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

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: May 22, 2014

POLICY LETTER (PL) 14-004
SUPERSEDES PL 02-002

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: SITE REVIEWS: FACILITY SITE REVIEW AND MEDICAL RECORD REVIEW

PURPOSE:
The purpose of this PL is to inform all Medi-Cal managed care health plans (MCP) of the updates to the Department of Health Care Services' (DHCS) site review policy. DHCS previously published this policy in PL 02-002. This revised PL supersedes PL 02-002 and reflects changes made to the criteria and scoring of the Medi-Cal Managed Care Division's (MMCD) Facility Site Review (FSR) Survey Tool and Guidelines (Attachment A) and the Medical Record Review (MRR) Survey Tool (Attachment B) and the use of the Physical Accessibility Review Survey (PARS) Tool (see PL 12-006 Attachment C). PL 12-006 can be found at the following link: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2012/PL12-006.pdf.

DHCS updated criteria to reflect current guidelines of professional organizations, unbundled these criteria groups to better identify deficiencies, and adjusted scoring methods to better generalize the scores.

DHCS conducts site reviews to ensure that all primary care provider (PCP) sites, used by MCPs to deliver health care services to MCP members, have sufficient capacity to:

- Provide appropriate primary health care services;
- Carry out processes that support continuity and coordination of care;
- Maintain patient safety standards and practices; and
- Operate in compliance with all applicable local, state, and federal laws and regulations.

BACKGROUND:
In 1991, the Centers for Medicaid and Medicare Services (CMS) stipulated that managed care organizations (MCOs) must adhere to all applicable local, state, and federal laws and regulations. When the MCO contracts with state Medicaid programs, the MCO must have an internal program for quality assurance. The site review process is part of an MCP's quality improvement program that focuses on the capacity of each PCP site to ensure and support the safe and effective provision of clinical services.

CMS requires MCPs to offer a range of services, including preventive and primary care services. Primary care services include all health care and laboratory services customarily provided by 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, Section 438).

CMS requires MCPs to have adequate facilities and sufficient site locations available to meet contractual requirements for the delivery of primary care within their service areas. All PCP sites must have the capacity to support the safe and effective provision of primary care clinical services to MCP members (Title 22, California Code of Regulations [CCR], Section 56230).

In 1998, DHCS established a collaborative workgroup, containing representatives from each of the models of managed care, to revise DHCS's site review policy. In 2010, a DHCS workgroup updated the FSR and MRR Survey Tools and Guidelines. The objective of this workgroup was to develop a uniform, system-wide process that clarified the requirements and decreased duplicative site reviews for MCP providers who serve the Seniors and Persons with Disabilities (SPD) population. MCPs began to use the new FSR and MRR tools and guidelines in January 2012.

DHCS published PL 12-006 in 2012 that required MCPs to use the PARS Tool to assess the level of physical accessibility of provider sites, including specialist and ancillary service provider sites that provide care to SPDs. DHCS continues to monitor MCP use of the PARS Tool.

POLICY:
DHCS must review all MCP PCP sites (Title 22 CCR Section 56230). MCPs must ensure that PCP sites comply with all applicable local, state, and federal standards. Each provider site must be appropriately licensed and accredited. Before DHCS approves an MCP to provide services to its members, each of the MCP's contracted or subcontracted PCP sites is subject to an initial site review, and periodic site reviews thereafter consisting of an FSR and MRR, to evaluate the site's capacity to deliver quality services.

Accountability
MCPs are accountable for all activities on PCP sites, whether those services are provided by contracted or subcontracted health plans, independent physician association, or other delegated or sub-delegated entity. MCP accountability includes ensuring that the PCP sites comply with regulatory, contractual, and policy requirements, and that PCP sites complete all necessary corrective actions.

Delegation
DHCS must approve all delegated responsibilities. MCPs are responsible for:

- Identifying specific delegated functions;
- Overseeing and monitoring delegated activities;
- Ensuring that delegated functions are properly carried out; and
- Establishing a formal, mutually agreed upon document.

MCPs may choose whether or not to delegate site review responsibilities to another MCP or appropriate entity. Each collaborating MCP determines whether or not to accept the delegated entity's site review findings.

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

Credentialing and Recredentialing
MCPs must ensure that providers are credentialed according to MMCD contractual and policy requirements. Each MCP must complete a site review as part of its initial credentialing process when the MCP adds a new provider to its provider network who works at a site the MCP has not previously reviewed. An MCP does not need to repeat a site review as part of the initial credentialing or recredentialing process if a new provider works at a provider site that has a current passing site review score. MCPs may consider a site review "current" if it is dated within the last three years. An MCP does not need to repeat a site review until the due date of its next scheduled site review unless the MCP, through its monitoring activities, determines a site review is necessary. Because network providers change over time, the timeline for provider recredentialing and subsequent site reviews may not be on a synchronized schedule.

Facility Site Review
A site review consists of the MMCD FSR and MRR Survey Tools. All MCPs and subcontracted entities must use MMCD survey criteria and scoring methods to audit facility sites and medical records.

MCPs must complete initial site reviews and subsequent periodic site reviews comprised of the FSR and MRR of all PCP sites that intend to participate in their provider networks regardless of the status of a PCP site's other accreditations and certifications (Title 22 CCR Section 56230). MCPs must apply the same standard to conduct site reviews at each PCP site. The most current FSRs and MRRs will be shared among all MCPs contracting with a particular provider. Each MCP is responsible for tracking the survey status of all of its contracted provider sites. MCPs must collaborate locally to determine how they will notify each other of the survey status and results for their shared providers.

I. Initial Site Review

All PCP sites serving MCP members must undergo an initial site review and receive a minimum passing score of 80 percent on the FSR Survey Tool. An initial site review, which does not include an MRR, is the first onsite inspection of a site that has not had a previous review, or is a PCP site that is returning to the Medi-Cal managed care program and has not had a passing review in the past three years. The MCP may waive the initial site review for a pre-contracted provider site if the provider has documented proof that another local MCP completed a site review with a passing score within the past three years.

Prior to initiating operations in a service area, an MCP must complete initial site reviews consisting of the FSR, on five percent of the PCP sites in its provider network, or on 30 PCP sites, whichever is greater in number. The PCP sites reviewed must include a variety of providers from throughout the provider network and from each subcontracted entity. If there are 30 or fewer PCP sites in the network, the MCP must review 100 percent of the sites prior to beginning operations. The MCP must complete an initial site review on 100 percent of the remaining proposed PCP sites within the first six months of operation or expansion.

II. Subsequent Periodic Site Review

MCPs must conduct subsequent site reviews no later than three years after the initial reviews. MCPs may review sites more frequently per local collaborative decisions or when determined necessary based on monitoring, evaluation, or corrective action plan (CAP) follow-up issues.

MCPs must have a process in place that instructs providers to notify the MCP of a provider site relocation at least 30 days prior to the move so the MCP can conduct a site review on the new location. However, if the provider notifies the MCP after the move:

- The MCP must allow assigned MCP members to continue to see the provider;
- The MCP must not assign new members to the provider until the site review is completed; and
- The MCP must complete the review within 30 days of notification of the move.

Medical Record Review

MCPs review medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services. The medical record provides legal proof that the patient received care. Incomplete records or lack of documentation implies the MCP's failure to provide care.

MCPs must review ten medical records using the most recent MRR Survey Tool at each provider site as part of the site review and every three years thereafter. During any MRR, reviewers must have the option to request additional records for review. If the MCP reviews additional records, the MCP must calculate the scores accordingly. Preventive care criteria cover pediatric, adult, and obstetric services. The medical record score is based on a survey standard of the ten randomly selected records per provider, consisting of five pediatric and five adult and/or obstetric records. For sites with only pediatric, only adult, or only obstetric patients, all ten records surveyed must be only in that preventive care area.

MCPs must review medical records of a new provider within 90 calendar days of the date the MCP first assigns members to a provider. An MCP may defer that review an additional 90 calendar days only if the new provider does not have enough assigned MCP members to complete a review of the ten medical records. At the end of six months, if the provider still has fewer than ten assigned member records, the MCP must complete an MRR on the total number of records available and adjust the scoring according to the number of records reviewed.

At PCP sites that document patient care performed by multiple PCPs in the same record, the MCP must consider these records a "shared" medical record system. The MCP must consider shared medical records those that are not identifiable as "separate" records belonging to any specific PCP. The MCP must review a minimum of ten records if two or three PCPs share records, 20 records if four to six PCPs share records, and 30 records if seven or more PCPs share records.

Scoring Facility Site Reviews and Medical Record Reviews

MCPs must base their survey scores on available documented evidence, demonstration of the criteria, and verbal interviews with site personnel. If an MCP chooses to audit additional criteria not included on the FSR or MRR Survey Tool, the MCP must not add the additional criteria to the existing scoring method. MCPs must not alter scored criteria or assigned weights in any way. Score calculations are based on the total survey points, or on the adjusted survey points for "not applicable" items.

The minimum passing score for the FSR and the MRR is 80 percent of the total points available. A PCP site may earn up to 150 points for a site review with the following compliance level categories:

- Exempted Pass: 90 percent or above, without deficiencies in Critical Elements, Pharmaceutical Services or Infection Control;

- Conditional Pass: 80-89 percent, or 90 percent or above with deficiencies in Critical Elements, Pharmaceutical Services, or Infection Control; and
- Not Pass: below 80 percent.

The MRR contains three general categories of Format, Documentation, and Coordination/Continuity of Care and three specific preventive categories of Pediatric Preventive, Adult Preventive, and Obstetrics (OB)/Comprehensive Perinatal Services Program (CPSP).

PCP sites may earn up to 23 points for the three general categories multiplied by the number of medical records reviewed, plus the points given for the preventive services categories, as follows:

- Pediatric Preventive: 19 points multiplied by the number of pediatric medical records reviewed;
- Adult Preventive: 15 points multiplied by the number of adult medical records reviewed; and
- OB/CPSP: 20 points multiplied by the number of OB/CPSP medical records reviewed.

PCP sites may earn a full point if the scored element meets the applicable criteria. MCPs must not award partial points for any scored element that the reviewer considers only "partially" met. PCP sites must earn zero points if an element does not meet the applicable criteria. The reviewer must determine the "not applicable" (N/A) status of each criterion based on a site-specific assessment. The reviewer must explain all criteria scored as zero points or assessed as N/A.

The MRR compliance levels are as follows:

- Exempted Pass: 90 percent or above;
- Conditional Pass: 80-89 percent; and
- Not Pass: below 80 percent.

For detailed scoring procedures, see the FSR Survey Tool and Guidelines (Attachment A) and the MRR Survey Tool and Guidelines (Attachment B).

If a site receives a non-passing score by one MCP, all other MCPs must consider the site as having a non-passing score. MCPs must use the local collaborative process to identify shared providers and to determine their methods for sharing survey information.

