



Criteria	VI. Infection Control Reviewer Guidelines
<p>D. Reusable medical instruments are properly sterilized after each use.</p> <p> </p>	<ul style="list-style-type: none"> • Deficiencies: All deficiencies related to Infection Control must be addressed in a corrective action plan. • Cleaning prior to sterilization: Prior to undergoing the sterilization process, soiled instruments/equipment are thoroughly cleaned, rinsed, dried and inspected for the presence of dried blood or other debris. Personnel are able to demonstrate or verbally explain procedure(s) used for cleaning prior to sterilization, and to locate written directions on site. • Cold/chemical sterilization: Product manufacturer’s directions are strictly followed for instrument pre-soaking treatment, solution preparation, solution exposure procedures, safety precautions (e.g., room temperature, area ventilation), and post-sterilization processes. Sterilization exposure times and solution expiration date/time is communicated to staff. Written procedures for cold sterilization are available on site to staff. • Autoclave/steam sterilization: Autoclave manufacturer’s directions are strictly followed for instrument pre-cleaning, machine loading, operation safety precautions, minimum time-temperature criteria, and post sterilization processes. Written operating procedures for autoclave are available on site to staff. Documentation of sterilization loads includes: date, time and duration of run cycle, temperature, steam pressure, and operator of each run. If instruments/equipment are transported off-site for sterilization, equipment-handling and transport procedures are available on site to staff. • Autoclave maintenance: Autoclave is maintained and serviced according to manufacturer’s guidelines. Documentation of maintenance should include: mechanical problems, inspection dates, results/outcome of routine servicing, calibration, repairs, etc. Note: If the manufacturer’s guidelines are not present on site, then the autoclave is serviced annually by a qualified technician. A dated sticker on the autoclave or a service receipt is acceptable documentation of appropriate maintenance. • Spore testing: Autoclave spore testing is performed <i>at least monthly</i>, unless otherwise stated in manufacturer’s guidelines. Documentation of biological spore testing includes: date, results, types of spore test used, person performing/documenting test results. Written procedures for performing routine spore testing and for handling positive spore test results are available on site to staff. For positive spore tests, the autoclave is removed from service immediately until inspection is completed and a negative retest occurs. Procedures include: report problem, repair autoclave, retrieve all instruments sterilized since last negative spore test, re-test autoclave and re-sterilize retrieved instruments (Report/Re-sterilize/Re-sterilize/Re-sterilize). Note: Sterilization methods include autoclaves (steam under pressure), Ethylene Oxide (EO) gas sterilizer, dry-heat sterilizer, and liquid chemical sterilants. Biologic spore test products vary, and are designed for use based on specific autoclave type. Biologic control testing challenges the autoclave sterilization cycle with live, highly resistant, nonpathogenic spores. If spores are killed during processing, it is assumed that all other microorganisms are also killed and that the autoclave load is sterile. • Sterile Packages: Storage areas for sterilized packages are clean, dry and separated from non-sterile items by a functional barrier (e.g., shelf, cabinet door, and drawer). Sterilized package labels include date of sterilization, load run identification information, and general contents (e.g. suture set). Each item in a sterile package need not be listed on the label if a master list of package contents is available elsewhere on site. Maintenance of sterility is event related, not time related. Sterilized items are considered sterile until use, unless an event causes contamination. Sterilized items are not considered sterile if package is opened, wet/moist, discolored or damaged, and should be kept removed from sterile package storage area. Site has a process for routine evaluation of sterilized packages.

Facility Site Review Survey

Attachment A

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

Health Plan _____ IPA _____ Site ID No. _____ Review Date: _____ Last review: _____

Provider/Address _____ Phone _____ Fax _____ Fire Clearance _____
Current Yes/No
Contact person/title _____

No. of staff on site _____ Physician _____ NP _____ CNM _____ PA _____ Reviewer/title _____
RN _____ LVN _____ MA _____ Clerical _____ other _____ Reviewer/title _____

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

Site Scores						Scoring Procedure				Compliance Rate	
	Points Poss.	Yes Pts. Given	No's	N/A's	CE's	1) Add points given in each section. 2) Add total points given for all six sections. 3) Adjust score for "N/A" criteria (if needed), by subtracting N/A points from 150 total points poss. 4) Divide total points given by 150 or by "adjusted" total points. 5) Multiply by 100 to get the compliance (percent) rate. $\frac{\text{Points Given}}{\text{Total / Adjusted Points}} = \text{Decimal Score} \times 100 = \text{Compliance Rate \%}$				<input type="checkbox"/> Exempted Pass: 90% or above <i>(without deficiencies in Critical Elements, Pharmaceutical Services or Infection Control)</i> <input type="checkbox"/> Conditional Pass: 80-89%, or 90% and above <i>with deficiencies in Critical Elements, Pharmaceutical Services or Infection Control</i> <input type="checkbox"/> Not Pass: Below 80% <input type="checkbox"/> CAP Required <input type="checkbox"/> Other follow-up Next Review Due: _____	
I. Access/Safety	(29)										
II. Personnel	(22)										
III. Office Management	(25)										
IV. Clinical Services	(34)										
V. Preventive Services	(13)										
VI. Infection Control	(27)										
	(150)					Note: CE's column may be used for easy reference to see if there are Critical Elements that trigger a CAP.					
	Total Pts. Poss.	Yes Pts. Given	No's	N/A's	CE's						

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I. Access/Safety (continued on next page)

