State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services
DIANA M. BONTÁ, R.N., Dr. P.H.
Director

GRAY DAVIS
Governor

May 16, 2002

MMCD Policy Letter 02-02
Supercedes MMCD Policy Letter 96-6

TO:
- [X] County Organized Health Systems (COHS)
- [X] Geographic Managed Care (GMC) Plans
- [X] Prepaid Health Plans (PHP)
- [X] Primary Care Case Management (PCCM) Plans
- [X] Two-Plan Model Plans

SUBJECT: SITE REVIEW

PURPOSE

This letter defines a standardized site review policy that complies with DHS contractual requirements, and is applicable to all Medi-Cal managed care health plan models (hereafter referred to as plans) for review of primary care provider (PCP) sites. The purpose of conducting site reviews is to ensure that all PCP sites used by plans for delivery of services to plan members have sufficient capacity to:

1) provide appropriate primary health care services;
2) carry out processes that support continuity and coordination of care;
3) maintain patient safety standards and practices; and
4) operate in compliance with all applicable federal, state and local laws and regulations.

This policy letter describes a system-wide process to minimize site review duplication and support consistency in PCP site reviews.

BACKGROUND

In 1991, the Centers for Medicaid and Medicare Services (CMS), formerly the Health Care Financing Administration (HCFA) Medicaid Bureau, as part of the Quality Assurance Reform Initiative (QARI), stipulated that provision of managed care health services must adhere to all current applicable federal, state and local statutory and regulatory requirements. CMS also required that all managed care organizations contracting with State Medicaid programs have an internal program for quality assurance. In addition, plans are required to offer a range of services, including both preventive and primary care services that meet the needs of the populations served. The site review process is the part of a plan's quality improvement program that focuses on the capacity of the PCP site to ensure and support the safe and effective provision of clinical services provided at the primary care sites within the provider network.

Primary care services include all health care and laboratory services customarily provided by or through a general practitioner, family practice physician, internal medicine physician, pediatrician, or obstetrician/gynecologist serving as a PCP, in accordance with State licensure and certification laws and regulations (Title 42, Code of Federal Regulations (CFR), Section 438.6).

Plans are required to have adequate facilities and sufficient site locations available to meet contractual requirements for the delivery of primary care within its service area (Title 22, California Code of Regulations (CCR), Section 56230).

Past efforts to ensure compliance with regulatory requirements have resulted in multiple overlapping and duplicative reviews of physician offices by various agencies, often with little or no communication between agencies. Multiple reviews have often resulted in significant disruption in the provision of patient care at provider sites. In 1998, a workgroup, composed of representatives from the commercial, local initiative, geographic managed care, and county organized health system plans, was established by the Department of Health Services (DHS) Medi-Cal managed care division (MMCD) to revise the Medi-Cal managed care site review policy. The objective of the policy revision workgroup was to develop a uniform, system-wide process that both clarifies mandated requirements and decreases duplicative site reviews for Medi-Cal managed care plan providers. This policy letter defines the site review process established by the collaborative workgroup.

POLICY

Health plans are subject to requirements established in statute by Title 22, CCR, for participation in the Medi-Cal Program and Title 28, CCR, for Knox Keene-licensed health plans. Review of PCP sites is required for all health plans participating in the

Medi-Cal managed care program (Title 22, CCR, Section 56230). Plans shall ensure that PCP sites are compliant with all applicable local, state and federal standards. Each provider site, where applicable, must be licensed and accredited by appropriate agencies, and maintain compliance with all licensing standards (Title 22, CCR, Section 56230). Prior to approval for use in providing services to members, all contracted or subcontracted sites where primary health care services are provided shall be subject to an initial onsite inspection, and thereafter periodic inspections to evaluate the continuing capacity of the site to support the delivery of quality health care services (Title 22, CCR, Section 56230).

Accountability

Contracting Medi-Cal managed care plans have ultimate accountability for all functions performed within their jurisdiction of responsibility, whether those functions are performed by the plan itself, or a delegated and/or sub-delegated entity. Plans are accountable for all primary care provider sites from which health care services are delivered to members. Plan accountability includes ensuring that a PCP site inspection is completed according to regulatory, contractual and policy requirements, and that all necessary corrective actions have been completed. Plans must provide ongoing oversight and monitoring of sites between reviews.

Health plans and Independent Physician Associations (IPAs) that are subcontracted for provision of health care services to plan members are accountable to the DHS-contracted plan for compliance with all applicable regulatory, contractual and policy requirements.

Delegation

All delegated responsibilities must be approved by DHS. The plan is responsible for:

- establishing a formal, mutually agreed upon document;
- identifying specific delegated functions;
- overseeing and monitoring delegated activities; and
- ensuring that delegated functions are properly carried out.

All delegated and sub-delegated entities shall follow the most current MMCD site review policy requirements. Site review personnel from delegated and sub-delegated entities shall be trained, certified and supervised according to the policy standards established for contracting plans.

Credentialing and Recredentialing

Plans shall ensure that providers are credentialed according to MMCD contractual and policy requirements. A site review shall be completed as part of the initial credentialing process if a new provider at a site that has not previously been reviewed is added to a contractor's provider network. A site review need not be repeated as part of the initial credentialing process if a new provider is added to a provider site that has a current passing site survey score. A site review survey need not be repeated as part of the recredentialing process if the site has a current passing site survey score. A passing Site Review Survey shall be considered "current" if it is dated within the last 3 years, and need not be repeated until the due date of the next scheduled site review survey or when determined necessary through monitoring activities by the plan.

Full Scope Site Review

All primary care provider sites participating in the Medi-Cal managed care program are required by California statute (Title 22, Section 56230) to complete an initial site inspection and subsequent periodic site inspections regardless of the status of other accreditation and/or certifications. The Full Scope site review shall be the system-wide standard for conducting the initial and subsequent periodic reviews of PCP sites. A Full Scope review consists of the MMCD Site Review Survey (Attachment A) and Medical Record Review Survey (Attachment B). All contracting plans and subcontracted entities shall use MMCD survey criteria and scoring methodology for site and medical record audits.

I. Initial Full Scope Site Review

All primary care sites serving Medi-Cal managed care members shall undergo an initial site review with attainment of a minimum passing score of 80% on both the Site Review Survey and Medical Record Review Survey. The initial site review is the first onsite inspection of a site that has not previously had a full scope survey, or a PCP site that is returning to the Medi-Cal managed care program and has not had a passing full scope survey within the past three years. The initial full scope site review survey can be waived by a plan for a pre-contracted provider site if the provider has documented proof that a current full scope survey with a passing score was completed by another plan within the past three years.

Prior to initiating plan operations in a service area, an initial full scope survey shall be completed on 5% of the provider network, or on 30 PCP sites, whichever is greater in number. The 5% or 30 PCP sample sites shall include a variety of providers from throughout the provider network and/or from each subcontracted entity. If there are 30 or fewer PCP sites in the network, 100% of the sites must be completed prior to beginning plan operations. Corrective actions shall be completed as outlined in

this policy. An initial full scope survey shall be completed on 100% of the remaining proposed PCP sites within the first 6 months of plan operation or expansion.

II. Subsequent Periodic Full Scope Site Review

After the initial full scope survey, the maximum time period before conduction of the next required full scope site survey shall be three years. Plans may review sites more frequently per local collaborative decision, or when determined necessary based on monitoring, evaluation or corrective actions plan (CAP) follow-up issues.

Medical Record Review

Ten (10) medical records shall be reviewed initially for each provider as part of the site review process and every three years thereafter. During any medical record survey, reviewers shall have the option to request additional records for review. If additional records are reviewed, scores must be calculated accordingly (See Attachment B).

Medical records of new providers shall be reviewed within 90 calendar days of the date on which members are first assigned to the provider. An additional extension of 90 calendar days may be allowed *only if* the new provider does not have sufficient assigned Medi-Cal managed care plan members to complete a review of 10 medical records. If there are still fewer than 10 assigned member records at the end of six months, a medical record review shall be completed on the total number of records available, and the scoring shall be adjusted according to the number of records reviewed.

Sites where documentation of patient care by multiple PCPs occurs in the same record shall be reviewed as a "shared" medical record system. Shared medical records shall be considered those that are not identifiable as "separate" records belonging to any specific PCP. A minimum of 10 records shall be reviewed if two to three PCPs share records, 20 records shall be reviewed for four to six PCPs, and 30 records shall be reviewed for seven or more PCPs.

Scoring

The minimum passing score for the site review survey and the medical record survey is 80%. The site review survey contains a total of 150 points, with the following compliance level categories:

- Exempted Pass: 94% or above, *without* deficiencies in critical elements;
- Conditional Pass: 80-93%, or 94% or above *with* deficiencies in critical elements; and
- Not Pass: below 80%.

The Medical Record Survey contains a total of 320 points, with the following compliance level categories:

- Full Pass: 100%:
- Conditional Pass: 80-99%; and
- Not Pass: below 80%.

A full point(s) shall be given if the scored element meets the applicable criterion. Partial points shall not be given for any scored element that is considered only "partially" met by the reviewer. Zero points shall be given if an element does not meet criteria. The reviewer shall determine the "not applicable" (N/A) status of each criterion based on site-specific assessment. The reviewer must explain all criteria scored as zero points or assessed as N/A.

If a site receives a non-passing score by one plan, the site shall be considered to have a non-passing score by all other Medi-Cal managed care plans. Plans shall use the local collaborative process to identify shared providers and to define methodology and determine systems for sharing survey information.

Critical Elements

Nine critical survey elements related to the potential for adverse effect on patient health or safety have a scored "weight" of two points. All other survey elements are weighted at one point. All critical element deficiencies found during a full scope site survey, focused survey, or monitoring visit shall be corrected by the provider within 10 business days of the survey date, and verified as corrected by the plan within 30 calendar days of the survey date. Sites found deficient in any critical element during a Full Scope Site Review Survey shall be required to correct 100% of the survey deficiencies, regardless of survey score. Critical elements include the following nine criteria:

1) exit doors and aisles are unobstructed and egress (escape) accessible;
2) airway management equipment, appropriate to practice and populations served, are present on site;
3) only qualified/trained personnel retrieve, prepare or administer medications;
4) office practice procedures are utilized on-site that provide timely physician review and follow-up of referrals, consultation reports and diagnostic test results;
5) only lawfully-authorized persons dispense drugs to patients;
6) personal protective equipment (PPE) is readily available for staff use;
7) needlestick safety precautions are practiced on-site;
8) blood, other potentially infectious materials (specimens) and regulated wastes (sharps/biohazardous non-sharps) are placed in appropriate leak-proof, labeled containers for collection, processing, storage, transport or shipping; and

9) spore testing of autoclave/ steam sterilizer is completed (at least monthly), with documented results.

Corrective Action Plans

Sites that receive an Exempted Pass (94% or above, *without* deficiencies in critical elements) shall not be required to complete a CAP unless determined necessary by the plan. All sites that receive a Conditional Pass (80-93%, or 94% and above with deficiencies in critical elements) shall be required to establish a CAP to correct 100% of cited deficiencies. The plan conducting the survey is responsible for the follow-up, re-survey and closure of the CAP. CAP documentation shall identify the specific deficiency, corrective action(s) needed, projected and actual date(s) of the deficiency correction, re-evaluation timelines/dates, and responsible person(s). The closed CAP also shall include documentation of problems in completing corrective actions (if any), education and/or technical assistance provided by plan, evidence of the correction(s), completion/closure dates, and name/title of reviewer. CAP notification and completion shall occur according to following timeline:

I. Providers with Conditional Pass score (80% or above)

A) At the time of the survey: reviewers shall notify providers of non-passing survey scores, critical element deficiencies, other deficiencies determined by the reviewer or plan to require immediate corrective action, and the CAP requirements for these deficiencies.

B) Within 10 business days of the survey date:
   1) providers shall submit a completed CAP with verification for all critical element and/or other survey deficiencies requiring immediate correction to the requesting plan; and
   2) plans shall provide a survey findings report and a formal written request for corrections of all other (i.e., non-critical, non-immediate) deficiencies to providers.

C) Within 30 days of the survey date, plans shall re-evaluate and verify corrections of critical elements and other survey deficiencies requiring immediate correction.

D) Within 30 calendar days from the date of the written CAP request:
   1) providers shall submit a CAP for all deficiencies (other than critical) to plan; and
   2) plans shall review/revise/approve CAP and timelines.

E) Within 60 calendar days from the date of written CAP request:
   1) providers shall complete all other corrective actions; and
   2) plans shall provide educational support and technical assistance as needed, re-evaluate/verify corrections, and close the CAP.

F) Beyond 60 calendar days of the date of written CAP request:
1) providers may request a definitive, time-specific extension period (not to exceed 90 calendar days from survey findings report and CAP notification date, unless a longer extension is approved by the Department) to complete corrections if extenuating circumstances that prevented completion of corrections can be clearly demonstrated, and if agreed to by the plan; and
2) plans shall re-survey any provider site in 12 months that required an extension period beyond 90 calendar days to complete corrections prior to closing the CAP.

II. Non-Passing Pre-contractual Provider

A pre-contractual provider who scores below 80% on the full scope site review survey shall not be counted as a network provider. Prior to being approved as a network provider, a non-passing provider must be re-surveyed and pass the full scope site review survey at 80% or higher. After achieving a score of 80% or higher, a CAP shall be completed as specified under CAP timeline requirements.

III. Non-Passing Contracted Network Provider

Providers shall be notified of the survey score, all cited deficiencies and CAP requirements at the time of a non-passed survey. Plans shall have the right to remove any provider with a non-passing score from the provider network. However, if a provider with a non-passing score is allowed to remain in the provider network, survey deficiencies must be corrected by the provider and verified by the plan within the CAP timelines established in this policy. New members shall not be assigned to network providers that score below 80% on a subsequent full scope site review survey until corrections are verified and the CAP is closed.

IV. Non-Compliant Provider

Providers who do not correct survey deficiencies within the established CAP timelines shall not be assigned new members until such time as corrections are verified and the CAP is closed. Any network provider who does not come into compliance with survey criteria within the established timelines shall be removed from the network and plan members shall be appropriately re-assigned to other network providers. Plans shall provide affected members with a 30-day notice that the non-compliant provider is being removed from the network.

V. Provider Appeal Process

Providers removed from the network shall have the right to appeal the decision with the plan. Plans shall have a formal and fair process to resolve grievances and complaints

submitted by providers of medical services. If verified evidence of corrections is acceptable by the plan and the decision is reversed, the plan shall repeat the full scope survey or accept the current survey and CAP as completed and re-survey the site in 12 months. If the decision is not reversed by the plan, the provider may re-apply through application processes established by the plan. All applicants shall undergo an initial Full Scope Survey, and be required to adhere to the requirements and standards established by this policy.

Monitoring

Plans shall systematically monitor *all* PCP sites between each regularly scheduled full scope site review survey. Monitoring methods may include site visits, but shall also include methodologies other than site visits. Monitoring sites between audits shall include the use of both internal (e.g., quality improvement) systems and external (e.g., public health) sources of information. Evaluation of the nine critical elements shall be monitored on all sites between full scope site surveys. When problems are identified through monitoring processes, plans shall determine the appropriate course of action to assure that problems are fully investigated and corrected in a timely manner.

