan. IHA must be completed within 120 days of plan enrollment or PCP effective date (whichever is more recent) or documented within the 12 months prior to Plan enrollment/PCP effective date. Reference: PLs 08–003 and 13-001, or any superseding APL.
1) Comprehensive History and Physical	**New members**: The history must be comprehensive to assess and diagnose acute and chronic conditions it includes: ○ History of present illness ○ Past medical history ○ Social history ○ Review of Organ Systems (ROS) including dental assessment Referrals for any abnormal findings must be documented. If an H&P is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented. A review of the organ systems that include documentation of "inspection of the mouth" or "seeing dentist" meets the criteria for dental assessment during a comprehensive history and physical.
	New members: An age-appropriate IHEBA ("Staying Healthy" or other DHCS-approved tool) is completed by the member within 120 days of the effective date of

V. Adult Preventive Criteria	
2) **Individual Health Education Behavioral Assessment (IHEBA)**	enrollment into the Plan or PCP effective date (whichever is more recent), or within the 12 months prior to Plan enrollment/PCP effective date. Staff may assist. The IHEBA has evidence of practitioner review: ○ Printed name ○ Signature ○ Date ○ Interventions, which may be documented on the IHEBA form, in progress notes, or other areas of the paper or electronic medical record system. If an initial IHEBA is not found in the medical record, the reasons (e.g., member's refusal, missed appointment) and contact attempts to reschedule are documented. SHA Questionnaires are available at: http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx
B. Periodic Health Evaluation according to most recent USPSTF guidelines	The type, quantity, and frequency of preventive services is based on the most recent USPSTF recommendations.
1) **Comprehensive History and Physical Exam completed at age-appropriate frequency.**	• Periodic health evaluations occur in accordance with the frequency that is appropriate for individual risk factors. • In addition to USPSTF recommendations, periodic health evaluations are scheduled as indicated by the member's needs and according to the clinical judgment of the practitioner. Example: A patient with elevated cholesterol levels and other risk factors for coronary heart disease (CHD) may be evaluated more frequently than other persons of the same age without similar risk factors.
2) **Subsequent Periodic IHEBA**	• The adult or senior assessment must be re-administered every 3 to 5 years, at a minimum.

V. Adult Preventive Criteria	
	• The PCP must review previously completed SHA questionnaires with the patient every year, except years when the assessment is re-administered. • Documentation requirements are the same as the initial IHEBA. • For subsequent annual reviews, PCP must sign, print name, and date "SHA Annual Review" section (last page) to verify the annual review was conducted and discussed with the patient. SHA Questionnaires are available at: http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx
C. Adult Preventive Care Screenings	The following adult preventive care screenings are based on USPTSF Grade A and B recommendations. • If the patient falls within the eligible condition (e.g. obesity, post-menopausal, etc.), age and gender parameters of the criterion, the provider shall assess for risk factors. • The IHEBA screening tool may assist in screening for risk factors for many preventive care criteria (i.e. Alcohol misuse, STI, HIV, Tobacco, etc.). • Evidence of risk assessments and screenings for other preventive care criteria may be found elsewhere in the medical record if the IHEBA was completed, reviewed, and signed by the provider, and the patient is negative for risk, the provider may be given a point. • If the patient is positive for risk factors, the provider shall offer and document follow-up intervention(s). • Providers who fail to document the presence or absence of risk factors shall receive zero (0) points. • An "NA" score is warranted if the patient falls outside of the eligible condition, age and gender parameters of the specific criterion. If specific preventive care screening tests are ordered, but results are not found in the member's record, and no documentation of follow-up is documented, these deficiencies will be cited under the appropriate preventive care criteria. The Follow-up of Specialty Referrals criteria pertain to referrals/lab tests that are not specified under preventive care criteria (i.e. ophthalmology, nephrology, etc.).

V. Adult Preventive Criteria	
	Use the following scoring methodology under adult preventive care screenings: ○ If ordered and result found, score as 1. ○ If ordered and patient refused, score as 1. ○ If ordered and no result found, but outreach efforts are documented, score as 1. ○ If ordered but no result or outreach efforts documented, score as 0.
1) Abdominal Aneurysm Screening	Assess all individuals during well adult visits for past and current tobacco use. USPSTF recommends that medical providers should perform a one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked 100 or more cigarettes in their lifetime. Indirect evidence shows that smoking is the strongest predictor of Abdominal Aortic Aneurysm (AAA) prevalence, growth, and rupture rates.[27] There is a dose-response relationship, as greater smoking exposure is associated with an increased risk for AAA. The USPSTF Grade A and B Recommendations are available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations.
2) Alcohol Use Disorder Screening and Behavioral Counseling	Assess all adults at each well visit for alcohol misuse. If at any time the PCP identifies a potential alcohol misuse problem (e.g., patient answered “yes” to the alcohol questions in the IHEBA), the provider shall: • Refer any member identified with possible alcohol use disorders to the alcohol and drug program in the county where the member resides for evaluation and treatment. • Use the Alcohol Use Disorder Identification Test (AUDIT) or Alcohol Use Disorder Identification Test-Consumption (AUDIT-C). • Complete at least one expanded screening, using a validated screening tool every year and additional screenings can be provided in a calendar year if medical necessity is documented by the member’s provider.

[27] See the USPSTF recommendation on AAA Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/abdominal-aortic-aneurysm-screening.

V. Adult Preventive Criteria	
	• Offer behavioral counseling intervention(s) to those members that a provider identifies as having risky or hazardous alcohol use. 1) A member responds affirmatively to the alcohol questions in the IHEBA. 2) Member provides responses on the expanded screening that indicate hazardous use, or when otherwise identified. When a member responds affirmatively to the alcohol questions in the IHEBA, provides responses on the expanded screening that indicate hazardous use, or when otherwise identified. Behavioral counseling intervention(s) typically include one to three sessions, 15 minutes in duration per session, offered in-person, by telephone, or by telehealth modalities. See the NIH guidance on Screening Tests, available at: https://pubs.niaaa.nih.gov/publications/arh28-2/78-79.htm See APL 21-014, Alcohol and Drug Screenings, Assessment, Brief Interventions and Referral to Treatment, or any superseding APL, for additional information. The USPSTF uses the term “unhealthy alcohol use” to define a spectrum of behaviors, from risky drinking to alcohol use disorder (AUD) (e.g., harmful alcohol use, abuse, or dependence). Risky or hazardous alcohol use means drinking more than the recommended daily, weekly, or per-occasion amounts, resulting in increased risk for adverse health consequences but not meeting criteria for AUD (e.g. the National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines “risky use” as exceeding the recommended limits of 4 drinks per day (56 g/d based on the US standard of 14 g/drink) or 14 drinks per week (196 g/d) for healthy adult men aged 21 to 64 years or 3 drinks per day or 7 drinks per week (42 g/d or 98 g/week) for all adult women of any age and men 65 years or older). Screening Unhealthy alcohol use screening must be done with validated screening tools.

V. Adult Preventive Criteria	
	The US Surgeon General, NIAAA, CDC, and ASAM recommend routinely screening adult patients for unhealthy alcohol use and providing them with appropriate interventions, https://www.niaaa.nih.gov/guide Brief Assessment When a screen is positive, providers should use validated assessment tools to determine if an alcohol use disorder is present. Validated alcohol assessment tools may be used without first using validated screening tools. Validated assessment tools include, but are not limited to: • CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) • NIDA-modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST) • Alcohol Use Disorders Identification Test (AUDIT) Brief Interventions and Referral to Treatment For recipients with brief assessments revealing alcohol misuse, brief misuse counseling should be offered. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment (MAT), should be offered to recipients whose brief assessment demonstrates probable alcohol use disorder. Alcohol brief interventions includes alcohol misuse counseling and counseling a member regarding additional treatment options, referrals, or services. Brief interventions must include the following: • Providing feedback to the patient regarding screening and assessment results. • Discussing negative consequences that have occurred and the overall severity of the problem. • Supporting the patient in making behavioral changes. • Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated. Documentation Requirements Member medical records must include the following: • The service provided, for example: screen and brief intervention.

V. Adult Preventive Criteria	
	• The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record). • The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record). • If and where a referral to an alcohol or substance use disorder program was made. A recommended substance abuse assessment tool is available at http://crafft.org. Please refer to the following link to The Medi-Cal Provider Manual: https://www.dhcs.ca.gov/formsandpubs/publications/Pages/Manuals.aspx.
3) **Breast Cancer Screening**	A routine screening mammography for breast cancer is completed every 1-2 years on all women starting at age 50, concluding at age 75 unless pathology has been demonstrated.[28]
4) Cervical Cancer Screening	• Screen for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years. • Women ages 30 to 65 years who want to lengthen the screening interval, screen with a combination of cytology and human papillomavirus (HPV) co-testing every 5 years OR with high-risk human papillomavirus (hrHPV) testing alone every 5 years. • Follow-up of abnormal test results are documented. Routine Pap testing may not be required for the following: • Women who have undergone hysterectomy in which the cervix is removed (TAH - Total Abdominal Hysterectomy), unless the hysterectomy was performed because of invasive cancer. • Women 66 years and older who have had regular previous screening in which the Pap result have been consistently normal.

[28] See the USPSTF recommendation on Breast Cancer Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening.

V. Adult Preventive Criteria	
	The USPSTF recommendation on Cervical Cancer Screening is available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening.
5) Colorectal Cancer Screening	All adults are screened for colorectal cancer beginning at age 45 years old and concluding at age 75 years to include: • High sensitivity gFOBT or FIT every year • sDNA-FIT every 1 to 3 years • CT colonography every 5 years • Flexible sigmoidoscopy every 5 years • Flexible sigmoidoscopy every 10 years + FIT every year • Colonoscopy screening every 10 years. When abnormal results are found on flexible sigmoidoscopy or CT colonography, follow-up with colonoscopy is needed for further evaluation. Rates of colorectal cancer incidence are higher in Black adults and American Indian and Alaskan Native adults, persons with a family history of colorectal cancer (even in the absence of any known inherited syndrome such as Lynch syndrome or familial adenomatous polyposis), men, and persons with other risk factors (such as obesity, diabetes, long-term smoking, and unhealthy alcohol use. The decision to screen for colorectal cancer in adults **aged 76 to 85 years** should be an individual one,taking into account the patient's overall health and prior screening history. The USPSTF recommendation on Colorectal Cancer Screening is available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening.
6) Depression Screening	• Per USPSTF, screen for depression in the general adult population, including pregnant and postpartum women. • Screening should be implemented at each well visit with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

V. Adult Preventive Criteria	
	• Providers should screen all adults who have not been previously screened using a validated screening tool. If the depression screening is positive, a follow up plan must be documented. • Providers should use clinical judgment in consideration of risk factors, comorbid conditions, and life events to determine if additional screening of high-risk patients is warranted. Recommended screening tools include: ○ Patient Health Questionnaire (PHQ) in various forms ○ Hospital Anxiety and Depression Scales in adults ○ Geriatric Depression Scale in older adults ○ The Edinburgh Postnatal Depression Scale (EPDS) pregnant and postpartum IHEBA forms when used solely for depression screening do not have psychometric properties and may not be reliable screening tools for depression. The USPSTF Grade A and B Recommendations are available at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations. The USPSTF recommendation on Screening for Depression in Adults is available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-adults-screening.
7) Diabetic Screening and Comprehensive Care	• Per USPSTF, screen for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 35 to 70 years who are overweight or obese. • Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity. • Glucose abnormalities can be detected by measuring HbA1c or fasting plasma glucose or with an oral glucose tolerance test.

V. Adult Preventive Criteria	
	• Hemoglobin A1C (HbA1c) is a measure of long-term blood glucose concentration and is not affected by acute changes in glucose levels due to stress or illness. HbA1c measurements do not require fasting, they are more convenient than using a fasting plasma glucose or oral glucose tolerance test. The oral glucose tolerance test is done in the morning in a fasting state; blood glucose concentration is measured 2 hours after ingestion of a 75-g oral glucose load. • The diagnosis of IFG, IGT, or type 2 diabetes should be confirmed; repeated testing with the same test on a different day is the preferred method of confirmation. See the USPSTF recommendation on Prediabetes and Type 2 Diabetes Screening, available at: https://uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-prediabetes-and-type-2-diabetes. See APL 18-018, Diabetes Prevention Program, or any superseding APL for additional information. • When reviewing medical records of patients with a diagnosis of Diabetes, the reviewer should score based on documented routine comprehensive diabetic care/screening: retinal exams, podiatry, nephrology, etc. • Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life. With support from health care providers, patients can manage their diabetes with self-care, taking medications as instructed, eating a healthy diet, being physically active, and quitting smoking. See the National Community for Quality Assurance guidance on Comprehensive Diabetes Care, available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. See the USPSTF recommendation on Prediabetes and Type 2 Diabetes Screening, available at:

V. Adult Preventive Criteria	
	https://uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-prediabetes-and-type-2-diabetes.
8) Drug Use Disorder Screening and Behavioral Counseling	Assess all adults at each well visit for drug misuse. If at any time the PCP identifies a potential drug use problem (e.g., patient answered "yes" to the drug use questions in the IHEBA), the provider shall: • Refer any member identified with possible drug use disorders to the drug treatment program in the county where the member resides for evaluation and treatment. • Complete at least one expanded screening, using a validated screening tool, every year and additional screenings can be provided in a calendar year if medical necessity is documented by the member's provider. • Offer behavioral counseling intervention(s) to those members that a provider identified as having as having risky or hazardous drug use. **1)** A member responds affirmatively to the drug use questions in the IHEBA. **2)** Member provides responses on the expanded screening that indicate hazardous use, or when otherwise identified. When a member responds affirmatively to the drug use questions in the IHEBA, provides responses on the expanded screening that indicate hazardous use, or when otherwise identified. Behavioral counseling intervention(s) typically include one to three sessions, 15 minutes in duration per session, offered in-person, by telephone, or by telehealth modalities. See APL 21-014, Alcohol and Drug Screenings, Assessment, Brief Interventions and Referral to Treatment, or any superseding APL, for additional information. The term "unhealthy drug use" is defined as the use of illegally obtained substances, excluding alcohol and tobacco, or the use of nonmedical prescription medications that differ than the parameters for which they were prescribed such as duration, frequency, and amount.

V. Adult Preventive Criteria	
	Brief Assessment When a screen is positive, providers should use validated assessment tools to determine if a drug use disorder is present. Validated drug assessment tools may be used without first using validated screening tools. Validated assessment tools include, but are not limited to: • CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) • NIDA-modified Alcohol, Smoking, and Substance Involvement Screening Test (NM-ASSIST) • Drug Abuse Screening Test (DAST-20) Brief Interventions and Referral to Treatment For recipients with brief assessments revealing drug misuse, brief misuse counseling should be offered. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment (MAT), should be offered to recipients whose brief assessment demonstrates probable substance use disorder. Drug brief interventions includes misuse counseling and counseling a member regarding additional treatment options, referrals, or services. Brief interventions must include the following: • Providing feedback to the patient regarding screening and assessment of results. • Discussing negative consequences that have occurred and the overall severity of the problem. • Supporting the patient in making behavioral changes. • Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated. Documentation Requirements Member medical records must include the following: • The service provided, for example: screen and brief intervention. • The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electric health record). • The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health

V. Adult Preventive Criteria	
	record). • If and where a referral to an alcohol or substance use disorder program was made. A recommended substance abuse assessment tool is available at: http://crafft.org. Please refer to the following link to the Medi-Cal Provider Manual: https://www.dhcs.ca.gov/formsandpubs/publications/Pages/Manuals.aspx.
9) Dyslipidemia Screening	USPSTF recommends that adults without a history of cardiovascular disease (CVD) (e.g., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all the following criteria are met: 1) They are aged 40 to 75 years; 2) They have one or more CVD risk factors (e.g., dyslipidemia, diabetes, hypertension, or smoking); and 3) They have a calculated 10-year risk of a cardiovascular event of 10% or greater. Screen universal lipids at every well visit for those with increased risk of heart disease and at least every 6 years for healthy adults. The USPSTF Grade A and B Recommendations are available at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.
10) Folic Acid Supplementation	• The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.[29] • USPSTF and WHO categorize women in the age range of 12-49 years as “women who are capable of becoming pregnant”.

[29] See the USPSTF recommendation on Folic Acid to Prevent Neural Tube Defects, available at: https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/folic-acid-to-prevent-neural-tube-defects-preventive-medication.

V. Adult Preventive Criteria	
11) Hepatitis B Virus Screening	Assess all adults for risk of acquiring Hepatitis B Virus (HBV) at each well visit. Screening those at risk should include testing to three HBV screening seromarkers (HBsAg, antibody to HBsAg [anti-HBs], and antibody to hepatitis B core antigen [anti-HBc]) so that persons can be classified into the appropriate hepatitis B category and properly recommended to receive vaccination, counseling, and linkage to care and treatment. Important risk groups for HBV infection with a prevalence of ≥2% that should be screened include: • Persons born in countries and regions with a high prevalence of HBV infection (≥2%), such as sub-Saharan Africa and Central and Southeast Asia (Egypt, Algeria, Morocco, Libya, Afghanistan, Vietnam, Cambodia, Thailand, Philippines, Malaysia, Indonesia, Singapore, etc.). • U.S.-born persons not vaccinated as infants whose parents were born in regions with a very high prevalence of HBV infection (≥8%). • HIV-positive persons • Injection drug users • MSM • Household contacts or sexual partners of persons with HBV infection See the CDC guidance on Viral Hepatitis, available at: https://www.cdc.gov/hepatitis/hbv/hbvfaq.htm
12) Hepatitis C Virus Screening	• All adults 18 to 79 years old shall be assessed for risk of Hepatitis C Virus (HCV) exposure at each well visits. • Testing should be initiated with anti-HCV. For those with reactive test results, the anti-HCV test should be followed with an HCV RNA. Persons for whom HCV Testing is recommended: • All Adults ages 18 to 79 years should be tested once. • Currently, or had history of, ever injecting drugs.

V. Adult Preventive Criteria	
	• Medical Conditions: Long term hemodialysis, persons who received clotting factor concentrates produced before 1987; HIV infection; Persistent abnormal alanine aminotransferase levels (ALT). • Prior recipients of transfusions or organ transplant before July 1992 or donor who later tested positive for HCV infection. Persons with continued risk for HCV infection (e.g., injection drug users) should be screened periodically. There is limited information about the specific screening interval that should occur in persons who continue to be at risk for new HCV infection or how pregnancy changes the need for additional screening. See the USPSTF recommendation on Screening for HCV in Adolescents and Adults Practice Considerations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening#bootstrap-panel--6. See the CDC Recommendations for Hepatitis C Screening Among Adults in the United States, available at: https://www.cdc.gov/hepatitis/hcv/guidelinesc.htm. See the USPSTF Grade A and B Recommendations, available at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.
13) High Blood Pressure Screening	• All adults including those without known hypertension are screened. • A blood pressure (B/P) measurement for the normotensive adult is documented at least once every 2 years if the last systolic reading was below 120 mmHg and the diastolic reading was below 80 mmHg. • B/P is measured annually if the last systolic reading was 120 to 139 mmHg and the diastolic reading was 80 to 89 mmHg. See the USPSTF Grade A and B Recommendation, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hypertension-in-adults-screening.

V. Adult Preventive Criteria	
14) HIV Screening	USPSTF recommends risk assessment shall be completed at each well visit for patients 65 years old and younger: • Those at high risk (regardless of age) i.e., having intercourse without a condom or with more than one sexual partner whose HIV status is unknown. • IV drug users. • MSM. All shall be tested for HIV and offered pre-exposure prophylaxis (PrEP). [30] Lab results are documented. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening
15) Intimate Partner Violence Screening for Women of Reproductive Age	• Per the USPSTF, clinicians shall screen for Intimate Partner Violence (IPV) on asymptomatic women of reproductive age, which is defined across studies as ranging from 12 to 49 years, with most research focusing on women age 18 years or older. • Provide or refer those who screen positive to ongoing support services. The SHA is an incomplete tool to screen for IPV, however, per USPSTF the following instruments accurately detect IPV in the past year among adult women: ○ Humiliation, Afraid, Rape, Kick (HARK) ○ Hurt, Insult, Threaten, Scream (HITS) ○ Extended–Hurt, Insult, Threaten, Scream (E-HITS) ○ Partner Violence Screen (PVS) ○ Woman Abuse Screening Tool (WAST) The USPSTF A and B recommendations are the minimum that is required by DHCS.

[30] See the USPSTF recommendation on Prevention of HIV Infection, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis.

V. Adult Preventive Criteria	
	The term “intimate partner violence” describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy. See the CDC guidance on IPV, available at: https://www.cdc.gov/violenceprevention/intimatepartnerviolence/
16) Lung Cancer Screening	• Assess all individuals during well adult visits for past and current tobacco use. • Per USPSTF, screen annually for lung cancer with low-dose computed tomography in adults ages 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. • Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. See the USPSTF recommendation on Lung Cancer Screening, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/lung-cancer-screening.
17) Obesity Screening and Counseling	• USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. • Documentation shall include weight and BMI • There is fair to good evidence that high-intensity counseling—about diet, exercise, or both—together with behavioral interventions aimed at skill development, motivation, and support strategies produces modest, sustained weight loss (typically 3-5 kg for 1 year or more) in adults who are obese (as defined by BMI ≥ 30 kg/m2). Although the USPSTF did not find direct evidence that behavioral interventions lower mortality or morbidity from obesity, the USPSTF concluded that changes in intermediate outcomes, such as improved glucose metabolism, lipid levels, and blood pressure, from modest weight loss provide indirect evidence of health benefits.

V. Adult Preventive Criteria	
	See the USPSTF recommendation on Screening and Counseling for Obesity in Adults, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/obesity-in-adults-screening-and-counseling-2003.
18) Osteoporosis Screening	Assess all postmenopausal women during well adult visits for risk of osteoporosis. USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, or who have at least one risk factor, as determined by a formal clinical risk assessment tool.[31] These risk factors include: • Parental history of hip fracture • Smoking • Excessive alcohol consumption • Low body weight. USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older. For postmenopausal women younger than 65 years who have at least 1 risk factor, a reasonable approach to determine who should be screened with bone measurement testing is to use a clinical risk assessment tool.
19) Sexually Transmitted Infection (STI) Screening and Counseling	Assess all individuals during well adult visits for risk of STI.[32] Chlamydia & Gonorrhea: • Test all sexually active women under 25 years old • Older women who have new or multiple sex partners

[31] See the USPSTF recommendations on Screening for Osteoporosis to Prevent Fractures, available at: https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/osteoporosis-screening.
[32] See the USPSTF recommendation on STIs: Behavioral Counseling, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/sexually-transmitted-infections-behavioral-counseling.