Critical Elements

Nine critical elements of the site review define the potential for adverse effects on patient health or safety and have a scored weight of two points. All other survey elements have a scored weight of one point. The PCP site must correct any critical element deficiency identified during a site review, focused survey, or monitoring visit within ten business days of the survey date and the MCP must verify the corrective

actions within 30 calendar days of the survey date. MCPs must ensure that sites that are found deficient in any critical element during a site review correct 100 percent of the survey deficiencies, regardless of the site's survey score. The nine critical elements are the following:

1) Exit doors and aisles are unobstructed and egress (escape) is accessible;
2) Airway management equipment, appropriate to practice and populations served, is present onsite;
3) Only qualified/trained personnel retrieve, prepare or administer medications;
4) Office practice procedures are utilized onsite 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 is readily available for staff use;
7) Needlestick safety precautions are practiced onsite;
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 each autoclave/steam sterilizer is completed (at least monthly), with documented results.

Corrective Action Plan

A CAP is required on all cited deficiencies for sites with a Conditional Pass score on the FSR or MRR Survey Tool, on a focused review or for deficiencies identified by the MCP, or State through oversight and monitoring activities. MCPs must require all provider sites that receive a Conditional Pass to develop a CAP to correct 100 percent of cited deficiencies.

MCPs must not require PCP sites that receive an Exempted Pass for FSR to complete a CAP unless the MCP determines that one is needed.

MCPs must not require provider sites that receive an Exempted Pass for an MRR to complete a CAP. A CAP is required for a total MRR score below 90 percent. Also, any section score of less than 80 percent requires a CAP for the entire MRR, regardless of the total MRR score.

MCPs must establish a process for treating providers who pass the site review at 80 percent or higher but fail to respond to a request for a CAP or fail to complete the corrective actions. MCPs must 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 timeline. If removed from the network, providers may file a formal appeal to the MCP.

New provider sites with a score of less than 80 percent are not eligible to participate in the Medi-Cal managed care program. At its discretion, an MCP may decide to provide additional training, give technical assistance or develop a CAP with non-passing pre-contract provider sites. Pre-contract providers who do not pass the survey may correct deficiencies, reapply to the MCP and be resurveyed. If the provider passes, the MCP will follow the procedures outlined for implementing corrective actions for all cited deficiencies.

The MCP conducting the site review is responsible for follow-up, resurvey and closure of the CAP.

The CAP documentation must identify:

- The specific deficiency;
- Corrective actions needed;
- Projected and actual dates of the deficiency correction;
- Reevaluation of timelines and dates; and
- Responsible persons.

The closed CAP must include:

- Documentation of problems in completing corrective actions (if any);
- Training and technical assistance provided by the MCP;
- Evidence of the corrections;
- Completion and closure dates; and
- Name and title of the MCP reviewer.

MCPs must follow the timeline below for CAP notification and completion:

I. Providers with a Conditional-Pass Score

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

B) Within ten business days of the survey date:

1) Providers must submit a completed CAP with verification for all critical elements or other survey deficiencies requiring immediate correction to the requesting MCP; and

2) MCPs must provide a survey findings report and a formal written request for corrections of all other deficiencies (i.e., noncritical, non-immediate) to providers.

C) Within 45 days of the survey date, MCPs must reevaluate and verify that PCP sites have corrected critical element deficiencies and other site review deficiencies that require immediate correction.

D) Within 45 calendar days from the date of the written CAP request:

1) Providers must submit a CAP for all deficiencies (other than critical) to the MCP; and

2) MCPs must review, revise or approve the CAP and timelines.

E) Within 90 calendar days from the date of a written CAP request:

1) Providers must complete all other corrective actions; and

2) MCPs must provide educational support and technical assistance as needed, reevaluate or verify corrections and close the CAP.

F) Beyond 90 calendar days of the date of a written CAP request:

1) Providers may request a definitive, time-specific extension period. The period is not to exceed 120 calendar days from the date of the survey findings report and CAP notification, unless a longer extension is approved by DHCS to complete corrections if extenuating circumstances that prevented completion of corrections can be clearly demonstrated and if agreed to by the MCP; and

2) MCPs must resurvey any provider site that required an extension period beyond 120 calendar days to complete corrections prior to closing the CAP in 12 months.

II. Non-Passing Pre-Contract Provider

An MCP must not consider a pre-contract provider who scores below 80 percent as a network provider. The MCP must resurvey the provider before it approves the non-passing provider as a network provider. After the pre-contract provider achieves a score of 80 percent or higher, the MCP must complete the CAP as specified under CAP timeline requirements.

III. Non-Passing Contracted Network Provider

When a network provider receives a non-passing score, the MCP must notify the provider of the score, all cited deficiencies and CAP requirements. MCPs may remove any provider with a non-passing score from their provider networks. However, if an MCP allows a provider with a non-passing score to remain in its provider network, the provider must correct deficiencies and the MCP must verify that the provider has corrected the deficiencies within the CAP timelines established in this policy. MCPs must not assign new members to network providers that score below 80 percent on a subsequent site review until the MCP has verified that the provider has corrected the deficiencies and the CAP is closed.

IV. Noncompliant Provider

MCPs must not assign new members to providers who do not correct survey deficiencies within the established CAP timelines until the MCP verifies that the provider has corrected the deficiencies and the CAP is closed. MCPs must remove

any provider from the network who does not come into compliance with survey criteria within the established timelines, and the MCP must appropriately reassign that provider's MCP patients to other network providers. MCPs must provide affected members with a 30-day notice that it will remove the noncompliant provider from the network.

In addition, provider sites that score below 80 percent in either the FSR or MRR for two consecutive reviews must score a minimum of 80 percent in the next site review in both the FSR and MRR (including sites with open CAPs in place). Sites that do not score a minimum of 80 percent in both the FSR and MRR despite the MCP's ongoing monitoring, must be removed from the network and MCP members must be appropriately reassigned to other network providers. MCPs must provide affected members with a 30-day notice that it will remove the noncompliant provider from the network.

V. Provider Appeal Process

Providers removed from an MCP's provider network must have the right to appeal the decision with the MCP. MCPs must have a formal and fair process to resolve grievances and complaints submitted by providers of medical services. If verified evidence of corrections is acceptable to the MCP and the MCP reverses its decision, the MCP must repeat the site review or the MCP may accept the current survey and CAP as completed and resurvey the PCP site in 12 months. If the MCP does not reverse its decision, then the provider may reapply through the MCP's application process. All provider applicants must undergo an initial site review and must be required to adhere to the requirements and standards established by this policy.

Monitoring

MCPs must systematically monitor all PCP sites between each regularly scheduled site review. Monitoring methods may include site reviews, but must also include additional methods such as information gathered through established internal MCP processes and provider and program-specific reports from external sources. When MCPs monitor PCP sites between audits, they must use both internal systems (e.g., quality improvement) and external sources of information (e.g., public health). MCPs must monitor and evaluate the nine critical elements on all PCP sites between site reviews. When MCPs identify problems through monitoring, they must determine the appropriate course of action, such as repeating the site review or conducting additional focused reviews, to investigate and correct these problems in a timely manner.

Focused Review

A focused review is a "targeted" audit of one or more specific areas of the FSR or MRR, and MCPs must not substitute a focused review for a site review. MCPs may use focused reviews to monitor providers between site reviews to investigate problems identified through monitoring activities or to follow up on corrective actions. Reviewers may use the appropriate sections of FSR and MRR Survey Tools for the focused review or other methods to investigate identified problems or situations. All deficiencies found

in a focused review must require the completion and verification of corrective actions according to CAP timelines established in this policy.

Local Collaboration

Pursuant to Health and Safety Code Section 1342.8, MCPs must 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 PCPs. All MCPs within a county have equal responsibility and accountability for participation in the local site review collaborative processes.

MCPs must submit an initial written description and periodic update reports (as requested by DHCS) to DHCS's Medical Monitoring Unit (MMU) describing the local collaboration processes, which include but are not limited to the following:

- Names and titles of participating personnel from each MCP;
- Work plan that includes goals, objectives, activities, and timelines;
- Scheduled meeting dates, times, and locations;
- Meeting processes and outcomes;
- Communication and information-sharing processes;
- Roles and responsibilities of each MCP;
- Delegated activities and use of delegated or subdelegated entities; and
- Memorandum of Agreement requirements established for MCPs and providers.

MCPs must establish policies and procedures to define local collaborative methodology for:

- 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

Each MCP's Medical Director and Chief Medical Officer are responsible for site review activities implemented by MCP personnel or contracted entities. Each MCP must retain responsibility for oversight of the site review whether the MCP retains its site review functions, delegates site review functions to another MCP or subcontracts site review functions to a third-party entity. MCPs must designate physicians or registered nurses (RN) as certified trainers responsible for training and supervising reviewers, certifying RN and physician reviewers, monitoring reviews and evaluating reviewers for reliability. Certified site review trainers may include personnel from subcontracted agencies.

MCPs must determine the composition of the teams performing site reviews. A variety of personnel may be part of the survey team, including pharmacists, dietitians and

others able to provide assistance and clarification. Each site review must have a certified reviewer (RN or physician) who must sign the FSR and/or MRR.

Reviewers must only examine site review criteria that are appropriate to their level of education, expertise, training, professional licensing and scopes of practice as determined by state law. MCPs must have written policies and procedures that clearly define the duties and responsibilities of all review personnel. MCPs must demonstrate that site review activities established for their reviewers comply with the reviewers' scope of practice as defined by state law, in accordance with the state licensing and certification agencies and are appropriate to the reviewers' education and training.

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 overlapping functions between physicians and RNs and permits the sharing of functions within organized health care systems that provide for collaboration between them (Business and Professions [B&P] Code Section 2725). 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.

The RN is the minimal level of reviewer acceptable for independently performing the site review. RN reviewers may independently make determinations regarding "direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients and the performance of disease prevention and restorative measures" (Title 16 CCR Section 1443.5). Additionally, RN reviewers may independently make determinations regarding implementation of appropriate reporting or referral of abnormal survey findings to initiate peer review procedures. An RN may only delegate tasks to a subordinate based on the subordinate's legal scope of practice and on the degree of preparation and ability required by the tasks the RN would delegate.

Licensed vocational nurses (LVN) must not be employed as independent practitioners. LVNs are described by the California 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." State law stipulates that the LVN must perform only manual skills under the direction of a licensed physician or licensed professional nurse and perform only basic data collection (B&P Code Section 2859). The performance of manual skills or basic data collection does not include evaluation, analysis, interpretation, or synthesis of survey information or data or of making determinations about the information or data that was collected. Although an LVN may collect basic explicitly defined data, he or she is not qualified to evaluate or analyze the data. Therefore, LVN reviewers must not independently review any facility site or medical record, but, as part of a survey team, may collect data on those survey elements that

DHCS and the California Board of Vocational Nursing and Psychiatric Technicians have identified as within the LVN scope of practice. Non-licensed, nonregistered, noncertified personnel and dependent licensed medical personnel may be members of a site review team as appropriate, but must not be employed as independent site reviewers.