Focused Review

The focused review is a "targeted" audit of one or more specific site or medical record review survey areas, and shall not be substituted for the full scope survey. Focused reviews may be used to monitor providers between full scope site review surveys, to investigate problems identified through monitoring activities, or to follow up on corrective actions. Reviewers may use the appropriate section(s) of site review and/or medical record review survey tools for the focused review, and/or other methods to investigate identified problems or situations. All deficiencies found in a focused review shall require the completion and verification of corrective actions according to CAP timelines established previously in this policy.

Local Collaboration

Plans shall collaborate locally, within each Medi-Cal managed care county, to establish systems and implement procedures for the coordination and consolidation of site audits for mutually shared primary care providers. All contracting plans within a county have equal responsibility and accountability for participation in the local site review collaborative processes.

An initial written description and periodic update reports (as requested by MMCD) shall be submitted to the MMCD Medical Monitoring Unit nurse describing the local collaboration processes, which includes but are not limited to the following information:

- names and titles of participating personnel from each plan;
- work plan that includes goals, objectives, activities, and timelines;
- scheduled meeting dates/times/locations, meeting processes and outcomes;
- communication and information sharing processes;
- roles and responsibilities of each plan;
- delegated activities, and use of delegated and/or subdelegated entities/agencies; and
- Memoranda of Agreement (MOA) requirements established for plans and providers.

Policies and procedures shall also be established to define local collaborative methodology for the following:

- confidentiality, disclosure and release of shared provider survey information;
- oversight and monitoring of survey processes;
- site review personnel and training processes;
- collection and maintenance of a local survey information database system; and
- evaluation processes.

Review Personnel

The Medical Director and/or Chief Medical Officer are ultimately responsible for site review activities implemented by plan personnel and/or contracted agency or entity. The plan shall retain site review program oversight responsibility whether survey functions are maintained within the plan, delegated to another plan, or subcontracted to a third agency or entity. Plans shall identify designated physician and/or registered nurse (RN) personnel to become certified trainers responsible for training and supervising reviewers, certifying RN and physician reviewers, monitoring reviews and evaluating reviewers for interrater reliability. Certified site review trainers may also include personnel from subcontracted agencies.

Plans shall determine the composition of the review teams performing site review surveys. A variety of personnel, such as pharmacists, dietitians and others able to provide assistance and clarification may be part of the survey team. The responsible reviewer for each survey shall be at minimum an RN, who shall sign the site review and/or medical record survey.

Reviewers shall only review survey criteria that are *appropriate* to their level of education, expertise, training and professional licensing scope of practice as determined by California statute. Plans shall have written policies and procedures that clearly define the duties and responsibilities of all review personnel. Plans shall demonstrate that survey activities established for reviewers are in compliance with scope of practice as defined by California statute, in accordance with the State licensing and/or certification agencies, and are appropriate to the reviewer's education and training.

Site Review Training and Certification

Site Review trainers shall be certified as trainers, and recertified every two years thereafter. Physician and RN reviewers shall be certified as reviewers of the full scope site review survey, and recertified every two years thereafter. All reviewers shall complete site review training prior to conducting surveys, and periodically thereafter as established in the site review training program curriculum and site review certification process.

Site Review Data Submission Procedures

Plans shall submit site review data to the MMCD Medical Monitoring Unit nurse evaluator every six months (See Attachment D), by June 30 and December 31 of each calendar year. Data may, at the Plan's discretion, be submitted more frequently than every six months. For pre-operational and expansion site reviews, site review data must be submitted to the MMCD Medical Monitoring Unit nurse evaluator at least six weeks prior to site operation, and then by June 30 and December 31, of each calendar year, thereafter. Data will be submitted in Microsoft Access.mdb format (version 97 or later).

DISCUSSION

Delegation
Plans may delegate site review responsibilities to another DHS-contracted Medi-Cal managed care plan, or subcontract responsibilities to an appropriate agency/entity. Delegation of site review responsibilities is a determination made by each plan. However, each collaborating plan shall determine the *acceptance* of surveys completed by the entities delegated or subcontracted by another local plan.

Credentialing and Recredentialing
For a new provider on a site that has not previously been reviewed, initial provider credentialing and site review will occur simultaneously. As providers at a site may change over time, the timeline for provider recredentialing and subsequent site review surveys may become independent processes that are not on a synchronized schedule.

Full Scope Site Review Survey
A PCP site is required to undergo an initial full scope site review if there is no evidence of a current passing survey completed by another local plan, or when a contracted provider from an approved site moves to a new site that has not previously been reviewed. An initial site survey need not be completed by a "new" contracting plan if a copy of the current passing site survey is provided by the provider or another local plan.

The most current site review and medical record surveys shall be shared with and accepted by all plans contracting with the provider. Each plan is responsible for tracking the survey status of all contracted provider sites. Plans shall collaborate locally to determine processes for notification of survey status and/or results on shared providers.

Medical Records

Medical records are reviewed for format, legal documentation practices, and documented evidence of the provision of preventive care and coordination and continuity of primary care services. The medical record provides legal proof of the care a patient receives. Documentation of patient care has become synonymous with the care itself. Failure to document appropriately implies failure to provide care.

Preventive care criteria cover three content areas: pediatric, adult health, and obstetric services. The medical record score is based on a survey standard of 10 randomly selected records per provider, consisting of five pediatric records and five adult and/or obstetric records. For sites with *only* adult, *only* obstetric, or *only* pediatric patients, all ten records surveyed are *only* in that preventive care area.

Scoring

Survey scoring is based on available documented evidence, actual demonstration of criteria being met and verbal interviews with site personnel. If a plan chooses to audit additional criteria not included on the site review or medical record review surveys, the additional criteria *cannot* be added to the existing scoring methodology. Scored criteria or assigned weights *cannot* be altered in any way. Calculation of scores is based on the total survey points, or on the adjusted survey points for "not applicable" items. For scoring procedure, see the site review survey guidelines (Attachment A) and the medical record review guidelines (Attachment B). Although an immunization checklist (Attachment C) is included for evaluation of documented immunizations, checklist information is not included in medical record scoring.

Corrective Action Plans

Plans have the option to require a Corrective Action Plan (CAP) for sites with an exempted pass score on the site review survey. A CAP is required on *all* cited deficiencies for sites with a conditional pass score on the site review or medical record review survey, on a focused review, or for deficiencies identified by the plan or State through oversight and monitoring activities.

Plans shall establish a process for handling providers who pass the full scope survey at 80% or higher, but fail to respond to a request for a CAP or to complete the corrective actions. Plans shall remove a provider from the network regardless of survey scores if criteria are not met or corrective actions are not taken within the established CAP time period. If removed from the network, providers may file a formal appeal to the plan.

New provider sites with a score below 80% are not eligible for participation in the Medi-Cal managed care program. At its discretion, a plan may decide to provide additional education, give supportive technical assistance, or develop a CAP with non-passing pre-contractual provider sites. Pre-contractual providers who do not pass the survey may correct deficiencies, reapply to the plan(s) and be re-surveyed. If the provider passes, the plan will follow the procedures outlined for implementing corrective actions for all cited deficiencies.

Monitoring

Plans are required to monitor their primary care providers between regularly scheduled site review surveys. Monitoring strategies may include information gathered through established internal plan processes, provider-and program-specific reports from external sources, focused reviews and/or onsite visit(s). When problems are identified through monitoring, plans may choose to repeat the full scope site review audit, conduct additional focused onsite reviews, or implement other appropriate methods to ensure that problems are investigated and corrected.

Local Collaboration

In 1998, Assembly Bill 162 (CA Health and Safety Code, Section 1342.8) required the streamlining of regulatory processes and the reduction in redundant reviews of offices of physicians by coordinating, to the extent feasible, as many of those regulatory functions as possible. In each county, plans shall determine the collaborative processes, systems and methods that will be used locally to coordinate review processes and decrease redundant site visits. Site review responsibilities may be shared equally by all plans within a county, delegated to one or more plans or individual physician practices (e.g., IPA), and/or subcontracted to other agencies/entities. All plans are responsible for the coordination and consolidation of provider site reviews, and therefore share responsibilities for defining the local process.

Level of Reviewer

Physicians are responsible for the oversight and implementation of peer review determinations regarding the appropriateness of medical care and treatment. However, the California Legislature recognizes the existence of overlapping functions between physicians and RNs and permits the sharing of functions within organized health care systems that provide for collaboration between them (CA B&P Code, Division 2, Chapter 6, Article 2, Section 2725 (a)). Activities that overlap the practice of medicine may require adherence to a standardized procedure when it is the RN who determines that they are to be undertaken (CA B&P Code, Section 2725).

The RN is the minimal level of reviewer acceptable for *independently* performing the full scope site review survey. RN reviewers can *independently* make determinations regarding "direct and indirect patient care services that insure the safety, comfort,

personal hygiene, and protection of patients, and the performance of disease prevention and restorative measures" (CA Title 16, Chapter 14, Section 1443.5 (2)). Additionally, RN reviewers can *independently* make determinations regarding implementation of appropriate reporting or referral of abnormal survey findings to initiate peer review procedures. RNs can only delegate tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated (CA Title 16, Chapter 14, Section 1443.5 (4)).

LVNs, described by the CA Board of Licensed Vocational Nursing and Psychiatric Technicians as "dependent" practitioners and "entry-level health care providers responsible for rendering basic bedside nursing care under the direction of a physician or registered nurse," *cannot* be utilized as independent practitioners. State statute stipulates that the LVN shall perform only manual skills under the direction of a licensed physician or licensed professional nurse, and/or perform only basic data collection (CA B&P Code, Section 2859, Section 2518.5). The performance of manual skills or basic data collection does not include evaluation, analysis, interpretation or synthesis of survey information or data, and/or making determinations about the information or data that was collected. Although an LVN may collect basic explicitly defined data, he/she cannot evaluate or analyze the data. Therefore, LVN reviewers cannot independently review any site or medical record, but, as part of a survey team, can collect basic data on those survey elements that have been identified by DHS and the CA Board of Vocational Nursing and Psychiatric Technicians as within the LVN scope of practice.

Non-licensed, non-registered, non-certified personnel and dependent licensed medical personnel may be members of a site survey team as appropriate, but cannot be utilized as *independent* site reviewers.

Reviewer Training and Certification

Plans are responsible for ensuring that all reviewers conducting site review and medical record review surveys are appropriately trained, monitored and evaluated. Plans may collaborate to determine local systems for training and certifying reviewers. Training shall include attendance at educational seminars provided by MMCD, and may include periodic classes conducted collaboratively by one or more plans, individual or small group training sessions provided by a certified site review trainer, and/or completion of self-study learning packets.

Site Review Data Submission Procedures

MMCD Office of Clinical Standards and Quality (OCSQ) will distribute to all plans an Access database containing all necessary tables and data input forms. Although use of this database for data entry and storage is optional, its use for data submission is not. Site review data that is submitted in non-conforming formats will be rejected.

DHS Responsibility

MMCD shall collaborate with plans to develop, implement and evaluate Site Review training and certification, revise training curriculum and materials as needed, and provide technical assistance to site review trainers. The training curriculum includes self-learning modules, lesson plans for didactic instruction, and guidelines for trainer and reviewer certification.

MMCD shall oversee and monitor plans for implementation of the site review policy. Monitoring areas may include, but are not limited to, oversight of plan methodology for monitoring provider sites between full scope site reviews, use of the appropriate level of reviewer according to established scope of practice legislation and the standards outlined in this policy, and local collaborative processes. Monitoring methodologies may include, but are not limited to, participation in local collaborative processes, observation of reviewer training and certification processes, assessment of data collection methodologies, and evaluation of aggregate reports.

If an onsite review is done as part of the MMCD monitoring activities, plans will be notified in advance of the date established for commencement of the onsite survey. In general, plans shall notify providers of onsite inspections whether conducted by the Department or by the plan(s). However, inspection of plan facilities or other elements of a survey may be conducted, without prior notice, either in conjunction with the medical survey or as part of an unannounced inspection program (Title 28, CCR, section 1300.80).

If you have any questions regarding this policy letter, please contact your contract manager.

Cheri Rice

Cheri Rice, Chief
Medi-Cal Managed Care Division

Attachment

Full Scope

Site Review Survey

California Department of Health Services
Medi-Cal Managed Care Division

Attachment A

Health Plan_____ **IPA** _____ **Review Date:** _____ **Last review:** _____

Provider/Address _____ **Phone** _____ **Fax** _____ **Fire Clearance**_____ **Current** **Yes/No**

_____ **Contact person/title**_____

No. of staff on site _____ **Physician** _____ **NP** _____**CNM** _____ **PA** **Reviewer/title**_____

_____ **RN** _____ **LVN** _____ **MA** _____ **Clerical** _____ **other** **Reviewer/title**_____

Visit Purpose	Site-Specific Certification(s)	Provider type	Clinic type
_____ Initial Full Scope _____ Monitoring	_____ AAAHC _____ JCAHO	_____ Family Practice _____ Internal Medicine	_____ Primary Care _____ Community
_____ Periodic Full Scope _____ Follow-up	_____ CHDP _____ NCQA	_____ Pediatrics _____ OB/GYN	_____ Hospital _____ FQHC
_____ Focused Review _____ Ed/TA	_____ CPSP _____ None	_____ General Practice _____ Specialist	_____ Rural Health _____ Other _____ (type)
_____ Other _____ (type)	_____ Other _____	_____ Non-physician _____ Mid-level Practitioner (type)	_____ Solo _____ Group _____ Staff/Teaching

Site Scores	Scoring Procedure	Compliance Rate
I. Access/Safety _____ /29	1) Add points given in each section.	_____ **Exempted Pass: 94%/above** (w/o critical element deficit)
II. Personnel _____ /22	2) Add total points given for all six sections.	_____ **Conditional Pass: 80-93%, or 94%/above** (w/Critical element deficit)
III. Office Management _____ /25	3) Adjust score for "N/A" criteria (if needed). Subtract "N/A" points from 150 total points possible.	_____ **Not Pass: Below 80%** ➤➤➤➤➤➤➤➤➤➤➤➤
IV. Clinical Services _____ /34	4) Divide total points given by 150 or by "adjusted" total points.	_____ CAP Required
V. Preventive Services _____ /13	5) Multiply by 100 to get the compliance (percent) rate.	_____ Other follow-up
VI Infection Control _____ /27	6) Calculate	**Next Review Due:** _____
_____ **Total** (Points given)	_____ ÷ _____ = _____ X 100 = _____% **Points given** **Total/Adjusted Points** **Decimal Score** **Compliance Rate**	

Site Review Guidelines

California Department of Health Services
Medi-Cal Managed Care Division

Purpose: Site Review Guidelines provide the standards, directions, instructions, rules, regulations, perimeters, or indicators for the site review survey. These Guidelines shall be used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions.".