V. Adult Preventive Criteria	
	• MSM regardless of condom use or persons with HIV shall be tested at least annually Syphilis: • MSM or persons with HIV shall be screened at least annually Trichomonas: • Sexually active women seeking care for vaginal discharge • Women who are IV drug users • Exchanging sex for payment • HIV+, have History of STD, etc. Herpes: • Men and women requesting STI evaluation who have multiple sex partners shall be tested. • HIV+ • MSM w/ undiagnosed genital tract infection. Intensive behavioral counseling for adults who are at increased risk for STIs includes counseling on use of appropriate protection and lifestyle.
20) Skin Cancer Behavioral Counseling	USPSTF recommends that young adults and parents of young children should be counseled to minimize exposure to Ultraviolet (UV) radiation for persons aged 6 months to 24 years to reduce their risk of skin cancer.[33]
21)Tobacco Use: Screening, Counseling, and Intervention	• Assess all individuals during well adult visits for tobacco use and document prevention and/or counseling services to potential/active tobacco users. • If the PCP identifies tobacco use (e.g. Patient answered “Yes” on IHEBA).

[33] See the USPSTF Grade A and B Recommendations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/skin-cancer-counseling.

V. Adult Preventive Criteria	
	○ Per USPSTF, providers can document any combination of the following since not all may apply especially to pregnant tobacco users: tobacco cessation services, behavioral counseling and/or pharmacotherapy. See APL 16-014, Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries, or any superseding APL, for additional information. If the PCP identifies tobacco use (i.e., Patient answered "Yes" on IHEBA), documentation that the provider offered tobacco cessation services, behavioral counseling, and/or pharmacotherapy to include any or a combination of the following must be in the patient's medical record: • FDA-approved tobacco cessation medications (for non-pregnant adults of any age). • Individual, group, and telephone counseling for members of any age who use tobacco's products. • Services for pregnant tobacco users. See APL 16-014, Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries, or any superseding APL, for additional information.
22) Tuberculosis Screening	• Adults are assessed for TB risk factors or symptomatic assessments upon enrollment and at periodic physical evaluations. • The Mantoux skin test, or other approved TB infection screening test,[34] is administered to all asymptomatic persons at increased risk of developing TB irrespective of age or periodicity if they had not had a test in the previous year. • Adults already known to have HIV or who are significantly immunosuppressed require annual TB testing. The Mantoux is not given if a previously positive Mantoux is documented. Documentation of a positive test includes follow-up care, for example: ○ Further medical evaluation

[34] Per June 25, 2010, CDC MMWR, the FDA approved IGRA serum TB tests, such as QuantiFERON®-TB Gold (QFT-G and QFT-GIT) and T-SPOT®.TB (T-Spot).

V. Adult Preventive Criteria	
	○ Chest x-ray ○ Diagnostic laboratory studies ○ Referral to specialist Practitioners are required to follow current CDC and American Thoracic Society guidelines for TB diagnosis and treatment. See the CDPH guidance on California Adult TB Risk Assessment, available at: https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-TB-Risk-Assessment-and-Fact-Sheet.pdf. See the USPSTF recommendation on Latent TB Infection Screening, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/latent-tuberculosis-infection-screening. See the CDC publications on TB, available at: www.cdc.gov/tb/publications//.
D) Adult Immunizations	
1) Given according to ACIP guidelines	Immunization status is assessed at periodic health evaluations. Practitioners are required to ensure the provision of immunizations according to CDC's most recent ACIP guidelines, unless medically contraindicated or refused by the member.[35] Vaccination status must be assessed for the following: ○ Td/Tdap (every 10 years) ○ Flu (annually) ○ Pneumococcal (ages 65 and older; or anyone with underlying conditions) ○ Zoster (starting at age 50) ○ Varicella and MMR Documented evidence of immunity (i.e. titers, childhood acquired infection) in the medical record meets the criteria for Varicella and MMR.

[35] See the CDC ACIP Guidance on Immunization Schedules, available at: https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html.

V. Adult Preventive Criteria	
	The name of the vaccines and date the member received the vaccines must be documented as part of the assessment. See APL 18-004, Immunization Requirements, or any superseding APL for additional information.
2) Vaccine administration documentation	The name, manufacturer, date of administration, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries, in accordance with the National Childhood Vaccine Injury Act.
3) Vaccine Information Statement (VIS) documentation	The date the VIS was given (or presented and offered) and the VIS publication date are documented in the medical record.

Rationale: Perinatal assessments are provided according to the current American College of Obstetrics and Gynecologists (ACOG) standards and Comprehensive Perinatal Services Program (CPSP) Guidelines.[36] Reviewers please note, if the OB-GYN provider is also acting as the member's PCP and the member is/was pregnant during the review period (e.g. the last three years), the appropriate preventive services criteria, based on the members' age, i.e. Pediatric or Adult shall ALSO be reviewed and scored.

RN/NP/MD/PA/CNM/LM

VI. OB/CPSP Preventive Criteria	
A. Initial Comprehensive Prenatal Assessment (ICA)	**Initial Prenatal Visit - First entry to OB Care:** During the initial Comprehensive assessment, provider gathers baseline information on the pregnant woman, such as: ○ Obstetric and medical history, including medical documentation from prior visits with other providers. ○ Nutrition status ○ Health education ○ Psychosocial needs Based on the information gathered, the provider and the pregnant woman develop an individualized care plan (ICP) to meet her unique needs. Documentation of ICP services received, or reasons why not received, must be provided. See VI, B, below, for the First Trimester Comprehensive Assessment, which may be completed over more than one visit during the trimester. See the CDPH CPSP Provider Handbook, available at: https://custom.cvent.com/C506006261F8428CB7CCB91AAA9A05B4/files/8a01c5b0dd744c0aa06f0dece9dec3f1.pdf.
1) Initial Prenatal Visit	Documentation of initial prenatal visit completed within four weeks of entry to prenatal care. Optimally within the first trimester.
	Obstetric/medical: The H&P exam must be consistent with the most recent ACOG Guidelines for Perinatal Care.[37]

[36] See the CDPH webpage on CPSP, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx
[37] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.

VI. OB/CPSP Preventive Criteria	
2) Obstetrical and Medical History	
3) Physical Exam	Physical exam: includes breast and pelvic exam and calculation of estimated date of delivery. https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx
4) Dental Assessment	Dental Screening and referral as indicated must be documented. Oral health problems are associated with other diseases including heart disease, diabetes, and respiratory infections.[38]
5) Healthy Weight Gain and Behavior Counseling	The USPSTF recommends that clinicians offer pregnant women effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.[39] Effective behavioral counseling interventions promotes healthy weight gain and decreases risk of gestational diabetes mellitus, emergency cesarean delivery, infant macrosomia, and LGA infants.
6) Lab tests	
a) Bacteriuria Screening	USPSTF recommends screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at their first prenatal visit, if later.[40]

[38] See the ACOG guidance on Oral Health Care During Pregnancy and Through the Lifespan, available at: https://www.acog.org/en/Clinical/Clinical%20Guidance/Committee%20Opinion/Articles/2013/08/Oral%20Health%20Care%20During%20Pregnancy%20and%20Through%20the%20Lifespan

[39] See the USPSTF recommendation on Healthy Weight and Weight Gain in Pregnancy, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/healthy-weight-and-weight-gain-during-pregnancy-behavioral-counseling-interventions

[40] See the USPSTF recommendation on Screening for Asymptomatic Bacteria in Adults, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/asymptomatic-bacteriuria-in-adults-screening.

VI. OB/CPSP Preventive Criteria	
	Urine culture is recommended for bacteriuria screening in pregnancy and is the method for diagnosis. Pregnant women with asymptomatic bacteriuria usually receive antibiotic therapy, based on urine culture results and follow-up monitoring.
b) Rh Incompatibility Screening	• Rh incompatibility screening: 24-28 weeks gestation.[41] • Rh incompatibility is a condition that occurs during pregnancy if a woman has Rh-negative blood and her baby has Rh-positive blood.
c) Diabetes Screening	USPSTF recommends screening for gestational diabetes mellitus **(**GDM**)** in asymptomatic pregnant women after 24 weeks of gestation.[42] • In the two-step approach: the 50-g OGCT is performed between 24 and 28 weeks of gestation. A diagnosis of GDM is made when two or more glucose values fall at or above the specified glucose thresholds. • One-step approach: a 75-g glucose load is administered after fasting and plasma glucose levels are evaluated after 1 and 2 hours. Gestational diabetes is diagnosed if 1 glucose value falls at or above the specified glucose threshold. Self-monitoring of blood glucose can be a useful tool in the management of pregnant woman with pre-existing and with gestational diabetes.
d) Hepatitis B Virus Screening	All pregnant women are screened for Hepatitis B during their first trimester or prenatal visit, whichever comes first.[43]

[41] See the USPSTF recommendation on Rh(D) Incompatibility Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/rh-d-incompatibility-screening, and the NIH guidance on Rh Incompatibility, available at: https://www.nhlbi.nih.gov/health-topics/rh-incompatibility.
[42] See the USPSTF recommendation on Gestational Diabetes Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/gestational-diabetes-screening.
[43] See the USPSTF recommendation on HBV Infection in Pregnant Women, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-in-pregnant-women-screening.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2864180/

VI. OB/CPSP Preventive Criteria	
	The screening tests for detecting maternal HBV infection is the serologic identification of HBsAg. Screening should be performed in each pregnancy, regardless of previous HBV vaccination or previous negative HBsAg test results. Following referral required for women with positive HBV: • Case management during pregnancy • HBV DNA viral load testing • Referral to specialty care for counseling and medical management of HBV infection. See Hepatitis B information on the CDC website, available at: https://www.cdc.gov/hepatitis/hbv/index.htm.
e) Hepatitis C Virus Screening	Per ACOG all pregnant women should receive Hepatitis C screening with blood assessment during the first prenatal visit. Pregnant woman with newly diagnosed HCV infection and abnormal serum aminotransferase and/or platelet levels should be referred for further medical assessment to rule out liver fibrosis or injury and so antiviral treatment can be initiated at the appropriate time. Providers should report HCV infection in a pregnant person to infant's health care provider so that follow-up HCV testing can be conducted at the recommended time, and to the local health department so that ongoing risk factors can be assessed and relevant contacts can receive hepatitis A and hepatitis B testing and vaccination, as indicated, and can be linked, as appropriate, to preventive services. https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2021/05/routine-hepatitis-c-virus-screening-in-pregnant-individuals
f) Chlamydia Infection Screening	Per CDC, All pregnant women under 25 years old and older women with increased risk such as new or multiple sex partners, or a sex partner who has an STD, should be tested for chlamydia at their first prenatal visit pregnant women with chlamydial

VI. OB/CPSP Preventive Criteria	
	infection should have a test-of-cure four weeks after treatment and be retested within three months. Retest during the 3rd trimester for women under 25 years of age or at risk. See the CDC guidance on Chlamydia, available at: https://www.cdc.gov/std/chlamydia. See the CDC guidance on STD Tests, available at: https://www.cdc.gov/std/prevention/screeningreccs.htm. See the USPSTF recommendation on Chlamydia and Gonorrhea Screening, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/chlamydia-and-gonorrhea-screening.
g) Syphilis Infection Screening	Per CDC, all pregnant women should be tested for syphilis at the first prenatal visit.[44] High risk women need to be tested again during the third trimester (28 weeks gestation) and at delivery. This includes women who live in areas of high syphilis morbidity, are previously untested, had a positive screening test in the first trimester, or are at higher risk for syphilis (i.e., multiple sex partners, drug use, transactional sex, late entry into prenatal care or no prenatal care, meth or heroin use, incarceration themselves or of sex partners, unstable housing, or homelessness).
h) Gonorrhea Infection Screening	All pregnant women under 25 years old, and older pregnant women who are at increased risk, are screened for gonorrhea during their first prenatal visit.[45] Specific microbiologic diagnosis of *N. gonorrhea* infection should be performed for all women at risk for or suspected of having gonorrhea.

[44] See the CDC information on syphilis, available at: https://www.cdc.gov/std/syphilis/stdfact-syphilis-detailed.htm.
[45] See the CDC guidance on Gonococcal Infections Among Adolescents and Adults, available at: https://www.cdc.gov/std/treatment-guidelines/gonorrhea-adults.htm, and the USPSTF recommendation on Chlamydia and Gonorrhea Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/chlamydia-and-gonorrhea-screening.

VI. OB/CPSP Preventive Criteria	
	See the CDC guidance on Gonococcal Infections Among Adolescents and Adults, available at: https://www.cdc.gov/std/treatment-guidelines/gonorrhea-adults.htm.
i) Human Immunodeficiency Virus (HIV) Screening	Per ACOG, all pregnant women should be informed that HIV test is part of the routine panel of the prenatal tests.[46] If woman declines HIV testing this should be documented in the medical record. Repeat testing in the third trimester is recommended for woman known to be at high risk of acquiring HIV infection, and women who declined testing earlier in pregnancy.
B. First Trimester Comprehensive Assessment	A Comprehensive Perinatal Assessment must be completed each trimester and during the postpartum period. A Comprehensive Assessment tool must be used and updated every trimester and during the 12-month post-pregnancy period. The assessment tool must be consistent with CDPH's template tool, as confirmed by the local county or city Perinatal Health Coordinator.[47] See the CPSP Integrated Initial 1, 2, and 3 Trimester Assessments and ICP, available link bottom of the page.
1) Individualized Care Plan (ICP)	ICP documentation includes specific obstetric, nutrition, psychosocial, and health education risk problems/conditions, interventions, and referrals. **ICP must be developed based on the comprehensive assessment in each trimester and during the 12-month post-pregnancy period. The ICP must be updated based on the Comprehensive Assessments in each trimester, during the 12-month post-pregnancy period, and more frequently as needed. Documentation must be provided of the services offered and whether received.**

[46] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx, and the USPSTF recommendation on HIV Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening

[47] See the CDPH CPSP webpage, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx, and the Title 22 CPSP regulations, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-Title22CPSPRegulations.pdf

VI. OB/CPSP Preventive Criteria	
2) Nutrition Assessment	A complete initial nutrition assessment should be performed at the initial visit or within four weeks thereafter and should be documented in the pregnant woman medical record: • anthropometric data • biochemical data • clinical data • dietary data
3) Psychosocial Assessment	The psychosocial screening should be performed on a regular basis and documented in the woman's prenatal record.[48] The assessment should include the following: ○ Depression assessment ○ Social and mental history ○ Substance use Disorder including alcohol and tobacco ○ Unintended pregnancy ○ Support systems ○ Documentation of referral as appropriate. See the proposed changes for the 20202 Prenatal and Postpartum care HEDIS measures, available at: https://www.ncqa.org/wp-content/uploads/2019/02/20190208_08_Perinatal_Depression.pdf.
a) Maternal Mental Health Screening	Screening for maternal mental health conditions must be part of the Comprehensive Assessments at each trimester. Identified needs must be incorporated into the Individualized Care Plan and follow up services documented. *Health and Safety Code (HSC) Section 123640: and* AB-1477 Maternal mental *health: Licensed health care practitioner who provides prenatal, postpartum or*

[48] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx, and the CDPH CPSP Provider Handbook, available at: https://custom.cvent.com/C506006261F8428CB7CCB91AAA9A05B4/files/8a01c5b0dd744c0aa06f0dece9dec3f1.pdf.

VI. OB/CPSP Preventive Criteria	
	interpregnancy care for a patient shall ensure that the mother is offered screening or is appropriately screened for maternal mental health conditions. Counselling, referrals, or any interventions is documented. *"Maternal mental health condition" means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.* • USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. • CMS Technical Specifications include screening using validated tools and documentation of a follow-up plan if the depression screening is positive that aligns with USPSTF's referral and documentation of counseling or interventions with those found at risk for perinatal depression. • Patient is screened for depression on the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen. Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. • Edinburgh Postnatal Depression Scale (EPDS), • Patient Health Questionnaire (PHQ) 9 Follow-Up Plan – Documented follow-up for a positive depression screening must include one or more of the following: • Additional evaluation or assessment for depression • Suicide Risk Assessment • Referral to a practitioner who is qualified to diagnose and treat depression • Pharmacological interventions • Other interventions or follow-up for the diagnosis or treatment of depression

VI. OB/CPSP Preventive Criteria	
	Additional information on CMS Technical Specifications, is available at: https://www.medicaid.gov/license/form/6466/4391. See the USPSTF Grade A and B Recommendations, available at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.
b) Social Needs Assessment	The comprehensive Assessments in each trimester must also provide social needs assessment includes housing, food, transportation, unintended pregnancy, support system available.[49] Identified needs must be incorporated into the Individualized Care Plan, and follow up services documented
c) Substance Use Disorder Assessment	• All pregnant women should be routinely asked about their use of alcohol, tobacco and drug, including prescription opioids and other medications used for nonmedical reasons. • If the woman acknowledges the use of alcohol, cocaine, opioids, amphetamines, or other mood-altering drugs or if chemical dependence is suspected, she should be counseled about the perinatal implications of their use during pregnancy and offered referral to an appropriate treatment program. See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx.
3) Breastfeeding and other Health Education Assessment	• Health Education including breast feeding, preparation to breastfeed, language, cultural competence. And education needs must be assessed at least once during each trimester and more frequently as needed. Identified needs must be incorporated into the Individualized Care Plan, and follow up services documented.

[49] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx.

VI. OB/CPSP Preventive Criteria	
	• Materials must be available in the appropriate threshold languages and must meet readability and suitability requirements for educational material distributed to Medi-Cal members.[50]
4) Preeclampsia Screening	USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.[51]
5) Intimate Partner Violence Screening	• USPSTF recommends that clinicians screen IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services.[52] • Provision of a Domestic Violence Screening is documented. • Assessment checklists, body diagrams and/or documentation in progress notes are acceptable. Domestic violence screening includes: • Medical screening • Documentation of physical injuries • Documentation of illnesses attributable to spousal/partner abuse • Referral to appropriate community service agencies[53]
C. Second Trimester Comprehensive Assessment	See the CDPH CPSP webpage, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx. See the Title 22 CPSP Regulations, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-Title22CPSPRegulations.pdf.

[50] See APL 18-016, Readability and Suitability of Written Health Education Materials, or any superseding APL.
[51] See the USPSTF recommendation on Preeclampsia Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/preeclampsia-screening.
[52] See the USPSTF recommendation on IPV, Elder Abuse, and Abuse of Vulnerable Adults Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening.
[53] HSC 1233.5

VI. OB/CPSP Preventive Criteria	
1) Individualized Care Plan (ICP)	ICP documentation includes specific obstetric, nutrition, psychosocial, and health education risk problems/conditions, interventions, and referrals. ICP must be updated every trimester and more frequently as needed
2) Nutrition Assessment	A nutrition reassessment using updated information should be offered to each client at least once every trimester and the individualized care plan should be revised accordingly. Nutrition ICP component should address: • The prevention and/or resolution of nutrition problems. • The support and maintenance of strengths and habits oriented toward optimal nutritional status • Dispensing, as medically necessary, prenatal vitamin/mineral supplement to each pregnant woman. • Treatment and intervention directed toward helping the patient understand the importance of, and maintain good nutrition during pregnancy and lactation, with referrals as appropriate.
3) Psychosocial Assessment	The psychosocial screening should be performed on a regular basis and documented in the woman's prenatal record. The assessment should include the following: ○ Depression assessment ○ Social and mental history ○ Substance use/abuse including alcohol and tobacco ○ Unintended pregnancy ○ Support systems ○ Documentation of referrals as appropriate. See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx.

VI. OB/CPSP Preventive Criteria	
	https://www.ncqa.org/wp-content/uploads/2019/02/20190208_08_Perinatal_Depression.pdf

a) Maternal Mental Health Screening	Screening for maternal mental health conditions must be part of the Comprehensive Assessments at each trimester. Identified needs must be incorporated into the Individualized Care Plan and follow up services documented.
	
	Health and Safety Code (HSC) Section 123640 and AB-1477 Maternal Mental Health: Licensed health care practitioner who provides prenatal, postpartum or interpregnancy care for a patient shall ensure that the mother is offered screening or is appropriately screened for maternal mental health conditions. Counseling, referrals or any interventions is documented.
	
	"Maternal mental health condition" means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.
	
	• USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women.
	• CMS Technical Specifications includes screening using validated tools and documentation of a follow-up plan if the depression screening is positive that aligns with USPSTF's referral and documentation of counseling or interventions with those found at risk for perinatal depression.
	• Patient screened for depression on the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen.
	
	  • Edinburgh Postnatal Depression Scale (EPDS),
	  • Patient Health Questionnaire (PHQ) 9
	
	Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The

VI. OB/CPSP Preventive Criteria	
	name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. Follow-Up Plan – Documented follow-up for a positive depression screening must include one or more of the following: ○ Additional evaluation or assessment for depression • Suicide Risk Assessment • Referral to a practitioner who is qualified to diagnose and treat depression • Pharmacological interventions • Other interventions or follow-up for the diagnosis or treatment of depression For additional information on CMS Technical Specifications, see: https://www.medicaid.gov/license/form/6466/4391. See the USPSTF Grade A and B recommendations, available at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.
b) Social Needs Assessment	Social needs assessment including housing, food, transportation, unintended pregnancy, support system available.[54]
c) Substance Use Disorder Assessment	• All pregnant women should be routinely asked about their use of alcohol, tobacco, and drugs, including prescription opioids and other medications used for nonmedical reasons. • If the woman acknowledges the use of alcohol, cocaine, opioids, amphetamines, or other mood-altering drugs or if chemical dependence is suspected, she should be counseled about the perinatal implications of their use during pregnancy and offered referral to an appropriate treatment program.

[54] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx.

VI. OB/CPSP Preventive Criteria	
	See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx See the USPSTF Grade A and B Recommendations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations.
4) Breastfeeding and Other Health Education Assessment	• Health Education including breast feeding, language, cultural competence, and education needs must be assessed. • Materials must be available in the appropriate threshold languages and must meet readability and suitability requirements for educational material distributed to Medi-Cal members.[55]
5) Preeclampsia Screening	USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.[56]
a) Low Dose Aspirin	The Provider should advise on the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.[57]
6) Intimate Partner Violence Screening	• USPSTF recommends that clinicians screen for IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services.[58] • Provision of a Domestic Violence Screening is documented.

[55] See APL 18-106, Readability and Suitability of Written Health Education Materials, or any superseding APL.
[56] See the USPSTF recommendation on Preeclampsia Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/preeclampsia-screening.
[57] See the USPSTF Grande A and B recommendations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations.
[58] See the USPSTF recommendation on IPV, Elder Abuse, and Abuse of Vulnerable Adults Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening.

