
6. SITE REVIEW

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

APPLIES TO:

- A. This policy applies to all PCPs and PCP OBs who treat IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. IEHP requires all Primary Care Physician (PCP) sites to undergo an initial Site Review and Medical Record Review Survey performed by a Certified Site Reviewer (CSR), utilizing state mandated audit tools, prior to the PCP site participating with IEHP.
- B. PCPs are not eligible to receive enrollment until they pass the IEHP required Site Survey. Preparation for the Site Review and Medical Record Review Survey should include Site and Medical Record Reviews.
- C. Focused site visits are conducted within 60 days if a Member complaint is received and the provider has had a complaint related to the same issue within the past 12 months about the quality of a practitioner's office related to physical accessibility, physical appearance, adequacy of waiting and examining room space, adequacy of record keeping and any other issue that could impact quality of care. All complaints regarding appointment availability will be addressed by the Quality Management Department. Sites will be monitored every 6 months until all deficiencies are resolved.
- D. A Medical Record Review Survey is performed at the time of the Site Review if medical records are available; otherwise the Medical Record Review Survey is performed within 90-180 days of the PCP's effective date after the initial review.
- E. All PCP sites have Site Review and Medical Record Review performed by a Certified Site Reviewer as part of the credentialing process.
- F. All PCPs that provide OB services are required to undergo an audit specific to OB Site and Medical Records requirements in addition to the Site Review and Medical Records Review.
- G. All PCP facilities, high volume specialists and high volume ancillary service providers are assessed for specific American Disability Act (ADA) access requirements for Persons with Disabilities, using the FSR-Attachment C, Physical Accessibility Review Survey (PARS) Tool initially and every three years thereafter (see Attachment 6-4 in Section 6, "Attachments").
- H. The results of the FSR-Attachment C, PARS Assessment are informational and unlike the FSR Site Review Survey Tool (see Attachment 6-4 in Section 6, "Attachments"). This does not require a corrective action plan (CAP).

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

- I. Information gathered from the FSR-Attachment C, PARS Assessment will be made available to IEHP Members through the IEHP Provider Directory and IEHP Website categorizing the Provider as having basic or limited accessibility, as well as noting the accessibility indicators.

PROCEDURE:

PCP Site Review and Medical Record Review Surveys

- A. All PCP sites must pass an initial Site Review Survey prior to receiving assignment of Members.
- B. Medical Record Reviews are performed at the time of the Site Review if medical records are available; otherwise, medical record reviews are performed within 90 days of the PCP's effective date after the initial review. An additional extension of 90 days may be allowed only if the new provider does not have sufficient Members to complete a review of 10 medical records. If there are still fewer than 10 assigned Member records at the end of 6 months, a Medical Record Review is completed on the total number of records available, or on a sample chart, and the scoring adjusted according to the number of records reviewed.
- C. IEHP schedules the Site and Medical Record Review directly with the PCP office.
- D. IEHP utilizes the California Department of Health Care Services Site Review Survey (see Attachments 6-1a and 6-1b in Section 6, "Attachments") and the California Department of Health Care Services Medical Record Review Survey (see Attachments 6-2a and 6-2b in Section 6, "Attachments").
1. The Site Review Survey is used to verify the following site and compliance information and assign scores accordingly:

Site Information

- a. Access and Safety;
- b. Personnel;
- c. Office Management;
- d. Clinical Services; and
- e. Infection Control.

Medical Record Information

The medical record compliance portion of the survey verifies IPA/PCP compliance with IEHP's policies and procedures regarding the following:

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- a. Format;
 - b. Documentation;
 - c. Continuity/Coordination of Care;
 - d. Pediatric Preventive Services
 - e. Adult Preventive Services; and
 - f. OB/Prenatal Preventive Services (when applicable).
- E. Residency Teaching Clinics are subject to the Site Review and Medical Record Survey. See Policy 6D, “Residency Teaching Clinics” for more information on the requirements.
- F. The PCP receives a Corrective Action Plan (CAP) notification letter at the time the survey is performed. Any deficiencies found during the site review are noted on the form. The CAP letter notes the PCP status, timeframes for corrective action, and any other pertinent information.
- G. Categories for Site and Medical Record Review score results are as follows:
1. Exempted Pass 90% or 90% and above (w/o critical element deficiencies, or deficiencies in pharmacy and/or infection control)
 2. Conditional Pass 80-89% and above (with critical element deficiencies, or deficiencies in pharmacy and/or infection control)
 3. Fail Below 80%
- H. Full points are given if the scored element meets the applicable criteria. Partial points are not given for any scored element that is considered only “partially” met. Zero points are given if an element does not meet criteria.
- I. Nine critical survey elements related to the potential for adverse effect on patient health or safety have a scored “weight” of two points. All other survey elements are weighted at one point.
- J. All critical element deficiencies found during the survey, focused survey, or monitoring visit must be addressed by the practitioner within 10 working days of the survey date, and verified as corrected by IEHP within 30 calendar days of receipt of the CAP. Sites found deficient in any critical element during the survey are required to address 100% of the survey deficiencies, regardless of survey score.
- K. Critical elements include the following nine criteria:
1. Exit doors and aisles are unobstructed and egress (escape) accessible;
 2. Airway management equipment, appropriate to practice and populations served are present on site;

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

3. Only qualified/trained personnel retrieve, prepare or administer medications;
 4. Office practice procedures are utilized on-site that provide timely physician review and follow-up of referrals, consultation reports, and diagnostic test results;
 5. Only lawfully-authorized persons dispense drugs to patients;
 6. Personal protective equipment (PPE) is readily available for staff use;
 7. Needle stick safety precautions are practiced on-site;
 8. Blood, other potentially infectious materials (specimens) and regulated wastes (sharps/biohazardous non-sharps) are placed in appropriate leak-proof, labeled containers, for collection, processing, storage, transport or shipping; and
 9. Spore testing of autoclave/steam sterilizer is completed at least monthly, unless otherwise stated in the manufacturers guidelines, with documented results.
- L. Ten (10) Medical Records are reviewed initially for each provider as part of the site review process. During any medical record survey, IEHP has the option to request additional records for review if necessary.
- M. Sites where documentation of patient care by multiple PCPs occurs in the same record are reviewed as a “shared” medical record system. Shared medical records are considered those that are not identifiable as “separate” records belonging to any specific PCP. A minimum of 10 records are reviewed if two to three PCPs share records, 20 records are reviewed for four to six PCPs, and 30 records are reviewed for seven or more PCPs.
- N. Sites that receive an Exempted Pass are not required to complete a CAP unless determined necessary by the reviewer. All sites that receive a Conditional Pass are required to establish a CAP to address 100% of cited deficiencies. Refer to Policy 13C, “Corrective Action Plan (CAP) Requirements,” for more information.
- O. An initial site that scores below 80% on the Site Review and/or Medical Record Review Survey is considered a “failed site.” Failed sites are not approved for participation with IEHP. The PCP may appeal this decision to the IEHP Chief Medical Officer.
- P. PCPs wishing to appeal the results of a Site Review and Medical Record Review Survey must do so in writing, to the IEHP Chief Medical Officer, within 14 working days of the date of the notification letter.
- Q. After receiving a written appeal, the IEHP Chief Medical Officer responds to the appealing PCP in writing within 30 calendar days noting the status of the appeal.
- R. If the appeal is accepted by IEHP, the PCP has 30 calendar days to submit a CAP addressing all deficiencies noted in the Site Review and Medical Record Review Survey.

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

- S. If the CAP is approved by IEHP, a re-assessment is scheduled. If upon re-assessment either the site and/or medical record score are less than 80%, it is considered a “failed site” and is not approved as a participating site with IEHP.
- T. Initial providers who do not pass the survey may correct deficiencies, reapply to IEHP after six months and be re-surveyed.
- U. Any PCP whose review reveals significant quality of care issues is not eligible for initial participation in IEHP’s network, pending the outcome of a review by IEHP’s Chief Medical Officer, and possible further review by IEHP’s Peer Review Subcommittee.
- V. For existing sites that score below 80% on a Site Review and/or Medical Record Review Survey, IEHP reserves the right to remove PCPs from the network and transfer Members to other PCPs as necessary to protect the health and safety of Members. Should the practitioner be allowed to remain in the network, survey deficiencies must be corrected by the practitioner and verified by IEHP. New Members are not assigned to existing network providers that score below 80% until corrections are verified and the CAP is closed. Providers with scores below 80% are also placed on annual review.
- W. Existing Providers, who do not correct survey deficiencies within the established CAP timelines, are not assigned new Members until such time as corrections are verified and the CAP is closed. See Policy 13C, “Corrective Action Plan (CAP) Requirements” for details.
- X. Any provider who does not come into compliance with survey criteria within the established timelines is referred to the Peer Review Subcommittee for appropriate action.

CAP Verification Visit

- A. A CAP must be submitted for all Site Review and Medical Record Reviews of 80-89% or 90% and above with deficiencies in critical elements, pharmacy, and/or infection control. Once it has been demonstrated that a site has met IEHP’s threshold of conditional pass and a CAP has been accepted and verified, no further follow-up is required; however, continued monitoring may be done at IEHP’s discretion. Those existing sites with scores of less than 80% must have follow-up visits until the CAP is approved and verified and are placed on annual review.
- B. IEHP verifies the PCP’s compliance for implementing the submitted CAP as follows:
 - 1. At the CSR’s discretion or if the CAP cannot be verified by desk review alone (desk reviews require definitive proof).
 - 2. If a verification site visit results in a score less than the original initial site audit, or a new deficiency is identified, IEHP requires an additional CAP within the timeframe noted above and a second CAP verification is performed within 30 days.

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

Provider Relocation

- A. Credentialed PCPs who move their offices to new locations are subject to the following:
 - 1. If the new location is not currently an approved IEHP PCP site, the PCP is required to have an initial Site and Medical Record Review Survey within 30 days of the effective date of the move.
 - 2. If the PCP relocating takes his/her medical records to the new location, a new Medical Record Review is not required if medical record review was done within the past 12 months and received a score of Exempted Pass and the PCP retains the medical record score from the previous site.
- B. New PCPs applying for participation with IEHP who join a currently approved IEHP PCP site are subject to a Medical Record Review specific to the new PCP, which is performed 90-180 days after the PCP's eligibility date, unless records are shared.
- C. Unless significant discrepancies are found, only one site survey is performed in the three-year period following the most recent full audit. Additional PCPs joining such sites receive an integrated facility score, however, a Focused FSR may be required if the new PCP has a different specialty, i.e., Peds VS IM.

On-Site Hours Requirements

- A. PCPs must be physically on-site and available for patient care a minimum of 20 hours per week, as verified by IEHP.
- B. Exceptions to the 20 hours per week on-site requirements for PCPs at a site are:
 - 1. Residency Teaching Clinics - Refer to Policy 6D, "Residency Teaching Clinics", for more information.
 - 2. Rural Clinics – PCPs at sites that are in federal rural designated areas are considered for exception on a case-by-case basis by the IEHP Chief Medical Officer. Refer to Policy 6C, "PCP Sites Denied Participation or Removed from IEHP Network."

Monitoring

- A. IEHP systematically monitors all PCP sites between each regularly scheduled Site Review and Medical Record Review Survey. Monitoring sites between audits includes the use of both internal quality management systems and external sources of information. The nine critical elements are monitored on all sites between full surveys. This is done through review of Grievance Data, Quality of Care (QOC) referrals, and focused reviews when necessary. All deficiencies identified by the monitoring process require the completion of corrective actions according to CAP timelines.

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

- B. Provider sites that were audited because of a Member complaint related to facility issues, record keeping or availability will be monitored every 6 months until deficiencies are resolved. Monitoring will be done by reviewing Member complaints or additional focused audits.
- C. A focused review is a “targeted” audit used to investigate issues identified through quality monitoring Member complaint, or to follow-up on corrective actions. All deficiencies found in a focused review require the completion and verification of corrective actions according to CAP timelines.
- D. Provider Sites that receive a member complaint and the provider has had a complaint related to the same issue within the past 12 months related to facility issues, record keeping or availability will be audited within 60 days of the complaint. If the provider’s site meets the performance standards, then the site will resume the regular scheduled audit timeframe. If the provider’s site does not meet the performance standards, it will be given a CAP and monitored every 6 months until deficiencies are resolved. Monitoring will be done by reviewing Member complaints or through Focused Audits.

Site Reviews for PCPs that Provide Obstetrical (OB) Care

- A. PCPs that provide OB care must pass an initial Site Review Survey and Medical Record Review Survey, as well as the IEHP Site Review and Medical Record Review Survey Addendum by IEHP prior to receiving Members.
- B. A medical record review is performed at the time of the site survey if records are available; otherwise, medical record reviews are performed as outlined earlier.
- C. IEHP utilizes state mandated audit tools (see Attachment 6-1a, 6-1b, 6-2a, and 6-2b in Section 6, “Attachments”).
 - 1. The IEHP Site Review and Medical Record Addendum is used to verify the following site and medical record information (see Attachment 6-3 in Section 6, “Attachments”):
 - Site Information
 - a. OB referrals for transfer of care
 - b. Policies and procedures for high-risk OB referrals
 - c. Ultrasound
 - d. Required equipment
 - 1) Nitrazine paper;
 - 2) Urine dipsticks for glucose and ketones;
 - 3) Doppler.

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

Medical Record Information

- a. The medical record portion of the audit verifies PCP-OB compliance with IEHP's policies and procedures regarding Perinatal Preventive Care including:
- 1) Initial Comprehensive Prenatal Assessment;
 - 2) Subsequent Comprehensive Prenatal Trimester Assessments
 - 3) Prenatal care visits according to ACOG standards;
 - 4) Individualized Care Plan;
 - 5) WIC referral; (if the Member meets the financial requirements);
 - 6) HIV – related services;
 - 7) AFP testing;
 - 8) Family Planning; and
 - 9) Postpartum Assessments.
- D. The PCP receives a CAP notification letter at the time the survey is performed. Any deficiencies found during the site review are noted on the form. The CAP letter notes the PCP-OB status, timeframes for corrective action, and any other pertinent information.
- E. The Site Review and Medical Record Addendum is not associated with a score but may require a Corrective Action Plan.
- F. A CAP addressing all deficiencies from the Site Review and Medical Record Survey must be submitted and implemented as delineated above.

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6. SITE REVIEW

B. Facility Site Review – Attachment C, Physical Accessibility Review Survey (PARS)

APPLIES TO:

- A. This policy applies to all Providers (PCPs, High Volume Specialists and designated High Volume Ancillary Sites) who treat IEHP Medicare DualChoice (HMO SNP) Members as well as IEHP Members who are Seniors and Persons with Disabilities (SPD).

POLICY:

- A. Per the California Department of Health Care Services (DHCS) and Medi-Cal Managed Care Division (MMCD) Policy Letter 10-016, all PCP, high volume specialists and designated high volume ancillary sites are required to undergo a Facility Site Review-Attachment C, Physical Accessibility Review Survey (PARS). The PARS assessment will be performed initially for all new sites and every 3 years thereafter as part of the periodic Facility Site Review and Medical Record Review process (see Attachment 6-4 in Section 6 “Attachments”).
- B. The results of the FSR-Attachment C, Physical Accessibility Review Survey (PARS) are informational and unlike the FSR and MRR Site Review Surveys do not require a Corrective Action Plan (CAP).
- C. Information gathered from the PARS assessment will be made available to IEHP Members through the IEHP provider directory and the IEHP website categorizing the provider as having Basic or Limited accessibility, as well as noting the Accessibility Indicators.
- D. Results of the PARS assessment will be shared with other Medi-Cal Health Plans as part of the collaboration process to minimize duplication.
- E. IEHP is required to submit to DHCS updated documentation of any changes made to high volume benchmarks as a result of the availability of more complete utilization data by January 31st of each year.

PROCEDURE:

- A. **Physical Accessibility Review Survey**
 - 1. IEHP Reviewers will complete a PARS assessment for all newly contracted PCPs, high volume specialists and designated high volume ancillary sites and reassess those sites every 3 years with the FSR periodic cycle.
 - 2. IEHP Reviewers will complete a PARS assessment for all PCP, high volume specialists and high volume ancillary sites that move locations.

6. SITE REVIEW

B. Facility Site Review – Attachment C, Physical Accessibility Review Survey (PARS)

3. The most current PARS results will be shared with and accepted by all Medi-Cal Health Plans
4. IEHP may review sites more frequently based upon request for review due to site remodel.
5. IEHP is responsible to make PARS results available to Members on the IEHP website noting the site as having Basic Access, Limited Access, Medical Equipment Access, as well as the Accessibility Indicators: P= Parking, EB= Exterior Building, IB= Interior Building, R= Restroom, E+ Exam Room and ME=Medical Equipment.
6. IEHP is responsible to make PARS results available to Members in the IEHP provider directory noting the Accessibility Indicators: P= Parking, EB= Exterior Building, IB= Interior Building, R= Restroom, E+ Exam Room and ME=Medical Equipment.
7. IEHP is responsible to make PARS results available to DHCS, upon request, for evaluation and monitoring.
8. No CAP is required; this is a site accessibility assessment.

B. Reviewer Qualifications

1. Reviewer may be IEHP non-clinical staff.
2. Reviewer does NOT need to be an RN or MD.
3. Reviewer will use the DHCS PARS tool and guidelines.
4. Reviewer will undergo PARS Training

C. Provider Education

1. IEHP Nurse Evaluators will offer on site PCP and staff education regarding PARS requirements in conjunction with the optional FSR/MRR training that is offered to PCPs prior to review for all initial and periodic surveys.
2. High volume specialists and designated high volume ancillary sites will be offered training at the time of scheduling.
3. IEHP Reviewers will discuss the PARS findings with the provider at the time of the exit interview.

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6. SITE REVIEW

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

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. PCP (includes both PCPs and PCP-OB/GYNs) sites that have been removed from the IEHP network or are denied participation on initial application due to site review failure, or because the PCP was not physically present a minimum of 20 hours per week at the site, can re-apply after 6-months, to IEHP to be reconsidered as a participating PCP site.
- B. PCPs applying for reconsideration must meet specific conditions as outlined below to be reinstated in the IEHP network.
- C. PCPs who are denied participation or who have been terminated twice by IEHP, for any reason, are not eligible for re-application with IEHP. IEHP reserves the right to remove PCPs from the network and transfer Members to other PCPs as necessary to protect the health and safety of Members.

PROCEDURE:

- A. PCP sites can be removed, limited, or denied participation in the IEHP network under the following circumstances:
1. Site Review and Medical Record Review Surveys
 - a. Sites that score:
 - 1) Less than 80% on either site or medical record reviews;
 - 2) Less than 80% on any review, with a non-compliant Corrective Action Plan (CAP); or
 - 3) Any provider who does not come into compliance with the survey criteria within established timelines.
 2. On-Site Hours
 - a. If a site visit or other information confirmed by IEHP reveals:
 - 1) The PCP appears to be at the site less than 20 hours per week; the site is initially frozen to new enrollment. The PCP is requested to submit a CAP verifying that the PCP is present a minimum of 20 hours per week. The CAP is validated by IEHP. If the PCP does not submit a CAP or the PCP is not present a minimum of 20 hours per week, the site is removed from the IEHP network.

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

- 2) The PCP is present less than 10 hours per week; the site is removed from the IEHP network.
- B. PCPs who are removed from or denied participation in the IEHP network can apply to IEHP to be reconsidered for IEHP participation at either their original site or a new site. The re-application cannot be completed until six months after a site was terminated or denied participation in the IEHP network. In either case, all conditions applicable below must be met.
- C. If the PCP site was removed from or denied participation in the IEHP network due to facility site and/or medical record review failure, the following condition must be met:
1. A re-assessment Site Review and Medical Record Review Survey performed by IEHP must result in a score of 90% or greater with no critical element, pharmacy, and/or infection control deficiencies.
- D. Repeat site review surveys are scheduled by IEHP within 90 days of re-application.
- E. If the PCP site was removed from or denied participation due to the PCP not being physically present at a site for a minimum of 20 hours per week, the following conditions must be met:
1. The PCP must submit a schedule that covers a minimum of a six-month period and demonstrates that he/she is on-site at least 20 hours per week.
 2. The PCP must submit a letter committing to this schedule and timeframe. PCPs may change the schedule in terms of days of the week (or increasing on-site time); however, a minimum of 20 hours per week must be maintained. The PCP must provide IEHP with advance written notice of changes to the schedule.
 3. IEHP confirms that the PCP is present according to the schedule by conducting telephone or in-person visits.
- F. To be reinstated, PCPs removed from the IEHP network due to failing the Site and/or Medical Record Review and being physically present less than 20 hours per week must meet all conditions outlined above to be reinstated.
- G. The IEHP Chief Medical Officer reviews all submitted information, including repeat Site Review and Medical Record Review results, and notifies PCP, in writing, of the decision on the reconsideration request.
- H. PCP sites that fail the re-assessment are not considered as a PCP site for a minimum of six months. If the site re-applies, it must meet the conditions noted above for PCP sites removed from the IEHP network.
- I. PCPs denied participation or who have been terminated twice from IEHP for any reason related to quality or compliance, are not allowed to reapply for participation with IEHP. PCPs that voluntarily terminate their contract with IEHP may reapply even after they have

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

requested termination on two other occasions if there are no quality issues involved.