Site Review Training and Certification

MCPs are responsible for ensuring that all reviewers conducting FSRs and MRRs are appropriately trained, monitored and evaluated. MCPs may collaborate to determine local systems for training and certifying reviewers. Training must include MMCD seminars, and may also include MCP classes, individual or small group training sessions provided by a certified site review trainer and self-study learning programs. MCPs must certify site review trainers and certify physicians and RNs as site reviewers and recertify them every three years thereafter.

Site Review Data Submission Procedures

MCPs must submit site review data to MMU's nurse evaluators every six months (due July 31 for the period January through June, and due January 31 for the period July through December). MCPs may submit data at their discretion more frequently than every six months. For preoperational and expansion site reviews, MCPs must submit site review data to MMU's nurse evaluators at least six weeks prior to site operation. MCPs must submit data in an approved Microsoft Excel format uploaded to a designated DHCS secure site. MMU will make available through its site review web portal an Excel database containing all necessary tables and data input forms for the mandatory biannual submission of FSR and MRR data. DHCS will reject site review data that MCPs submit in nonconforming formats.

Department of Health Care Services/Medi-Cal Managed Care Health Plan Responsibility

DHCS must collaborate with MCPs 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.

DHCS must oversee and monitor MCPs for implementation of the site review policy. Monitoring areas may include, but are not limited to, oversight of MCP methods for monitoring provider sites between 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 methods may include, but are not limited to, participating in local collaborative processes, observing reviewer training and certification processes, assessing data collection methods and evaluating aggregate reports.

As part of the DHCS's ongoing monitoring process, DHCS nurses conduct separate onsite site reviews of randomly chosen PCP sites to validate FSR and MRR processes

and to monitor MCP services. DHCS will provide MCPs with a written report of the DHCS-conducted review.

An MCP must, within 30 days from the report date of the DHCS-conducted site review, provide a CAP to DHCS responding to all cited deficiencies documented in the report. The MCP's CAP response must include:

- The deficiency;
- A description of action(s) taken to correct the deficiency; and
- The result of the action(s) taken.

If a deficiency is determined to require long-term corrective action, the MCP's CAP response must additionally include indication the MCP has:

- Initiated remedial action;
- Developed a plan to achieve an acceptable level of compliance; and
- Documented the date the provider is in full compliance or when full compliance will be achieved.

Additional supporting documentation and remedial action may be required if DHCS determines the CAP is insufficient to correct a deficiency.

When DHCS conducts a site review, DHCS notifies the affected MCP in advance. Each MCP must notify its providers in advance of site reviews whether the site review is conducted by DHCS or by the MCP. However, inspection of an MCP's facilities or other elements of a survey may be conducted **without prior notice**, in conjunction with the medical survey or as part of an unannounced inspection program (Title 28 CCR Section 1300.80).

If you have questions regarding this PL, please contact your assigned MMU nurse.

Sincerely,

Original Signed by Margaret Tatar

Margaret Tatar
Acting Deputy Director
Health Care Delivery Systems

Attachments

Site Review Guidelines

California Department of Health Care 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: 90% or above *without deficiencies* in Critical Elements, Pharmaceutical or Infection Control
2) Conditional Pass: 80-89%, or 90% and above with deficiencies in either Critical Elements, Pharmaceutical or Infection Control
3) Not Pass: below 80%

A corrective action plan (CAP) is required for a total score less than 90%, *OR* for a total score of 90% or above if there are deficiencies in Critical Elements, Pharmaceutical Services or Infection Control. Compliance rates are based on 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 CAPs, and establish follow-up/verification timeline.

1) Add the points given in each section.
2) Add points given for all six (6) sections to determine total points given for the site.
3) Subtract all "N/A" items from 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.

Example:
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.

$$\frac{\text{Points given}}{\text{150 or "adjusted" total}} \quad \text{or} \quad \frac{140}{145} = 0.97 \times 100 = \mathbf{97\%}$$

Criteria	I. 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. or reasonable accommodation) 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 wheel-chair 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.**

Criteria	I. 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 devices. 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.**

RN/MD Review only

Criteria	I. Access/Safety Reviewer Guidelines
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week.	• **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). There is a written procedure for providing immediate emergent medical care on site until the local EMS is on the scene. Although site proximity to emergency care facilities may be considered when evaluating medical emergency procedures, the key factor is the ability to provide immediate care to patients *on site* until the patient is stable or EMS has taken over care/treatment. When the MD or NPMP is not onsite, staff/MA may call 911, and CPR-certified staff may initiate CPR if needed. Non-CPR-certified staff may only call 911 and stay with the patient until help arrives. • **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), and appropriate State, County, City and local agencies (e.g., local poison control number). The 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. Health care personnel at the site must demonstrate that they can turn on the oxygen tank**.** • **Anaphylactic reaction management**: Severe allergic reaction can cause urticaria (hives), hypotension, bronchospasm, wheezing and pulmonary edema. Minimum equipment includes Epinephrine 1:1000 (injectable), and Benadryl 25 mg. (oral) or Benadryl 50 mg/ml (injectable), appropriate sizes of ESIP needles/syringes*and alcohol wipes. (*If the emergency kit or "crash cart" has only non-safety needles/syringes, score that deficiency in Section VI., Infection Control, criteria B.2. See Infection Control guidelines). There is a current medication administration reference (e.g. medication dosage chart) available for readily identifying the correct medication dosages (e.g. adult, pediatric, infant, etc.). Package inserts are not acceptable as dosage charts. **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

Criteria	I. 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 clean. • **Documentation**: There is documented evidence that standard operating procedures have been followed for routine inspection/ maintenance, calibration, repair of failure or malfunction, and testing and cleaning of all specialized equipment. Appropriate written records include calibration or other written logs, work orders, service receipts, dated inspection sticker, etc. All equipment used to measure or assess patient health status/condition is functioning properly. All specialized equipment (e.g., ultrasonography equipment, electrocardiogram (EKG) machine, defibrillator, audiometer, hemoglobin meter, glucometer, scales, etc.) are adequately maintained according to the specified manufacturer's guidelines for the equipment, or is serviced annually by a qualified technician. Blood pressure cuffs, monitors, and other related equipment need not be calibrated unless required by the manufacturer. Manufacturer guidelines must be available on site, indicating that it is not necessary to calibrate the equipment. Note: The term monitor includes, but not limited to, glucometers, EKG, BP monitors, hemacues, and audiometers.

Criteria	II. Personnel Reviewer Guidelines		
A. Professional health care personnel have current California licenses and certifications.	**Medical Professional**	**License/Certification**	**Issuing Agency**
	Certified Nurse Midwife (CNM)	RN License & Nurse-Midwife Certificate. DEA Registration, *if appropriate*	CA Board of Registered Nursing Drug Enforcement Administration (DEA)
	Certified Radiological Technologist (CRT)	CRT Certificate.	CDPH, Radiologic Health Branch
	Doctor of Osteopathy (DO)	Physician's & Surgeon's Certificate. DEA Registration	Osteopathic Medical Board of CA DEA
	Licensed Vocational Nurse (LVN):	LVN License.	CA Board of Vocational Nursing and Psychiatric Technicians
	Nurse Practitioner (NP)	RN License w/NP Certification & Furnishing Number. DEA Registration, *if appropriate*	CA Board of Registered Nursing DEA
	Pharmacist (Pharm. D)	Pharmacist License	CA State Board of Pharmacy
	Physician/Surgeon (MD)	Physician's & Surgeon's Certificate. DEA Registration	Medical Board of CA DEA
	Physicians' Assistant (PA)	PA License. DEA Registration, *if appropriate*	Physician Assistant Examining Committee/Medical Board of CA, DEA
	Radiological Technician	Limited Permit.	CDPH, Radiologic Health Branch
	Registered Dietitian (RD)	RD Registration Card.	Commission on Dietetic Registration
	Registered Nurse (RN)	RN License.	CA Board of Registered Nursing
	Note: All medical professional licenses and certifications must be current and issued from the appropriate agency for practice in California, and available on site. Although sites with centralized personnel departments are not required to keep documents or copies on site, copies and/or lists of currently certified or credentialed personnel must be readily available when requested by reviewers.		
	Note: Effective June 27, 2010, per CCR, Title 16, 1355.4, mandated by Business and Professions Code section 138, MDs (does not apply to Osteopaths) shall provide notification to each patient that states the MD(s) on site is licensed and regulated by the Board, and includes the following: NOTICE Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322 www.mbc.ca.gov.	**Note:** Effective August 11, 2011, per CCR, Title 16, 1399.547, mandated by Business and Professions Code section 138, PAs shall provide notification to each patient that states the PA(s) is licensed and regulated by the Physician Assistant Committee, and includes the following: NOTIFICATION TO CONSUMERS Physician Assistants are licensed and regulated by the Physician Assistant Committee (916) 561-8780 www.pac.ca.gov	
	The notice to consumers above shall be provided by one of the following methods: 1) prominently posted sign in an area visible to patients in at least 48-pt Arial font, 2) a written statement signed and dated by the patient (or patient's representative) and kept in the medical record, stating the patient understands that the MD is licensed and licensed and regulated by the board (for PA's, that the PA is licensed and regulated by the PA Committee), or 3) a statement on letterhead, discharge instructions or other document given to the patient (or patient's representative), where the notification is placed immediately above the signature line for the patient in a at least 14-pt font.		
B. Health care personnel are properly identified.	Health care personnel shall disclose, while working, their name and title on a name tag at least 18-point type. It is acceptable for health care personnel in a practice or an office, whose license is prominently displayed, to opt not to wear a nametag. 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 CA B&P 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.		

RN/MD Review only

Criteria	II. 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. **All medications including vaccines must be verified with (shown to) a 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. **MAs cannot administer anesthetics, including local anesthetic agents (such as Rocephin hydrated with Xylocaine).** 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

Criteria	II. Personnel Reviewer Guidelines
D. Scope of practice for non-physician medical practitioners (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

Criteria	II. 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, 4 physician's assistants, or 4 of the above individuals in any combination which does not exceed the limit stated. This ratio is based on each physician, not the number of offices. 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. Ref: Assembly Bill 3 Bass, Chapter 376, October 2007, effective January 1, 2008, allows 4 PAs to 1 MD; Business & Professions Code 3516(b); W & I Code 14132.966. Physician Assistant Committee is at: http://www.pac.ca.gov/ or the PAC office at 916-561-8780. • **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 oversee the activities of, and accept 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.

RN/MD Review only

Criteria	II. Personnel Reviewer Guidelines
F. Site personnel receive safety training/information.	• **Bloodborne Pathogens**: Site personnel treat all blood and other potentially infectious materials (OPIM) as if these *are* infectious. Site personnel who are reasonably anticipated to have eye, skin, mucous membranes and potential exposure to blood and/or 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 locat*e information on site and *how to use* information. **Note:** Health practitioners (e.g., physicians, surgeons, licensed nurses, licensed social workers, paramedics) in a health facility, (e.g., clinic, physician's office, public health clinic) are legally mandated reporters of known or reasonably suspected cases of child abuse, elder abuse and domestic violence. Legally mandated reporters must make telephone and written reports according to timeliness standards established by the designated local law enforcement agencies in each county. "Reasonably 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

Criteria	II. 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 (#B)

Criteria	III. 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 handles 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.