VI. OB/CPSP Preventive Criteria	
	• Assessment checklists, body diagrams and/or documentation in progress notes are acceptable. Domestic violence screening includes: • Medical screening. • Documentation of physical injuries or illnesses attributable to spousal/partner abuse. • Referral to appropriate community service agencies.[59]
7) Diabetes Screening	The **USPSTF** recommends screening for **gestational diabetes** mellitus **(GDM)** in asymptomatic pregnant women after 24 and 28 weeks of gestation.[60] • In the 2-step approach, the 50-g OGCT is performed between 24 and 28 weeks of gestation in a non-fasting state. If the screening threshold is met or exceeded, patients receive the oral glucose tolerance test (OGTT). A diagnosis of GDM is made when 2 or more glucose values fall at or above the specified glucose thresholds. • 1-step approach, a 75-g glucose load is administered after fasting and plasma glucose levels are evaluated after one and two hours. Gestational diabetes is diagnosed if 1 glucose value falls at or above the specified glucose threshold.
D. Third Trimester Comprehensive Assessment	See the CDPH CPSP webpage, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx. See the Title 22 CPSP Regulations, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-Title22CPSPRegulations.pdf.

[59] HSC 1233.5
[60] See the USPSTF recommendation on Gestational Diabetes Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/gestational-diabetes-screening.

VI. OB/CPSP Preventive Criteria	
1) Individualized Care Plan (ICP) Update and Follow Up	ICP documentation includes specific obstetric, nutrition, psychosocial and health education risk problems/conditions, interventions, and referrals. See the CPSP Integrated Initial 1, 2, and 3 Trimester Assessments and ICP, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-CombinedInitialandTrimesterAssessmentandCarePlan.pdf. See the CPCP Postpartum Assessment and ICP, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-PostpartumAssessmentandCarePlan.pdf.
2) Nutrition Assessment	A nutrition reassessment using updated information should be offered to each client at least once every trimester and the individualized care plan should be revised accordingly. Nutrition ICP component should address: • The prevention and/or resolution of nutrition problems. • The support and maintenance of strengths and habits oriented toward optimal nutritional status. • Dispensing, as medically necessary, prenatal vitamin/mineral supplement to each pregnant woman. • Treatment and intervention directed toward helping the patient understand the importance of, and maintain good nutrition during pregnancy and lactation, with referrals as appropriate. https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-Title22CPSPRegulations.pdf
3) Psychosocial Assessment	Psychosocial assessment must be performed on a regular basis and documented in the woman's prenatal record. The assessment should include the following: • Depression Assessment • Social and Mental History

VI. OB/CPSP Preventive Criteria	
	• Substance use/abuse including alcohol and tobacco; unintended pregnancy • Support systems • Documentation of referrals as appropriate See the CDPH CPSP Provider Handbook, available at: https://custom.cvent.com/C506006261F8428CB7CCB91AAA9A05B4/files/8a01c5b0dd744c0aa06f0dece9dec3f1.pdf. See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx
a) Maternal Mental Health Screening	*Practitioner who provides prenatal, interpregnancy, or postpartum care for a patient shall ensure that the mother is offered screening or is appropriately screened for maternal mental health conditions.* Counselling, referrals or any interventions is documented. *"Maternal mental health condition" means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.*[61] • USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. • CMS Technical Specifications includes screening using validated tools and documentation of a follow-up plan if the depression screening is positive that aligns with USPSTF's referral and documentation of counseling or interventions with those found at risk for perinatal depression. • Patient screened for depression on the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen.

[61] HSC 123640

VI. OB/CPSP Preventive Criteria	
	Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. • Edinburgh Postnatal Depression Scale (EPDS), • Patient Health Questionnaire (PHQ) 9 Follow-Up Plan – Documented follow-up for a positive depression screening must include one or more of the following: • Additional evaluation or assessment for depression • Suicide Risk Assessment • Referral to a practitioner who is qualified to diagnose and treat depression • Pharmacological interventions • Other interventions or follow-up for the diagnosis or treatment of depression For additional information on CMS Technical Specifications, see: https://www.medicaid.gov/license/form/6466/4391. See the USPSTF recommendation on Screening Depression in Adults, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-adults-screening. The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.[62]
b) Social Needs Assessment	The comprehensive assessments in each trimester must also provide social needs assessment including housing, food, transportation, unintended pregnancy, support system available.[63]

[62] See the USPSTF recommendation on Perinatal Depression, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/perinatal-depression-preventive-interventions.
[63] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx.

VI. OB/CPSP Preventive Criteria	
	Identified needs must be incorporated into the Individualized Care Plan, and follow up services documented
c) Substance Use Disorder Assessment	• All pregnant women should be routinely asked about their use of alcohol, tobacco and drug, including prescription opioids and other medications used for nonmedical reasons. • If the woman acknowledges the use of alcohol, cocaine, opioids, amphetamines, or other mood-altering drugs or if chemical dependence is suspected, she should be counseled about the perinatal implications of their use during pregnancy and offered referral to an appropriate treatment program. The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use. See APL 21-014, Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment, or any superseding APL for additional information. The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco.[64] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx. See the USPSTF Grade A and B Recommendations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations.

[64] See the USPSTF recommendation on Tobacco Smoking Cessation in Adults, Including Pregnant Persons, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions.

VI. OB/CPSP Preventive Criteria	
4) Breastfeeding and other Health Education Assessment	• Health Education including breast feeding, preparation to breastfeed, language, cultural competence, and education needs must be assessed at least once during each trimester and more frequently as needed. Identified needs must be incorporated into the Individualized Care Plan and follow up services documented. • Materials must be available in the appropriate threshold languages and must meet readability and suitability requirements for educational material distributed to Medi-Cal members.[65]
5) Preeclampsia Screening	USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.[66]
a) Low-Dose Aspirin	USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.[67]
6) Intimate Partner Violence Screening	• USPSTF recommends that clinicians screen for IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services.[68] • Provision of a Domestic Violence Screening is documented. • Assessment checklists, body diagrams and/or documentation in progress notes are acceptable. Domestic violence screening includes: • Medical screening.

[65] See APL 18-016, Readability and Suitability of Written Health Education Materials, or any superseding APL.
[66] See the ACIP recommendations on Routine Vaccination of Infants, Children, Adolescents, Pregnant Women, and Adults, available at: https://www.cdc.gov/vaccines/vpd/dtap-tdap-td/hcp/recommendations.html.
[67] See the USPSTF recommendation on Aspirin Use to Prevent Preeclampsia and Related Morbidity and Mortality, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/low-dose-aspirin-use-for-the-prevention-of-morbidity-and-mortality-from-preeclampsia-preventive-medication.
[68] See the USPSTF recommendation on IPV, Elder Abuse, and Abuse of Vulnerable Adults Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening.

VI. OB/CPSP Preventive Criteria	
	• Documentation of physical injuries or illnesses attributable to spousal/partner abuse. • Referral to appropriate community service agencies.[69]
7) Diabetic Screening	The **USPSTF** recommends screening for **gestational diabetes** mellitus **(GDM)** in asymptomatic pregnant women after 24 and 28 weeks of gestation.[70] • In the 2-step approach, the 50-g OGCT is performed between 24 and 28 weeks of gestation in a non-fasting state. If the screening threshold is met or exceeded, patients receive the oral glucose tolerance test (OGTT). A diagnosis of GDM is made when 2 or more glucose values fall at or above the specified glucose thresholds. • 1-step approach, a 75-g glucose load is administered after fasting and plasma glucose levels are evaluated after one and two hours. Gestational diabetes is diagnosed if 1 glucose value falls at or above the specified glucose threshold. • Self-monitoring of blood glucose can be a useful tool in the management of pregnant woman with pre-existing and with gestational diabetes.
8) Screening for Strep B	All pregnant women are screened for Group B Streptococcus (GBS) between their 35th and 37th week of pregnancy. Vaginal or rectal swab cultures at 36 – 37 weeks of gestation are positive for GBS, they should receive appropriate intrapartum antibiotic prophylaxis unless a prelabor cesarean birth is performed in the setting of intact membranes. Please refer to the following link for ACOG Frequently Asked Questions on Group B Streptococcus and pregnancy: https://www.acog.org/womens-health/faqs/group-b-strep-and-pregnancy.

[69] HSC 1233.5
[70] See the USPSTF recommendation on Screening for Gestational Diabetes, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/gestational-diabetes-screening.

VI. OB/CPSP Preventive Criteria	
	See the ACOG guidance on Prevention of Group B Streptococcal Early-Onset Disease in Newborns, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/02/prevention-of-group-b-streptococcal-early-onset-disease-in-newborns?utm_source=vanity&utm_medium=web&utm_campaign=clinical.
9) Screening for Syphilis	Pregnant women with high risk for syphilis and women who live in areas with high syphilis morbidity should be re-tested for syphilis between 28 and 32 weeks and at delivery. Stat RPR should be performed at delivery for women with no prenatal care. https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/CS_Eval_Management_pregnant%20women.pdf
10)Tdap Immunization	• Pregnant women should receive a single dose of Tdap during every pregnancy, preferably at 27 through 36 weeks gestation. • Tdap is recommended only in the immediate postpartum period before discharge from the hospital or birthing center for new mothers who have never received Tdap before or whose vaccination status is unknown. • Practitioners are required to ensure the provision of immunizations according to CDC's most recent ACIP guidelines, unless medically contraindicated or refused by the member. See the CDC's ACIP recommendations on Routine Vaccination of Infants, Children, Adolescents, Pregnant Women, and Adults, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/preeclampsia-screening1. See the CDC's ACIP guidelines on vaccines, available at: https://www.cdc.gov/vaccines/hcp/acip-recs/index.html. Please note-the administration of pertussis is eligible for the Valued Based Payment (VBP) program. Please consult with the MCP for details.

VI. OB/CPSP Preventive Criteria	
E. Prenatal care visit periodicity according to most recent ACOG Standards	ACOG's *Guidelines for Perinatal Care* recommend the following prenatal schedule for a 40-week uncomplicated pregnancy: 1) First visit by 6-8th week 2) Approximately every 4 weeks for the first 28 weeks of pregnancy 3) Every 2-3 weeks until 36 weeks gestation 4) Weekly thereafter until delivery If the recommended ACOG schedule is not met, documentation shows missed appointments, attempts to contact member and/or outreach activities. Refer the following link to ACOG for further details: https://www.acog.org/clinical
F. Influenza Vaccine	CDC and ACIP recommend that pregnant women gets vaccinated during any trimester of their pregnancy. Refer to the following link for further information on vaccination schedules: https://www.cdc.gov/vaccines/pregnancy/hcp-toolkit/guidelines.html https://www.cdc.gov/vaccines/hcp/acip-recs/rec-vac-preg.html See CDC guidance on pregnancy and vaccination, available at: https://www.cdc.gov/vaccines/pregnancy/pregnant-women/index.html See APL 18-004, Immunization Requirements, or any superseding APL for additional information.
G. COVID Vaccine	The American College of Obstetricians and Gynecologists (ACOG) recommends that all eligible persons greater than age 12 years, including pregnant and lactating individuals, receive a COVID-19 vaccine or vaccine series. Provider should document the discussion in the medical record if pregnant woman refused to receive the vaccine.

VI. OB/CPSP Preventive Criteria	
	During the subsequent office visits, obstetrician–gynecologists should address ongoing questions and concerns and offer vaccination again. https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2020/12/covid-19-vaccination-considerations-for-obstetric-gynecologic-care
H. Referral to Special Supplemental Nutrition Program for Women, Infants, and Children (**WIC) and assessment of Infant Feeding Status**	Pregnant and breastfeeding mothers must be referred to WIC.[71] • Referral to WIC is documented in the medical record.[72] • Infant feeding plans are documented during the prenatal period. • Infant feeding/breastfeeding status is documented during the postpartum period.[73] Refer to the following link for information on the WIC program: https://m.wic.ca.gov/ **Note:** Although WIC determines eligibility for program participation, nearly all Medi-Cal beneficiaries are income eligible for WIC. Federal regulations specify that pregnant and breastfeeding women are given the highest priority for WIC Program enrollment.
I. HIV-related services *offered*	Per ACOG, repeat testing in the third trimester is recommended for women known to be at high risk of acquiring HIV infection, and women who declined testing earlier in pregnancy. • The ***offering*** of prenatal HIV information, counseling, and HIV antibody testing is documented.[74] • Practitioners are ***not required*** to document that the HIV test was given or disclose (except to the member) the results (positive or negative) of an HIV test. • Offering a prenatal HIV test is not required if a positive HIV test is already documented in the patient's record or if the patient has AIDS diagnosed by a physician.

[71] Public Law 103-448, Section 203(e)
[72] 42 CFR 431.635
[73] PL 98-010, Breastfeeding Promotion
[74] HSC 125107

VI. OB/CPSP Preventive Criteria	
	See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx. See the CDC STI Screening Recommendations, available at: https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm. See the ACOG guidance on Prenatal and Perinatal HIV Testing, available at: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Prenatal-and-Perinatal-Human-Immunodeficiency-Virus-Testing?IsMobileSet=false. See the USPSTF recommendation on HIV Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening.
J. AFP/Genetic Screening *offered*	The offering of blood screening tests prior to 20 weeks gestation counting from the first day of the last normal menstrual period is documented.[75] Genetic screening documentation includes: • Family history • Triple marker screening tests: Alpha Fetoprotein (AF), unconjugated estriol (UE), human chorionic gonadotropin (HCG) • Member's consent or refusal to participate For information on the Alpha-Fetoprotein Test, see: https://americanpregnancy.org/prenatal-testing/alpha-fetoprotein-test **Note:** Member's participation is voluntary. Testing occurs through CDPH Expanded AFP Program, and only laboratories designated by CDPH may be used for testing.
K. Family Planning Evaluation	

[75] 17 CCR 6521-6532

VI. OB/CPSP Preventive Criteria	
	• Women should be counseled about the risks and benefits of repeat pregnancy sooner than 18 months which have been associated with adverse perinatal outcomes, including preterm birth, low birth weight, and small size of gestational age, as well as adverse maternal outcomes. • All postpartum women can be considered at risk for unintended pregnancy for that period of time. Family Planning counseling, including counseling of interpregnancy intervals, contraceptive care, referral or provision of services is documented.[76] Prenatal discussions should include the woman's reproductive life plans, including the desire for and timing of any future pregnancies. See the HHS guidance on Contraceptive Care Measures, available at: https://opa.hhs.gov/research-evaluation/title-x-services-research/contraceptive-care-measures See DHCS' Office of Family Planning webpage, available at: https://www.dhcs.ca.gov/services/ofp/Pages/OfficeofFamilyPlanning.aspx See APL 18-019, Family Planning Services Policy for Self-Administered Hormonal Contraceptives, or any superseding APL for additional information.
L. Comprehensive Postpartum Assessment	The weeks following birth are a critical period for a woman and her infant, setting the stage for long-term health and well-being. To optimize the health of women and infants, postpartum care should become an ongoing process, rather than a single encounter, with services and support tailored to each woman's individual needs. As of April 1, 2022, Medi-Cal's postpartum period is extended from 60 to 365 days, regardless of how the pregnancy ends. • Per ACOG, women should contact their OB-GYN or other obstetric care providers within the first three weeks postpartum.

[76] See PL 98-011, Family Planning Services in Medi-Cal Managed Care, or any superseding APL for additional information.

VI. OB/CPSP Preventive Criteria	
	• The comprehensive postpartum visit should be scheduled between four weeks and six weeks after delivery. • This initial postpartum assessment should be followed up with ongoing care as needed throughout the 12 month postpartum period, including with a comprehensive postpartum visit no later than 12 weeks after birth. The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being, including the following domains: ○ Mood and emotional well-being ○ Infant care and feeding ○ Sexuality ○ Contraception ○ Birth spacing ○ Sleep and fatigue ○ Physical recovery from birth ○ Chronic disease management ○ Health maintenance Women with chronic medical conditions such as hypertensive disorders, obesity, diabetes, thyroid disorders, renal disease, and mood disorders should be counseled regarding the importance of timely follow-up with their OB-GYN or primary care providers for ongoing coordination of care. During the postpartum period, the woman and her OB-GYN or other obstetric care provider should identify the health care provider who will assume primary responsibility for her ongoing care in her primary medical home. See the ACOG guidance on Optimizing Postpartum Care, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care. See the ACOG guidance on Postpartum Care, available at: https://www.acog.org/news/news-releases/2018/04/acog-redesigns-postpartum-care

VI. OB/CPSP Preventive Criteria	
	See the CDPH CPSP Postpartum Assessment and ICP, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-PostpartumAssessmentandCarePlan.pdf. https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/I21-13.pdf#:~:text=Individuals%20in%20Medi-Cal%20with%20a%20SOC%20may%20be,for%20the%20rest%20of%20pregnancy%20and%20postpartum%20period. See PL 12-003, Obstetrical Care-Perinatal Services, or any superseding APL for additional information. See ACOG information on Optimizing Postpartum Care, available at: https://www.acog.org/More-Info/OptimizingPostpartumCare. **Note:** Postpartum care is eligible for the VBP program. Please consult with the MCP for details. For screening: If the postpartum assessment visit is not documented a point will not be given. A point can be given if there is documentation in the medical record of missed appointments and attempts to contact member and/or outreach activities. If appointments are documented in a separate system from medical records, they must be readily accessible and meet the medical retention requirements.
1) Individualized Care Plan (ICP)	ICP documentation includes specific obstetric, nutrition, psychosocial and health education risk problems/conditions, interventions, and referrals. **ICP must be developed based on the comprehensive assessment in each trimester and post-partum.** See the CDPH CPSP Integrated Initial 1st, 2nd, and 3rd Trimester Assessments and ICP, available at:

VI. OB/CPSP Preventive Criteria	
	https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-CombinedInitialandTrimesterAssessmentandCarePlan.pdf. See the CDPH CPSP Postpartum Assessment and ICP, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-PostpartumAssessmentandCarePlan.pdf.
2) Nutrition Assessment	• USPSTF recommends providing interventions during pregnancy and after birth to support breastfeeding. Nutrition Assessment should include mother and infant including support for breast feeding.[77] • Any needed interventions must be noted. • Documentation of referrals as indicated. Infant feeding/breastfeeding status is documented during the postpartum period.[78] See the ACOG guidance on Optimizing Support for Breastfeeding as Part of Obstetric Practice, available at: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Support-for-Breastfeeding-as-Part-of-Obstetric-Practice?IsMobileSet=false. https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-PostpartumAssessmentandCarePlan.pdf
3) Psychosocial Assessment	Psychosocial Assessment includes mood and emotional wellbeing; sleep and fatigue.[79] See the ACOG guidance on Optimizing Postpartum Care, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care.

[77] See the USPSTF recommendation on Breastfeeding: Primary Care Interventions, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breastfeeding-primary-care-interventions.
[78] See PL 98-010, Breastfeeding Promotion, or any superseding APL for additional information.
[79] See the ACOG guidance on Optimizing Postpartum Care, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care?utm_source=redirect&utm_medium=web&utm_campaign=otn.

VI. OB/CPSP Preventive Criteria	
a) Maternal Mental Health Screening/Postpartum Depression screening	*Practitioner who provides prenatal or postpartum care for a patient shall ensure that the mother is offered screening or is appropriately screened for maternal mental health conditions.* Counselling and intervention must be documented. • USPSTF recommends that clinicians provide or refer postpartum persons who are at increased risk of postpartum depression to counseling interventions.[80] • CMS Technical Specifications includes screening using validated tools and documentation of a follow-up plan if the depression screening is positive that aligns with USPSTF's referral and documentation of counseling or interventions with those found at risk for postpartum depression. • Patient screened for depression on the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen. Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. Follow-Up Plan – Documented follow-up for a positive depression screening must include one or more of the following: ○ Additional evaluation or assessment for depression ○ Suicide Risk Assessment ○ Referral to a practitioner who is qualified to diagnose and treat depression ○ Pharmacological interventions ○ Other interventions or follow-up for the diagnosis or treatment of depression For additional information on CMS Technical Specifications, see: https://www.medicaid.gov/license/form/6466/4391.

[80] See the USPSTF recommendation on Perinatal Depression, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/abdominal-aortic-aneurysm-screening.

VI. OB/CPSP Preventive Criteria	
	Edinburgh Postnatal Depression Scale (EPDS) is most commonly used and has been translated in 50 different languages.[81]
b) Social Needs Assessment	Social and Mental History (past and current). Follow up on pre-existing mental health disorders and social care needs such as housing, food, and transportation refer as appropriate.
c) Substance Use Disorder Assessment	Screen for tobacco and alcohol use and provide counseling; Screen for substance use disorder and refer as indicated. USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.[82] See APL 21-014, Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment, or any superseding APL for additional information. USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco.[83]
4) Breastfeeding and other Health Education Assessment	• Health Education on infant care and feeding including breast feeding, contraception, and birth spacing.

[81] HSC 123640
[82] See the USPSTF recommendation on Unhealthy Alcohol Use in Adolescents and Adults, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions.
[83] See the USPSTF recommendation on Tobacco Smoking Cessation in Adults, Including Pregnant Persons, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions

VI. OB/CPSP Preventive Criteria	
	• Materials must be in threshold language and must meet readability and suitability requirements for educational material distributed to Medi-Cal members.[84] See the USPSTF recommendation on Breastfeeding, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breastfeeding-primary-care-interventions. See APL 18-019, Family Planning Services Policy for Self-Administered Hormonal Contraceptives, or any superseding APL for additional information.
5) Comprehensive Physical Exam	The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being, including the following domains: • Mood and emotional well-being • Infant care and feeding • Sexuality • Contraception • Birth spacing • Sleep and fatigue • Physical recovery from birth • Chronic disease management • Health maintenance Women with chronic medical conditions such as hypertensive disorders, obesity, diabetes, thyroid disorders, renal disease, and mood disorders should be counseled regarding the importance of timely follow-up with their OB-GYN or primary care providers for ongoing coordination of care. During the postpartum period, the woman and her OB-GYN or other obstetric care provider should identify the health care provider who will assume primary responsibility for her ongoing care in her primary medical home.

[84] See APL 18-016, Readability and Suitability of Written Health Education Materials, or any superseding APL for additional information.

VI. OB/CPSP Preventive Criteria	
	It is recommended that all women have contact with their OB-GYN or other obstetric care providers within the first three weeks postpartum. This initial assessment should be followed up with ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth. See the ACOG guidance on Optimizing Postpartum Care, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care

Facility Site Review Standards

Purpose: The Facility Site Review Standards provide the instructions, rules, regulations, parameters, and indicators for conducting Facility Site Reviews using the Facility Site Review tool. The site reviewer must use these Standards for measuring, evaluating, assessing, and making decisions.

Scoring: Site reviews include on-site inspection and interviews with site personnel. Reviewers are expected to use reasonable evidence available during the review process to determine if practices and systems on site meet review criteria. Critical Elements have a weight of two (2) points each and non-Critical Elements have a weight of one (1) point on the site review tool. Compliance levels include:

1) Exempted Pass: 90% or above *without deficiencies* in Critical Elements, Pharmaceutical or Infection Control
2) Conditional Pass: 80-89%, or 90% and above with deficiencies in either Critical Elements, Pharmaceutical or Infection Control
3) Fail: 79% and below

A corrective action plan (CAP) is required for a total score less than 90%, *OR* for a total score of 90% or above if there are deficiencies in Critical Elements, Pharmaceutical Services or Infection Control. Compliance rates are based on 170 total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer. Reviewers are expected to determine how to ascertain information needed to complete the review. Review criteria that shall be reviewed *only* by a registered nurse (RN), nurse practitioner (NP), Certified Nurse Midwife (CNM), Licensed Midwife (LM), physician (MD), or physician assistant (PA) is labeled "**RN/NP/CNM/LM/MD/PA".**

Directions: Score full point(s) if review item is met. Score zero (0) points if item is not met. Do not score partial points for any item. Explain all "N/A" and "No" (0 point) items in the comment section. Provide assistance/consultation as needed for CAPs and establish follow-up/verification timeline.