- J. The following actions take place when a site is removed from the IEHP network:
1. The PCP is notified that the site is removed from the IEHP network.
 2. Members are transferred to another PCP within the immediate geographic area, as outlined in IEHP policies.
 3. The timeframe for the transfer depends on an assessment of the potential risk to the health and safety of Members by the IEHP Chief Medical Officer. In certain cases, it may be necessary to effectuate the immediate transfer of Members with subsequent retroactive notification.
 4. All affected Members are mailed a notification letter informing them of the change and outlining their options. Refer to Policy 18J, "IEHP Termination of PCPs, Specialists and Vision Providers" for more information on Member notification.
- K. IEHP reserves the right to add additional requirements or perform specific additional monitoring as determined by IEHP.
- L. IEHP reserves the right to remove PCPs from the network and transfer Members to other PCPs as necessary to protect the health and safety of Members.
- M. PCPs may appeal adverse credentialing decisions of any type, including Site Review and Medical Records Review Surveys, by submitting an appeal in writing to the IEHP Chief Medical Officer. Refer to Policy 5E, "Credentialing Appeals Process for Practitioners Denied Participation with IEHP," for more information.
- N. PCPs whose sites are denied from participation in or are removed from the IEHP network may appeal in writing in accordance with the Level 1 Peer Review process and Level II Appeals process (see Attachments 5-1 and 5-2 in Section 5, "Attachments").

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6. SITE REVIEW

D. Residency Teaching Clinics

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. Residency teaching clinics, as defined below, may be exempt from the minimum 20-hour on-site requirement for PCPs.
- B. All attending physicians providing services to IEHP Members at exempted residency clinics must be credentialed and approved by the Health Plan, and open for enrollment through IEHP.

PROCEDURE:

- A. Residency teaching clinics are defined by IEHP as clinics that operate full time (Monday-Friday, approximately 8am-5pm) as sites for the training of residents in a primary care discipline from an accredited residency training program.
- B. Except in cases specifically approved by the IEHP Chief Medical Officer, IEHP assigns Members only to attending physicians at residency teaching clinics. Resident physicians are not assigned Members.
- C. For attending physicians to receive Member assignment as a PCP at a residency teaching clinic, the following conditions must be met:
1. Residency teaching clinics are subject to a site review and medical record survey as outlined in Policy 6A, "Site Review and Medical Record Review Survey Requirements and Monitoring." The number of medical records reviewed depends on the number of practitioners as follows:

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| Two to Three PCP's | 10 Records |
| Four to Six PCP's | 20 Records |
| Seven or More PCP's | 30 Records |

Each attending physician receives the same medical record score.

2. The attending physicians receiving Membership must be on-site a minimum of eight hours per week.
3. There must be an attending physician present at all times during clinic office hours.
4. The attending physician shall serve in a supervisory capacity for residents, but the attending physician need not examine every patient that is examined by a resident.

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D. Residency Teaching Clinics

5. When possible, IEHP Members should be followed by one resident physician to ensure continuity of care.

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6. SITE REVIEW

E. Rural Clinics

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. Rural Clinics, as defined below, may be exempt from the minimum 20-hour on-site requirement for PCPs.
- B. To be considered for an exemption to the 20-hour on-site PCP requirement, rural clinics must be in a federally designated rural area or meet other IEHP standards upon review.

PROCEDURE:

- A. A PCP site can be defined as rural in one of two ways:
1. It is located in a federally designated rural location; or
 2. IEHP review of the location determines that it is in an area outside of an urban setting and there are limited IEHP PCP sites available in that location.
- B. For physicians to receive Member assignment as a PCP at a rural clinic, the following conditions must be met:
1. The physician must be available on-site a minimum of eight hours per week.
 2. There must be a credentialed non-physician practitioner [Nurse Practitioner (NP) or Physician Assistant (PA)] or another credentialed physician available on-site for the remainder of the open clinic hours.
 3. Members specifically requesting to see their PCP must be accommodated within IEHP appointment access standards as described in Policy 9A, "Access Standards."
 4. Any non-physician practitioner seeing Members must be supervised by the physician assigned to the Members and practice under specific protocols available at the clinic site.
 5. The PCP must be available during clinic hours to the non-physician practitioner via phone or pager, and meet all after-hours access requirements.
- C. Final determination of exemption from the 20 hour PCP on-site policy is at the discretion of the IEHP Chief Medical Officer.

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6. SITE REVIEW

F. Non-Physician Practitioner Requirements

APPLIES TO:

- A. This policy applies to all IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. Non-physician practitioners include the following categories: Nurse Practitioners, Physician Assistants, or Certified Nurse Midwives.
- B. Non-physician practitioners are not directly assigned Members and are not listed in the Provider Directory. At the discretion of the IEHP Chief Medical Officer, Nurse Practitioners may be assigned Membership if practicing in a designated rural area.
- C. A PCP's maximum enrollment may be increased if a non-physician practitioner is present at the site as addressed in Policy 18A2, "PCP– Enrollment Limits."
- D. The ratio of non-physician practitioners to the Supervising Physician must not exceed the full-time equivalent (FTE) of one of the following:
1. Nurse Practitioners (NPs) 4:1 Physician
 2. Certified Nurse Midwives (CNM) 3:1 Physician
 3. Physician Assistants (PA) 4:1 Physician

Four is the maximum number of non-physician practitioners to one physician, in any combination of the above, which does not include more than three CNMs.

PROCEDURE:

- A. PCPs must provide the required credentialing information to the IPA for all non-physician practitioners as outlined in Policy 5B, "Provider Credentialing Requirements."
- B. All credentialed sites with a PA must have a site specific, on-site "Delegation of Services Agreement between the Supervising Physician and Physician Assistant." This Agreement must define specific services identified in practice protocols or specifically authorized by the supervising physician, and both the physician and PA must attest to, date and sign the agreement. An original or copy must be readily accessible at all practice sites in which the PA works. The Agreement must 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 MBHC against a PA licensure (see Attachment 5-5a in Section 5, "Attachments").
- C. All PAs act as the agent of the supervising physician in which they have an agreement. A Delegation of Services Agreement may authorize a PA to provide or perform the following activities as long as there is documentation evidencing the activity was actually performed:

6. SITE REVIEW

F. Non-Physician Practitioner Requirements

1. Physical examinations, including interscholastic athletic program examinations.
 2. Order DME and make arrangements with regard to home health services or personal care services, as applicable. For home health and/or personal care services, after consultation with the supervising physician, the PA may approve, sign, modify or add to the plan of treatment or care.
 3. Routine visual screening. This includes non-invasive, non-pharmacological, simple testing for visual acuity, visual field defects, color blindness and depth perception.
- D. All credentialed sites with a PA must have the Supervising Physician sign on an annual basis, and have on-site, an “Approved Supervising Physician’s Responsibility for Supervision of Physician Assistants” (see Attachment 5-5b in Section 5, “Attachments”).
- E. All sites must have on-site written protocols for NPs, PAs, and CNMs, signed by the non-physician practitioner and the physician initially and when changes occur.
- F. Requirements for non-physician practitioners for licensure, education, training and experience must meet credentialing standards as set by the IPA and outlined in Policy 5A, “IEHP Practitioner Guidelines.”
- G. Non-physician practitioners must identify themselves in all aspects of care as a non-physician practitioner and staff must not use the terminology “doctor” to refer to non-physician practitioners.

| INLAND EMPIRE HEALTH PLAN | | |
|---|------------------------|-----------------|
| Chief Approval: <i>Signature on file</i> | Effective Date: | January 1, 2007 |
| Chief Title: Chief Medical Officer | Revised Date: | January 1, 2012 |

6. SITE REVIEW

G. Primary Care Physician (PCP) Referral Audits

APPLIES TO:

- A. This policy applies to all PCPs and PCP OBs who treat IEHP Medicare DualChoice (HMO SNP) Members.

POLICY:

- A. IEHP is responsible for the oversight and monitoring of Primary Care Physician (PCP) referrals.
- B. IEHP reserves the right to perform referral audits or to verify accuracy of information on referral logs as stated in Policy 14B1, “Review Procedures - Primary Care Physician (PCP) Referrals.”
- C. This policy will develop and maintain a standardized system-wide process for performing, scoring and follow-up of Referral Audits.

PURPOSE:

- A. To ensure IEHP consistently applies the same procedural guidelines for all Referral Audits.

PROCEDURE:

- A. IEHP Monitors sites for Referral issues. This includes the use of both internal quality management systems and external sources of information. This is done through review of Grievance Data, Quality of Care (QOC) referrals, and focused reviews when necessary.
- B. Once a PCP has been identified as having Referral issues, a Quality Program Nurse (QPN) will schedule the Referral Audit directly with the PCP office to determine if all procedures are being followed as stated in Policy 14B1, “Review Procedures - Primary Care Physician (PCP) Referrals.”
- C. IEHP will audit twenty-five (25) approved referrals.
- D. Categories for Referral Audit score results are as follows:

| Compliance Categories | Compliance Rate |
|-----------------------|-----------------|
| Exempted Pass | 90% or above |
| Conditional Pass | 80-89% |
| Fail | Below 80%. |

6. SITE REVIEW

G. Primary Care Physician (PCP) Referral Audits

1. A minimum score of 80% must be achieved to pass a Referral Audit. If the score is below 80%, it is considered a failed audit.
- E. Follow-up Guidelines for each Category:
1. Exempted Pass - No further action is required
 2. Conditional Pass - The PCP receives a Corrective Action Plan (CAP) notification letter within 10 business days after the audit is performed. Any deficiencies found during the referral audit are noted in the CAP notification letter. The PCP has 30 calendar days to submit a CAP addressing all deficiencies. If the CAP is approved by IEHP, a CAP Verification is scheduled within 3 to 4 months from receipt of the CAP.
 - a. If upon re-assessment the PCP receives a score greater than 80%, no other follow up is required. However, further monitoring of referral grievances will be done through the quality monitoring process.
 - b. If upon re-assessment the PCP receives a score less than 80%, it is considered a "Failed Site." Failure of the CAP Verification will result in referral to the IEHP Peer Review Subcommittee.
 3. Fail - The PCP receives a Corrective Action Plan (CAP) notification letter within 10 business days after the audit is performed. Any deficiencies found during the referral audit are noted in the CAP notification letter. The PCP has 30 calendar days to submit a CAP addressing all deficiencies. If the CAP is approved by IEHP, a CAP Verification is scheduled within 3 to 4 months from receipt of the CAP.
 - a. If upon re-assessment the PCP receives a score greater than 80%, no further action is required; however, further monitoring may be required if additional issues are identified through the quality monitoring process and a referral is made to the IEHP Medical Director at the discretion of the nurse reviewer.
 - b. If upon re-assessment the PCP receives a score less than 80%, it is considered a "Failed Site." Failure of the CAP Verification will result in referral to the IEHP Peer Review Subcommittee.

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| INLAND EMPIRE HEALTH PLAN | | |
| Chief Approval: <i>Signature on file</i> | Effective date: | January 1, 2011 |
| Chief Title: Chief Medical Officer | Revised date: | |

6. SITE REVIEW


Attachments

| <u>ATTACHMENT</u> | <u>DESCRIPTION</u> | <u>POLICY CROSS REFERENCE</u> |
|-------------------|---|-------------------------------|
| 6-1 | California Department of Health Care Services a. Reviewer Guidelines | 6A |
| | b. Reviewer Tool | 6A |
| 6-2 | California Department of Health Care Services MMCD Full Scope Medical Record Review Survey a. Reviewer Guidelines | 6A |
| | b. Reviewer Survey | 6A |
| 6-3 | IEHP Site Review and Medical Record Survey Addendum | 6A |
| 6-4 | DHCS MMCD Physical Accessibility Review Survey – Attachment C | 6A, 6B, 9C |



| Criteria | Access/Safety Reviewer Guidelines |
|---|--|
| <p>A. Site is accessible and useable by individuals with physical disabilities.</p> <p>*Related Q & As Section II: # 5,16,17,18,19, 20, 21 & 22</p> | <ul style="list-style-type: none"> • ADA Regulations: Site must meet city, county and state building structure and access ordinances for persons with physical disabilities. A site/facility includes the building structure, walkways, parking lots, and equipment. All facilities designed, constructed; or altered by, on behalf of, or for the use of a public entity must be readily accessible and usable by individuals with disabilities, if the construction or alteration was begun after January 26, 1992 (28 CFR 35.151). Any alteration to a place of public accommodation or a commercial facility, after January 26, 1992, must be made to ensure that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and useable by individuals with disabilities, including individuals who use wheelchairs (28 CFR 36.402). • Parking: Parking spaces for persons with physical disabilities are located in close proximity to handicap-accessible building entrances. Each parking space reserved for the disabled is identified by a permanently affixed reflectorized sign posted in a conspicuous place. If provider has no control over availability of disabled parking lot or nearby street spaces, provider must have a plan in place for making program services available to persons with physical disabilities. • Ramps: A clear and level landing is at the top and bottom of all ramps and on each side of an exit door. Any path of travel is considered a ramp if its slope is greater than a 1-foot rise in 20 feet of horizontal run. • Exit doors: The width of exit doorways (at least 32-in.) allows for passage clearance of a wheelchair. Exit doors include all doors required for access, circulation and use of the building and facilities, such as primary entrances and passageway doors. Furniture and other items do not obstruct exit doorways or interfere with door swing pathway. • Elevators: If there is no passenger elevator, a freight elevator may be used to achieve program accessibility if it is upgraded for general passenger use and if passageways leading to and from the elevator are well-lit, neat and clean. • Clear Floor Space: Clear space in waiting/exam areas is sufficient (at least 30-in. x 48-in.) to accommodate a single, stationary adult wheelchair and occupant. A minimum clear space of 60-in. diameter or square area is needed to turn a wheelchair. • Sanitary Facilities: Restroom and hand washing facilities are accessible to able-bodied and physically disabled persons. A wheelchair accessible restroom stall allows sufficient space for a wheelchair to enter and permits the door to close. If wheelchair accessible restrooms are not available within the office site, reasonable alternative accommodations are provided. Alternatives may include: grab bars located behind and/or along the sides of toilet with assistance provided as needed by site personnel; provision of urinal, bedpan, or bedside commode placed in a private area; wheelchair accessible restroom located in a nearby office or shared within a building. Sufficient knee clearance space underneath the sink allows for wheelchair users to safely use a lavatory sink for hand washing. A reasonable alternative may include, but is not limited to, hand washing items provided as needed by site personnel. <p>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.</p> |

| Criteria | Access/Safety Reviewer Guidelines |
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| <p>B. Site environment is maintained in a clean and sanitary condition.</p> | <p>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.</p> |
| <p>C. Site environment is safe for all patients, visitors and personnel.</p> <p>*Related Q & As Section II: # 28, 30</p> | <ul style="list-style-type: none"> • <u>Ordinances</u>: Sites must meet city, county and state fire safety and prevention ordinances. Reviewers should be aware of applicable city and county ordinances in the areas in which they conduct reviews. • <u>Non-medical emergency procedures</u>: Non-medical emergencies include incidents of fire, natural disaster (e.g. earthquakes), workplace violence, etc. Specific information for handling fire emergencies and evacuation procedures is available on site to staff. Personnel know <i>where to locate</i> information on site, and <i>how to use</i> 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. • <u>Evacuation Routes</u>: 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. • <u>Illumination</u>: 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. • <u>Access Aisle</u>: 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. • <u>Exits</u>: Exit doorways are unobstructed and clearly marked by a readily visible “Exit” sign. • <u>Electrical Safety</u>: 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. • <u>Fire Fighting/Protection Equipment</u>: 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: <ol style="list-style-type: none"> 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. <p><u>Note</u>: Specific measurements are provided strictly for “reference only” for the reviewer. Site reviewers are <i>NOT</i> expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.</p> |

 RN/MD Review only

| Criteria | Access/Safety Reviewer Guidelines |
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| <p>D., Emergency health care services are available and accessible 24 hours a day, 7 days a week. </p> <p>*Related Q & As Section II: # 2, 3, 4, 6, 7, 8, 9, 11, 12, 13, 14, 23, 29, 31</p> | <ul style="list-style-type: none"> • Site Specific Emergency procedures: *Calling 911 is not sufficient. The staff should be able to describe site-specific actions or procedures for handling medical emergencies (and demonstrate equipment proficiency) until the individual is stable or under care of local emergency medical services (EMS). It is <i>not sufficient</i> for provider/staff to state “we call 911”. If a site does not have basic medical equipment and medication for handling airway and anaphylactic medical emergencies, there is a written procedure for providing immediate emergent medical care on site until the local EMS is on the scene and has taken over care/treatment. Although site proximity to emergency care facilities may be considered when evaluating medical emergency procedures, the key factor is the ability to provide immediate care to patients <i>on site</i> until the patient is stable or EMS has taken over care/treatment. • Emergency medical equipment: During business hours providers are prepared to provide emergency services for management of emergency medical conditions that occur on site <i>until</i> 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: <ol style="list-style-type: none"> 1) establish and maintain a patent/open airway, and 2) manage anaphylactic reaction. <p>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).</p> • Emergency phone number list: Posted list includes local emergency response services (e.g., fire, police/sheriff, ambulance), emergency contacts (e.g., responsible managers, supervisors), appropriate State, County, City and local agencies (e.g., local poison control number). List should be dated, and updated annually. • Airway management: Without the ability to adequately maintain the patient’s airway, all other interventions are futile. Minimum airway control equipment includes a wall oxygen delivery system or portable oxygen tank, oropharyngeal airways, nasal cannula or mask, and Ambu Bag. Various sizes of airway devices appropriate to patient population within the practice are on site. Portable oxygen tanks are maintained at least ¾ full. *Providers may not use small oxygen tanks where the liter flow cannot be adjusted. There is a method/system in place for oxygen tank replacement, *including checking periodically that the tank is full. If oxygen tanks are less than ¾ full at time of site visit, site has a back up method for supplying oxygen if needed <i>and</i> a scheduled plan for tank replacement. Oxygen tubing need not be connected to oxygen tank, but must be kept in close proximity to tank. *Staff 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), Benadryl 25 mg. (oral), or Benadryl 50 mg/ml (injectable), tuberculin syringes, alcohol wipes. There is a current medication administration reference (e.g. medication dosage chart) available for readily identifying the correct medication dosages (e.g. adult, pediatric, infant, etc) and treatment. |



  **RN/MD Review only**

| Criteria | Access/Safety Reviewer Guidelines |
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| <p>E. Medical and lab equipment used for patient care is properly maintained.  </p> <p>*Related Q & As Section II: # 10, 14, 15, 24, 25, 26, 27</p> | <ul style="list-style-type: none"> • <u>Medical and laboratory equipment:</u> All equipment used to measure or assess patient health status/condition is functioning properly. All specialized equipment (e.g., ultrasonography equipment, electrocardiogram (EKG) machine, defibrillator, audiometer, hemoglobinometer, glucometer, scales, etc.) is adequately maintained according to the specified manufacturer's guidelines for the equipment, or is serviced annually by a qualified technician. *Blood pressure cuffs, monitors and other related equipment need not be calibrated unless required by the manufacturer. They do need to be maintained in operating order. • <u>Documentation:</u> There is documented evidence that standard operating procedures have been followed for routine inspection/maintenance, calibration, repair of failure or malfunction, testing and cleaning of all specialized equipment. Appropriate written records include calibration or other written logs, work orders, service receipts, dated inspection sticker, etc. |

| Criteria | Personnel Reviewer Guidelines | | |
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| <p>A. Professional health care personnel have current California licenses and certifications.</p> <p>*Related Q & As Section III: 4, 5, 6, 8, 13, 14, 22</p> | Medical Professional | License/Certification | Issuing Agency |
| | Certified Nurse Midwife (CNM) | RN License and Nurse-Midwife Certificate *DEA Registration, if appropriate | CA Board of Registered Nursing |
| | Certified Radiological Technologist (CRT) | CRT Certificate | CA Department of Health Care Services (Radiological Branch) |
| | Doctor of Osteopathy (DO) | Physician's & Surgeon's Certificate DEA Registration | Osteopathic Medical Board of CA Drug Enforcement Administration |
| | Licensed Vocational Nurse (LVN): | LVN License | CA Board of Vocational Nursing and Psychiatric Technicians |
| | Nurse Practitioner (NP) | RN License w/NP Certification and Furnishing Number *DEA Registration, if appropriate | CA Board of Registered Nursing |
| | Pharmacist (Pharm. D) | Pharmacist License | CA State Board of Pharmacy |
| | Physician/Surgeon (MD) | Physician's & Surgeon's Certificate DEA Registration | Medical Board of CA Drug Enforcement Administration |
| | Physicians' Assistant (PA) | PA License *DEA Registration, if appropriate | Physician Assistant Examining Committee/Medical Board of CA |
| | Radiological Technician | Limited Permit | CA Department of Health Care Services (Radiological Branch) |
| | Registered Dietitian (RD) | RD Registration Card | Commission on Dietetic Registration |
| | Registered Nurse (RN) | RN License | CA Board of Registered Nursing |
| <p>Note: All medical professional licenses and certifications must be current and issued from the appropriate agency for practice in California. Any licenses/certifications not included in the re/credentialing process must be checked for current status as part of the site review process. Although sites with centralized personnel departments are not required to keep documents or copies on site, copies and/or lists of currently certified or credentialed personnel must be readily available when requested by reviewers.</p> | | | |