Site Access/Safety Survey Criteria	Yes	No	N/A	Wt.	Site Score
<p>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)</p> <p>Sites must have the following safety accommodations for physically disabled persons:</p>					
1) Clearly marked (blue) curb or sign designating disabled-parking space near accessible primary entrance.	1) ____	1) ____	1) ____	1	
2) Pedestrian ramps have a level landing at the top and bottom of the ramp.	2) ____	2) ____	2) ____	1	
3) Exit doorway openings allow for clear passage of a person in a wheelchair.	3) ____	3) ____	3) ____	1	
4) Accessible passenger elevator or reasonable alternative for multi-level floor accommodation.	4) ____	4) ____	4) ____	1	
5) Clear floor space for wheelchair in waiting area and exam room.	5) ____	5) ____	5) ____	1	
6) Wheelchair accessible restroom facilities or reasonable alternative.	6) ____	6) ____	6) ____	1	
7) Wheelchair accessible hand washing facilities or reasonable alternative.	7) ____	7) ____	7) ____	1	

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


I. Access/Safety (continued on next page)

Site Access/Safety Survey Criteria	Yes	No	N/A	Wt.	Site Score
B. Site environment is maintained in a clean and sanitary condition. 8 CCR §5193; 28 CCR §1300.80					
1) All patient areas including floor/carpet, walls, and furniture are neat, clean and well maintained.	1)_____	1)_____	1)_____	1	
2) Restrooms are clean and contain appropriate sanitary supplies.	2)_____	2)_____	2)_____	1	
C. Site environment is safe for all patients, visitors and personnel. 8 CCR §3220; 22 CCR §53230; 24 CCR, §2, §3, §9; 28 CCR §1300.80; 29 CFR §1910.301, §1926.34					
There is evidence that staff has received safety training and/or has safety information available in the following:					
1) Fire safety and prevention	1)_____	1)_____	1)_____	1	
2) Emergency non-medical procedures (e.g. site evacuation, workplace violence)	2)_____	2)_____	2)_____	1	
The following fire and safety precautions are evidenced on site:					
3) Lighting is adequate in all areas to ensure safety.	3)_____	3)_____	3)_____	1	
4) <u>Exit doors and aisles are unobstructed and egress (escape) accessible.</u>	4)_____	4)_____	4)_____	2	
5) Exit doors are clearly marked with “Exit” signs.	5)_____	5)_____	5)_____	1	
6) Clearly diagramed “Evacuation Routes” for emergencies are posted in a visible location.	6)_____	6)_____	6)_____	1	
7) Electrical cords and outlets are in good working condition.	7)_____	7)_____	7)_____	1	
8) At least one type of fire fighting/protection equipment is accessible at all times.	8)_____	8)_____	8)_____	1	

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

I. Access/Safety (continued on next page)


 **RN/MD Review only**

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

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

I. Access/Safety (continued from previous page)

 **RN/MD Review only**

Site Access/Safety Survey Criteria	Yes	No	N/A	Wt.	Site Score
<p>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 </p> <p>1) Medical equipment is clean.</p> <p>2) Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines.</p>	<p>1) _____</p> <p>2) _____</p>	<p>1) _____</p> <p>2) _____</p>	<p>1) _____</p> <p>2) _____</p>	<p>1</p> <p>1</p>	
<p>Comments: Write comments for all "No" (0 points) and "N/A" scores.</p> <p style="text-align: right;">TOTALS</p>					



II. Personnel (continued on next page)

Site Personnel Survey Criteria	Yes	No	N/A	Wt.	Site Score
<p>A. Professional health care personnel have current California licenses and certifications. CA Business & Professional (B&P) Code §2050, §2085, §2725, §2746, §2834, §3500, §4110; CCR, Title 16, §1355.4, §1399.547</p> <p>1) All required Professional Licenses and Certifications, issued from the appropriate licensing/certification agency, are current. Notification is provided to each member that the MD(s) is licensed and regulated by the Medical Board, and that the Physician Assistant(s) is licensed and regulated by the Physician Assistant Committee.</p>	1)_____	1)_____	1)_____	1	
<p>B. Health care personnel are properly identified. CA B&P Code §680, AB 1439</p> <p>1) Health care personnel wear identification badges/tags printed with name and title.</p>	1)_____	1)_____	1)_____	1	

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

II. Personnel (continued on next page)



  RN/MD Review only

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

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

II. Personnel (continued on next page)



  **RN/MD Review only**

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

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

II. Personnel (continued on next page)



  RN/MD Review only

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

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

II. Personnel (continued from previous page)


 **RN/MD Review only**

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

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

III. Office Management (continued on next page)



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

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

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

III. Office Management (continued on next page)



  RN/MD Review only (#C)

Office Management Survey Criteria	Yes	No	N/A	Wt.	Site Score
<p>C. Health care services are readily available. 22 CCR §56000(2)  </p> <p>1) Appointments are scheduled according to patients' stated clinical needs within the timeliness standards established for Plan members.</p> <p>2) Patients are notified of scheduled routine and/or preventive screening appointments.</p> <p>3) There is a process in place verifying follow-up on missed and canceled appointments.</p>	<p>1) _____</p> <p>2) _____</p> <p>3) _____</p>	<p>1) _____</p> <p>2) _____</p> <p>3) _____</p>	<p>1) _____</p> <p>2) _____</p> <p>3) _____</p>	<p>1</p> <p>1</p> <p>1</p>	
<p>D. There is 24-hour access to interpreter services for non- or limited-English proficient (LEP) members. 22 CCR §53851; 28 CCR 1300.67.04</p> <p>1) Interpreter services are made available in identified threshold languages specified for location of site.</p> <p>2) Persons providing language interpreter services on site are trained in medical interpretation.</p>	<p>1) _____</p> <p>2) _____</p>	<p>1) _____</p> <p>2) _____</p>	<p>1) _____</p> <p>2) _____</p>	<p>1</p> <p>1</p>	

