

PCP/Clinic Name:
Address:

QM Nurse:

CAP Notification

Date of Review:

PCP ID# _____

Health Plan Performing Evaluation		IEHP	Molina	HealthNet	LA Care	Kaiser	
Facility Name:		PCP Name(s):				# of PCPs Reviewed:	
						# of Charts Reviewed:	
Address:				Contact Person and Title:			
Telephone:		Fax:		<input type="checkbox"/> Exempted Pass for the Site Review Survey – No CAP Due <input type="checkbox"/> Exempted Pass for the Medical Record Review Survey – No CAP Due			
Site Review Score:	Date Critical Element CAP Due:		CAP Follow-up: <input type="checkbox"/> Mail/Fax <input type="checkbox"/> Schedule Follow-up visit			CAP Closed Date:	
	Date Site Review CAP Due:		<input type="checkbox"/> Critical Element <input type="checkbox"/> Site Review <input type="checkbox"/> Medical Records				
	Date Medical Record CAP Due:		<input type="checkbox"/> Follow-up visit scheduled date/time : _____				
Medical Record Score:							
Reviewer's Name/Title (Print):				Reviewer's signature/Title:			

Corrective Action Plan (CAP) Completion and Submission Requirements

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

Disclosure and Release

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

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

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

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

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INSTRUCTIONS FOR USE

- 1st Column: (Health Plan Use Only)** Health Plan verification and date – The Health Plans Certified Site Reviewer (CSR) will initial and date the deficiency that the site has addressed/corrected. The Provider’s Corrective Action Plan will be verified by the CSR through a desk review by the Health Plan and/or a follow-up on site visit.
 - 2nd Column: (Health Plan Use Only)** Criteria – The Health Plan’s CSR will check the criteria(s) that were found deficient during the site review and/or medical record review processes. The criteria(s) checked should be addressed/corrected by the provider’s office. A corrective action plan (CAP) for all critical element deficiencies, which are bolded and underlined, should be submitted to the Health Plan within 10 business days. A corrective action plan for other criteria found deficient is due to the Health Plan within 45 days from the date of audit.
 - 3rd Column: (Health Plan Use Only)** Deficiency Cited/Reviewer Comments – This column is for the purpose of notifying the provider and/or designated staff of the deficiency found and/or the CSR findings/comments.
 - 4th Column: (Health Plan and Provider’s Office Use)** Recommended Corrective Action – The Health Plan’s CSR will check and/or write comments for the Provider’s office in order to notify the Provider and/or designated staff the documents and/or evidence needed in order to fulfill a deficiency.
 - 5th Column: (Provider’s Office Use Only)** Correction Date – The provider’s office will document the date that a deficiency has been addressed and/or corrected.
 - 6th Column: (Provider’s Office Use Only)** Practitioners Comments – The provider’s office will document corrective actions taken to address/correct a deficiency, as well as provide appropriate documents to support corrective actions taken. If provider’s office agrees with items checked in the 4th Column (Recommended Corrective Action) then the provider’s office would write “agree with recommended corrective action,” as well as submit supporting documents.
 - 7th Column: (Provider’s Office Use Only)** Signature and Title of Responsible Physician or Designee – The office staff who is responsible for maintaining compliance with a deficiency found during a site audit would put their name, title, and initial in this column.
- NOTE:** The Health Plan’s Certified Site Reviewer (CSR) may conduct a follow-up on site review to verify corrective action within 45 days from the date of audit and/or request the corrective action plan (CAP) to be submitted to the Health Plan via mail and/or fax.

CAP COMPLETION SIGNATURE PAGE

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

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

Physician/Designee Signature	Printed Name and Title	Date
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Please Return Completed Corrective Action Plan and this signature sheet. via U.S. Mail or FAX to:

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

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Site Review Survey Critical Element CAP

DATE DUE:

Signature Responsible Person:

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

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

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	I AS D 5 <input type="checkbox"/>	<u>Emergency medicine such as asthma, chest pain, hypoglycemia and anaphylactic reaction management: Epinephrine 1:1000 (injectable), and Benadryl 25 mg. (oral) or Benadryl 50 mg./ml. (injectable), Naloxone, chewable Aspirin 81 mg, Nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), and glucose. Appropriate sizes of ESIP needles/syringes and alcohol wipes.</u>	<input type="checkbox"/> A copy of the receipt/invoice for the following: (Circle those that apply) Naloxone, chewable Aspirin, Nitroglycerine spray/tablet, nebulizer, or metered dose inhaler and glucose. <input type="checkbox"/> A copy of the office policy and procedure regarding emergency medications is attached. <input type="checkbox"/> Other:			