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| <p>B. Health care practitioners are properly identified.</p> <p>* Related Q & As Section III: # 1, 2, 3, 15, 16, 33</p> | <p>*Health care personnel shall disclose, while working, his or her name and practitioner’s license status, as granted by the State of California, on a nametag. It is acceptable if a health care practitioner in a practice or an office, whose license is prominently displayed, may opt not to wear a nametag. * Health care practitioners have the option to wear a nametag. The reviewer would use nursing judgment as to how the requirement would be scored, with documentation justifying the decision of the score.</p> <p>Note: “Health care practitioner” means any person who engages in acts that are the subject of licensure or regulation under the California Business and Professional Code (Section 680-681). If a health care practitioner or licensed clinical social worker is working in a psychiatric setting or in a setting that is not licensed by the state, the employing entity or agency shall have the discretion to make an exception from the name tag requirement for the individual safety or therapeutic concerns.</p> |
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  **RN/MD Review only**



| Criteria | Personnel Reviewer Guidelines |
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| <p>C. Site personnel are qualified and trained for assigned responsibilities.</p> <p> </p> <p>*Related Q & As Section III: # 17, 18, 19, 23, 24, 29, 30, 34, 35, 37, 38</p> | <ul style="list-style-type: none"> • 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 physician supervising the MA is responsible for all work performed by the MA. 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: <ul style="list-style-type: none"> A) Diploma or certification from an accredited training program/school, <i>or</i> B) Letter/statement from the current supervising physician that certifies in writing: date, location, content, and duration of training, demonstrated proficiency to perform current assigned scope of work, and signature. • Medications: Unlicensed staff (e.g. medical assistants) has evidence of appropriate training and supervision in all medication administration methods performed within their scope of work. Medication administration by a MA means the direct application of pre-measured medication orally, sublingually, topically, vaginally or rectally; or by providing a single dose to a patient for immediate self-administration by inhalation or by simple injection. The pre-labeled medication container must be shown to the licensed person prior to administration. To administer medications by subcutaneous or intramuscular injection, or to perform intradermal skin tests or venipunctures for withdrawing blood, an MA must have completed at least the minimum number of training-hours established in CCR, Title 16, Section 1366.1. An MA may administer injections of scheduled drugs, including narcotic medications, <i>only</i> if the dosage is verified and the injection is intradermal, subcutaneous, or intramuscular. Medical assistants may not place an intravenous needle, start or disconnect the intravenous infusion tube, administer medications or injections into an intravenous line, or *administer anesthetics. 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. |

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| | <p>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.</p> |
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  **RN/MD Review only**

| Criteria | Personnel Reviewer Guidelines |
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| <p>D. Scope of practice for non-physician medical provider (NPMP) is clearly defined.</p> <p> </p> <p>*Related Q & As Section III: # 11, 20</p> | <p>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 and updated periodically. Reviewers are <i>not</i> 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.</p> <ul style="list-style-type: none"> • Drug Enforcement Agency (DEA): Each NP, CNM, and PA that prescribes controlled substances is required to have a valid DEA Registration Number. |


  **RN/MD Review only**

| Criteria | Personnel Reviewer Guidelines |
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| <p>E. Non-physician medical practitioners (NPMP) are supervised according to established standards.</p> <p> </p> <p>* Related Q & As Section III: # 7, 12, 20, 27</p> | <ul style="list-style-type: none"> • <u>Non-physician medical practitioners</u>: The Supervising Physician holds ultimate responsibility for the practice of each supervised non-physician medical practitioner. The number of non-physician medical practitioners who may be supervised by a single primary care physician is limited to the full-time equivalent of one of the following: 4 nurse practitioners, 3 nurse midwives, 2 physician’s assistants, or 4 of the above individuals in any combination which does not exceed the limit stated. A primary care physician, an organized outpatient clinic or a hospital outpatient department cannot utilize more non-physician medical practitioners than can be supervised within these stated limits (Title 22, CCR, Division 3, §51240). *Medi-Cal Managed Care follows Title 22 which is a stricter rule of one supervising physician to 4 mid-levels. • <u>Supervising physician</u>: “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. * To supervise mid-levels by electronic means, there must be availability of a paging system, pager, or a telephone number available onsite, where the supervising physician can be reached at all times. They should be at a reasonable distance in case an emergency arises, or there is a back-up physician available. |



  RN/MD Review only

| Criteria | Personnel Reviewer Guidelines |
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| <p>F. Site personnel receive safety training/information.  </p> <p>* Related Q & As Section III: # 9, 10, 25, 28</p> | <ul style="list-style-type: none"> • Bloodborne Pathogens: Site personnel treat all blood and other potentially infectious materials (OPIM) as if these <i>are</i> 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 <i>prior to</i> 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. *Documentation of training may be informal by way of sign-in sheets, flyers, minutes and in-service records. Training <i>minimally</i> includes the following: <ul style="list-style-type: none"> ▶ universal/standard precautions ▶ use of personal protective equipment ▶ accessible copy of Bloodborne Pathogens Standard ▶ work practice controls/exposure prevention ▶ modes of transmitting blood borne 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 blood borne pathogen exposure plan ▶ opportunity for discussion/questions <p>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.</p> <ul style="list-style-type: none"> • Abuse Reporting: Site personnel have specific knowledge of local reporting requirements, agencies, and procedures, and know <i>where to locate</i> information on site and <i>how to use</i> information. <p>FYI: 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 could result in criminal or civil prosecutions, punishable by monetary fines and/or county jail confinement.</p> |


 **RN/MD Review only**

| Criteria | Personnel Reviewer Guidelines |
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| <p>G. Site personnel receive training and/or information on member rights. </p> <p>*Related Q & As Section III: # 31, 32 Section VIII: # 64</p> | <p>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. *Sites must have information on sensitive services that are appropriate to the office.</p> |



  RN/MD Review only (#B)

| Criteria | Office Management Reviewer Guidelines |
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| <p>A. Physician coverage is available 24 hours a day, 7 days a week.</p> | <p>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.</p> <p>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.</p> |
| <p>B. There is sufficient health care personnel to provide timely, appropriate health care services.  </p> <p>*Related Q & As Section IV: # 9, 10, 11, 12, 17</p> | <p>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)).</p> <p>*Title 22 Sections 2860.5 and 2860.7 of the Business and Professional’s Code also addresses the use of standardized procedures and whether LVNs can operate under a written protocol. LVN s cannot give advice and can only perform those procedures for which there are orders or standardized procedures, and that are within their scope of practice. They cannot analyze data or provide telephone advice, but they may work under procedures that are specifically written for them by the physician supervisor.</p> <p>Note: Telephone triage is the system for managing telephone callers during and after office hours.</p> |


 RN/MD Review only (#C)

| Criteria | Office Management Reviewer Guidelines |
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| <p>C. Health care services shall be readily available. </p> <p>* Related Q & As Section IV: # 3, 6, 7, 8,13, 31 Section VIII: # 53</p> | <p>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.</p> <p>Note: The Medi-Cal Managed Care Health Plans have accepted the following timeliness standards for access to appointments:</p> <ul style="list-style-type: none"> • Urgent Care: 24 hours; • Prenatal Care: 7 days; • Non-Urgent Care: 14 days; • Well Baby Visit: 14 days. <p>Missed and/or canceled appointments, and contact attempts must be documented in the patient's medical record.</p> |
| <p>D. There is 24-hour access to interpreter services for non/limited English proficient (LEP) members.</p> <p>* Related Q & As Section IV: # 1, 2, 3, 4, 5, 15, 16, 23, 24, 27, 28, 29, 30 Section VIII: # 60</p> | <p>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. *The provider and/or an appropriate clinic staff member that speaks the member's language fluently may be considered a qualified interpreter. There is no requirement to document the name of the interpreter.</p> <p>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. * The reviewer is not to verify any interpreter agencies like ATT. The reviewer needs to identify the process/system used to provide interpreter services and inform members about their rights to use free interpreter services. Qualified interpreter is defined as, "an interpreter who is able to interpret effectively, accurately and impartially both receptively and expressively, using any necessary specialized vocabulary".</p> |

  **RN/MD Review only (#E)**



| Criteria | Office Management Reviewer Guidelines |
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| <p>E. Procedures for referral/ consultative services are established on site.  </p> <p>*Related Q & As Section IV: 14, 18</p> | <p>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.</p> |
| <p>F. Member grievance/ complaint processes are established on site.</p> <p>*Related Q & As Section IV: # 19, 20</p> | <p>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.</p> <p>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.</p> |

 **RN/MD Review only (#H)**

| Criteria | Office Management Reviewer Guidelines |
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| <p>G. Medical records are available for the Provider at each scheduled patient encounter.</p> <p>* Related Q & As Section IV: # 21</p> | <p>The process/system established on site provides for the availability of medical records, including outpatient, inpatient, referral services, and significant telephone consultations for patient encounters. Medical records are filed that allows for ease of accessibility within the facility, or in an approved health record storage facility off the facility premises (22 CCR, § 75055).</p> |
| <p>H. Medical record confidentiality is maintained according to State and federal guidelines.</p> <p></p> <p>* Related Q & As Section IV: #25</p> | <ul style="list-style-type: none"> • 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: 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 | Pharmaceutical Services Reviewer Guidelines |
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| <p>A. Drugs and medication supplies are maintained secured to prevent unauthorized access.</p> <p>* Related Q & As Section V: # 1, 2, 3, 30</p> | <ul style="list-style-type: none"> • 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 (means locked) at all times (CA B&P Code, §4051.3). Keys to locked storage area are available only to staff authorized by the physician to have access (16 CCR, Chapter 2, Division 3, Section 1356.32). The Medical Board of California interprets “all drugs” to also include both sample and over-the-counter drugs. The Medical Board defines “area that is secure” to mean a locked storage area within a physician’s office. <p>Note: During business hours, the drawer, cabinet or room containing drugs, medication supplies or hazardous substances may remain unlocked <i>only</i> 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 <i>at all times</i>. At all other times, drugs, medication supplies and hazardous substances must be securely locked. Controlled substances are locked at all times.</p> |

  RN/MD Review only

| Criteria | Pharmaceutical Services Reviewer Guidelines |
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| <p>B. Drugs are handled safely and appropriately stored.  </p> <p>* Related Q & As Section V: # 5, 8, 9, 10, 12, 22, 23, 24, 25, 26, 27, 28, 29, 30</p> | <ul style="list-style-type: none"> • Deficiencies: All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan. • Drug preparation: A drug or device is considered “adulterated” if it contains any filthy, putrid, or decomposed substance, or if it has been prepared, packed or held under unsanitary conditions (21 USC, Section 351). A drug is considered contaminated if it has been held under unsanitary conditions that may have been contaminated with filth, or rendered injurious to health. • Storage: Medications are kept separate from food, lab specimens, cleaning supplies, and other items that may potentially cause contamination. Drugs are stored under appropriate conditions of temperature, humidity, and light so that the identity, strength, quality, and purity of the drug product is not affected (21 CFR, Section 211.142). Room temperature where drugs are stored does not exceed 30°C (86°F) (Title 22, Section 75037 (d)). • Immunobiologics: Vaccines are refrigerated immediately upon receipt on site and stored according to specific instructions on the package insert for each vaccine. Vaccines, such as MMR, DTP, DTaP, DT, Td, Hep A, Hep B, Enhanced Inactivated Polio (E-IPV), and Pneumococcal, are kept in a refrigerator maintained at 2° to 8°C or 35° to 46°F. MMR and varicella are protected from light at all times, and kept cold. Vaccines are not stored in the doors of refrigerator or freezer. Diluent does not need refrigeration if vaccine is administered right after diluent is added. Oral polio vaccine (OPV) and varicella vaccines are stored in the freezer at -15°C or 5°F, or lower. If stored vaccines are in solid state and contain ice crystals on the outside of vial, vaccines are considered appropriately frozen. Refrigerator and freezer temperatures are checked at least once each day. • 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: <ol style="list-style-type: none"> 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. *However, if solutions such as betadine, hydrogen peroxide and alcohol are left in the room they do need to be labeled. <p>* Disposing of Drugs: Providers may conduct their own drug destruction if authorized by the DEA. Those authorizations will remain in effect until rescinded, revoked or procedures are changed. Controlled drugs may be sent to DEA registered disposal firm (reverse distributor) for destruction. Provider may return controlled drugs to the drug manufacturer. Providers are not required to use reverse distributor; however, the DEA does require documentation maintenance on disposal of controlled drugs.</p> <p>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.</p> |



| Criteria | Pharmaceutical Services Reviewer Guidelines |
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| <p>C. Drugs are dispensed according to State and federal drug distribution laws and regulations.</p> <p>* Related Q & As Section V: # 4, 5, 6, 7, 18, 19, 32</p> | <ul style="list-style-type: none"> • <u>Deficiencies:</u> All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan. • <u>Expiration date:</u> 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. • <u>Prescription labeling:</u> 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 <i>does not</i> 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). • <u>Drug distribution:</u> Each clinic that provides drug distribution services has written policies and procedures for the safe and effective distribution control, storage, use and disposition of drugs. • <u>Drug dispensing:</u> 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. • <u>Vaccine Immunization Statements (VIS):</u> Since 1994, the National Childhood Vaccine Injury Act, Section 2126 of the Public Health Service Act, mandates that parents/guardians or adult patients be informed before vaccinations are administered. Health care providers must give a copy of the most recent VIS to patients prior to each vaccination dose of Td, MMR, varicella, polio or hepatitis B vaccine. The date the VIS was given <i>and</i> the publication date of the VIS must be documented in the patient’s medical record. The most current VISs are available from state and local health departments or can be downloaded from the CDC web site at www.cdc.gov/nip/publications/VIS or by calling the CDC Immunization Hotline at 800/232-2522. • <u>Pharmacy:</u> If a pharmacy is located on site, a licensed pharmacist monitors drug distribution and policies/procedures for medication dispensing/storage. * The reviewer needs only to verify that there is a current pharmacy license. They are reviewed by other agencies. <p>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.</p> |

| Criteria | Laboratory Services Reviewer Guidelines |
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| <p>D. Site operates in compliance with Clinical Laboratory Improvement Amendment (CLIA) regulations.</p> <p>* Related Q & As Section V: # 11, 12, 18, 21, 27, 28</p> | <ul style="list-style-type: none"> • CLIA Certificates: All sites that perform laboratory testing for human health assessment, diagnosis, prevention, or treatment of disease has a current, unrevoked, unsuspended site-specific Clinical Laboratory Improvement Amendment (CLIA) certificate, or evidence of renewal. Acceptable documentation such as the original certificate, copy of the original certificate, renewal receipt or other evidence of renewal submission is present on site or readily available upon request. The CLIA Certificate on site includes one of the following: <ul style="list-style-type: none"> A) <u>Certificate of Waiver:</u> Site is able to perform only exempt waived tests. B) <u>Certificate for Provider-Performed Microscopy (PPM):</u> Physicians, dentists, or mid-level practitioners are able to perform PPM procedures and waived tests. C) <u>Certificate of Registration:</u> Allows moderate and/or high complexity lab testing to be conducted until compliance with CLIA regulations is determined by survey. D) <u>Certificate of Compliance:</u> Lab has been surveyed and found in compliance with all applicable CLIA requirements. E) <u>Certificate of Accreditation:</u> Lab is accredited by an accreditation organization approved by the Health Care Financing Administration (HCFA). • Waived tests: If only waived tests are performed, site has a current CLIA Certificate of Waiver. There are no specific CLIA regulations regarding the performance of waived tests. Site personnel are expected to follow the test manufacturer’s instructions. Laboratories with certificates of waiver may not be routinely inspected by 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. • 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. <p>* Laboratory Sites: The reviewer only needs to verify that there is a current license for the laboratory to operate. They are reviewed by other agencies.</p> <p>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/cliawaived.html. CLIA re/certification includes an evaluation every two years (or sooner of complaint driven) by DHCS of personnel licenses/training, laboratory site inspection and demonstration of testing proficiency for moderate and high-complexity test sites. For questions regarding CLIA certification, laboratory licensing, and personnel, call CA DHCS Laboratory Field Services at (510) 873-6328.</p> |

| Criteria | Radiology Services Reviewer Guidelines |
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| <p>E. Site meets California DHCS Radiological inspection and safety regulations.</p> <p>* Related Q & As Section V: # 13, 14, 15, 16, 17, 20, 31</p> | <ul style="list-style-type: none"> • DHCS Radiologic Health Branch Inspection Report: If site has <i>current</i> documentation of one of the following, give the full 9 points and survey items 2-9 will not need to be surveyed. <ol style="list-style-type: none"> 1) Inspection Report, <i>or</i> 2) Inspection Report <i>and</i> Short Form Sign-off sheet, <i>or</i> 3) Inspection Report <i>and</i> Notice of Violation form <i>and</i> approval letter for corrective action plan from the CA Radiologic Health Branch. <p>The Radiologic Inspection Report, issued by the Radiologic Health Branch, must be present if there is radiology equipment on site. If any violations are found, one of two documents is issued to the site. The Short Form Sign-off sheet” is issued for minimal problems that are easily corrected. The “Notice of Violation” form, requiring a site corrective action plan, is issued if there are more serious violations. All “Notice of Violation” corrective action plans must be accompanied by an approval letter from the CA Radiologic Health Branch. If documents are not available on site, or if reviewer is uncertain about the “current” status of documents on site, proceed to score all items 1-9.</p> <ul style="list-style-type: none"> • 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 <i>and</i> 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. <p>Note: The Radiologic Health Branch of the Food, Drug, and Radiation Safety Division of the CA Department of Health Care Services enforces the Radiation Control Laws and Regulations designed to protect both the public and employees against radiation hazards. Enforcement is carried out through licensing, registration and periodic inspection of sources of radiation, such as radiation machines. For questions regarding radiologic safety (e.g. expired or no inspection letters on site), call CA DHCS Radiologic Health Branch (Compliance Unit) General Information (daytime hours) at (916) 445-0931 or Radiation Emergency Assistance (all hours) at 1-800-853-7550.</p> |

| Criteria | Preventive Services Reviewer Guidelines |
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| <p>A. Preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases.</p> <p>* Related Q & As Section VI: # 1, 2, 3, 9, 10, 12, 13, 15 Section IX: # 6</p> | <ul style="list-style-type: none"> • Examination table: A protective barrier that is changed between patient contacts 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. *Scales must be maintained by manufacturer’s guidelines and /or serviced by a qualified technician. • Measuring devices: Equipment on site for measuring stature (length/height) and head circumference includes: <ol style="list-style-type: none"> 1) rigid 90° right angle headboard block that is perpendicular to the recumbent measurement surface, or vertical to the wall-mounted standing measurement surface. 2) flat, paper or plastic non-stretchable tape or yardstick, marked to one-eighth (1/8 in. or 1 mm) or less, attached to a firm, flat surface. The “0” of the tape is exactly at the base of the headboard for recumbent measurement, or exactly at foot level for standing measurement. 3) moveable, non-flexible footboard at 90° right angle perpendicular to the recumbent measurement surface, or a flat floor surface for standing. 4) A non-stretchable tape measuring devise marked to one-eighth (1/8 in. or 1 mm) or less for measuring head circumference. • Basic equipment: Exam gown sizes are appropriate to population served on site. • Vision testing: Site has both a literate (e.g., Snellen) and an illiterate eye chart (e.g., “E” Chart, “Kindergarten” chart, Allen Picture Card Test). “Heel” lines are aligned with center of eye chart at a distance of 10 or 20-feet depending on whether the chart is for the 10 foot or 20 foot distance. Eye charts are located in an area with adequate lighting and at height(s) appropriate to use. Disposable eye “occluders” (e.g., Dixie cups or tongue blades with back-to-back- stickers) are acceptable. Non-disposable occluders are cleaned between patients. <p>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.</p> |

  RN/MD Review only


| Criteria | Preventive Services Reviewer Guidelines |
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| <p>B. Health education services are available to Plan members.  </p> <p>* Related Q & As Section VI: # 4, 5, 6, 8</p> | <ul style="list-style-type: none"> • Health Education services: Services may include individual instruction, group classes, family counseling and/or other health educational programs and materials provided to members by the provider, health plan, or community sponsored programs. • Health Education materials: Materials may be located in an accessible area on site (e.g., exam room, waiting room, health education room or area), or provided to members by clinic staff and/or by Plan upon request. *Materials must be available in the appropriate threshold languages and 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 <i>each</i> 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. <p>Note: Threshold languages are the primary languages spoken by Limited English Proficient (LEP) population groups residing in a county. A numeric threshold of 3,000 eligible LEP Medi-Cal beneficiaries, or a concentration standard of 1,000 residing in a single ZIP code or 1,500 in two contiguous ZIP codes establishes the threshold languages identified by the Department of Health Care Services for each county.</p> |

| Criteria | Infection Control Reviewer Guidelines |
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| <p>A. Infection control procedures for Standard/Universal precautions are followed.</p> <p>* Related Q & As Section VII: # 25, 26, 27</p> | <ul style="list-style-type: none"> • 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 <i>and</i> cannot locate written isolation procedure instructions, site is considered deficient. Isolation procedures will vary from site to site. <p>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 blood borne pathogens. “Universal precautions” refer to the OSHA mandated program that requires implementation of work practice controls, engineering controls, blood borne pathogen orientation/education, and record keeping in healthcare facilities.</p> |