Scoring: Site survey includes 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 survey criteria. Compliance levels include: 1) Exempted Pass: 94% or above *without deficiencies* in critical elements, 2) Conditional Pass: 80-93%, or 94% and above *with deficiencies* in critical elements, and 3) Not Pass: below 80%. Compliance rates are based on 150 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 survey. Survey criteria to be reviewed only by a R.N. or physician is labeled **RN/MD Review only**

Directions: Score full point(s) if survey 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 corrective action plans, 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 150 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 150 points.
4) Divide the total points given by 150 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. 25 (Access/safety) 22 (Personnel) 23 (Office Management) 34 (Clinical Services) 11 (Preventive Services) 25 (Infection Control) **140 (POINTS)**
Step 3: Subtract "N/A" points from 150 total points possible. 150 (Total points possible) – 5 (N/A points) 145 ("Adjusted" total points possible)	**Step 4**: Divide total points given by 150 or by the "adjusted" points, then multiply by 100 to calculate percentage rate. $\frac{\text{Points given}}{\text{150 or "adjusted" total}}$ or $\frac{140}{145} = 0.97 \times 100 = 97\%$

Criteria	Access/Safety Reviewer Guidelines
A. Site is accessible and useable by individuals with physical disabilities.	• **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 a 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 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 (28 CFR 36.402). • **Parking**: Parking spaces for persons with physical disabilities are located in close proximity to handicap-accessible building entrances. Each parking space reserved for the disabled is identified by a permanently affixed reflectorized sign posted in a conspicuous place. If provider has no control over availability of disabled parking lot or nearby street spaces, provider must have a plan in place for making program services available to persons with physical disabilities. • **Ramps**: 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. • **Exit doors**: The width of exit doorways (at least 32-in.) allows for passage clearance of 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. Furniture and other items do not obstruct exit doorways or interfere with door swing pathway. • **Elevators**: If there is no passenger 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. • **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-in. diameter or square area is needed to turn a wheelchair. • **Sanitary Facilities**: Restroom and hand washing facilities are accessible to able-bodied and physically disabled persons. A wheelchair accessible restroom stall allows sufficient space for a wheelchair to enter and permits the door to close. If wheelchair accessible restrooms are not available within the office site, reasonable alternative accommodations are provided. Alternatives may include: grab bars located behind and/or along the sides of toilet with assistance provided as needed by site personnel; provision of urinal, bedpan, or bedside commode placed in a private area; wheelchair accessible restroom located in a nearby office or shared within a building. Sufficient knee clearance space underneath the sink allows for wheelchair users to safely use a lavatory sink for hand washing. A reasonable alternative may include, but is not limited to, hand washing items provided as needed by site personnel. **Note:** A public entity may not deny the benefits of its program, activities, and services to individuals with disabilities because its facilities are inaccessible (28 CFR 35.149-35.150). Every feature need not be accessible, if a reasonable portion of the facilities and accommodations provided is accessible (Title 24, Section 2-419, California Administrative Code, the State Building Code). 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 (ADA, Title II, 5.2000). Points shall not be deducted if Reasonable Portion or Reasonable Alternative is made available on site. **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.**

Access/Safety

Site Access/Safety Survey Criteria	Yes	No	N/A	Wt	Site Score
A. Site is accessible and useable by individuals with physical disabilities. 3 CCR §504; 24 CCR (CA Building Standards Code); 28 CFR §35 (American Disabilities Act of 1990, Title II, Title III) 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 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 or reasonable alternative.	⑥____	⑥____	⑥____	1	
⑦ Wheelchair accessible hand washing facilities or reasonable alternative.	⑦____	⑦____	⑦____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

Criteria	Access/Safety Reviewer Guidelines
B. Site environment is maintained in a clean and sanitary condition.	The physical appearance of floors/carpets, walls, furniture, patient areas and restrooms are clean and well maintained. 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.	• **Ordinances**: 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. • **Non-medical emergency procedures:** 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. Evidence of training must be verifiable, and may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • **Evacuation Routes**: Clearly marked, easy-to-follow escape routes are posted in visible areas, such as hallways, exam rooms and patient waiting areas. 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. • **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. • **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. 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 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. • **Exits**: Exit doorways are unobstructed and clearly marked by a readily visible "Exit" sign. • **Electrical Safety**: Electrical cords are in good working condition with no exposed wires, or 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. 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. • **Fire Fighting/Protection Equipment**: There is fire fighting/protection equipment in an accessible location on site 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 step stool, ladder or other assistive devises. At least one of the following types of fire safety equipment is on site: 1) Smoke Detector with intact, working batteries 2) Fire Alarm Device with code and reporting instructions posted conspicuously at phones and employee entrances 3) Automatic Sprinkler System with sufficient clearance (10-in.) between sprinkler heads and stored materials. 4) Fire Extinguisher in an accessible location that displays readiness indicators or has an attached current dated inspection tag. **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.**

Site Access/Safety Survey Criteria	Yes	No	N/A	Wt.	Site Score
B. Site environment is maintained in a clean and sanitary condition. 8 CCR §5193; 28 CCR §1300.80					
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; 22 CCR §53230; 24 CCR, §2, §3, §9; 28 CCR §1300.80; 29 CFR §1910.301, §1926.34					
There is evidence that staff has received safety training and/or has safety information available in 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	
The following fire and safety precautions are evidenced on site: ③ Lighting is adequate in all areas to ensure safety.	③____	③____	③____	1	
④ **Exit doors and aisles are unobstructed and egress (escape) accessible.**	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.	⑥____	⑥____	⑥____	1	
⑦ Electrical cords and outlets are in good working condition.	⑦____	⑦____	⑦____	1	
⑧ At least one type of fire fighting/protection equipment is accessible at all times.	⑧____	⑧____	⑧____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only

Criteria	Access/Safety Reviewer Guidelines
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week.	• **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: 1) establish and maintain a patent/open airway, and 2) manage anaphylactic reaction. Emergency equipment and medication, appropriate to patient population, are available in an accessible location. 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. Documented evidence that emergency equipment is checked at least monthly may include a log, checklist or other appropriate method(s). • **Emergency phone number list**: Posted list 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). List should be dated, and updated annually. • **Airway management**: Without the ability to adequately maintain the patient's airway, all other interventions are futile. Minimum airway control equipment includes a wall oxygen delivery system or portable oxygen tank, oropharyngeal airways, nasal cannula or mask, and Ambu Bag. Various sizes of airway devices appropriate to patient population within the practice are on site. 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 need not be connected to oxygen tank, but must be kept in close proximity to tank. • **Anaphylactic reaction management**: Severe allergic reaction can cause urticaria (hives), hypotension, bronchospasm, wheezing and pulmonary edema. Minimum equipment includes Epinephrine 1:1000 (injectable), Benadryl 25 mg. (oral), or Benadryl 50 mg/ml (injectable), tuberculin syringes, alcohol wipes. 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). • **Site Specific Emergency procedures**: Staff is able to describe site-specific actions or procedures for handling medical emergencies until the individual is stable or under care of local emergency medical services (EMS). It is ***not sufficient*** for provider/staff to state "we call 911". If a site does not have basic medical equipment and medication for handling airway and anaphylactic medical emergencies, there is a written procedure for providing immediate emergent medical care on site until the local EMS is on the scene and has taken over care/treatment. 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. 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, and 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.

RN/MD Review only

Site Access/Safety Survey Criteria	Yes	No	N/A	Wt	Site Score
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)					
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.	②____	②____	②____	1	
③ Emergency phone number contacts are posted.	③____	③____	③____	1	
Emergency medical equipment appropriate to practice/patient population is available on site: ④ **Airway management: oxygen delivery system, oral airways, nasal cannula or mask, Ambu bag.**	④____	④____	④____	2	
⑤ Anaphylactic reaction management: Epinephrine 1:1000 (injectable), Benadryl 25 mg. (oral) or Benadryl 50 mg./ml. (injectable), tuberculin syringes, alcohol wipes.	⑤____	⑤____	⑤____	1	
⑥ Medication dosage chart (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 equipment/supplies for expiration and operating status at least monthly.	⑦____	⑦____	⑦____	1	
⑧ Replace/re-stock emergency equipment immediately after use.	⑧____	⑧____	⑧____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only

Criteria	Access/Safety Reviewer Guidelines
E. Medical and lab equipment used for patient care is properly maintained.	• **Medical and laboratory equipment**: 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, hemoglobinometer, glucometer, scales, etc.) is adequately maintained according to the specified manufacturer's guidelines for the equipment, or is serviced annually by a qualified technician. • **Documentation**: There is documented evidence that standard operating procedures have been followed for routine inspection/ maintenance, calibration, repair of failure or malfunction, testing and cleaning of all specialized equipment. Appropriate written records include calibration or other written logs, work orders, service receipts, dated inspection sticker, etc.

RN/MD Review only

Site Access/Safety Survey Criteria	Yes	No	N/A	Wt.	Site Score
E Medical and lab equipment used for patient care is properly maintained. CA Health & Safety (H&S) Code, §1374.30, §111255; 28 CCR §1300.80; 21 CFR §800-1299; 21 USC §201 (h) ① Medical equipment is clean, functioning properly and maintained in operational condition. ② Written documentation demonstrates the appropriate maintenance of all specialized medical equipment according to equipment manufacturer's guidelines.	①____ ②____	①____ ②____	①____ ②____	1 1	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **TOTALS**					

<table>
<tr><th>Criteria</th><th colspan="3">Personnel Reviewer Guidelines</th></tr>
<tr><td rowspan="11">A. Professional health care personnel have current California licenses and certifications.</td><th>Medical Professional</th><th>License/Certification</th><th>Issuing Agency</th></tr>
<tr><td>Certified Nurse Midwife (CNM)</td><td>RN License and
Nurse-Midwife Certificate</td><td>CA Board of Registered Nursing</td></tr>
<tr><td>Certified Radiological Technologist (CRT)</td><td>CRT Certificate</td><td>CA Department of Health Services (Radiological Branch)</td></tr>
<tr><td>Doctor of Osteopathy (DO)</td><td>Physician's & Surgeon's Certificate
DEA Registration</td><td>Osteopathic Medical Board of CA
Drug Enforcement Administration</td></tr>
<tr><td>Licensed Vocational Nurse (LVN):</td><td>LVN License</td><td>CA Board of Vocational Nursing and Psychiatric Technicians</td></tr>
<tr><td>Nurse Practitioner (NP)</td><td>RN License w/NP Certification and Furnishing Number</td><td>CA Board of Registered Nursing</td></tr>
<tr><td>Pharmacist (Pharm. D)</td><td>Pharmacist License</td><td>CA State Board of Pharmacy</td></tr>
<tr><td>Physician/Surgeon (MD)</td><td>Physician's & Surgeon's Certificate
DEA Registration</td><td>Medical Board of CA
Drug Enforcement Administration</td></tr>
<tr><td>Physicians' Assistant (PA)</td><td>PA License</td><td>Physician Assistant Examining Committee/Medical Board of CA</td></tr>
<tr><td>Radiological Technician</td><td>Limited Permit</td><td>CA Department of Health Services (Radiological Branch)</td></tr>
<tr><td>Registered Dietitian (RD)</td><td>RD Registration Card</td><td>Commission on Dietetic Registration</td></tr>
<tr><td>Registered Nurse (RN)</td><td>RN License</td><td>CA Board of Registered Nursing</td></tr>
<tr><td colspan="3">Note: All medical professional licenses and certifications must be current and issued from the appropriate agency for practice in California. Any license/certification that has been approved during the current re/credentialing process need not be re-checked during the site review. Any licenses/certifications not included in the re/credentialing process must be checked for current status as part of the site review process. 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>B. Health care practitioners are properly identified.</td><td colspan="3">A health care practitioner shall disclose, while working, his or her name and practitioner's license status, as granted by the State of California, on a name tag at least 18-point type. A health care practitioner in a practice or an office, whose license is prominently displayed, may opt not to wear a nametag. In the interest of public safety and consumer awareness, it shall be unlawful for any person to use the title "nurse" in reference to himself or herself, in any capacity, except for an individual who is a registered nurse, or a licensed vocational nurse.

Note: "Health care practitioner" means any person who engages in acts that are the subject of licensure or regulation under the California Business and Professional Code (Section 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 name tag requirement for the individual safety or therapeutic concerns.</td></tr>
</table>

2. Personnel

Site Personnel Survey Criteria	Yes	No	N/A	Wt	Site Score
A. Professional health care personnel have current California Licenses and Certifications. CA Business & Professional (B&P) Code §2050, §2585, §2725, §2746, §2834, §3500, §4110 ① All required Professional Licenses and Certifications, issued from the appropriate licensing/certification agency, are current.	①____	①____	①____	1	
B. Health care personnel are properly identified. CA B&P Code §680, AB 1439 ① Health care personnel wear identification badges/tags printed with name and title.	①____	①____	①____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only

Criteria	Personnel Reviewer Guidelines
C. Site personnel are qualified and trained for assigned responsibilities.	• **Medical equipment:** Provider and/or staff are able to 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. • **Unlicensed personnel**: Medical assistants (MA) 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. Training may be administered under a licensed physician; or under a 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: A) Diploma or certification from an accredited training program/school, ***or*** B) 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. • **Medications**: Unlicensed staff (e.g. medical assistants) has evidence of appropriate training and supervision in all medication administration methods performed within their scope of work. Medication administration by a 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. The pre-labeled medication container must be shown to the licensed person ***prior to*** administration. 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. An MA may administer injections of scheduled drugs, including narcotic medications, ***only*** if the dosage is verified and the injection is intradermal, subcutaneous, or intramuscular. Medical assistants 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. **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.

RN/MD Review only

Site Personnel Survey Criteria	Yes	No	N/A	Wt	Site Score
C. Site personnel are qualified and trained for assigned responsibilities. CA B&P Code §2069; 16 CCR §1366; 22 CCR §75034, §75035					
① **Only qualified/trained personnel retrieve, prepare or administer medications.**	①____	①____	①____	2	
② Only qualified/trained personnel operate medical equipment.	②____	②____	②____	1	
③ Documentation of education/training for non-licensed medical personnel is maintained on site.	③____	③____	③____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only

Criteria	Personnel Reviewer Guidelines
D. Scope of practice for non-physician medical provider (NPMP) is clearly defined.	Reviewers are expected to verify that NP and/or CNM standardized procedures, and PA Delegation of Services 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. Documents may be utilized to determine and/or clarify practice procedures and supervisory processes on site. • **Certified Nurse Midwives** (CNM): The certificate to practice nurse-midwifery authorizes the holder, under supervision of a licensed physician or surgeon, to attend cases of normal child-birth 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. • **Nurse Practitioners** (NP): Nurse practitioners 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. • **Physician Assistants** (PA): Every PA is required to have the following documents: 1) Delegation of Services Agreement: Defines specific procedures identified in practice protocols or specifically authorized by the supervising physician, and must be dated and signed by physician and PA. An original or copy must be readily accessible at all practice sites in which the PA works. There is no established time period for renewing the Agreement, but it is expected that the Agreement will be revised, dated and signed whenever any changes occur. Failure to maintain a Delegation of Services Agreement is a violation of the Physician Assistant Regulations and is grounds for disciplinary action by the Medical Board of California against a physician assistant's licensure. 2) Approved Supervising Physician's Responsibility for Supervision of Physician Assistants 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: a) Transport and back-up procedures for when the supervising physician is not on the premises. b) One or more methods for performing medical record review by the supervising physician: c) Responsibility for physician review and countersigning of medical records d) Responsibility of the PA to enter the name of approved supervising physician responsible for the patient on the medical record. • **Drug Enforcement Agency** (DEA): Each NP, CNM, and PA that prescribes controlled substances is required to have a valid DEA Registration Number. **Note:** Standardized procedures legally define the expanded scope of nursing practice that overlaps the practice of medicine. 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. 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. Standardized Procedures shall undergo periodic review, with signed, dated revisions completed at each change in scope of work.