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

C. Site personnel are qualified and trained for assigned responsibilities.
CA Business & Professional (B&P) Code 2069.16 CCR 1366, 22 CCR 75034, 75035

	IIP C 2 <input type="checkbox"/>	<u>No evidence that a qualified/trained personnel retrieve, prepare or administer medications</u>	<input type="checkbox"/> A copy of the office policy and procedure regarding qualified/trained personnel retrieve, prepare or administer medications is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> Other:		
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III Office Management
Office management survey Criteria

E. Procedures for timely referral/consultative services are established on site.
22CCR §53851: 28CCR § 1300.67 RN or MD Review Only

	III O M E 2 <input type="checkbox"/>	<u>Physician review and follow-up of referral/consultation reports and diagnostic test results is not evident.</u>	<input type="checkbox"/> A copy of the office policy and procedure regarding referrals to include the physician review and follow-up of referral/consultation reports and diagnostic test results is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the actual referral log utilized by the office is attached. <input type="checkbox"/> Other:		
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<p>IV Clinical Services Pharmaceutical Services Survey Criteria</p>						
<p>C. Drugs are dispensed according to State and federal drug distribution laws and regulations. <i>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</i></p>						
	<p>IV CS C 4 <input type="checkbox"/></p>	<p><u>Drugs are being dispensed to patients by other than lawfully authorized persons</u></p>	<p><input type="checkbox"/> A copy of the office policy and procedure regarding dispensing of medications is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A signed written explanation of the corrective action taken in regards to dispensing of medications. <input type="checkbox"/> Other:</p>			
	<p>IV CS C5</p>	<p><u>Personnel are unable to demonstrate or verbally explain procedures that vaccines are prepared and drawn only prior to administration.</u></p>	<p><input type="checkbox"/> A copy of the office policy and procedure regarding preparing and drawing up of medications is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A signed written explanation of the corrective action taken in regards to prepping of medications. <input type="checkbox"/> Other:</p>			

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VI Infection Control Infection Control Survey Criteria					
B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. 8CCR 5193 (Cal OSHA Health Care Worker Needlestick Prevention Act, 1999); H&S Code, 117600-118360 (CA Medical Waste Management Act, 1997); 29 CFR 1910.1030.					
	VI IC B 1 <input type="checkbox"/>	<u>Personal protective equipment is not readily available for staff use.</u>	<input type="checkbox"/> A copy of the receipt/invoice for the following is attached: (Circle those that apply) clothing barrier/gown, water repelling gloves, goggles/face shield, mask. <input type="checkbox"/> A copy of the office policy and procedure regarding personal protective equipment is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> Other:		

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	VI IC B 2 <input type="checkbox"/>	<u>Blood, other potentially infectious material and regulated wastes are not placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport or shipping.</u>	<input type="checkbox"/> A copy of the receipt/invoice for the purchase of an appropriate biohazardous container is attached. <input type="checkbox"/> A copy of the office policy and procedure regarding Biohazardous waste handling is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A signed written explanation of the corrective action taken in regards to regulated wastes. <input type="checkbox"/> Other:			
	VI IC B 3 <input type="checkbox"/>	<u>Needle stick safety precautions are not practiced on site.</u>	<input type="checkbox"/> A copy of the receipt/invoice for the purchase of Engineered Sharps Injury Protection (ESIP) is attached. <input type="checkbox"/> A copy of the office policy and procedure regarding needle stick safety precautions is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> Other:			

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

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Site Review Survey

1.

I. Access/Safety
Site Access/Safety Survey Criteria

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

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

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

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	I AS A 1 <input type="checkbox"/>	There is not a clearly marked (blue) curb or sign designating disabled-parking space near an accessible primary entrance.	<input type="checkbox"/> A picture of parking space(s) for the disabled have been designated and are designated using reflectorized signs posted conspicuously. <input type="checkbox"/> Signed written explanation of corrective action taken in regards to disabled parking space(s). <input type="checkbox"/> Facility is located in residential area where designated parking is not permitted. <input type="checkbox"/> A copy of the local ordinance is attached. <input type="checkbox"/> A copy of the work invoice with completion date or receipts are attached. <input type="checkbox"/> Other:			