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

III. Office Management (continued on next page)



  RN/MD Review only (#E)

Office Management Survey Criteria	Yes	No	N/A	Wt.	Site Score
<p>E. Procedures for timely referral/consultative services are established on site. 22 CCR §53851; 28 CCR §1300.67 and §1300.80  </p> <p>Office practice procedures allow timely provision and tracking of:</p> <p>1) Processing internal and external referrals, consultant reports and diagnostic test results</p> <p>2) <u>Physician review and follow-up of referral/consultation reports and diagnostic test results.</u></p>	<p>1) _____</p> <p>2) _____</p>	<p>1) _____</p> <p>2) _____</p>	<p>1) _____</p> <p>2) _____</p>	<p>1</p> <p>2</p>	
<p>F. Member Grievance/Complaint processes are established on site. 22 CCR §53858, §56260</p> <p>1) Phone number(s) for filing grievances/complaints are located on site.</p> <p>2) Complaint forms and a copy of the grievance procedure(s) are available on site.</p>	<p>1) _____</p> <p>2) _____</p>	<p>1) _____</p> <p>2) _____</p>	<p>1) _____</p> <p>2) _____</p>	<p>1</p> <p>1</p>	

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

III. Office Management (continued from previous page)

  RN/MD Review only (#H)

Office Management Survey Criteria	Yes	No	N/A	Wt.	Site Score
G. Medical records are available for the practitioner at each scheduled patient encounter. 22 CCR §75055; 28 CCR §1300.80 1) Medical records are readily retrievable for scheduled patient encounters. 2) Medical documents are filed in a timely manner to ensure availability for patient encounters.	1)____ 2)____	1)____ 2)____	1)____ 2)____	1 1	
H. Confidentiality of personal medical information is protected according to State and federal guidelines. 22 CCR §51009, §53861, §75055; §28 CCR §1300.80; CA Civil Code §56.10 (Confidentiality of Medical Information Act)   1) Exam rooms and dressing areas safeguard patients' right to privacy. 2) Procedures are followed to maintain the confidentiality of personal patient information. 3) Medical record release procedures are compliant with State and federal guidelines. 4) Storage and transmittal of medical records preserves confidentiality and security. 5) Medical records are retained for a minimum of 7 years according to 22 CCR Section 75055.	1)____ 2)____ 3)____ 4)____ 5)____	1)____ 2)____ 3)____ 4)____ 5)____	1)____ 2)____ 3)____ 4)____ 5)____	1 1 1 1 1	
Comments: Write comments for all "No" (0 points) and "N/A" scores.					
Totals					



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

Pharmaceutical Services Survey Criteria	Yes	No	N/A	Wt.	Site Score
A. Drugs and medication supplies are maintained secure to prevent unauthorized access. CA B&P Code §4172; 22 CCR §75037(a-g), §75039; 21 CFR §1301.75, §1301.76, §1302.22; 16 CCR §1356.3					
1) Drugs are stored in specifically designated cupboards, cabinets, closets or drawers.	1) _____	1) _____	1) _____	1	
2) Prescription, sample and over-the counter drugs, hypodermic needles/syringes, prescription pads are securely stored in a lockable space (cabinet or room) within the office/clinic.	2) _____	2) _____	2) _____	1	
3) Controlled drugs are stored in a locked space accessible only to authorized personnel.	3) _____	3) _____	3) _____	1	
4) A dose-by-dose controlled substance distribution log is maintained.	4) _____	4) _____	4) _____	1	

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

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

 **RN/MD Review only**

Pharmaceutical Services Survey Criteria	Yes	No	N/A	Wt.	Site Score
B. Drugs are handled safely and stored appropriately. 22 CCR §75037(a-g), §75039; 21 CFR §211.137; 21 USC §351  					
1) Drugs are prepared in a clean area, or “designated clean” area if prepared in a multipurpose room.	1)_____	1)_____	1)_____	1	
2) Drugs for external use are stored separately from drugs for internal use.	2)_____	2)_____	2)_____	1	
3) Items other than medications in refrigerator/freezer are kept in a secured, separate compartment from drugs.	3)_____	3)_____	3)_____	1	
4) Refrigerator thermometer temperature is 35°-46° Fahrenheit or 2°-8° Centigrade (at time of site visit).	4)_____	4)_____	4)_____	1	
5) Freezer thermometer temperature is 5° Fahrenheit or –15° Centigrade, or lower (at time of site visit).	5)_____	5)_____	5)_____	1	
6) Daily temperature readings of medication refrigerator and freezer are documented.	6)_____	6)_____	6)_____	1	
7) Drugs are stored separately from test reagents, germicides, disinfectants and other household substances.	7)_____	7)_____	7)_____	1	
8) Hazardous substances are appropriately labeled.	8)_____	8)_____	8)_____	1	
9) Site has method(s) in place for drug and hazardous substance disposal.	9)_____	9)_____	9)_____	1	