1) Add the points given in each section.
2) Add points given for all six (6) sections to determine total points given for the site.
3) Subtract all "N/A" items from 170 total possible points to determine the "adjusted" total possible points. If there are no "N/A" items, calculation of site score will be based on 170 points.
4) Divide the total points given by 170 or by the "adjusted" total. Multiply by 100 to calculate percentage rate.

Scoring Example:

Step 1: Add the points given in each section.

Step 2: Add points given for all six (6) sections.

Example: 31 (Access/Safety)
27 (Personnel)
25 (Office Management)
40 (Clinical Services)
13 (Preventive Services)
34 (Infection Control)
170 (POINTS GIVEN)

Step 3: Subtract "N/A" points from 170 total points possible.

170 (Total points possible)
- 5 (N/A points)
165 ("Adjusted" total points possible)

Step 4: Divide total points given by the "adjusted" points, then multiply by 100 to calculate percentage rate.

$$\frac{\text{Points given}}{\text{"Adjusted" total}} \quad \text{or} \quad \frac{140}{165} = 0.8485 \times 100 = \mathbf{85\%}$$

Criteria	I. Access/Safety Standards
A. Site is accessible and useable by individuals with physical disabilities.	**Sites must have the following safety accommodations for physically disabled persons:** **<u>Americans with Disabilities Act (ADA) Regulations</u>:** • Site must meet city, county, and state building structure and access ordinances for persons with physical disabilities. A site/facility includes the building structure, walkways, parking lots, and equipment. • All facilities designed, constructed; or altered by, on behalf of, or for the use of a public entity must be readily accessible and usable by individuals with disabilities, if the construction or alteration was begun after January 26, 1992.[1] • Any alteration to a place of public accommodation or a commercial facility, after January 26, 1992, must be made to ensure that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and useable by individuals with disabilities, including individuals who use wheelchairs.[2] **I.A.1) Clearly marked (blue) curb or sign designating disabled-parking space near accessible primary entrance.** **<u>Parking</u>:** • Parking spaces for persons with physical disabilities are located in close proximity to accessible building entrances. • Each parking space reserved for persons with disabilities is identified by a permanently affixed reflectorized sign posted in a conspicuous place. • If the provider has no control over availability of accessible parking within lot or nearby street spaces for persons with disabilities, the provider must have a plan in place for making program services available to persons with physical disabilities. **I.A.2) Pedestrian ramps have a level landing at the top and bottom of the ramp.** **<u>Ramps</u>:** • A clear and level landing is at the top and bottom of all ramps and on each side of an exit door. • Any path of travel is considered a ramp if its slope is greater than a 1-foot rise in 20 feet of horizontal run. • Ramps must be a minimum of 36-inches wide. Some areas require wider ramps.

[1] Title 28, Code of Federal Regulations (CFR), section 35.151. The CFR is searchable at: https://www.ecfr.gov/search.
[2] 28 CFR section 36.402.

Criteria	I. Access/Safety Standards
	• All edges must be protected to keep anyone from slipping off. • All ramps that are 5 feet long shall have a level top and bottom landings. • Ramps must have handrails on both sides if length is longer than 6 feet. **I.A.3) Exit and exam room doorway openings allow for clear passage of a person in a wheelchair.** **<u>Exit Doors</u>:** • All entrances and exterior and interior exit doors, regardless of the occupant load shall be made accessible to persons with disabilities. • Exam room and exit doorways have a minimum opening of 32 inches with the door open at 90 degrees that will allow for passage of wheelchairs. • Door hardware = operable with a single effort without requiring ability to grasp hardware. • Effort to operate doors = a maximum pressure of 5 pounds at interior doors. • Door hardware height = 30” – 44” above floor. • Exit doors include all doors required for access, circulation and use of the building and facilities, such as primary entrances and passageway doors. • Furniture and other items do not obstruct exit doorways or interfere with door swing pathway. **I.A.4) Accessible passenger elevator or reasonable alternative for multi-level floor accommodation.** **<u>Elevators</u>:** • If there is no elevator, a freight elevator may be used to achieve program accessibility if it is upgraded for general passenger use and if passageways leading to and from the elevator are well-lit, neat, and clean. **I.A.5) Clear floor space for wheelchair in waiting area and exam room.** **<u>Clear Floor Space</u>:** • Clear space in waiting/exam areas is sufficient (at least 30-in. x 48-in.) to accommodate a single, stationary adult wheelchair and occupant. • A minimum clear space of 60-inch diameter or square area is needed to turn a wheelchair. **<u>Sanitary Facilities</u>:** **I.A.6) Wheelchair accessible restroom facilities.** • A wheelchair accessible restroom stall allows sufficient space for a wheelchair to enter and permits the door to close.

Criteria	I. Access/Safety Standards
	• Sufficient knee clearance space underneath the sink allows wheelchair users to safely use a lavatory sink for hand washing. • If wheelchair-accessible restrooms are not available within the office site, reasonable alternative accommodation are provided such as a wheelchair-accessible restroom located within the building. Other reasonable alternatives may include, but is not limited to, urinal, bedpan, or bedside commode in a private area. **IA.7) Wheelchair accessible handwashing facilities or reasonable alternative.** • Restroom and hand washing facilities are accessible to able-bodied and physically disabled persons. • If wheelchair-accessible handwashing facilities are not available within the office site, reasonable alternative accommodation are provided such as sanitizers and wheelchair-accessible restroom located within the building. **Note:** • A public entity may not deny the benefits of its program, activities, and services to individuals with disabilities because its facilities are inaccessible.[3] • Every feature need not be accessible, if a reasonable portion of the facilities and accommodations provided is accessible.[4] • Reasonable Portion and/or Reasonable Alternatives are acceptable to achieve program accessibility. • Reasonable Portion applies to multi-storied structures and provides exceptions to the regulations requiring accessibility to all portions of a facility/site. • Reasonable Alternatives are methods other than site structural changes to achieve program accessibility, such as acquisition or redesign of equipment, assignment of assistants/aides to beneficiaries, provision of services at alternate accessible sites, and/or other site-specific alternatives to provide services.[5] • Points shall not be deducted if Reasonable Portion or Reasonable Alternative is made available on site.

[3] 28 CFR sections 35.149 – 35.150.
[4] Title 24, California Code of Regulations (CCR), sections 2-419, California Administrative Code, the State Building Code. CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index.
[5] Title II-5.2000 of the ADA Technical Assistance Manual, available at: https://www.ada.gov/taman2.html.

Criteria	I. Access/Safety Standards
	Specific measurements are provided strictly for "*reference only"* for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.
B. Site environment is maintained in a clean and sanitary condition.	**I.B.1) All patient areas including floor/carpet, walls, and furniture are neat, clean, and well maintained.** • The physical appearance of floors/carpets, walls, furniture, patient areas, and restrooms are clean and well maintained. **I.B.2) Restrooms are clean and contain appropriate sanitary supplies.** • Appropriate sanitary supplies, such as toilet tissue, hand washing soap, cloth/paper towels or antiseptic towelettes are made available for restroom use. • Environmental safety includes the "housekeeping" or hygienic condition of the site. • Clean means unsoiled, neat, tidy, and uncluttered. • "Well maintained" means being in good repair or condition.
C. Site environment is safe for all patients, visitors and personnel.	**<u>Ordinances</u>:** • Sites must meet city, county, and state fire safety and prevention ordinances. • Reviewers should be aware of applicable city and county ordinances in the areas in which they conduct reviews. **There is evidence staff has received safety training and/or has safety information available on the following:** **I.C.1) Fire safety and prevention.** **I.C.2) Emergency non-medical procedures (e.g. site evacuation, workplace violence).** **<u>Emergency Action Plans</u>:** • Non-medical emergencies include incidents of fire, natural disaster (e.g. earthquakes), workplace violence, etc. • Specific information for handling fire emergencies and evacuation procedures is available on site to staff. Personnel know ***where to locate*** information on site, and ***how to use*** information.[6]

[6] 29 CFR section 1910.38

Criteria	I. Access/Safety Standards
	I.C.3) Lighting is adequate in all areas to ensure safety. **Illumination:** Lighting is adequate in-patient flow working and walking areas such as corridors, walkways, waiting and exam rooms, and restrooms to allow for a safe path of travel. **I.C.4) (CE) Exit doors and aisles are unobstructed and egress (escape) accessible.** **Access Aisle:** • Accessible pedestrian paths of travel (ramps, corridors, walkways, lobbies, elevators, etc.) between elements (seats, tables, displays, equipment, parking spaces, etc.) provide a clear circulation path. • The minimum clear passage needed for a single wheelchair is 36 inches along an accessible route but may be reduced to a minimum of 32 inches at a doorway. • Means of egress (escape routes) are maintained free of obstructions or impediments to full instant use of the path of travel in case of fire or other type of emergency. • Building escape routes provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied. • Cords (including taped cords) or other items are not placed on or across walkway areas. **I.C.5) Exit doors are clearly marked with "Exit" signs.** **Exits:** Exit doorways are unobstructed and clearly marked by a readily visible "Exit" sign.[7] **I.C.6) Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location at all elevators, stairs and exits.** **Evacuation Routes**: • Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location at all elevators, stairs and exits.[8] **I.C.7) Electrical cords and outlets are in good working condition.** **Electrical Safety:** • Electrical cords are in good working condition with no exposed wires, frayed or cracked areas. Cords are not affixed to structures, placed in or across walkways, extended through walls, floors, and ceiling, or under doors or floor coverings.

[7] 29 CFR 1910.37
[8] 29 CFR 1910.33-39, 19 CCR 3.09 (a) (1) (B).

Criteria	I. Access/Safety Standards
	• Extension cords are not used as a substitute for permanent wiring. • All electrical outlets have an intact wall faceplate. • Sufficient clearance is maintained around lights and heating units to prevent combustible ignition. **I.C.8) Fire Fighting Equipment in accessible location.** **Firefighting equipment:** **There is firefighting equipment that must be in accessible locations on site. At least one of the following types of fire safety equipment is on site:** • **Fire Extinguisher:** The employer shall provide portable fire extinguishers and shall mount, locate, and identify them so that they are readily accessible. Fire extinguishers are maintained in a fully charged and operable condition and kept in their designated places at all times except during use.[9] • Smoke Detector with intact batteries. • Automatic Sprinkler System With a 10-inch clearance between sprinkler heads and stored materials. **I.C.9) An employee alarm system.** **Employee Alarm System:** • Employers must install and maintain an operable employee alarm system that has a distinctive signal to warn employees of fire or other emergencies, unless employees can promptly see or smell a fire or other hazard in time to provide adequate warning to them.[10] OSHA: For those employers with 10 or fewer employees in a workplace, direct voice communication is an acceptable procedure for sounding the alarm provided all employees can hear the alarm. Such workplaces do not need a back-up system. **Note:** Specific measurements are provided strictly for "*reference only"* for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.

[9] 29 CFR 1910.157
[10] 29 CFR 1910.37

Criteria	I. Access/Safety Standards
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week. **RN/NP/CNM/LM/MD/PA**	**I.D. 1) Personnel are trained in procedures/action plan to be carried out in case of medical emergency on site.** **Site Specific Emergency Procedures:** • Staff can describe site-specific actions or procedures for handling medical emergencies until the individual is stable or under care of local emergency medical services (EMS). • There is a written procedure for providing immediate emergent medical care on site until the local EMS is on the scene. Although site proximity to emergency care facilities may be considered when evaluating medical emergency procedures, the key factor is the ability to provide immediate care to patients *on site* until the patient is stable or EMS has taken over care/treatment. • When the physician or non-physician medical practitioner (NPMP) is not on site, staff/MA may call 911, and CPR-certified staff may initiate CPR if needed. • Non-CPR-certified staff may only call 911 and stay with the patient until help arrives. **I.D.2) Emergency equipment is stored together in easily accessible location and is ready to be used.** **Emergency Medical Equipment:** During business hours providers are prepared to provide emergency services for management of emergency medical conditions that occur on site ***until*** the emergent situation is stabilized and/or treatment is initiated by the local 911 Emergency Medical Service (EMS) system. Minimum emergency equipment is available on site to: ○ Establish and maintain a patent/open airway. ○ Manage emergency medical conditions. Emergency equipment and medication, appropriate to patient population served, are available in an accessible location and ready for use. • An accessible location is one that is reachable by personnel standing on the floor, or other permanent working area, without locating/retrieving step stool, ladder or other assistive devices. • For emergency “Crash” cart/kit, contents are appropriately sealed and are within the expiration dates posted on label/seal. • Site personnel are appropriately trained and can demonstrate knowledge and correct use of all medical equipment they are expected to operate within their scope of work. https://www.aafp.org/afp/2007/0601/p1679.html

Criteria	I. Access/Safety Standards
	I.D. 3) Emergency phone number contacts are posted, updated annually and as changes occur. **<u>Emergency Phone Number list</u>:** Posted in an accessible and prominent location(s) and includes: ○ Local emergency response services (e.g., fire, police/sheriff, ambulance). ○ Emergency contacts (e.g., responsible managers, supervisors). ○ Appropriate State, County, City, and local agencies (e.g., local poison control number). The list should be dated, and telephone numbers updated annually and as changes occur. **Emergency medical equipment appropriate to practice/patient population is available on site:** **<u>I.D. 4) (CE) Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag</u>:** Without the ability to adequately maintain the patient's airway, all other interventions are futile. Minimum airway control equipment with various sizes of airway devices appropriate to patient population within the practice and examples of oxygen delivery systems include: ○ Wall oxygen delivery system ○ Portable oxygen tank ○ Portable oxygen concentrator (POC) All oxygen delivery systems must be able to be regulated up to 6 liters of oxygen per minute, maintained for a minimum of 15 minutes. This flow rate establishes a minimum total oxygen delivery capacity of 90 liters for these devices:[11] ○ Nasal cannula or mask ○ Bulb syringe ○ Ambu bag as appropriate to patient population served. Mask should be replaced when they no longer make a solid seal.

[11] See the Food and Drug Administration (FDA) guidelines for oxygen generators and oxygen equipment for emergency use, available at: https://www.fda.gov/regulatory-information/search-fda-guidance-documents/review-guidelines-oxygen-generators-and-oxygen-equipment-emergency-use

	○ Portable oxygen tanks are maintained at least ¾ full. There is a method/system in place for oxygen tank replacement. If oxygen tanks are less than ¾ full at time of site visit, site has a back-up method for supplying oxygen if needed ***and*** a scheduled plan for tank replacement. ○ Oxygen tubing does not need be connected to oxygen tank, but must be kept in close proximity to tank. Oropharyngeal airways are no longer required. **I.D.5) (CE) Emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia:** Severe allergic reaction can cause urticaria (hives), hypotension, bronchospasm, wheezing, and pulmonary edema. Per the American Academy of Family Practice (AAFP), the minimum equipment to manage emergency anaphylactic reaction, asthma exacerbation, chest pain, opioid overdose, and hypoglycemia, based on the patient population served, shall include: ○ Epinephrine 1mg/mL (injectable) ○ Diphenhydramine 25 mg (oral) or 50 mg/ml (injectable) ○ Naloxone[12] ○ Chewable aspirin 81 mg[13] ○ Nitroglycerin spray/tablet[14] ○ Bronchodilator medication (solution for nebulizer or metered dose inhaler) ○ Glucose (any type of glucose containing at least 15 grams) ○ Appropriate sizes of ESIP needles/syringes[15] and alcohol wipes • The typical adult strength to address cardiac emergencies is 325 mg (four doses of 81 mg chewable aspirin or one dose of 325 non-enteric coated aspirin). • If the site is seeing adults, the reviewer shall assess whether the appropriate number of chewable aspirin tablets of 81 mg is available (at least four tablets). **I.D.6) Medication dosage chart for all medications included with emergency equipment (or other method for determining dosage) is kept with emergency medications.** • There is a current medication administration reference (e.g. medication dosage chart) available for readily identifying the correct medication dosages (e.g. adult, pediatric, infant, etc.). • Package inserts are not acceptable as dosage charts. • All emergency medications in the emergency kit/ crash cart must have dosage charts. Score should be either a **Yes or No only** **There is a process in place on site to:**

[12] In 2018, the U.S. Surgeon General issued an advisory emphasizing the importance of health care professionals having naloxone (an opioid antagonist) on hand and being trained in how to use it. The U.S. Surgeon General's advisory is available at: https://www.hhs.gov/surgeongeneral/priorities/opioids-and-addiction/naloxone-advisory/index.html. Also see the FDA's approval of Narcan to reverse opioid overdose: https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/narcan-naloxone-nasal-spray-approved-reverse-opioid-overdose, and articles regarding overdose preparedness for ambulatory clinics, available at: https://www.aafp.org/fpm/2021/0100/p17.html and https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5753997/.

[13] See the American Heart Association's article on Aspirin and Heart Disease, available at: https://www.heart.org/en/health-topics/heart-attack/treatment-of-a-heart-attack/aspirin-and-heart-disease.

[14] Pediatric offices only serving patients under 18 years old are not required to keep Nitroglycerin in their emergency kit. According to the FDA, "The safety and effectiveness of nitroglycerin in pediatric patients (under 18 years old) have not been established." Also see page 8 of an article on Nitrostat, available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2014/021134s007lbl.pdf.

[15] If the emergency kit or "crash cart" has only non-safety needles/syringes, score that deficiency in Section VI., Infection Control, criteria B.2. See Infection Control Standards.

Criteria	I. Access/Safety Standards
	I.D.7) Document checking of emergency equipment/supplies for expiration and operating status at least monthly. Documented evidence that emergency medication and equipment is checked at least monthly may include a log, checklist or other appropriate method(s). **I.D.8) Replace/re-stock emergency medication, equipment, and supplies immediately after use.** A receipt or documentation showing medication is ordered is acceptable for any medication shortage. **Note:** An "emergency medical condition" is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: 1) placing the health of the individual (or unborn child of a pregnant woman) in serious jeopardy 2) serious impairment to bodily functions 3) serious dysfunction of any bodily organ or part "Emergency services" means those services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death.
E. Medical and lab equipment used for patient care is properly maintained. **RN/NP/CNM/LM/MD/PA**	**I.E.1) Medical equipment is clean.** **Medical and Laboratory Equipment:** All equipment used to measure or assess patient health status/condition is clean. **I.E.2) Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines.** **Documentation:** • There is documented evidence that standard operating procedures have been followed for routine inspection/maintenance, calibration, repair of failure or malfunction, and testing and cleaning of all specialized equipment. • Appropriate written records include calibration or other written logs, work orders, service receipts, dated inspection sticker, etc.

Criteria	I. Access/Safety Standards
	• All equipment used to measure or assess patient health status/condition is functioning properly. All specialized equipment (e.g., ultrasonography equipment, electrocardiogram (EKG) machine, defibrillator, audiometer, hemoglobin meter, glucometer, scales, etc.) are adequately maintained according to the specified manufacturer's guidelines for the equipment or is serviced annually by a qualified technician. • Blood pressure cuffs, monitors, and other related equipment need not be calibrated unless required by the manufacturer. Manufacturer guidelines must be available on site, indicating that it is not necessary to calibrate the equipment. **Note:** The term monitor includes, but not limited to, glucometers, EKG, BP monitors, hemocues, and audiometers.

Criteria	II. Personnel Standards		
A.1. Professional health care personnel have current California licenses and certifications.	**Medical Professional**	**License/Certification**	**Issuing Agency**
	Certified Nurse Midwife (CNM)	RN License & Nurse-Midwife Certificate. Drug Enforcement Agency (DEA) Registration, *if appropriate*	CA Board of Registered Nursing DEA
	Certified Radiological Technologist (CRT)	CRT Certificate.	California Department of Public Health (CDPH), Radiologic Health Branch
	Doctor of Osteopathy (DO)	Physician's & Surgeon's Certificate DEA Registration	Osteopathic Medical Board of CA DEA
	Licensed Midwife (LM)	Licensed Midwife Certificate. Drug Enforcement Agency (DEA) Registration, *if appropriate*	Medical Board of CA DEA
	Licensed Vocational Nurse (LVN):	LVN License	CA Board of Vocational Nursing and Psychiatric Technicians
	Nurse Practitioner (NP)	RN License w/NP Certification & Furnishing Number DEA Registration, *if appropriate*	CA Board of Registered Nursing DEA
	Pharmacist (Pharm. D)	Pharmacist License	CA State Board of Pharmacy
	Physician/Surgeon (MD)	Physician's & Surgeon's Certificate DEA Registration	Medical Board of CA DEA
	Physicians' Assistant/ Associate (PA)	PA License DEA Registration, *if appropriate*	Physician Assistant Examining Committee/Medical Board of CA DEA
	Radiological Technician	Limited Permit	CDPH, Radiologic Health Branch

<table>
<tr><th>Criteria</th><th colspan="3">II. Personnel Standards</th></tr>
<tr><td></td><td>Registered Dietitian (RD)</td><td>RD Registration Card</td><td>Commission on Dietetic Registration</td></tr>
<tr><td></td><td>Registered Nurse (RN)</td><td>RN License</td><td>CA Board of Registered Nursing</td></tr>
<tr><td></td><td colspan="3">II.A.1) All required Professional Licenses and Certifications, issued from the appropriate licensing/certification agency, are current.
<u>Note</u>: All medical professional licenses and certifications must be current and issued from the appropriate agency for practice in California, and available on site. Although sites with centralized personnel departments are not required to keep documents or copies on site, copies and/or lists of currently certified or credentialed personnel must be readily available when requested by reviewers.</td></tr>
<tr><td rowspan="2">A.2. All required professional licenses and certifications, issued from the appropriate licensing/certification agency, are current.</td><td colspan="2"><u>Note</u>:
Effective June 27, 2010, MDs (does not apply to Osteopaths) shall provide notification to each patient that states the MD(s) on site is licensed and regulated by the Board, and includes the following:[16]

NOTICE
Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov.</td><td><u>Note</u>:
Effective August 11, 2011, PAs shall provide notification to each patient that states the PA(s) is licensed and regulated by the Physician Assistant Board , and includes the following:[17]

NOTIFICATION TO CONSUMERS
Physician Assistants are licensed and regulated by the Physician Assistant Board
(916) 561-8780
www.pab.ca.gov</td></tr>
<tr><td colspan="3">II.A.2) Notification is provided to each member that the MD(s) is licensed and regulated by the Medical Board, and that the Physician Assistant(s) is licensed and regulated by the Physician Assistant Board.