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	I AS A 2 <input type="checkbox"/>	Pedestrian ramps do not have a level landing at the top and bottom of the ramp.	<input type="checkbox"/> A picture of a clear and level landing at the top and bottom of all ramps and on each side of the exit door has been provided. <input type="checkbox"/> A copy of the work invoice with completion date or receipts are attached. <input type="checkbox"/> Other:			
	I AS A 3 <input type="checkbox"/>	Exit doorway openings do not allow for clear passage of a person in a wheelchair.	<input type="checkbox"/> All appropriate doorways have been remodeled to accommodate patients in wheelchairs. <input type="checkbox"/> A 32 inch clearance for exit doorway-openings had been established. <input type="checkbox"/> A copy of the completed and dated work invoice or receipts is attached. <input type="checkbox"/> A copy of the building wavier is attached. <input type="checkbox"/> Other:			
	I AS A 4 <input type="checkbox"/>	There is not an accessible passenger elevator or reasonable alternative for multi-level floor accommodation.	<input type="checkbox"/> Elevator service has been provided for the facility. <input type="checkbox"/> A copy of the completed and dated work invoice or receipts is attached. <input type="checkbox"/> A freight elevator has been upgraded for general passenger use. <input type="checkbox"/> A building waiver is in effect and is attached. <input type="checkbox"/> Other:			
	I AS A 5 <input type="checkbox"/>	Floor space for wheelchair in waiting area and exam room is not clear.	<input type="checkbox"/> Waiting room and exam/treatment room have been rearranged to provide for a stationary adult wheelchair with appropriate room for turning. <input type="checkbox"/> An appropriate procedure is in place to accommodate a wheelchair. A copy of the procedure is attached. <input type="checkbox"/> Other:			

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	I AS A 6 <input type="checkbox"/>	Restroom facilities are not wheelchair accessible and/or there was no reasonable alternative.	<input type="checkbox"/> Restroom facilities have been remodeled to accommodate wheelchair accessibility. <input type="checkbox"/> A copy of the receipt and/or work invoice is attached. <input type="checkbox"/> An alternative procedure is in place and the policy and procedure is attached. <input type="checkbox"/> Other:			
	I AS A7 <input type="checkbox"/>	Hand washing facilities are not wheelchair accessible and/or there was no reasonable alternative.	<input type="checkbox"/> A sink has been modified to meet wheelchair access and safety requirements. <input type="checkbox"/> A copy of the receipt and/or work invoice is attached. <input type="checkbox"/> An alternative for hand washing facilities for wheelchair patients is in place and a copy of the policy and procedure is attached. <input type="checkbox"/> Other:			
<p>B. Site environment is maintained in a clean and sanitary condition 8 CCR §5193; 28 CCR §1300.80</p>						
	I AS B 1 <input type="checkbox"/>	All patient areas including floor/carpet, walls, and furniture are not neat, clean, and well maintained.	<input type="checkbox"/> The floors, carpets, walls, and furniture have been cleaned and/or repaired. <input type="checkbox"/> A copy of the receipt and/or work invoice is attached. <input type="checkbox"/> Other:			
	I AS B 2 <input type="checkbox"/>	Restrooms are not clean and/or do not contain appropriate sanitary supplies.	<input type="checkbox"/> Appropriate sanitary supplies have been obtained and placed in the restrooms. <input type="checkbox"/> Circle which supply is needed: toilet tissue, hand washing soap, cloth/paper towels or antiseptic towelettes. <input type="checkbox"/> A copy of the receipt and/or work invoice is attached. <input type="checkbox"/> Other:			

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<p>C. Site environment is safe for all patients, personnel and visitors 8 CCR §3220; 22 CCR §53230; 24 CCR, §2, § 3, §9; 28 CCR §1300.80; 29 CFR §1910.301, §1926.34</p>						
<p>Evidence that site staff has received training and/or information in the following:</p>						
	<p>I AS C 1 <input type="checkbox"/></p>	<p>There is no evidence that site staff has received training and/or information in fire safety and prevention.</p>	<p><input type="checkbox"/> Training has been provided to site personnel regarding fire prevention/safety. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office fire safety and prevention policy and procedure is attached. <input type="checkbox"/> Other:</p>			
	<p>I AS C 2 <input type="checkbox"/></p>	<p>There is no evidence that site staff has received training and/or information in emergency non-medical procedures (e.g. site evacuation, workplace violence, abusive patients)</p>	<p><input type="checkbox"/> Training has been provided to site personnel regarding non-medical emergency procedures-site evacuation, workplace violence, and abusive patients. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office non-medical emergency policy and procedure is attached. <input type="checkbox"/> Other:</p>			
	<p>I AS C 3 <input type="checkbox"/></p>	<p>There is not adequate lighting in all areas to ensure safety.</p>	<p><input type="checkbox"/> Lighting in working and walking areas has been installed. <input type="checkbox"/> A copy of the receipt and/or work invoice is attached. <input type="checkbox"/> Other:</p>			