RN/MD Review only (#C)

Criteria	III. Office Management Reviewer Guidelines
C. Health care services are readily available.	The process established on site provides timely access to appointments for routine care, urgent care, prenatal care, pediatric periodic health assessments/immunizations, adult initial health assessments, specialty care and emergency care. 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. Systems, practices and procedures used for making services readily available to patients will vary from site to site. Missed and/or canceled appointments, and contact attempts must be documented in the patient's medical record. **Note:** Medi-Cal Managed Care Health Plans *require* the following timeliness standards for access to appointments: • Urgent Care: 48 hours • Access to the first Prenatal Visit: 10 business days • Non-urgent (Routine) Care: 10 business days
D. There is 24-hour access to interpreter services for non- or 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. **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. A request for or refusal of language/ interpreter services must be documented in the member's medical record.

RN/MD Review only (#E)

Criteria	III. Office Management Reviewer Guidelines
E. Procedures for timely 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 (#H)

Criteria	III. Office Management Reviewer Guidelines
G. Medical records are available for the practitioner at each scheduled patient encounter.	The process/system established on site provides for the availability of medical records (paper and electronic), including outpatient, inpatient, referral services, and significant telephone consultations for patient encounters. 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. Confidentiality of personal medical information is protected 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).

Criteria	IV. Clinical Services - Pharmaceutical 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, §4172). Keys to locked storage area are available only to staff authorized by the physician to have access (16 CCR, Chapter 2, Division 13, Section 1356.3). 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.

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Criteria	IV. Clinical Services - Pharmaceutical Reviewer Guidelines
B. Drugs are handled safely and stored appropriately.	• **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 are not affected (21 CFR, Section 211.142). Room temperature where drugs are stored does not exceed 30ºC (86ºF) (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. Diluent does not need refrigeration if vaccine is administered right after diluent is added. Vaccines are not stored in the doors of refrigerator or freezer. Refrigerator and freezer temperatures are documented at least once a day. Site personnel must be able to verbalize the procedure used to promptly respond to OUT OF RANGE TEMPERATURES. Contacting VFC or manufacturer are acceptable procedures. Refrigerator: Vaccines are kept in a refrigerator **maintained at 2-8ºC or 35-46ºF,** and include, but are not limited to, DTaP, Td, Tdap, Hepatitis A, Hepatitis B, IPV, Pneumococcal, Rotavirus, Hib, Influenza (inactivated and FluMist), MCV, HPV, Zoster, or any combinations of these listed vaccines. Freezer: Varicella and MMRV vaccines are stored in the **freezer at -15ºC or 5ºF, or lower,** and are protected from light at all times. MMR may be stored in a refrigerator or freezer; VFC recommends MMR be stored in the freezer with MMRV. If vaccines are in solid state and contain ice crystals on the outside of vial, they are considered appropriately frozen. • **Hazardous substances labeling**: Safety practices 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.

Criteria	IV. Clinical Services - Pharmaceutical 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 present and offer a copy of the most recent VIS to patients prior to any vaccine.* The date the VIS was given (or presented and offered) *and* the publication date of the VIS must be documented in the patient's medical record. The most current VIS are available from state and local health departments or can be downloaded from the CDC web site at http://www.cdc.gov/vaccines/pubs/vis/default.htm or by calling the CDC Immunization Hotline at (800) 232-2522. The Vaccines for Children (VFC) also contains current VIS and provider notifications at http://www.eziz.org/. *VIS published by CDC is to be provided to the patient/parent/guardian prior to administration of that vaccination. (42USC, 300aa-26(D)(2)). As of 2009, CDC allows providers to present a copy of the current VIS (such as a laminated copy in a binder, etc.) to the patient/parent/guardian and allow time for the patient to read and ask questions. Staff should also *offer* a copy each time (www.cdc.gov/vaccines/pubs/vis/vis-facts.htm). • **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.

Criteria	IV. Clinical Services – Laboratory Reviewer Guidelines
D. Site is compliant 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 or evidence of renewal should include the current site/clinic address. Note: Per 42 CFR, 493.35(b)(1-3), 493.43(b)(1-3) and 493.55(b)(1-3), laboratories must file a separate application for each laboratory location, with the following *exceptions*: 1) Laboratories that are not at a fixed location, that is, laboratories that move from testing site to testing site, such as mobile units providing laboratory testing, health screening fairs, or other temporary testing locations may be covered under the certificate of the designated primary site or home base, using its address, 2) Not-for-profit or Federal, State, or local government laboratories that engage in limited (not more than a combination of 15 moderately complex or waived tests per certificate) public health testing may file a single application, or 3) Laboratories within a hospital that are located at contiguous buildings on the same campus and under common direction may file a single application or multiple applications for laboratory sites within same physical location or street address. 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 are 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 Centers for Medicare & Medicaid Services (CMS). • **Waived tests**: If only waived tests are performed, site has a current CLIA Certificate of Waiver. There are no specific CLIA regulations regarding the performance of waived tests. Site personnel are expected to follow the test manufacturer's instructions. Laboratories with certificates of waiver may not be routinely inspected by DHCS Laboratory Field Services Division, but may be inspected as part of complaint investigations and on a random basis to determine whether only waived tests are being performed. • **Moderate and High complexity tests**: Tests not listed as waived are divided into one of two categories, moderate complexity or high complexity, based on the complexity of the testing procedure. CLIA regulations for these categories list specific requirements for laboratory proficiency testing, patient test management, quality control, quality assurance, personnel, and inspections. • **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 CDPH of personnel licenses/training, laboratory site inspection and demonstration of testing proficiency for moderate and high-complexity test sites. **Contact CDPH Laboratory Field Services (510) 620-3800 for CLIA certification, laboratory license, or personnel questions.**

Criteria	IV. Clinical Services - Radiology Reviewer Guidelines
E. Site meets CDPH Radiological inspection and safety regulations.	• **CDPH Radiologic Health Branch (RHB) 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 RHB. The Radiologic Inspection Report, issued by the RHB, 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 RHB. **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: Per RHB, dexascanners do not require lead aprons or gonadal shields, however, criteria 1-7 are still required. RHB uses the ALARA (As Low As Reasonably Achievable) principle, which is the foundation of all radiation safety programs. The ALARA principle means to minimize exposure to radiation doses by employing all *reasonable* methods. Dexascanner manufacturer guidelines do not require gonadal shielding or lead aprons because the amount of radiation is very low, and there is potential for the shield to obscure the area being scanned, which could render the scan non-diagnostic. Operators do not need aprons because the beam is extremely focused, so that the amount of exposure of even "scattered" beams to an operator sitting at a seat near the scanner is about the same level as that found in the natural environment. (A traditional x-ray machine used for bone density testing, that is not a dexascanner, *may* require shielding/apron.) **Note:** The Radiologic Health Branch of the Food, Drug, and Radiation Safety Division of the CA Department of Public Health enforces the Radiation Control Laws and Regulations designed to protect both the public and employees against radiation hazards. Enforcement is carried out through licensing, registration and periodic inspection of sources of radiation, such as radiation machines. For questions regarding radiologic safety (e.g. expired or no inspection letters on site), call CDPH Radiologic Health Branch at (916) 327-5106, or for general information at (916) 440-7888. For Radiation Emergency Assistance, call 1-800-*852*-7550. Ref: CCR, Title 17, Chapter 5, Subchapter 4 regulations at www.cdph.ca.gov/programs/Pages/RadiologicHealthBranch.aspx

Criteria	V. 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 90º 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 90º 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. • **Hearing testing:** Offices that provide pediatric preventive services should have an audiometer available since audiometric testing is required at preventive health visits starting at 3 years of age. PCP offices (such as Family Practitioners or General Practitioners) with less than 15% of their patients that are pediatric, and that refer all members to another provider for audiometric testing, must have a system in place that clearly demonstrates that the PCP office verifies that audiometric testing has been completed and that those results are returned to the PCP for review. **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.

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Criteria	V. 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 must be available in the appropriate threshold languages, and may be located in an accessible area on site (e.g., exam room, waiting room, health education room or area), or provided to members by clinic staff and/or by Plan upon request. 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 DHCS for each county.

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Criteria	VI. 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). Antimicrobial agents or alcohol-based antiseptic hand rubs are used for hand washing when indicated to remove debris and destroy transient microorganisms (e.g., before performing invasive procedures, after contact with potentially infectious materials). Plain and antiseptic hand wash products are properly maintained and/or dispensed to prevent contamination. • **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.

RN/MD Review only **VI . Infection Control Reviewer Guidelines – B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act.**

- **Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan.
- **Personal Protective Equipment (PPE):** PPE for protection against bloodborne pathogen hazards is available on site and includes: water repelling gloves; clothing barrier/gown; face/eye protection (e.g., goggles/face shield); and respiratory infection protection (e.g., mask). It 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 biohazard symbol with word "BIOHAZARD" *or* the words "Biohazardous Waste" label (fluorescent orange or red-orange with contrasting lettering/symbols) is part of, or affixed to, the container. Sharps containers are labeled with the words "Sharps Waste" or with the international biohazard symbol and the word "BIOHAZARD". Individual containers of blood or OPIM are exempted from warning labels if placed inside a labeled secondary container for storage, transport, or disposal. Alternative marking or color coding may be used to label contaminated laundry or specimen containers if the alternative marking permits employees on site to recognize that container requires compliance with Universal Precautions.
- **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, needles with Engineered Sharps Injury Protection (ESIP) devices, and non-needle sharps are used (incl. in emergency kits), unless exemptions have been approved by Cal/OSHA (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) is laundered by a commercial laundry service, or a washer and dryer on site. Contaminated laundry should not contain sharps, and when transported, should have the appropriate warning label (see Labels bullet above). Manufacturer's guidelines are followed to decontaminate and launder reusable protective clothing. Laundry requirements are "not applicable" if only disposable patient gowns and PPE are used on site.
- **Regulated Waste storage:** 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. Regulated waste is contained separately from other wastes (e.g., contaminated wastes)* *and* placed in red biohazardous bags with Biohazard label, and stored in a closed container that is not accessible to unauthorized persons. If stored outside the office, a lock secures the entry door, gate or receptacle lid, and posted warning sign(s) in English *and* Spanish are visible for 25-feet: "**CAUTION-BIOHAZARDOUS WASTE STORAGE AREA- UNAUTHORIZED PERSONS KEEP OUT" or "CUIDADO-ZONA DE RESIDUOUS-BIOLOGICOS PELIGOROS-PROHIBIDA LE ENTRADA A PERSONAS NO AUTHORIZADAS."** Signs prior to the passage of the Medical Waste Act are permitted for the "life" of the sign.
- **Medical Waste disposal:** Medical wastes are hauled to a permitted offsite medical waste treatment facility, transfer station, or other registered generator by a registered hazardous waste transporter *OR* person with an approved limited-quantity hauling exemption granted by the CDPH Division of Drinking Water and Environmental Management Branch. Limited-quantity hauling exemptions are renewed annually. A medical waste tracking document that includes the name of the person transporting, number of waste containers, types of medical wastes, and date of transportation, is kept a minimum of 3 years for large waste generators and 2 years for small generators. Medical Waste (including sharps) transported by mail are only acceptable through vendors on the approved CDPH Mail Back Service List at: www.cdph.ca.gov/certlic/medicalwaste/Documents/MedicalWaste/SharpsMailBackList.pdf .