- **Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan. (Q & As, Section VII: # 3, 7, 8, 10, 12, 24, 28, 30, 31, 32)
- **Personal Protective Equipment (PPE):** PPE is available for staff use on site, and includes water repelling gloves, clothing barrier (e.g., gown, sheets), face/eye protection (e.g., goggles, face shield), and respiratory infection protection (e.g., mask). Availability of other necessary PPE is specific to the practice and types of procedures performed on site. PPE is specialized clothing and/or equipment for protection against blood borne pathogen hazards, and does not include general work clothes (e.g., uniforms, cloth lab coats) that permit liquid to soak through. General work clothes are appropriate only if blood/OPIM does not penetrate through employee's work clothes, undergarments, skin, eyes, mouth, or other mucous membranes under NORMAL conditions of use.
 - **Blood and Other Potentially Infectious Materials (OPIM):** OPIM are all human body fluids, any unfixed tissue or organ (other than intact skin) from a human (living or dead), and HIV or HBV-containing blood, cells, tissue, organs, cultures, medium or solutions. Containers for blood and OPIM are closable, leak proof, and labeled and/or color-coded. Double bagging is required only if leakage is possible.
 - **Labels:** A warning label is affixed to red bagged regulated wastes, sharps containers, refrigerators/freezers containing blood or OPIM, containers used to store or transport blood or OPIM, and contaminated laundry or equipment for storage or transporting. The international "BIOHAZARDOUS WASTE" label, (fluorescent orange or red-orange with contrasting lettering/symbols) is an integral part of the container or affixed to container. Sharps containers are labeled with the words "Sharps Waste" or with the international biohazard symbol and the word "BIOHAZARD". Individual containers of blood or OPIM are exempted from warning labels if placed inside a labeled secondary container for storage, transport, or disposal. Alternative marking or color coding may be used to label contaminated laundry or specimen containers if the alternative marking permits employees on site to recognize that container requires compliance with Universal Precautions. If the contaminated laundry or specimen leaves the site, an international "Biohazardous Waste" warning label and/or red color-coding is required
 - **Needlestick Safety:** Contaminated sharps are discarded immediately. Sharps containers are located close to the immediate area where sharps are used, and are inaccessible to unauthorized persons. Sharps are not bent, removed from a syringe, or recapped except by using a one-handed technique. Needleless systems, ***needle with ESIP** and non-needle sharps are used unless exemptions have been approved by Cal/OSHA (8CCR, Section 5193). Security of portable containers in patient care areas is maintained at all times. Any device capable of cutting or piercing (e.g. syringes, hypodermic needles, needleless devices, blades, broken glass, slides, vials) are placed in a closable, puncture-resistant, labeled, leak-proof container. If these requirements are met, containers made of various materials (e.g., cardboard, plastic) are acceptable. Containers are not overfilled past manufacturer's designated fill line, or more than ¾ full. Supply of containers on hand is adequate to ensure routine change-out when filled.
 - **Sharps Injury documentation:** Site has a method in place to document sharps injuries. Date, time, description of exposure incident, sharp type/brand, follow-up care is documented within 14 days of injury incident.
 - **Contaminated Laundry:** Contaminated laundry (soiled with blood/OPIM or containing contaminated sharps) is laundered at a ***commercial laundry service**, by contracted laundry service, or a washer and dryer on site. Manufacturer's guidelines are followed to decontaminate and launder reusable protective clothing. Laundry requirements are "not applicable" if only disposable PPE is used on site.
 - **Regulated Waste storage:** Regulated waste is contained separately from other wastes (e.g., contaminated wastes) at the point of origin in the producing facility, placed in red biohazardous bags with Biohazard label, and stored in a closed container that is not accessible to unauthorized persons. If stored outside of the office, a lock secures the entry door, gate or receptacle lid, and posted warning sign(s) in English and Spanish are visible for a distance of 25-feet. The sign wording states "**CAUTION—BIOHAZARDOUS WASTE STORAGE AREA—UNAUTHORIZED PERSONS KEEP OUT**" or "**CUIDADO—ZONA DE RESIDUOS—BIOLÓGICOS PELIGROSOS—PROHIBIDA LA ENTRADA A PERSONAS NO AUTORIZADAS.**" Signs prior to the passage of the Medical Waste Act, Infectious Waste, are permitted for the "life" of the sign. Regulated wastes include: 1) *Biohazardous wastes*, e.g., laboratory wastes, human specimens/tissue, blood/contaminated materials "known" to be infected with highly communicable diseases for humans and/or that require isolation, and 2) *Medical wastes*, e.g., liquid/semi-liquid blood or OPIM, items caked with dry blood or OPIM and capable of releasing materials during handling, and contaminated sharps (Health and Safety Code, Chapter 6.1, CA Medical Waste Management Act).
 - **Medical Waste disposal:** Medical wastes are hauled to a permitted offsite medical waste treatment facility, to a transfer station, or to another registered generator for consolidation. Hauling is by a registered hazardous waste transporter or by a person with an approved limited-quantity hauling exemption granted by the CA DHCS Waste Management Division. The limited-quantity hauling exemption is valid for a period of one year and is renewed annually. When hauling medical wastes, the transporter carries the exemption form in the transporting vehicle. A medical waste tracking document is maintained that includes name of person transporting, number of waste containers, type of medical wastes, and date of transportation. Tracking document is kept a minimum of 3 years for large waste generators and 2 years for small generators ***(both certificate and tracking log is needed).**


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 | Infection Control Reviewer Guidelines |
|---|---|
| <p>C. Contaminated surfaces are decontaminated according to established regulations/standards.</p> <p></p> <p>* Related Q & As Section VII: # 4, 5, 6, 13, 14, 15, 23, 29</p> | <ul style="list-style-type: none"> • 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. Decontamination products are reconstituted and applied according to manufacturer’s guidelines for “decontamination.” • 10% Bleach Solution: 10% bleach solution is changed/reconstituted <i>every</i> 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, <i>specific</i> to every bleach product, are followed carefully. <p>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 blood borne pathogens so that a surface or item is no longer capable of transmitting infectious particles and is rendered safe for handling, use or disposal. Current EPA product lists and information is available from the EPA, Antimicrobial Division (703) 305-1284 or (703) 308-0127.</p> |

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Revised 8/05

| Criteria | Infection Control Reviewer Guidelines |
|--|---|
| <p>D. Reusable medical instruments are properly sterilized after each use.</p>  <p>* Related Q & As Section VII: # 1, 2, 16, 17, 19, 20, 21, 22, 33</p> | <ul style="list-style-type: none"> • Deficiencies: All deficiencies related to Infection Control must be addressed in a corrective action plan. • Cleaning prior to sterilization: Prior to undergoing the sterilization process, soiled instruments/equipment are thoroughly cleaned, rinsed, dried and inspected for the presence of dried blood or other debris. Personnel are able to demonstrate or verbally explain procedure(s) used for cleaning prior to sterilization, and to locate written directions on site. • Cold/chemical sterilization: Product manufacturer’s directions are strictly followed for instrument pre-soaking treatment, solution preparation, solution exposure procedures, safety precautions (e.g., room temperature, area ventilation), and post-sterilization processes. Sterilization exposure times and solution expiration date/time is communicated to staff. Written procedures for cold sterilization are available on site to staff. • Autoclave/steam sterilization: Autoclave manufacturer’s directions are strictly followed for instrument pre-cleaning, machine loading, operation safety precautions, minimum time-temperature criteria, and post sterilization processes. Written operating procedures for autoclave are available on site to staff. If instruments/equipment are transported off-site for sterilization, equipment-handling and transport procedures are available on site to staff. • Autoclave maintenance: Autoclave is maintained and serviced according to manufacturer’s guidelines. If the manufacturer’s guidelines are not present on site, the autoclave is serviced annually by a qualified technician. A dated sticker on the autoclave or a service receipt is acceptable documentation of appropriate maintenance. • Spore testing: Autoclave spore testing is performed <i>at least monthly</i>, unless otherwise stated in manufacturer’s guidelines. Written procedures for performing routine spore testing and for handling positive spore test results are available on site to staff. For positive spore tests, the autoclave is removed from service immediately until inspection is completed and a negative retest occurs. Procedures include: <i>report</i> problem, <i>repair</i> autoclave, <i>retrieve</i> all instruments sterilized since last negative spore test, <i>re-test</i> autoclave and <i>re-sterilize</i> retrieved instruments (<u>R</u>eport/<u>R</u>e<u>p</u>air/<u>R</u>e<u>r</u>trieve/<u>R</u>e<u>t</u>est/<u>R</u>e-sterilize). • Documentation: Documentation of the following activities is maintained on site: <ul style="list-style-type: none"> ▸ Autoclave maintenance: mechanical problems, inspection dates, results/outcome of routine servicing, calibration, repairs, etc., ▸ Sterilization loads: date, time and duration of run cycle, temperature, steam pressure, operator of each run, ▸ Biological spore testing: date, results, types of spore test used, person performing/documenting test results • Sterile Packages: Storage areas for sterilized packages are clean, dry and separated from non-sterile items by a functional barrier (e.g., shelf, cabinet door, drawer). Sterilized package labels include date of sterilization, load run identification information, and general contents (e.g. suture set). Each item in a sterile package need not be listed on the label if a master list of package contents is available elsewhere on site. Maintenance of sterility is event related, not time related. Sterilized items are considered sterile until use, unless an event causes contamination. Sterilized items are not considered sterile if package is opened, wet/moist, discolored or damaged, and should be kept removed from sterile package storage area. Site has a process for routine evaluation of sterilized packages. <p>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.</p> |



| Site Access/Safety Survey Criteria | Yes | No | N/A | Wt | Site Score |
|---|-----|----|-----|----|------------|
|---|-----|----|-----|----|------------|

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

| 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 | |
| 2. Restrooms are clean and contain appropriate sanitary supplies | 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 | |
| 2. Emergency non-medical procedures (e.g. site evacuation, workplace violence) | 2_____ | _____ | _____ | 1 | |
| The following fire and safety precautions are evidenced on site: | | | | | |
| 3. Lighting is adequate in all areas to ensure safety. | 3_____ | _____ | _____ | 1 | |
| 4. <u>Exit doors and aisles are unobstructed and egress (escape) accessible.</u> | 4_____ | _____ | _____ | 2 | |
| 5. Exit doors are clearly marked with “Exit” signs. | 5_____ | _____ | _____ | 1 | |
| 6. Clearly diagramed “Evacuation Routes” for emergencies are posted in a visible location. | 6_____ | _____ | _____ | 1 | |
| 7. Electrical cords and outlets are in good working condition. | 7_____ | _____ | _____ | 1 | |
| 8. At least one type of fire fighting/protection equipment is accessible at all times. | 8_____ | _____ | _____ | 1 | |



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

  **RN/MD Review only**

| Site Access/Safety Survey Criteria | Yes | No | N/A | Wt | Site Score |
|---|--------|-------|-------|----------|------------|
| D. Emergency health care services are available and accessible 24 hours a day, 7 days a week. 22 CCR §51056, §53216; 28 CCR §1300.67; 42 USC §139.5 (d)   | | | | | |
| 1. Personnel are trained in procedures/action plan to be carried out in case of medical emergency on site. | 1_____ | _____ | _____ | 1 | |
| 2. Emergency equipment is stored together in easily accessible location. | 2_____ | _____ | _____ | 1 | |
| 3. Emergency phone number contacts are posted. | 3_____ | _____ | _____ | 1 | |
| Emergency medical equipment appropriate to practice/patient population is available on site: | | | | | |
| 4. <u>Airway management: oxygen delivery system, oral airways, nasal cannula or mask, Ambu bag.</u> | 4_____ | _____ | _____ | 2 | |
| 5. Anaphylactic reaction management: Epinephrine 1:1000 (injectable), Benadryl 25 mg. (oral) or Benadryl 50 mg./ml. (injectable), tuberculin syringes, alcohol wipes. | 5_____ | _____ | _____ | 1 | |
| 6. Medication dosage chart (or other method for determining dosage) is kept with emergency medications. | 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_____ | _____ | _____ | 1 | |
| 8. Replace/re-stock emergency equipment immediately after use. | 8_____ | _____ | _____ | 1 | |

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

  **RN/MD Review only**

| Site Access/Safety Survey Criteria | Yes | No | N/A | Wt. | Site Score |
|---|-------------------------------|---------------------------|---------------------------|---|------------|
| <p>E Medical and lab equipment used for patient care is properly maintained. CA Health & Safety (H&S) Code, §1374.30, §111255; 28 CCR §1300.80; 21 CFR §800-1299; 21 USC §201 (h)  </p> <p>1. Medical equipment is clean, functioning properly and maintained in operational condition.</p> <p>2. Written documentation demonstrates the appropriate maintenance of all specialized medical equipment according to equipment manufacturer’s guidelines.</p> | <p>1 _____</p> <p>2 _____</p> | <p>_____</p> <p>_____</p> | <p>_____</p> <p>_____</p> | <p style="text-align: center;">1</p> <p style="text-align: center;">1</p> | |
| TOTALS | | | | | |



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

2. Personnel

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



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

  **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. <u>Only qualified/trained personnel retrieve, prepare or administer medications.</u> | 1 _____ | _____ | _____ | 2 | |
| 2. Only qualified/trained personnel operate medical equipment. | 2 _____ | _____ | _____ | 1 | |
| 3. Documentation of education/training for non-licensed medical personnel is maintained on site. | 3 _____ | _____ | _____ | 1 | |



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

  **RN/MD Review only**

| Site Personnel Survey Criteria | Yes | No | N/A | Wt | Site Score |
|---|---|---|---|---|-------------------|
| <p>D. Scope of practice for non-physician medical practitioners is clearly defined. 16 CCR §1379, §1399.540, §1399.545, §1474, CA B&P Code §2725.1  </p> <p>1. Standardized Procedures are provided by Nurse Practitioners (NP) and/or Certified Nurse Midwives (CNM). 2. A Delegation of Services Agreement is provided by Physician Assistants (PA) and Supervisory Guidelines define the method of supervision by the Supervising Physician. 3. Standardized Procedures, Delegation of Services Agreements and Supervisory Guidelines are revised, updated <u>and</u> signed by the supervising physician and NPMP when changes in scope of services occur. 4. Each NPMP that prescribes controlled substances has a valid DEA Registration Number.</p> | <p>1 _____</p> <p>2 _____</p> <p>3 _____</p> <p>4 _____</p> | <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> | <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> | <p>1</p> <p>1</p> <p>1</p> <p>1</p> | |



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

  **RN/MD Review only**

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

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



  RN/MD Review only

| Site Personnel Survey Criteria | Yes | No | N/A | Wt | Site Score |
|--|---|---|---|---|------------|
| <p>G. Site personnel receive training and/or information on member rights. 22 CCR §51009, §51014.1, §51305.1, §53452, §53858; 28 CCR §1300.68  </p> <p>There is evidence that site staff has received training and/or information on the following:</p> <p>1. Patient Confidentiality</p> <p>2. Informed consent, including Human Sterilization</p> <p>3. Prior Authorization requests</p> <p>4. Grievance/Complaint Procedure</p> <p>5. Sensitive Services/Minors' Rights</p> <p>6. Health Plan referral process/procedures/resources</p> | <p>1 _____</p> <p>2 _____</p> <p>3 _____</p> <p>4 _____</p> <p>5 _____</p> <p>6 _____</p> | <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> | <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> | <p>1</p> <p>1</p> <p>1</p> <p>1</p> <p>1</p> <p>1</p> | |
| Totals | | | | | |

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



3. Office Management

  RN/MD Review only (#B)

| Office Management Survey Criteria | Yes | No | N/A | Wt | Site Score |
|--|--|--|--|--|---|
| <p>A. Physician coverage is available 24 hours a day, 7 days a week. 22 CCR §56500, §53855</p> <p>The following are maintained current on site:</p> <p>1. Clinic office hours are posted, or readily available upon request.</p> <p>2. Provider office hour schedules are available to staff.</p> <p>3. Arrangement/schedule for after-hours, on-call, supervisory back-up physician coverage is available to site staff.</p> <p>4. Contact information for off-site physician(s) is available at all times during office hours.</p> <p>5. After-hours emergency care instructions/telephone information is made available to patients.</p> | <p>1 _____</p> <p>2 _____</p> <p>3 _____</p> <p>4 _____</p> <p>5 _____</p> | <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> | <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> | <p>1</p> <p>1</p> <p>1</p> <p>1</p> <p>1</p> | <p></p> <p></p> <p></p> <p></p> <p></p> |
| <p>B. There is sufficient health care personnel to provide timely, appropriate health care services. 22 CCR §53855; 28 CCR §1300.67.1, §1300.80  </p> <p>1. Appropriate personnel handle emergent, urgent, and medical advice telephone calls.</p> <p>2. Telephone answering machine, voice mail system or answering service is used whenever office staff does not directly answer phone calls.</p> <p>3. Telephone system, answering service, recorded telephone information, and recording device are periodically checked and updated.</p> | <p>1 _____</p> <p>2 _____</p> <p>3 _____</p> | <p>_____</p> <p>_____</p> <p>_____</p> | <p>_____</p> <p>_____</p> <p>_____</p> | <p>1</p> <p>1</p> <p>1</p> | <p></p> <p></p> <p></p> |



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

  **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 | |
| 2. Patients are notified of scheduled routine and/or preventive screening appointments. | 2_____ | _____ | _____ | 1 | |
| 3. There is a system in place to follow-up on missed and canceled appointments. | 3_____ | _____ | _____ | 1 | |
| D. There is 24-hour access to interpreter services for limited-English proficient members. 22 CCR §53855; CA H&S Code §1259; 42 USC §2000d | | | | | |
| 1. Interpreter services are made available in identified threshold languages specified for location of site. | 1_____ | _____ | _____ | 1 | |
| 2. Persons providing language interpreter services on site are trained in medical interpretation. | 2_____ | _____ | _____ | 1 | |



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

  **RN/MD Review only (#E)**

| Office Management Survey Criteria | Yes | No | N/A | Wt | Site Score |
|---|------------|-----------|------------|-----------|-------------------|
| E. Procedures for timely referral/consultative services are established on site. 22 CCR §53851; 28 CCR §1300.67   | | | | | |
| Office practice procedures allow timely provision for: 1. Processing internal and external referrals, consultant reports and diagnostic test results | 1 _____ | _____ | _____ | 1 | |
| 2. <u>Physician review and follow-up of referral/consultation reports and diagnostic test results.</u> | 2 _____ | _____ | _____ | 2 | |
| F. Member Grievance/Complaint processes is established on site. 22 CCR §53858, §56260; 28 CCR §1300.67 | | | | | |
| 1. Phone number(s) for filing grievances/complaints are located on site. | 1 _____ | _____ | _____ | 1 | |
| 2. Complaint forms and a copy of the grievance procedure(s) are available on site. | 2 _____ | _____ | _____ | 1 | |

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

  **RN/MD Review only (#H)**

| Office Management Survey Criteria | Yes | No | N/A | Wt | Site Score |
|--|---------|-------|-------|----|------------|
| G. Medical records are available for the Provider at each scheduled patient encounter. | | | | | |
| 22 CCR §75055; 28 CCR §1300.80 | | | | | |
| 1. Medical records are readily retrievable for scheduled patient encounters. | 1 _____ | _____ | _____ | 1 | |
| 2. Medical documents are filed in a timely manner to ensure availability for patient encounters. | 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 | |
| 2. Procedures are followed to maintain the confidentiality of personal patient information. | 2 _____ | _____ | _____ | 1 | |
| 3. Medical record release procedures are compliant with State and federal guidelines. | 3 _____ | _____ | _____ | 1 | |
| 4. Storage and transmittal of medical records preserves confidentiality and security. | 4 _____ | _____ | _____ | 1 | |
| 5. Medical records are retained for a minimum of 5 years, or according to current State DHCS standard. | 5 _____ | _____ | _____ | 1 | |

| Office Management Survey Criteria | Yes | No | N/A | Wt | Site Score |
|---|-----|----|-----|----|------------|
| Comments: Write comments for all “No” (0 points) and “N/A” scores. | | | | | |
| Totals | | | | | |

4. Clinical Services

| Pharmaceutical Services Survey Criteria | Yes | No | N/A | Wt | Site Score |
|---|---------|-------|-------|----|------------|
| A. Drugs and medication supplies are maintained secure to prevent unauthorized access. CA B&P Code §4051.3, §4071, §4172; 22 CCR §75037(a-g), §75039; 21 CFR §1301.75, §1301.76, §1302.22 | | | | | |
| 1. Drugs are stored in specifically designated cupboards, cabinets, closets or drawers. | 1 _____ | _____ | _____ | 1 | |
| 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 _____ | _____ | _____ | 1 | |
| 3. Controlled drugs are stored in a locked space accessible only to authorized personnel. | 3 _____ | _____ | _____ | 1 | |
| 4. A dose-by-dose controlled substance distribution log is maintained. | 4 _____ | _____ | _____ | 1 | |

| Pharmaceutical Services Survey Criteria | Yes | No | N/A | Wt | Site Score |
|--|-----|----|-----|----|------------|
|--|-----|----|-----|----|------------|