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	I AS C 5 <input type="checkbox"/>	Exit doors are not clearly marked with "Exit" signs.	<input type="checkbox"/> "Exit" signs have been posted in the following areas: <input type="checkbox"/> A copy of the receipt and/or work invoice is attached. <input type="checkbox"/> Other:			
	I AS C 6 <input type="checkbox"/>	There are no clearly diagramed "Evacuation Routes" for emergencies posted in a visible location.	<input type="checkbox"/> Clearly marked, easy-to-follow escape routes have been posted in visible areas. <input type="checkbox"/> A copy of the office evacuation diagram posted is attached. <input type="checkbox"/> Other:			
	I AS C 7 <input type="checkbox"/>	Electrical cords and outlets are not in good working condition.	<input type="checkbox"/> Electrical cords have been replaced/repared. <input type="checkbox"/> Electrical outlets have been replaced/repared. <input type="checkbox"/> A copy of the receipt and/or work invoice is attached. <input type="checkbox"/> Other:			
	I AS C 8 <input type="checkbox"/>	There is not at least one type of fire-fighting/protection equipment that is accessible at all times.	<input type="checkbox"/> Smoke detector with intact, working batteries. <input type="checkbox"/> Fire alarm device with code and reporting instructions posted conspicuously at phones and employee entrances. <input type="checkbox"/> Automatic sprinkler system with sufficient clearance (10-in.) between sprinkler heads and stored materials. <input type="checkbox"/> Fire extinguisher in an accessible location that displays readiness indicators or has an attached current dated inspection tag. A copy of the current dated inspection tag is attached. <input type="checkbox"/> Other:			
	I AS C 9 <input type="checkbox"/>	There is no employee alarm system in place to warn employees of fire or other emergencies.	<input type="checkbox"/> Invoice or receipt for employee alarm system. <input type="checkbox"/> Policy or procedure addressing employee notification of fire or other emergencies. <input type="checkbox"/> Other:			

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

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	I AS D 6 <input type="checkbox"/>	Medication dosage chart (or other method for determining dosage) is not kept with emergency medications.	<input type="checkbox"/> A medication dosage chart has been included for each medication in the emergency kit. <input type="checkbox"/> A copy of the following medication dosage chart is attached: <input type="checkbox"/> Other:			
	I AS D 7 <input type="checkbox"/>	There is no documentation on checking of emergency equipment/supplies for expiration and operating status at least monthly.	<input type="checkbox"/> Emergency equipment/supplies are checked at least monthly for expiration and operating status. <input type="checkbox"/> A copy of the office log is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> Other:			
	I AS D 8 <input type="checkbox"/>	No evidence that emergency equipment is replaced/re-stocked immediately after use.	<input type="checkbox"/> Emergency equipment is replaced/re-stocked immediately after use. <input type="checkbox"/> A copy of the office policy and procedure is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> Other:			

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

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	I AS E 1 <input type="checkbox"/>	There is no evidence that medical equipment is clean.	<input type="checkbox"/> All specialized medical equipment is cleaned according to manufacturer’s guidelines after use. <input type="checkbox"/> A signed written explanation of corrective action taken in regards to cleaning of medical equipment. <input type="checkbox"/> Other:			
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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	I AS E 2 <input type="checkbox"/>	There is no evidence of written documentation demonstrating the appropriate maintenance of all specialized medical equipment according to equipment manufacturer’s guidelines.	<input type="checkbox"/> All medical equipment is serviced annually by a qualified technician or according to manufacturer’s guidelines. <input type="checkbox"/> A copy of the receipt and/or work invoice is attached. <input type="checkbox"/> A copy of the calibration log for the following equipment: <input type="checkbox"/> Glucometer <input type="checkbox"/> Hemocue <input type="checkbox"/> Other: <input type="checkbox"/> Other:			

II. Personnel
Site Personnel Survey Criteria

PCP/Clinic Name:
Address:

QM Nurse:

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

PCP/Clinic Name:
Address:

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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	II P C 3 <input type="checkbox"/>	Site does not have a written policy or procedure documenting the process for confirming correct patient/medication/vaccine dosage prior to administration.	<input type="checkbox"/> A copy of the office policy and procedure is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> Other:			
	II P C 4 <input type="checkbox"/>	There was no evidence that qualified/trained personnel operate medical equipment.	<input type="checkbox"/> A copy of documentation of training for the following staff and medical equipment operated is attached: <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> Other:			
D. Scope of practice for Non-Physician Medical Provider (NPMP) is clearly defined. 16 CCR §1379, §1399.540, §1399.545, §1474, CA B&P Code §2725.1 In order to be fully compliant with this section, please submit a copy of the current Procedures, Agreements, or License						
	II P D 1 <input type="checkbox"/>	There is no evidence of Standardized Procedures defining the scope of services provided for Nurse Practitioners (NP) and/or Certified Nurse Midwives (CNM).	<input type="checkbox"/> A copy of the currently signed and dated Standardized Procedures defining the scope of services provided for the Nurse Practitioner(s) (NP) and/or Certified Nurse Midwives (CNM) is attached: <input type="checkbox"/> Other:			
	II P D 2 <input type="checkbox"/>	There is no evidence of a Practice Agreement defining the scope of services provided by Physician Assistants (PA) and Supervisory Guidelines defining the method of supervision by the Supervising Physician.	<input type="checkbox"/> A copy of the currently signed and dated Practice Agreement(s) is attached for the following physician assistant(s): <input type="checkbox"/> A copy of the Practice Agreement(s) defining the method of supervision by the Supervising Physician is attached for the above PAs listed. <input type="checkbox"/> Other:			

PCP/Clinic Name:
Address:

QM Nurse:

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

PCP/Clinic Name:

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

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

PCP/Clinic Name:
Address:

QM Nurse:

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

PCP/Clinic Name:
Address:

QM Nurse:

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

PCP/Clinic Name:
Address:

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

PCP/Clinic Name:
Address:

QM Nurse:

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

PCP/Clinic Name:
Address:

QM Nurse:

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

PCP/Clinic Name:
Address:

QM Nurse:

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

PCP/Clinic Name:
Address:

QM Nurse:

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

PCP/Clinic Name:
Address:

QM Nurse:

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

PCP/Clinic Name:
Address:

QM Nurse:

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

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Address:

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

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

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	IV CS B 11 <input type="checkbox"/>	Site does not have method(s) in place for drug and hazardous substance disposal.	<input type="checkbox"/> A disposal method is in place for drug and hazardous substance disposal that is within county and city ordinances. <input type="checkbox"/> A copy of the office procedure regarding drug and hazardous substance disposal is attached. <input type="checkbox"/> A copy of an appropriate medical waste disposal contract. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> Other:			
C. Drugs are dispensed according to State and federal drug distribution laws and regulations. <i>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</i>						
	IV CS C 1 <input type="checkbox"/>	Expired drugs were found on site.	<input type="checkbox"/> All expired drugs were removed and disposed of properly on site. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> Other:			
Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE

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						PHYSICIAN OR DESIGNEE
	IV CS C 2 <input type="checkbox"/>	The site has no procedure to check expiration date of all drugs (including vaccines and samples), and infant and therapeutic formulas.	<input type="checkbox"/> A copy of the office procedure regarding checking expiration dates of all drugs on site is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of a log utilized to document checking of expired drugs and supplies. <input type="checkbox"/> Other:			
	IV CS C 3 <input type="checkbox"/>	All stored and dispensed prescriptions drugs are not appropriately labeled.	<input type="checkbox"/> A copy of the office procedure regarding labeling of stored and dispensed prescription drugs is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of a sample label for dispensing medications is attached. <input type="checkbox"/> Other:			

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

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	<input type="checkbox"/>		<input type="checkbox"/> Attached are copies of VIS information is available according to patient population. <input type="checkbox"/> Other:			
	IV CS C 7 <input type="checkbox"/>	Pharmacy on site, is not licensed by the CA state Board of Pharmacy.	<input type="checkbox"/> A copy of the current pharmacy license is attached. <input type="checkbox"/> A copy of the office procedure regarding medication dispensing/storage is attached. <input type="checkbox"/> A licensed pharmacist monitoring drug distribution and current CA license is attached. <input type="checkbox"/> Other:			
	IV CS C8 <input type="checkbox"/>	Site does not utilize California Immunization Registry (CAIR) or most current version.	<input type="checkbox"/> A copy of the office procedure regarding entering dates of all immunizations given into CAIR is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> Other:			

Laboratory Services Survey Criteria

D. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations 17 CCR §1050; 22 CCR §51211.2, §51137.2; B&P Code §1220; 42 USC 263a; Public Law 100-578

	IV CS D 1 <input type="checkbox"/>	Laboratory test procedures are not performed according to current site-specific CLIA Certificate.	<input type="checkbox"/> A copy of the current CLIA certificate is attached. <input type="checkbox"/> A copy of the application/renewal for a CLIA certificate is attached. <input type="checkbox"/> Other:			
	IV CS D 2 <input type="checkbox"/>	Testing personnel performing clinical lab procedures have not been trained.	<input type="checkbox"/> Documentation of training and/or certificate of training for the following procedure(s) is attached: <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> Other:			