Ref: CDPH Medical Waste Management Program: www.cdph.ca.gov/certlic/medicalwaste/Pages/Contact.aspx or www.cdph.ca.gov/certlic/medicalwaste/Pages/default.aspx.
The full CA Medical Waste Management Act (H&SC 117600-11836) is at www.cdph.ca.gov/certlic/medicalwaste/Documents/MedicalWaste/MedicalWasteManagementAct.pdf

***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 solid waste in regular trash receptacle.

RN/MD Review only

Criteria	VI. Infection Control Reviewer Guidelines
C. Contaminated surfaces are decontaminated according to Cal-OSHA 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 that is EPA registered, effective against TB, is changed/reconstituted ***every*** 24 hours (due to instability of bleach once mixed with water). Surface is cleaned prior to disinfecting (due to presence of organic matter (e.g., dirt, blood, excrement) inactivates active ingredient, sodium hypochlorite). Surface is air dried or allowed appropriate time (stated on label) before drying. Manufacturer's directions, *specific* to every bleach product, are followed carefully. **Note:** "Contamination" means the presence or reasonably anticipated presence of blood or OPIM on any item or surface. "Decontamination" is the use of appropriate physical or chemical means to remove, inactivate or destroy bloodborne pathogens so that a surface or item is no longer capable of transmitting infectious particles and is rendered safe for handling, use or disposal. Current EPA product lists and information is available from the EPA, Antimicrobial Division at (703) 305-1284, or at www.epa.gov/oppad001/chemregindex.htm.

RN/MD Review only

Criteria	VI. 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. Documentation of sterilization loads includes: date, time and duration of run cycle, temperature, steam pressure, and operator of each run. 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. Documentation of maintenance should include: mechanical problems, inspection dates, results/outcome of routine servicing, calibration, repairs, etc. Note: If the manufacturer's guidelines are not present on site, then the autoclave is serviced annually by a qualified technician. A dated sticker on the autoclave or a service receipt is acceptable documentation of appropriate maintenance. • **Spore testing**: Autoclave spore testing is performed *at least monthly*, unless otherwise stated in manufacturer's guidelines. Documentation of biological spore testing includes: date, results, types of spore test used, person performing/documenting test results. Written procedures for performing routine spore testing and for handling positive spore test results are available on site to staff. For positive spore tests, the autoclave is removed from service immediately until inspection is completed and a negative retest occurs. Procedures include: ***report*** problem, ***repair*** autoclave, ***retrieve*** all instruments sterilized since last negative spore test, ***re-test*** autoclave and ***re-sterilize*** retrieved instruments (**R**eport/**R**epair/**R**etrieve/**R**etest/**R**e-sterilize). **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. • **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, and 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.

Facility Site Review Survey

Attachment A

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

Health Plan_____ **IPA** _____**Site ID No.**_____ **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 _____ Periodic Full Scope _____ Follow-up _____ Focused Review _____ Ed/TA _____Other _____ (type)	_____ AAAHC _____ JCAHO _____ CHDP _____ NCQA _____ CPSP _____ None _____ Other _____	_____ Family Practice _____ Internal Medicine _____ Pediatrics _____ OB/GYN _____ General Practice _____ Specialist _____ Mid level (type) _____	_____ Primary Care _____ Community _____ Hospital _____ FQHC _____ Rural Health _____ Other _____ (type) _____ Solo _____ Group _____ Staff/Teaching

Site Scores

	Points Poss.	Yes Pts. Given	No's	N/A's	CE's
I. Access/Safety	**(29)**				
II. Personnel	**(22)**				
III. Office Management	**(25)**				
IV. Clinical Services	**(34)**				
V. Preventive Services	**(13)**				
VI. Infection Control	**(27)**				
	(150)				
	Total Pts. Poss.	**Yes Pts. Given**	**No's**	**N/A's**	**CE's**

Scoring Procedure

1) Add points given in each section.
2) Add total points given for all six sections.
3) Adjust score for "N/A" criteria (if needed), by subtracting N/A points from 150 total points poss.
4) Divide total points given by 150 or by "adjusted" total points.
5) Multiply by 100 to get the compliance (percent) rate.

_____ ÷ _____ = _____ X 100 = _____%
Points Given / **Total / Adjusted Points** / **Decimal Score** / **Compliance Rate**

Note: CE's column may be used for easy reference to see if there are Critical Elements that trigger a CAP.

Compliance Rate

_____ **Exempted Pass: 90% or above** (*without* deficiencies in Critical Elements, Pharmaceutical Services or Infection Control)

_____ **Conditional Pass: 80-89%, or 90% and above** *with* deficiencies in Critical Elements, Pharmaceutical Services or Infection Control

_____ **Not Pass: Below 80%**

_____ CAP Required

_____ Other follow-up

Next Review Due: _____

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I. Access/Safety (continued on next page)

Site Access/Safety Survey Criteria	Yes	No	N/A	Wt.	Site Score
A. Site is accessible and useable by individuals with physical disabilities. 24 CCR (CA Building Standards Code); 28 CFR §35 (American Disabilities Act of 1990, Title II, Title III) 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.

I. Access/Safety (continued on next page)

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.

I. Access/Safety (continued on next page)

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					
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), and Benadryl 25 mg. (oral) or Benadryl 50 mg./ml. (injectable), appropriate sizes of ESIP needles/syringes and 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.

I. Access/Safety (continued from previous page)

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 Code §111255; 28 CCR §1300.80; 21 CFR §800-1299					
1) Medical equipment is clean.	1)_____	1)_____	1)_____	1	
2) Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines.	2)_____	2)_____	2)_____	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **TOTALS**					

II. Personnel (continued on next page)

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, §2085**,** §2725, §2746, §2834, §3500, §4110; CCR, Title 16, §1355.4, §1399.547 1) All required Professional Licenses and Certifications, issued from the appropriate licensing/certification agency, are current. Notification is provided to each member that the MD(s) is licensed and regulated by the Medical Board, and that the Physician Assistant(s) is licensed and regulated by the Physician Assistant Committee.	**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.

II. Personnel (continued on next page)

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.

II. Personnel (continued on next page)

RN/MD Review only

Site Personnel Survey Criteria	Yes	No	N/A	Wt.	Site Score
D. Scope of practice for non-physician medical practitioners (NPMP) is clearly defined. 16 CCR §1379, §1399.540, §1399.545, §1474, CA B&P Code §2725.1					
1) Standardized Procedures provided for 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.

II. Personnel (continued on next page)

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. B&P Code 3516(b); W&I Code 14132.966					
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) 1:4 Physicians Assistants	**1)_____**	**1)_____**	**1)_____**	**1**	
2) The designated supervising or back-up physician is available in person or by electronic communication at all times when a NPMP is caring for patients.	**2)_____**	**2)_____**	**2)_____**	**1**	

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

II. Personnel (continued on next page)

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 (annually)	**1)_____**	**1)_____**	**1)_____**	**1**	
2) Blood Borne Pathogens Exposure Prevention (annually)	**2)_____**	**2)_____**	**2)_____**	**1**	
3) Biohazardous Waste handling (annually)	**3)_____**	**3)_____**	**3)_____**	**1**	
4) Child/Elder/Domestic Violence Abuse	**4)_____**	**4)_____**	**4)_____**	**1**	

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

II. Personnel (continued from previous page)

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**					

III. Office Management (continued on next page)

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.

III. Office Management (continued on next page)

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 process in place verifying follow-up on missed and canceled appointments.	3)_____	3)_____	3)_____	1	
D. There is 24-hour access to interpreter services for non- or limited-English proficient (LEP) members. 22 CCR §53851; 28 CCR 1300.67.04					
1) Interpreter services are made available in identified threshold languages specified for location of site.	1)_____	1)_____	1)_____	1	
2) Persons providing language interpreter services on site are trained in medical interpretation.	2)_____	2)_____	2)_____	1	

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

III. Office Management (continued on next page)

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 and §1300.80 Office practice procedures allow timely provision and tracking of: 1) Processing internal and external referrals, consultant reports and diagnostic test results 2) **Physician review and follow-up of referral/consultation reports and diagnostic test results**.	1)_____ 2)_____	1)_____ 2)_____	1)_____ 2)_____	1 2	
F. Member Grievance/Complaint processes are established on site. 22 CCR §53858, §56260 1) Phone number(s) for filing grievances/complaints are located on site. 2) Complaint forms and a copy of the grievance procedure(s) are available on site.	1)_____ 2)_____	1)_____ 2)_____	1)_____ 2)_____	1 1	

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

III. Office Management (continued from previous page)

RN/MD Review only (#H)

Office Management Survey Criteria	Yes	No	N/A	Wt.	Site Score
G. Medical records are available for the practitioner at each scheduled patient encounter. 22 CCR §75055; 28 CCR §1300.80					
1) Medical records are readily retrievable for scheduled patient encounters.	**1)**_____	**1)**_____	**1)**_____	**1**	
2) Medical documents are filed in a timely manner to ensure availability for patient encounters.	**2)**_____	**2)**_____	**2)**_____	**1**	
H. Confidentiality of personal medical information is protected according to State and federal guidelines. 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 7 years according to 22 CCR Section 75055.	**5)**_____	**5)**_____	**5)**_____	**1**	
Comments: Write comments for all "No" (0 points) and "N/A" scores.					
Totals					

IV. Clinical Services - Pharmaceutical (continued on next page)

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 §4172; 22 CCR §75037(a-g), §75039; 21 CFR §1301.75, §1301.76, §1302.22; 16 CCR §1356.3					
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.

IV. Clinical Services - Pharmaceutical (continued on next page)

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.

IV. Clinical Services - Pharmaceutical (continued from previous page)

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) Current 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.