RN/MD Review only

Site Personnel Survey Criteria	Yes	No	N/A	Wt	Site Score
D. Scope of practice for non-physician medical practitioners is clearly defined. 16 CCR §1379, §1399.540, §1399.545, §1474, CA B&P Code §2725.1					
① Standardized Procedures define the scope of services provided by Nurse Practitioners (NP) and/or Certified Nurse Midwives (CNM).	①____	①____	①____	1	
② A Delegation of Services 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, Delegation of Services 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 DEA Registration Number.	④____	④____	④____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only

Criteria	Personnel Reviewer Guidelines
E. Non-physician medical practitioners (NPMP) are supervised according to established standards.	• **Non-physician medical practitioners**: The Supervising Physician holds ultimate responsibility for the practice of each supervised non-physician medical practitioner. The number of non-physician medical practitioners who may be supervised by a single primary care physician is limited to the full-time equivalent of one of the following: 4 nurse practitioners, 3 nurse midwives, 2 physician's assistants, or 4 of the above individuals in any combination which does not exceed the limit stated. A primary care physician, an organized outpatient clinic or a hospital outpatient department cannot utilize more non-physician medical practitioners than can be supervised within these stated limits (Title 22, CCR, Division 3, §51240). • **Supervising physician**: "Supervising physician" means a physician and/or surgeon licensed by the Medical Board or by the Osteopathic Medical Board of California who supervises one or more physician assistants, possesses a current valid license to practice medicine, and is not currently on disciplinary probation for improper use of a physician assistant. "Supervision" means that a licensed physician and surgeon oversees the activities of, and accepts responsibility for, the medical services rendered by a physician assistant. Physicians must comply with all current and/or revised requirements established by the Medical Board of CA for supervising physician assistants. **Note:** Beginning July 1, 2001, physicians are no longer required to submit an application or pay a fee to supervise a physician assistant (PA). Any California-licensed physician, except those who are expressly prohibited by the Medical Board from supervising a PA, will be able to supervise a PA. ***All other*** legal requirements concerning PA supervision remain the same.

RN/MD Review only

Site Personnel Survey Criteria	Yes	No	N/A	Wt	Site Score
E. Non-physician medical practitioners (NPMP) are supervised according to established standards. 22 CCR §51240, §51241 The designated supervising physician(s) on site: ① ratio to number of NPMPs does not exceed established ratios in any combination. a) 1:4 Nurse Practitioners b) 1:3 Certified Nurse Midwives c) 1:2 Physicians Assistants 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.	①____ ②____	①____ ②____	①____ ②____	1 1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only

Criteria	Personnel Reviewer Guidelines
F. Site personnel receive safety training/information.	• **Bloodborne Pathogens**: Site personnel treats 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 other potentially infectious materials (OPIM) receive training as required by the Bloodborne Pathogens Standard, Title 8, CCR, Section 5193. 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. 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 and participation lists, etc. Training documentation must contain the employee's name, job titles, training date(s), type of training, contents of training session, and names/qualifications of trainers. Records must be kept for three (3) years. • **Abuse Reporting**: Site personnel have specific knowledge of local reporting requirements, agencies, and procedures, and know *where to locate* 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 suspects" 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. 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 (CA Penal Code 11166.5).

RN/MD Review only

Site Personnel Survey Criteria	Yes	No	N/A	Wt	Site Score
F. Site personnel receive safety training/information. 8 CCR §5193; CA H&S Code §117600; CA Penal Code §11164, §11168; 29 CFR §1910.1030 There is evidence that site staff has received training and/or information on the following: ① Infection control/universal precautions	①____	①____	①____	1	
② Blood Borne Pathogens Exposure Prevention	②____	②____	②____	1	
③ Biohazardous Waste handling	③____	③____	③____	1	
④ Child/Elder/Domestic Violence Abuse	④____	④____	④____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only

Criteria	Personnel Reviewer Guidelines
G. Site personnel receive training and/or information on member rights.	Site personnel have received information and/or training about member rights. 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 member rights information on site and explain how to use information.

//

RN/MD Review only

Site Personnel Survey Criteria	Yes	No	N/A	Wt	Site Score
G. Site personnel receive training and/or information on member rights. 22 CCR §51009, §51014.1, §51305.1, §53452, §53858; 28 CCR §1300.68					
There is evidence that site staff has received training and/or information 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 Sensitive Services/Minors' Rights	⑤____	⑤____	⑤____	1	
⑥ Health Plan referral process/procedures/resources	⑥____	⑥____	⑥____	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores.					
Totals					

RN/MD Review only (#B)

Criteria	Office Management Reviewer Guidelines
A. Physician coverage is available 24 hours a day, 7 days a week.	Current clinic office hours are posted within the office or readily available upon request. Current site-specific resource information is available to site personnel 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. 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. **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 is sufficient health care personnel to provide timely, appropriate health care services.	In addition to the physician, only appropriately licensed medical personnel such as a CNM, NP, RN, or PA shall handle emergency, urgent, and medical advice/triage telephone calls. 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 (MCPB Letter 92-15). 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 (Title 16, §1366 (b)). **Note:** Telephone triage is the system for managing telephone callers during ***and*** after office hours.

3. Office Management

RN/MD Review only (#B)

Office Management Survey 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 After-hours emergency care instructions/telephone information is made available to patients.	⑤____	⑤____	⑤____	1	
B. There is 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/MD Review only (#C)

Criteria	Office Management Reviewer Guidelines
C. Health care services shall be readily available.	The process/system 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. An organized system must be clearly evident (in use) for scheduling appointments appropriately, notifying and reminding members of scheduled appointments, and following up of missed or canceled appointments. Missed and/or canceled appointments, and contact attempts are documented in the patient's medical record. Systems, practices and procedures used for making services readily available to patients will vary from site to site. **Note:** The Medi-Cal Managed Care Health Plans have accepted the following timeliness standards for access to appointments: • Urgent Care: 24 hours • Prenatal Care: 7 days • Non-Urgent Care: 14 days • Well Baby Visit: 14 days
D. There is 24-hour access to interpreter services for non/limited English proficient (LEP) members.	All sites must provide 24-hour interpreter services for all members either through telephone language services or interpreters on site. Site personnel used as interpreters have been assessed for their medical interpretation performance skills/capabilities. A family member or friend may be used as an interpreter if requested by the LEP individual after being informed of their right to use free interpreter services. A request for or refusal of language/ interpreter services must be documented in the member's medical record. **Note:** Assessment of interpreter skills may include written or oral assessment of bilingual skills, documentation of the number of years of employment as an interpreter or translator, documentation of successful completion of a specific type of interpreter training programs (medical, legal, court, semi-technical, etc.), and/or other reasonable alternative documentation of interpreter capability.

RN/MD Review only (#C)

Office Management Survey Criteria	Yes	No	N/A	Wt	Site Score
C. Health care services are readily available. 22 CCR §56000 (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 system in place to follow-up on missed and canceled appointments.	③____	③____	③____	1	
D. There is 24-hour access to interpreter services for limited-English proficient members. 22 CCR §53855; CA H&S Code §1259; 42 USC §2000d					
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 on site are trained in medical interpretation.	②____	②____	②____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only (#E)

Criteria	Office Management Reviewer Guidelines
E. Procedures for referral/ consultative services are established on site.	An organized, timely referral system is clearly 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.
F. Member grievance/ complaint processes are established on site.	At least one telephone number for filing grievances is posted on site, or is readily available upon request. Complaint forms and a copy of the grievance procedure are readily available on site, and can be provided to members promptly upon request. **Note:** A "grievance" is defined as any written or oral expression of dissatisfaction and shall include any complaint, dispute, 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.

RN/MD Review only (#E)

Office Management Survey Criteria	Yes	No	N/A	Wt	Site Score
E. Procedures for timely referral/consultative services are established on site. 22 CCR §53851; 28 CCR §1300.67 Office practice procedures allow timely provision for: 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 is established on site. 22 CCR §53858, §56260; 28 CCR §1300.67 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(s) are available on site.	②____	②____	②____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only (#H)

Criteria	Office Management Reviewer Guidelines
G. Medical records are available for the Provider at each scheduled patient encounter.	The process/system established on site provides for the availability of medical records, including outpatient, inpatient, referral services, and significant telephone consultations for patient encounters. Medical records are filed that allows for ease of accessibility within the facility, or in an approved health record storage facility off the facility premises (22 CCR, § 75055).
H. Medical record confidentiality is maintained according to State and federal guidelines.	• **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. • **Confidentiality**: Personnel follow 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. • **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. 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. • **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, 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. • **Record retention:** Hospitals, acute psychiatric hospitals, skilled nursing facilities, *primary care clinics*, psychology and psychiatric clinics must maintain medical records and exposed x-rays for a minimum of 7 years following patient discharge, except for minors (Title 22, CCR, Section 75055). Records of minors must be maintained for at least one year after a minor has reached age 18, but in no event for less than 7 years (Title 22, CCR, Section 75055). Each Plan must maintain all records and documentation (including medical records) necessary to verify information and reports required by statute, regulation or contractual obligation for 5 years from the end of the fiscal year in which the Plan contract expires or is terminated (Title 22, CCR, Section 53861).

RN/MD Review only (#H)

Office Management Survey Criteria	Yes	No	N/A	Wt	Site Score
G. Medical records are available for the Provider 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. 22 CCR §51009, §53861, §75055; §28 CCR §1300.80; CA Civil Code §56.10 (Confidentiality of Medical Information Act)					
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 5 years, or according to current State DHS standard.	⑤____	⑤____	⑤____	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores.					
Totals					

Criteria	Pharmaceutical Services Reviewer Guidelines
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, etc.) must be addressed in a corrective action plan. • **Controlled substances**: Written records are maintained of controlled substances inventory list(s) that includes: provider's 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. Controlled substances are stored separately from other drugs in a securely locked, substantially constructed cabinet (Control Substances Act, CFR 1301.75). 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, physician's assistants, licensed nurses and pharmacists. • **Security**: All drugs for dispensing are stored in an area that is secured at all times (CA B&P Code, §4051.3). Keys to locked storage area are available only to staff authorized by the physician to have access (16 CCR, Chapter 2, Division 3, Section 1356.32). The Medical Board of California interprets "all drugs" to also include both sample and over-the-counter drugs. The Medical Board defines "area that is secure" to mean a locked storage area within a physician's office. 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 remain in the immediate area ***at all times***. At all other times, drugs, medication supplies and hazardous substances must be securely locked. Controlled substances are locked at all times.

4. Clinical Services

Pharmaceutical Services Survey Criteria	Yes	No	N/A	Wt	Site Score
A. Drugs and medication supplies are maintained secure to prevent unauthorized access. CA B&P Code §4051.3, §4071, §4172; 22 CCR §75037(a-g), §75039; 21 CFR §1301.75, §1301.76, §1302.22					
① Drugs are stored in specifically designated cupboards, cabinets, closets or drawers.	①____	①____	①____	1	
② Prescription, sample and over-the counter drugs, hypodermic needles/syringes, 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	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only

Criteria	Pharmaceutical Services Reviewer Guidelines
B. Drugs are handled safely and appropriately stored.	• **Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan. • **Drug preparation**: 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 (21 USC, Section 351). 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. • **Storage**: Medications are kept separate from food, lab specimens, cleaning supplies, and other items that may potentially cause contamination. Drugs are stored under appropriate conditions of temperature, humidity, and light so that the identity, strength, quality, and purity of the drug product is not affected (21 CFR, Section 211.142). Room temperature where drugs are stored does not exceed 30°C (86°F) (Title 22, Section 75037 (d)). • **Immunobiologics**: Vaccines are refrigerated immediately upon receipt on site and stored according to specific instructions on the package insert for each vaccine. Vaccines, such as MMR, DTP, DTaP, DT, Td, Hep A, Hep B, Enhanced Inactivated Polio (E-IPV), and Pneumococcal, are kept in a refrigerator maintained at 2° to 8°C or 35° to 46°F. MMR and varicella are protected from light at all times, and kept cold. Vaccines are not stored in the doors of refrigerator or freezer. Diluent does not need refrigeration if vaccine is administered right after diluent is added. Oral polio vaccine (OPV) and varicella vaccines are stored in the freezer at -15°C or 5°F, or lower. If stored vaccines are in solid state and contain ice crystals on the outside of vial, vaccines are considered appropriately frozen. Refrigerator and freezer temperatures are checked at least once each day. The U.S. Pharmacopeial Convention Regulations and Recommendations, recommend daily monitoring and documentation of temperatures. The CA DHS Immunization Branch recommends checking temperatures twice a day, first thing in the morning and last thing at night. Failure to adhere to recommended specifications for storage and handling of immunobiologics could make these products impotent. The most current VISs are available from state and local health departments or can be downloaded from the CDC web site at www.cdc.gov/nip/publications/VIS or by calling the CDC Immunization Hotline at 800/232-2522. • **Hazardous substances labeling**: Safety practices on site are followed in accordance with current/updated CAL-OSHA standards. The manufacturer's label is not removed from a container (bag, bottle, box, can, cylinder, etc.) as long as the hazardous material or residues of the material remain in the container. 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 work place. A hazardous substance is any substance that is a physical or health hazard. Examples of a physical hazard include substances that are a combustible liquid, a compressed gas, explosive, flammable, an organic peroxide, an oxidizer, pyrophoric, unstable (reactive) or water-reactive. Examples of a health hazard include substances where acute or chronic health effects may occur with exposure, such as carcinogens, toxic or highly toxic agents, irritants, corrosives, sensitizers and agents that damage the lungs, skin, eyes, or mucous membranes.