The notice to consumers above shall be provided by one of the following methods:</td></tr>
</table>

[16] 16 CCR 1355.4, as mandated by Business and Professions Code (BPC) section 138.
[17] 16 CCR 1399.547, as mandated by BPC section 138.

Criteria	II. Personnel Standards
	○ Prominently posted sign in an area visible to patients in at least 48-pt Arial font. ○ A written statement signed and dated by the patient (or patient's representative) and kept in the medical record, stating the patient understands that the MD is licensed and licensed and regulated by the board (for PA's, that the PA is licensed and regulated by the PA Board). ○ A statement on letterhead, discharge instructions or other document given to the patient (or patient's representative), where the notification is placed immediately above the signature line for the patient in at least 14-pt font.
B. Health care personnel are properly identified.	**II.B.1) Health care personnel wear identification badges/tags printed with name and title.** • Health care personnel shall disclose, while working, their name and title on a name tag at least 18-point type. • It is acceptable for health care personnel in a practice or an office, whose license is prominently displayed, to opt not to wear a nametag. **<u>Note</u>:** • In the interest of public safety and consumer awareness, it shall be unlawful for any person to use the title "nurse" in reference themselves, in any capacity, except for an individual who is a registered nurse, or a licensed vocational nurse. • "Health care practitioner" means any person who engages in acts that are the subject of licensure or regulation under Business and Professions Code (Sections 680-681). If a health care practitioner or licensed clinical social worker is working in a psychiatric setting or in a setting that is not licensed by the state, the employing entity or agency shall have the discretion to make an exception from the nametag requirement for the individual safety or therapeutic concerns.
C. Site personnel are qualified and trained for assigned responsibilities. **RN/NP/CNM/LM/MD/PA**	**<u>Unlicensed Personnel</u>:** Medical assistants (MAs) are unlicensed health personnel, at least 18 years of age, who perform basic administrative, clerical, and non-invasive routine technical supportive services under the supervision of a licensed physician, surgeon, or podiatrist in a medical office or clinic setting. • "Supervision" means the licensed physician must be physically present in the treatment facility during the performance of authorized procedures by the MA.

Criteria	II. Personnel Standards
	• Per Business and Professions Code Section 2069 (a) (1), a supervising physician and surgeon at a "community clinic" licensed under Health and Safety Code section 1204(a) may, at their discretion, in consultation with the nurse practitioner, nurse midwife, or physician assistant provide written instructions to be followed by a medical assistant in the performance of tasks or supportive services. • The written instructions may provide that the supervisory function for the medical assistant in performing these tasks or supportive services may be delegated to the nurse practitioner, nurse midwife, or physician assistant and that those tasks may be performed when the supervising physician and surgeon is not on site. **II.C.1) Documentation of education/training for non-licensed medical personnel is maintained on site.** • Training may be administered under a licensed physician; or under an RN, LVN, PA, or other qualified medical assistant acting under the direction of a licensed physician. The supervising physician is responsible for determining the training content and ascertaining proficiency of the MA. Training documentation maintained on site for the MA must include the following: • Diploma or certification from an accredited training program/school, or • Letter/statement from the current supervising physician that certifies in writing: date, location, content, and duration of training, demonstrated proficiency to perform current assigned scope of work, and signature. **II.C.2) (CE) Only qualified/trained personnel retrieve, prepare or administer medications.** Medication administration by an MA means the direct application of pre-measured medication orally, sublingually, topically, vaginally or rectally; or by providing a single dose to a patient for immediate self-administration by inhalation or by simple injection. • **All medications including vaccines must be verified with (shown to) a licensed person prior to administration.** • Unlicensed staff (e.g. MAs) have evidence of appropriate training and supervision in all medication administration methods performed within their scope of work. • To administer medications by subcutaneous or intramuscular injection, or to perform intradermal skin tests or venipunctures for withdrawing blood, an MA must have completed at least the minimum number of training-hours established in CCR, Title 16, Section 1366.1.

Criteria	II. Personnel Standards
	Note: • **MAs cannot administer anesthetics, including local anesthetic agents (such as Rocephin hydrated with Xylocaine).** [18] • MAs may not place an intravenous needle, start or disconnect the intravenous infusion tube, administer medications or injections into an intravenous line, or administer anesthesia. • The supervising physician must specifically authorize all medications administered by an MA. "Authorization" means a specific written or standing order prepared by the supervising physician. **II.C.3) Site has a procedure in place for confirming correct patient, correct medication/vaccine, correct dosage, and correct route prior to administration.** • To help reduce the risk of medication errors, staff shall follow procedures for confirming the correct patient, correct medication/vaccine, correct dosage, and correct route prior to administration. **II.C.4) Only qualified/trained personnel operate medical equipment.** **Medical Equipment:** • Provider and/or staff can demonstrate appropriate operation of medical equipment used in their scope of work. Not all staff is required to be proficient in use of all equipment but at any given time, a staff must be prepared to operate equipment that is not routinely needed by every patient such as patient lifts and accessible scales. Health care personnel at the site must demonstrate that they can turn on the oxygen tank and tell when an oxygen tank needs to be replaced and/or refilled. **Note:** • Personnel on site must be qualified for their responsibilities and adequately trained for their scope of work. • Site staff should have a general understanding of the systems/processes in place, appropriate supervision, and knowledge of the available sources of information on site.

[18] 16 CCR 1366.3(a) (1), also see information from the Medical Board of California on Medical Assistants, available at: https://www.mbc.ca.gov/Licensing/Physicians-and-Surgeons/Practice-Information/Medical-Assistants.aspx. https://www.mbc.ca.gov/FAQs/?cat=Licensees&topic=Medical%20Assistants

Criteria	II. Personnel Standards
	• Family members and personal care assistants, whether paid or unpaid, are not "unlicensed personnel" or otherwise captured within the scope of this tool.
D. Scope of practice for non-physician medical practitioners (NPMP) is clearly defined. 🗣 🗁 **RN/NP/CNM/LM/MD/PA**	**II.D.1) Standardized Procedures provided for NPs and/or CNMs.** • The scope of practice for NPs and CNMs is clearly defined including the delegation of the supervision of MAs when supervising physician is off premises. • Documents may be utilized to determine and/or clarify practice procedures and supervisory processes on site. • Reviewers are expected to verify that NP and/or CNM standardized procedures, and PA Practice Agreement and Supervision Physician's Responsibility documentation are present on site. • Reviewers are ***not*** expected to make in-depth evaluation of "appropriateness" of the NPMP's scope of practice. **NPs:** • NPs are prepared through education and experience to provide primary care and to perform advanced procedures. • The extent of required supervision must be specified in the Standardized Procedures. • Standardized procedures legally define the expanded scope of nursing practice that overlaps the practice of medicine. • Standardized Procedures should identify the furnishing of drugs or devices, extent of physician or surgeon supervision, method of periodic review of competence, including peer review, and review of provisions in the Standardized Procedures. **CNM:** • The certificate to practice nurse-midwifery authorizes the holder, under supervision of a licensed physician or surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family planning care for the mother, and immediate care for the newborn. • The supervising and back-up physician or surgeon for the CNM must be credentialed to perform obstetrical care in the same delivering facility in which the CNM has delivery privileges.

Criteria	II. Personnel Standards
	Note: CNMs and NPs operate under written Standardized Procedures that are collaboratively developed and approved by the supervising physician, the NP and administration within the organized health care facility/system in which standardized procedures will be used. **II.D.2) A Practice Agreement defines the scope of services provided by PAs and Supervisory Guidelines define the method of supervision by the Supervising Physician.** **PA:** • Practice Agreement: a) Defines specific procedures identified in practice protocols or specifically authorized by the supervising physician, and must be dated and signed by physician and PA. b) The delegation of the supervision of MAs when supervising physician is off premises. c) An original or copy must be readily accessible at all practice sites in which the PA works. d) Failure to maintain a Practice Agreement is a violation of the PA Regulations and is grounds for disciplinary action by the Medical Board of California against a physician assistant's licensure. • Supervising Physician's Responsibility for Supervision of PAs' Practice Agreement: Defines supervision responsibilities and methods required by Title 16, section 1399.545 of the Physician Assistant Regulations, and is signed by the physician. The following procedures must be identified: ○ Emergency transport of patients and back-up procedures (e.g., can call 911, name of hospital to transport patient included in Practice Agreement) for when the supervising physician is not on the premises. **Note:** • A Delegation of Services Agreement (DSA) in effect prior to January 1, 2020, shall be updated to meet the current requirements.[19] • DSAs that still reflect components that are no longer required by BPC section 3502.3 should be enforced since the DSA is the currently established agreement between the PA and the supervising physician. • The reviewer should assess the site's process for compliance with the DSA.

[19] BPC 3502.3

Criteria	II. Personnel Standards
	• Any deficiency shall result in a CAP requesting the site to adhere to the DSA components or establish a new Practice Agreement. **II.D.3) Standardized Procedures, Practice Agreements, and Supervisory Guidelines are revised, updated, and signed by the supervising physician and NPMP when changes in scope of services occur.** • Standardized Procedures, Practice Agreements shall undergo periodic review, with signed, dated revisions completed at each change in scope of work by supervising physician. • Frequency of the review to identify changes in scope of service shall be specified in writing. **II.D.4) Each NPMP that prescribes controlled substances has a valid DEA Registration Number.** **DEA:** Each NP, CNM, and PA that prescribes controlled substances is required to have a valid DEA Registration Number.

E. Non-physician medical practitioners (NPMP) are supervised according to established standards.
RN/NP/CNM/LM/MD/PA
	The designated supervising physician(s) on site:
	
	II.E.1) Ratio to number of NPMPs does not exceed established ratios in any combination.
	NPMPs:
	• The supervising physician holds ultimate responsibility for the practice of each supervised NPMP.
	• The maximum number of NPMPs who may be supervised by a single primary care physician (PCP) is limited to the following at any given time/shift in any of their locations:[20]
	  ○ 4 NPs with furnishing license (there is no limit to the number of NPs the physician may supervise if the NP does not hold a furnishing license);
	  ○ 4 CNMs; and
	  ○ 4 PAs.

[20] BPC 3516(b), Welfare and Institutions Code (WIC) section 14132.966

Criteria	II. Personnel Standards
	This ratio is based on each physician, not the number of offices. A PCP, an organized outpatient clinic, or a hospital outpatient department cannot utilize more NPMPs than can be supervised within these stated limits. Physician Assistant Board (PAB) is at https://www.pab.ca.gov/ or the PAB office at 916-561-8780. **II.E.2) The designated supervising or back-up physician is available in person or by electronic communication at all times when a NPMP is caring for patients.** **Supervising Physician**: • "Supervision" means that a licensed physician and surgeon oversee the activities of, and accept responsibility for, the medical services rendered by a PA. • Supervising or back-up physician is available in person or by electronic communication at all times when a NPMP is caring for patients. **II.E.3) Evidence of NPMP supervision.** **Evidence of NPMP Supervision:** • Standardized Procedures for NP or CNM should identify the furnishing of drugs or devices, extent of physician or surgeon supervision, method of periodic review of competence, including peer review, and review of provisions in the Standardized Procedures.[21] • Standardized Procedures shall undergo periodic review, with signed, dated revisions completed at each change in scope of work. • Evidence of supervision of NPMP(s) are verifiable through on-site observation of supervisory processes, documentation, or supervisor/NPMP's knowledge of the process.
F. Site personnel receive safety training. 🗁 **RN/NP/CNM/LM/MD/PA**	**II.F. There is evidence that site staff has received training on the following:** **1) Infection Control/Universal Precautions (annually)** **2) Bloodborne Pathogens Exposure Prevention (annually)** **3) Biohazardous Waste Handling (annually)** Training occurs ***prior to*** initial exposure to potentially infectious and/or biohazardous materials. Review and re-training sessions occur ***at least annually***. Training content is appropriate (language, educational level, etc.) to personnel on site.

[21] BPC 2834

Criteria	II. Personnel Standards
	Training *minimally* includes the following: ○ Universal/standard precautions ○ Use of personal protective equipment ○ Accessible copy of Bloodborne Pathogens Standard ○ Work practice controls/exposure prevention ○ Modes of transmitting bloodborne pathogens ○ Epidemiology/symptoms of HBV and HIV ○ Recognition of activities with exposure element ○ Handling and labeling of biohazardous waste(s) ○ Hepatitis B vaccination protocol and requirements ○ Explanation of emergency procedures ○ Post exposure reporting/evaluation/follow-up procedures ○ Decontamination of equipment/work areas ○ Site's written bloodborne pathogen exposure plan ○ Opportunity for discussion/questions Personnel must know ***where to locate*** information/resources on site about infection control, the Bloodborne Pathogens Exposure Plan, and ***how to use*** the information. Evidence of training must be verifiable. Evidence of training may include: ○ Informal in-services ○ New staff orientation ○ External training courses ○ Educational curriculum ○ Participation lists, etc. Training documentation must contain: 1) Employee's name 2) Job titles 3) Training date(s) 4) Type of training 5) Contents of training session 6) Names/qualifications of trainers Records must be kept for three (3) years.

Criteria	II. Personnel Standards
	Note: Site personnel treat all blood and other potentially infectious materials (OPIM) as if these *are* infectious. Site personnel who are reasonably anticipated to have eye, skin, mucous membranes and potential exposure to blood and/or OPIM receive training as required by the Bloodborne Pathogens Standard.[22]
G. Site personnel receive training on member rights. **RN/NP/CNM/LM/MD/PA**	**II.G. There is evidence that site staff has received information and/or training on the following:** **II.G.1) Patient Confidentiality** • Site personnel have received information and/or training about patient confidentiality and must be prepared to provide information on how patient confidentiality is protected at the site. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written patient confidentiality information on site and explain how to use information. **II.G.2) Informed Consent, including Human Sterilization** • Site personnel have received information and/or training on informed consent, including human sterilization. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written informed consent, including human sterilization information on site and explain how to use information. **II.G.3) Prior Authorization Requests** • Site personnel have received information and/or training on prior authorization requests.

[22] 8 CCR 5193

Criteria	II. Personnel Standards
	• Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written prior authorization requests information on site and explain how to use information. **II.G.4) II.F.4) Grievance/Complaint Procedure** • Site personnel have received information and/or training on grievance/complaint procedure. Staff must be prepared to provide information to patient when requested. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written grievance/complaint procedures information on site and explain how to use information. **II.G.5) Child/Elder/Domestic Violence Abuse Reporting**: Site personnel have specific knowledge of local reporting requirements, agencies, and procedures, and know *where to locat*e information on site and *how to use* information. **Note:** • Health practitioners (e.g., physicians, surgeons, licensed nurses, licensed social workers, paramedics) in a health facility, (e.g., clinic, physician's office, public health clinic) are legally mandated reporters of known or reasonably suspected cases of child abuse, elder abuse and domestic violence. • Legally mandated reporters must make telephone and written reports according to timeliness standards established by the designated local law enforcement agencies in each county. "Reasonably suspected" means having objectively reasonable suspicion based upon facts that could cause a reasonable person in a like position, drawing when appropriate on his or her training and experience, to suspect abuse (CA Penal Code 11164). • Failure to report by legally mandated reporters can result in criminal or civil prosecutions, punishable by monetary fines and/or county jail confinement.

Criteria	II. Personnel Standards
	Any person entering employment, which makes him/her a mandated reporter, must sign a statement, provided and retained by the employer, that the employee has knowledge of the Child Abuse reporting law and will comply with its provision.[23] **II.G.6) Sensitive Services/Minors' Rights** • Site personnel have received information and/or training on sensitive services/minors' rights. Sensitive Services include family planning, pregnancy, sexually transmitted infections, etc. • PCP sites must have basic information on sensitive services that are appropriate to their practice office and be prepared to provide information to patients when needed. • Minor's Rights: California Family Code provides that a minor may, without parental consent, receive a number of sensitive services including outpatient mental health treatment and counseling for children 12 years and older. **II.G.7) Health Plan Referral Process/Procedures/Resources** • Site personnel have received information and/or training on health plan referral process/procedures/resources. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written health plan referral process/procedures/resources information on site and explain how to use information. **II.G.8) Cultural and Linguistic Training** • Site personnel have received information and/or training on cultural and linguistic appropriate services. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written cultural and linguistic information on site and explain how to use information. Cultural and Linguistic

[23] Penal Code section 11166.5

Criteria	II. Personnel Standards
	Training- Culturally and Linguistically Appropriate Services (CLAS) mandates are Federal requirements for all recipients of Federal funds.[24] **II.G.9) Disability Rights and Provider Obligations** • Site personnel have received information and/or training on patient rights and provider obligations under the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and/or Section 1557 of the Affordable Care Act • Training content should include information about physical access, reasonable accommodations, policy modifications, and effective communication in healthcare settings. **https://www.hhs.gov/sites/default/files/ocr/civilrights/resources/factsheets/504.pdf** **https://www.hhs.gov/sites/default/files/section-1557-final-rule-faqs.pdf** **https://www.hhs.gov/sites/default/files/1557-fs-lep-508.pdf**

[24] See the National Standards on CLAS, available at: https://www.health.pa.gov/topics/Documents/Health%20Equity/CLAS%20Standards%20FactSheet.pdf.

Criteria	III. Office Management Standards
A. Physician coverage is available 24 hours a day, 7 days a week.	**III.A.1) Clinic office hours are posted or readily available upon request.** Current clinic office hours are posted within the office or readily available upon request. **III.A.2) Provider office hour schedules are available to staff.** **III.A.3) Arrangement/schedule for after-hours, on-call, supervisory back-up physician coverage is available to site staff and members after-hours.** Current site-specific resource information is available to site personnel and members about physician office hour schedule(s), local and/or Plan-specific systems for after-hours urgent care, emergent physician coverage available 24 hours a day, 7 days per week, and system for providing follow-up care. **III.A.4) Contact information for off-site physician(s) is available at all times during office hours.** When a physician is not on site during regular office hours, personnel are able to contact the physician (or covering physician) at all times by telephone, cell phone, pager, etc. **III.A.5) Routine, urgent and after-hours emergency care instructions/telephone information is made available to patients.** **Note:** One objective of effective clinic office management is to support the provision of appropriate, coordinated health care services. The review of clinic office management is to evaluate if effective systems are in place and whether site personnel appropriately follow established site-specific procedures.
B. There are sufficient health care personnel to provide timely, appropriate health Care services. **RN/NP/CNM/LM/MD/PA**	**III.B.1) Appropriate personnel handle emergent, urgent, and medical advice telephone calls.** • In addition to the physician, only appropriately licensed medical personnel such as a CNM, LM, NP, RN, or PA handles emergency, urgent, and medical advice/triage telephone calls.

Criteria	III. Office Management Standards
	• The California Board of Vocational Nursing and Psychiatric Technician Examiners has determined that the Licensed Vocational Nurse Practice Act does not permit the LVN to perform triage independently.[25] • The LVN may perform that part of the triage process that includes observation and data collection relative to basic physical assessment. • The LVN may not perform that part of the triage process that includes independent evaluation, interpretation of data, and determination of treatment priorities and levels of care. • Unlicensed personnel, such as medical assistants, may provide patient information or instructions only as authorized by the physician.[26] **Note:** Telephone triage is the system for managing telephone calls during ***and*** after office hours. **III.B.2) Telephone answering machine, voice mail system, or answering service is used whenever office staff does not directly answer phone calls.** • Telephone answering machine, voice mail system, or answering service is used whenever office staff does not directly answer phone calls. **III.B.3) Telephone system, answering service, recorded telephone information, and recording device are periodically checked and updated.** • Telephone system, answering service, recorded telephone information, and recording device are periodically checked and updated.
C. Health care services are readily available. **RN/NP/CNM/LM/MD/PA**	**III.C.1) Appointments are scheduled according to patients stated clinical needs within the timeliness standards established for Plan members.** **Note:** Medi-Cal Managed Care Health Plans *require* the following timeliness standards for access to appointments: ○ Urgent Care: 48 hours ○ Access to the first Prenatal Visit: 10 business days ○ Non-urgent (Routine) Care: 10 business days

[26] 16 CCR 1366(b)

Criteria	III. Office Management Standards
	III.C.2) Patients are notified of scheduled routine and/or preventive screening appointments. • The process established on site provides timely access to appointments for routine care, urgent care, prenatal care, pediatric periodic health assessments/immunizations, adult initial health assessments, specialty care, and emergency care. • Systems, practices, and procedures used for making services readily available to patients will vary from site to site. **III.C.3) There is a process in place verifying follow-up on missed and canceled appointments.** • An organized system must be evident (in use) for scheduling appointments appropriately, notifying, and reminding members of scheduled appointments, and following up on missed or canceled appointments. • Missed and/or canceled appointments and contact attempts must be documented in the patient's medical record.
D. There is 24-hour access to interpreter services for non- or limited-English proficient (LEP) members.	**III.D.1) Interpreter services are made available in identified threshold languages specified for location of site.** • Sites must provide 24-hour interpreter services for all members either through telephone language services or interpreters on site. **III.D.2) Persons providing language interpreter services, including sign language on site, are trained in medical interpretation.** • Site personnel used as interpreters have been assessed for their medical interpretation performance skills/capabilities. • Reviewer should ask for a written policy which includes the languages spoken by bilingual providers and staff. **Note:** https://www.lep.gov; 22 CCR 51309.5 • If bilingual staff are asked to interpret or translate, they should be qualified to do so. Assessment of ability, training on interpreter ethics and standards, and clear policies that delineate appropriate use of bilingual staff, staff or contract interpreters and translators, will help ensure quality and effective use of resources.

Criteria	III. Office Management Standards
	• Those utilizing the services of interpreters and translators should request information about certification, assessments taken, qualifications, experience, and training. Quality of interpretation should be a focus of concern for all recipients. • Family or friends should not be used as interpreters, unless specifically requested by the member's circumstances. Minors, under 18 years old, accompanying members shall not be used as interpreters. • The Affordable Care Act of 2010, Section 1557: prohibits from using low-quality video remote interpreting services or relying on unqualified staff, translators when providing language assistance services. • A request for or refusal of language/interpreter services must be documented in the member's medical record. Sign language interpreter services may be utilized for medically necessary health care services and related services such as: ○ Obtaining medical history and health assessments ○ Obtaining informed consents and permission for treatments ○ Medical procedures ○ Providing instructions regarding medications ○ Explaining diagnoses ○ Treatment and prognoses of an illness ○ Providing mental health assessment ○ Therapy or counseling
E. Procedures for timely referral/ consultative services are established on site. 💬 🗁 **RN/NP/CNM/LM/MD/PA**	**Office practice procedures allow timely provision and tracking of:** **III.E.1)Processing internal and external referrals, consultant reports, and diagnostic test results.** • An organized, timely referral system is evident for making and tracking referrals, reviewing reports, providing/scheduling follow-up care and filing reports in medical records. • Referral informational resources are readily available for use by site personnel. • Site staff can demonstrate (e.g., "walk through") the office referral process from beginning to end Systems, practices, and procedures used for handling referrals will vary from site-to-site.