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

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

Pharmaceutical Services Survey Criteria	Yes	No	N/A	Wt.	Site Score
C. Drugs are dispensed according to State and federal drug distribution laws and regulations. CA B&P Code §4024, §4076, §4170, §4171, §4173, §4174; 22 CCR §75032, §75033, §75036, §75037(a-g), §75038, §75039; 16 CCR §1718.1; 21 CFR §211.137; 42 USC 6A §300AA-26					
1) There are no expired drugs on site.	1) _____	1) _____	1) _____	1	
2) Site has a procedure to check expiration date of all drugs (including vaccines and samples), and infant and therapeutic formulas.	2) _____	2) _____	2) _____	1	
3) All stored and dispensed prescription drugs are appropriately labeled.	3) _____	3) _____	3) _____	1	
4) <u>Only lawfully authorized persons dispense drugs to patients.</u>	4) _____	4) _____	4) _____	2	
5) Current Vaccine Information Sheets (VIS) for distribution to patients are present on site.	5) _____	5) _____	5) _____	1	
6) If there is a pharmacy on site, it is licensed by the CA State Board of Pharmacy.	6) _____	6) _____	6) _____	1	

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

IV. Clinical Services - Laboratory

Laboratory Services Survey Criteria	Yes	No	N/A	Wt.	Site Score
D. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations. 17 CCR §1050; 22 CCR §51211.2, §51137.2; B&P Code §1220; 42 USC 263a; Public Law 100-578					
1) Laboratory test procedures are performed according to current site-specific CLIA certificate.	1) _____	1) _____	1) _____	1	
2) Testing personnel performing clinical lab procedures have been trained.	2) _____	2) _____	2) _____	1	
3) Lab supplies (e.g. vacutainers, vacutainer tubes, culture swabs, test solutions) are inaccessible to unauthorized persons.	3) _____	3) _____	3) _____	1	
4) Lab test supplies are not expired.	4) _____	4) _____	4) _____	1	
5) Site has a procedure to check expiration date and a method to dispose of expired lab test supplies.	5) _____	5) _____	5) _____	1	

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

IV. Clinical Services - Radiology

Radiology Services Survey Criteria	Yes	No	N/A	Wt.	Site Score
E. Site meets CDPH Radiological inspection and safety regulations. 17 CCR §30255, §30305, §30404, §30405					
1) Site has current CA Radiologic Health Branch Inspection Report, if there is radiological equipment on site.	1)_____	1)_____	1)_____	1	
The following documents are <u>posted</u> on site:					
2) Current copy of Title 17 with a posted notice about availability of Title 17 and its location	2)_____	2)_____	2)_____	1	
3) “Radiation Safety Operating Procedures” posted in highly visible location.	3)_____	3)_____	3)_____	1	
4) “Notice to Employees Poster” posted in highly visible location.	4)_____	4)_____	4)_____	1	
5) “Caution, X-ray” sign posted on or next to door of each room that has X-ray equipment	5)_____	5)_____	5)_____	1	
6) Physician Supervisor/Operator certificate posted <i>and</i> within current expiration date	6)_____	6)_____	6)_____	1	
7) Technologist certificate posted <i>and</i> within current expiration date	7)_____	7)_____	7)_____	1	
The following radiological protective equipment is present on site:					
8) Operator protection devices: radiological equipment operator must use lead apron or lead shield.	8)_____	8)_____	8)_____	1	
9) Gonadal shield (0.5 mm or greater lead equivalent): for patient procedures in which gonads are in direct beam.	9)_____	9)_____	9)_____	1	
Comments: Write comments for all “No” (0 points) and “N/A” scores.					



V. Preventive Services (continued on next page)

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

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

V. Preventive Services (continued from previous page)

  **RN/MD Review only**

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

VI. Infection Control (continued on next page)

  **RN/MD Review only**

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

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

VI. Infection Control (continued on next page)



  RN/MD Review only

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

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

VI. Infection Control (continued on next page)


  **RN/MD Review only**

Infection Control Survey Criteria	Yes	No	N/A	Wt.	Site Score
C. Contaminated surfaces are decontaminated according to Cal-OSHA Standards. 8 CCR §5193; CA H&S Code §118275  					
1) Equipment and work surfaces are appropriately cleaned and decontaminated after contact with blood or other potentially infectious material.	1)_____	1)_____	1)_____	1	
2) Routine cleaning and decontamination of equipment/work surfaces is completed according to site-specific written schedule.	2)_____	2)_____	2)_____	1	
Disinfectant solutions used on site are:	3)_____	3)_____	3)_____	1	
3) approved by the Environmental Protection Agency (EPA).	4)_____	4)_____	4)_____	1	
4) effective in killing HIV/HBV/TB.	5)_____	5)_____	5)_____	1	
5) used according to product label for desired effect.					

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

VI. Infection Control (continued from previous page)


 RN/MD Review only

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

Medical Record Review Guidelines

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

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

Scoring: Survey score is based on a review standard of 10 records per individual primary care physician (PCP). Documented evidence found in the hard copy (paper) medical records and/or electronic medical records, including immunization registries, are used for survey criteria determinations. An Exempted Pass is 90%. Conditional Pass is 80-89%. Not Pass is below 80%. The minimum passing score is 80%. A corrective action plan (CAP) is required for a total MRR score below 90%. Also, any section score of less than 80% requires a CAP for the entire MRR, regardless of the total MRR score. Not applicable (“N/A”) applies to any criterion that does not apply to the medical record being reviewed, and must be explained in the comment section. Medical records shall be randomly selected using methodology decided upon by the reviewer. Ten (10) medical records are surveyed for each PCP, five (5) adult and/or obstetric records and five (5) pediatric records. For sites with *only* adult, *only* obstetric, or *only* pediatric patient populations, all ten records surveyed will be in *only* one preventive care service area. Sites where documentation of patient care by all PCPs on site occurs in universally shared medical records shall be reviewed as a “shared” medical record system. Scores calculated on shared medical records apply to each PCP sharing the records. A minimum of ten shared records shall be reviewed for 2-3 PCPs, twenty records for 4-6 PCPs, and thirty records for 7 or more PCPs. Survey criteria to be reviewed *only* by a R.N. or physician are labeled “ RN/MD Review only”.