RN/MD Review only

Pharmaceutical Services Survey Criteria	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					
① Drugs are prepared in a clean area, or "designated clean" area if prepared in a multipurpose 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 35°-46° Fahrenheit or 2°-8° Centigrade (at time of site visit).	④____	④____	④____	1	
⑤ Freezer thermometer temperature is 5° Fahrenheit or –15° Centigrade, or lower (at time of site visit).	⑤____	⑤____	⑤____	1	
⑥ Daily temperature readings of medication refrigerator and freezer are documented.	⑥____	⑥____	⑥____	1	
⑦ Drugs are stored separately from test reagents, germicides, disinfectants and other household substances.	⑦____	⑦____	⑦____	1	
⑧ Hazardous substances are appropriately labeled.	⑧____	⑧____	⑧____	1	
⑨ Site has method(s) in place for drug and hazardous substance disposal.	⑨____	⑨____	⑨____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

Criteria	Pharmaceutical Services Reviewer Guidelines
C. Drugs are dispensed according to State and federal drug distribution laws and regulations.	• **Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan. • **Expiration date**: The manufacturer's expiration date must appear on the labeling of all drugs. 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 unconstituted drug. Expired drugs may not be distributed or dispensed. • **Prescription labeling**: Each prescription medication dispensed is in a container that is not cracked, soiled or without secure closures (Title 22, CCR, Section 75037 (a)). 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 (CA Business and Professions Code, Sections 4170, 4171). • **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. • **Drug dispensing**: 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 (e.g., NP, CNM, RN, PA) lawfully authorized to dispense medications upon the order of a licensed physician or surgeon. Personnel such as medical assistants, office managers, and receptionists do not dispense drugs. Drugs are not offered for sale, charged or billed to Medi-Cal members (Business and Professions Code, Article 13, Section 4193). A record of all drugs dispensed is entered in the patient's medical record. • **Vaccine Immunization Statements** (VIS): 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 give a copy of the most recent VIS to patients prior to each vaccination dose of Td, MMR, varicella, polio or hepatitis B vaccine. The date the VIS was given ***and*** the publication date of the VIS must be documented in the patient's medical record. Reviewers shall interview personnel about standard practices on site regarding VIS distribution. • **Pharmacy**: If a pharmacy is located on site, a licensed pharmacist monitors drug distribution and policies/procedures for medication dispensing/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.

Pharmaceutical Services Survey Criteria	Yes	No	N/A	Wt.	Site Score
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					
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 Vaccine Information Sheets (VIS) for distribution to patients are present on site.	⑤____	⑤____	⑤____	1	
⑥ If there is a pharmacy on site, it is licensed by the CA State Board of Pharmacy.	⑥____	⑥____	⑥____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

Criteria	Laboratory Services Reviewer Guidelines
D. Site operates in compliance with Clinical Laboratory Improvement Amendment (CLIA) regulations.	• **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 on site includes one of the following: A) Certificate of Waiver: Site is able to perform only exempt waived tests. B) Certificate for Provider-Performed Microscopy (PPM): Physicians, dentists, or mid-level practitioners are able to perform PPM procedures and waived tests. C) Certificate of Registration: Allows moderate and/or high complexity lab testing to be conducted until compliance with CLIA regulations is determined by survey. D) Certificate of Compliance: Lab has been surveyed and found in compliance with all applicable CLIA requirements. E) Certificate of Accreditation: Lab is accredited by an accreditation organization approved by the Health Care Financing Administration (HCFA). • **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 DHS 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. For these categories the CLIA regulations list specific requirements for laboratory proficiency testing, patient test management, quality control, quality assurance, personnel, and inspections. • **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 are able to follow test manufacturer's instructions. When requested, site personnel are able to provide a step-by-step verbal explanation or demonstration of test procedure and how to determine test results. The required training and certification is established by legislation (CA B&P Codes, §1200-1213) for personnel performing moderate and high complexity tests. Reviewers are not expected to complete an in-depth evaluation of personnel performing moderate and high complexity tests. **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.fda.gov/cdrh/clia/testswaived.html. CLIA re/certification includes an evaluation every two years (or sooner of complaint driven) by DHS of personnel licenses/training, laboratory site inspection and demonstration of testing proficiency for moderate and high-complexity test sites. For questions regarding CLIA certification, laboratory licensing, and personnel, call CA DHS Laboratory Field Services at (510) 873-8328.

Laboratory Services Survey Criteria	Yes	No	N/A	Wt	Site Score
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					
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 are inaccessible to unauthorized persons.	③____	③____	③____	1	
④ Lab test supplies (e.g. vacutainers, culture swabs, test solutions) 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.

Criteria	Radiology Services Reviewer Guidelines
E. Site meets California DHS Radiological inspection and safety regulations.	• **DHS Radiologic Health Branch Inspection Report**: 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. 1) Inspection Report, ***or*** 2) Inspection Report *and* Short Form Sign-off sheet, ***or*** 3) Inspection Report *and* Notice of Violation form *and* approval letter for corrective action plan from the CA Radiologic Health Branch. The Radiologic Inspection Report, issued by the Radiologic Health Branch, must be present if there is radiology equipment on site. If any violations are found, one of two documents is issued to the site. The Short Form Sign-off sheet" is issued for minimal problems that are easily corrected. The "Notice of Violation" form, requiring a site corrective action plan, is issued if there are more serious violations. All "Notice of Violation" corrective action plans must be accompanied by an approval letter from the CA Radiologic Health Branch. **If documents are not available on site, or if reviewer is uncertain about the "current" status of documents on site, proceed to score all items 1-9.** • **Radiological equipment**: Equipment inspection, based on a "priority" rating system, is established by legislation (CA H&S Code, Section 115115). 1) Mammography equipment is inspected annually (Mammography Quality Standards Act, 21 CFR, Section 900), and must have federal FDA Certification on site ***and*** CA Mammography X-ray Equipment and Facility Accreditation Certification posted on the machine. 2) High Priority equipment (e.g. fluoroscopy, portable X-ray) is inspected every three years. 3) Medium Priority equipment is inspected every 4-5 years depending on the volume of patients, frequency of x-ray equipment use, and likelihood of radiation exposure. If reviewer is uncertain about the "current" status of equipment inspection, call the Radiological Health Branch. • **Radiology Personnel**: All certificates/licenses are posted and show expiration dates. If there are a large number of 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" limits 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. **Note:** The Radiologic Health Branch of the Food, Drug, and Radiation Safety Division of the CA Department of Health Services 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 CA DHS Radiologuc Health Branch (Compliance Unit) General Information (daytime hours) at (916) 445-0931 or Radiation Emergency Assistance (all hours) at 1-800-853-7550.

Radiology Services Survey Criteria	Yes	No	N/A	Wt	Site Score
E. Site meets California DHS Radiological inspection and safety regulations. 17 CCR §30255, §30305, §30404, §30405					
① Site has current CA Radiologic Health Branch Inspection Report, if there is radiological equipment on site.	①____	①____	①____	1	
The following documents are posted 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					

Criteria	Preventive Services Reviewer Guidelines
A. Preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases.	• **Examination table**: A protective barrier that is changed between patient contact is used to cover exam table surface. "Good repair" means clean and well maintained in proper working order. • **Scales**: 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 or electronic scales are appropriate for clinic use. Balance 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 because, over time, the spring counter balance mechanism loses its accuracy. • **Measuring devices**: Equipment on site for measuring stature (length/height) and head circumference includes: 1) rigid 90° right angle headboard block that is perpendicular to the recumbent measurement surface, or vertical to the wall-mounted standing measurement surface. 2) 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. 3) moveable, non-flexible foot board at 90° right angle perpendicular to the recumbent measurement surface, or a flat floor surface for standing. 4) A non-stretchable tape measuring devise marked to one-eighth (1/8 in. or 1 mm) or less for measuring head circumference. • **Basic equipment**: Exam gown sizes are appropriate to population served on site. • **Vision testing**: Site has both a literate (e.g., Snellen) and an illiterate eye chart (e.g., "E" Chart, "Kindergarten" chart, Allen Picture Card Test). "Heel" lines are aligned with center of eye chart at a distance of 10 or 20-feet depending on whether the chart is for the 10 foot or 20 foot distance. Eye charts are located in an area with adequate lighting and at height(s) appropriate to use. Disposable eye "occluders" (e.g., Dixie cups or tongue blades with back-to-back- stickers) are acceptable. Non-disposable occluders are cleaned between patients. **Note:** Although patient population varies from site-to-site, screening equipment listed in this section is the standard equipment most often used in performing a physical health screening examination for children and adults.

5. Preventive Services

Preventive Services Survey Criteria	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, §56210; 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 Thermometers: oral and/or tympanic, and rectal.	③____	③____	③____	1	
④ Scales: standing balance beam and infant scales.	④____	④____	④____	1	
⑤ Measuring devices for stature (height/length) measurement *and* head circumference measurement.	⑤____	⑤____	⑤____	1	
⑥ Basic exam equipment: percussion hammer, tongue blades, patient gowns.	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 adult and pediatric ear speculums.	⑨____	⑨____	⑨____	1	
⑩ Audiometer in quiet location for testing.	⑩____	⑩____	⑩____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only

Criteria	Preventive Services Reviewer Guidelines
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**: Materials 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. Materials may include written information, audio and/or videotapes, computerized programs, and visual presentation aids. General topics for health educational materials may include Immunizations, Pregnancy, Injury Prevention, Smoking Cessation, Dental Health, Nutrition, Physical Activity, STD/HIV Prevention, Family Planning, Asthma, Hypertension, and Diabetes. • **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 the Department of Health Services for each county.

RN/MD Review only

Health Education Survey Criteria

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,

② applicable to the practice and population served on site,

③ available in threshold languages identified for county and/or area of site location.

Comments: Write comments for all "No" (0 points) and "N/A" scores.

	Yes	No	N/A	Wt	Site Score
	①_____ ②_____ ③_____	①_____ ②_____ ③_____	①_____ ②_____ ③_____	1 1 1	
Totals					

Criteria	Infection Control Reviewer Guidelines
A. Infection control procedures for Standard/Universal precautions are followed.	• **Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan. • **Hand washing facilities**: 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 is able to 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 (29 CFR 1919.1030). • **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). Antimicrobrial 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. • **Waste disposal container**: Contaminated wastes (e.g. dental drapes, band aids, sanitary napkins, soiled disposal 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. • **Isolation procedures**: Personnel are able to 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 will 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.

6. Infection Control

Infection Control Survey 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 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	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

Infection Control Reviewer Guidelines

• **Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan.

• **Personal Protective Equipment (PPE):** PPE is available for staff use on site, and includes water repelling gloves, clothing barrier (e.g., gown, sheets), face/eye protection (e.g., goggles, face shield), and respiratory infection protection (e.g., mask). Availability of other necessary PPE is specific to the practice and types of procedures performed on site. PPE is specialized clothing and/or equipment for protection against bloodborne pathogen hazards, and does not include general work clothes (e.g., uniforms, cloth lab coats) that permit liquid to soak through. General work clothes are appropriate only if blood/OPIM does not penetrate through employee's work clothes, undergarments, skin, eyes, mouth, or other mucous membranes under NORMAL conditions of use.

• **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:** 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 "BIOHAZARDOUS WASTE" label, (fluorescent orange or red-orange with contrasting lettering/symbols) is an integral part of the container or affixed to 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. If the contaminated laundry or specimen leaves the site, an international "Biohazardous Waste" warning label and/or red color-coding is required

• **Needlestick Safety:** 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 except by using a one-handed technique. Needleless systems, needle devices and non-needle sharps are used unless exemptions have been approved by Cal/OSHA (8CCR, Section 5193). Security of portable containers in patient care areas is maintained at all times. 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, leak-proof container. If these requirements are met, containers made of various materials (e.g., cardboard, plastic) are acceptable. Containers are not overfilled past manufacturer's designated fill line, or more than ¾ full. Supply of containers on hand is adequate to ensure routine change-out when filled.

• **Sharps Injury documentation:** Site has a method in place to document sharps injuries. Date, time, description of exposure incident, sharp type/brand, follow-up care is documented within 14 days of injury incident.

• **Contaminated Laundry:** Contaminated laundry (soiled with blood/OPIM or containing contaminated sharps) is laundered at a commercial Laundromat, by contracted laundry service, or a washer and dryer on site. Manufacturer's guidelines are followed to decontaminate and launder reusable protective clothing. Laundry requirements are "not applicable" if only disposable PPE is used on site.

• **Regulated Waste storage:** Regulated waste is contained separately from other wastes (e.g., contaminated wastes) at the point of origin in the producing facility, placed in red biohazardous bags with Biohazard label, and stored in a closed container that is not accessible to unauthorized persons. If stored outside of the office, a lock secures the entry door, gate or receptacle lid, and posted warning sign(s) in English and Spanish are visible for a distance of 25-feet. The sign wording states **"CAUTION—BIOHAZARDOUS WASTE STORAGE AREA—UNAUTHORIZED PERSONS KEEP OUT" or "CUIDADO—ZONA DE RESIDUOS—BIOLOGICOS PELIGROSOS—PROHIBIDA LA ENTRADA A PERSONAS NO AUTHORIZADAS."** Signs prior to the passage of the Medical Waste Act, Infectious Waste, are permitted for the "life" of the sign. Regulated wastes include: 1) ***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, and 2) ***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 (Health and Safety Code, Chapter 6.1, CA Medical Waste Management Act).

• **Medical Waste disposal:** Medical wastes are hauled to a permitted offsite medical waste treatment facility, to a transfer station, or to another registered generator for consolidation. Hauling is by a registered hazardous waste transporter or by a person with an approved limited-quantity hauling exemption granted by the CA DHS Waste Management Division. The limited-quantity hauling exemption is valid for a period of one year and is renewed annually. When hauling medical wastes, the transporter carries the exemption form in the transporting vehicle. A medical waste tracking document is maintained that includes name of person transporting, number of waste containers, type of medical wastes, and date of transportation. Tracking document is kept a minimum of 3 years for large waste generators and 2 years for small generators.

Note: Contaminated wastes include materials soiled with blood during the course of 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 s[illegible] waste in regular trash receptacle.

Infection Control Survey Criteria	Yes	No	N/A	Wt	Site Score
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.					
① **Personal Protective Equipment is readily available for staff use.**	①____	①____	①____	2	
② **Needlestick safety precautions are practiced on site.**	②____	②____	②____	2	
③ All sharp injury incidents are documented.	③____	③____	③____	1	
④ **Blood, other potentially infectious materials and Regulated Wastes are placed in appropriate *leak proof, labeled* containers for collection, handling, processing, storage, transport or shipping.**	④____	④____	④____	2	
⑤ Biohazardous (non-sharp) wastes are contained separate from other trash/waste.	⑤____	⑤____	⑤____	1	
⑥ Contaminated laundry is laundered at the workplace or at a commercial laundry.	⑥____	⑥____	⑥____	1	
⑦ Storage areas for regulated medical wastes are maintained secure and inaccessible to unauthorized persons.	⑦____	⑦____	⑦____	1	
⑧ Transportation of regulated medical wastes is only by a registered hazardous waste hauler or by a person with an approved limited-quantity exemption.	⑧____	⑧____	⑧____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only

Criteria	Infection Control Reviewer Guidelines
C. Contaminated surfaces are decontaminated according to established regulations/ standards.	• **Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan. • **Routine Decontamination**: Contaminated work surfaces are decontaminated with an appropriate disinfectant (29 CFR 1910.1030). Written "housekeeping" schedules have been established and are followed for regular routine daily cleaning. Staff is able to identify frequency for routine cleaning of surfaces and equipment, the disinfectant used and responsible personnel. • **Spill Procedure**: Staff is able to identify procedures for prompt decontamination of blood/body fluid spills, the disinfectant used, and the responsible person(s). • **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 reconstituted and applied according to manufacturer's guidelines for "decontamination." • **10% Bleach Solution**: 10% bleach solution 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. Current EPA product lists and information is available from the EPA, Antimicrobial Division (703) 305-1284 or (703) 308-0127.