Criteria	III. Office Management Standards
	III.E.2 (CE) Physician Review and follow-up of referral/consultation reports and diagnostic test results. • There is a documented process of the practitioner review of diagnostic tests/consultations and subsequent outreach to follow-up with the patient to communicate results and provide next steps. • Practitioner review is evidenced by date and signature/initials on the report of the reviewing practitioner.
F. Member grievance/ complaint processes are established on site.	**III.F.1) Phone number(s) for filing grievances/complaints are located on site.** • At least one telephone number for filing grievances is posted on site or is readily available upon request. **III.F.2) Complaint forms and a copy of the grievance procedure are available on site.** • Complaint forms and a copy of the grievance procedure are readily available on site and can be provided to members promptly upon request. • Includes The Department of Managed Health Care Help Center 1-888-466-2219 and Ombudsman 1-888-452-8609. **Note:** A "grievance" is defined as any written or oral expression of dissatisfaction and shall include any complaint, dispute, and request for reconsideration or appeal made by an enrollee or their representative to a Plan or entity with delegated authority to resolve grievances on behalf of the Plan.
G. Medical records are available for the practitioner at each scheduled patient encounter.	**III.G.1) Medical records are readily retrievable for scheduled patient encounters.** • The process/system established on site provides for the availability of medical records (paper and electronic), including outpatient, inpatient, referral services, and significant telephone consultations for patient encounters.

Criteria	III. Office Management Standards
	III.G.2) Medical documents are filed in a timely manner to ensure availability for patient encounters. • Medical records are filed in a timely manner that allows for ease of accessibility within the facility or in an appropriate health record storage facility if stored off-premises.[27]
H. Confidentiality of personal medical information is protected according to State and federal guidelines. **RN/NP/CNM/LM/MD/PA**	**III.H.1) Exam rooms and dressing areas safeguard patients' right to privacy.** **Privacy:** • Patients have the right to privacy for dressing/undressing, physical examination, and medical consultation. • Practices are in place to safeguard patient privacy. • Because dressing areas and examination room configurations vary greatly, reviewers will make site-specific determinations. **III.H.2) Procedures are followed to maintain the confidentiality of personal patient information.** **Confidentiality:** • Personnel follows site policy/procedures for maintaining confidentiality of individual patient information. • Individual patient conditions or information is not discussed in front of other patients or visitors, displayed or left unattended in reception and/or patient flow areas (this includes unattended electronic devices, patient registration sign-in sheets with more than one unique patient identifier). • There must be a confidentiality agreement between the provider and the cleaning service agency/persons if the medical records are kept in an open space and/or are unsecured. **Electronic Records:** • Electronic record-keeping system procedures have been established to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures, and maintain upkeep of computer systems.

[27] 22 CCR 75055

Criteria	III. Office Management Standards
	• Security protection includes an off-site backup storage system, an image mechanism with the ability to copy documents, a mechanism to ensure that recorded input is unalterable, and file recovery procedures. • Confidentiality protection may also include use of encryption, detailed user access controls, transaction logs, and blinded files. **III.H. 3) Medical record release procedures are compliant with State and federal guidelines.** **<u>Record Release</u>:** • Medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released. • The release terms, such as to whom records are released and for what purposes, and the expiration date of the consent to medical record release should also be described. • This does not prevent release of statistical or summary data, or exchange of individual identifiable medical information between individuals or institutions providing care, fiscal intermediaries, research entities and State or local official agencies.[28] **III.H.4) Storage and transmittal of medical records preserves confidentiality and security.** **<u>Storage and transmittal:</u>** • Health care services rendered under the Medi-Cal program or any other health care program administered by the department or its agents or contractors, shall confidentially and securely keep and maintain records of each service rendered under the Medi-Cal program or any other health care program administered by the department or its agents or contractors, the beneficiary or person to whom rendered, the date the service was rendered, and any additional information as the department may by regulation require. • FAX cover sheet shall have confidentiality statement. **III.H.5) Medical records are retained for a minimum of 10 years.** **<u>Record Retention:</u>** • Records required to be kept and maintained under this section (including minors under 18 years old) shall be retained by the provider for a period of 10 years from the final date of the contract

[28] 45 CFR 164.524

Criteria	III. Office Management Standards
	period between the plan and the provider, from the date of completion of any audit, or from the date the service was rendered, whichever is later, in accordance with 42 CFR 438.3(u).[29]

[29] WIC 14124.1

Criteria	IV. Clinical Services - Pharmaceutical Standards
A. Drugs and medication supplies are maintained secured to prevent unauthorized access.	**Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, disposition, etc.) must be addressed in a corrective action plan. **IV.A.1) Drugs are stored in specifically designated cupboards, cabinets, closets or drawers.** **Security**: • All drugs for dispensing are stored in an area that is secured at all times.[30] The Medical Board defines "area that is secure" to mean a locked storage area within a physician's office. • Keys to locked storage area are available only to staff authorized by the physician to have access.[31] • The Medical Board of California interprets "all drugs" to also include both sample and over-the-counter drugs.[32] **IV.A.2) Drugs, drug samples, and over-the-counter drugs, hypodermic needles/syringes, all medical sharp instruments, hazardous substances and prescription pads are securely stored in a lockable space (cabinet or room) within the office/clinic.** • All drugs (including sample and over the counter), medication supplies, hazardous substances and prescription pads are securely stored in a lockable space (room, closet, cabinet, drawer) within the office/clinic.[33] (CA B&P Code, 4051.3) • A secure area means that drugs and biologicals are stored in a manner to prevent unmonitored access by unauthorized individuals. Drugs and biologicals must not be stored in areas that are readily accessible to unauthorized persons. (42 CFR 482.13-CMS Manual System; 42 CFR Part 482.25) • Keys to the locked storage area are available only to staff authorized by the physician to have access.[34] (16 CCR, Chapter 2, Division 3, Section 1356.32) • During business hours, the lockable space may remain unlocked ONLY if there is no access to

[30] BPC 4172
[31] 16 CCR 1356.3
[32] 22 CCR 75032 and 75033
[33] BPC 4051.3
[34] 16 CCR 1356.32

Criteria	IV. Clinical Services - Pharmaceutical Standards
	this area by unauthorized persons and authorized clinic personnel remain in the immediate area at all times. At all other times, all drugs (including sample and over the counter), medication supplies, prescription pads and hazardous substances must be securely locked. **IV.A.3) Controlled drugs are stored in a locked space accessible only to authorized personnel.** **<u>Controlled substances</u>**: • Controlled substances are stored separately from other drugs in a securely locked, substantially constructed cabinet accessible only to authorized personnel.[35] **IV.A.4) A dose-by-dose controlled substance distribution log is maintained.** • Written records are maintained of controlled substances inventory list(s) that includes: 1) Provider's DEA number 2) Name of medication 3) Original quantity of drug 4) Dose 5) Date 6) Name of patient receiving drug 7) Name of authorized person dispensing drug and 8) Number of remaining doses • Control substances include all Schedule I, II, III, IV, and V substances listed in the CA Health and Safety Code, Sections 11053-11058, and do not need to be double locked. • Personnel with authorized access to controlled substances include physicians, dentists, podiatrists, PAs, licensed nurses, and pharmacists and specifically authorized employees.[36] **IV.A.5) Written site-specific policy/procedure for dispensing of sample drugs are available on site.** • A list of drugs available for use in the clinic shall be maintained. Site should have written site-specific policies and procedures (P&Ps) for use of sample medications including governing activities of pharmaceutical manufacturers' representatives American Society of hospital

[35] 21 CFR 1301.75
[36] 21 CFR 1301.72

Criteria	IV. Clinical Services - Pharmaceutical Standards
	pharmacist (ASHP) Guidelines: Minimum Standard for pharmaceutical services in ambulatory care).[37] • Each clinic, which provides drug distribution services, shall have written policy and procedures for the safe and effective distribution, control, storage, use and disposition of drugs. **Note:** During business hours, the drawer, cabinet or room containing drugs, medication supplies or hazardous substances may remain unlocked ***only*** if there is no access to area by unauthorized persons. Whenever drugs, medication supplies or hazardous substances are unlocked, authorized clinic personnel must ***always remain*** in the immediate area. At all other times, drugs, medication supplies, and hazardous substances must be securely locked. Controlled substances are ***always locked***.
B. Drugs are handled safely and stored appropriately. **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan (CAP). **IV.B.1) Drugs are prepared in a clean area or "designated clean" area if prepared in a multi-purpose room.** **Drug Preparation:** Drugs shall be drawn up in a designated clean medication preparation area that is not adjacent to potential sources of contamination, including sinks or other water sources. The drug preparation area should be cleaned and disinfected on a regular basis. CDC guidelines for drug preparation and safety: https://www.cdc.gov/injectionsafety/providers/provider_faqs_med-prep.html **IV.B.2) Drugs for external use are stored separately from drugs for internal use.** **Storage:** • Drugs shall be separated by route of administration, especially ophthalmic and otic preparations. • Vaccines and other drugs should be stored separately from food, lab specimens, human specimens, cleaning supplies, and other items that may potentially cause contamination.

[37] The ASHP Guidelines for Minimum Standard for Ambulatory Care Pharmacy Practice is available at: https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/anticoagulation/guidelines-minimum-standard-ambulatory-care-pharmacy.ashx?la=en&hash=ABF816352CAF1AB846B7C339A45AA74D80F820A6.

Criteria	IV. Clinical Services - Pharmaceutical Standards

	• The Center for Disease Control (CDC) recommends avoiding storing other medications and biological products such as lab specimens/human specimens in a vaccine storage unit.
	
	IV.B.3) Items other than medications in refrigerator/freezer are kept in a secured, separate compartment from drugs.
	• Storing food, other medications, and biological products with vaccines put vaccines at risk for temperature fluctuation, excessive light exposure, administration errors, and contamination.
	  ○ If food, other medications and biological products must be stored in the same refrigerator with vaccines, they must be in the sealed containers and stored below vaccines on the different shelves.
	• Drugs are stored under appropriate conditions of temperature, humidity, and light so that the identity, strength, quality, and purity of the drug product are not affected.[38]
	• Room temperature where drugs are stored does not exceed 30ºC (86ºF).[39]
	• A drug or device is considered "adulterated" if it contains any filthy, putrid, or decomposed substance, or if it has been prepared, packed or held under unsanitary conditions.[40]
	• A drug is considered contaminated if it has been held under unsanitary conditions that may have been contaminated with filth or rendered injurious to health.
	• Drugs that are unused are considered by the Environmental Protection Agency (EPA) to be toxic wastes and must be disposed in accordance with 40 CFR, part 261.
	
	American College of Physician guidelines state sound management procedures include:
	  ○ Routinely checking for expiration dates.
	  ○ Keeping medicines off the floor.
	  ○ Labeling the sample medicines or writing prescribing information directly on the sample package.
	  ○ Keeping a log of sample medicines given. In case of a recall, keeping a log allows to track down a patient to whom the recalled drug had been prescribed.
	  ○ When a medication sample is given to a patient, the name and strength of the medication, instructions for use and the quantity or duration of therapy is always documented in the patient's chart.

[38] 21 CFR 211.142
[39] 22 CCR 75037(d)
[40] Title 21, United States Code (USC), section 351. USC is searchable at: https://uscode.house.gov/search/criteria.shtml.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	ASHP guidelines for minimum standard for pharmaceutical services in ambulatory care: ○ Site should have written site-specific policies and procedures (P&Ps) for use of sample medications including governing activities of pharmaceutical manufacturers' representatives. ○ Each clinic, which provides drug distribution services, shall have written policy and procedures for the safe and effective distribution, control, storage, use and disposition of drugs.[41] **Immunobiologics:**[42] • Sites should have a written Vaccine Management Plan for routine and emergency vaccine management (required for Vaccines for Children (VFC) providers). • Vaccines are refrigerated immediately upon receipt on site and stored according to specific instructions on the package insert for each vaccine. • Diluent does not need refrigeration if vaccine is administered right after diluent is added. • Vaccines are not stored in the doors, floors, vegetable bins, or under or near cooling vents of a refrigerator or freezer. **IV.B.4) Refrigerator thermometer temperature is 36º-46º Fahrenheit or 2º-8º Centigrade (at time of site visit).** **Refrigerator:** Vaccines are kept in a refrigerator **maintained at 2-8ºC or 36-46ºF,** and include, but are not limited to, DTaP, Td, Tdap, Hepatitis A, Hepatitis B, IPV, Pneumococcal, Rotavirus, Hib, Influenza (inactivated and FluMist), MCV, HPV, recombinant Zoster, or any combinations of these listed vaccines.[43] **IV.B. 5) Freezer thermometer temperature is 5º Fahrenheit or –15º Centigrade, or lower (at time of site visit).**

[41] The ASHP Guidelines for Minimum Standard for Ambulatory Care Pharmacy Practice is available at: https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/anticoagulation/guidelines-minimum-standard-ambulatory-care-pharmacy.ashx?la=en&hash=ABF816352CAF1AB846B7C339A45AA74D80F820A6.
[42] See the FDA's webpage on Vaccines, available at: https://www.fda.gov/vaccines-blood-biologics/vaccines/questions-about-vaccines.
[43] See the CDC Vaccine Recommendation and Guidelines of the Advisory Committee on Immunization Practices, available at: https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/storage.html, and the CDC Vaccine Storage and Handling Toolkit, available at: https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	Freezer: Varicella and MMRV vaccines are stored in the **freezer at -15ºC or 5ºF, or lower,** and are always protected from light. ○ MMR may be stored in a refrigerator or freezer; VFC recommends MMR be stored in the freezer with MMRV. ○ Never freeze vaccine diluents. **IV.B. 6) Site utilizes drugs/vaccine storage units that are able to maintain required temperature.** CDC recommends for both temporary and long-term storage refrigerators and freezers using: ○ Purpose-built units designed to either refrigerate or freeze (can be compact, under-the counter style or large units). ○ Stand-alone household units. ○ Units dedicated to storage of biologics. Measures should be in place to ensure that vaccine storage units are not accidentally physically disconnected from the power supply, such as “Do Not Disconnect” labels and not plugging units into surge protectors with an on/off switch. **Do not store any vaccine in a dormitory-style or bar-style combined refrigerator/freezer unit under any circumstances.**[44] **IV.B. 7) Daily temperature readings of drugs/vaccines refrigerator and freezer are documented.** Refrigerator and freezer temperatures are documented at least once a day (required twice daily for VFC providers). CDC recommends use of a continuous temperature monitoring device (digital data loggers). ○ Digital data loggers (DDL) should have a minimum accuracy of +/- 1°F (0.5°C) ○ Equipped with buffered probe ○ Active temperature display outside of the unit ○ Capacity for continuous monitoring and recording where the data can be routinely downloaded ○ Calibrated at least every 2 years, to monitor vaccine storage unit temperatures

[44] See the CDC Vaccine & Immunization webpage, available at: https://www.cdc.gov/vaccines/.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	At least one back-up device should be readily available for emergency vaccine transport or when primary DDL is sent in for calibration. **IV.B. 8) Has a written plan for vaccine protection in case of power outage or malfunction of the refrigerator or freezer.** • A written plan for vaccine protection in case of power outage or malfunction of the refrigerator or freezer is required. www.cdc.gov https://www.cdc.gov/disasters/poweroutage/vaccinestorage.html • Site personnel must be able to verbalize the procedures in the plan used to promptly respond to OUT OF RANGE TEMPERATURES. • Quarantine vaccines until guidance is obtained. • Action is taken when temperatures are identified to be outside of the recommended range. • Contacting VFC (http://eziz.org/vfc/overview/) or manufacturer are acceptable procedures. • For VFC providers, follow program requirements for documentation and reporting. Consultation with CDC is available when necessary.[45] www.cdc.gov **IV.B. 9) Drugs and vaccines are stored separately from test reagents, germicides, disinfectants, and other household substances.** • As these items may potentially cause contamination to verify that drugs are stored separately from test reagents, germicides, disinfectants, and other household substances. **IV.B.10) Hazardous substances are appropriately labeled.** **IV.B.11) Site has method(s) in place for drug and hazardous substance disposal.** **Hazardous Substances Labeling and Disposal**: • Safety practices are followed in accordance with current/updated CAL-OSHA standards and 29 CFR 1910.1030.

[45] See the CDC General Best Practice Guidelines for Immunization: Best Practices Guidance of the ACIP, available at: https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/storage.html, the CDC Vaccine Storage and Handling Toolkit, available at: https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf, the FDA Questions about Vaccines, available at: https://www.fda.gov/vaccines-blood-biologics/vaccines/questions-about-vaccines, and the CDC webpage on Vaccines and Immunizations, available at: https://www.cdc.gov/vaccines/.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	• The manufacturer's label is not removed from a container (bag, bottle, box, can, cylinder, etc.) only if the hazardous material or residues of the material remain in the container. • Containers for biohazard waste shall comply with United States Department of Transportation requirements when prepared for transport offsite from the facility. • A hazardous waste transporter transporting medical waste shall maintain a completed tracking document and provide a copy of that document to the medical waste generator (clinic, etc.). All portable containers of hazardous chemicals and secondary containers into which hazardous substances are transferred or prepared require labeling. Labels must provide the following information: 1) Identity of hazardous substance 2) Description of hazard warning: can be words, pictures, symbols 3) Date of preparation or transfer **Exception**: Labeling is not required for portable containers into which hazardous chemicals are transferred from labeled containers, and which are intended only for the immediate use of the individual who performs the transfer. **Note:** The purpose of hazard communication is to convey information about hazardous substances used in the workplace. A hazardous substance is any substance that is a physical or health hazard.
C. Drugs are dispensed according to State and federal drug distribution laws and regulations. **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan. **IV.C.1) There are no expired drugs on site.** **Expiration Date:** • The manufacturer's expiration date must appear on the labeling of all drugs and formulas. • All prescription drugs not bearing the expiration date are deemed to have expired. • If a drug is to be reconstituted at the time of dispensing, its labeling must contain expiration information for both the reconstituted and unreconstituted drug. • Expired drugs may not be distributed or dispensed. • Per CDC – Medication Vials should be discarded whenever sterility is compromised or questionable.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	• Per CDC "If a multi-dose has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial". • Per VFC "For multi-dose vials that do not require reconstitution, doses that remain after withdrawal of a dose can be administered until the expiration date printed on the vial unless otherwise specified by the manufacturer (Polio, meningococcal polysaccharide vaccine (MPSV4), PPSV, TIV, IPV, and yellow fever that are available in multi-dose vials)".[46] Both CDC and VFC recommend to follow the manufacturer's product information. **IV.C.2) Site has a procedure to check expiration date of all drugs (including vaccines and samples), and infant and therapeutic formulas.** • Site has a procedure to check expiration date of all drugs (including vaccines and samples) and infant and therapeutic formula AT LEAST monthly. **IV.C.3) All stored and dispensed prescription drugs are appropriately labeled.** **Prescription Labeling**: • Labels shall be carefully preserved, and all medications shall be stored in their original containers. • Each prescription medication dispensed is in a container that is not cracked, soiled, or without secure closures.[47] • Each commercial container of a controlled substance shall have printed on the label the symbol designating the schedule in which such controlled substance is listed. • Drug container is labeled with the provider's name, patient's name, drug name, dose, frequency, route, quantity dispensed, and manufacturer's name and lot number. • California Pharmacy Law *does not* prohibit furnishing a limited quantity of sample drugs if dispensed to the patient in the package provided by the manufacturer, no charge is made to the patient, and appropriate documentation is made in the patient's medical record.[48]

[46] See the CDC Frequently Asked Questions regarding Multi-dose vials, available at: https://www.cdc.gov/injectionsafety/providers/provider_faqs_multivials.html, and the CDC Vaccine Storage and Handling Toolkit, available at: https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf.
[47] 22 CCR 75037(A)
[48] BPC 4170 and 4171

Criteria	IV. Clinical Services - Pharmaceutical Standards
	<u>Drug Distribution</u>: • Each clinic that provides drug distribution services has written policies and procedures for the safe and effective distribution control, storage, use and disposition of drugs. • In order to prevent inadvertent exposure to out-of-range temperatures, vaccines should never be re-distributed beyond the manufacturer/distributer-to-clinic distribution chain unless during an emergency. • In the event of necessary vaccine transport (emergency/power outage), vaccines must be packaged following CDC recommendations and include temperature monitoring devices during transport (approval is required for VFC providers prior to any vaccine transfer). **<u>IV.C.4) (CE) Only lawfully authorized persons dispense drugs to patients.</u>** **<u>Drug Dispensing</u>:** • Drug dispensing complies with all applicable State and federal laws and regulations. • Drugs are dispensed only by a physician, pharmacist, or other persons (e.g., NP, CNM, RN, PA) lawfully authorized to dispense medications upon the order of a licensed physician or surgeon. • Personnel such as MAs, office managers, and receptionists do not dispense drugs. • Drugs are not offered for sale, charged or billed to Medi-Cal members.[49] • A record of all drugs and formulas dispensed shall be entered in the patient's medical record. **<u>Drug Administration</u>:** • Basic safe practices for medication/vaccine administration, assess and document: 1) Patient's identity 2) Correct medication 3) Correct dose 4) Correct route 5) Appropriate time CMS Manual System;[50] • Proper preparation is critical for maintaining the integrity of the vaccine during transfer from the vial to the syringe.