Directions: Score one point if criterion is met. Score zero points if criterion is not met. Do not score partial points for any criterion. If 10 shared records are reviewed, score calculation shall be the same as for 10 records reviewed for a single PCP. If 20 records are reviewed, divide total points given by the “adjusted” total points possible. If 30 records are reviewed, divide total points given by the “adjusted” total points possible. Multiply by 100 to calculate percentage rate. Reviewers have the option to request additional records to review, but must calculate scores accordingly. Reviewers are expected to determine the most appropriate method(s) on each site to ascertain information needed to complete the survey.

Scoring Example:

Step 1: Add the points given in each section.

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

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

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

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

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

Total points given Example: 267
“Adjusted” total points possible 305 = 0.875 X 100 = **88%**

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

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

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


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



  **RN/MD Review only**

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

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

Criteria	IV. Pediatric Preventive Reviewer Guidelines (continued on next page)
A. Initial Health Assessment (IHA) IHA includes H&P and IHEBA	The IHA (H&P and IHEBA) enables the PCP to assess current acute, chronic and preventive needs <i>and</i> to identify those Members whose health needs require coordinated services with appropriate community resources/other agencies not covered by the Plan.
1. History and physical (H&P)	<u>New members:</u> An H&P is completed within 120 days of the effective date of enrollment into the Plan, or documented within the 12 months prior to Plan enrollment. The H&P is sufficiently comprehensive to assess and diagnose acute and chronic conditions, which may include: history of present illness, past medical and social history, and review of organ systems. If an H&P is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented.
2. Individual Health Education Behavioral Assessment (IHEBA)	<u>New members:</u> An age-appropriate IHEBA (“Staying Healthy” or other DHCS-approved tool) is completed by the member or parent/guardian within 120 days of the effective date of enrollment into the Plan, or within the 12 months prior to Plan enrollment. Staff may assist. The IHEBA has evidence of practitioner review such as signature/initials, and dates and intervention codes, which may be documented on the IHEBA form, in progress notes, or other areas of the paper or electronic medical record system. If an initial IHEBA is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented.
B. Subsequent Periodic IHEBA	An age-appropriate IHEBA is re-administered when the member has reached the next specific age interval designated by MMCD. Documentation requirements are the same as the initial IHEBA.
C. Well-Child Visit	
1. Well-child exam completed at age appropriate frequency	Health assessments containing CHDP age-appropriate content requirements are provided according to the most recent AAP periodicity schedule for pediatric preventive health care. Assessments and identified problems recorded on the PM160 form are documented in the progress notes. Follow-up care or referral is provided for identified physical health problems as appropriate. <u>Note:</u> Where the AAP periodicity exam schedule is more frequent than the CHDP periodicity examination schedule, the AAP scheduled visit must include all assessment components required by the CHDP program for the lower age nearest to the current age of the child.
2. Anthropometric measurements	Height and weight are documented at each well-child exam. Include head circumference for infants up to 24 months.
3. BMI Percentile	BMI percentile is plotted on an appropriate CDC growth chart for each well-child exam ages 2-20 years. Note: The BMI percentile calculation is based on the CDC’s BMI-for-age- growth charts, which indicates the relative position of the patient’s BMI number among others of the same sex and age. Ref: www.cdc.gov/nccdphp/dnpa/bmi/index.htm
4. Developmental screening	Developmental surveillance at each visit and screening for developmental disorders at the 9 th , 18 th and 30 th month visits. Children identified with potential delays require further assessment and/or referral. (Ref: AAP and CHDP periodicity schedules)
5. Anticipatory guidance	Includes age appropriate counseling/health education provided to parent or pediatric member.
6. STI screening on all sexually active adolescents, incl. chlamydia for females	All sexually active adolescents should be screened for sexually transmitted infections (STIs), including chlamydia for females.
7. Pap smear on sexually active females	Pap smear within 3 years of onset of sexual intercourse.
D. Vision Screening	Age-appropriate visual screening occurs at each health assessment visit, with referral to optometrist/ophthalmologist as appropriate. Note: Although specific screening details are not generally documented in the medical record, screening for infants and children (birth to 3 years) may consist of evaluations such as external eye inspection, ophthalmoscopic red reflex examination, or corneal penlight evaluation. Visual acuity screening usually begins at age 3 years.