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
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	<p>IV CS D 3 <input type="checkbox"/></p>	<p>Lab supplies (e.g. vacutainers, vacutainer tubes, culture swabs, test solutions) are accessible to unauthorized persons.</p>	<p><input type="checkbox"/> A written explanation of the corrective action(s) taken for lab supplies to not be accessible to unauthorized persons. <input type="checkbox"/> A copy of the receipt and/or invoice is attached. <input type="checkbox"/> Other:</p>			
	<p>IV CS D 4 <input type="checkbox"/></p>	<p>Lab test supplies are expired.</p>	<p><input type="checkbox"/> Expired laboratory supplies were removed from the storage area. <input type="checkbox"/> A copy of a log utilized to document checking of expired drugs and supplies. <input type="checkbox"/> Other:</p>			
	<p>IV CS D 5 <input type="checkbox"/></p>	<p>Site does not have a procedure to check expiration date and a method to dispose of expired lab test supplies.</p>	<p><input type="checkbox"/> A copy of a log utilized to document checking of expired drugs and supplies. <input type="checkbox"/> A copy of the office procedure regarding medication dispensing/storage is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> Other:</p>			

Radiology Services Survey Criteria

**E. Site meets CDPH Radiological inspection and safety regulations.
 17 CCR §30255, §30305, §30404, §30405**

	<p>IV CS E 1 <input type="checkbox"/></p>	<p>The site does not have a current California Radiologic Health Branch Inspection Report and/or Proof of Registration, if there is radiological equipment on site.</p>	<p><input type="checkbox"/> A copy of the current California Radiologic Health Branch Inspection Report is attached. <input type="checkbox"/> A copy of the Inspection Report and short form sign-off sheet is attached. <input type="checkbox"/> A copy of the Inspection Report and notice of violation form and approval letter for corrective action plan is attached. <input type="checkbox"/> A copy of Proof of Registration is attached. <input type="checkbox"/> Other:</p>			
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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
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PCP/Clinic Name:

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Address:

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

PCP/Clinic Name:
Address:

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

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

PCP/Clinic Name:
Address:

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

PCP/Clinic Name:
Address:

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

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Address:

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

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Address:

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	VI IC A 3 <input type="checkbox"/>	There is no site procedure for effectively isolating infectious patients with potential communicable conditions.	<input type="checkbox"/> A copy of the office policy and procedure regarding isolating infectious patients with potential communicable conditions is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> Other:			

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
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B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. 8 CCR §5193 (Cal OSHA Health Care Worker Needlestick Prevention Act, 1999); H&S Code, §117600-118360 (CA Medical Waste Management Act, 1997); 29 CFR §1910.1030.

	VI IC B 4 <input type="checkbox"/>	No Sharps Injury Log available on site. Sharp injury incidents are not documented.	<input type="checkbox"/> A copy of the sharps injury incidents form and log which describe the date, time, description of exposure incident, sharp type/brand, and follow-up care received within 14 days. <input type="checkbox"/> A copy of the office policy and procedure regarding documentation of sharp injury incidents is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> Other:			
	VI IC B 5 <input type="checkbox"/>	Biohazardous (non-sharp) wastes are not contained separately from other trash/waste.	<input type="checkbox"/> Biohazardous wastes are contained separately from other trash/waste. <input type="checkbox"/> A copy of the office policy and procedure regarding biohazardous wastes is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the receipt is attached. <input type="checkbox"/> Other:			

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Address:

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

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

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

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

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

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

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

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

Medical Record Review Survey

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

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

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

II. Documentation Criteria

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

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

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Address:

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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	H F <input type="checkbox"/>	All entries were not signed, dated and legible	<input type="checkbox"/> A copy of the policy and procedure regarding medical records is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> Other:			
	H G <input type="checkbox"/>	Errors were not corrected according to legal medical documentation standards.	<input type="checkbox"/> A copy of the policy and procedure regarding medical records is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> Other:			

PCP/Clinic Name:

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

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

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

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			<input type="checkbox"/> Other:		
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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	IV C2 <input type="checkbox"/>	Well-Child Visit: Anemia Screening	<input type="checkbox"/> A copy of the policy and procedure regarding Anemia Screening is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			