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

  **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 |
| 2. Drugs for external use are stored separately from drugs for internal use. | 2 | _____ | _____ | 1 |
| 3. Items other than medications in refrigerator/freezer are kept in a secured, separate compartment from drugs. | 3 | _____ | _____ | 1 |
| 4. Refrigerator thermometer temperature is 35°-46° Fahrenheit or 2°-8° Centigrade (at time of site visit). | 4 | _____ | _____ | 1 |
| 5. Freezer thermometer temperature is 5° Fahrenheit or –15° Centigrade, or lower (at time of site visit). | 5 | _____ | _____ | 1 |
| 6. Daily temperature readings of medication refrigerator and freezer are documented. | 6 | _____ | _____ | 1 |
| 7. Drugs are stored separately from test reagents, germicides, disinfectants and other household substances. | 7 | _____ | _____ | 1 |
| 8. Hazardous substances are appropriately labeled. | 8 | _____ | _____ | 1 |
| 9. Site has method(s) in place for drug and hazardous substance disposal. | 9 | _____ | _____ | 1 |

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

| 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 | |
| 2. Site has a procedure to check expiration date of all drugs (including vaccines and samples), and infant and therapeutic formulas. | 2 _____ | _____ | _____ | 1 | |
| 3. All stored and dispensed prescription drugs are appropriately labeled. | 3 _____ | _____ | _____ | 1 | |
| 4. <u>Only lawfully authorized persons dispense drugs to patients.</u> | 4 _____ | _____ | _____ | 2 | |
| 5. Vaccine Information Sheets (VIS) for distribution to patients are present on site. | 5 _____ | _____ | _____ | 1 | |
| 6. If there is a pharmacy on site, it is licensed by the CA State Board of Pharmacy. | 6 _____ | _____ | _____ | 1 | |

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

| 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 | |
| 2. Testing personnel performing clinical lab procedures have been trained. | 2 _____ | _____ | _____ | 1 | |
| 3. Lab supplies are inaccessible to unauthorized persons. | 3 _____ | _____ | _____ | 1 | |
| 4. Lab test supplies (e.g. vacutainers, culture swabs, test solutions) are not expired. | 4 _____ | _____ | _____ | 1 | |
| 5. Site has a procedure to check expiration date and a method to dispose of expired lab test supplies. | 5 _____ | _____ | _____ | 1 | |

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



| Radiology Services Survey Criteria | Yes | No | N/A | Wt | Site Score |
|---|------------|-----------|------------|-----------|-------------------|
| E. Site meets California DHCS 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 | |
| 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 _____ | _____ | _____ | 1 | |
| 3. “Radiation Safety Operating Procedures” posted in highly visible location. | 3 _____ | _____ | _____ | 1 | |
| 4. “Notice to Employees Poster” posted in highly visible location. | 4 _____ | _____ | _____ | 1 | |
| 5. “Caution, X-ray” sign posted on or next to door of each room that has X-ray equipment | 5 _____ | _____ | _____ | 1 | |
| 6. Physician Supervisor/Operator certificate posted <i>and</i> within current expiration date | 6 _____ | _____ | _____ | 1 | |
| 7. Technologist certificate posted <i>and</i> within current expiration date | 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 _____ | _____ | _____ | 1 | |
| 9. Gonadal shield (0.5 mm or greater lead equivalent): for patient procedures in which gonads are in direct beam. | 9 _____ | _____ | _____ | 1 | |
| Comments: Write comments for all “No” (0 points) and “N/A” scores. | | | | | |
| | | | | | |

5. Preventive Services

| Preventive Services Survey Criteria | Yes | No | N/A | Wt | Site Score |
|--|----------|-------|-------|----|------------|
| A. Preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases. 22 CCR §53851, §56210; 28 CCR §1300.67 | | | | | |
| Examination equipment, appropriate for primary care services, is available on site: | | | | | |
| 1. Exam tables and lights are in good repair. | 1 _____ | _____ | _____ | 1 | |
| 2. Stethoscope and sphygmomanometer with various size cuffs (e.g. child, adult, obese/thigh). | 2 _____ | _____ | _____ | 1 | |
| 3. Thermometers: oral and/or tympanic.. | 3 _____ | _____ | _____ | 1 | |
| 4. Scales: standing balance beam and infant scales. | 4 _____ | _____ | _____ | 1 | |
| 5. Measuring devices for stature (height/length) measurement <i>and</i> head circumference measurement. | 5 _____ | _____ | _____ | 1 | |
| 6. Basic exam equipment: percussion hammer, tongue blades, patient gowns. | 6 _____ | _____ | _____ | 1 | |
| 7. Eye charts (literate and illiterate) and occluder for vision testing. | 7 _____ | _____ | _____ | 1 | |
| 8. Ophthalmoscope. | 8 _____ | _____ | _____ | 1 | |
| 9. Otoscope with adult and pediatric ear speculums. | 9 _____ | _____ | _____ | 1 | |
| 10. Audiometer in quiet location for testing. | 10 _____ | _____ | _____ | 1 | |

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

  **RN/MD Review only**

| Health Education Survey Criteria | Yes | No | N/A | Wt | Site Score |
|--|--|--|--|---|-------------------|
| <p>B. Health education services are available to Plan members. 22 CCR §53851; 28 CCR 1300.67  </p> <p>Health education materials and Plan-specific resource information are:</p> <ol style="list-style-type: none"> 1. readily accessible on site, or are made available upon request, 2. applicable to the practice and population served on site, 3. available in threshold languages identified for county and/or area of site location. | <p>1_____</p> <p>2_____</p> <p>3_____</p> | <p>_____</p> <p>_____</p> <p>_____</p> | <p>_____</p> <p>_____</p> <p>_____</p> | <p>1</p> <p>1</p> <p>1</p> | |
| <p>Comments: Write comments for all “No” (0 points) and “N/A” scores.</p> | | | | | |
| <p>Totals</p> | | | | | |

6. Infection Control



| Infection Control Survey Criteria | Yes | No | N/A | Wt | Site Score |
|--|---------|-------|-------|----|------------|
| A. Infection control procedures for Standard/Universal precautions are followed. 8 CCR §5193; 22 CCR §53230; 29 CFR §1910.1030; Federal Register 1989, §54:23042 | | | | | |
| 1. Antiseptic hand cleaner and running water are available in exam and/or treatment areas for hand washing. | 1 _____ | _____ | _____ | 1 | |
| 2. A waste disposal container is available in exam rooms, procedure/treatment rooms and restrooms. | 2 _____ | _____ | _____ | 1 | |
| 3. Site has procedure for effectively isolating infectious patients with potential communicable conditions. | 3 _____ | _____ | _____ | 1 | |

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

| 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. <u>Personal Protective Equipment is readily available for staff use.</u> | 1_____ | _____ | _____ | 2 | |
| 2. <u>Needlestick safety precautions are practiced on site.</u> | 2_____ | _____ | _____ | 2 | |
| 3. All sharp injury incidents are documented. | 3_____ | _____ | _____ | 1 | |
| 4. <u>Blood, other potentially infectious materials and Regulated Wastes are placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport or shipping.</u> | 4_____ | _____ | _____ | 2 | |
| 5. Biohazardous (non-sharp) wastes are contained separate from other trash/waste. | 5_____ | _____ | _____ | 1 | |
| 6. Contaminated laundry is laundered at the workplace or at a commercial laundry. | 6_____ | _____ | _____ | 1 | |
| 7. Storage areas for regulated medical wastes are maintained secure and inaccessible to unauthorized persons. | 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_____ | _____ | _____ | 1 | |



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

  **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 | |
| 2. Routine cleaning and decontamination of equipment/work surfaces is completed according to site-specific written schedule. | 2 _____ | _____ | _____ | 1 | |
| Disinfectant solutions used on site are: | | | | | |
| 3. approved by the Environmental Protection Agency (EPA). | 3 _____ | _____ | _____ | 1 | |
| 4. effective in killing HIV/HBV/TB. | 4 _____ | _____ | _____ | 1 | |
| 5. used according to product label for desired effect. | 5 _____ | _____ | _____ | 1 | |

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

  **RN/MD Review only**

| Infection Control Survey Criteria | Yes | No | N/A | Wt | Site Score |
|---|---------|-------|-------|----------|------------|
| D. Reusable medical instruments are properly sterilized after each use. 22 CCR §53230, §53856; CA H&S Code, Chapter 6.1, §25090   | | | | | |
| 1. Written site-specific policy/procedures or Manufacturer’s Instructions for instrument/equipment sterilization are available to staff. | 1 _____ | _____ | _____ | 1 | |
| Staff adheres to site-specific policy <u>and/or</u> manufacturer/p oduct label directions for the following procedures: | | | | | |
| 2. Cleaning reusable instruments/equipment prior to sterilization | 2 _____ | _____ | _____ | 1 | |
| 3. Cold chemical sterilization | 3 _____ | _____ | _____ | 1 | |
| 4. Autoclave/steam sterilization | 4 _____ | _____ | _____ | 1 | |
| 5. Autoclave maintenance | 5 _____ | _____ | _____ | 1 | |
| 6. <u>Spore testing of autoclave/steam sterilizer with documented results (at least monthly)</u> | 6 _____ | _____ | _____ | 2 | |
| 7. Sterilized packages are labeled with sterilization date and load identification information. | 7 _____ | _____ | _____ | 1 | |
| Comments: Write comments for all “No” (0 points) and “N/A” scores. | | | | | |
| Totals | | | | | |

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

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

| |
|-------------------|
| Access/Safety |
| Personnel |
| Office Management |
| Clinical Services |

Infection Control


Reviewer(s)/Title _____

Date _____

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 provider. Documented evidence found in the hard copy (paper) medical records and/or electronic medical records are used for survey criteria determinations. Full Pass is 100%. Conditional Pass is 80-99%. Not Pass is below 80%. The minimum passing score is 80%. ***Sites that receive an Exempted Pass (90% or above) for medical record review may not be required to complete a CAP for the medical record review. On-site CAP follow-up visits are intended to verify that processes are in place to remedy deficiencies.** Not applicable (“N/A”) applies to any criterion that does not apply to the medical record being reviewed, and must be explained in the comment section. Medical records shall be randomly selected using methodology decided upon by the reviewer. Ten (10) medical records are surveyed for each provider, five (5) adult and/or obstetric records and five (5) pediatric records. For sites with *only* adult, *only* obstetric, or *only* pediatric patient populations, all ten records surveyed will be in *only* one preventive care service area. Sites where documentation of patient care by all PCPs on site occurs in universally shared medical records shall be reviewed as a “shared” medical record system. Scores calculated on shared medical records apply to each PCP sharing the records. A minimum of ten shared records shall be reviewed for 2-3 PCPs, twenty records for 4-6 PCPs, and thirty records for 7 or more PCPs. Survey criteria to be reviewed *only* by a R.N. or physician is labeled “ **RN/MD Review only**”.

CAP Scoring: * (1) Review each line item criteria for deficiencies to determine if a CAP is required according to reviewer guidelines. (2) The following findings for each criterion would require a corrective action (CAP): if the majority of charts did not document particular criteria (excluding NA’s), or determined at the reviewer’s discretion.

Scoring Directions: Score one point if criterion is met. Score zero points if criterion is not met. Do not score partial points for any criterion. ***Calculate the total points possible for each section, then add the total points possible for all sections. Calculate the actual points given for each section, then add the actual points given for all sections reviewed. Subtract the “NA” points from the total points possible. Divide the total actual points given by the total points possible, or by the “adjusted” points, then multiply by 100 to calculate the percentage. If more than 10 records are reviewed, the totals are calculated accordingly.** 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.

***For shared records: If 10 shared records are reviewed, score calculation shall be the same as for 10 records reviewed for a single provider. If 20 records are reviewed, divide total points given by 640, or by the “adjusted” total points possible. If 30 records are reviewed, divide total points given by 960, or by the “adjusted” total points possible. Multiply by 100 to calculate percentage rate. Reviewers have the option to request additional records to review, but must calculate scores accordingly. Reviewers are expected to determine the most appropriate method(s) at each site to ascertain information needed to complete the survey.**



The following sample provides an exercise on how to calculate the score:

Scoring Example:

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

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

| Criteria | Format Reviewer Guidelines |
|--|--|
| A. An individual medical record is established for each family member.) | Providers are able to readily identify each individual treated. A medical record is started upon the initial visit. "Family charts" are not acceptable. |
| B. Member identification is on each page. (Q&A, Section VIII: # 44, 45, 46, 47, 58, 63) | Member identification includes first and last name, and/or a unique patient number established for use on clinical site. Electronically maintained records and printed records from electronic systems contain patient identification. |
| C. Individual personal biographical information is documented. | Personal biographical information includes date of birth, current address, home/work phone numbers, and name of parent(s) if patient is a minor. If patient refused to provide information, "refused" is noted in the medical record. If portions of the personal biographical information are not completed (left blank), reviewer should attempt to determine if patient has refused to provide information. Do not deduct points if member has refused to provide all personal information requested by the provider. |
| D. Emergency "contact" is identified. (Q&A, Section VIII: # 1, 2, 3, 61) | The name and phone number of an "emergency contact" person is identified for all patients. Listed emergency contacts may include a relative or friend, or a home, work, pager, cellular or message phone number. If the patient is a minor, the contact person must be a parent or legal guardian. Adults and emancipated minors may list anyone of their choosing. If a patient refuses to provide an emergency contact, "refused" is noted in the record. Do not deduct points if member has refused to provide personal information requested by the provider. |
| E. Medical records are consistently organized. | Contents and format of printed and/or electronic records within the practice site are uniformly organized. |
| F. Chart contents are securely fastened. | Printed chart contents are securely fastened, attached or bound to prevent medical record loss. Electronic medical record information is readily available. |
| G. Patient's assigned primary care physician (PCP) is identified. (Q&A, Section VIII: 6) | The assigned PCP is <i>always</i> identified when there is more than one PCP on site and/or when the patient has selected health care from a non-physician medical practitioner. If there is only one PCP on site, the provider's documentation and signature in the record identifies the primary care physician/provider of services. Since various methods are used to identify the assigned PCP, reviewers must identify specific method(s) used at each individual site. |
| H. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing-impaired persons are prominently noted. (Q&A, Section IV: # 23, 24, 27, 28, 29, 30 and Section VIII: # 40, 41, 42, 49, 60) | The primary language and requests for language and/or interpretation services by a non-or limited-English proficient person is documented. Member refusal of interpreter services is documented. If English is the primary language, then language documentation is not necessary. Note: Title VI of the Civil Rights Act of 1964 prohibits recipients of federal funds from providing services to LEP persons that are limited in scope or lower in quality than those provided to others. Since Medi-Cal is partially funded by federal funds, <i>all</i> 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 | Documentation Reviewer Guidelines |
|---|--|
| A. Allergies are prominently noted. (Q&A, Section VIII: # 33, 62) | *List the drug that a member has allergies and adverse reactions to in a consistent location in the medical record. If member has no allergies or adverse reactions, “No Known Allergies” (NKA), “No known Drug Allergies” (NKDA), or ∅ is documented. *The provider does not need to document the manifestations of the reactions, only a list of the drugs. |
| B. Chronic problems and/or significant conditions are listed. (Q&A, Section VIII: # 19, 26, 27, 29) | Documentation may be on a separate “problem list” page, or a clearly identifiable problem list in the progress notes. All chronic or significant problems are considered current if no “end date” is documented. Note: Chronic conditions are current long-term, on-going conditions with slow or little progress |
| C. Current continuous medications are listed. (Q&A, Section VIII: # 18,19, 23, 24, 25, 27) | Documentation may be on a separate “medication list” page, or a clearly identifiable medication list in the progress notes. List of current , on-going medications identifies the medication name, dosage, route (*if other than PO), and frequency. Discontinued medications are noted on the medication list or in progress notes. |
| D. Signed Informed Consents are present, when appropriate. (Q&A, Section VIII: #2, 57, 59, 64 and Section IX: # 8) | Adults, parents/legal guardians of a minor or emancipated minors may sign consent forms for medical treatment. Informed Consents are signed for operative and invasive procedures. Human sterilization requires DHCS Consent Form 330. Signed authorization is documented in the medical record for release of medical information. Note: Persons under the age of 18 years are emancipated if they have entered into a valid marriage, are on military active duty, or have received a court declaration of emancipation under the CA Family Code, Section 7122. |
| E. Advance Health Care Directive information is offered (Adults (18 years); Emancipated minors). (Q&A, Section VIII: # 14, 15, 16, 17) | Adult medical records include documentation of whether member has been offered information or has executed an Advance Health Care Directive (California Probate Code, Sections 4701). |
| F. Entries are made in accordance with acceptable legal medical documentation standards. (Q&A, Section VIII: # 6, 7, 8, 9, 10, 20, 21) | All entries are signed, dated and legible. Signature includes the first initial, last name and title. Initials may be used only if signatures are specifically identified elsewhere in the medical record (e.g. signature page). Stamped signatures are acceptable, but must be authenticated. Methods used to authenticate signatures in electronic medical records will vary, and must be individually evaluated by reviewers. 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. |
| G. Errors are corrected according to legal medical documentation standards. (Q&A, Section VIII: # 30) | The person that makes the documentation error corrects the error. A single line is drawn through the error, with “error” written above or near the lined-through incorrect entry. The corrected information is written as a separate entry and includes date of the entry, signature (or initials), and title. There are no unexplained cross-outs, erased entries or use of correction fluid. Both the original entry and corrected entry are clearly preserved. Reviewers must determine method(s) used for correction of documentation errors of computerized records on a case by case basis. Note: The <u>S.L.I.D.E.</u> rule is one method used to correct documentation errors: Single Line, Initial, Date, and Error. |

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

  **RN/MD Review only**

| Criteria | Coordination/Continuity of Care Reviewer Guidelines |
|---|--|
| A. History of present illness is documented. | Each focused visit (e.g., primary care, urgent care, acute care, etc.) includes a documented history of present illness. |
| B. Working diagnoses are consistent with findings. (Q&A, Section VIII: # 28, 51) | Each visit has a documented “working” diagnosis/impression derived from a physical exam, and/or “Subjective” information such as chief complaint or reason for the visit as stated by patient/parent. “Objective” information such as assessment findings and conclusion that is documented relate to the working diagnoses. Note: For scoring purposes, reviewers shall <u><i>not make determinations</i></u> about the “ <i>rightfulness or wrongfulness</i> ” of documented information, but shall initiate the peer review process as appropriate. |
| C. Treatment plans are consistent with diagnoses. (Q&A, Section VIII: # 28, 34) | A plan of treatment, care and/or education related to the stated diagnosis is documented for each diagnosis. Note: For scoring purposes, reviewers shall <u><i>not make determinations</i></u> about the “ <i>rightfulness or wrongfulness</i> ” of treatment rendered or care plan, but shall initiate the peer review process as appropriate. |
| D. Instruction for follow-up care is documented. (Q&A, Section VIII: # 13) | Specific follow-up instructions and a definite time for return visit or other follow-up care is documented. Time period for return visits or other follow-up care is definitively stated in number of days, weeks, months, or PRN (as needed). |
| E. Unresolved and/or continuing problems are addressed in subsequent visit(s). | Previous complaints and unresolved or chronic problems are addressed in subsequent notes until problems are resolved or a diagnosis is made. Each problem need not be addressed at every visit. Documentation demonstrates that provider follows up with patients about treatment regimens, recommendations, counseling, and/or referrals. |
| F. A physician reviewed consult/referral reports, and diagnostic test results. (Q&A, Section VIII: 35, 36, 37) | Consultation reports and diagnostic test results are documented for ordered requests. Records such as diagnostic studies, lab tests, X-ray reports, consultation summaries, inpatient/discharge records, emergency and urgent care reports, and all abnormal and/or “STAT” reports show documented evidence of physician review. Evidence of review may include the physician’s initials or signature on the report, notation in the progress notes, or other site-specific method of documenting physician review. Abnormal test results/diagnostic reports have explicit notation in the medical record. Documentation includes patient contact or contact attempts, follow-up treatment, instructions, return office visits, referrals and/or other pertinent information. Electronically maintained medical reports must also show evidence of physician review, and may differ from site to site. |
| G. Missed appointments and follow-up contacts/outreach efforts are noted. (Q&A, Section VIII: # 52, 53, 54) | Documentation includes incidents of missed/broken appointments (cancellations or “No shows”) for PCP examinations, diagnostic procedures, lab tests, specialty appointments, and/or other referral services. Attempts to contact the patient and/or parent/guardian (if minor), and the results of follow-up actions are also documented. |