RN/MD Review only

Infection Control Survey Criteria	Yes	No	N/A	Wt	Site Score
C. Contaminated surfaces are decontaminated according to Cal-OSHA Standards. 8 CCR §5193; CA H&S Code §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 used according to product label for desired effect.	⑤____	⑤____	⑤____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

RN/MD Review only

Criteria	Infection Control Reviewer Guidelines
D. Reusable medical instruments are properly sterilized after each use.	• **Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan. • **Cleaning prior to sterilization**: Prior to undergoing the sterilization process, soiled instruments/equipment are thoroughly cleaned, rinsed, dried and inspected for the presence of dried blood or other debris. Personnel are able to demonstrate or verbally explain procedure(s) used for cleaning prior to sterilization, and to locate written directions on site. • **Cold/chemical sterilization**: 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 exposure times and solution expiration date/time is communicated to staff. Written procedures for cold sterilization are available on site to staff. • **Autoclave/steam sterilization**: 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. If instruments/equipment are transported off-site for sterilization, equipment-handling and transport procedures are available on site to staff. • **Autoclave maintenance**: Autoclave is maintained and serviced according to manufacturer's guidelines. If the manufacturer's guidelines are not present on site, 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. • **Spore testing**: Autoclave spore testing is performed *at least monthly*, unless otherwise stated in manufacturer's guidelines. 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 (Report/Repair/Retrieve/Retest/Re-sterilize). • **Documentation**: Documentation of the following activities is maintained on site: ▸ Autoclave maintenance: mechanical problems, inspection dates, results/outcome of routine servicing, calibration, repairs, etc., ▸ Sterilization loads: date, time and duration of run cycle, temperature, steam pressure, operator of each run, ▸ Biological spore testing: date, results, types of spore test used, person performing/documenting test results • **Sterile Packages**: Storage areas for sterilized packages are clean, dry and separated from non-sterile items by a functional barrier (e.g., shelf, cabinet door, drawer). Sterilized package labels include date of sterilization, load run identification information, and 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. 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. **Note:** Sterilization methods include autoclaves (steam under pressure), Ethylene Oxide (EO) gas sterilizer, dry-heat sterilizer, and liquid chemical sterilants. 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.

RN/MD Review only

Infection Control Survey Criteria	Yes	No	N/A	Wt	Site Score
D. Reusable medical instruments are properly sterilized after each use. 22 CCR §53230, §53856; CA H&S Code, Chapter 6.1, §25090					
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	③____	③____	③____	1	
④ Autoclave/steam sterilization	④____	④____	④____	1	
⑤ Autoclave maintenance	⑤____	⑤____	⑤____	1	
⑥ **Spore testing of autoclave/steam sterilizer with documented results (at least monthly)**	⑥____	⑥____	⑥____	2	
⑦ Sterilized packages are labeled with sterilization date and load identification information.	⑦____	⑦____	⑦____	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores.					
Totals					

Site Review Full Scope Survey Summary
California Department of Health Services
Medi-Cal Managed Care Division

Access/Safety	Personnel	Office Mgnt.	Clinical Svcs.	Preventive Svcs.	Infection Control	Total
29	22	25	34	13	27	Exempted Pass 94-100% w/o critical element deficiencies Conditional Pass: 80-93%, or 94-98% w/critical element deficiencies Not Pass: Below 80%

Access/Safety
Personnel
Office Management
Clinical Services
Infection Control

Reviewer(s)/Title _____ Date _____

Full Scope

Medical Record Review Survey

Attachment B

California Department of Health Services
Medi-Cal Managed Care Division

Health Plan _____ **IPA** _____ **Review Date** _____ **Last review** _____

Provider/Address _____ **Phone** _____ **Fax** _____

_____ **Contact person/title** _____

Other Providers _____ **Reviewer/title** _____

Visit Purpose	Site-Specific Certification(s)	Provider type	Clinic type
_____ Initial Full Scope _____ Monitoring	_____ AAAHC _____ JCAHO	_____ Family Practice _____ Internal Medicine	_____ Primary Care _____ Community
_____ Periodic Full Scope _____ Follow-up	_____ CHDP _____ NCQA	_____ Pediatrics _____ OB/GYN	_____ Hospital _____ FQHC
_____ Focused Review _____ Ed/TA	_____ CPSP _____ None	_____ General Practice _____ Specialist	_____ Rural Health _____ Other _____ (type)
_____ Other _____ (type)	_____ Other _____	_____ Non-physician _____ Mid-level Practitioner (type)	_____ Solo _____ Group _____ Staff/Teaching

Scoring Procedure	Medical Record Scores	Compliance Rate
Ten (10) medical records may be surveyed in ***any*** combination, but must ***not*** exceed 100 points total for preventive care sections. **I. Format** _____ **/80 (10)** **II. Documentation** _____ **/70 (10)** **III. Continuity/Coordination** _____ **/70 (10)** **IV. Pediatric Preventive** _____ **/50 (5)** **V. Adult Preventive** _____ **/50 (5)** **VI OB/CPSP Preventive** _____ **/50 (5)** _____ **Total** (Points given)	Scoring is based on 10 medical records. 1) Add criterion points given for each individual section. 2) Adjust score for "N/A" criteria (if needed). Subtract "N/A" points from 320 total points possible. 3) Add points given for all sections. 4) Divide total given by 320 or by the "adjusted" total points. 5) Multiply by 100 to determine compliance (percent) rate. 6) **Calculate.** _____ ÷ _____ = _____ x 100 = _____ % Points given / Total/Adjusted Points / Decimal Score / Compliance Rate	_____ **Full Pass: 100%** _____ **Conditional Pass: 80-99%** _____ **Not Pass: Below 80%** ➤➤➤➤➤➤➤➤➤➤➤➤➤➤➤➤ _____ CAP Required _____ Other follow-up **Next Review Due:** _____

Rationale: Perinatal assessments are provided according to the American College of Obstetrics and Gynecologists (ACOG) standards and Comprehensive Perinatal Services Program (CPSP) Guidelines. **RN/MD Review only**

Criteria	Perinatal Preventive Reviewer Guidelines
F. HIV-related services *offered*.	The ***offering*** of prenatal HIV information, counseling and HIV antibody testing is documented (Health & Safety Code, Section 125107). Providers are ***not required*** to document that the HIV test was given or disclose (except to the patient) 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. **Note:** Member's participation is voluntary. Providers may provide HIV test or refer other testing program/site. DHS requires that HIV test results be maintained in a separate and distinct part of the patient's medical file, and that this separate part of the file be made accessible only to those individuals who provide direct patient care. Documentation or disclosure of HIV related information must be in accordance with confidentiality and informed consent regulations.
G. 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 (CCR, Title 17, Sections 6521-6532). Genetic screening documentation includes: 1) family history, 2) Triple marker screening tests: Alpha Fetoprotein (AF), unconjugated estriol (UE), human chorionic gonadotropin (HCG), 3) member's consent or refusal to participate. **Note:** Member's participation is voluntary. Testing occurs through DHS' Expanded AFP Program, and only laboratories designated by DHS may be used for testing.
H. Domestic violence abuse screening.	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, and referral to appropriate community service agencies (CA Health & Safety Code, Section 1233.5).
I. Family Planning evaluation.	Family Planning counseling, referral or provision of services is documented (MMCD Policy Letter 98-11).
J. Postpartum assessments.	Comprehensive postpartum reassessment includes the 4 components: medical exam, nutrition (mother and infant), psychosocial, health education are completed within 4-8 weeks postpartum (MMCD Policy Letter 96-01). If the postpartum assessment visit is not documented, medical record documents missed appointments, attempts to contact patient and/or outreach activities.

6. Perinatal Preventive Criteria

RN/MD Review only

Criteria met: Give one (1) point. Criteria not met: 0 points Criteria not applicable: N/A Member ID No. Age	Wt	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	Score
A. Initial Comprehensive Prenatal Assessment (ICA).	1											
B. Subsequent Comprehensive Prenatal trimester re-assessments.	1											
C. Prenatal care visits according to most recent ACOG standards.	1											
D. Individualized Care Plan (ICP).	1											
E. Referral to WIC and assessment of Infant Feeding status.	1											

Comments:

Rationale: Perinatal assessments are provided according to the American College of Obstetrics and Gynecologists (ACOG) standards and Comprehensive Perinatal Services Program (CPSP) Guidelines. **RN/MD Review only**

Criteria	Perinatal Preventive Reviewer Guidelines
A. Initial Comprehensive Assessment (ICA).	The ICA, completed within 4 weeks of entry to prenatal care, includes the following assessments: Obstetric/medical: Health and obstetrical history (past/current), LMP, EDD. • Physical exam: includes breast and pelvic exam • Lab tests: hemoglobin/hematocrit, urinalysis, urine culture, ABO blood group, Rh type, rubella antibody titer, STI screen. Nutrition: Anthropometric (height/weight), dietary evaluation, prenatal vitamin/mineral supplementation. Psychosocial: Social and mental health history (past/current), substance use/abuse, support systems/resources. Health education: Language and education needs.
B. Subsequent Comprehensive Prenatal trimester re-assessments.	Subsequent comprehensive prenatal re-assessments include Obstetric/medical, Nutrition, Psychosocial and Health Education re-assessments are completed during the 2nd trimester and 3rd trimester.
C. Prenatal care visits according to most recent ACOG standards.	ACOG's *Guidelines for Perinatal Care* recommend the following prenatal schedule for a 40-week uncomplicated pregnancy: • First visit by 6-8th week • Approximately every 4 weeks for the first 28 weeks of pregnancy • Every 2-3 weeks until 36 weeks gestation • Weekly thereafter until delivery • Postpartum visit within 4-8 weeks after delivery If the recommended ACOG schedule is not met documentation shows missed appointments, attempts to contact patient and/or outreach activities.
D. Individualized Care Plan (ICP).	ICP documentation includes specific obstetric, nutrition, psychosocial and health education risk problems/conditions, interventions, and referrals.
E. Referral to WIC and assessment of Infant Feeding status.	All potentially eligible Plan members must be referred to WIC (Public Law 103-448, Section 203(e)). Referral to WIC is documented in the medical record (Title 42, CFR 431.626(c)). Infant feeding plans are documented during the prenatal period, and infant feeding/breastfeeding status is documented during the postpartum period (MMCD Policy Letter 98-10). **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.

RN/MD Review only

Criteria met: Give one (1) points. Criteria not met: 0 points Criteria not applicable: N/A Member ID No. Age/Gender	Wt	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	Score
G. Chlamydia screening.	1											
H. Mammogram.	1											
I. Pap Smear.	1											
J. Adult Immunizations	1											
Comments:	10 Pts											

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

Criteria	Adult Preventive Reviewer Guidelines
G. Chlamydia screening.	Women who are sexually active are screened from the time they become sexually active until they are 25 years of age. Providers may screen women older than 25 years of age if the provider determines that the patient is at risk for infection. Lab results are documented.
H. Mammogram.	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.
I. Pap Smear.	Routine screening for cervical cancer with Papanicolaou (Pap) testing is done on all women who are or have been sexually active and who have a cervix. Pap smears should begin with the onset of sexual activity and repeated at least every 1-3 years depending on individual risk factors. Follow-up of abnormal test results is documented. According to the USPSTF, routine Pap testing may not be required for the following: 1) women who have undergone hysterectomy in which the cervix is removed, unless the hysterectomy was performed because of cervical cancer or its precursors, 2) women after age 65 who have had regular previous screening in which the smears have been consistently normal.
J. Adult Immunizations.	Immunization status and/or immunizations administered, date Vaccine Information Sheet (VIS) was given ***and*** publication date of the VIS are documented in the medical record. The name of each vaccine, date given, the manufacturer, and lot number is recorded in the medical record, by electronic record or on medication logs. **Note:** Providers are required to administer immunizations according to the most recent guidelines established for adults by the USPSTF.

5. Adult Preventive Criteria

RN/MD Review only

Criteria met: Give one (1) point. Criteria not met: 0 points Criteria not applicable: N/A Member ID No Age/Gender	Wt	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	Score
A. Initial Health Assessment (IHA).	1											
B. Individual Health Education Behavioral Assessment (IHEBA).	1											
C. Periodic Health Evaluation.	1											
D. Tuberculosis screening.	1											
E. Blood Pressure.	1											
F. Cholesterol.	1											

Comments:

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

Criteria	Adult Preventive Reviewer Guidelines
A. Initial Health Assessment (IHA).	An IHA is completed on all adult members within 120 days of the effective date of enrollment into the Plan, or documented within the past 12 months prior to member's enrollment. The IHA includes a past health history, a comprehensive physical examination and the IHEBA. If an IHA is not present in the medical record, member's refusal, missed appointments or other reason must be documented. The IHA consists of a core set of services as described in the contract and as outlined below.
B. Individual Health Education Behavioral Assessment (IHEBA).	The "Staying Healthy" Assessment Tool or other DHS-approved assessment tool is completed initially on all adults within 120 days of enrollment into Health Plan, or as part of the IHA. For adults age 18 and older, the IHEBA is re-administered every 3-5 years, or more frequently for young adults. Intervention codes, dates and PCP signature is documented directly on the assessment form. Follow-up clinical interventions, health education and counseling and/or referrals are noted in the progress notes or other areas of the medical record. **Note:** Age-appropriate, gender-specific preventive health education and/or clinical counseling will depend on the identified problems and specific needs of each individual patient.
C. Periodic Health Evaluation.	Periodic health evaluations occur in accordance with the frequency that is appropriate for individual risk factors. The type, quantity and frequency of preventive services will depend on the most recent USPSTF recommendations. Public health evaluations are scheduled as indicated by the patient's needs and according to the clinical judgement of the provider. **Note:** 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.
D. Tuberculosis screening.	Adults are screened for tuberculosis (TB) risk factors upon enrollment. The Mantoux skin test is administered to ***all*** asymptomatic persons at increased risk of developing TB irrespective of age or periodicity if they have not had a test in the previous year. The Mantoux is not administered if the individual has had a previously documented positive Mantoux skin test. When a positive skin test is noted, there is documentation of follow-up care (e.g. further medical evaluation, chest x-ray, diagnostic laboratory studies and/or referral to specialist). **Note:** Providers are required to follow the American Thoracic Society and Centers for Disease Control (CDC) guidelines for TB diagnosis and treatment.
E. Blood Pressure.	A blood pressure (B/P) measurement for the normotensive adult is documented at least once every 2 years if the last diastolic B/P reading was below 85 mm Hg and systolic B/P reading was below 140 mm Hg. B/P is measured annually if the last diastolic reading was 85-89/above.
F. Cholesterol.	Men (aged 35 years and older) and women (aged 45 years and older) are screened for lipid disorders, which includes measurement of total cholesterol (TC) and high-density lipoprotein cholesterol (HDL-C). **Note:** Providers may screen men (aged 25-35 years) and women (aged 20-45 years) for lipid disorders if they have other risk factors for CHD such as family history of myocardial infarction before age 50 or family hypercholesterolemia.