Criteria	<p style="text-align: center;">IV. Pediatric Preventive Reviewer Guidelines</p> <p style="text-align: center;">  RN/MD Review only (continued from previous page) </p>
E. Hearing Screening	<p>Non-audiometric screening for infants/children (2 months to 3 years) includes family and medical history, physical exam and age-appropriate screening. Audiometric screening for children and young adults (3 -20) is done at each health assessment visit and includes follow-up care as appropriate. A failed audiometric screening is followed up with a repeat screening at least two weeks and no later than 6 weeks after the initial screening. If the second screening also fails, there is a referral to a specialist.</p>
F. Nutrition Assessment	<p>Screening includes: 1) height and weight, 2) hematocrit or hemoglobin to screen for anemia starting at 9-12 months, and 3) breastfeeding and infant feeding status, food/nutrient intake and eating habits (including evaluation of problems/conditions/needs of the breastfeeding mother). Based on problems/conditions identified, nutritionally at-risk children under 5 years of age are referred to the Women, Infants and Children (WIC) Supplemental Nutrition Program for medical nutrition therapy or other in-depth nutritional assessment.</p>
G. Dental Assessment	<p>Inspection of the mouth, teeth and gums is performed at every health assessment visit. Children are referred to a dentist <i>at any age</i> if a dental problem is detected or suspected. Beginning at 3 years of age, all children are referred annually to a dentist regardless of whether a dental problem is detected or suspected.</p>
H. Blood Lead Screening Test	<p>Children receiving health services through Medi-Cal Managed Care Plans must have blood lead level (BLL) testing as follows:</p> <ol style="list-style-type: none"> 1) at <u>12</u> month <i>and</i> <u>24</u> months of age, 2) between 12 months and 24 months of age <i>if</i> there is no documented evidence of BLL testing at 12 months or thereafter, <i>and</i> 3) between 24 months and 72 months of age <i>if</i> there is no documented evidence of BLL testing at 24 months or thereafter. <p>Elevated BLL of 10 µg/dL or greater require additional BLL and follow-up in accordance with current DHCS policy or as follows:</p> <ul style="list-style-type: none"> • 10-14 µg/dL: Confirm with venous sample within 3 months of original test; • 15-19 µg/dL: Confirm with venous sample within 2 months of original test, then retest 2 months following the confirmatory testing; • 20-44 µg/dL: Confirm with venous sample in 1 week to 1 month, depending on severity of BLL; • 45-59 µg/dL: Retest with venous sample within 48 hour; • 60-69 µg/dL: Retest with venous sample within 24 hours; • ≥ 70 µg/dL: EMERGENCY. Retest immediately with venous sample. <p>Children with elevated BLLs are referred to the local Childhood Lead Poisoning Prevention Branch or, if none, to the local health department. All children with confirmed (venous) BLLs of ≥ 20 µg/dL must be referred to CCS.</p>
I. Tuberculosis Screening	<p>All children are assessed for risk of exposure to tuberculosis (TB) at each health assessment. The Mantoux skin test, or other approved TB infection screening test,* is administered to children <i>identified at risk</i>, if there has not been a test in the previous year. The Mantoux is not given if a previously positive Mantoux is documented. Documentation of a positive test includes follow-up care (e.g. further medical evaluation, chest x-ray, diagnostic laboratory studies and/or referral to specialist). Practitioners are required to follow current CDC and American Thoracic Society guidelines for TB diagnosis and treatment. *Per June 25, 2010 CDC MMWR, FDA approved IGRA serum TB tests, i.e., QuantiFERON®-TB Gold (QFT-G and QFT-GIT) and T-SPOT®.TB (T-Spot). The Mantoux is preferred over IGRA for children under 5 years of age. Ref: www.cdc.gov/tb/publications/factsheets/testingIGRA.htm</p>
J. Childhood Immunizations	
1. Given according to ACIP guidelines	<p>Immunization status is assessed at each health assessment visit. Practitioners are required to ensure the provision of immunizations according to CDC's most recent Advisory Committee on Immunization Practices (ACIP) guidelines, unless medically contraindicated or refused by the parent.</p>
2. Vaccine administration documentation	<p>The name, manufacturer, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries.</p>
3. Vaccine Information Statement (VIS) documentation	<p>The date the VIS was given (or presented and offered) <i>and</i> the VIS publication date are documented in the medical record.</p>

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

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

Criteria	V. Adult Preventive Reviewer Guidelines (continued from previous page)
G. Tuberculosis Screening	<p>Adults are screened for tuberculosis (TB) risk factors upon enrollment and at periodic physical evaluations. The Mantoux skin test, or other approved TB infection screening test,* is administered to all asymptomatic persons at increased risk of developing TB irrespective of age or periodicity if they had not had a test in the previous year. Adults already known to have HIV or who are significantly immunosuppressed require annual TB testing.** The Mantoux is not given if a previously positive Mantoux is documented. Documentation of a positive test includes follow-up care (e.g. further medical evaluation, chest x-ray, diagnostic laboratory studies and/or referral to specialist). Practitioners are required to follow current CDC and American Thoracic Society guidelines for TB diagnosis and treatment. * Per June 25, 2010 CDC MMWR, the FDA approved IGRA serum TB tests, such as QuantiFERON®-TB Gold (QFT-G and QFT-GIT) and T-SPOT®.TB (T-Spot). Ref: www.cdc.gov/tb/publications/factsheets/testingIGRA.htm ** Per CTCA/CDPH: www.ctca.org/guidelines/IIA2targetedskintesting.pdf</p>
H. Breast Cancer Screening	<p>A routine screening mammography for breast cancer is completed every 1-2 years on all women starting at age 50, concluding at age 75 unless pathology has been demonstrated. USPSTF link: http://www.uspreventiveservicestaskforce.org/uspstf/uspbrca.htm</p>
I. Cervical Cancer Screening	<p>Routine screening for cervical cancer with Papanicolaou (Pap) testing is done on all women who are or have been sexually active and who have a cervix. Pap smears should begin within 3 years of onset of sexual activity or age 21 (whichever comes first) and repeated at least every 1-3 years depending on individual risk factors. Follow-up of abnormal test results is documented. According to the USPSTF, routine Pap testing may not be required for the following: 1) women who have undergone hysterectomy in which the cervix is removed, unless the hysterectomy was performed because of invasive cancer, 2) women after age 65 who have had regular previous screening in which the smears have been consistently normal.</p> <p>USPSTF link for cervical cancer screening: http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm</p>
J. Chlamydia Infection Screening	<p>Women who are sexually active are screened from the time they become sexually active until they are 25 years of age. Practitioner may screen women older than 25 years of age if the practitioner determines that the patient is at risk for infection. Lab results are documented.</p>
K. Colorectal Cancer Screening	<p>All adults are screened for colorectal cancer beginning at age 50 years and continuing until age 75 years to include:</p> <ol style="list-style-type: none"> 1. Annual screening with high-sensitivity fecal occult blood testing, or 2. Sigmoidoscopy every 5 years with high sensitivity fecal occult blood testing every 3 years, or 3. Screening colonoscopy every 10 years. <p>USPSTF link for colorectal cancer screening: http://www.uspreventiveservicestaskforce.org/uspstf/uspcolo.htm</p>
L. Adult Immunizations	
1. Given according to ACIP guidelines	<p>Immunization status is assessed at periodic health evaluations. Practitioners are required to ensure the provision of immunizations according to CDC's most recent Advisory Committee on Immunization Practices (ACIP) guidelines, unless medically contraindicated or refused by the member.</p>
2. Vaccine administration documentation	<p>The name, manufacturer, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries.</p>
3. Vaccine Information Statement (VIS) documentation	<p>The date the VIS was given (or presented and offered) <i>and</i> the VIS publication date are documented in the medical record.</p>