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

| Criteria | Pediatric Preventive Reviewer Guidelines |
|---|--|
| A. Initial Health Assessment (IHA). (Q&A, Section IX: # 1) | An IHA must be completed on all members within 120 days of the effective date of enrollment into the Plan, or documented within the past 12 months prior to member’s enrollment. The IHA is a comprehensive history and physical that includes an Individual Health Education Behavioral Assessment (e.g. “Staying Healthy” or other DHCS-approved tool) at age-appropriate intervals. The IHA must include a core set of preventive services. If evidence of an IHA is not present in the medical record, the reason must be documented in the record (member’s refusal, missed appointments, etc.) *A prior IHA is acceptable from a prior provider if done within the last year of enrollment. |
| B. Individual Health Education Behavioral Assessment (IHEBA). (Q&A, Section IX: # 9, 17, 23) | <u>New Members:</u> Age-appropriate IHEBA is conducted within 120 days of effective enrollment date as part of initial health assessment. <u>Existing members:</u> Age-appropriate IHEBA is conducted at member’s next non-acute care visit, but no later than the next scheduled health-screening exam. The IHEBA tool is re-administered at appropriate age intervals: 0-3 years, 4-8 years, 9-11 years, 12-17 years and 18 years and older. The IHEBA tool and risk-reduction plan is reviewed at least annually with members who present for a scheduled visit (see documented date and PCP initials). Provision of health education and anticipatory guidance is documented at each health assessment visit, which includes providing appropriate educational materials and/or providing or referring to counseling. Problems, interventions and referrals are documented in the progress notes or elsewhere in the medical records. |
| C. Age-appropriate physical exams according to most recent AAP schedule. (Q&A, Section IX: # 2, 3, 10, 12, 18, 21, 29, 31) | Periodic health assessments are provided according to the AAP recommended schedule for pediatric preventive health care. Where the AAP periodicity exam schedule is more frequent than the Child Health and Disability Prevention (CHDP) periodicity examination schedule, the AAP scheduled assessment must include all components required by the CHDP program for the lower age nearest to the current age of the child. A physical examination is completed at each health assessment visit which includes: <ol style="list-style-type: none"> 1) anthropometric measurements of weight and length/height, and head circumference of infants up to age 24 months, 2) physical examination/body inspection, including screen for sexually transmitted infection (STI) on sexually active adolescents, 3) urine test (Urine Dipstick or urinalysis) at each health assessment visit starting at age 4-5 years. Assessments and identified problems recorded on the PM160 form are documented in the progress notes *and is acceptable documentation for assessing preventive screens, dental assessments and referrals. If the PM-160 is not complete, the reviewer will need to look for other documentation. Using “HEENT” is an acceptable documentation for dental assessment. Follow-up care or referral is provided for identified physical health problems as appropriate. *For pediatric age appropriate physicals the reviewer should stay with the guidelines as currently written. Look to see that an assessment has been documented and if it is abnormal, then review for follow-up documentation. |

| | |
|--|---|
| <p>D. Vision screening. (Q&A, Section IX: # 13, 14, 33)</p> | <p>Age-appropriate visual screening occurs at each health assessment visit, with referral to optometrist/ophthalmologist as appropriate.</p> <p>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.</p> |
| <p>E. Hearing screening. (Q&A, Section IX: # 4, 5, 6, 13, 33)</p> | <p>Non-audiometric screening for infants/children (2 months to 3 years) includes family and medical history, physical exam and age-appropriate screening. Audiometric screening for children and young adults (3-21years) is done at each health assessment visit and includes follow-up care as appropriate. Failed audiometric screenings are followed up with a repeat screening. Children who fail to respond on 2 screenings separated by an interval of at least 2 weeks and no later than 6 weeks after the initial screening are referred to a specialist.</p> |
| <p>F. Nutrition assessment. (Q&A, Section VIII: # 69 and Section IX: # 15, 19)</p> | <p>Screening includes: 1) Anthropometric measurements, 2) Laboratory test to screen for anemia (hematocrit or hemoglobin), 3) Breastfeeding/infant feeding status, food/nutrient intake and eating habits. Based on problems/conditions identified, nutritionally at-risk children under 5 years of age are referred to the Women, Infants and Children (WIC) Supplemental Nutrition Program, for medical nutrition therapy or other in-depth nutritional assessment as appropriate. *If nutrition is marked on the IHEBA credit is not given unless there is an indication that the provider has looked at the IHEBA. WIC referrals would be marked separately.</p> <p>Note: Assessment of infant feeding status includes evaluation of problems/conditions/needs of the breastfeeding mother.</p> |

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

| Criteria | Pediatric Preventive Reviewer Guidelines |
|--|--|
| <p>G. Dental assessment. (Q&A, Section VIII: # 51 and Section IX: # 7, 10, 26, 30)</p> | <p>Inspection of the mouth, teeth and gums is performed at every health assessment visit. Children are referred to a dentist at any age if a dental problem is detected or suspected. Beginning at age 3 years, all children are referred annually to a dentist regardless of whether a dental problem is detected or suspected. *Dental checked on the IHEBA only is <u>not</u> acceptable documentation and the point is not given.</p> |

| | |
|---|---|
| <p>H. *Serum Blood Lead Test.</p> | <p>Children receiving health services through Medi-Cal Managed Care Plans must have blood lead level (BLL) testing as follows:</p> <ol style="list-style-type: none"> 1) at 12 months <i>and</i> 24 months of age, 2) between 12 months and 24 months of age if there is no documented evidence of BLL testing at 12 months or thereafter, 3) between 24 months and 72 months of age if there is no documented evidence of BLL testing at 24 months or thereafter. <p>All screening results indicating an elevated BLL of 10 micrograms of lead per deciliter ($\mu\text{g}/\text{dL}$) of blood (or greater) require additional follow-up and blood lead testing in accordance with current DHCS policy letter or as summarized below:</p> <ul style="list-style-type: none"> • BLL of 10-14 $\mu\text{g}/\text{dL}$: Confirm with venous sample within 3 months of original test. • BLL of 15-19 $\mu\text{g}/\text{dL}$: Confirm with venous sample within 2 months of original test, then retest at 2 months following the confirmatory testing. • BLL of 20-44 $\mu\text{g}/\text{dL}$: Confirm with venous sample in 1 week to 1 month, depending on severity of BLL. • BLL of 45-59 $\mu\text{g}/\text{dL}$: Retest with venous sample within 48 hours. • BLL of 60-69 $\mu\text{g}/\text{dL}$: Retest with venous sample within 24 hours. • BLL of ≥ 70 $\mu\text{g}/\text{dL}$: EMERGENCY. Retest immediately with venous sample. <p>Children with elevated BLLs are referred to local Childhood Lead Poisoning Prevention Branch or, if none, to the local health department. All children with confirmed (venous) BLLs of ≥ 20 $\mu\text{g}/\text{dL}$ must be referred to CCS. *Lead assessment forms are no longer required.</p> |
| <p>I. Tuberculosis screening. (Q&A, Section IX: # 16)</p> | <p>All children are screened for risk of exposure to tuberculosis (TB) at each health assessment visit. The Mantoux skin test is administered during health assessment visits at age 4-5 years and age 11-16 years. The Mantoux skin test is administered to <i>all</i> asymptomatic persons at increased risk of developing TB irrespective of age or periodicity if they have not had a test in the previous year. The Mantoux skin test is not administered if the child has had a previously documented positive Mantoux skin test. For all positive skin tests, there is documentation of follow-up care (e.g. further medical evaluation, chest x-ray, diagnostic laboratory studies and/or referral to specialist).</p> <p>Note: Providers are required to follow the American Thoracic Society and Centers for Disease Control (CDC) guidelines for TB diagnosis and treatment.</p> |
| <p>J. Childhood Immunizations. (Q&A, Section IX: # 20, 22, 25, 27, 28, 32 and Section X: # 8)</p> | <p>Immunization status is assessed at each health assessment visit. The date the Vaccine Information Sheet (VIS) was given <i>and</i> the publication date of the VIS is documented. The name of each vaccine given, the manufacturer, and lot number is recorded in the medical record, by electronic record or on medication logs. *If immunizations are given at another office, the office being reviewed does not need a VIS.</p> <p>Note: Providers are required to administer immunizations according to the most recent guidelines established by the Public Health Service Advisory Committee on Immunization Practices (ACIP), unless medically contraindicated or refused by the parent.</p> |

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


 **RN/MD Review only**

| Criteria | Adult Preventive Reviewer Guidelines |
|---|--|
| A. Initial Health Assessment (IHA). (Q&A, Section X: # 1, 18) | An IHA must be completed on all members within 120 days of the effective date of enrollment into the Plan, or documented within the past 12 months prior to member's enrollment. The IHA is a comprehensive history and physical that includes an Individual Health Education Behavioral Assessment (e.g. "Staying Healthy" or other DHCS-approved tool) at age-appropriate intervals. The IHA must include a core set of preventive services. If evidence of an IHA is not present in the medical record, the reason must be documented in the record (member's refusal, missed appointments, etc.) |
| B. Individual Health Education Behavioral Assessment (IHEBA). (Q&A, Section X: # 2, 3) | The "Staying Healthy" Assessment Tool or other DHCS-approved assessment tool is completed initially on all adults within 120 days of enrollment into Health Plan, or as part of the IHA. For adults age 18 and older, the IHEBA is re-administered every 3-5 years, or more frequently for young adults. Intervention codes, dates and PCP signature are documented directly on the assessment form. Follow-up clinical interventions, health education and counseling and/or referrals are noted in the progress notes or other areas of the medical record. Note: Age-appropriate, gender-specific preventive health education and/or clinical counseling will depend on the identified problems and specific needs of each individual patient. |
| C. Periodic Health Evaluation. (Q&A, Section X: # 18) | Periodic health evaluations occur in accordance with the frequency that is appropriate for individual risk factors. The type, quantity and frequency of preventive services will depend on the most recent USPSTF recommendations. Public health evaluations are scheduled as indicated by the patient's needs and according to the clinical judgement of the provider. *Fecal occult blood screening according to USPSTF guidelines and at the physician's discretion Note: Example: A patient with elevated cholesterol levels and other risk factors for coronary heart disease (CHD) may be evaluated more frequently than other persons of the same age without similar risk factors. |
| D. Tuberculosis screening. (Q&A, Section X: # 16,17) | Adults are screened for tuberculosis (TB) risk factors upon enrollment. The Mantoux skin test is administered to <i>all</i> asymptomatic persons at increased risk of developing TB irrespective of age or periodicity if they have not had a test in the previous year. The Mantoux is not administered if the individual has had a previously documented positive Mantoux skin test. When a positive skin test is noted, there is documentation of follow-up care (e.g. further medical evaluation, chest x-ray, diagnostic laboratory studies and/or referral to specialist). *Routine healthcare evaluation should include assessment of TB exposure and development risk (beginning with the initial health assessment required within 120 days of enrollment). PPD skin testing is recommended only for adults deemed to have increased risk of acquiring tuberculosis infection or developing tuberculosis disease in accordance with CDC guidelines. The need for and frequency of repeat testing depends upon the degree of ongoing exposure risk, as determined by locally generated data Note: Providers are required to follow the American Thoracic Society and Centers for Disease Control (CDC) guidelines for TB diagnosis and treatment. |
| E. Blood Pressure. | A blood pressure (B/P) measurement for the normotensive adult is documented at least once every 2 years, *or may be taken more frequently according to the judgment of the physician and/or documented risk factors. |
| F. Cholesterol. (Q&A, Section X: # 4, 19) | According to the USPSTF guidelines men (aged 35 years and older) and women (aged 45 years and older) are screened for lipid disorders, which includes measurement of total cholesterol (TC) and high-density lipoprotein cholesterol (HDL-C). |

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

  **RN/MD Review only**

| Criteria | Adult Preventive Reviewer Guidelines |
|--|--|
| G. Chlamydia screening. | Women who are sexually active are screened from the time they become sexually active until they are 25 years of age. Providers may screen women older than 25 years of age if the provider determines that the patient is at risk for infection. Lab results are documented. *Male patients may be screened if the provider determines the patient is at risk. |
| H. Mammogram. (Q&A, Section X: # 6) | 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. *(DHCS requires mammograms at age 50 years, even though the USPSTF guidelines differ.) |
| I. Pap Smear. | Routine screening for cervical cancer with Papanicolaou (Pap) testing is done on all women who are or have been sexually active and who have a cervix. Pap smears should begin with the onset of sexual activity and repeated at least every 1-3 years depending on individual risk factors. Follow-up of abnormal test results is documented. According to the USPSTF, routine Pap testing may not be required for the following: 1) women who have undergone hysterectomy in which the cervix is removed, unless the hysterectomy was performed because of cervical cancer or its precursors, 2) women after age 65 who have had regular previous screening in which the smears have been consistently normal. |
| J. Adult Immunizations. (Q&A, Section X: # 7, 8, 9, 10, 11, 12, 13, 14, 15) | Immunization status and/or immunizations administered, date Vaccine Information Sheet (VIS) was given <i>and</i> publication date of the VIS are documented in the medical record. The name of each vaccine, date given, the manufacturer, and lot number is recorded in the medical record, by electronic record or on medication logs. *Adult immunizations include: tetanus, flu and pneumonia. Members should be asked if they ever received an MMR and varicella. Per the USPSTF guidelines, MMR should be administered to all persons born after 1956 who lack evidence of immunity to measles. Two doses of varicella vaccine delivered 4-8 weeks apart are recommended for healthy adults with no history of varicella infection or previous vaccination. The provider is held accountable for the integrity of giving all medications and vaccines. Note: Providers are required to administer immunizations according to the most recent guidelines established for adults by the USPSTF. |

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

| Criteria | Perinatal Preventive Reviewer Guidelines |
|--|---|
| A. Initial Comprehensive Assessment (ICA). (Q&A, Section XI: # 5, 6, 7, 9, 10, 12, 13) | The ICA, completed within 4 weeks of entry to prenatal care, includes the following assessments: <u>Obstetric/medical:</u> Health and obstetrical history (past/current), LMP, EDD. <ul style="list-style-type: none"> • Physical exam: includes breast and pelvic exam • Lab tests: hemoglobin/hematocrit, urinalysis, urine culture, ABO blood group, Rh type, rubella antibody titer, STI screen. <u>Nutrition:</u> Anthropometric (height/weight), dietary evaluation, prenatal vitamin/mineral supplementation. <u>Psychosocial:</u> Social and mental health history (past/current), substance use/abuse, support systems/resources. <u>Health education:</u> Language and education needs. |
| B. Subsequent Comprehensive Prenatal trimester re-assessments. | Subsequent comprehensive prenatal re-assessments include Obstetric/medical, Nutrition, Psychosocial and Health Education re-assessments are completed during the 2 nd trimester <u>and</u> 3 rd trimester. |
| C. Prenatal care visits according to most recent ACOG standards. (Q&A, Section XI: # 8) | ACOG's <i>Guidelines for Perinatal Care</i> recommend the following prenatal schedule for a 40-week uncomplicated pregnancy: <ul style="list-style-type: none"> • First visit by 6-8th week • Approximately every 4 weeks for the first 28 weeks of pregnancy • Every 2-3 weeks until 36 weeks gestation • Weekly thereafter until delivery • Postpartum visit within 4-8 weeks after delivery If the recommended ACOG schedule is not met documentation shows missed appointments, attempts to contact patient and/or outreach activities. |
| D. Individualized Care Plan (ICP). | ICP documentation includes specific obstetric, nutrition, psychosocial and health education risk problems/conditions, interventions, and referrals. |
| E. Referral to WIC and assessment of Infant Feeding status. | All potentially eligible Plan members must be referred to WIC (Public Law 103-448, Section 203(e)). Referral to WIC is documented in the medical record (Title 42, CFR 431.626(c)). Infant feeding plans are documented during the prenatal period, and infant feeding/breastfeeding status is documented during the postpartum period (MMCD Policy Letter 98-10). <u>Note:</u> 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. |

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

| Criteria | Perinatal Preventive Reviewer Guidelines |
|---|---|
| F. HIV-related services <i>offered</i> . (Q&A, Section XI: # 3, 4, 14) | * This element will only be reviewed for Perinatal providers. The <i>offering</i> of prenatal HIV information, counseling and HIV antibody testing is documented (Health & Safety Code, Section 125107). Providers are <i>not required</i> to document that the HIV test was given or disclose (except to the patient) the results (positive or negative) of an HIV test. Offering a prenatal HIV test is not required if a positive HIV test is already documented in the patient’s record or if the patient has AIDS diagnosed by a physician. *The CPSP requires HIV testing results be in a separate, distinct part of the medical record for the CPSP providers, and that this separate part of the file be made accessible only to those individuals who provide direct patient care. . |
| G. AFP/Genetic screening <i>offered</i> . | The <i>offering</i> 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 DHCS’ Expanded AFP Program, and only laboratories designated by DHCS may be used for testing. |
| H. Domestic violence abuse screening. (Q&A, Section XI: # 11) | Provision of a Domestic Violence Screening is documented. Assessment checklists, body diagrams and/or documentation in progress notes are acceptable. Domestic violence screening includes medical screening, documentation of physical injuries or illnesses attributable to spousal/partner abuse, and referral to appropriate community service agencies (CA Health & Safety Code, Section 1233.5). |
| I. Family Planning evaluation. | Family Planning counseling, referral or provision of services is documented (MMCD Policy Letter 98-11). |
| J. Postpartum assessments. (Q&A, Section XI: # 1, 2) | Comprehensive postpartum reassessment includes the 4 components: medical exam, nutrition (mother and infant), psychosocial, health education and are completed within 4-8 weeks postpartum (MMCD Policy Letter 96-01). If the postpartum assessment visit is not documented, medical record documents missed appointments, attempts to contact patient and/or outreach activities. |

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1. Format Criteria

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

2. Documentation Criteria

 **RN/MD Review only**

| Criteria met: Give one (1) point. Criteria not met: 0 points Criteria not applicable: N/A | Wt | MR# | MR# | MR# | MR# | MR# | MR# | MR# | MR# | MR# | MR# | Score |
|--|------------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|--------------|
| Member ID No. Age/Gender | | | | | | | | | | | | |
| A. Allergies are prominently noted. | 1 | | | | | | | | | | | |
| B. Chronic problems and/or significant conditions are listed. | 1 | | | | | | | | | | | |
| C. Current <i>continuous</i> medications are listed. | 1 | | | | | | | | | | | |
| D. Signed Informed Consents are present, when appropriate. | 1 | | | | | | | | | | | |
| E. Advance Health Care Directive information is offered. (Only: Adults, 18 years/older; Emancipated minors) | 1 | | | | | | | | | | | |
| F. Medical record entries are in accordance with acceptable legal medical documentation standards. | 1 | | | | | | | | | | | |
| G. Errors are corrected according to legal medical documentation standards. | 1 | | | | | | | | | | | |
| Comments: | 7 Pts | | | | | | | | | | | |

3. Coordination/Continuity of Care Criteria

 **RN/MD Review only**

| Criteria met: Give one (1) point. Criteria not met: 0 points Criteria not applicable: N/A | Wt | MR# | MR# | MR# | MR# | MR# | MR# | MR# | MR# | MR# | MR# | MR# | Score |
|--|------------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|--------------|
| Member ID No. Age/Gender | | | | | | | | | | | | | |
| A. History of present illness is documented. | 1 | | | | | | | | | | | | |
| B. Working diagnoses are consistent with findings. | 1 | | | | | | | | | | | | |
| C. Treatment plans are consistent with diagnoses. | 1 | | | | | | | | | | | | |
| D. Instruction for follow-up care is documented. | 1 | | | | | | | | | | | | |
| E. Unresolved/continuing problems are addressed in subsequent visit(s). | 1 | | | | | | | | | | | | |
| F. A physician reviewed consult/referral reports and diagnostic test results. | 1 | | | | | | | | | | | | |
| G. Missed appointments and follow-up contacts/outreach efforts are noted. | 1 | | | | | | | | | | | | |
| Comments: | 7 Pts | | | | | | | | | | | | |

4. Pediatric Preventive Criteria

 **RN/MD Review only**

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

Comments:

 **RN/MD Review only**

| Criteria met: Give one (1) point. Criteria not met: 0 points Criteria not applicable: N/A <div style="text-align: right; margin-right: 10px;">Member ID No. Age/Gender</div> | Wt | MR# | MR# | MR# | MR# | MR# | MR# | MR# | MR# | MR# | MR# | Score |
|--|-------------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|--------------|
| G. Dental assessment. | 1 | | | | | | | | | | | |
| H. Lead screening. | 1 | | | | | | | | | | | |
| I. Tuberculosis screening. | 1 | | | | | | | | | | | |
| J. Childhood immunizations. | 1 | | | | | | | | | | | |
| Comments: | 10 Pts | | | | | | | | | | | |

5. Adult Preventive Criteria

 **RN/MD Review only**

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

Comments:

 **RN/MD Review only**

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

6. Perinatal Preventive Criteria

 RN/MD Review only

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

Comments:

 RN/MD Review only

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

Medical Record Review Summary

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

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

| | | | | | | | |
|--------|---------------|-------------|--|-----------|-------|---------|-------|
| Format | Documentation | Coord/Cont. | | Pediatric | Adult | OB/CPSP | Total |
|--------|---------------|-------------|--|-----------|-------|---------|-------|

| | | | | | | | |
|----------------------------------|----------------------------------|----------------------------------|---|---|---|---|---|
| | | | | | | | |
| 10 records/ 80 points | 10 records/ 70 points | 10 records/ 70 points | PLUS 10 of any of the following medical records | 5 records/ 50 points or 10 records/ 100 points | 5 records/ 50 points or 10 records/ 100 points | 5 records/ 50 points or 10 records/ 100 points | Full Pass: 100% Conditional Pass: 80-99% Not Pass: Below 80% |

Comments

| |
|---------------------------|
| Format |
| Documentation |
| Continuity of Care |
| Preventive Content |

Reviewer(s)/Title _____

Date: _____

IEHP SITE REVIEW AND MEDICAL RECORD SURVEY ADDENDUM

This Addendum has no scoring value, however, findings may require corrective action.