IV. Clinical Services - Laboratory

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 (e.g. vacutainers, vacutainer tubes, culture swabs, test solutions) are inaccessible to unauthorized persons.	**3)_____**	**3)_____**	**3)_____**	**1**	
4) Lab test supplies are not expired.	**4)_____**	**4)_____**	**4)_____**	**1**	
5) Site has a procedure to check expiration date and a method to dispose of expired lab test supplies.	**5)_____**	**5)_____**	**5)_____**	**1**	

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

IV. Clinical Services - Radiology

Radiology Services Survey Criteria	Yes	No	N/A	Wt.	Site Score
E. Site meets CDPH 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 <u>posted</u> on site: 2) Current copy of Title 17 with a posted notice about availability of Title 17 and its location	**2)____**	**2)____**	**2)____**	**1**	
3) "Radiation Safety Operating Procedures" posted in highly visible location.	**3)____**	**3)____**	**3)____**	**1**	
4) "Notice to Employees Poster" posted in highly visible location.	**4)____**	**4)____**	**4)____**	**1**	
5) "Caution, X-ray" sign posted on or next to door of each room that has X-ray equipment	**5)____**	**5)____**	**5)____**	**1**	
6) Physician Supervisor/Operator certificate posted *and* within current expiration date	**6)____**	**6)____**	**6)____**	**1**	
7) Technologist certificate posted *and* within current expiration date	**7)____**	**7)____**	**7)____**	**1**	
The following radiological protective equipment is present on site: 8) Operator protection devices: radiological equipment operator must use lead apron or lead shield.	**8)____**	**8)____**	**8)____**	**1**	
9) Gonadal shield (0.5 mm or greater lead equivalent): for patient procedures in which gonads are in direct beam.	**9)____**	**9)____**	**9)____**	**1**	
Comments: Write comments for all "No" (0 points) and "N/A" scores.					

V. Preventive Services (continued on next page)

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) Thermometer with a numeric reading**.**	**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.

V. Preventive Services (continued from previous page)

RN/MD Review only

Health Education Survey Criteria	Yes	No	N/A	Wt.	Site Score
B. Health education services are available to Plan members. 22 CCR §53851; 28 CCR 1300.67					
Health education materials and Plan-specific resource information are: 1) readily accessible on site, or are made available upon request,	**1)____**	**1)____**	**1)____**	**1**	
2) applicable to the practice and population served on site,	**2)____**	**2)____**	**2)____**	**1**	
3) available in threshold languages identified for county and/or area of site location.	**3)____**	**3)____**	**3)____**	**1**	
Comments: Write comments for all "No" (0 points) and "N/A" scores.					
Totals					

VI. Infection Control (continued on next page)

RN/MD Review only

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.

VI. Infection Control (continued on next page)

RN/MD Review only

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 by a commercial laundry service.	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.

VI. Infection Control (continued on next page)

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.

VI. Infection Control (continued from previous page)

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					
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					

Medical Record Review Guidelines

California Department of Health Care 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 be 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 primary care physician (PCP). Documented evidence found in the hard copy (paper) medical records and/or electronic medical records, including immunization registries, are used for survey criteria determinations. An Exempted Pass is 90%. Conditional Pass is 80-89%. Not Pass is below 80%. The minimum passing score is 80%. A corrective action plan (CAP) is required for a total MRR score below 90%. Also, any section score of less than 80% requires a CAP for the entire MRR, regardless of the total MRR score. Not applicable ("N/A") applies to any criterion that does not apply to the medical record being reviewed, and must be explained in the comment section. Medical records shall be randomly selected using methodology decided upon by the reviewer. Ten (10) medical records are surveyed for each PCP, 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 are 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 PCP. If 20 records are reviewed, divide total points given by the "adjusted" total points possible. If 30 records are reviewed, divide total points given by the "adjusted" total points possible. Multiply by 100 to calculate percentage rate. Reviewers have the option to request additional records to review, but must calculate scores accordingly. 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.

(Format points given)
(Documentation points given)
(Coordination/Continuity-of-care points given)
(Pediatric Preventive points given)
(Adult Preventive points given)
+ (OB/CPSP Preventive points given)
= (Total points given)

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

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

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

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

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

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

Criteria	I. Format Reviewer Guidelines
A. An individual medical record is established for each member.	Practitioners are able to readily identify each individual treated. A medical record is started upon the initial visit. "Family charts" are not acceptable.
B. Member identification is on each page.	Member identification includes first and last name, and/or a unique identifier established for use on clinical site. Electronically maintained records and printed records from electronic systems must contain member 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) /legal guardian if member is a minor. If member refused to provide information, "refused" is documented in the medical record. Do not deduct points if member has refused to provide all personal information requested by the practitioner.
D. Emergency "contact" is identified.	The name and phone number of an "emergency contact" person is identified for all members. Listed emergency contacts may include a spouse, relative or friend, and must include at least one of the following: home, work, pager, cellular or message phone number. If the member is a minor, the primary (first) emergency contact person must be a parent or legal guardian and then other persons may be listed as additional emergency contacts. Adults and emancipated minors may list anyone of their choosing. If a member refuses to provide an emergency contact, "refused" is noted in the record. Do not deduct points if member has refused to provide personal information requested by the practitioner.
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. Member'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 member has selected health care from a non-physician medical practitioner. Since various methods are used to identify the assigned PCP, reviewers must identify specific method(s) used at each individual site such as Health Plan ID Card, practitioner stamp, etc.
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 member are documented. Member refusal of interpreter services is documented. The PCP and/or appropriate clinic staff member who speak the member's language fluently can be considered a qualified interpreter. Family or friends should not be used as interpreters, unless specifically requested by the member. Language documentation is not necessary "N/A," if English is the primary language, however, if "English" *is documented,* the point may be given. **Note:** Title VI of the Civil Rights Act of 1964 prohibits recipients of federal funds from providing services to LEP persons that are limited in scope or lower in quality than those provided to others. Since Medi-Cal is partially funded by federal funds, ***all*** Plans with Medi-Cal LEP members must ensure that these members have equal access to all health care services (MMCD Policy Letter 99-03).

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

Criteria	II. Documentation Reviewer Guidelines
A. Allergies are prominently noted.	Allergies and adverse reactions are listed in a prominent, easily identified and consistent location in the medical record. If member has no allergies or adverse reactions, "No Known Allergies" (NKA), "No known Drug Allergies" (NKDA), or ∅ is documented.
B. Chronic problems and/or significant conditions are listed.	Documentation may be on a separate "problem list," or a clearly identifiable problem list in the progress notes. All chronic or significant problems are considered current if no "end date" is documented. **Note:** Chronic conditions are current long-term, on-going conditions with slow or little progress.
C. Current *continuous* medications are listed.	Documentation may be on a separate "medication list," or a clearly identifiable medication list in the progress notes. List of current, on-going medications identifies the medication name, strength, dosage, route (if other than oral), and frequency. Discontinued medications are noted on the medication list or in progress notes.
D. Signed Informed Consents are present when any invasive procedure is performed.	Adults, parents/legal guardians of a minor or emancipated minors may sign consent forms for operative and invasive procedures.* Persons under 18 years of age are emancipated if they have entered into a valid marriage, are on military active duty, or have received a court declaration of emancipation under the CA Family Code, Section 7122. Note: Human sterilization requires DHCS Consent Form PM 330. * An invasive procedure is a medical procedure that invades (enters) the body, usually by cutting or puncturing the skin or by inserting instruments into the body. Very minor procedures such as drawing blood testing, umbilical cord blood donations and a few other very specific tests are not considered invasive and do not require a consent. Consent is implied by entering the provider's office or lab and allowing blood to be drawn. Ref: National Institutes of Health; American Cancer Society. Note: Written consent for HIV testing is no longer required (AB 682) 2007.
E. Advance Health Care Directive information is offered. (Adults 18 years or age or older; Emancipated minors)	Adult medical records include documentation of whether the member has been offered information or has executed an Advance Health Care Directive (California Probate Code, Sections 4701).
F. All entries are signed, dated and legible.	**Signature:** includes the first initial, last name and title of health care personnel providing care, including Medical Assistants. 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, meaning the stamped signature can be verified, validated, confirmed, and is countersigned or initialed. Note: In electronic records (EMR), methods to document signatures (and/or authenticate initials) will vary, and must be individually evaluated. Reviewers should assess the log-in process and may need to request print-outs of entries. **Date:** includes the month/day/year. Only standard abbreviations are used. Entries are in reasonably consecutive order by date. Handwritten documentation does not contain skipped lines or empty spaces where information can be added. Entries are not backdated or inserted into spaces above previous entries. Omissions are charted as a new entry. Late entries are explained in the medical record, signed and dated. **Legibility:** means the record entry is readable by a person other than the writer. Handwritten documentation, signatures and initials are entered in ink that can be readily/clearly copied.
G. Errors are corrected according to legal medical documentation standards.	The person that makes the documentation error corrects the error. One correction method is (single line drawn through the error, with the writer's initial and date written above or near the lined-through entry). Similar variations such as (single line and initial) are also used. The corrected information is written as a separate entry and includes date of the entry, signature (or initials), and title. There are no unexplained cross-outs, erased entries or use of correction fluid. Both the original entry and corrected entry are clearly preserved. Note: Reviewers must determine the method used for error corrections for EMR on a case by case basis. This should include the log-in process and whether the EMR allows for corrections to be made after entries are made.

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

Criteria	III. 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 member/parent. The documented "Objective" information (such as assessment, findings and conclusion) relate to the working diagnoses. **Note:** For scoring purposes, reviewers shall ***not make determinations*** about the "*rightfulness or wrongfulness*" of documented information, but shall initiate the peer review process 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 the practitioner follows up with members about treatment regimens, recommendations, and counseling.
F. There is evidence of practitioner *review* of consult/referral reports and diagnostic test results.	There is documented evidence of practitioner review of records such as diagnostic studies, lab tests, X-ray reports, consultation summaries, inpatient/discharge records, emergency and urgent care reports, and all abnormal and/or "STAT" reports. Evidence of review may include the practitioner's initials or signature on the report, notation in the progress notes, or other site-specific method of documenting practitioner review. Note: Electronically maintained medical reports must also show evidence of practitioner review, and may differ from site to site.
G. There is evidence of *follow-up* of specialty referrals made, and results/reports of diagnostic tests, when appropriate.	Consultation reports and diagnostic test results are documented for ordered requests. Abnormal test results/diagnostic reports have explicit notation in the medical record, including attempts to contact the member/guardian, follow-up treatment, instructions, return office visits, referrals and/or other pertinent information. Missed/broken appointments for diagnostic procedures, lab tests, specialty appointments and/or other referrals are noted, and include attempts to contact the member/parent and results of follow-up actions.
H. Missed primary care appointments and outreach efforts/follow-up contacts are documented.	Documentation includes incidents of missed/broken appointments, cancellations or "No shows" with the PCP office. Attempts to contact the member or parent/guardian and the results of follow-up actions are documented.