RN/MD Review only

Criteria met: Give one (1) point. Criteria not met: 0 points Criteria not applicable: N/A Member ID No. Age/Gender	Wt	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	Score
G. Dental assessment.	1											
H. Lead screening.	1											
I. Tuberculosis screening.	1											
J. Childhood immunizations.	1											
Comments:	10 Pts											

Rationale: Pediatric preventive services are provided in accordance with the American Academy of Pediatrics Guidelines. **RN/MD Review only**

Criteria	Pediatric Preventive Reviewer Guidelines
G. Dental assessment.	Inspection of the mouth, teeth and gums is performed at every health assessment visit. Children are referred to a dentist at any age if a dental problem is detected or suspected. Beginning at age 3 years, all children are referred annually to a dentist regardless of whether a dental problem is detected or suspected.
H. Lead screening.	Children receiving health services through Medi-Cal Managed Care Plans must have blood lead level (BLL) testing as follows: 1) at 12 months ***and*** 24 months of age, 2) between 12 months and 24 months of age if there is no documented evidence of BLL testing at 12 months or thereafter, 3) between 24 months and 72 months of age if there is no documented evidence of BLL testing at 24 months or thereafter. All screening results indicating an elevated BLL of 10 micrograms of lead per deciliter (μg/dL) of blood (or greater) require additional follow-up and blood lead testing in accordance with current DHS policy letter or as summarized below: • BLL of 10-14 μg/dL: Confirm with venous sample within 3 months of original test. • BLL of 15-19 μg/dL: Confirm with venous sample within 2 months of original test, then retest at 2 months following the confirmatory testing. • BLL of 20-44 μg/dL: Confirm with venous sample in 1 week to 1 month, depending on severity of BLL. • BLL of 45-59 μg/dL: Retest with venous sample within 48 hours. • BLL of 60-69 μg/dL: Retest with venous sample within 24 hours. • BLL of ≥ 70 μg/dL: EMERGENCY. Retest immediately with venous sample. Children with elevated BLLs are referred to local Childhood Lead Poisoning Prevention Branch or, if none, to the local health department. All children with confirmed (venous) BLLs of ≥ 20 μg/dL must be referred to CCS.
I. Tuberculosis screening.	All children are screened for risk of exposure to tuberculosis (TB) at each health assessment visit. The Mantoux skin test is administered during health assessment visits at age 4-5 years and age 11-16 years. The Mantoux skin test is administered to ***all*** asymptomatic persons at increased risk of developing TB irrespective of age or periodicity if they have not had a test in the previous year. The Mantoux skin test is not administered if the child has had a previously documented positive Mantoux skin test. For all positive skin tests, there is documentation of follow-up care (e.g. further medical evaluation, chest x-ray, diagnostic laboratory studies and/or referral to specialist). **Note:** Providers are required to follow the American Thoracic Society and Centers for Disease Control (CDC) guidelines for TB diagnosis and treatment.
J. Childhood Immunizations.	Immunization status is assessed at each health assessment visit. The date the Vaccine Information Sheet (VIS) was given ***and*** the publication date of the VIS is documented. The name of each vaccine given, the manufacturer, and lot number is recorded in the medical record, by electronic record or on medication logs. **Note:** Providers are required to administer immunizations according to the most recent guidelines established by the Public Health Service Advisory Committee on Immunization Practices (ACIP), unless medically contraindicated or refused by the parent.

4. Pediatric Preventive Criteria

RN/MD Review only

Criteria met: Give one (1) point. Criteria not met: 0 points Criteria not applicable: N/A Member ID No. Age/Gender	Wt	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	Score
A. Initial Health Assessment (IHA).	1											
B. Individual Health Education Behavioral Assessment (IBEHA).	1											
C. Age-appropriate physical exams according to AAP schedule.	1											
D. Vision screening.	1											
E. Hearing screening.	1											
F. Nutrition assessment.	1											

Comments:

Rationale: Pediatric preventive services are provided in accordance with the American Academy of Pediatrics Guidelines (AAP). **RN/MD Review only**

Criteria	Pediatric Preventive Reviewer Guidelines
A. Initial Health Assessment (IHA).	An IHA must be completed on all members within 120 days of the effective date of enrollment into the Plan, or documented within the past 12 months prior to member's enrollment. The IHA is a comprehensive history and physical that includes an Individual Health Education Behavioral Assessment (e.g. "Staying Healthy" or other DHS-approved tool) at age-appropriate intervals. The IHA must include a core set of preventive services. If evidence of an IHA is not present in the medical record, the reason must be documented in the record (member's refusal, missed appointments, etc.)
B. Individual Health Education Behavioral Assessment (IBEHA).	**New Members:** Age-appropriate IHEBA is conducted within 120 days of effective enrollment date as part of initial health assessment. **Existing members:** Age-appropriate IHEBA is conducted at member's next non-acute care visit, but no later than the next scheduled health-screening exam. The IHEBA tool is re-administered at appropriate age intervals: 0-3 years, 4-8 years, 9-11 years, 12-17 years and 18 years and older. The IHEBA tool and risk-reduction plan is reviewed at least annually with members who present for a scheduled visit (see documented date and PCP initials). Provision of health education and anticipatory guidance is documented at each health assessment visit, which includes providing appropriate educational materials and/or providing or referring to counseling. Problems, interventions and referrals are documented in the progress notes or elsewhere in the medical records.
C. Age-appropriate physical exams according to most recent AAP schedule.	Periodic health assessments are provided according to the AAP recommended schedule for pediatric preventive health care. Where the AAP periodicity exam schedule is more frequent than the Child Health and Disability Prevention (CHDP) periodicity examination schedule, the AAP scheduled assessment must include all components required by the CHDP program for the lower age nearest to the current age of the child. A physical examination is completed at each health assessment visit which includes: 1) anthropometric measurements of weight and length/height, and head circumference of infants up to age 24 months, 2) physical examination/body inspection, including screen for sexually transmitted infection (STI) on sexually active adolescents, 3) urine test (Urine Dipstick or urinalysis) at each health assessment visit starting at age 4-5 years. Assessments and identified problems recorded on the PM160 form are documented in the progress notes. Follow-up care or referral is provided for identified physical health problems as appropriate.
D. Vision screening.	Age-appropriate visual screening occurs at each health assessment visit, with referral to optometrist/ophthalmologist as appropriate. **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, ophthalmoscopic red reflex examination, or corneal penlight evaluation. Visual acuity screening usually begins at age 3 years.
E. Hearing screening.	Non-audiometric screening for infants/children (2 months to 3 years) includes family and medical history, physical exam and age-appropriate screening. Audiometric screening for children and young adults (3-21years) is done at each health assessment visit and includes follow-up care as appropriate. Failed audiometric screenings are followed up with a repeat screening. Children who fail to respond on 2 screenings separated by an interval of at least 2 weeks and no later that 6 weeks after the initial screening are referred to a specialist.
F. Nutrition assessment.	Screening includes: 1) Anthropometric measurements, 2) Laboratory test to screen for anemia (hematocrit or hemoglobin), 3) Breastfeeding/infant feeding status, food/nutrient intake and eating habits. Based on problems/conditions identified, nutritionally at-risk children under 5 years of age are referred to the Women, Infants and Children (WIC) Supplemental Nutrition Program, for medical nutrition therapy or other in-depth nutritional assessment as appropriate. **Note:** Assessment of infant feeding status includes evaluation of problems/conditions/needs of the breastfeeding mother.

3. Coordination/Continuity of Care Criteria

RN/MD Review only

Criteria met: Give one (1) point. Criteria not met: 0 points Criteria not applicable: N/A Member ID No. Age/Gender	Wt	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	Score
A. History of present illness 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. A physician reviewed consult/referral reports and diagnostic test results.	1											
G. Missed appointments and follow-up contacts/outreach efforts are noted.	1											
Comments:	7 Pts											

Rationale: Pediatric preventive services are provided in accordance with the American Academy of Pediatrics Guidelines (AAP). **RN/MD Review only**

Criteria	Pediatric Preventive Reviewer Guidelines
A. Initial Health Assessment (IHA).	An IHA must be completed on all members within 120 days of the effective date of enrollment into the Plan, or documented within the past 12 months prior to member's enrollment. The IHA is a comprehensive history and physical that includes an Individual Health Education Behavioral Assessment (e.g. "Staying Healthy" or other DHS-approved tool) at age-appropriate intervals. The IHA must include a core set of preventive services. If evidence of an IHA is not present in the medical record, the reason must be documented in the record (member's refusal, missed appointments, etc.)
B. Individual Health Education Behavioral Assessment (IBEHA).	**New Members:** Age-appropriate IHEBA is conducted within 120 days of effective enrollment date as part of initial health assessment. **Existing members:** Age-appropriate IHEBA is conducted at member's next non-acute care visit, but no later than the next scheduled health-screening exam. The IHEBA tool is re-administered at appropriate age intervals: 0-3 years, 4-8 years, 9-11 years, 12-17 years and 18 years and older. The IHEBA tool and risk-reduction plan is reviewed at least annually with members who present for a scheduled visit (see documented date and PCP initials). Provision of health education and anticipatory guidance is documented at each health assessment visit, which includes providing appropriate educational materials and/or providing or referring to counseling. Problems, interventions and referrals are documented in the progress notes or elsewhere in the medical records.
C. Age-appropriate physical exams according to most recent AAP schedule.	Periodic health assessments are provided according to the AAP recommended schedule for pediatric preventive health care. Where the AAP periodicity exam schedule is more frequent than the Child Health and Disability Prevention (CHDP) periodicity examination schedule, the AAP scheduled assessment must include all components required by the CHDP program for the lower age nearest to the current age of the child. A physical examination is completed at each health assessment visit which includes: 1) anthropometric measurements of weight and length/height, and head circumference of infants up to age 24 months, 2) physical examination/body inspection, including screen for sexually transmitted diseases (STD) on sexually active adolescents, 3) urine test (Urine Dipstick or urinalysis) at each health assessment visit starting at age 4-5 years. Assessments and identified problems recorded on the PM160 form are documented in the progress notes. Follow-up care or referral is provided for identified physical health problems as appropriate.
D. Vision screening.	Age-appropriate visual screening occurs at each health assessment visit, with referral to optometrist/ophthalmologist as appropriate. **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, ophthalmoscopic red reflex examination, or corneal penlight evaluation. Visual acuity screening usually begins at age 3 years.
E. Hearing screening.	Non-audiometric screening for infants/children (2 months to 3 years) includes family and medical history, physical exam and age-appropriate screening. Audiometric screening for children and young adults (3-21years) is done at each health assessment visit and includes follow-up care as appropriate. Failed audiometric screenings are followed up with a repeat screening. Children who fail to respond on 2 screenings separated by an interval of at least 2 weeks and no later that 6 weeks after the initial screening are referred to a specialist.
F. Nutrition assessment.	Screening includes: 1) Anthropometric measurements, 2) Laboratory test to screen for anemia (hematocrit or hemoglobin), 3) Breastfeeding/infant feeding status, food/nutrient intake and eating habits. Based on problems/conditions identified, nutritionally at-risk children under 5 years of age are referred to the Women, Infants and Children (WIC) Supplemental Nutrition Program, for medical nutrition therapy or other in-depth nutritional assessment as appropriate. **Note:** Assessment of infant feeding status includes evaluation of problems/conditions/needs of the breastfeeding mother.

3. Coordination/Continuity of Care Criteria

RN/MD Review only

Criteria met: Give one (1) point. Criteria not met: 0 points Criteria not applicable: N/A Member ID No. Age/Gender	Wt	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	Score
A. History of present illness 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. A physician reviewed consult/referral reports and diagnostic test results.	1											
G. Missed appointments and follow-up contacts/outreach efforts are noted.	1											
Comments:	7 Pts											

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/MD Review only

Criteria	Coordination/Continuity of Care Reviewer Guidelines
A. History of present illness is documented.	Each focused visit (e.g., primary care, urgent care, acute care, etc.) includes a documented history of present illness.
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 patient/parent. "Objective" information such as assessment findings and conclusion that is documented 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 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 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).
E. Unresolved and/or 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. Each problem need not be addressed at every visit. Documentation demonstrates that provider follows up with patients about treatment regiments, recommendations, counseling, and/or referrals.
F. A physician reviewed consult/referral reports, and diagnostic test results.	Consultation reports and diagnostic test results are documented for ordered requests. 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 show documented evidence of physician review. Evidence of review may include the physician's initials or signature on the report, notation in the progress notes, or other site-specific method of documenting physician review. Abnormal test results/diagnostic reports have explicit notation in the medical record. Documentation includes patient contact or contact attempts, follow-up treatment, instructions, return office visits, referrals and/or other pertinent information. Electronically maintained medical reports must also show evidence of physician review, and may differ from site to site.
G. Missed appointments and follow-up contacts/outreach efforts are noted.	Documentation includes incidents of missed/broken appointments (cancellations or "No shows") for PCP examinations, diagnostic procedures, lab tests, specialty appointments, and/or other referral services. Attempts to contact the patient and/or parent/guardian (if minor), and the results of follow-up actions are also documented.

2. Documentation Criteria

RN/MD Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Member ID No. Age/Gender	Wt	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	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. Signed Informed Consents are present, when appropriate.	1											
E. Advance Health Care Directive information is offered. (Only: Adults, 18 years/older; Emancipated minors)	1											
F. Medical record entries are in accordance with acceptable legal medical documentation standards.	1											
G. Errors are corrected according to legal medical documentation standards.	1											
Comments:	7 Pts											

Rationale: Well-documented records facilitate communication and coordination, and promote efficiency and effectiveness of treatment. **RN/MD Review only**

Criteria	Documentation Reviewer Guidelines
A. Allergies are prominently noted.	Allergies and adverse reactions are listed in a 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.
B. Chronic problems and/or significant conditions are listed.	Documentation may be on a separate "problem list" page, 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
C. Current continuous medications are listed.	Documentation may be on a separate "medication list" page, or a clearly identifiable medication list in the progress notes. List of current, on-going medications identifies the medication name, strength, dosage, route, and start/stop dates. Discontinued medications are noted on the medication list or in progress notes.
D. Signed Informed Consents are present, when appropriate.	Adults, parents/legal guardians of a minor or emancipated minors may sign consent forms for medical treatment. Informed Consents are signed for operative and invasive procedures. Human sterilization requires DHS Consent Form 330. Signed authorization is documented in the medical record for release of medical information. **Note:** Persons under the age of 18 years 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.
E. Advance Health Care Directive information is offered (Adults (18 years); Emancipated minors).	Adult medical records include documentation of whether member has been offered information or has executed an Advance Health Care Directive (California Probate Code, Sections 4701).
F. Entries are made in accordance with acceptable legal medical documentation standards.	All entries are signed, dated and legible. Signature includes the first initial, last name and title. Initials 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. Methods used to authenticate signatures in electronic medical records will vary, and must be individually evaluated by reviewers. Date includes the month/day/year. Only standard abbreviations are used. Entries are in reasonable consecutive order by date. Handwritten documentation, signatures and initials are entered in ink that can be readily copied. 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. **Note:** Legibility means the record entry is readable by a person other than the writer. Authentication means that stamped signature can be verified, validated, confirmed, and is countersigned/initialed.
G. Errors are corrected according to legal medical documentation standards.	The person that makes the documentation error corrects the error. A single line is drawn through the error, with "error" written above or near the lined-through incorrect entry. 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. Reviewers must determine method(s) used for correction of documentation errors of computerized records on a case by case basis. **Note:** The **S.L.I.D.E.** rule is one method used to correct documentation errors: Single Line, Initial, Date, and Error.