	IV C3 <input type="checkbox"/>	Well-Child Visit: Anthropometric Measurements	<input type="checkbox"/> A copy of the policy and procedure regarding Anthropometric measurements is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
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	IV C4 <input type="checkbox"/>	Well-Child Visit: Anticipatory Guidance	<input type="checkbox"/> A copy of the policy and procedure regarding Anticipatory Guidance is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
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	IV C5 <input type="checkbox"/>	Well-Child Visit: Autism Spectrum Disorder Screening	<input type="checkbox"/> A copy of the policy and procedure regarding Autism Spectrum Disorder screening is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
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	IV C6 <input type="checkbox"/>	Well-Child visit: Blood Lead Screening Test	<input type="checkbox"/> A copy of the policy and procedure regarding Blood Lead Screening is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	IV C7 <input type="checkbox"/>	Well-Child Visit: Blood Pressure Screening	<input type="checkbox"/> A copy of the policy and procedure regarding Blood Pressure Screening is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	IV C8 <input type="checkbox"/>	Well-Child Visit: Dental/Oral Health Assessment	<input type="checkbox"/> A copy of the policy and procedure regarding Dental/Oral Health Assessment is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	IV C 8a <input type="checkbox"/>	Well-Child Visit: Dental Assessment: Fluoride Supplements	<input type="checkbox"/> A copy of the policy and procedure regarding Fluoride supplementation is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	IV C 8b <input type="checkbox"/>	Well-Child Visit: Dental Assessment: Fluoride Varnish	<input type="checkbox"/> A copy of the policy and procedure regarding Fluoride Varnish is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached.			

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

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

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

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

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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	IV D2 <input type="checkbox"/>	No evidence that documentation of immunization administration included manufacturer's name, lot number, site and initials.	<input type="checkbox"/> A copy of the policy and procedure regarding medical records is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	IV D3 <input type="checkbox"/>	No evidence that publication date of Vaccine Information Statement (VIS) was documented for each immunization administered.	<input type="checkbox"/> A copy of the policy and procedure regarding medical records is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			

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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
<i>V. Adult Preventive Criteria</i>						
	V A1 <input type="checkbox"/>	Initial Health Assessment (IHA): No evidence that History and Physical (H&P) was performed within the first 120-days of enrollment in the health plan.	<input type="checkbox"/> A copy of the policy and procedure regarding IHA is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	V A2 <input type="checkbox"/>	No evidence that an initial Individual Health Education Behavioral Assessment (IHEBA) was performed within the first 120-days of enrollment in the health plan.	<input type="checkbox"/> A copy of the policy and procedure regarding IHEBA/SHA is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	V B1 <input type="checkbox"/>	Periodic Health Evaluation according to most recent USPSTF Guidelines.	<input type="checkbox"/> A copy of the policy and procedure regarding adult periodic health evaluations is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	V B2 <input type="checkbox"/>	Subsequent Periodic IHEBA	<input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	V C1 <input type="checkbox"/>	Adult Preventive Care Screenings: Abdominal Aneurysm Screening	<input type="checkbox"/> A copy of the policy and procedure regarding Abdominal Aneurysm screening is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached.			

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

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Address:

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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	V C3 <input type="checkbox"/>	Adult Preventive Care Screenings: Breast Cancer Screening	<input type="checkbox"/> A copy of the policy and procedure regarding Breast Cancer Screening is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	V C4 <input type="checkbox"/>	Adult Preventive Care Screenings: Cervical Cancer Screening	<input type="checkbox"/> A copy of the policy and procedure regarding Cervical Cancer Screening is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	V C5 <input type="checkbox"/>	Adult Preventive Care Screenings: Colorectal Cancer Screening	<input type="checkbox"/> A copy of the policy and procedure regarding Colorectal Cancer Screening is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	V C6 <input type="checkbox"/>	Adult Preventive Care Screenings: Depression Screening	<input type="checkbox"/> A copy of the policy and procedure regarding Depression Screening is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	V C7 <input type="checkbox"/>	Adult Preventive Care Screenings: Diabetic Screening	<input type="checkbox"/> A copy of the policy and procedure regarding Diabetic Screening is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached.			

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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	V C 7a <input type="checkbox"/>	Adult Preventive Care Screenings: Diabetic Comprehensive Care	<input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other: <input type="checkbox"/> A copy of the policy and procedure regarding Diabetic Comprehensive Care is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	V C8 <input type="checkbox"/>	Adult Preventive Care Screenings: Drug Disorder Screening and Behavioral Counseling	<input type="checkbox"/> A copy of the policy and procedure regarding Drug Disorder Screening and Behavioral Counseling is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	V C9 <input type="checkbox"/>	Adult Preventive Care Screenings: Dyslipidemia Screening	<input type="checkbox"/> A copy of the policy and procedure regarding Dyslipidemia Screening is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	V C 10 <input type="checkbox"/>	Adult Preventive Care Screenings: Folic Acid Supplementation	<input type="checkbox"/> A copy of the policy and procedure regarding Folic Acid Supplementation is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			