Rationale: Pediatric preventive services are provided in accordance with current AAP periodicity, and include CHDP assessments. **RN/MD Review only**

Criteria	IV. Pediatric Preventive Reviewer Guidelines (continued on next page)
A. Initial Health Assessment (IHA) IHA includes H&P and IHEBA	The IHA (H&P and IHEBA) enables the PCP to assess current acute, chronic and preventive needs *and* to identify those Members whose health needs require coordinated services with appropriate community resources/other agencies not covered by the Plan.
1. History and physical (H&P)	**New members**: An H&P is completed within 120 days of the effective date of enrollment into the Plan, or documented within the 12 months prior to Plan enrollment. The H&P is sufficiently comprehensive to assess and diagnose acute and chronic conditions, which may include: history of present illness, past medical and social history, and review of organ systems. If an H&P is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented.
2. Individual Health Education Behavioral Assessment (IHEBA)	**New members**: An age-appropriate IHEBA ("Staying Healthy" or other DHCS-approved tool) is completed by the member or parent/guardian within 120 days of the effective date of enrollment into the Plan, or within the 12 months prior to Plan enrollment. Staff may assist. The IHEBA has evidence of practitioner review such as signature/initials, and dates and intervention codes, which may be documented on the IHEBA form, in progress notes, or other areas of the paper or electronic medical record system. If an initial IHEBA is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented.
B. Subsequent Periodic IHEBA	An age-appropriate IHEBA is re-administered when the member has reached the next specific age interval designated by MMCD. Documentation requirements are the same as the initial IHEBA.
C. Well-Child Visit	
1. Well-child exam completed at age appropriate frequency	Health assessments containing CHDP age-appropriate content requirements are provided according to the most recent AAP periodicity schedule for pediatric preventive health care. 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. **Note**: Where the AAP periodicity exam schedule is more frequent than the CHDP periodicity examination schedule, the AAP scheduled visit must include all assessment components required by the CHDP program for the lower age nearest to the current age of the child.
2. Anthropometric measurements	Height and weight are documented at each well-child exam. Include head circumference for infants up to 24 months.
3. BMI Percentile	BMI percentile is plotted on an appropriate CDC growth chart for each well-child exam ages 2-20 years. Note: The BMI percentile calculation is based on the CDC's BMI-for-age- growth charts, which indicates the relative position of the patient's BMI number among others of the same sex and age. Ref: www.cdc.gov/nccdphp/dnpa/bmi/index.htm
4. Developmental screening	Developmental surveillance at each visit and screening for developmental disorders at the 9th, 18th and 30th month visits. Children identified with potential delays require further assessment and/or referral. (Ref: AAP and CHDP periodicity schedules)
5. Anticipatory guidance	Includes age appropriate counseling/health education provided to parent or pediatric member.
6. STI screening on all sexually active adolescents, incl. chlamydia for females	All sexually active adolescents should be screened for sexually transmitted infections (STIs), including chlamydia for females.
7. Pap smear on sexually active females	Pap smear within 3 years of onset of sexual intercourse.
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.

Criteria	IV. Pediatric Preventive Reviewer Guidelines RN/MD Review only (continued from previous page)
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 -20) is done at each health assessment visit and includes follow-up care as appropriate. A failed audiometric screening is followed up with a repeat screening at least two weeks and no later than 6 weeks after the initial screening. If the second screening also fails, there is a referral to a specialist.
F. Nutrition Assessment	Screening includes: 1) height and weight, 2) hematocrit or hemoglobin to screen for anemia starting at 9-12 months, and 3) breastfeeding and infant feeding status, food/nutrient intake and eating habits (including evaluation of problems/conditions/needs of the breastfeeding mother). 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.
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 3 years of age, all children are referred annually to a dentist regardless of whether a dental problem is detected or suspected.
H. Blood Lead Screening Test	Children receiving health services through Medi-Cal Managed Care Plans must have blood lead level (BLL) testing as follows: 1) at 12 month *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, *and* 3) between 24 months and 72 months of age *if* there is no documented evidence of BLL testing at 24 months or thereafter. Elevated BLL of 10 µg/dL or greater require additional BLL and follow-up in accordance with current DHCS policy or as follows: • 10-14 µg/dL: Confirm with venous sample within 3 months of original test; • 15-19 µg/dL: Confirm with venous sample within 2 months of original test, then retest 2 months following the confirmatory testing; • 20-44 µg/dL: Confirm with venous sample in 1 week to 1 month, depending on severity of BLL; • 45-59 µg/dL: Retest with venous sample within 48 hour; • 60-69 µg/dL: Retest with venous sample within 24 hours; • ≥ 70 µg/dL: EMERGENCY. Retest immediately with venous sample. Children with elevated BLLs are referred to the 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 assessed for risk of exposure to tuberculosis (TB) at each health assessment. The Mantoux skin test, or other approved TB infection screening test,* is administered to children *identified at risk*, if there has not been a test in the previous year. The Mantoux is not given if a previously positive Mantoux is documented. Documentation of a positive test includes follow-up care (e.g. further medical evaluation, chest x-ray, diagnostic laboratory studies and/or referral to specialist). Practitioners are required to follow current CDC and American Thoracic Society guidelines for TB diagnosis and treatment. *Per June 25, 2010 CDC MMWR, FDA approved IGRA serum TB tests, i.e., QuantiFERON®-TB Gold (QFT-G and QFT-GIT) and T-SPOT®.TB (T-Spot). The Mantoux is preferred over IGRA for children under 5 years of age. Ref: www.cdc.gov/tb/publications/factsheets/testingIGRA.htm
J. Childhood Immunizations	
1. Given according to ACIP guidelines	Immunization status is assessed at each health assessment visit. Practitioners are required to ensure the provision of immunizations according to CDC's most recent Advisory Committee on Immunization Practices (ACIP) guidelines, unless medically contraindicated or refused by the parent.
2. Vaccine administration documentation	The name, manufacturer, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries.
3. Vaccine Information Statement (VIS) documentation	The date the VIS was given (or presented and offered) *and* the VIS publication date are documented in the medical record.

Rationale: Current 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	V. Adult Preventive Reviewer Guidelines (continued on next page)
A. Initial Health Assessment (IHA) Includes H&P and IHEBA	The IHA (H&P and IHEBA) enables the PCP to assess current acute, chronic and preventive needs *and* identify those Members whose health needs require coordinated services with appropriate community resources/other agencies not covered by the Plan.
1. History and physical (H&P)	**New members**: An H&P is completed within 120 days of the effective date of enrollment into the Plan, or documented within the 12 months prior to Plan enrollment. The H&P is sufficiently comprehensive to assess and diagnose acute and chronic conditions, which may include: history of present illness, past medical and social history, and review of organ systems. If an H&P is not found in the medical record, the reasons (e.g., member's refusal, missed appointment) and contact attempts to reschedule are documented.
2. Individual Health Education Behavioral Assessment (IHEBA)	**New members**: An age-appropriate IHEBA ("Staying Healthy" or other DHCS-approved tool) is completed by the member within 120 days of the effective date of enrollment into the Plan, or within the 12 months prior to Plan enrollment. Staff may assist. The IHEBA has evidence of practitioner review such as signature/initials, and dates and intervention codes, which may be documented on the IHEBA form, in progress notes, or other areas of the paper or electronic medical record system. If an initial IHEBA is not found in the medical record, the reasons (e.g., member's refusal, missed appointment) and contact attempts to reschedule are documented.
B. Subsequent Periodic IHEBA	An age-appropriate IHEBA is re-administered when the member has reached the next specific age interval designated by MMCD. Documentation requirements are the same as the initial IHEBA.
C. Periodic Health Evaluation according to most recent USPSTF Guidelines.	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. In addition to USPSTF recommendations, periodic health evaluations are scheduled as indicated by the member's needs and according to the clinical judgment of the practitioner. Example: A patient with elevated cholesterol levels and other risk factors for coronary heart disease (CHD) may be evaluated more frequently than other persons of the same age without similar risk factors.
D. High Blood Pressure Screening	All adults 18 years and older including those without known hypertension are screened. A blood pressure (B/P) measurement for the normotensive adult is documented at least once every 2 years if the last systolic reading was below 120 mmHg and the diastolic reading was below 80 mmHg. B/P is measured annually if the last systolic reading was 120 to 139 mmHg and the diastolic reading was 80 to 89 mmHg. USPSTF link for high blood pressure screening: http://www.uspreventiveservicestaskforce.org/uspstf07/hbp/hbprs.htm
E. Obesity Screening	Includes weight and body mass index (BMI).
F. Lipid Disorders Screening	All men (ages 35 years and older) are screened. Women (ages 45 years and older) are screened if at increased risk for coronary heart disease. Screening includes measurement of total cholesterol (TC) and high-density lipoprotein cholesterol (HDL-C). **Note:** Men under 35 years and women under 45 year may also be screened for lipid disorders if at increased risk for coronary artery disease. USPSTF link for lipid disorder screening: http://www.uspreventiveservicestaskforce.org/uspstf/uspschol.htm

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

Criteria	V. Adult Preventive Reviewer Guidelines (continued from previous page)
G. Tuberculosis Screening	Adults are screened for tuberculosis (TB) risk factors upon enrollment and at periodic physical evaluations. The Mantoux skin test, or other approved TB infection screening test,* is administered to **all** asymptomatic persons at increased risk of developing TB irrespective of age or periodicity if they had not had a test in the previous year. Adults already known to have HIV or who are significantly immunosuppressed require annual TB testing.** The Mantoux is not given if a previously positive Mantoux is documented. Documentation of a positive test includes follow-up care (e.g. further medical evaluation, chest x-ray, diagnostic laboratory studies and/or referral to specialist). Practitioners are required to follow current CDC and American Thoracic Society guidelines for TB diagnosis and .treatment. * Per June 25, 2010 CDC MMWR, the FDA approved IGRA serum TB tests, such as QuantiFERON®-TB Gold (QFT-G and QFT-GIT) and T-SPOT®.TB (T-Spot). Ref: www.cdc.gov/tb/publications/factsheets/testingIGRA.htm ** Per CTCA/CDPH: www.ctca.org/guidelines/IIA2targetedskintesting.pdf
H. Breast Cancer Screening	A routine screening mammography for breast cancer is completed every 1-2 years on all women starting at age 50, concluding at age 75 unless pathology has been demonstrated. USPSTF link: http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrca.htm
I. Cervical Cancer Screening	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 within 3 years of onset of sexual activity or age 21 (whichever comes first) 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 invasive cancer, 2) women after age 65 who have had regular previous screening in which the smears have been consistently normal. USPSTF link for cervical cancer screening: http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm
J. Chlamydia Infection Screening	Women who are sexually active are screened from the time they become sexually active until they are 25 years of age. Practitioner may screen women older than 25 years of age if the practitioner determines that the patient is at risk for infection. Lab results are documented.
K. Colorectal Cancer Screening	All adults are screened for colorectal cancer beginning at age 50 years and continuing until age 75 years to include: 1. Annual screening with high-sensitivity fecal occult blood testing, **or** 2. Sigmoidoscopy every 5 years with high sensitivity fecal occult blood testing every 3 years, **or** 3. Screening colonoscopy every 10 years. USPSTF link for colorectal cancer screening: http://www.uspreventiveservicestaskforce.org/uspstf/uspscolo.htm
L. Adult Immunizations	
1. Given according to ACIP guidelines	Immunization status is assessed at periodic health evaluations. Practitioners are required to ensure the provision of immunizations according to CDC's most recent Advisory Committee on Immunization Practices (ACIP) guidelines, unless medically contraindicated or refused by the member.
2. Vaccine administration documentation	The name, manufacturer, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries.
3. Vaccine Information Statement (VIS) documentation	The date the VIS was given (or presented and offered) *and* the VIS publication date are documented in the medical record.