[49] BPC 4193
[50] 42 CFR 482.23(c)

Criteria	IV. Clinical Services - Pharmaceutical Standards
	• Personnel can demonstrate or verbally explain procedure(s) used on site to confirm correct patient, medication/vaccine, dosage and route and vaccine are prepared and drawn only prior to administration. • Proper vaccine administration is critical to ensure that vaccination is safe and effective. • CDC recommends that all health care personnel who administer vaccines receive comprehensive, competency-based training on vaccine administration policies and procedures before administering vaccines. • Comprehensive, skills-based training should be integrated into existing staff education programs such as new staff orientation and annual education requirements. **IV.C.5) (CE) Drugs and Vaccines are prepared and drawn only prior to administration.** ACIP discourages the routine practice of providers' prefilling syringes. • Vaccines have a similar appearance after being drawn into a syringe, prefilling may result in administration errors. • Unused, provider prefilled syringes must be discarded if not used within the same day that they are filled. • Unused syringes that are prefilled by the manufacturer and activated (i.e., syringe cap removed, or needle attached) should be discarded at the end of the clinic day. In certain circumstances in which a single vaccine type is being used (e.g., in preparation for a community influenza vaccination campaign), filling a small number (10 or fewer) of syringes may be considered (*5*). The doses should be administered as soon as possible after filling, by the same person who filled the syringes. The Center for Biologics Evaluation and Research (CBER) at the FDA offers information concerning the storage and use of temperature-sensitive biological products that have been involved in a temporary electrical power failure or flood conditions.[51] **IV.C.6) Current Vaccine Information Sheets (VIS) for distribution to patients are present on site.** **Vaccine Immunization Statements**:

[51] See the CDC's Vaccine Recommendations and Guidelines of the ACIP, available at: https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/administration.html.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	• Since 1994, the National Childhood Vaccine Injury Act, Section 2126 of the Public Health Service Act, mandates that parents/guardians or adult patients be informed before vaccinations are administered. • Health care providers must present and offer a VIS to patients prior to any vaccine.[52] As of 2009, CDC allows providers to present a current VIS (such as a laminated copy in a binder, etc.) to the patient/parent/guardian and allow time for the patient to read and ask questions. Staff should also offer a copy each time.[53] • The date the VIS was given (or presented and offered) *and* the publication date of the VIS must be documented in the patient's medical record. • Federal law allows up to 6 months for a new VIS to be used. The most current VIS are available from state and local health departments or can be downloaded from the CDC web site at: http://www.cdc.gov/vaccines/pubs/vis/default.htm or by calling the CDC Immunization Hotline at (800) 232-2522. VFC contains current VIS and provider notifications at: http://www.eziz.org/ **IV.C.7) If there is a pharmacy on site, it is licensed by the CA State Board of Pharmacy.** **Pharmacy:** • If a pharmacy is located on site and owned by the clinic, the license issued by the CA State Board of Pharmacy must be present on site. • Every pharmacy that dispenses a controlled substance must be registered with the DEA and be licensed by the CA State Board of Pharmacy. • A licensed pharmacist monitors drug distribution and policies and procedures for medication dispensing and storage. **Note:** "Dispensing" of drugs means the furnishing of drugs or devices directly to a patient or upon a prescription from a physician, dentist, optometrist, podiatrist, veterinarian, or upon an order to furnish drugs or transmit a prescription from a certified nurse midwife, nurse practitioner, physician assistant or pharmacist acting within the scope of his or her practice. **IV.C.8) Site utilizes California Immunization Registry (CAIR) or the most current version.**

[52] 42 USC 300aa-26(D)(2)
[53] See the CDC's Facts about VIS, which is available at: https://www.cdc.gov/vaccines/hcp/vis/about/facts-vis.html.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	Immunization Registry Utilization: Scoring must be No or Yes. • DHCS requires documentation of immunizations in the California CAIR or the local registry. • If the clinic does not offer vaccines administration, the site staff shall be able to utilize the registry to access the member's immunization record. Contractor shall ensure that member-specific immunization information is periodically reported to an immunization registry (is) established in the Contractor's Service Area(s) as part of the Statewide Immunization Information System. Reports shall be made following the Member's initial health assessment and all other health care visits which result in an immunization being provided. Reporting shall be in accordance with all applicable State and Federal laws. DHCS Contract; CDC Recommendations at: www.cdc.gov/vaccines.

Criteria	IV. Clinical Services – Laboratory Review
D. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations.	**IV.D.1) Laboratory test procedures are performed according to current site-specific CLIA certificate.** **<u>CLIA Certificates</u>**: • All sites that perform laboratory testing for human health assessment, diagnosis, prevention, or treatment of disease has a current, unrevoked, unsuspended site-specific Clinical Laboratory Improvement Amendment (CLIA) certificate, or evidence of renewal. • Acceptable documentation such as the original certificate, copy of the original certificate, renewal receipt or other evidence of renewal submission is present on site or readily available upon request. The CLIA certificate or evidence of renewal should include the current site/clinic address. **<u>Note</u>:** Per 42 CFR, 493.35(b)(1-3), 493.43(b)(1-3) and 493.55(b)(1-3), laboratories must file a separate application for each laboratory location, with the following *<u>exceptions</u>*: 1) Laboratories that are not at a fixed location, that is, laboratories that move from testing site to testing site, such as mobile units providing laboratory testing, health screening fairs, or other temporary testing locations may be covered under the certificate of the designated primary site or home base, using its address. 2) Not-for-profit or Federal, State, or local government laboratories that engage in limited (not more than a combination of 15 moderately complex or waived tests per certificate) public health testing may file a single application, or 3) Laboratories within a hospital that are located at contiguous buildings on the same campus and under common direction may file a single application or multiple applications for laboratory sites within same physical location or street address. 4) A multi-site CLIA waiver can be used at all affiliated locations. A copy of the CLIA waiver must be at each individual location with the address of the main location on the waiver. A copy of the CLIA application must be reviewed by the CSR to verify the locations included for old and new locations. The CLIA Certificate on site includes one of the following: ○ Certificate of Waiver: Site can perform only exempt waived tests ○ Certificate for Provider-Performed Microscopy (PPM): Physicians, dentists, or NPMPs can perform PPM procedures and waived tests

Criteria	IV. Clinical Services – Laboratory Review
	○ Certificate of Registration: Allows moderate and/or high complexity lab testing to be conducted until compliance with CLIA regulations are determined by survey ○ Certificate of Compliance: Lab has been surveyed and found in compliance with all applicable CLIA requirements ○ Certificate of Accreditation: Lab is accredited by an accreditation organization approved by CMS **Waived Tests**: • If only waived tests are performed, site has a current CLIA Certificate of Waiver. • There are no specific CLIA regulations regarding the performance of waived tests. • Site personnel are expected to follow the test manufacturer's instructions. • Laboratories with certificates of waiver may not be routinely inspected by DHCS Laboratory Field Services Division but may be inspected as part of complaint investigations and on a random basis to determine whether only waived tests are being performed. **Moderate and High Complexity Tests:** Tests not listed as waived are divided into one of two categories, moderate complexity or high complexity, based on the complexity of the testing procedure. CLIA regulations for these categories list specific requirements for laboratory proficiency testing, patient test management, quality control, quality assurance, personnel, and inspections. **IV.D.2) Testing personnel performing clinical lab procedures have been trained.** **Personnel Training:** • Prior to testing biological specimens, personnel have been appropriately trained for the type and complexity of the laboratory services performed. • Personnel have demonstrated the ability to perform all testing operations reliably and to report results accurately. • Site personnel that perform CLIA waived tests have access to and can follow test manufacturer's instructions. • When requested, site personnel can provide a step-by-step verbal explanation or demonstration of test procedure and how to determine test results.

Criteria	IV. Clinical Services – Laboratory Review
	• The required training and certification are established by legislation for personnel performing moderate and high complexity tests.[54] Reviewers are not expected to complete an in-depth evaluation of personnel performing moderate and high complexity tests. **IV.D.3) Lab supplies (e.g. vacutainers, vacutainer tubes, culture swabs, test solutions) are inaccessible to unauthorized persons.** **IV.D.4) Lab test supplies are not expired.** Lab supplies are disposed of by manufacturer's expiration date. **IV.D.5) Site has a procedure to check expiration date and a method to dispose of expired lab test supplies.** **Note:** Any site that performs tests or examinations on human biological specimens derived from the human body is, by definition, "laboratories" under State and federal law, and includes locations such as nurses' stations within hospitals, clinics, surgical centers, physician offices, and health fairs. The current listing of waived tests may be obtained at www.cms.gov or www.fda.gov includes an evaluation every two years (or sooner of complaint driven) by CDPH of personnel licenses/training, laboratory site inspection and demonstration of testing proficiency for moderate and high-complexity test sites. **Contact CDPH Laboratory Field Services (510) 620-3800 or LFSrecep@cdph.ca.gov for CLIA certification, laboratory license, or personnel questions.**

[54] BPC 1200-1213

Criteria	IV. Clinical Services – Radiology Review
E. Site meets CDPH Radiological inspection and safety regulations	**IV.E.1) Site has current CA Radiologic Health Branch Inspection Report and Proof of Registration if there is radiological equipment on site.** **<u>CDPH Radiologic Health Branch (RHB) Inspection Report</u>**: If site has ***current*** documentation of one of the following, give the full 9 points and survey items 2-9 will not need to be surveyed. Acceptable documentation is: ○ Inspection Report and Proof of Registration, ***or*** ○ Inspection Report and Proof of Registration *and* Short Form Sign-off sheet, ***or*** ○ Inspection Report and Proof of Registration *and* Notice of Violation form *and* approval letter for corrective action plan from the CA RHB The Radiologic Inspection Report and Proof of Registration (receipt of payment or cancelled check), issued by the RHB, must be present if there is radiology equipment on site. If any violations are found, one of two documents are issued to the site: ○ "Short Form Sign-off sheet" is issued for minimal problems that are easily corrected. ○ "Notice of Violation" form, requiring a site corrective action plan, is issued if there are more violations that are serious. All "Notice of Violation" corrective action plans must be accompanied by an approval letter from the CA RHB. **If documents are not available on site, or if reviewer is uncertain about the "status of documents on site, proceed to score all items 1-9.** **The following documents are posted on site:** **IV.E.2) Current copy of Title 17 with a posted notice about availability of Title 17 and its location.** **IV.E.3) "Radiation Safety Operating Procedures" posted in highly visible location.** **IV.E.4) "Notice to Employees Poster" posted in highly visible location.** **IV.E.5) "Caution, X-ray" sign posted on or next to door of each room that has X-ray equipment.** **IV.E.6) Physician Supervisor/Operator certificate posted and within current expiration date.**

Criteria	IV. Clinical Services – Radiology Review
	IV.E.7) Technologist certificate posted and within current expiration date. **The following radiological protective equipment is present on site:** **IV.E.8) Operator protection devices: radiological equipment operator must use lead apron or lead shield.** **IV.E.9) Gonadal shield (0.5 mm or greater lead equivalent): for patient procedures in which gonads are in direct beam.** **Radiological Equipment:** Equipment inspection, based on a "priority" rating system, is established by legislation. https://blink.ucsd.edu/_files/safety-tab/rad/Title-17-CCR.pdf • Mammography equipment is inspected annually, and must have federal FDA Certification on site ***and*** CA Mammography X-ray Equipment and Facility Accreditation Certification posted on the machine.[55] • High Priority equipment (e.g. fluoroscopy, portable X-ray) is inspected every three years. • Medium Priority equipment is inspected every 4-5 years depending on the volume of patients, frequency of x-ray equipment uses, and likelihood of radiation exposure. If reviewer is uncertain about the "status of equipment inspection, call the RHB. **Radiology Personnel:** • All certificates/licenses are posted and show expiration dates. • If there are many technicians, a list of names, license numbers, and expiration dates may be substituted. • The Certified Radiological Technologist (CRT) certificate permits the technologist to perform all radiology films except mammography and fluoroscopy, which require separate certificates. • The "Limited Permit" restricts the technician to one of the ten-(10) x-ray categories specified on the limited certificate: Chest, Dental laboratory, Dermatology, Extremities, Gastrointestinal, Genitourinary, Leg-podiatric, Skull, Torso-skeletal, and X-ray bone densitometry.

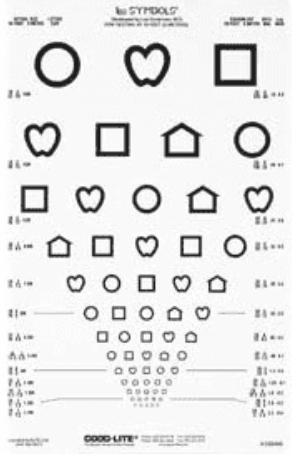
[55] 21 CFR 900

Criteria	IV. Clinical Services – Radiology Review
	Note: • Per RHB, dexascanners do not require lead aprons or gonadal shields, however, criteria 1-7 are still required. • RHB uses the ALARA (As Low As Reasonably Achievable) principle, which is the foundation of all radiation safety programs. The ALARA principle means to minimize exposure to radiation doses by employing all *reasonable* methods. • Dexascanners manufacturer guidelines do not require gonadal shielding or lead aprons due to very low radiation output, and potential for the shield to obscure the area being scanned, possibly rendering the scan non-diagnostic. With the focused beam, operators do not need aprons, the amount of exposure of "scattered" beams to an operator seated near the scanner is about the same level as that found in the natural environment. A traditional x-ray machine used for bone density testing, is not a dexascanner, and *may* require shielding/apron. **Note:** The RHB of the Food, Drug, and Radiation Safety Division of CDPH enforces the Radiation Control Laws and Regulations designed to protect both the public and employees against radiation hazards. Enforcement is carried out through licensing, registration and periodic inspection of sources of radiation, such as radiation machines. For questions regarding radiologic safety (e.g. expired or no inspection letters on site), call CDPH RHB at (916) 327-5106. For Radiation Emergency Assistance, call 1-800-*852*-7550. Ref: CCR, Title 17, Chapter 5, Subchapter 4 regulations at https://www.cdph.ca.gov/rhb

Criteria	V. Preventive Services Standards
A. Preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases.	**Examination equipment, appropriate for primary care services, is available on site:** **V.A.1) Exam tables and lights are in good repair.** **<u>Examination Table and Lights</u>:** • Lights and exam tables shall be in good repair. "Good repair" means clean and well maintained in proper working order. • Examination tables must have a protective barrier such as paper which is changed between patients, to cover the exam surface. **V.A.2) Stethoscope and sphygmomanometer with various size cuffs (e.g. child, adult, obese, thigh).** **V.A.3) Thermometer with a numeric reading.** **V.A.4) Basic exam equipment: in addition to items mentioned above, offices should have the following:** o Percussion hammer o Tongue blades o Patient gowns **V.A.5) Scales: Standing balance beam and infant scales.** **<u>Scales:</u>** • Infant scales are marked and accurate to increments of one (1) ounce or less and have a capacity of at least 35 pounds. • Standing floor scales are marked and accurate to increments of one-fourth (1/4) pound or less and have a capacity of at least 300 pounds. • Balance beam scales have an adjustment mechanism and zeroing weight to enable routine balancing at zero. • Electronic or digital scales have automatic zeroing and lock-in weight features. • Spring balance scales (e.g. bathroom scales) are unsatisfactory for clinical use as, over time, the spring counterbalance mechanism loses its accuracy.

Criteria	V. Preventive Services Standards
	V.A.6) Measuring devices for stature (height/length) measurement and head circumference measurement. **<u>Measuring Devices</u>:** Equipment on site for measuring stature (length/height) and head circumference includes: ○ Rigid 90º right angle headboard block that is perpendicular to the recumbent measurement surface. ○ Vertical to the wall-mounted standing measurement surface. ○ Flat, paper or plastic non-stretchable tape or yardstick, marked to one-eighth (1/8 in. or 1 mm) or less, attached to a firm, flat surface. The "0" of the tape is exactly at the base of the headboard for recumbent measurement, or exactly at foot level for standing measurement. ○ Moveable, non-flexible footboard at 90º right angle perpendicular to the recumbent measurement surface, or a flat floor surface for standing. ○ A non-stretchable tape measuring device marked to one-eighth (1/8 in. or 1 mm) or less for measuring head circumference (re-usable measuring device must be appropriately cleaned in between use). **V.A.7) Eye charts (literate and illiterate) and occluder for vision testing.** **<u>Vision Testing</u>:**[56] • Site has both literate (e.g., Snellen) and illiterate eye charts • The current preferred optotypes (figures or letters of different sizes) for patients who cannot distinguish letters are the LEA or HOTV symbols (see figures below)

[56] See the Procedures for the Evaluation of the Visual System by Pediatricians, available at: https://pediatrics.aappublications.org/content/137/1/e20153597. Also see the American Association for Pediatric Ophthalmology and Strabismus Vision Screening Committee's Pediatric Screening Guidance during the COVID-19 Pandemic, available at: https://aapos.org/education/allied-health/covid.

Criteria	V. Preventive Services Standards
	  • Wall mounted eye charts should be height adjustable and positioned at the eye-level of the patient • Examiners shall stand their patients with their heels to the line unless the eye chart that is being used to screen specifically instructs the patient to be positioned elsewhere. “Heel” lines are aligned with center of eye chart at 10 or 20-feet depending on whether the chart is for the 10-foot or 20-foot distance. • Eye charts are in an area with adequate lighting and at height(s) appropriate to use • Effective occlusion, such as with tape or an occlusive patch of the eye not being tested, is important to eliminate the possibility of peeking. **V.A.8) Ophthalmoscope.** Ophthalmoscope is in good working condition. **V.A.9) Otoscope with adult and pediatric ear speculums.** Otoscope with multi-size ear speculums appropriate to the population served. **V.A.10) A pure tone, air conduction audiometer is located in a quiet location for testing.**

Criteria	V. Preventive Services Standards

	Hearing Testing:[57]
	• The pure tone audiometer must have the minimum ability to:
	  ○ Produce intensities between 0 to 80 dB
	  ○ Have a headset with right and left earphones
	  ○ Be operated manually
	  ○ Produce frequencies at 1000, 2000, 3000, 4000, 6000, and 8000 Hz
	• Offices that provide pediatric preventive services should have a pure tone; air conduction audiometer available, audiometric testing is required at preventive health visits starting at 4 years of age.
	• PCP offices (such as Family Practitioners or General Practitioners) that refer all members to another provider for audiometric testing, must have a system in place that clearly demonstrates that the PCP office verifies that audiometric testing has been completed and that those results are returned to the PCP for review.

B. Health education services are available to Plan members.	**Health Education Services:** Services may include individual instruction, group classes, family counseling and/or other health educational programs and materials provided to members by the provider, health plan, or community sponsored programs. **Health education materials and Plan-specific resource information are:** **V.B.1) Readily accessible on site or are made available upon request.** **V.B.2) Applicable to the practice and population served on site.** **V.B.3) Available in threshold languages identified for county and/or area of site location.** **Health Education Materials:**

[57] See the American Speech-Language-Hearing Association's guidance on Audiograms, available at: https://www.asha.org/public/hearing/audiogram/.

Criteria	V. Preventive Services Standards
	• Must be available in the appropriate threshold languages and may be located in an accessible area on site (e.g., exam room, waiting room, health education room or area), or provided to members by clinic staff and/or by Plan upon request. • Must be available in accessible format which may include written information, audio and/or videotapes, computerized programs, and visual presentation aids for people with disabilities. • Should include general topics for health educational material such as: Immunizations, Pregnancy, Injury Prevention, Smoking Cessation, Dental Health, Nutrition, Physical Activity, STD/HIV Prevention, Family Planning, Asthma, Hypertension, and Diabetes. • Must meet the Medi-Cal Managed Care readability and suitability requirements for educational material distributed to Medi-Cal members.[58] **Plan-Specific Referral Information:** Plan-specific informing materials and/or resources are available on site in languages that are applicable to member population(s) primarily seen on site. ○ For example, if primarily English and Spanish-speaking members are seen on site, then Plan-specific informing materials are available on site in those languages. ○ Although a site may not stock informing materials in each threshold language identified for the county, site personnel has access to contact resource information for locating Plan-specific informing materials in threshold languages not typically seen on site. ○ Interpreter services are provided in all identified threshold and concentration standard languages. **Note:** Threshold languages are the primary languages spoken by Limited English Proficient (LEP) population groups residing in a county. A numeric threshold of 3,000 eligible LEP Medi-Cal beneficiaries or a concentration standard of 1,000 residing in a single ZIP code or 1,500 in two contiguous ZIP codes establishes the threshold languages identified by DHCS for each county.

[58] See All Plan Letter (APL) 18-016, "Readability and Suitability of Written Health Education Materials". APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

Criteria	VI. Infection Control Standards
A. Infection control procedures for Standard/Universal precautions are followed.  **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan (CAP). **Hand Washing Facilities:**[59] • Hand washing facilities are available in the exam room and/or utility room, and include an adequate supply of running potable water, soap and single use towels or hot air-drying machines. • Sinks with a standard faucet, foot-operated pedals, 4-6-inch wing-type handle, automatic shut-off systems or other types of water flow control mechanism are acceptable. • Staff can demonstrate infection control "barrier" methods used on site to prevent contamination of faucet handle, door handles and other surfaces until hand washing can be performed. • On occasions when running water is not readily available, an antiseptic hand cleanser, alcohol-based hand rub, or antiseptic towelettes is acceptable until running water is available.[60] **VI.A.1) Soap or antiseptic hand cleaner and running water are available in exam and/or treatment areas for hand washing.** **Soap or Antiseptic Hand Cleaner:** Hand washing prevents infection transmission by removing dirt, organic material and transient microorganisms from hands. ○ Hand washing with plain (non-antimicrobial) soap in any form (e.g., bar, leaflet, liquid, powder, granular) is acceptable for general patient care (Association for Professionals in Infection Control and Epidemiology, Inc., 1995). ○ Antimicrobial agents or alcohol-based antiseptic hand rubs are used for hand washing when indicated to remove debris and destroy transient microorganisms (e.g., before performing invasive procedures, after contact with potentially infectious materials). ○ Plain and antiseptic hand wash products are properly maintained and/or dispensed to prevent contamination.

[59] See the World Health Organization's Hand Hygiene guidelines, available at: https://www.who.int/gpsc/5may/Hand_Hygiene_Why_How_and_When_Brochure.pdf.
[60] 29 CFR 1919.1030

Criteria	VI. Infection Control Standards
	VI.A.2) A waste disposal container is available in exam rooms, procedure/treatment rooms, and restrooms. **Waste Disposal Container:**[61] • Contaminated wastes (e.g. dental drapes, band-aids, sanitary napkins, soiled disposable diapers) are disposed of in regular solid waste (trash) containers, and are maintained to prevent potential contamination of patient/staff areas and/or unsafe access by infants/children. • Closed containers are not required for regular, solid waste trash containers. **VI.A.3) Site has procedure for effectively isolating infectious patients with potential communicable conditions.** **Isolation Procedures**:[62] • Personnel can demonstrate or verbally explain procedure(s) used on site to isolate patients with potentially contagious conditions from other patients. • If personnel are unable to demonstrate or explain site-specific isolation procedures *and* cannot locate written isolation procedure instructions, site is considered deficient. • Isolation procedures may vary from site to site. **Note:** • Infection Control standards are practiced on site to minimize risk of disease transmission. • Site personnel are expected to apply the principles of "Standard Precautions" (CDC, 1996), used for all patients regardless of infection status. • Standard precautions apply to blood, all body fluids, non-intact skin, and mucous membranes, which are treated as potentially infectious for HIV, HBV or HCV, and other bloodborne pathogens. • "Universal precautions" refer to the OSHA mandated program that requires implementation of work practice controls, engineering controls, bloodborne pathogen orientation/education, and record keeping in healthcare facilities.

[61] HSC 118275-118320. Also see the OSHA Standards for Bloodborne Pathogens, available at: https://www.hercenter.org/rmw/osha-bps.php.
[62] See the CDC's Guidelines for Isolation Precautions, available at: https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html.