Criteria	VI. OB/CPSP Preventive Reviewer Guidelines (continued on next page)
A. Initial Comprehensive Assessment (ICA)	Note: Item A.1 assesses the timeframe of a completed ICA. Items A2-9 assess the individual components of the ICA, and can receive a “yes” score - apart from the timeframe.
1. ICA completed within 4 weeks of entry to prenatal care	The ICA was completed within 4 weeks of entry to prenatal care.
2. Obstetrical and Medical History	Obstetric/medical: Health and obstetrical history (past/current), LMP, EDD.
3. Physical Exam	Physical exam: includes breast and pelvic exam.
4. Lab tests	Lab tests: hemoglobin/hematocrit, urinalysis, urine culture, ABO blood group, Rh type, rubella antibody titer, STI screen.
5. Nutrition	Nutrition: Anthropometric (height/weight), dietary evaluation, prenatal vitamin/mineral supplementation.
6. Psychosocial	Psychosocial: Social and mental health history (past/current), substance use/abuse, support systems/resources.
7. Health Education	Health education: Language and education needs.
8. Screening for Hepatitis B Virus	All pregnant women are screened for Hepatitis B during their first trimester or prenatal visit, whichever comes first.
9. Screening for Chlamydia Infection	All pregnant women ages 25 and younger, and older pregnant women who are at increased risk, are screened for chlamydia during their first prenatal visit.
B. Second Trimester Comprehensive Re-assessment	Subsequent comprehensive prenatal re-assessments include Obstetric/medical, Nutrition, Psychosocial and Health Education re-assessments are completed during the 2nd trimester.
C. Third Trimester Comprehensive Re-assessment	Subsequent comprehensive prenatal re-assessments include Obstetric/medical, Nutrition, Psychosocial and Health Education re-assessments are completed during the 3rd trimester.
1. Screening for Strep B	All pregnant women are screened for Group B Streptococcus between their 35th and 37th week of pregnancy.
D. Prenatal care visit periodicity according to most recent ACOG standards	<p>ACOG’s <i>Guidelines for Perinatal Care</i> recommend the following prenatal schedule for a 40-week uncomplicated pregnancy:</p> <ul style="list-style-type: none"> • First visit by 6-8th week • Approximately every 4 weeks for the first 28 weeks of pregnancy • Every 2-3 weeks until 36 weeks gestation • Weekly thereafter until delivery • Postpartum visit within 4-8 weeks after delivery <p>If the recommended ACOG schedule is not met, documentation shows missed appointments, attempts to contact member and/or outreach activities.</p>