**Medical Record
(Questions for Quality Study Purpose Only)**

Name: _____

Medical Record ID: _____

| IEHP Identifier | | | | | |
|--|--|--|--|--|--|
| Specialist Consultation Notes Received within 30 days of the Appointment | | | | | |
| Laboratory/Diagnostic Reports are Received within 30 days of the Service | | | | | |
| Emergency Department Reports are Received within 30 days of the encounter | | | | | |
| Hospital Discharge Summary Received within 30 days | | | | | |
| SNF Discharge Summary Received within 30 days | | | | | |
| Home Health Discharge Summary/Notes Received within 30 days | | | | | |
| Surgical Center Operation Report/Discharge Summary Received within 30 days | | | | | |

| Pediatric Charts Only | IEHP Identifier | | | | |
|--|------------------------|--|--|--|--|
| Nutrition Assessment | | | | | |
| Developmental Assessment | | | | | |
| Anticipatory Guidance/Health Education | | | | | |

| OB-GYN Specialist, OB-PCP Only | IEHP Identifier | | | | |
|--|------------------------|--|--|--|--|
| CPSP-Like Services are offered | | | | | |
| Referral Services Rendered/Member Notified | | | | | |
| Hospital Delivery Record Received within 30 days | | | | | |

IEHP SITE REVIEW AND MEDICAL RECORD SURVEY ADDENDUM

This Addendum has no scoring value, however, findings may require corrective action.

| | | | | | | |
|---|------------------------|--|--|--|--|--|
| PRENATAL CARE | IEHP Identifier | | | | | |
| Blood Pressure | | | | | | |
| Fundal Height | | | | | | |
| Fetal Heart Tones | | | | | | |
| Maternal complications – check for urine, edema, nausea, bleeding | | | | | | |
| POST PARTUM CARE | | | | | | |
| Weight | | | | | | |
| Blood Pressure | | | | | | |
| Breast Exam | | | | | | |
| Abdomen or Pelvic Exam | | | | | | |
| Family Planning | | | | | | |

| YES | NO | N/A | EVALUATION CRITERIA | PTS | FINDINGS | CAP |
|-----|----|-----------|--|-----|----------|-----|
| | | 1. | CPSP (For PCP/ OB, FP1, FP2 & OB Specialist) | | | |
| | | | A. Is the office CPSP Certified? | | | |
| | | | B. Is the office using IEHP forms? (1) | | | |
| | | | C. Who in the office is assigned to perform CPSP services? | | | |
| | | | D. Interventions: (For CPSP Certified & Non-CPSP Certified Providers) | | | |
| | | | 1. How is the member referred to the following: | | | |
| | | | a. Nutrition (1) | | | |
| | | | b. Social Worker (1) | | | |
| | | | c. Health Education (1) | | | |
| | | 2. | OB REFERRAL (For FP1 and FP2 Providers) | | | |
| | | | A. What OB does the office refer to? | | | |
| | | | B. Is there a letter from OB acknowledging the relationship? (1) | | | |

IEHP SITE REVIEW AND MEDICAL RECORD SURVEY ADDENDUM

This Addendum has no scoring value, however, findings may require corrective action.

| | | | | | | |
|--|--|-----------|--|--|--|--|
| | | | C. When are Members transferred to OB for delivery? (1) | | | |
| | | | D. When are records transferred? (1) (PCP/OB & OB Specialist) | | | |
| | | 3. | POLICY AND PROCEDURES (FOR FP1 & FP2 PROVIDERS) | | | |
| | | | A. Is there a policy for High Risk OB Referrals (1) | | | |
| | | | B. Is there a policy for OB Referral Process for Routine Deliveries (1) | | | |
| | | 4. | ULTRASOUND (For PCP/OB, OB Specialist, FP1 & FP2 Providers) | | | |
| | | | A. Trained Staff (1) | | | |
| | | | B. Written policies and procedures re: safety, confidentiality, and operating procedures. (1) | | | |
| | | | C. Equipment maintenance and calibration performed on all equipment (1) | | | |
| | | | D. Provide a setting for ultrasound exam that allows for patient safety and comfort. (1) | | | |
| | | | E. There is documentation done for each exam. (1) | | | |
| | | 5. | REQUIRED EQUIPMENT FOR OB SERVICES (For PCP/OB, OB Specialist, FP1 & FP2 Providers) | | | |
| | | | A. Examination equipment | | | |
| | | | 1. Nitrazine paper. | | | |
| | | | 2. Keto (urine) sticks. | | | |
| | | | 3. Doppler | | | |

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

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

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

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

Name: _____ Signature: _____ Date: _____

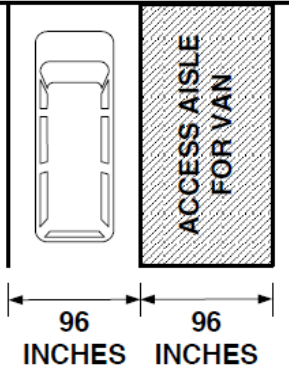
I certify that there have been no changes since the last physical accessibility review:


Name: _____ Signature: _____ Date: _____

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

PARKING

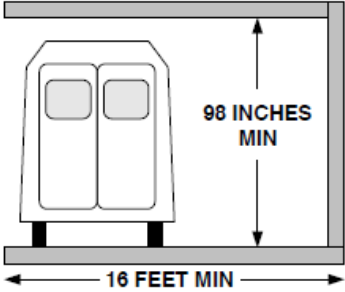
| | | | | | | |
|-----------|---|---|--|--|--|--|
| 1 | Is off-street public parking available? | Self explanatory. | | | | |
| 2 | Are accessible parking spaces provided in off-street parking? | Self explanatory. | | | | |
| 3 (CE) | Are the correct number of accessible parking spaces provided? 1 to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

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

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

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

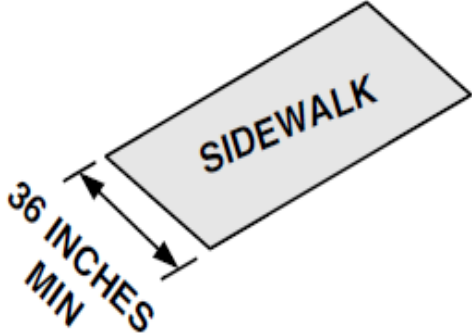
| Question # | Criteria (CE = Critical Elements) | Explanation/Guidelines | Yes | No | N/A | Comments |
|------------|-----------------------------------|------------------------|-----|----|-----|----------|
|------------|-----------------------------------|------------------------|-----|----|-----|----------|

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

EXTERIOR ROUTE (FROM ACCESSIBLE PARKING, PUBLIC TRANSPORTATION, AND PUBLIC SIDEWALK TO THE ENTRANCE)

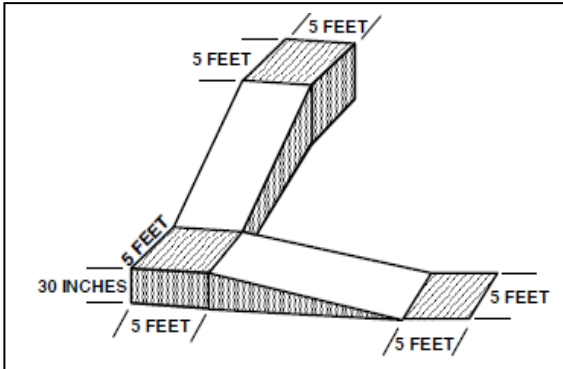
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|---------|--|-------------------|--|--|--|--|
| 14 (CE) | <p>For exterior routes, if the accessible route crosses a curb, is a curb ramp provided to the building entrance from the following: (Please mark NA for those that do not apply.)</p> | Self explanatory. | | | | |
| | a. Parking? | | | | | |
| | b. Public transportation? | | | | | |

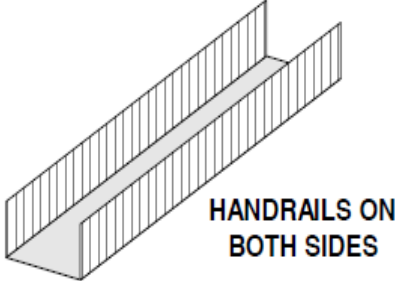
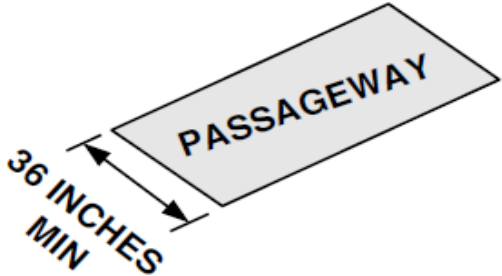
| Question # | Criteria (CE = Critical Elements) | Explanation/Guidelines | Yes | No | N/A | Comments |
|------------|-----------------------------------|------------------------|-----|----|-----|----------|
|------------|-----------------------------------|------------------------|-----|----|-----|----------|

| | | | | | | |
|----|--|---|--|--|--|--|
| | c. Public sidewalk? | | | | | |
| 15 | Is the accessible route to the building entrance at least 36 inches wide for exterior routes from the following: (Please mark NA for those that do not apply.) |  <p>A diagram showing a rectangular area labeled "SIDEWALK" tilted at an angle. A double-headed arrow indicates the width of the sidewalk, with the text "36 INCHES MIN" written below it.</p> | | | | |
| | a. Parking? | | | | | |
| | b. Public transportation? | | | | | |
| | c. Public sidewalk? | | | | | |
| 16 | Is the accessible route to the building entrance stable, firm, and slip resistant from the following: (Please mark NA for those that do not apply.) | <p>An example of a stable surface is a floor or ground surface without loose elements like gravel or wood chips.</p> <p>Firm surfaces include solid concrete or pavement as opposed to a grassy, graveled or soft soil surface.</p> <p>Avoid glossy or slick surfaces such as ceramic tile.</p> | | | | |
| | a. Parking? | | | | | |

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


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

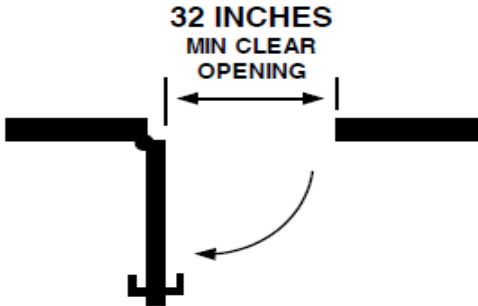
| | | | | | | |
|------------|--|---|--|--|--|--|
| 20 (CE) | Is each run (leg) of the ramp no longer than 30 feet between landings? | <p>Each "run," shown in the white sections in the diagram below, must be no longer than 30 feet.</p>  | | | | |
| 21 | Are 60 inches (5 feet) long, level landings provided at the top and bottom of each ramp run? | See Question 20 diagram above. | | | | |

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

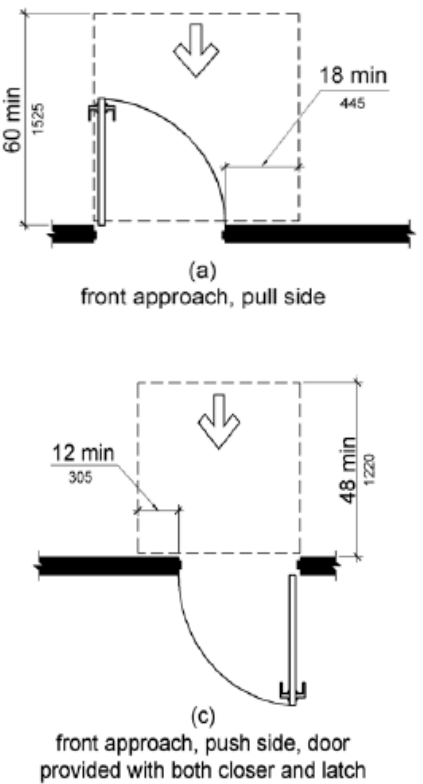
| Question # | Criteria (CE = Critical Elements) | Explanation/Guidelines | Yes | No | N/A | Comments |
|------------|-----------------------------------|------------------------|-----|----|-----|----------|
|------------|-----------------------------------|------------------------|-----|----|-----|----------|

BUILDING ENTRANCE

| | | | | | | |
|---------|--|---|--|--|--|--|
| 24 | Is the main entrance accessible? | Self explanatory. | | | | |
| 25 (CE) | If a main entrance is not accessible, is there another accessible entrance? | Self explanatory. | | | | |
| 26 | If a main entrance is not accessible, is there directional signage indicating the location of the accessible entrance? |  | | | | |

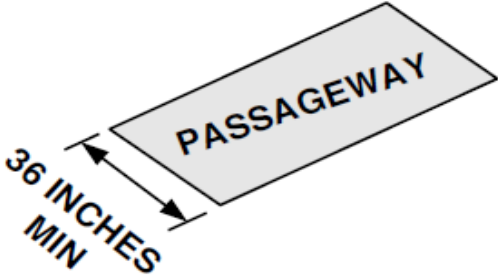
| Question # | Criteria (CE = Critical Elements) | Explanation/Guidelines | Yes | No | N/A | Comments |
|------------|--|--|-----|----|-----|----------|
| 27 (CE) | Do doors have an opening at least 32 inches wide (at the narrowest point below the opening hardware) when opened to 90°? | <p>When measuring double doors, measure the opening with one door open to 90°.</p>  | | | | |
| 28 (CE) | Is space available for a wheelchair user to approach, maneuver, and open the door? | <p>Appropriate space perpendicular and parallel to a doorway permits a wheelchair user, people using walkers and other mobility devices to open the door safely and independently. Following are two common examples of required minimum maneuvering clearances:</p> <ol style="list-style-type: none"> 1. Approaching the door and pulling it toward you to open requires 60 inches of clear space perpendicular to the doorway and 18 inches parallel to the doorway. 2. Approaching the door and pushing it away from you to open requires 48 inches of clear space perpendicular to the doorway. | | | | |


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

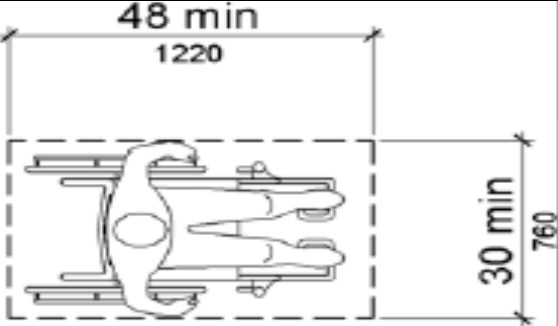
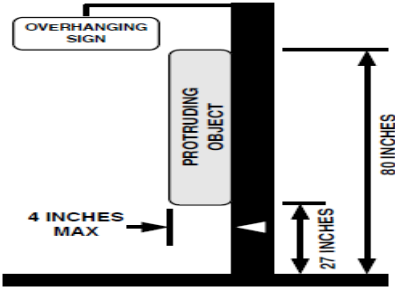
| | | | | | | |
|--|--|---|--|--|--|--|
| | |  <p>(a) front approach, pull side</p> <p>(c) front approach, push side, door provided with both closer and latch</p> | | | | |
|--|--|---|--|--|--|--|

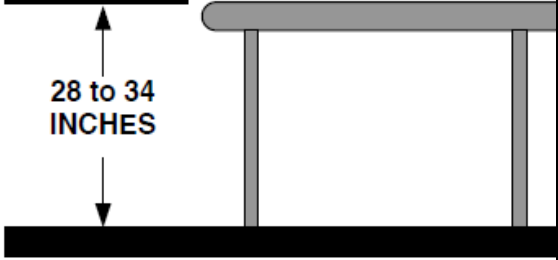
| | | | | | | |
|----|---|---|--|--|--|--|
| 29 | Is the space required to open the door level and clear of movable objects (chairs, trash cans, etc.)? | If there are nonpermanent items such as trash cans, merchandise, etc., located in these areas, they must be removed or relocated. | | | | |
|----|---|---|--|--|--|--|

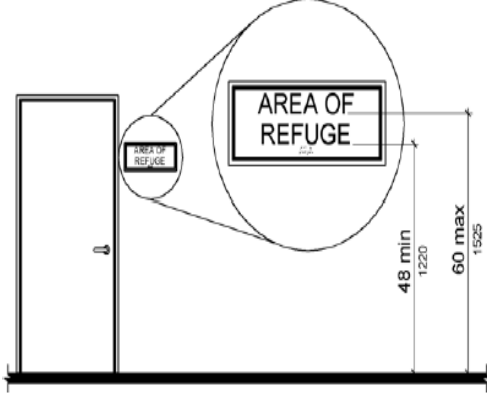
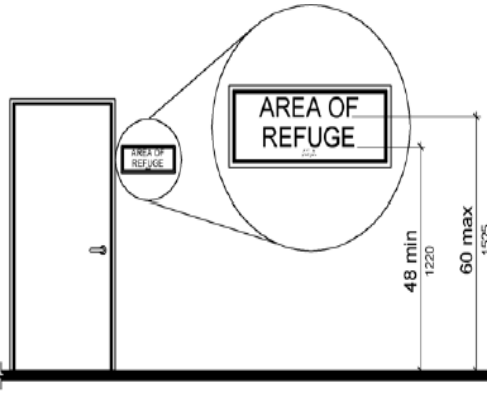
| Question # | Criteria (CE = Critical Elements) | Explanation/Guidelines | Yes | No | N/A | Comments |
|---|--|---|-----|----|-----|----------|
| 30 | Are there automatic doors? | Self explanatory. | | | | |
| 31 (CE) | Do entrance doors have handles that can be opened without grasping, pinching, or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

| Question # | Criteria (CE = Critical Elements) | Explanation/Guidelines | Yes | No | N/A | Comments |
|------------|--|---|-----|----|-----|----------|
| 33 | Is there an interior accessible route to the medical office that does not include stairs or steps? | Floors of a given story are level throughout the building, or connected by ramps, passenger elevators or access lifts. | | | | |
| 34 (CE) | Are <u>ALL</u> interior paths of travel at least 36 inches wide? |  | | | | |
| 35 | Is the interior accessible route stable, firm, and slip resistant? | <p>Avoid unsecured carpeting or other loose elements.</p> <p>It is easier for people using walkers, wheelchairs and other aids to walk or push on surfaces that have low pile carpeting without a pad underneath.</p> <p>Glossy or slick surfaces such as ceramic tile or marble can be slippery.</p> | | | | |
| 36 | Is the interior accessible route well lighted? | A brightly lit corridor will help avoid falls. | | | | |

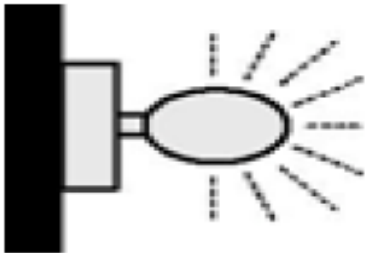
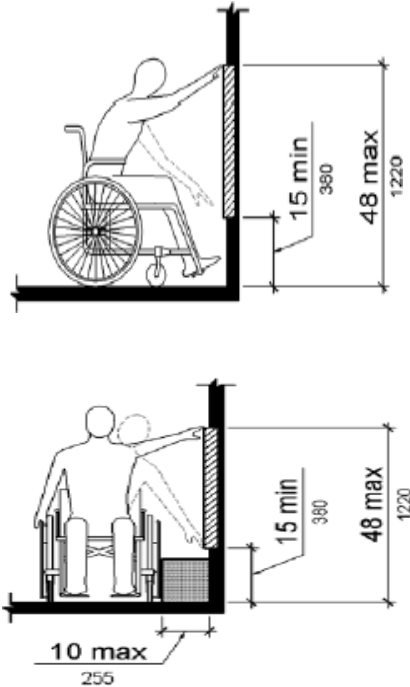
| Question # | Criteria (CE = Critical Elements) | Explanation/Guidelines | Yes | No | N/A | Comments |
|------------|--|--|-----|----|-----|----------|
| 37 (CE) | If there are stairs on the accessible route, are there handrails on each side? | If there are no stairs, check NA. | | | | |
| 38 | If there are stairs, are all stairs risers closed that are on the accessible route? |  | | | | |
| 39 | If there are stairs, are all stair treads marked by a stripe providing a clear visual contrast to assist people with visual impairments? | Contrast striping must be provided on the upper approach and lower tread for interior stairs and on the upper approach and all treads for exterior stairs. Stripes must be 2" to 4" wide placed parallel to and no more than 1" from the nose of the step or upper approach. The stripe must extend the full width of the step or upper approach and should be made of material that is at least as slip resistant as the other stair treads (a painted stripe is acceptable). | | | | |
| 40 (CE) | If a platform lift is used, can it be used without assistance? | If there is no platform lift, check NA. Lifts sometimes require a key for operation, thus preventing independent use. | | | | |