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

Criteria	VI. OB/CPSP Preventive Reviewer Guidelines (continued on next page)
A. Initial Comprehensive Assessment (ICA)	**Note: Item A.1 assesses the timeframe of a completed ICA. Items A2-9 assess the individual components of the ICA, and can receive a "yes" score - *apart from the timeframe*.**
1. ICA completed within 4 weeks of entry to prenatal care	The ICA was completed within 4 weeks of entry to prenatal care.
2. Obstetrical and Medical History	Obstetric/medical: Health and obstetrical history (past/current), LMP, EDD.
3. Physical Exam	Physical exam: includes breast and pelvic exam.
4. Lab tests	Lab tests: hemoglobin/hematocrit, urinalysis, urine culture, ABO blood group, Rh type, rubella antibody titer, STI screen.
5. Nutrition	Nutrition: Anthropometric (height/weight), dietary evaluation, prenatal vitamin/mineral supplementation.
6. Psychosocial	Psychosocial: Social and mental health history (past/current), substance use/abuse, support systems/resources.
7. Health Education	Health education: Language and education needs.
8. Screening for Hepatitis B Virus	All pregnant women are screened for Hepatitis B during their first trimester or prenatal visit, whichever comes first.
9. Screening for Chlamydia Infection	All pregnant women ages 25 and younger, and older pregnant women who are at increased risk, are screened for chlamydia during their first prenatal visit.
B. Second Trimester Comprehensive Re-assessment	Subsequent comprehensive prenatal re-assessments include Obstetric/medical, Nutrition, Psychosocial and Health Education re-assessments are completed during the 2nd trimester.
C. Third Trimester Comprehensive Re-assessment	Subsequent comprehensive prenatal re-assessments include Obstetric/medical, Nutrition, Psychosocial and Health Education re-assessments are completed during the 3rd trimester.
1. Screening for Strep B	All pregnant women are screened for Group B Streptococcus between their 35th and 37th week of pregnancy.
D. Prenatal care visit periodicity according to most recent ACOG standards	ACOG's *Guidelines for Perinatal Care* recommend the following prenatal schedule for a 40-week uncomplicated pregnancy: • 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 member and/or outreach activities.

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

Criteria	VI. OB/CPSP Preventive Reviewer Guidelines (continued from previous page)
E. Individualized Care Plan (ICP)	ICP documentation includes specific obstetric, nutrition, psychosocial and health education risk problems/conditions, interventions, and referrals.
F. Referral to WIC and assessment of Infant Feeding status	Pregnant and breastfeeding 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 431.635). 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.
G. HIV-related services *offered*	The ***offering*** of prenatal HIV information, counseling and HIV antibody testing is documented (CA Health & Safety Code, Section 125107). Practitioners are ***not required*** to document that the HIV test was given or disclose (except to the member) the results (positive or negative) of an HIV test. Offering a prenatal HIV test is not required if a positive HIV test is already documented in the patient's record or if the patient has AIDS diagnosed by a physician. **Note:** Member's participation is voluntary. Practitioner may provide HIV test or refer to other testing program/site. Documentation or disclosure of HIV related information must be in accordance with confidentiality and informed consent regulations.
H. 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 CDPH Expanded AFP Program, and only laboratories designated by CDPH may be used for testing.
I. 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).
J. Family Planning Evaluation	Family Planning counseling, referral or provision of services is documented (MMCD Policy Letter 98-11).
K. Postpartum Comprehensive Assessment	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 member and/or outreach activities. Infant feeding/breastfeeding status is documented during the postpartum period (MMCD Policy Letter 98-10).

Attachment B

Medical Record Review Survey

California Department of Health Care Services
Medi-Cal Managed Care

No. of Physicians _____

Health Plan_____ IPA _____Site No._____ Review Date _____ No. of Records_____

Provider _____ Phone _____ Fax _____

Address_____ Contact person/title _____

City/Zip Code_____ 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 _____	_____ Mid-level (type)_____	_____ Solo _____ Group _____ Staff/Teaching

Scoring Procedure

Note: Score only one Preventive section (Pediatric, Adult or OB/CPSP) per record. When scoring for OB/CPSP Preventive, do not score the Adult or Pediatric Preventive for that same record**.**

	Points possible	Yes Pts. Given	No's	N/A's	Section Score %
I. Format	**(8) x 10 = 80**				
II. Documentation	**(7) x 10 = 70**				
III. Continuity/Coordination	**(8) x 10 = 80**				
IV. Pediatric Preventive	**(19) x # of records**				
V. Adult Preventive	**(15) x # of records**				
VI. OB/CPSP Preventive	**(20) x # of records**				
	Total Points Possible	**Yes Pts. Given**	**No's**	**N/A's**	

Medical Record Scores

Scoring is based on **10** medical records.

1) Add points given in each section.
2) Add points given for all six (6) sections.
3) Subtract "N/A" points (if any) from total points possible to get "adjusted" total points possible.
4) Divide total points given by "adjusted" total points possible.
5) Multiply by 100 to determine compliance rate as a percentage.

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

Note: Since Preventive Criteria have different points possible per type (Ped-19, Adult-15, OB/CPSP-20), the total points possible will differ from site to site, depending on the number of *types* of records that are selected. The "NO" column *may* be used to help double-check math. The far right Section Score % column may be used to determine if section is <80%.

Compliance Rate

Note: Any section score of < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

___**Exempted Pass: 90% or above:** (Total score is ≥ 90% *and* all section scores are 80% or above)

__ **Conditional Pass: 80-89%:** (Total MRR is 80-89% *OR* *any* section(s) score is < 80%)

__**Not Pass: Below 80%**

__CAP Required

__Other follow-up

Next Review Due: _____

Blank Page (for numbering purposes)

I. Format Criteria

Note: A Format section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**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. Member'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**											
	Yes											
Comments:	No											
	N/A											
	8 **Pts. Possible**											

II. Documentation Criteria

Note: A Documentation section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Allergies are prominently noted.	**1**											
B. Chronic problems and/or significant conditions are listed.	**1**											
C. Current *continuous* medications are listed.	**1**											
D. Signed Informed Consents are present when any invasive procedure is performed.	**1**											
E. Advance Health Care Directive information is offered. (Adults 18 years of age or older; Emancipated minors)	**1**											
F. All entries are signed, dated and legible.	**1**											
G. Errors are corrected according to legal medical documentation standards.	**1**											
	Yes											
Comments:	No											
	N/A											
	7 **Pts. Possible**											

III. Coordination/Continuity of Care Criteria

Note: A Coordination/Continuity section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. History of present illness is documented.	**1**											
B. Working diagnoses are consistent with findings.	**1**											
C. Treatment plans are consistent with diagnoses.	**1**											
D. Instruction for follow-up care is documented.	**1**											
E. Unresolved/continuing problems are addressed in subsequent visit(s).	**1**											
F. There is evidence of practitioner *review* of consult/referral reports and diagnostic test results.	**1**											
G. There is evidence of *follow-up* of specialty referrals made, and results/reports of diagnostic tests, when appropriate	**1**											
H. Missed primary care appointments and outreach efforts/follow-up contacts are documented.	**1**											
	Yes											
	No											
	N/A											

Comments:

8
Pts. Possible

IV. Pediatric Preventive Criteria (continued on next page)

Note: A Pediatric Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only Note:

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Initial Health Assessment (IHA) Includes H&P and IHEBA												
1. History and physical (H&P)	**1**											
2. Individual Health Education Behavioral Assessment (IHEBA)	**1**											
B. Subsequent Periodic IHEBA	**1**											
C. Well-child visit												
1. Well-child exam completed at age appropriate frequency	**1**											
2. Anthropometric measurements	**1**											
3. BMI percentile	**1**											
4. Developmental screening	**1**											
5. Anticipatory guidance	**1**											
6. STI screening on all sexually active adolescents, including chlamydia for females	**1**											
7. Pap smear on sexually active females	**1**											
D. Vision Screening	**1**											

IV. Pediatric Preventive Criteria (continued from previous page)

Note: A Pediatric Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
E. Hearing Screening	**1**											
F. Nutrition Assessment	**1**											
G. Dental Assessment	**1**											
H. Blood Lead Screening Test	**1**											
I. Tuberculosis Screening	**1**											
J. Childhood Immunizations												
1. Given according to ACIP guidelines	**1**											
2. Vaccine administration documentation	**1**											
3. Vaccine Information Statement (VIS) documentation	**1**											
	Yes											
Comments:	No											
	N/A											

19
Pts. Possible

V. Adult Preventive Criteria (continued on next page)

Note: An Adult Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Initial Health Assessment (IHA): Includes H&P and IHEBA												
1. History and physical (H&P)	**1**											
2. Individual Health Education Behavioral Assessment (IHEBA)	**1**											
B. Subsequent Periodic IHEBA	**1**											
C. Periodic Health Evaluation according to most recent USPSTF Guidelines	**1**											
D. High Blood Pressure Screening	**1**											
E. Obesity Screening	**1**											
F. Lipid Disorders Screening	**1**											

V. Adult Preventive Criteria (continued from previous page)

Note: An Adult Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
G. Tuberculosis Screening	**1**											
H. Breast Cancer Screening	**1**											
I. Cervical Cancer Screening	**1**											
J. Chlamydia Infection Screening	**1**											
K. Colorectal Cancer Screening	**1**											
L. Adult Immunizations												
1. Given according to ACIP guidelines	**1**											
2. Vaccine administration documentation	**1**	y										
3. Vaccine Information Statement (VIS) documentation	**1**	y										
	Yes											
	No											
	N/A											

Comments:

15
Pts. Possible

VI. OB/CPSP Preventive Criteria (continued on next page)

Note: An OB/CPSP Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Initial Comprehensive Prenatal Assessment (ICA)												
1. ICA completed within 4 weeks of entry to prenatal care	1											
2. Obstetrical and Medical History	1											
3. Physical Exam	1											
4. Lab tests	1											
5. Nutrition	1											
6. Psychosocial	1											
7. Health Education	1											
8. Screening for Hepatitis B Virus	1											
9. Screening for Chlamydia Infection	1											
B. Second Trimester Comprehensive Re-assessment	1											
C. Third Trimester Comprehensive Re-assessment	1											
1. Screening for Strep B	1											
D. Prenatal care visit periodicity according to most recent ACOG standards	1											

VI. OB/CPSP Preventive Criteria (continued from previous page)

Note: An OB/CPSP Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
E. Individualized Care Plan (ICP)	**1**											
F. Referral to WIC and assessment of Infant Feeding status	**1**											
G. HIV-related services *offered*	**1**											
H. AFP/Genetic screening *offered*	**1**											
I. Domestic Violence/Abuse Screening	**1**											
J. Family Planning Evaluation	**1**											
K. Postpartum Comprehensive Assessment	**1**											
	Yes											
	No											
	N/A											

Comments:

20
Pts. Possible