Criteria	VI. OB/CPSP Preventive Reviewer Guidelines (continued from previous page)
E. Individualized Care Plan (ICP)	ICP documentation includes specific obstetric, nutrition, psychosocial and health education risk problems/conditions, interventions, and referrals.
F. Referral to WIC and assessment of Infant Feeding status	<p>Pregnant and breastfeeding Plan members must be referred to WIC (Public Law 103-448, Section 203(e)). Referral to WIC is documented in the medical record (Title 42, CFR 431.635). Infant feeding plans are documented during the prenatal period, and infant feeding/breastfeeding status is documented during the postpartum period (MMCD Policy Letter 98-10).</p> <p>Note: Although WIC determines eligibility for program participation, nearly all Medi-Cal beneficiaries are income eligible for WIC. Federal regulations specify that pregnant and breastfeeding women are given the highest priority for WIC Program enrollment.</p>
G. HIV-related services <i>offered</i>	<p>The <i>offering</i> of prenatal HIV information, counseling and HIV antibody testing is documented (CA Health & Safety Code, Section 125107). Practitioners are <i>not required</i> to document that the HIV test was given or disclose (except to the member) the results (positive or negative) of an HIV test. Offering a prenatal HIV test is not required if a positive HIV test is already documented in the patient's record or if the patient has AIDS diagnosed by a physician.</p> <p>Note: Member's participation is voluntary. Practitioner may provide HIV test or refer to other testing program/site. Documentation or disclosure of HIV related information must be in accordance with confidentiality and informed consent regulations.</p>
H. AFP/Genetic Screening <i>offered</i>	<p>The <i>offering</i> of blood screening tests prior to 20 weeks gestation counting from the first day of the last normal menstrual period is documented (CCR, Title 17, Sections 6521-6532). Genetic screening documentation includes:</p> <ol style="list-style-type: none"> 1) family history, 2) Triple marker screening tests: Alpha Fetoprotein (AF), unconjugated estriol (UE), human chorionic gonadotropin (HCG), 3) member's consent or refusal to participate. <p>Note: Member's participation is voluntary. Testing occurs through CDPH Expanded AFP Program, and only laboratories designated by CDPH may be used for testing.</p>
I. Domestic Violence/Abuse Screening	Provision of a Domestic Violence Screening is documented. Assessment checklists, body diagrams and/or documentation in progress notes are acceptable. Domestic violence screening includes medical screening, documentation of physical injuries or illnesses attributable to spousal/partner abuse, and referral to appropriate community service agencies (CA Health & Safety Code, Section 1233.5).
J. Family Planning Evaluation	Family Planning counseling, referral or provision of services is documented (MMCD Policy Letter 98-11).
K. Postpartum Comprehensive Assessment	Comprehensive postpartum reassessment includes the 4 components: medical exam, nutrition (mother and infant), psychosocial, health education are completed within 4-8 weeks postpartum (MMCD Policy Letter 96-01). If the postpartum assessment visit is not documented, medical record documents missed appointments, attempts to contact member and/or outreach activities. Infant feeding/breastfeeding status is documented during the postpartum period (MMCD Policy Letter 98-10).

Medical Record Review Survey
California Department of Health Care Services
Medi-Cal Managed Care

Health Plan _____ IPA _____ Site No. _____ Review Date _____ No. of Physicians _____
 No. of Records _____

Provider _____ Phone _____ Fax _____

Address _____ Contact person/title _____

City/Zip Code _____ Reviewer/title _____

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

Scoring Procedure						Medical Record Scores				Compliance Rate
Note: Score only one Preventive section (Pediatric, Adult or OB/CPSP) per record. When scoring for OB/CPSP Preventive, do not score the Adult or Pediatric Preventive for that same record.						Scoring is based on 10 medical records.				Note: Any section score of < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.
	Points possible	Yes Pts. Given	No's	N/A's	Section Score %	1) Add points given in each section. 2) Add points given for all six (6) sections. 3) Subtract "N/A" points (if any) from total points possible to get "adjusted" total points possible. 4) Divide total points given by "adjusted" total points possible. 5) Multiply by 100 to determine compliance rate as a percentage.				Exempted Pass: 90% or above: (Total score is ≥ 90% and all section scores are 80% or above)
I. Format	(8) x 10 = 80					$\frac{\text{Points Given}}{\text{Total/Adjusted Pts. Poss.}} = \frac{\text{Decimal Score}}{\text{Compliance Rate}} \times 100 = \text{Compliance Rate \%}$				Conditional Pass: 80-89%: (Total MRR is 80-89% OR any section(s) score is < 80%)
II. Documentation	(7) x 10 = 70									Not Pass: Below 80%
III. Continuity/Coordination	(8) x 10 = 80									__ CAP Required
IV. Pediatric Preventive	(19) x # of records									__ Other follow-up
V. Adult Preventive	(15) x # of records									Next Review Due: _____
VI. OB/CPSP Preventive	(20) x # of records									
	Total Points Possible	Yes Pts. Given	No's	N/A's						

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I. Format Criteria

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

Criteria met: Give one (1) point. Criteria not met: 0 points Criteria not applicable: N/A	Wt	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
Age/Gender												
A. An individual medical record is established for each member.	1											
B. Member identification is on each page.	1											
C. Individual personal biographical information is documented.	1											
D. Emergency "contact" is identified.	1											
E. Medical records on site are consistently organized.	1											
F. Chart contents are securely fastened.	1											
G. Member's assigned primary care physician (PCP) is identified.	1											
H. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing-impaired persons are prominently noted.	1											
Comments:	Yes											
	No											
	N/A											

8
Pts. Possible

II. Documentation Criteria

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

 **RN/MD Review only**

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

**7
Pts. Possible**

III. Coordination/Continuity of Care Criteria

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

 **RN/MD Review only**

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

8
Pts. Possible

IV. Pediatric Preventive Criteria (continued on next page)

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

 **RN/MD Review only Note:**

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

IV. Pediatric Preventive Criteria (continued from previous page)

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

 **RN/MD Review only**

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

19
Pts. Possible

V. Adult Preventive Criteria (continued on next page)

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

 **RN/MD Review only**

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

V. Adult Preventive Criteria (continued from previous page)

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

 **RN/MD Review only**

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

15
Pts. Possible

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

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

 **RN/MD Review only**

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

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

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

 **RN/MD Review only**

Criteria met: Give one (1) point. Criteria not met: 0 points Criteria not applicable: N/A	Wt	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
Age												
E. Individualized Care Plan (ICP)	1											
F. Referral to WIC and assessment of Infant Feeding status	1											
G. HIV-related services <i>offered</i>	1											
H. AFP/Genetic screening <i>offered</i>	1											
I. Domestic Violence/Abuse Screening	1											
J. Family Planning Evaluation	1											
K. Postpartum Comprehensive Assessment	1											
Comments:	Yes											
	No											
	N/A											
20												
Pts. Possible												