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

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

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

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			<input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	V D3 <input type="checkbox"/>	Adult Immunizations: Vaccine Information Statement (VIS) documentation	<input type="checkbox"/> A copy of the policy and procedure regarding Vaccine Information Statement (VIS) documentation is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			

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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
<i>VI. Perinatal Preventive Criteria</i>						
	VI A1 <input type="checkbox"/>	No evidence of an Initial Comprehensive Prenatal Assessment (ICA) completed within 4 weeks of entry to prenatal care	<input type="checkbox"/> A copy of the policy and procedure regarding Initial prenatal visit is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	VI A2 <input type="checkbox"/>	Initial Comprehensive Prenatal Assessment (ICA): Obstetrical and Medical History	<input type="checkbox"/> A copy of the policy and procedure regarding Obstetrical and Medical History is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	VI A3 <input type="checkbox"/>	Initial Comprehensive Prenatal Assessment (ICA): Physical Exam	<input type="checkbox"/> A copy of the policy and procedure regarding Physical Exam is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	VI A4 <input type="checkbox"/>	Initial Comprehensive Prenatal Assessment (ICA): Dental Assessment	<input type="checkbox"/> A copy of the policy and procedure regarding Dental Assessment is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	VI A5 <input type="checkbox"/>	Initial Comprehensive Prenatal Assessment (ICA): Healthy Weight Gain and Behavior Counseling	<input type="checkbox"/> A copy of the policy and procedure regarding Healthy Weight Gain and Behavior Counseling is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached.			

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			<input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
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Address:

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

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

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

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

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

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

PCP/Clinic Name:
Address:

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

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

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			<input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	VI E <input type="checkbox"/>	Prenatal care visit periodicity according to most recent ACOG standards	<input type="checkbox"/> A copy of the policy and procedure regarding Prenatal care visit periodicity according to most recent ACOG standards is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	VI F <input type="checkbox"/>	Influenza Vaccine	<input type="checkbox"/> A copy of the policy and procedure regarding Influenza Vaccine is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	VI G <input type="checkbox"/>	COVID Vaccine	<input type="checkbox"/> A copy of the policy and procedure regarding Covid Vaccine is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
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	VI H <input type="checkbox"/>	No evidence of a Referral to WIC and assessment of Infant Feeding status.	<input type="checkbox"/> A copy of the policy and procedure regarding Referral to WIC and assessment of Infant Feeding status.is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			

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	VI I <input type="checkbox"/>	No evidence that HIV-related services were <i>offered</i> .	<input type="checkbox"/> A copy of the policy and procedure regarding HIV-related services is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	VI J <input type="checkbox"/>	No evidence that AFP/Genetic screening was <i>offered</i> .	<input type="checkbox"/> A copy of the policy and procedure regarding AFP/Genetic screening is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	VI K <input type="checkbox"/>	No evidence of a Family Planning Evaluation.	<input type="checkbox"/> A copy of the policy and procedure regarding medical records is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	VI L1 <input type="checkbox"/>	Postpartum Comprehensive Assessment: Individualized Care Plan	<input type="checkbox"/> A copy of the policy and procedure regarding medical records is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
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	VI L2 <input type="checkbox"/>	Postpartum Comprehensive Assessment: Nutrition Assessment	<input type="checkbox"/> A copy of the policy and procedure regarding medical records is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	VI L 3a <input type="checkbox"/>	Postpartum Comprehensive Psychosocial Assessment: Maternal Mental Health /Postpartum depression screening	<input type="checkbox"/> A copy of the policy and procedure regarding medical records is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	VI L 3b <input type="checkbox"/>	Postpartum Comprehensive Psychosocial Assessment: Social Needs Assessment	<input type="checkbox"/> A copy of the policy and procedure regarding medical records is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	VI L 3c <input type="checkbox"/>	Postpartum Comprehensive Psychosocial Assessment: Substance Use/Abuse Assessment	<input type="checkbox"/> A copy of the policy and procedure regarding Substance Use/Abuse Assessment is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
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	VI L4 <input type="checkbox"/>	Postpartum Comprehensive Health Education Assessment	<input type="checkbox"/> A copy of the policy and procedure regarding Postpartum Comprehensive Health Education Assessment is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			
	VI L5 <input type="checkbox"/>	Postpartum Comprehensive Physical Exam	<input type="checkbox"/> A copy of the policy and procedure regarding Postpartum Comprehensive Physical Exam is attached. <input type="checkbox"/> A copy of the in-service outline (agenda) and sign-in sheet are attached. <input type="checkbox"/> A copy of the office form utilized is attached. <input type="checkbox"/> Other:			