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

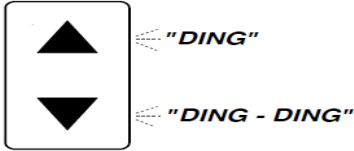
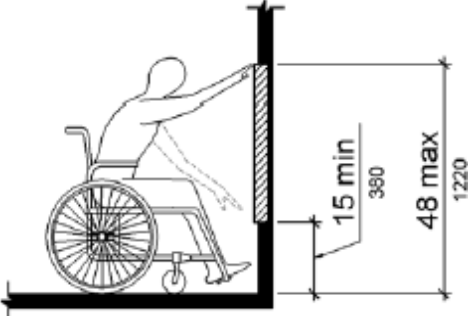
| Question # | Criteria (CE = Critical Elements) | Explanation/Guidelines | Yes | No | N/A | Comments |
|------------|---|--|-----|----|-----|----------|
| 44 | If floor mats are used, are the edges of floor mats stiff enough or secured so that they do not roll up? | <p>If floor mats are not in use, check NA.</p> <p>Floor mats that are not secured to the floor can roll up or bunch up under walkers or wheelchair casters and cause a tripping hazard.</p> | | | | |
| 45 | Is a section of the sign-in/registration counter no more than 34 inches high and at least 36 inches wide and free of stored items. |  <p>The diagram shows a side view of a counter section. A horizontal line at the top represents the counter surface. A vertical double-headed arrow indicates the height from the floor to this surface, labeled '28 to 34 INCHES'. The counter is supported by two vertical legs. The counter surface is shaded gray, and the floor is represented by a thick black line at the bottom.</p> | | | | |
| 46 | Does the office have a method, other than a lowered counter, by which people can sign in/register? (If yes, please note this method in comments.) | A medical office may use reasonable alternative methods to meet this need such as a clip board. | | | | |

| Question # | Criteria (CE = Critical Elements) | Explanation/Guidelines | Yes | No | N/A | Comments |
|------------|--|--|-----|----|-----|----------|
| 47 | Do signs identifying permanent rooms and spaces include raised letters and Braille? |  | | | | |
| 48 | Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor? |  <p data-bbox="667 1209 1207 1339">Raised letters and Braille signs are either on the latch side of doors or on the face of doors and are mounted between 48 inches and 60 inches from the floor.</p> | | | | |

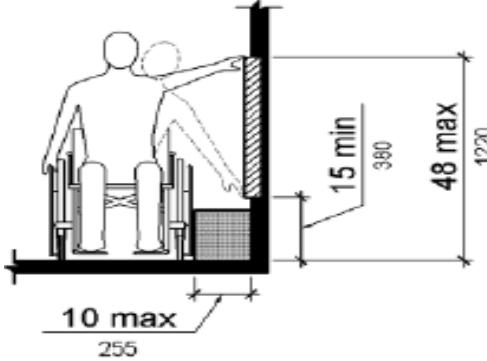
| Question # | Criteria (CE = Critical Elements) | Explanation/Guidelines | Yes | No | N/A | Comments |
|------------|-----------------------------------|------------------------|-----|----|-----|----------|
|------------|-----------------------------------|------------------------|-----|----|-----|----------|

| | | | | | | |
|----|---|--|--|--|--|--|
| 49 | <p>If the building has a fire alarm system, are visual signals provided in each public space, including toilet rooms and each room where patients are seen?</p> | <p>If the building does not have a fire alarm system, check NA.</p>  | | | | |
| 50 | <p>Are all patient-operated controls (call buttons, self-service literature, brochures, hand sanitizers, etc.) mounted or presented between 15 inches and 48 inches from the floor?</p> |  | | | | |

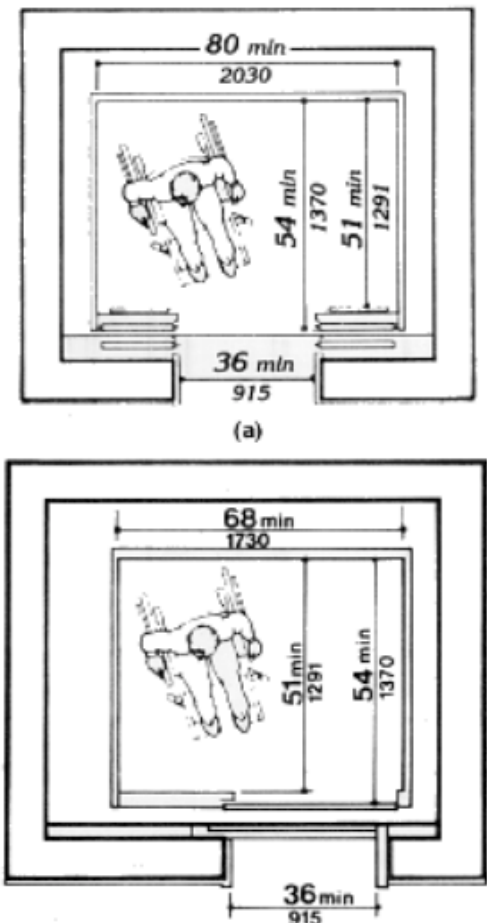
| Question # | Criteria (CE = Critical Elements) | Explanation/Guidelines | Yes | No | N/A | Comments |
|------------------|--|---|-----|----|-----|----------|
| 51 | Are all patient operated controls (e.g., call buttons, hand sanitizers) operable with one hand without grasping, pinching, or twisting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

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

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

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|--|--|--|--|--|--|--|
| | |  <p>The diagram shows a person in a wheelchair reaching for a control panel. The wheelchair width is labeled as 10 max (255). The reach distance from the wheelchair seat to the panel is labeled as 15 min (380). The panel height is labeled as 48 max (1220).</p> | | | | |
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| Question # | Criteria (CE = Critical Elements) | Explanation/Guidelines | Yes | No | N/A | Comments |
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| 57 (CE) | Is the elevator car large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit? | <p>The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide, depending on where the door is located.</p>  <p>Diagram (a) shows a wheelchair with a 36 min doorway, 54 min length, and 80 min width. Diagram (b) shows a wheelchair with a 36 min doorway, 51 min length, and 68 min width.</p> | | | | |
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| Question # | Criteria (CE = Critical Elements) | Explanation/Guidelines | Yes | No | N/A | Comments |
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| 58 (CE) | Do the buttons on the control panel inside the elevator have Braille and raised characters/symbols near the buttons? | Self explanatory. | | | | |
| 59 | Is there an emergency communication system in the elevator? | Self explanatory. | | | | |
| 60 | Is the elevator emergency communication system usable without requiring voice communication? | It is essential that emergency communication not be dependent on voice communications alone because the safety of people with hearing or speech impairments could be jeopardized. Visible signal requirement could be satisfied with something as simple as a button that lights when the message is answered, indicating that help is on the way. | | | | |

| Question # | Criteria (CE = Critical Elements) | Explanation/Guidelines | Yes | No | N/A | Comments |
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| 61 | Do raised letters and Braille identify the emergency intercom in the elevator? | Self explanatory. | | | | |
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TOILET ROOMS (INCLUDING THOSE USED FOR SPECIMEN COLLECTION)

ALL TOILET ROOMS:

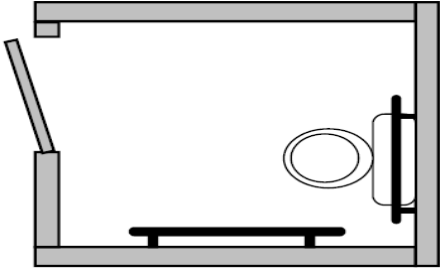
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| 62 | Is there an accessible toilet room? | Self explanatory. | | | | |
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| 63 | If there is an inaccessible toilet room, is there directional signage to an accessible toilet room? | Mark NA if there are no inaccessible toilet rooms. Self explanatory. | | | | |
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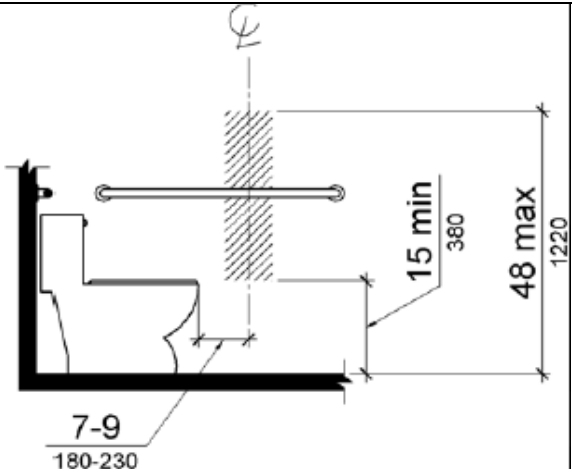
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| 64 | Does the interior door to the restroom require less than 5 pounds of pressure to open? | If restroom door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the | | | | |
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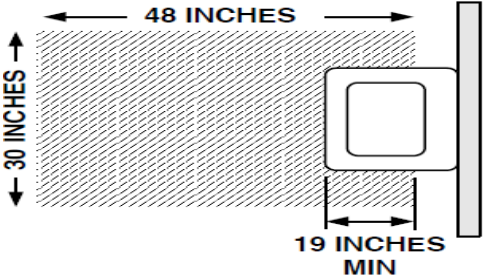
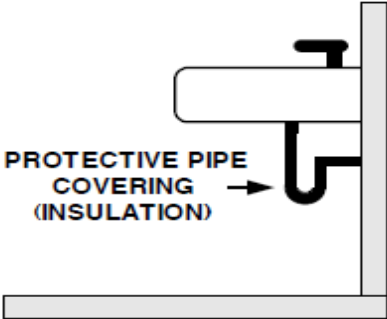
| Question # | Criteria (CE = Critical Elements) | Explanation/Guidelines | Yes | No | N/A | Comments |
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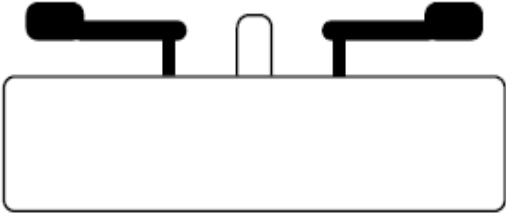
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| | | weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force. | | | | |
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| 65 (CE) | <p>For all toilet rooms with and without stalls:</p> <p>Are grab bars provided, one on the wall behind the toilet and one on the wall next to the toilet?</p> | <p>Grab bars should be installed in a horizontal position between 33 and 36 inches above the floor measured to the top of the gripping surface.</p>  | | | | |
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| 66 | Are all objects mounted at least 12 inches above and 1½ inches below the grab bars? | This includes seat cover dispensers, toilet paper dispensers, sanitizers, trash containers, etc. | | | | |
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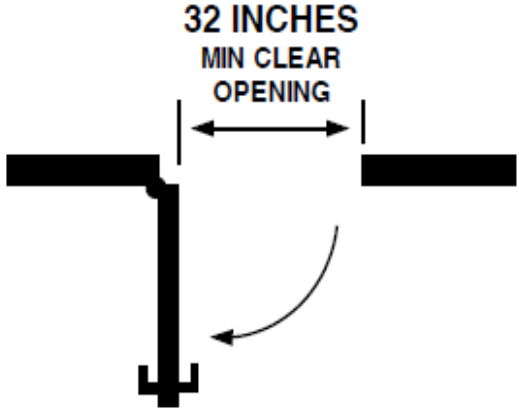
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| 67 (CE) | <p>Is the toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7 inches and 9 inches in front of the toilet, and at least 15 inches high?</p> |  | | | | |
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| Question # | Criteria (CE = Critical Elements) | Explanation/Guidelines | Yes | No | N/A | Comments |
|------------|--|--|-----|----|-----|----------|
| 68 (CE) | Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair users to park in front of the sink? | <p>This space must extend at least 17 inches under the sink from the front edge, although it can extend up to 19 inches underneath.</p>  | | | | |
| 69 | Is the space in front of the sink free of trash cans and other movable items? | Self explanatory. | | | | |
| 70 | Are the pipes and water supply lines under the sink wrapped with a protective cover? |  | | | | |
| 71 (CE) | Are faucet handles operable with one hand and without grasping, pinching, or twisting? (Check Yes if faucets are automatic.) | A knob handle would not be accessible. | | | | |

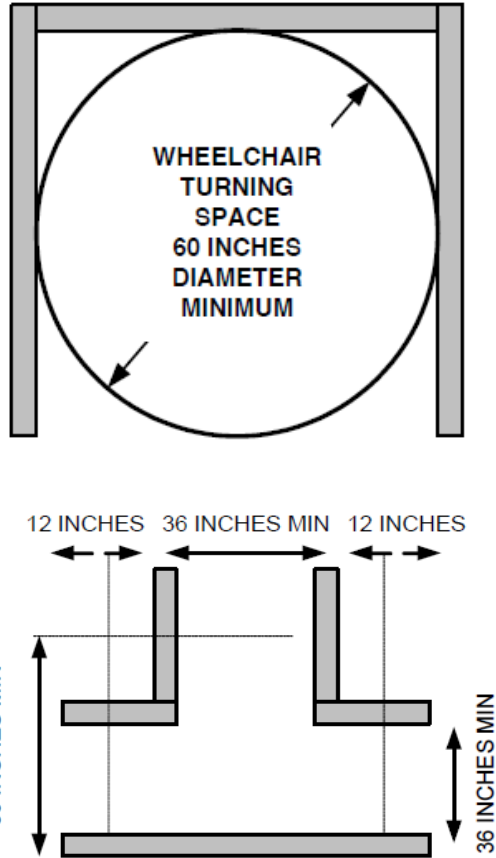
| Question # | Criteria (CE = Critical Elements) | Explanation/Guidelines | Yes | No | N/A | Comments |
|------------|---|--|-----|----|-----|----------|
| | | <p style="text-align: center;">LEVER HANDLES</p>  | | | | |
| 72 | Are all dispensers mounted no higher than 40 inches from the floor? | Included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

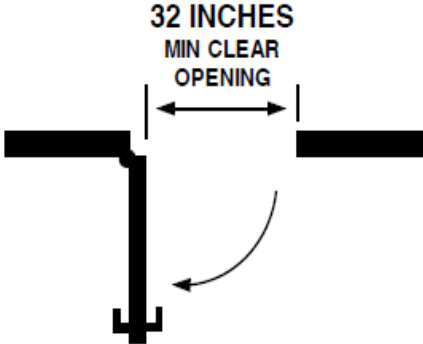
| Question # | Criteria (CE = Critical Elements) | Explanation/Guidelines | Yes | No | N/A | Comments |
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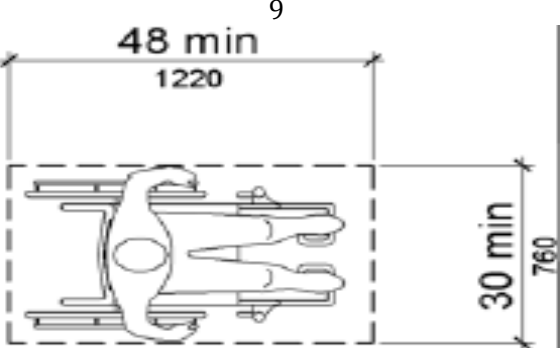
TOILET ROOM WITHOUT STALLS

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| 75 (CE) | <p><i>Toilet room without stalls:</i></p> <p>Do toilet room doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?</p> | <p>If there is no toilet room without stalls, check NA.</p>  <p>The diagram illustrates a door in an open position. A horizontal double-headed arrow above the door indicates the clear opening, labeled '32 INCHES MIN CLEAR OPENING'. A curved arrow points to the door's edge, indicating it is open at 90 degrees. The door is shown as a thick black line, and the stop is a small vertical line on the opposite side.</p> | | | | |
| 76 | <p>Is the space inside the toilet room without stalls clear, without trash cans, shelves, equipment, chairs, and other movable objects?</p> | <p>Self explanatory.</p> | | | | |

| Question # | Criteria (CE = Critical Elements) | Explanation/Guidelines | Yes | No | N/A | Comments |
|------------|--------------------------------------|------------------------|-----|----|-----|----------|
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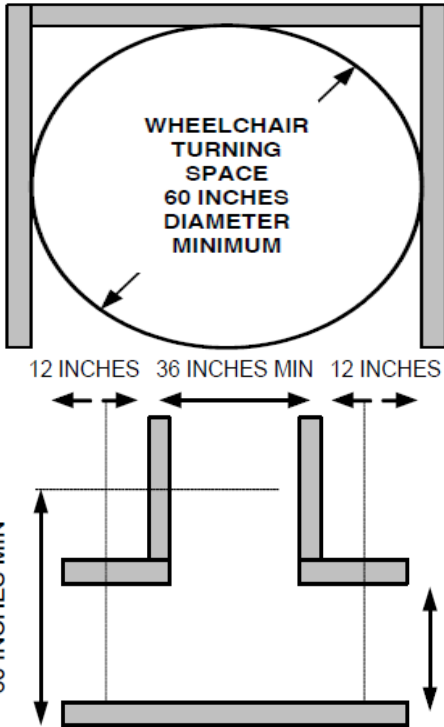
| TOILET ROOM WITH STALLS | | | | | | |
|-------------------------|--|---|--|--|--|--|
| 77 (CE) | <p><i>Toilet Room with stalls:</i></p> <p>Is there a 60-inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space inside the toilet room with stalls to allow a turn around for wheelchair and scooter users?</p> | <p>If there is no toilet room with stalls, check NA.</p>  <p>The diagram consists of two parts. The top part shows a square frame with a circle inside. The circle is labeled 'WHEELCHAIR TURNING SPACE 60 INCHES DIAMETER MINIMUM'. The bottom part shows a T-shaped space between two stalls. The horizontal distance between the centerlines of the two stalls is labeled '36 INCHES MIN'. The distance from the centerline of each stall to the side wall is labeled '12 INCHES'. The vertical distance from the top of the stalls to the top of the turning space is labeled '60 INCHES MIN'. The vertical distance from the top of the stalls to the bottom of the turning space is labeled '36 INCHES MIN'.</p> | | | | |

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

| Question # | Criteria (CE = Critical Elements) | Explanation/Guidelines | Yes | No | N/A | Comments |
|------------|---|---|-----|----|-----|----------|
| 81 (ME) | Is there a height adjustable exam table that lowers to between 17 inches and 19 inches from the floor to the top of the cushion? | Self explanatory | | | | |
| 82 (ME) | Is there space next to the height adjustable exam table for a wheelchair or scooter user to approach, park, and transfer or be assisted to transfer onto the table? |  <p>The diagram illustrates a wheelchair positioned next to a table. A dashed rectangular box indicates the required clearances. The width of the wheelchair is labeled as 48 min. The length of the wheelchair is labeled as 1220. The clearance between the wheelchair and the table is labeled as 30 min. The height of the table is labeled as 760.</p> | | | | |
| 83 | Does the exam table provide elements to assist during a transfer (such as rails) and support a person while on the table? (If yes, please list in comments.) | Items that could help support a patient while on the table would be armrests, side rails, padded straps, cushions, wedges, etc. | | | | |

| Question # | Criteria (CE = Critical Elements) | Explanation/Guidelines | Yes | No | N/A | Comments |
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| 84 | Is a lift available to assist staff with transfers (portable, overhead, or ceiling mounted)? | Self explanatory. | | | | |
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| 85 (CE) | Is there a 60 inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space so that a wheelchair or scooter user can make a 180° turn? |  <p style="text-align: center;">WHEELCHAIR TURNING SPACE 60 INCHES DIAMETER MINIMUM</p> <p style="text-align: center;">12 INCHES 36 INCHES MIN 12 INCHES</p> <p style="text-align: center;">60 INCHES MIN 36 INCHES MIN</p> | | | | |
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| Question # | Criteria (CE = Critical Elements) | Explanation/Guidelines | Yes | No | N/A | Comments |
|------------|--|--|-----|----|-----|----------|
| 86 (ME) | Is a weight scale available within the medical office with a platform to accommodate a wheelchair or scooter and the patient? | Accessible scales are usable by all people including: wheelchair users, people with activity limitations, and larger people who may exceed a standard weight scale limit. This includes people with conditions that interfere with mobility, walking, climbing, using steps (joint pain, short stature, pregnancy, fatigue, respiratory and cardiac conditions, post surgical conditions, orthopedic injuries); and/or who use mobility devices (e.g. canes, crutches, walkers). | | | | |

References

2010 ADA Standards for Accessible Design

U.S Department of Justice

http://www.ada.gov/2010ADASTandards_index.htm

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

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

1133B.4.4 – Striping for the visually impaired (Rev.1-1-2009), and 1115B-1 – Bathing and Toilet Facilities, placement of toilet paper dispensers. These standards can be found in:

2009 California Building Standards Code with California Errata and Amendments

State of California

Department of General Services

Division of the State Architect

Updated April 27, 2010

http://www.documents.dgs.ca.gov/dsa/pubs/access_manual_rev_04-27-10.pdf

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

“Health Care Usability Profile V3”

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Oregon Health & Science University RRTC: Health & Wellness

Authors: Drum, C.E., Davis, C.E., Berardinelli, M., Cline, A., Laing, R., Horner-Johnson, W., & Krahn, G.

Oregon Institute on Disability and Development

Portland, OR 97239

rrtc@ohsu.edu

healthwellness.org