1. Format Criteria

Criteria met: Give one (1) point. Criteria not met: 0 points Criteria not applicable: N/A Member ID No. Age/Gender	Wt	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	Score
A. An individual medical record is established for each member.	1											
B. Member identification is on each page.	1											
C. Individual personal biographical information is documented.	1											
D. Emergency "contact" is identified.	1											
E. Medical records on site are consistently organized.	1											
F. Chart contents are securely fastened.	1											
G. Patient's assigned primary care physician (PCP) is identified.	1											
H. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing-impaired persons are prominently noted.	1											
Comments:	8 Pts											

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

Criteria	Format Reviewer Guidelines
A. An individual medical record is established for each family member.	Providers are able to readily identify each individual treated. A medical record is started upon the initial visit. "Family charts" are not acceptable.
B. Member identification is on each page.	Member identification includes first and last name, and/or a unique patient number established for use on clinical site. Electronically maintained records and printed records from electronic systems contain patient identification.
C. Individual personal biographical information is documented.	Personal biographical information includes date of birth, current address, home/work phone numbers, and name of parent(s) if patient is a minor. If patient refused to provide information, "refused" is noted in the medical record. If portions of the personal biographical information are not completed (left blank), reviewer should attempt to determine if patient has refused to provide information. Do not deduct points if member has refused to provide all personal information requested by the provider.
D. Emergency "contact" is identified.	The name and phone number of an "emergency contact" person is identified for all patients. Listed emergency contacts may include a relative or friend, or a home, work, pager, cellular or message phone number. If the patient is a minor, the contact person must be a parent or legal guardian. Adults and emancipated minors may list anyone of their choosing. If a patient 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 provider.
E. Medical records are consistently organized.	Contents and format of printed and/or electronic records within the practice site are uniformly organized.
F. Chart contents are securely fastened.	Printed chart contents are securely fastened, attached or bound to prevent medical record loss. Electronic medical record information is readily available.
G. Patient's assigned primary care physician (PCP) is identified.	The assigned PCP is ***always*** identified when there is more than one PCP on site and/or when the patient has selected health care from a non-physician medical practitioner. If there is only one PCP on site, the provider's documentation and signature in the record identifies the primary care physician/provider of services. Since various methods are used to identify the assigned PCP, reviewers must identify specific method(s) used at each individual site.
H. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing-impaired persons are prominently noted.	The primary language and requests for language and/or interpretation services by a non-or limited-English proficient person is documented. The PCP and/or appropriate clinic staff member that speaks the person's language fluently can be considered a qualified interpreter. Friends or family members should not be used as interpreters, unless specifically requested by the member. Member refusal of interpreter services is documented. If English is the primary language, then language documentation is not necessary. 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 (MMCD Policy Letter 99-03).

Medical Record Review Guidelines

California Department of Health Services
Medi-Cal Managed Care Division

Purpose: Medical Record Survey Guidelines provide standards, directions, instructions, rules, regulations, perimeters, or indicators for the medical record survey, and shall used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions..

Scoring: Survey score is based on a review standard of 10 records per individual provider. Documented evidence found in the hard copy (paper) medical records and/or electronic medical records are used for survey criteria determinations. Full Pass is 100%. Conditional Pass is 80-99%. Not Pass is below 80%. The minimum passing score is 80%. A corrective action plan is required for ***all*** medical record criteria deficiencies. 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. Medical records shall be randomly selected using methodology decided upon by the reviewer. Ten (10) medical records are surveyed for each provider, five (5) adult and/or obstetric records and five (5) pediatric records. For sites with *only*adult, *only* obstetric, or *only* pediatric patient populations, all ten records surveyed will be in *only* one preventive care service area. Sites where documentation of patient care by all PCPs on site occurs in universally shared medical records shall be reviewed as a "shared" medical record system. Scores calculated on shared medical records apply to each PCP sharing the records. A minimum of ten shared records shall be reviewed for 2-3 PCPs, twenty records for 4-6 PCPs, and thirty records for 7 or more PCPs. Survey criteria to be reviewed *only* by a R.N. or physician is labeled "**RN/MD Review only**".

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 provider. If 20 records are reviewed, divide total points given by 640 or by the "adjusted" total points possible. If 30 records are reviewed, divide total points given by 960 or 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. Reviewers are expected to determine the most appropriate method(s) on each site to ascertain information needed to complete the survey.

Scoring Example:

Step 1: Add the points given in each section.	**Step 2**: Add points given for all six (6) sections. 72 (Format) 54 (Documentation) 58 (Coordination/Continuity-of-care) 43 (Pediatric Preventive) 40 (Adult Preventive) **267 (POINTS)**
Step 3: Subtract the "N/A" points from 320 total points possible. 320 (Total points possible) –15 (N/A points) 305 ("Adjusted" total points possible)	**Step 4**: Divide total points given by 320 or by the "adjusted" points, then multiply by 100 to calculate percentage rate. $\frac{\text{Total points}}{\text{320 or "Adjusted" points}} \quad \frac{267}{305} = 0.875 \times 100 = \mathbf{88\%}$

RN/M... Review only

Criteria met: Give one (1) point. Criteria not met: 0 points Criteria not applicable: N/A Member ID No. Age	Wt	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	MR#	Score
F. HIV-related services *offered.*	1											
G. AFP/Genetic screening *offered.*	1											
H. Domestic Violence/Abuse screening.	1											
I. Family Planning evaluation.	1											
J. Postpartum assessments.	1											
Comments:	10 Pts											

Medical Record Review Summary

California Department of Health Services
Medi-Cal Managed Care Division

Note: Survey is based on 10 medical records. Total points for Preventive Criteria are ***not*** to exceed 100 points in any combination.

Format	Documentation	Coord/Cont.	PLUS 10 of any of the following medical records	Pediatric	Adult	OB/CPSP	Total
10 records/ 80 points	10 records/ 70 points	10 records/ 70 points		5 records/ 50 points or 10 records/ 100 points	5 records/ 50 points or 10 records/ 100 points	5 records/ 50 points or 10 records/ 100 points	**Full Pass:** 100% **Conditional Pass:** 80-99% **Not Pass:** Below 80%

Comments

Format
Documentation
Continuity of Care
Preventive Content

Reviewer(s)/Title _____ Date: _____

Attachment C
Site Review Policy
Medi-Cal Managed Care

Childhood Immunization Checklist

(Birth through 18 years of age)

Directions: Check the immunizations documented in records on site. (Not to be counted as part of score.)

Schedule approved by the Advisory Committee on Immunization Practices (ACIP), American Academy of Pediatrics (AAP), and American Academy of Family Physicians (AFP).	Hep B #1	Hep B #2	DTaP #1	Hib #1	IPV #1	PCV #1	DTaP #2	Hib #2	IPV #2	PCV #2	Hep B #3	DTaP #3	Hib #3	IPV #3	PCV #3	Hib #4	MMR #1	VAR	PCV #4	DTaP #4	DTaP #5	IPV #4	MMR #2	Td
	Birth to 2 mos	1 mo after #1	2 mos	2 mos	2 mos	2 mos	4 mos	4 mos	4 mos	4 mos	6-18 mos	6 mos	6 mos	6-18 mos	6 mos	12-15 mos	12-15 mos	12-18 mos	12-18 mos	15-18 mos	4-6 yrs	4-6 yrs	4-6 yrs	11-12 yrs
Member ID/age																								
Member ID/age																								
Member ID/age																								
Member ID/age																								
Member ID/age																								

Comments:

Full Scope Site Review Survey Data Submission

Medi-Cal Managed Care Division

Site Review Survey

Site ID No.	Survey Date	County No.	Plan ID No.	Other Plans	Initial/ Periodic	Reviewer ID No.	A/S Pts.	Per Pts.	OM Pts.	CS Pts.	PS Pts.	IC Pts.	N/A Criteria	Total Score	Critical Element Deficiencies

CAP Due Date	CAP Closure Date	No. of Visits	Next Survey Date			

Site Review Data Submission Dictionary

Site Identification (ID) Number: An identification number must be assigned to each site reviewed. The identification number may be a consecutive number assigned for a given reporting period, or a number permanently assigned to a particular site. A separate list must be kept that identifies site/provider name, address, phone number, provider type or specialty, Independent Physician Association (IPA), if applicable, and number assigned to the site.

Survey Date: Enter the date (month/day/year) of site survey, which may be different from the medical record survey date.

County Number: Enter the number of the county in which site is located (e.g. Sacramento County is Number 34).

Plan Identification (ID) Number: Enter the identification number of the Health Plan conducting the survey.

Other Plans: Enter the identification number(s) of all other Plans that site is also contracted with at the time of survey.

Initial/Periodic: Identifies type of review. Enter 1 for initial Full Scope review. Enter 2 for periodic Full Scope review.

Reviewer Identification (ID) Number: Enter the specific identification assigned to each reviewer. All reviewers, including those from subcontracted agencies/entities, must have a reviewer identification number that also includes the Plan/agency identification.

Access/Safety (A/S) *Points: Enter the number of points scored out of 28 possible or "N/A" adjusted points. Enter all scores for each section as a ratio (e.g. 24/28).

Personnel (Per) *Points: Enter the number of points (ratio) scored out of 26 possible or "N/A" adjusted points.

Office Management (OM) *Points: Enter the number of points (ratio) scored out of 27 possible or "N/A" adjusted points.

Clinical Services (CS) *Points: Enter the number of points (ratio) scored out of 36 possible or "N/A" adjusted points.

Preventive Services (PS) *Points: Enter the number of points (ratio) scored out of 13 possible or "N/A" adjusted points.

Infection Control (IC) *Points: Enter the number of points (ratio) scored out of 26 possible or "N/A" adjusted points.

N/A Criteria: Enter only specific section/criteria/element number of "not applicable" elements (e.g. Per D 2, 3 = Personnel, Criteria "D", Elements "1" and "2").

Total Score: Enter the calculated percentage rate of total scored points for site.

Critical Elements: Enter only specific section/criteria/element number of critical elements found deficient (e.g. OME1 = Office Management, Criteria "E", Element "1").

CAP Due Date: Enter the date corrective action plan (CAP) is due to Plan from provider.

CAP Closure Date: Enter the date CAP is signed off as completed by Plan.

Total Number of visits: Enter the total number of onsite visits made to facilitate bringing the site into compliance with survey requirements. This number includes visits made for initial/periodic review, monitoring, provision of educational/technical assistance, focused review(s), CAP development and follow-up, etc.

Next Survey: Enter the date (month/year) of the next scheduled Full Scope Site Review.

***Note:** Points entered shall be the original points scored at the time of the survey.

Full Scope Site Review Survey Data Submission

Medi-Cal Managed Care Division

Medical Record Review Survey

Provider ID No.	Survey Date	Site ID No.	County No.	Plan ID No.	Other Plans	Initial/ Periodic	Reviewer ID No.	Format Pts.	Docu Pts.	C/C Pts.	PP Pts	AP Pts.	OB Pts.	N/A Criteria	Total Score	No. of Records Reviewed

No. of Providers Surveyed	CAP Due Date	CAP Closure Date	No. of Visits	Next Survey Date			

Medical Record Review Data Submission Dictionary

Provider Identification (ID) Number: An identification number must be assigned to each provider reviewed. Enter the identification number of the individual provider being review. If a site uses shared medical records, enter the identification numbers of all providers reviewed.

Site Identification (ID) Number: An identification number must be assigned to each site reviewed. The identification number may be a consecutive number assigned for a given reporting period, or a number permanently assigned to a particular site. A separate list must be kept that identifies site/provider name, address, phone number, provider type or specialty, Independent Physician Association (IPA), if applicable, and number assigned to the site.

Survey Date: Enter the date (month/day/year) of medical record survey, which may be different from the site survey date.

County Number: Enter the number of the county in which site is located (e.g. Sacramento County is Number 34).

Plan Identification (ID) Number: Enter the identification number of the Health Plan conducting the survey.

Other Plans: Enter the identification number(s) of all other Plans that site is also contracted with at the time of survey.

Initial/Periodic: Identifies type of review. Enter 1 for initial Full Scope review. Enter 2 for periodic Full Scope review.

Reviewer Identification (ID) Number: Enter the specific identification assigned to each reviewer. All reviewers, including those from subcontracted agencies/entities, must have a reviewer identification number that also includes the Plan/agency identification.

Format *Points: Enter the number of points (ratio) scored out of 80 possible or "N/A" adjusted points.

Documentation *Points: Enter the number of points (ratio) scored out of 70 possible or "N/A" adjusted points.

Continuity/Coordination *Points: Enter the number of points (ratio) scored out of 80 possible or "N/A" adjusted points.

Pediatric Preventive *Points: Enter the number of points (ratio) scored out of 60 possible (if 5 records), 120 possible (if 10 records), or "N/A" adjusted points.

Adult Preventive *Points: Enter the number of points (ratio) scored out of 60 possible (if 5 records), 120 possible (if 10 records), or "N/A" adjusted points.

OB/CPSP *Points: Enter the number of points (ratio) scored out of 60 possible (if 5 records), 120 possible (if 10 records), or "N/A" adjusted points.

N/A Criteria: Enter only specific section/criteria/element number of "not applicable" elements (e.g. AP I = Adult Preventive, Criteria "I").

Total Score: Enter the calculated percentage rate of total scored points for provider(s).

No. of Records Reviewed: Enter total number of medical records surveyed.

No. of Providers Surveyed: Enter "1" if records reviewed are for a single provider, or enter the number of "shared providers" for the records reviewed.

CAP Due Date: Enter the date corrective action plan (CAP) is due to Plan from provider.

CAP Closure Date: Enter the date CAP is signed off as completed by Plan.

Total Number of visits: Enter the total number of onsite visits made to facilitate bringing the site into compliance with survey requirements. This number includes visits made for initial/periodic review, monitoring, provision of educational/technical assistance, focused review(s), CAP development and follow-up, etc.

Next Survey: Enter the date (month/year) of the next scheduled Full Scope Site Review.

***Note:** Points entered shall be the original points scored at the time of the survey.