Criteria	VI. Infection Control Standards
B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. 🔍🗁 **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan. **VI.B.1) (CE) Personal Protective Equipment for Standard Precautions is readily available for staff use.** **Personal Protective Equipment (PPE):** PPE must be readily available.[63] PPE for protection against bloodborne pathogen hazards is available on site and must include: 1) Gloves 2) Water repellent clothing barrier/gown 3) Face/eye protection (e.g., goggles/face shield) 4) Respiratory infection protection (e.g., mask) PPE does not include general work clothes (e.g., uniforms, cloth lab coats) that will permit liquid to soak through. • The storage of PPE should be adequate to protect the PPE from contamination, loss, damage, water or sunlight. • Proper storage often requires a dry and clean place that is not subject to temperature extremes. **VI.B.2) (CE) Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport or shipping.** **Blood and Other Potentially Infectious Materials (OPIM):** • OPIM are all human body fluids, any unfixed tissue or organ (other than intact skin) from a human (living or dead), and HIV or HBV-containing blood, cells, tissue, organs, cultures, medium or solutions. • Containers for blood and OPIM are closable, leak proof, and labeled and/or color-coded. • Double bagging is required only if leakage is possible. **Labels:**

[63] 29 CFR 1910.1030

Criteria	VI. Infection Control Standards
	• A warning label is affixed to red-bagged regulated wastes, sharps containers, refrigerators/freezers containing blood or OPIM, containers used to store or transport blood or OPIM, and contaminated laundry or equipment for storage or transporting. • The international biohazard symbol with word "BIOHAZARD" *or* the words "Biohazardous Waste" label (fluorescent orange or red orange with contrasting lettering/symbols) is part of, or affixed to, the container. • Sharps containers are labeled with the words "Sharps Waste" or with the international biohazard symbol and the word "BIOHAZARD". • Individual containers of blood or OPIM are exempted from warning labels if placed inside a labeled secondary container for storage, transport, or disposal. • Alternative marking or color coding may be used to label contaminated laundry or specimen containers if the alternative marking permits employees on site to recognize that container requires compliance with Universal Precautions. **VI.B.3) (CE) Needlestick safety precautions are practiced on site.** **Needlestick Safety:**[64] • Contaminated sharps are discarded immediately. • Sharps containers are located close to the immediate area where sharps are used and are inaccessible to unauthorized persons. • Sharps are not bent, removed from a syringe, or recapped. Recapping, bending, or removing contaminated needles is permissible only if there is no feasible alternative or if such actions are required for a specific medical procedure. If recapping, bending, or removal is necessary, employers must ensure that workers use either a mechanical device or a one-handed technique. Needleless systems, needles with Engineered Sharps Injury Protection (ESIP) devices, and non-needle sharps are used (incl. in emergency kits), unless exemptions have been approved by Cal/OSHA.[65] • Security of portable containers in patient care areas is always maintained. • Any device capable of cutting or piercing (e.g. syringes, hypodermic needles, needleless devices, blades, broken glass, slides, vials) are placed in a closable, puncture-resistant, labeled,

[64] See the OSHA Needlestick Safety Frequently Asked Questions, available at: https://www.osha.gov/needlesticks/needlefaq.html, and the OSHA Standards for Bloodborne Pathogens, available at: https://www.hercenter.org/rmw/osha-bps.php.
[65] 8 CCR 5193

Criteria	VI. Infection Control Standards
	leak-proof container. If these requirements are met, containers made of various materials (e.g., cardboard, plastic) are acceptable. • Containers are not overfilled past the manufacturer's designated fill line, or more than ¾ full. • Supply of containers on hand is adequate to ensure routine change-out when filled. **VI.B.4) All sharp injury incidents are documented.** **Sharps Injury Documentation:**[66] • Site has a method in place to document sharps injuries. • The Sharps Injury Log must contain, at a minimum, information about the injury, the type and brand of device involved in the injury (if known), the department or work area where the exposure occurred, and an explanation of how the incident occurred. • The incident must be recorded in the log within 14 business days of the date the incident is reported to the employer and maintained in such a manner to protect the confidentiality of the injured employee (e.g., removal of personal identifiers) and follow-up care is documented within 14 days of injury incident. • Sites with 10 or fewer employees are exempt from OSHA recordkeeping requirements and are exempt from recording and maintaining a Sharps Injury Log, however, it is recommended to have a method in place to document sharps injuries regardless of the number of employees. **Regulated Waste Storage:** Regulated wastes include: ○ **Biohazardous wastes**, e.g., laboratory wastes, human specimens/tissue, blood/contaminated materials "known" to be infected with highly communicable diseases for humans and/or that require isolation. ○ **Medical wastes**, e.g., liquid/semi-liquid blood or OPIM, items caked with dry blood or OPIM and capable of releasing materials during handling, and contaminated sharps. **VI.B.5) Biohazardous (non-sharp) wastes are contained separate from other trash/waste.**

[66] See 8 CCR 5193, and the National Institute for Occupational Safety and Health's guidance on Preventing Needlesticks and Sharps Injuries, available at: https://www.cdc.gov/niosh/topics/bbp/sharps.html.

Criteria	VI. Infection Control Standards
	VI.B.6) Storage areas for regulated medical wastes are maintained secure and inaccessible to unauthorized persons.[67] • Regulated waste is contained separately from other wastes (e.g., contaminated wastes)* and placed in red biohazardous bags with Biohazard label and stored in a closed container that is not accessible to unauthorized persons. • If stored outside the office, a lock secures the entry door, gate or receptacle lid, and posted warning sign(s) in English and Spanish are visible for 25-feet: "CAUTION-BIOHAZARDOUS WASTE STORAGE AREA- UNAUTHORIZED PERSONS KEEP OUT" and CUIDADO-ZONA DE RESIDUOUS-BIOLOGICOS PELIGOROS-PROHIBIDA LE ENTRADA A PERSONAS NO AUTHORIZADAS". See HSC Sections 117915-117946, 49 CFR, Section 173.6; Core Infection Prevention and Control Practices -Centers for Disease Control and Prevention (CDC) The Healthcare Infection Control Advisory Committee (HICPAC), 2016. **VI.B.7) Contaminated laundry is laundered at the workplace or by a commercial laundry service.** **<u>Contaminated Laundry</u>:** • Contaminated laundry (soiled with blood/OPIM) is laundered by a commercial laundry service, or a washer and dryer on site. • Contaminated laundry should not contain sharps, and when transported, should have the appropriate warning label. • Manufacturer's guidelines are followed to decontaminate and launder reusable protective clothing. • Ensure that laundry areas have handwashing facilities and products and appropriate PPE available for staff. • Laundry requirements are "not applicable" if only disposable patient gowns and PPE are used on site.

[67] HSC 117600-118360, 29 CFR 1910.1030, CDC Guidelines for Isolating Precautions: Preventing Transmission of Infection Agents in Healthcare Settings, available at: https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html.

Criteria	VI. Infection Control Standards
	VI.B.8) Transportation of regulated medical wastes is only by a registered hazardous waste hauler or to a central location of accumulation in limited quantities (up to 35.2 pounds). **Medical Waste Disposal:** California adopted statutes into HSC affecting medical waste transporters in October 1993.[68] • Only medical waste transporters listed with CDPH can transport medical waste. • All medical waste transporters must carry paperwork issued by CDPH in each vehicle while transporting medical waste. • Medical wastes are hauled to a permitted offsite medical waste treatment facility, transfer station, or other registered generator by a registered hazardous waste transporter. • Limited-quantity exemption is not required for Small Quantity Generator (up to 35.2 pounds). However, a medical waste-tracking document that includes the name of the person transporting, number of waste containers (e.g., three sharps containers, or five biohazard bags), types of medical wastes, and date of transportation, is kept a minimum of 3 years for large waste generators and 2 years for small generators. For the CDPH list of current medical waste transporters, visit: https://www.cdph.ca.gov/Programs/CEH/DRSEM/CDPH%20Document%20Library/EMB/MedicalWaste/Haulist_012921.pdf For information on the United States Postal Service mailability standards for medical waste (including sharps) refer to the Domestic Mail Manual, section 601.10.17: https://pe.usps.com/Archive/HTML/DMMArchive20100607/601.htm CDPH Medical Waste Management Program: https://www.cdph.ca.gov/Programs/CEH/DRSEM/Pages/EMB/MedicalWaste/MedicalWaste.aspx CDPH Medical Waste Management Program Transporter Checklist: https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8660.pdf CDPH Medical Waste Transporter Annual Verification: https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8668.pdf

[68] HSC 117600-11836

Criteria	VI. Infection Control Standards
	CDPH Medical Waste Transfer Stations and Offsite Treatment Facilities: https://www.cdph.ca.gov/Programs/CEH/DRSEM/Pages/EMB/MedicalWaste/Transfer-and-Treatment.aspx CDPH Medical Waste Transporters Data Submission Protocol: https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8666.pdf Department of Toxic Substances Control-Managing Hazardous Waste Transporters Registration https://dtsc.ca.gov/transporters/ ***Note:** Contaminated wastes include materials soiled with blood during their use but are not within the scope of regulated wastes. Contaminated waste items need not be disposed as regulated waste in labeled red bags but can be discarded as solid waste in regular trash receptacle.
C. Contaminated surfaces are decontaminated according to Cal-OSHA standards. **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan (CAP). **VI.C.1) Equipment and work surfaces are appropriately cleaned and decontaminated after contact with blood or other potentially infectious material.** **Routine Decontamination:** ○ Contaminated work surfaces are decontaminated with an appropriate disinfectant.[69] ○ Written "housekeeping" schedules have been established and are followed for regular routine daily cleaning. ○ Staff can identify cleaning and disinfection of surfaces and equipment, the disinfectant used and responsible personnel in between patients use. **VI.C.2) Routine cleaning and decontamination of equipment/work surfaces is completed according to site-specific written schedule.** **The written schedule for cleaning and decontamination of the work site as follows:** ○ **Area cleaned/decontaminated**

[69] 29 CFR 1910.1030

Criteria	VI. Infection Control Standards
	○ **Frequency of cleaning/decontamination** ○ **Employee responsible for determining and implementing the written schedule** All equipment and environmental and work surfaces shall be cleaned and decontaminated after contact with blood or OPIM no later than at the end of the shift. Cleaning and decontamination of equipment and work surfaces is required more often as specified below: ○ Location within the facility ○ Type of surface or equipment to be treated ○ Type of soil or contamination present ○ Tasks or procedures being performed in the area Contaminated work surfaces shall be cleaned and decontaminated with an appropriate disinfectant immediately or as soon as feasible when: ○ Surfaces become overtly contaminated. ○ There is a spill of blood or OPIM. ○ Procedures are completed. ○ At the end of the work shift if the surface may have become contaminated since the last cleaning. **Spill Procedure:** Personnel can identify procedures for prompt decontamination of blood/body fluid spills, the disinfectant used, and the responsible person(s). **Disinfectant solutions used on site are:** **VI.C.3) Approved by the Environmental Protection Agency (EPA).** **VI.C.4) Effective in killing HIV/HBV/TB.** **VI.C.5) Follow manufacturer instructions.** **Disinfectant Products:** ○ Products used for decontamination have a current EPA-approved status. ○ Effectiveness in killing HIV/HBV/TB is stated on the manufacturer's product label. ○ Decontamination products are used according to manufacturer's guidelines for decontamination and contact times.

Criteria	VI. Infection Control Standards
	<u>10% Bleach Solution</u>: ○ 10% bleach solution that is EPA registered and effective against TB, is changed/reconstituted ***every*** 24 hours (due to instability of bleach once mixed with water). ○ Surface is cleaned prior to disinfecting (due to presence of organic matter (e.g., dirt, blood, excrement) inactivates active ingredient, sodium hypochlorite). ○ Surface is air-dried or allowed appropriate time (stated on label) before drying. ○ Manufacturer's directions, *specific* to every bleach product, are followed carefully. **<u>Note</u>:** "Contamination" means the presence or reasonably anticipated presence of blood or OPIM on any item or surface. "Decontamination" is the use of appropriate physical or chemical means to remove, inactivate or destroy bloodborne pathogens so that a surface or item is no longer capable of transmitting infectious particles and is rendered safe for handling, use or disposal.[70] Current EPA product lists and information is available from the EPA, Antimicrobial Division at (703) 305-1284, or at 29 CFR 1910.1030.
D. Reusable medical instruments are properly sterilized after each use. **RN/NP/CNM/LM/MD/PA**	**<u>Deficiencies</u>:** All deficiencies related to Infection Control must be addressed in a corrective action plan (CAP). **VI.D.1) Written site-specific policy/procedures or manufacturer's instructions for instrument/equipment sterilization are available to staff.** If site uses an autoclave or cold chemical solution to achieve sterilization and/or high level disinfection (HLD) of instruments/equipment, site shall have specific policy/procedures or manufacturer's instructions addressing instrument/equipment pre-treatment, cleaning and preparation, the management of chemical solutions, autoclave loading and operation, safety guidelines and precautions, and other required processes, which are available to staff to follow. **Staff adheres to site-specific policy and/or manufacturer/product label directions for the following procedures:** **VI.D.2) Cleaning reusable instruments/equipment prior to sterilization.** **<u>Cleaning Prior to Sterilization</u>:**

[70] 8 CCR 5193. Also see CalOSHA's Best Practices Approach for Reducing Bloodborne Pathogen Exposure, available at: https://www.dir.ca.gov/dosh/dosh_publications/BBPBest1.pdf.

Criteria	VI. Infection Control Standards
	• Prior to undergoing the sterilization process, soiled instruments/equipment are thoroughly cleaned using enzymatic detergent, rinsed, dried, and inspected for the presence of dried blood or other debris. **Cold chemical sterilization/high level disinfection:** **VI.D.3a) (CE) Staff demonstrate /verbalize necessary steps/process to ensure sterility and/or high-level disinfection of equipment.** • Personnel can demonstrate or verbally explain procedure(s) used for cleaning prior to sterilization, and to locate written directions on site. • Product efficacy tests (i.e. test strips) shall be performed according to manufacturer's guidelines. **Cold Chemical Sterilization/High Level disinfection:** • Product manufacturer's directions are strictly followed for instrument pre-soaking treatment, solution preparation, solution exposure procedures, safety precautions (e.g., room temperature, area ventilation), and post-sterilization processes. • Sterilization and or high-level disinfection exposure times and solution expiration date and time are available to staff. • Written procedures for cold sterilization and/or high-level disinfection is available on site to staff. **VI.D.3b) Confirmation from manufacturer item(s) is/are heat sensitive.** • Per CDC,[71] the use of liquid chemical germicides to sterilize instruments ("cold sterilization") are limited. Sterility is not verified or assured with cold chemical sterilization. The first choice is always heat sterilization. The CDC refers to heat sterilization as "the method of choice when sterilizing instruments and devices. If an item is heat sensitive, it is preferable to use a heat-stable alternative or disposable item". • The use of a liquid chemical sterilant should be restricted to reprocessing devices that are heat-sensitive and incompatible with other sterilization methods. All other items should be heat sterilized or disposable.

[71] See the CDC Guidelines for Disinfection and Sterilization, available at: https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf. Also see the CDC's Guidelines on other sterilization methods, available at: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/sterilization/other-methods.html.

Criteria	VI. Infection Control Standards
	VI.D.3c) (CE) Appropriate PPE is available, exposure control plan, Material Safety Data Sheets (MSDS) and clean up instructions in the event of a cold chemical sterilant spill. Cold Chemical Sterilants Spillage: The OSHA Hazard Communication Standard requires manufacturers and importers of hazardous chemicals to develop MSDS for each chemical or mixture of chemicals.[72, 73] ○ Employers must have the data sheets for cold chemical sterilants readily available to employees who work with the products to which they could be exposed. ○ Staff should attend training classes in safety awareness about the use and exposure to cold chemical sterilants used on site. ○ Personnel are familiar with and can recognize signs and symptoms of exposure to cold chemical sterilants used on site. ○ Staff must be aware of the procedures for clean up in the event of spillage. ○ Staff can demonstrate or verbally explain procedure(s) used on site for chemical spill cleanup. ○ If personnel are unable to demonstrate or explain site-specific chemical spill cleanup procedures *and* cannot locate written chemical spill cleanup procedure instructions, site is considered deficient. ○ Cleanup procedures may vary from site to site depending on the cold chemical sterilants used. ○ The appropriate PPE for cold chemical sterilants clean up must be readily available. National Institute for Occupational Safety and Health (NIOSH) with the Centers for Disease Control and Prevention. Environmental Health and Safety guidelines for disinfectants and sterilization methods. MSDS for cold chemical sterilants. The American National Standard (ANSI)/Advancing Safety in Medical Technology (AAMI) ST58:2013. Control Methods and Work Practices: are in place to prevent or reduce exposure to the cold chemical sterilants. Cold chemical sterilants have toxic properties and are hazardous.

[72] 29 CFR 1910.1200, 1915.99, 1917.28, 1918.90, 1926.59, and 1928.21.

[73] See CDC guidelines on sterilizing heat sensitive dental instruments, available at: https://oshareview.com/2013/10/cdc-guidelines-sterilizing-heat-sensitive-dental-instruments-dental-infection-control/. 29 CFR 1910.1030(d)(3)(i), 29 CFR 1910.1030(d)(3)(ii), 29 CFR 1910.1030(d)(4)(ii)(A), 29 CFR 1910.1030(d)(4)(iii)(B), 29 CFR 1910.132, 29 CFR 1910.134. See the CDC Guidelines for Disinfection and Sterilization in Healthcare Facilities, available at: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/sterilization/index.html.

Criteria	VI. Infection Control Standards
	• Cold chemical sterilants must be used strictly in accordance with the manufacturer's directions. Always consult the manufacturer for safety precautions and MSDS information. • The appropriate PPE must be used to avoid inhalation or skin contact exposure to during the cold chemical sterilization/high level disinfection process. Examples of cold chemical sterilants include: ○ Glutaraldehyde (Cidex) ○ Peracetic acid ○ Hydrogen peroxide-based solutions Glutaraldehyde is a common cold chemical sterilants. Exposure to glutaraldehyde can cause the following health effects: throat and lung irritation, breathing difficulty, nose irritation, nosebleed, burning eyes and conjunctivitis, rash, hives, headaches, and nausea. Exposure to glutaraldehyde may be prevented or reduced by using the following control methods and work practices: ○ Use local exhaust ventilation. ○ Keep glutaraldehyde baths under a fume hood where possible.[74] ○ Avoid skin contact (use appropriate PPE-gloves and aprons made of nitrile or butyl rubber wear goggles and face shields). ○ Use only enough sterilants to perform the required sterilization procedure. ○ Seal or cover all containers holding the sterilants. ○ Attend training classes. **Autoclave/Steam Sterilization:** **VI.D.4a) Staff demonstrate/verbalize necessary steps/process to ensure sterility.** • Autoclave manufacturer's directions are strictly followed for instrument pre-cleaning, machine loading, operation safety precautions, minimum time-temperature criteria, and post sterilization processes. • Written operating procedures for autoclave are available on site to staff. • Documentation of sterilization loads include date, time and duration of run cycle, temperature, steam pressure, and operator of each run.

[74] For more information on glutaraldehyde exposure and safety tips, refer to the CDC guidance, available at: https://www.cdc.gov/niosh/docs/2001-115/default.html.

Criteria	VI. Infection Control Standards
	• If instruments/equipment are transported off-site for sterilization, equipment handling, and transport procedures are available on site to staff. • Documentation of instruments and personnel transporting must be maintained. **VI.D.4 b) Autoclave maintenance per manufacturer's guidelines.** **Autoclave Maintenance:** Autoclave is maintained and serviced according to manufacturer's guidelines. Documentation of maintenance should include: o Mechanical problems o Inspection dates o Results/outcome of routine servicing o Calibration o Repairs, etc. **Note:** If the manufacturer's guidelines are not present on site, then the autoclave is serviced annually by a qualified technician. A dated sticker on the autoclave or a service receipt is acceptable documentation of appropriate maintenance. **VI.D.4c) (CE) Spore testing of autoclave/steam sterilizer with documented results (at least monthly).** **Spore Testing:** • Autoclave spore testing is performed *at least monthly*, unless otherwise stated in manufacturer's guidelines. • Documentation of biological spore testing includes: o Date o Results o Types of spore test used o Person performing/documenting test results • Written procedures for performing routine spore testing and for handling positive spore test results are available on site to staff. • For positive spore tests, the autoclave is removed from service immediately until inspection is completed and a negative retest occurs. Procedures include: o ***Report*** problem o ***Repair*** autoclave o ***Retrieve*** all instruments sterilized since last negative spore test

Criteria	VI. Infection Control Standards
	○ ***Re-test*** autoclave ○ ***Re-sterilize*** retrieved instruments • Biologic spore test products vary and are designed for use based on specific autoclave type. Biologic control testing challenges the autoclave sterilization cycle with live, highly resistant, nonpathogenic spores. If spores are killed during processing, it is assumed that all other microorganisms are also killed and that the autoclave load is sterile. **Note: Documentation of monthly spore testing must be maintained onsite even for sterilization that is performed offsite.** **VI.D.4.d) (CE) Management of positive mechanical, chemical, and biological indicators of the sterilization process.** **Autoclave/Steam Sterilization Mechanical, Chemical, and Biological Indicators:[75]** • Sterilization failure can occur for reasons such as slight variation in the resistance of the spores, improper use of the sterilizer, and laboratory contamination during the culture. • Per CDC, the autoclave/steam sterilization procedure should be monitored routinely by using a combination of: ○ Mechanical Indicator: monitor sterilization process with a daily assessment of cycle time and temperature by examining the temperature record chart and an assessment of pressure via the pressure gauge (e.g., graphs, gauges, printouts) ○ Chemical Indicator: are usually either heat-or chemical-sensitive inks that change color when one or more sterilization parameters (e.g., steam-time, temperature, and/or saturated steam; ETO-time, temperature, relative humidity and/or ETO concentration) are present. ○ Biological: spore test – an indicator to evaluate the sterilizing conditions and indirectly the microbiologic status of the processed items Staff should adhere to site-specific protocol and/or manufacturer/product label for management of positive indicator(s).

[75] See the CDC Guidelines for Disinfection and Sterilization in Healthcare Facilities, available at: https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf.

Criteria	VI. Infection Control Standards

	VI.D.4.e) Sterilized packages are labeled with sterilization date and load identification information.
	Package and storage of sterilized items:
	• Following the sterilization process, medical and surgical devices must be handled using aseptic technique in order to prevent contamination.
	• Storage areas for sterilized packages are clean, dry and separated from non-sterile items by a functional barrier (e.g., shelf, cabinet door, and drawer).
	• Sterilized package labels include:
	  ○ Date of sterilization
	  ○ Load run identification information
	  ○ Initials of staff member
	  ○ General contents (e.g. suture set) each item in a sterile package need not be listed on the label if a master list of package contents is available elsewhere on site
	
	VI.D.4.f) Storage of sterilized packages.
	Storage of sterilized packages:[76]
	• Storage areas for sterilized packages are clean, dry and separated from non-sterile items by a functional barrier (e.g., shelf, cabinet door, and drawer).
	• Maintenance of sterility is event related, not time related.
	• Sterilized items are considered sterile until use, unless an event causes contamination.
	• Sterilized items are not considered sterile if package is opened, wet/moist, discolored or damaged, and should be kept removed from sterile package storage area.
	• Site has a process for routine evaluation of sterilized packages.

[76] See the CDC Summary of Recommendations regarding Disinfection and Sterilization, available at: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html, and the CDC Guidelines for Disinfection and Sterilization in Healthcare Facilities, available at: https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf.