KERN HEALTH SYSTEMS

REGULAR MEETING OF THE QI/UM COMMITTEE

Thursday, February 25th, 2021
At
7:00 A.M.

At
2900 Buck Owens Boulevard
4th Floor Kern River Room
Bakersfield, CA 93308
(Virtual Meeting)

The public is invited

For more information, call (661) 664-5000

Agenda

Quality Improvement (QI) / Utilization Management (UM) Committee
(VIRTUAL) MEETING

Kern Health Systems
4th Floor Kern River Room
2900 Buck Owens Boulevard
Bakersfield, California 93308

Virtual Meeting
Thursday, February 25th, 2021

7:00 A.M.

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COMMITTEE MEMBERS: Jennifer Ansolabehere, PHN; Satya Arya, MD; Danielle C Colayco, PharmD; MS; Allen Kennedy; Philipp Melendez, MD; Chan Park, MD; Maridette Schloe; MS, LSSBB; Martha Tasinga; MD, CMO

CONSENT AGENDA/OPPORTUNITY FOR PUBLIC COMMENT: ALL ITEMS LISTED WITH A "CA" ARE CONSIDERED TO BE ROUTINE AND NON-CONTROVERSIAL BY KERN HEALTH SYSTEMS STAFF. THE "CA" REPRESENTS THE CONSENT AGENDA. CONSENT ITEMS WILL BE CONSIDERED FIRST AND MAY BE APPROVED BY ONE MOTION IF NO COMMITTEE MEMBER OR AUDIENCE WISHES TO COMMENT OR ASK QUESTIONS. IF COMMENT OR DISCUSSION IS DESIRED BY ANYONE, THE ITEM WILL BE REMOVED FROM THE CONSENT AGENDA AND WILL BE CONSIDERED IN LISTED SEQUENCE WITH AN OPPORTUNITY FOR ANY MEMBER OF THE PUBLIC TO ADDRESS THE COMMITTEE MEMBERS CONCERNING THE ITEM BEFORE ACTION IS TAKEN.

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Committee Members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Gov. Code Sec. 54954.2[a])
3) Announcements
4) Closed Session
5) CMO Report

CA-6) QI/UM Committee Summary of Proceedings November 12th, 2020 – APPROVE

7) Physician's Advisory Committee (PAC) Summary of Proceedings 4th Quarter 2020– RECEIVE AND FILE
   - October 2020
   - November 2020
   - December 2020

Pharmacy Reports

CA-8) Pharmacy TAR Log Statistics 4th Quarter 2020 – RECEIVE AND FILE

Quality Improvement Department Summary Reports

9) Quality Improvement Department Summary Reports 4th Quarter 2020 – APPROVE
   - COVID-19 Updates
   - Potential Inappropriate Care (PIC) Notifications
   - Facility Site Reviews (FSRs)
     a. Initial Full Site Reviews
     b. Periodic Full Site Reviews
     c. Interim/ Focus Reviews
   - Quality Improvement Projects
     a. Performance Improvement Projects (PIPs)
     b. MCAS Member Incentive and Engagement Project
     c. SWOT Project
   - MCAS Accountability Set (MCAS) Updates
   - Policy and Procedure and other program documents

Kaiser Reports

CA-10) Kaiser Reports **(PROPRIETARY AND CONFIDENTIAL)**
   - KFHC APL Grievance Report-4th Quarter 2020 –RECEIVE AND FILE
   - KFHC Volumes Report 4th Quarter 2020 – RECEIVE AND FILE
   - Kaiser Reports will be available upon Request

VSP Reports

11) VSP Reports

- VSP DER Effectiveness Report – APPROVE
- VSP- Medical Data Summary- APPROVE
- VSP Monthly Call Response Summary- APPROVE

Member Services

12) Grievance Operational Board Update - RECEIVE AND FILE

- 4th Quarter 2020

13) Grievance Summary Reports – RECEIVE AND FILE

- 4th Quarter 2020

Provider Relations

14) Re-credentialing Report 4th Quarter 2020 – RECEIVE AND FILE

CA-15) Board Approved New Contracts Report – RECEIVE AND FILE

CA-16) Board Approved Providers Report – RECEIVE AND FILE

CA-17) Provider Relations Network Review Report 4th Quarter 2020 – RECEIVE AND FILE

Disease Management

18) Disease Management 4th Quarter 2020 Report – APPROVE

Policies and Procedures

CA-19 QI/UM Policies and Procedures- APPROVE- Total 4

- 2.22-P Facility Site Review- APPROVE
- 3.01-P Excluded Services- APPROVE
- 3.13-P Supplemental Services and Targeted Case Management- APPROVE
- 11.21-I Population Needs Assessment- APPROVE

Health Education Report

CA-20) Health Education Activity Report 4th Quarter 2020 – APPROVE

UM Department Reports

21) Combined UM Reporting 4th Quarter 2020 – APPROVE

ADJOURN MEETING TO THURSDAY, MAY 27, 2021 IF COMMITTEE APPROVES DATE

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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SUMMARY OF PROCEEDINGS

Quality Improvement (QI) / Utilization Management (UM) Committee
(VIRTUAL) MEETING

Kern Health Systems
2900 Buck Owens Boulevard
Bakersfield, California 93308

Virtual Meeting
Thursday, November 12, 2020
7:00 A.M.

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Members Present: Satya Arya, MD; Danielle C Colayco, PharmD; MS; Allen Kennedy; Philipp Melendez, MD; Chan Park, MD; Maridette Schloe; MS, LSSBB; Martha Tasinga; MD, CMO

Members Absent: Jennifer Ansolabehere, PHN

Meeting was called to order at 7:00 A.M. by Dr. Martha Tasinga, M.D., C.M.O.

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NO ONE HEARD.

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3) Announcements – **N/A**

4) Closed Session – **N/A**

5) CMO Report –

- **Staff continue to work remote during COVID pandemic with only a select essential onsite staff at our building**
- **Rx Carve out on track to transition 1/1/2021 with retail/outpatient medications under State authority/oversight**

CA-6) QI/UM Committee Summary of Proceedings August 20th, 2020 – APPROVED
Arya-Melendez: All Ayes

7) Physician's Advisory Committee (PAC) Summary of Proceedings 3rd Quarter 2020 - RECEIVED AND FILED - **Arya-Kennedy: All Ayes**
- September 2020

Pharmacy Reports
CA-8) Pharmacy TAR Log Statistics 3rd Quarter 2020 – RECEIVED AND FILED
Arya-Melendez: All Ayes

Quality Improvement Department Summary Reports
9) Quality Improvement Department Summary Reports 3rd Quarter 2020 – APPROVED – **Park-Kennedy: All Ayes**

- DHCS Child and Adult Immunization QI Postcard
- Potential Quality Issue (PQI) Notifications
- Facility Site Reviews (FSRs)
    a. Initial Full Site Reviews
    b. Periodic Full Site Reviews
    c. Focus Reviews
        1. Critical Elements Monitoring
        2. IHEBA Monitoring
        3. IHA Monitoring
- Quality Improvement Projects
    a. Performance Improvement Projects (PIPs)
    b. Improvement Projects (IPs)
- MCAS Accountability Set (MCAS) Updates

Jane Daughenbaugh, Director of Quality Improvement, went over the following for the committee:

- **Discussed the impacts of the COVID-19 pandemic on QI activities:**
    - **Site & Medical Record reviews – we are conducting provisional, abbreviated reviews when possible.**
    - **PIPs initiated and approved in 2019 were stopped by DHCS in July.**
    - **MCAS scores for 2019 were significantly impacted by our inability to retrieve as many medical records for abstract reviews.**
        - **We anticipate even lower scores this year**
        - **We have initiated a 2-year SWOT analysis to establish an effective mechanism to achieve compliance with the MCAS measures**

- **PIC Notifications**
    - **Increased, in part, due to a backlog of referrals from the Grievance team. This has been resolved.**
    - **In reviewing the volume of PIC referrals by ethnicity, all groups are consistent with the corresponding ratio of membership for that group. The only exception is the Caucasian population that shows approximately 10% higher rate of grievances compared to the overall ration of Caucasians in KHS' membership. We will continue to track this to see if this is a consistent trend.**

- **Site & Medical Record Reviews**
    - **We have been conducting as many site and medical record reviews as possible and as providers are able to participate in during the pandemic emergency response phase. We are performing many of these using GoToMeeting video conferencing which has been a successful mode.**
    - **DHCS has not communicated the plan for addressing all of these reviews that were due during the pandemic. We anticipate that direction will not be forthcoming until more is known on the course**

of the pandemic. Note that the provisional reviews we have been performing are not a substitute for the required full site and medical record reviews required.

- **Quality Improvement Projects**
  - **Member Engagement & Incentives project**
    - **Project to establish a program using Member Rewards and Member Outreach to support member compliance with MCAS measures**
    - **Uses IVR and postcard mailers as outreach venues**
    - **Initial campaign scheduled to go live in November and includes Well Care Visits for Ages 0 - 21 years, Pre-natal visit in the 1st trimester, Post-partum visit between 7 and 84 days after delivery, Initial health assessments**
  - **DHCS Performance Improvement Projects (PIPs) were stopped by DHCS in July due to impacts from the pandemic and EQRO contracting issues. A new cycle of PIPs will begin in the 4th quarter**

- **MCAS Measures**
  - **Presented the MY 2019 MCAS measure results.**
    - **Results were significantly below the MPL. This was most likely due to:**
      - **Impacts of obtaining medical records due to the pandemic**
      - **The increase of the MPL from the 25th percentile to the 50th percentile**
      - **Discussed the SWOT project initiated with support from DHCS and collaboration with Health Net**

- **Policy Updates – presented the Policy 2.01-P General Exam Guidelines revisions. No significant changes.**

Kaiser Reports

CA-10) Kaiser Reports **(PROPRIETARY AND CONFIDENTIAL)**

- KFHC APL Grievance Report-3rd Quarter 2020 –RECEIVED AND FILED
- KFHC Volumes Report 3rd Quarter 2020 – RECEIVED AND FILED
- Kaiser Reports will be available upon Request

VSP Reports – Melendez-Arya: All Ayes

11) VSP Reports

- VSP Utilization Summary- APPROVED
- VSP DER Effectiveness Report – APPROVED
- VSP- Claim Summary- APPROVED

- VSP Monthly Call Response Summary- APPROVED

Member Services – Melendez-Arya: All Ayes

12) Grievance Operational Board Update – RECEIVED AND FILED
- 3rd Quarter 2020

13) Grievance Summary Reports – RECEIVED AND FILED
- 3rd Quarter 2020

Provider Relations – Melendez-Kennedy: All Ayes

14) Re-credentialing Report 3rd Quarter 2020 – RECEIVED AND FILED

CA-15) Board Approved New Contracts Report – RECEIVED AND FILED

CA-16) Board Approved Providers Report – RECEIVED AND FILED

CA-17) Provider Relations Network Review Report 3rd Quarter 2020 – RECEIVED AND FILED

Disease Management – Melendez-Arya: All Ayes

18) Disease Management 3rd Quarter 2020 Report – APPROVED

Michael Pitts, Director of CM/DM reviewed Q3 2020 Disease Management statistics with Committee.

Discussed primary focus of department is on members with dx:
- **Asthma**
- **Diabetes with Hypertension**

Reviewed statistics around:
- **Call and Answer Rates**
- **Assessments and Care Plans**
- **Diabetic Eye Exams**
- **Diabetic Clinic Enrollment**
- **Diabetes Prevention Program**

Policies and Procedures – Kennedy-Melendez: All Ayes

CA-19 QI/UM Policies and Procedures- APPROVED
- 2.17-P Access- Treatment of a Minor
- 2.20-P Infection Control Program
- 2.21-P Management of Biohazardous Waste
- 2.26-I Hospital Re-Admissions- Identification of Potential Inappropriate Care Issues
- 3.09-P Second Opinions
- 3.18-P Confidential HIV Testing
- 3.24-I Pregnancy Maternity Care
- 3.27-P Radiology Services
- 3.28-P Animal Bite Reporting
- 3.29-P Attachment A
- 3.29-P Condition Disease Reporting
- 3.31-P Emergency Services

- 3.43-P Hospice Services
- 3.46-I Tuberculosis Treatment
- 3.46-P Tuberculosis Treatment
- 3.61 Comprehensive Case Management and Coordination of Care Clean
- 10.01-I Clinical and Public Advisory Committee

Health Education Reports – Melendez-Arya: All Ayes
CA-20) Health Education Activity Report 3rd Quarter 2020 – APPROVED

UM Department Reports – Park-Kennedy: All Ayes
21) Combined UM Reporting 3rd Quarter 2020 – APPROVED

Meeting adjourned by Dr. Martha Tasinga, M.D., C.M.O. @ 8:14 A.M.
to Thursday, February 25, 2021 at 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
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SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE (VIRTUAL) MEETING

KERN HEALTH SYSTEMS
2900 Buck Owens Blvd.
Bakersfield, California 93308

Wednesday, October 7, 2020
7:00 A.M.

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COMMITTEE RECONVENED

Members Present: Hasmukh Amin, M.D., Ph.D; David Hair, M.D., Raju Patel, M.D., Martha Tasinga, M.D., C.M.O.

Members Absent: Miguel Lascano, M.D., Ashok Parmar, M.D.

Meeting called to order at 7:06 A.M. by Dr. Martha Tasinga, M.D., C.M.O.

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ADJOURNED TO CLOSED SESSION @ 7:09 A.M.

CLOSED SESSION

3) Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) – **BY A VOTE OF 4-0, THE COMMITTEE APPROVED PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING AND RECREDENTIALING.**

COMMITTEE RECONVENED TO OPEN SESSION @ 7:22 A.M.

CA-4) Minutes for KHS Physician Advisory Committee meeting on September 2, 2020 – APPROVED
Hair- Amin: All Ayes

5) Review Policy 2.70-I Potential Inappropriate Care (PIC) Issues – APPROVED
Amin-Patel: All Ayes

6) Medi-Cal Rx (By: Bruce Wearda, Director of Pharmacy) – PRESENTATION

- **Presented the basics of the Governor's Executive Order EO-01-19, carving out the pharmacy benefit from the health plans**
- **Defined the roles and responsibilities of DHCS, MCP, Magellan**
- **Shared how it would impact the providers and members**
- **Explained how the transition policy would work**

- **Explained how pharmacy claims would be handled in the future under Medi-Cal Rx**
- **Explained how pharmacy authorizations would be handled in the future under Medi-Cal Rx**
- **Explained how pharmacy appeals would be handled in the future under Medi-Cal Rx**

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 7:53 A.M. TO WEDNESDAY, NOVEMBER 4, 2020 @ 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
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SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE (VIRTUAL) MEETING

KERN HEALTH SYSTEMS
2900 Buck Owens Blvd.
Bakersfield, California 93308

Wednesday, November 4, 2020
7:00 A.M.

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COMMITTEE RECONVENED

Members Present: Hasmukh Amin, M.D., Ph.D; David Hair, M.D., Ashok Parmar, M.D.; Raju Patel, M.D., Martha Tasinga, M.D., C.M.O.

Members Absent: Miguel Lascano, M.D.

Meeting called to order at 7:01 A.M. by Dr. Martha Tasinga, M.D., C.M.O.

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ADJOURNED TO CLOSED SESSION @ 7:05 A.M.

CLOSED SESSION

3) Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) – **BY A VOTE OF 5-0, THE COMMITTEE APPROVED PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING AND RECREDENTIALING.**

- **PRV056422 – Provider returning under individual contract. While under previous affiliation, two-(2) PQOC cases were received on same day where parents had significant concerns/allegations against this provider in November 2019. Dr. Powell informed the committee that both complaints were thoroughly investigated and not found to have adverse effects and were closed with no quality of care issues that would prevent recommendation to add to the network.**

- **PRV048045 – Provider returning under existing group contract with past settlement from 2015 and misdemeanor DUI in 2019. Provider explanation and documentation of completed residential treatment, including steps program, and maintenance of AA meetings and community service work.**

COMMITTEE TO RECONVENED TO OPEN SESSION @ 7:16 A.M.

CA-4) Minutes for KHS Physician Advisory Committee meeting on October 7, 2020 – APPROVED
Amin-Parmar: All Ayes

5) Review VSP Reports – APPROVED
- Call Response Summary Report – August 2020
- Diabetic Exam Reminder Effectiveness Report
- Medical Data Collection Summary Report

Parmar- Amin: All Ayes

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 7:34 A.M. TO WEDNESDAY, DECEMBER 2, 2020 @ 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
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SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE (VIRTUAL) MEETING

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COMMITTEE RECONVENED

Members Present: Hasmukh Amin, M.D., Ph.D; David Hair, M.D., Ashok Parmar, M.D.; Raju Patel, M.D., Martha Tasinga, M.D., C.M.O.

Members Absent: Miguel Lascano, M.D.

Meeting called to order at 7:01 A.M. by Dr. Martha Tasinga, M.D., C.M.O.

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- **Dr. Parmar announced his partnership with Universal Health IPA. He has shared this information with Alan Avery and KHS accordingly.**

ADJOURNED TO CLOSED SESSION @ 7:04 A.M.

CLOSED SESSION

3) Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) – **BY A VOTE OF 5-0, THE COMMITTEE APPROVED PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING AND RECREDENTIALING.**

- **QI Potential Inappropriate Care (PIC) Cases:**
  Dr. Powell presented seven (7) PIC Cases for review by the Committee Members. Due to confidentiality and protections afforded to these peer review cases; separate peer review minutes are not available to the public nor part of the publicly disseminated minutes. Committee Members may refer to the separate peer review minutes dated 12/2/2020.

COMMITTEE TO RECONVENED TO OPEN SESSION @ 7:52 A.M.

CA-4) Minutes for KHS Physician Advisory Committee meeting on November 4, 2020 – APPROVED
Hair-Parmar: All Ayes

5) Review the following KHS Criteria; Recommending retirement from use – APPROVED - **Hair-Parmar: All Ayes**
- Synagis
- Intra-Epidermal Nerve Fiber Density (IENFD) Biopsy
- Varicose Vein Treatment Modalities

6) Review the following KHS policies – APPROVED - **Hair-Parmar: All Ayes**
- 2.20-P Infection Control Program
- 2.21-P Management of Biohazards Waste
- 3.09-P Second Opinions
- 3.18-P Confidential HIV Testing
- 3.28-P Animal Bite Reporting
- 3.31-P Emergency Services
- 3.46-P Tuberculosis Treatment

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 8:17 A.M. TO WEDNESDAY, FEBRUARY 3, 2021 @ 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

The meeting facilities at Kern Health Systems are accessible to persons with disabilities. Disabled individuals who need special assistance to attend or participate in a meeting of the KHS Finance Committee may request assistance at the Kern Health Systems office, 9700 Stockdale Highway, Bakersfield, California or by calling (661) 664-5000. Every effort will be made to reasonably accommodate individuals with disabilities by making meeting material available in alternative formats. Requests for assistance should be made five (5) working days in advance of a meeting whenever possible.

Quarter/Year of Audit	2020	2020	2020	2020	2020	2020	2020	2020	2020	2020	2020	2020
Month Audited	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Total TAR's for the month	3652	3300	3311	3367	3099	3409	3118	3038	2960	3293	2859	3039
TAT Compliant	100%	100%	100%	100%	99%	100%	100%	100%	100%	100%	100%	99%
NOA Compliant	98%	96%	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%
APPROVED TAR'S												
Timeliness - Reviewed & Returned in 1 busines day	77/77	76/76	79/79	87/87	73/74	68/68	86/86	93/93	81/81	90/90	79/79	74/74
Date Stamped	77/77	76/76	79/79	87/87	74/74	68/68	86/86	93/93	81/81	90/90	79/79	74/74
Fax copy attached	77/77	76/76	79/79	87/87	74/74	68/68	86/86	93/93	81/81	90/90	79/79	74/74
Decision marked	77/77	76/76	79/79	87/87	74/74	68/68	86/86	93/93	81/81	90/90	79/79	74/74
DENIED TAR'S												
Timeliness - Reviewed & Returned in 1 business day	64/64	47/47	61/61	58/58	56/56	59/59	61/61	43/43	46/46	44/44	41/41	48/49
Initally Denied - Signed by Medical Dir and/or Pharm	64/64	47/47	61/61	58/58	56/56	59/59	61/61	43/43	46/46	44/44	41/41	49/49
Letter sent within time frame	64/64	47/47	61/61	58/58	56/56	59/59	61/61	43/43	46/46	44/44	41/41	49/49
Date Stamped	64/64	47/47	61/61	58/58	56/56	59/59	61/61	43/43	46/46	44/44	41/41	49/49
Fax copy attached	64/64	47/47	61/61	58/58	56/56	59/59	61/61	43/43	46/46	44/44	41/41	49/49
Decision marked	64/64	47/47	61/61	58/58	56/56	59/59	61/61	43/43	46/46	44/44	41/41	49/49
Correct form letter, per current policies used	64/64	47/47	61/61	58/58	56/56	59/59	61/61	43/43	46/46	44/44	41/41	49/49
NOA Commentary Met	63/64	45/47	60/61	58/58	56/56	59/59	61/61	43/43	46/46	44/44	41/41	49/49
MODIFIED TAR'S												
Timeliness - Reviewed & Returned in 1 business day	0	0	0	0	0	0	0	0	0	0	0	0
Date Stamped	0	0	0	0	0	0	0	0	0	0	0	0
Fax copy attached	0	0	0	0	0	0	0	0	0	0	0	0
Decision marked	0	0	0	0	0	0	0	0	0	0	0	0
Correct form letter, per current policies used	0	0	0	0	0	0	0	0	0	0	0	0
NOA Commentary Met	0	0	0	0	0	0	0	0	0	0	0	0
DUPLICATE TAR'S												
Timeliness - Reviewd & Returned in 1 business day	17/17	21/21	9/9	7/7	15/15	16/16	4/4	3/3	8/8	12/12	10/10	6/6
Date Stamped	17/17	21/21	9/9	7/7	15/15	16/16	4/4	3/3	8/8	12/12	10/10	6/6
Fax copy attached	17/17	21/21	9/9	7/7	15/15	16/16	4/4	3/3	8/8	12/12	10/10	6/6

KERN HEALTH SYSTEMS

QUALITY IMPROVEMENT DEPARTMENT

QUARTERLY QI-UM COMMITTEE REPORT

Q4 2020

KERN HEALTH SYSTEMS
Quality Improvement Department Quarterly QI-UM Committee Report
Q4 2020

The purpose of this report is to provide a summary of the quarterly activities and outcomes for the QI department. This provides a window into both compliance with regulatory requirements as well as identifying opportunities for improving the quality of care for our members. Areas covered in the report include:

I. COVID-19 Updates

II. Potential Inappropriate Care (PIC) Notifications

III. Site Reviews

   a. Initial Full Site Reviews

   b. Periodic Full Site Reviews

   c. Interim/ Focus Reviews

IV. Quality Improvement Projects

   a. Performance Improvement Projects (PIPs)

   b. MCAS Member Incentive and Engagement Project

   c. SWOT Project

V. MCAS Accountability Set (MCAS) Updates

VI. Policy and Procedures and other program documents

I. COVID-Update:

The pandemic has continued throughout the 4th quarter of 2020 with stay at home and social distancing orders still in place. Kern County remains at the highest tier for the pandemic. Until the pandemic stabilizes, we are holding off on further promotion of preventive health services. We continue to complete as many virtual site reviews as possible with anticipation that some or all those reviews may be accepted in lieu of the in-person reviews. All virtual medical record reviews completed will be accepted by DHCS.

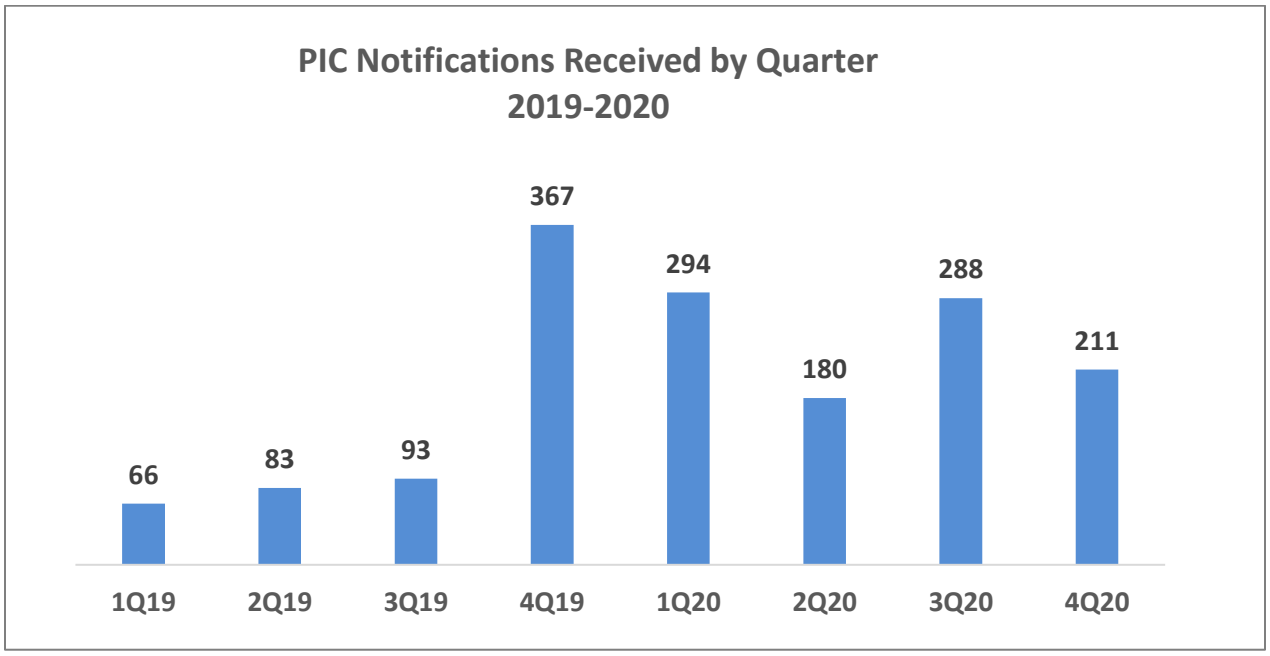
II. Potential Inappropriate Care (PIC) Notifications:

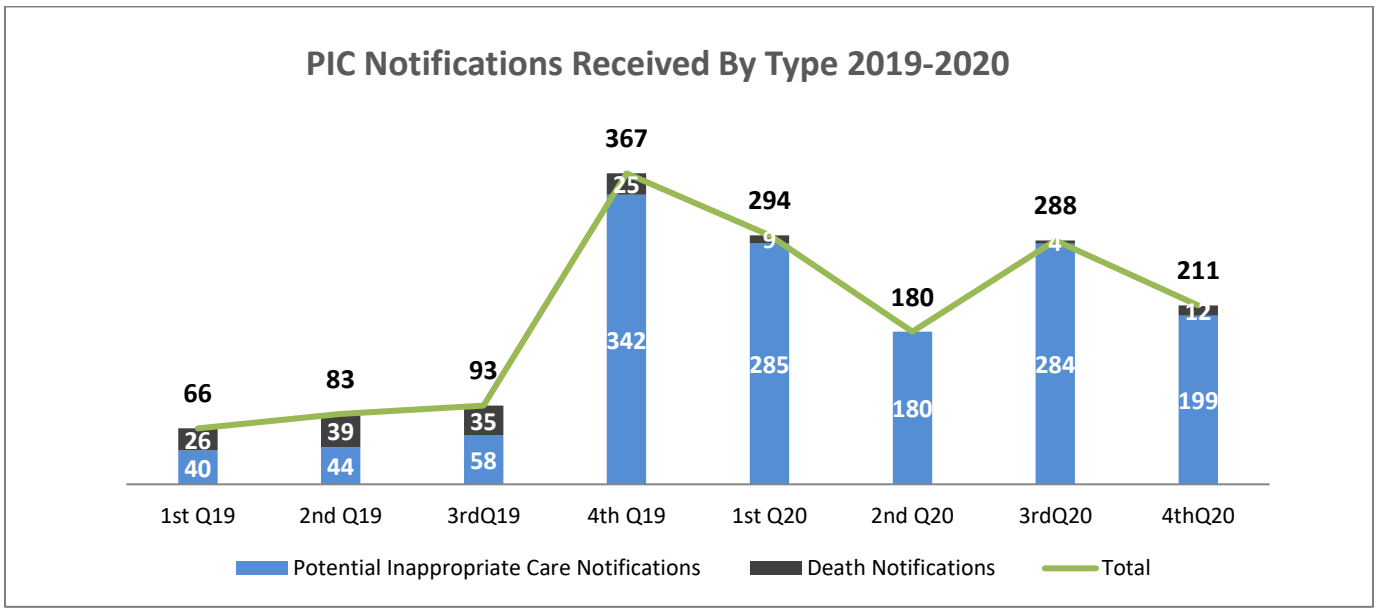
QI receives Notifications from various sources to review for potential inappropriate care issues.

On receipt of a potential inappropriate care issue, a high-level review is completed by a QI RN to determine what level of Potential Quality Issue exists.

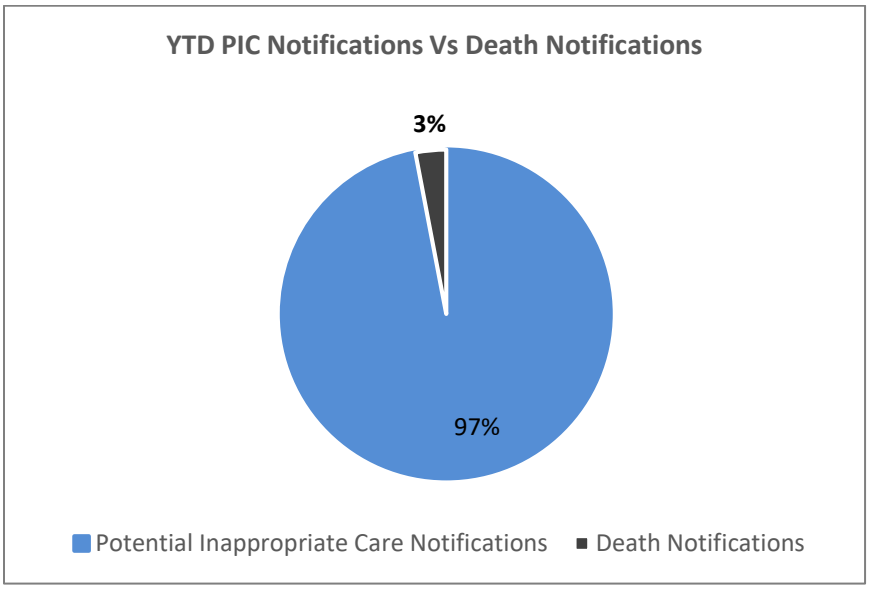
PICs are assigned a level based on the outcome of the review. The levels assigned are as follows:

- Level 0 = No Quality of Care Concern
  - Follow-up = Track and Trend and/or Provider Education
- Level 1 = Potential for Harm
  - Follow-up = Track and trend the area of concern for the specific provider and the Medical Director or their designee may provide additional actions that are individualized to the specific case or provider.
- Level 2 = Actual Harm
  - Follow-up = Corrective Action Plan plus direction from Medical Director or their designee which is individualized to the specific case or provider
- Level 3 = Actual Morbidity or Mortality Failure
  - Follow-up = Corrective Action Plan plus direction from Medical Director or their designee which is individualized to the specific case or provider

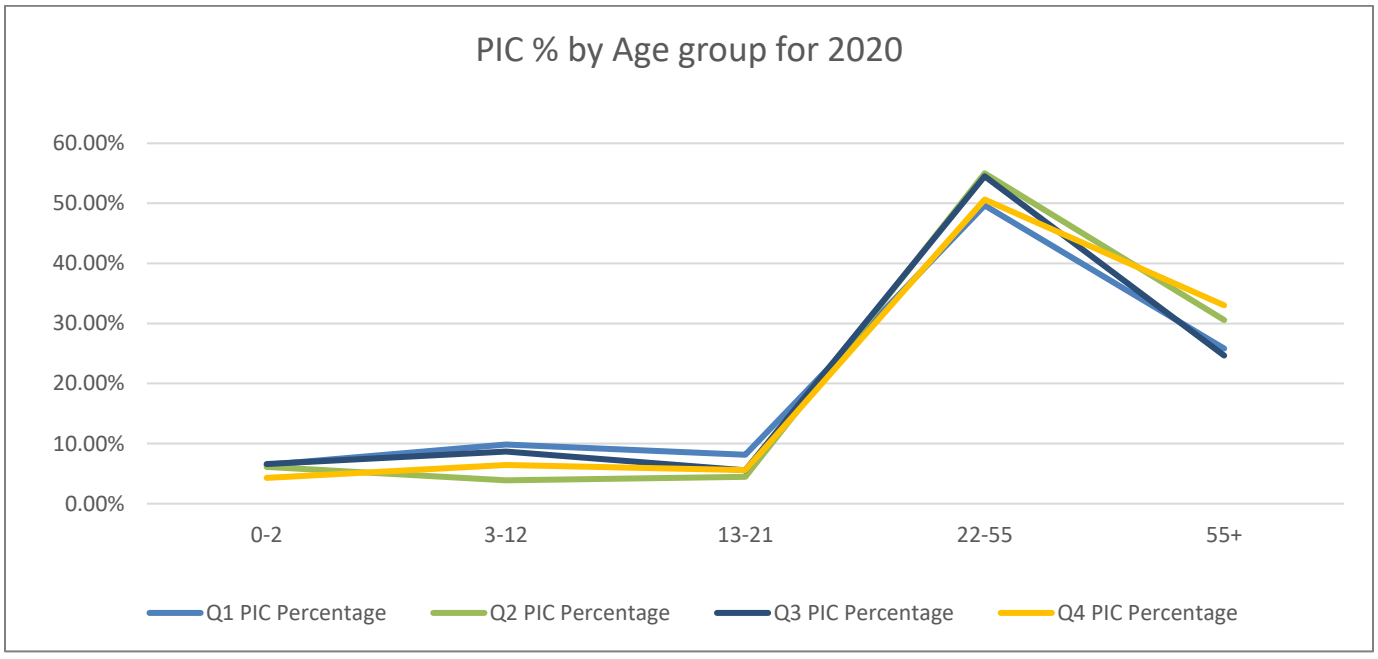




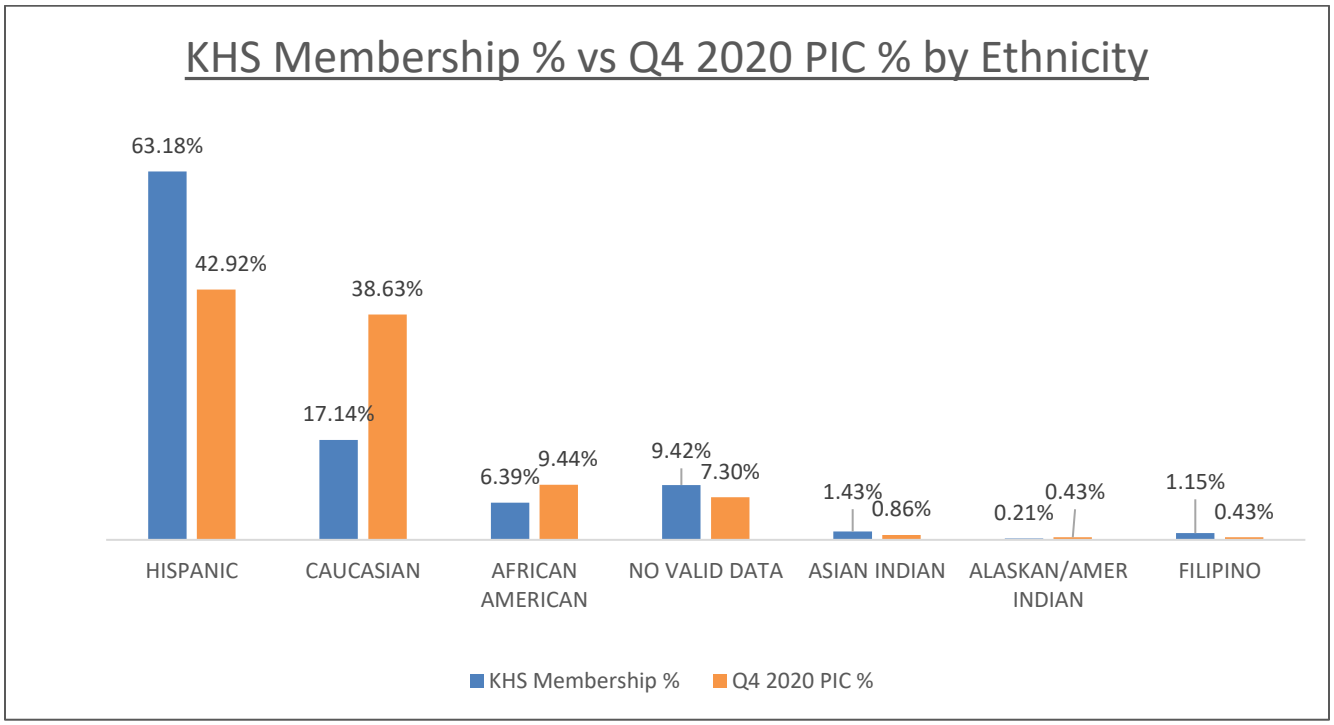
From the above charts, we received a total of 211 notifications for the 4th Quarter of 2020. This is a 27% decrease in the notifications compared to previous quarter. For Q4 2020 the total volume of PIC notifications received have been consistent. The number of deaths increased compared to the first and second quarters of 2020. None of these deaths were the direct cause from COVID 2019. We will continue to monitor for any trends.



For Q4 2020, YTD PIC vs death notifications there is 1% decrease in the PIC Notifications and 1% increase in Death Notifications. There were 12 death notifications received in Q4 2020 compared to 4 death notifications identified in Q3 of 2020. None of these deaths were the direct cause from COVID-19.



The chart above reflects the PIC percentage by age group for 2020. It is evident that most of the PICs received are within the age range of 22-55 years. The second highest number fall within the senior population.



This chart is providing a comparison by ethnicity for the % of PIC referrals received compared to the ethnicity breakdown for our population. In terms of the overall rate of PIC referrals, the Hispanic community has the highest rate followed by Caucasians. In comparing the percentage of the enrollment with the percentage of PIC referrals Caucasians followed by African Americans have the highest rate.

Facility Site Reviews (FSR) and Medical Record Review (MRR) Description:

Certified Site Reviewers perform a Facility Site Review on all contracted primary care provider sites (including OB/GYNs and pediatricians) as well as providers who serve a high volume of SPD beneficiaries. Per PL 14-004, certified site reviewers complete FSRs and MRRs for providers credentialed per DHCS and MMCD contractual and policy requirements.

An Initial Full Site Review (IFSR) is completed as part of the credentialing process on new providers at sites that have not previously been reviewed before being added to the KHS provider network. An IFSR is also completed when an existing KHS provider moves to a new site location. Approximately 3 months after the completion of an IFSR, an Initial Medical Record Review (IMRR) is conducted on sites other than Urgent Care (UC) Facilities. A passing FSR score is considered "current" if it is dated within the last three (3) years.

Subsequent Periodic Full Site Reviews (PFSRs) are conducted as part of the re-credentialing process for providers three (3) years after completion of the IFSR and every three (3) years thereafter.

Critical Elements

There are nine critical elements related to the potential for adverse effect on patient health or safety and include the following:

- Exit doors and aisles are unobstructed and egress (escape) accessible.
- Airway management equipment, appropriate to practice and populations served, are present on site.
- Only qualified/trained personnel retrieve, prepare or administer medications.
- Office practice procedures are utilized on-site that provide timely physician review and follow-up of referrals, consultation reports and diagnostic test results.
- Only lawfully authorized persons dispense drugs to patients.
- Personal protective equipment (PPE) is readily available for staff use.
- Needle stick safety precautions are practiced on-site.
- Blood, other potentially infectious materials (specimens) and regulated wastes (sharps/biohazardous non-sharps) are placed in appropriate leak-proof, labeled containers for collections, processing, storage, transport or shipping.
- Spore testing of autoclave/steam sterilizer is completed (at least monthly, with documented results).

Scoring and Corrective Action Plans

Provider sites that receive an FSR or MRR score with an Exempted Pass (90% or above, without deficiencies in critical elements) are not required to complete a corrective action plan (CAP). All sites that receive a Conditional Pass (80-89%, or 90% and above with deficiencies in critical elements) are required to complete a CAP addressing each of the noted deficiencies. The compliance level categories for both the FSR and MRR are as listed below:

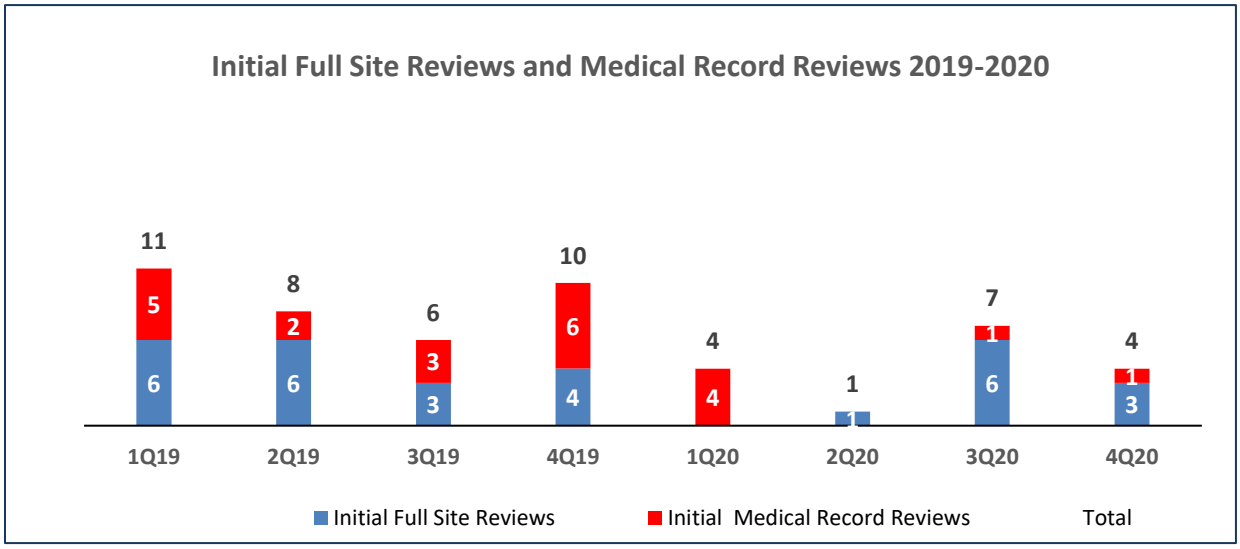
Exempted Pass: 90% or above
Conditional Pass: 80-89%
Not Pass: below 80%

Corrective Action Plans (CAPs)

A CAP is issued when an initial, periodic, or focus review has deficiencies identified. DHCS requires follow up at 10 days for failure of any critical element, follow up for other failed elements at 45 days, and if not corrected by the 45 day follow up, at 90 days after a CAP has been issued. Most CAPs issued are corrected and completed within the 45 Day follow up period. Providers are encouraged to speak with us if they have questions or encounter issues with CAP completion. QI nurses provide education and support during the CAP resolution process.

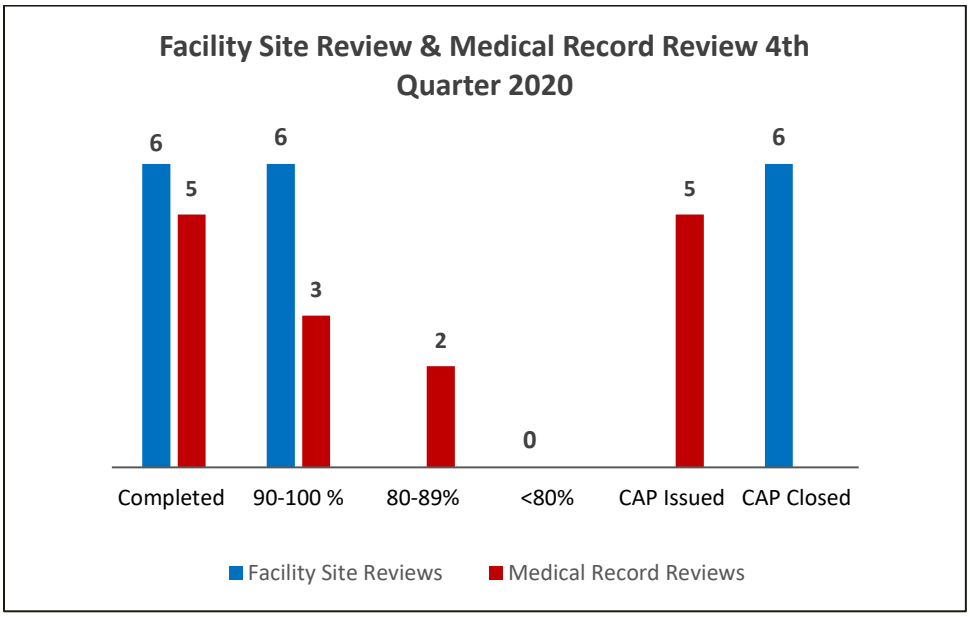
THE DEPARTMENT OF HEALTH CARE SERVICES (DHCS) HAS DELAYED MANAGED CARE PLANS FROM CONDUCTING SITE REVIEWS UNTIL 6 MONTHS AFTER THE COVID-19 EMERGENCY RESPONSE SITUATION HAS ENDED. KHS IS ATTEMPTING TO DO ABBREVIATED REVIEWS DURING THE PANDEMIC AS PROVIDERS ARE ABLE TO DO SO. IN AUGUST, WE DID A TRIAL OF REVIEWS USING GOTO MEETING AND WE ARE CONTINUING TO LEVERAGE THAT TOOL WHEN POSSIBLE.

Initial Facility Site Review and Medical Record Review Results:



The number of initial site and medical record reviews is determined by the number of new providers requesting to join KHS' provider network. There were four provisionary IFSRs and one IMRR was conducted in Q4 of 2020. This is an abbreviated review and is not a substitute for a full on-site review. Due to COVID-19 pandemic and for the safety of staff, providers and members, KHS staff are not physically going to provider offices. FSRs and MRRs are being done using an abbreviated model as an interim measure until we can return to doing full on-site reviews after the COVID-19 emergency response situation ends. Our ability to do this reduced form of review is dependent on the providers' ability to provide the necessary documentation. We are leveraging an audio-visual app to conduct portions of these reviews.

Facility Site Review and Medical Record Review Results (Initial & Periodic):



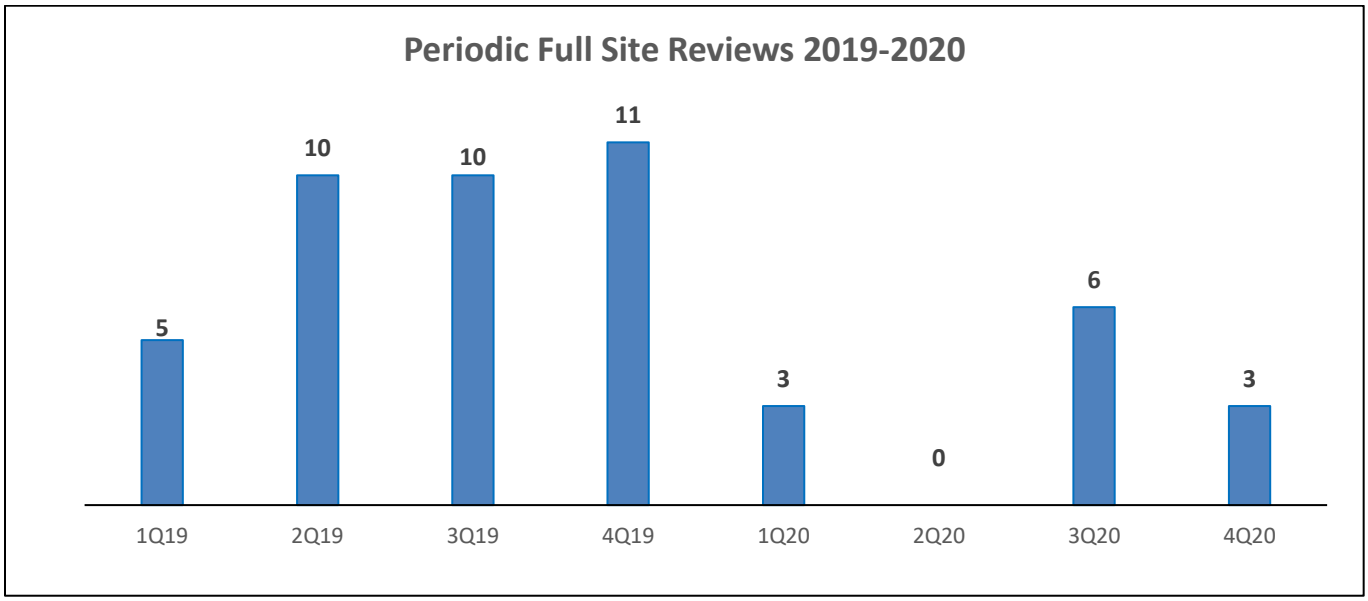
From the above chart:

- A total of 6 provisionary site reviews were completed in the 4th Quarter of 2020. Out of the 6 site reviews 3 were initial and 3 were periodic site reviews.
- A total of 5 Medical Record Reviews were completed out of which 1 was initial medical record review and 4 were periodic medical record reviews.
- The total CAPS issued were 5 for all the Medical Record Reviews conducted.
- There were 6 provisionary site review CAPs closed.

This is an abbreviated review and is not a substitute for a full on-site review. Due to COVID-19 pandemic and for the safety of staff, providers and members, KHS staff are not physically going to provider offices. FSRs and MRRs are being done using an abbreviated model as an interim measure until we can return to doing full on-site reviews after the COVID-19 emergency response situation ends. Our ability to do this reduced form of review is dependent on the providers' ability to provide the necessary documentation. We are leveraging an audio-visual app to conduct portions of these reviews.

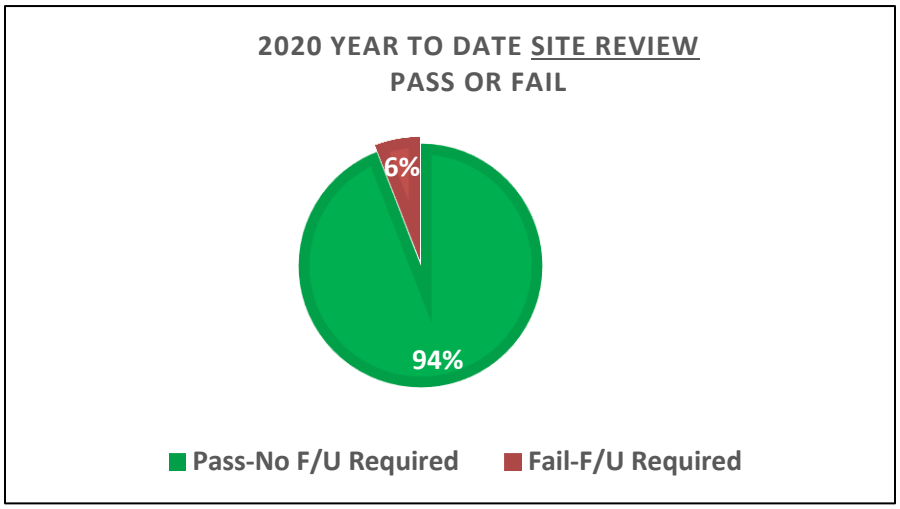
Periodic Full Site Reviews

Periodic Full Site Reviews are required every 3 years. The due date for Periodic FSRs is based on the last Initial or Periodic FSR that was completed. The volume of Periodic Reviews is not controlled by KHS. It is based on the frequency dictated by DHCS.

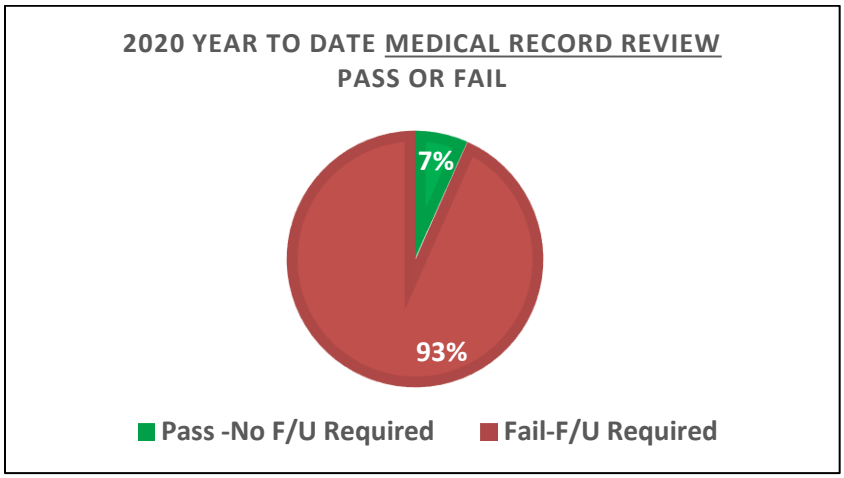


This above chart reflects the number of Periodic Full Site Reviews that were due and completed for each quarter. This is an abbreviated review and is not a substitute for a full on-site review. Due to COVID-19 pandemic and for the safety of staff, providers and members, KHS staff are not physically going to provider offices. FSRs and MRRs are being done using an abbreviated model as an interim measure until we can return to doing full on-site reviews after the COVID-19 emergency response situation ends. Our ability to do this reduced form of review is dependent on the providers' ability to provide the necessary documentation. We are leveraging an audio-visual app to conduct portions of these reviews.

Year to Date (YTD) Initial and Periodic FSR Pass or Fail Rate:



In 2020 YTD 94 % of the Initial and Periodic site reviews performed passed and 6% required follow-up. All the sites except passed in the first audit. Due to COVID-19 pandemic and for the safety of staff, providers and members, KHS staff are not physically going to provider offices. FSRs and MRRs are being done using an abbreviated model as an interim measure until we can return to doing full on-site reviews after the COVID-19 emergency response situation ends. This is an abbreviated review and is not a substitute for a full on-site review.



For 4th Quarter 2020, there were 5 medical reviews conducted and none of the reviews were passed in the first audit. Typically, there are more follow-ups required for Medical Record Reviews. Quality Improvement explores opportunities to improve areas on a broader basis for areas with consistent non-compliance. Since Q2 2020, due to COVID-19 pandemic and for the safety of staff, providers and members, KHS staff are not physically going to provider offices. FSRs and MRRs are being done using an abbreviated model as an interim measure until we can return to doing full on-site reviews after the COVID-19 emergency response situation ends. This is an abbreviated review and is not a substitute for a full on-site review.

For 4th Quarter all the provisionary site reviews conducted scored 100% and no deficiencies were identified.

For 4th Quarter top #3 deficiencies identified for Opportunities for improvement in medical record reviews are:

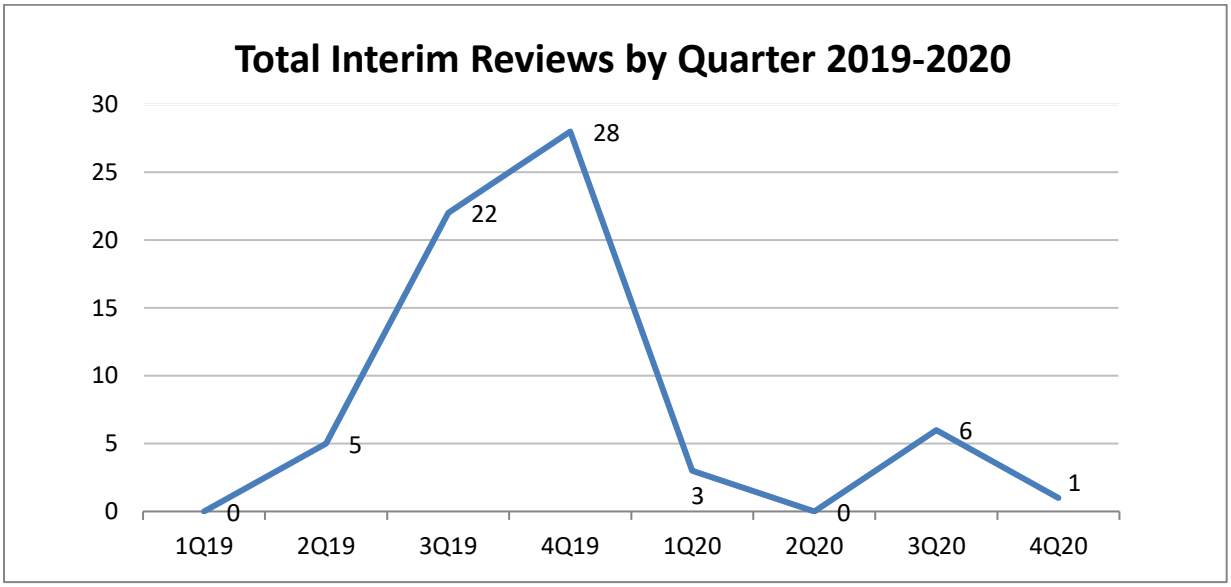
- No evidence of follow – up care of specialty referrals made and results/repots of diagnostic tests when appropriate
- IHEBA's
- Childhood Immunization not given according to ACIP guidelines

IHEBA's and Immunization deficiencies were found due to the pandemic as most of the sites were only conducting telehealth visits.

Interim Reviews:

Interim Reviews are conducted between Initial and first Periodic Full Site Reviews or between two Periodic Full Site Reviews. Typically, they occur about every 18 months. These reviews are intended to be a check-in to ensure

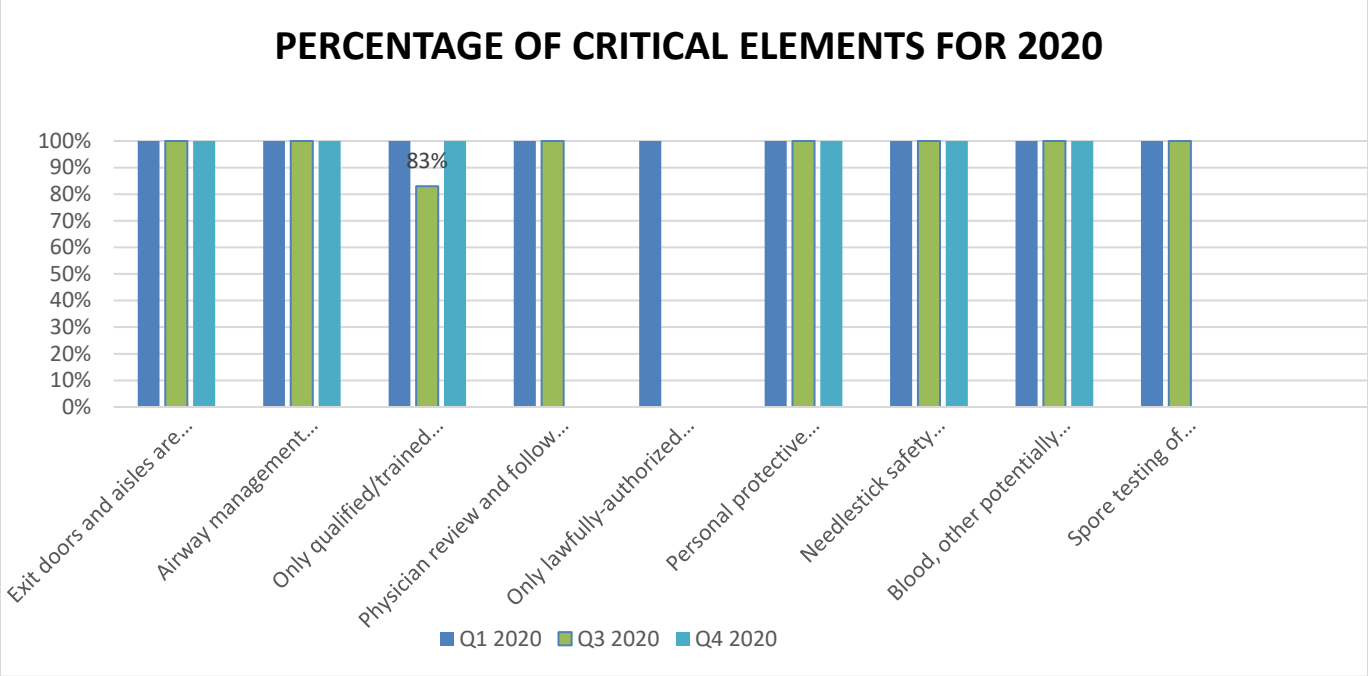
the provider is compliant with the 9 critical elements and as a follow up for any areas found to be non-compliant in the previous Initial or Periodic Full Site Review.



This above chart reflects the number of Interim Reviews that were due and completed for each quarter. This is an abbreviated review and is not a substitute for a full on-site review. Due to COVID-19 pandemic and for the safety of staff, providers and members, KHS staff are not physically going to provider offices. FSRs and MRRs are being done using an abbreviated model as an interim measure until we can return to doing full on-site reviews after the COVID-19 emergency response situation ends. Our ability to do this reduced form of review is dependent on the providers' ability to provide the necessary documentation. We are leveraging an audio-visual app to conduct portions of these reviews.

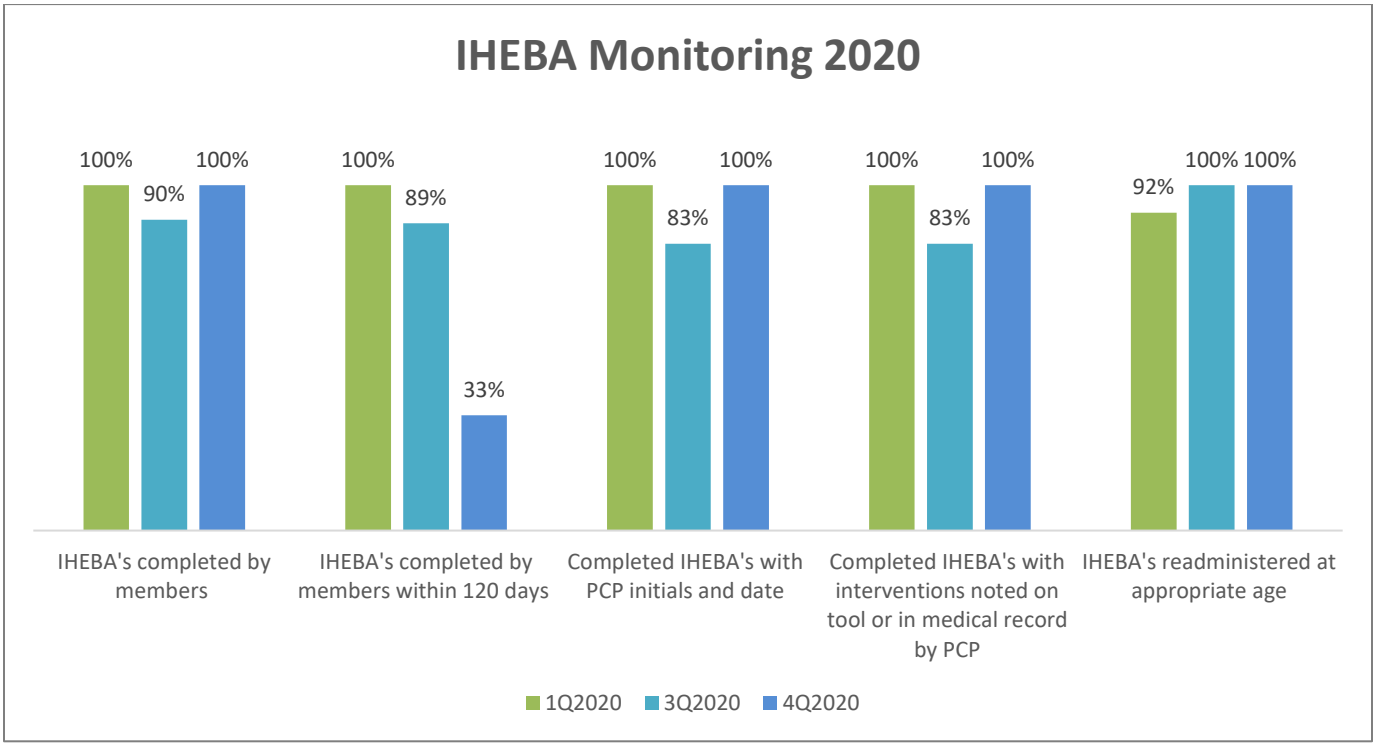
KHS is responsible for systematic monitoring of all PCP and OB/GYN sites between each regularly scheduled, full scope site review surveys. This monitoring includes the nine (9) critical elements. These nine critical survey elements are related to the potential for adverse effect on patient health or safety which have a scored "weight" of two points. All other survey elements are weighted at one point. All critical element deficiencies found during a full scope site review or monitoring visit must be corrected by the provider within 10 business days of the survey date. Sites found deficient in any critical element during a Focus Review are required to correct 100% of the survey deficiencies, regardless of survey score.

Other performance assessments may include previous deficiencies, patient satisfaction, grievance, and utilization management data. The PCP and/or site contact are notified of all critical element deficiencies found during a survey or monitoring visit. The PCP and/or site contact are required to correct 100% of the survey deficiencies regardless of the survey score.



Note: There is no data for Q2 2020 since there were no interim reviews performed due to COVID-19 pandemic.
Analysis for Critical Elements: The above Critical elements are reported only for Interim reviews. There was one interim review conducted for Q4 2020, Three out of the nine Critical elements were not applicable for the site and all remaining critical elements scored 100%.
Due to COVID-19 pandemic and for the safety of staff, providers and members, KHS staff are not physically going to provider offices. FSRs and MRRs are being done using an abbreviated model as an interim measure until we can return to doing full on-site reviews after the COVID-19 emergency response situation ends. Our ability to do this reduced form of review is dependent on the providers' ability to provide the necessary documentation. We are leveraging an audio-visual app to conduct portions of these reviews.

Individual Health Education Behavioral Assessment (IHEBA) Description: The IHEBA, commonly referred to as the Staying Healthy Assessment, is performed during the Initial Health Assessment (IHA). Thereafter, the PCP must re-administer the IHEBA at the appropriate age intervals. The minimum performance level (MPL) is 80%.



Note: There is no data for Q2 2020 since there were no interim reviews performed due to COVID-19 pandemic.

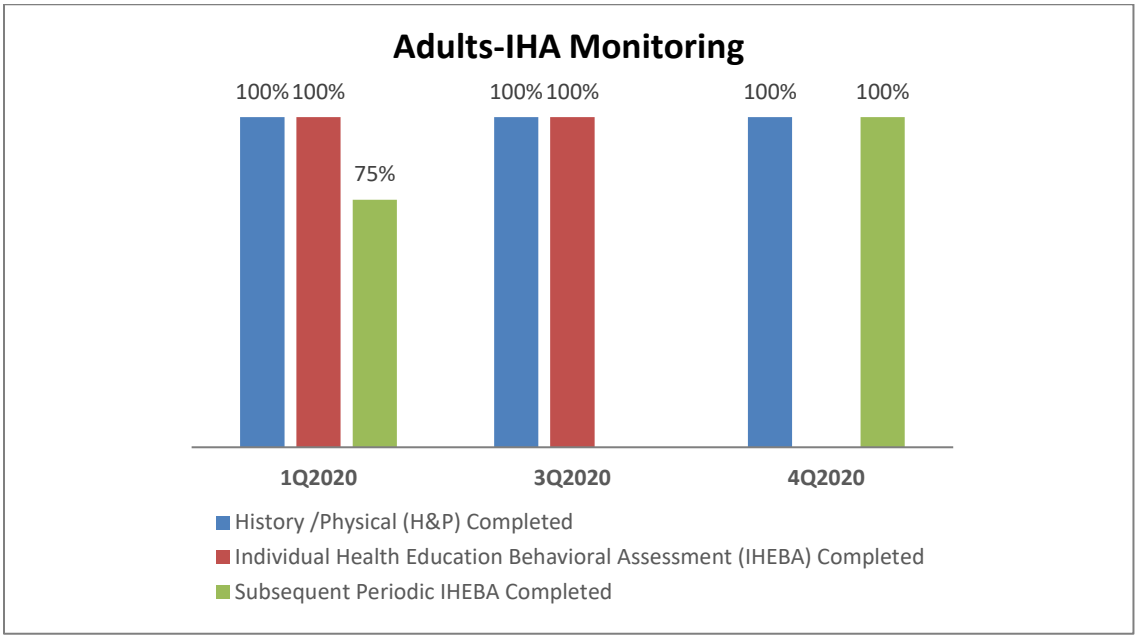
IHEBA Results:

In the 4th Quarter of 2020, 7 records were audited for one provider. This provider scored 100% in all the areas except IHEBA's completed by members within 120days. Necessary Corrective Action Plans (CAPS) were issued and the deficiencies were corrected.

Due to COVID-19 pandemic and for the safety of staff, providers and members, KHS staff are not physically going to provider offices. FSRs and MRRs are being done using an abbreviated model as an interim measure until we can return to doing full on-site reviews after the COVID-19 emergency response situation ends. Our ability to do this reduced form of review is dependent on the providers' ability to provide the necessary documentation. We are leveraging an audio-visual app to conduct portions of these reviews.

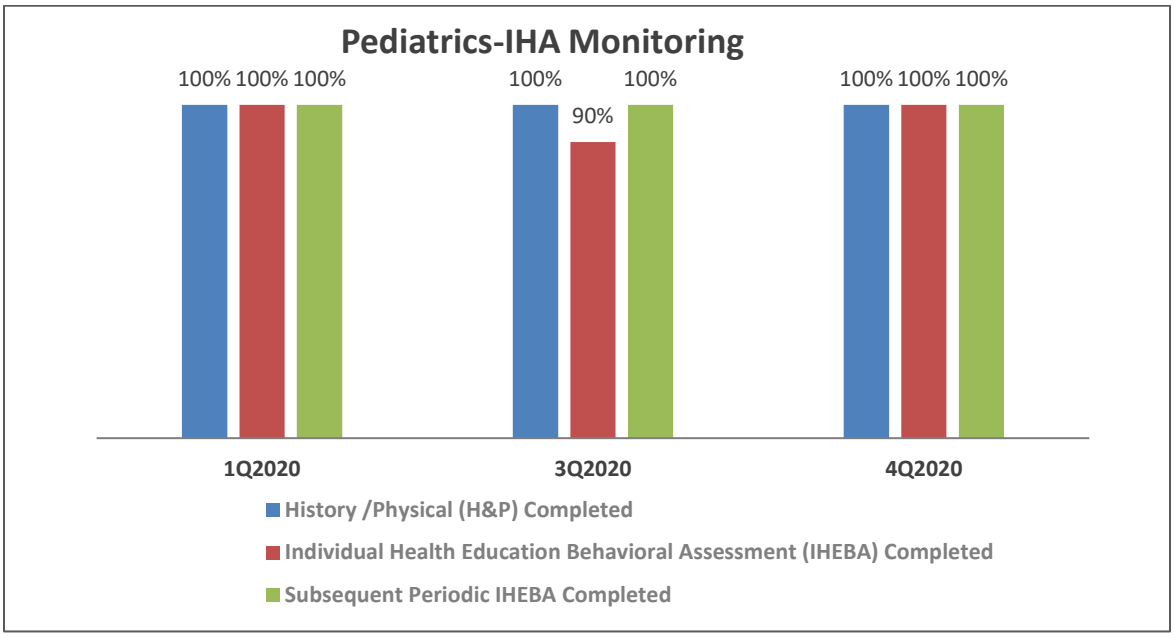
Initial Health Assessment (IHA) Description: An IHA must be provided to each member within 120 days of enrollment. As PCP's receive their assigned members, the practitioner's office contacts the member to schedule an IHA to be performed within the 120-day time limit. If the practitioner is unable to contact the member, he/she contacts the KHS Member Services Department for assistance. Contact attempts and results are documented by

both the PCP and member services staff. The MPL is 80% for this measure, and IHAs are performed on both adult and child members.



ADULT IHA Results: For the 4th Quarter of 2020, there was only one provider who had 3 adult IHA records audited. Records surveyed scored 100% in two areas. 'IHEBA completed' section was not applicable for the site reviwed during the time of review as they were all established members and have subsequent IHEBA's done.

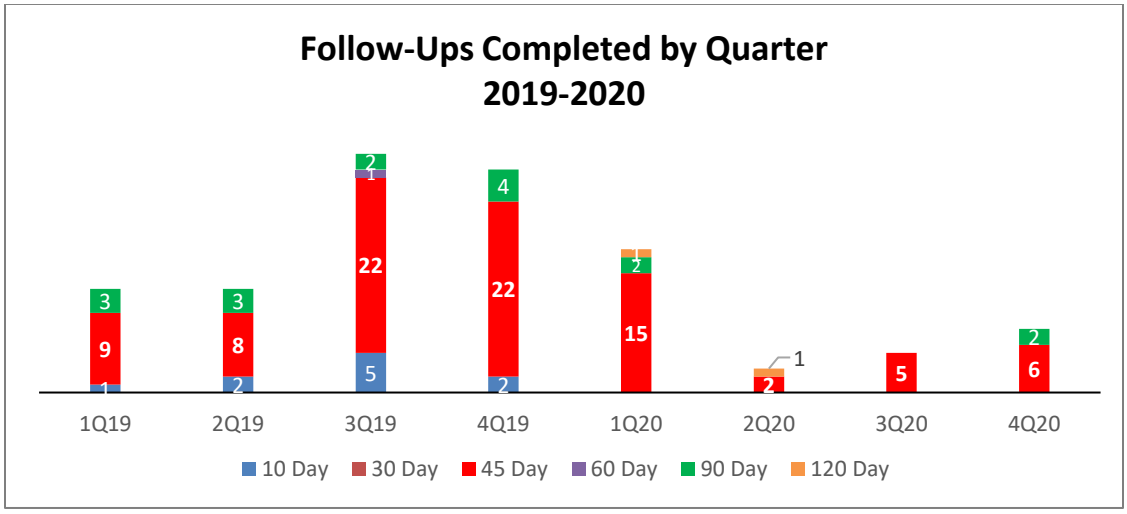
Note: There were no focus reviews performed in 2nd Quarter of 2020 due to COVID-19 pandemic.



PEDIATRIC IHA Results: For the 4th Quarter of 2020, there were 3 Pediatric-IHA records reviewed for one provider. All records surveyed scored 100% in all the three areas.

Note: There were no focus reviews performed in 2nd Quarter of 2020 due to COVID-19 pandemic.

Site Review Corrective Action Plans (CAPs):



There were six 45-day and two 90-day follow ups completed in Q4 of 2020. Due to COVID-19 pandemic and for the safety of staff, providers and members, KHS staff are not physically going to provider offices. FSRs and MRRs are being done using an abbreviated model as an interim measure until we can return to doing full on-site reviews

after the COVID-19 emergency response situation ends. Our ability to do this reduced form of review is dependent on the providers' ability to provide the necessary documentation. We are going to explore the possibility of using an audio-visual app to conduct portions of these reviews.

III. Quality Improvement Projects

a. Performance Improvement Projects (PIPs)

DHCS initiated a cycle of PIPs for 2020-2022 in November through the EQRO, HSAG. KHS opted to continue the PIPs that were stopped in July of 2020. Those 2 PIPs are:

Health Care Disparity in WCV (Well Care Visits ages 3-21)

This PIP targets health care disparities to Improve the health and wellness of low-income children and adolescents, ages 3 to 21, through well-care visits. This project is being done in collaboration with Kern Pediatrics. The narrowed focus has been identified for 8-10-year-old population and the PIP team plans to set up a meeting with Kern Pediatrics to review if interventions remain relevant and realistic especially considering the COVID-19 pandemic. Currently, the PIP team is working on Module 1, PIP Initiation, which is due for submission to HSAG by 03/26/2021

Child/Adolescent Health Asthma Medication Ratio (AMR)

KHS did not meet the MPL for the AMR measure for two consecutive years and this is one of the reasons the AMR measure was chosen for the PIP project. Bakersfield has many pediatric patients with a diagnosis of persistent asthma. We identified problems like lack of education on how to use the medication and when to use controller verses reliever mediation. This PIP will give us an opportunity to explore more challenges and come up with plans to improve the health of our population. After evaluating the level of compliance for Bakersfield and Riverwalk Pediatric clinics, their level of compliance is too high to gain any value from this PIP. We are in the process of identifying a provider with a significant number of Asthmatic children and adolescents who are not meeting the MPL for the AMR measure. The PIP team is currently working on Module 1 with an HSAG submission date of 3/1/2021.

b. MCAS Member Engagement and Rewards Project:

This is a project to establish a program for active member outreach and a rewards system to encourage member compliance with MCAS measures. Member Outreach includes the use of Interactive Voice Recognition (IVR) and Text Messaging. The campaign for the first set of MCAS measures was completed in December. Recent legislative clarification has identified that member consent is required for both text messaging and robo calls. Due to a low number of members who opted in for robo calls, we supplemented outreach with postcard mailings for all non-complaint members. Measures included are: Well Care Visits for Ages 0 - 21 years, Pre-natal visit in the 1st trimester, Post-partum visit between 7 and 84 days after delivery, Initial health assessments. A dashboard for review of campaign outcomes will be available in the Q1 of 2021.

c. SWOT Analysis Project:

Based on MY2019 results, DHCS suggested KHS consider conducting a SWOT analysis to improve scores for multiple measures. KHS opted to move forward with this more expansive evaluation and development of interventions that will improve MCAS measure compliance results. This will be a two-year project working closely with DHCS. Health Net is also conducting a SWOT analysis and there will be coordination between KHS and Health Net. KHS SWOT Work Group met with DHCS Liaison in December to discuss Initial SWOT submission and to guide KHS into choosing interventions that will allow a company-wide Quality Improvement framework to be established. QI Department is monitoring SWOT project activities weekly and monthly to identify any issues or impediments and resolve them. Below is the SWOT Analysis Project 2020-2022 Monthly Progress Timeline:

SWOT Analysis Project 2020-2022 -Progress Timeline

Items	Year 2020		
	Oct	Nov	Dec
Stragegy 1: Increase number of members attending preventive care appointments for W30, WCV, BCS, CIS, IMA, PPC Pre, PPC Post measures. Use MCAS trending reports and the minimum performance levels as benchmarks to evaluate effectiveness of actions.			
Action Item 1.A: The Quality Improvement Department will form a strategic group to meet regularly for review of MCAS trending data and timely initiation of interventions to increase measure compliance.			
Action Item 1.B: KHS will start a media 'Back to Care' campaign aimed at encouraging members to return to their providers for preventive and/or chronic care. Baseline will be monthly trending data starting October 01, 2019.			
Action Item 1.C: 'KHS is partnering with West Side Family Health Care and Alinea Mobile Imaging for a clinical outreach project for women, 50 years old and above, in Taft, CA, who have not had a mammogram in the last 2 years			
Strategy 2: KHS will increase compliance of MCAS Well Child Visits (W30 and WCV) and Prenatal and Post-Partum Visits (PPC) by 5 percentage points compared to HEDIS MY 2019 and for each year after until the minimum performance level is met.			
Action Item 2.A: Quality Improvement and Health Education Departments will perform outreach using robocalls to KHS non-compliant members to complete the PPC Prenatal, PPC Post, WCV, W30 visits.			
Action Item 2.B: SWOT Team will collaborate with Health Net, Kern County, for one year on a project aimed at increasing the MCAS Well Care Visits for members 3 to 21 years of age (WCV) measure by 5 percentage points.			
Action Item 2.C: Stakeholders will form the Member Engagement and Rewards Program, an on-going program that will increase members' knowledge of necessary preventive health care and support and increase compliance 5 percentage points from MCAS MY2019.			
Strategy 3: KHS will increase preventive care compliance for MCAS measures by implementing new processes within the health plan aimed at decreasing members' gaps in care.			
Action Item 3.A: KHS health services division will institute a new process to incorporate Gaps in Care lists into telephonic contact with members.			
Action Item 3.B Member Services Department will increase number of members who opted in to receive robocalls from Kern Health Systems. Goal will be to double the number of members opted in by the end of the first quarter in 2021.			
Action Item 3.C KHS will support use of telehealth visits to provide preventive health and chronic condition management services to members who are not accessing care due to the pandemic or who are challenged under normal conditions in accessing care.			
Action Item 3.D A $10 Gift Card will be sent to any member who enrolls in the Member Portal. The portal will provide the member with their Gaps in Care and a list of services needed for closing the gap.			
Strategy 4: KHS will increase compliance with MCAS AMR measure by 5 percentage points compared to MY 2019 and for each year after that until the minimum performance level is met.			
Action Item 4.A: SWOT Team will collaborate with Health Net, Kern County for one year to develop and implement a plan to increase the MCAS Asthma Medication Ratio measure by 5 percentage points			
Action Item 4.B KHS SWOT Team will conduct a meeting with Provider Network Management to review results of the P4P outcome-based program for 2020 as compared to a fee for service-based program that occurred in 2019 for the Asthma Medication Ratio. Results of this review may lead to changes to the 2021 P4P program.			
Action Item 4.C: Quality Improvement Department will meet with Public Health Department, Health Education and Provider Network Management quarterly in support of finding opportunities for improving AMR outcomes.			
Note: Completed/ Work In-Pro Need Progre No Progress			

Please note explanation for Action items in green:

Action Item 1.C: This action item on 'Mobile Mammogram Project' was completed successfully in December. A new action Item will be launched with Kern Medical, our county hospital system in January.

IV. Managed Care Accountability Set (MCAS) Updates (also referred to as HEDIS):

MCAS Measures have been significantly impacted by current COVID pandemic. Most of MCAS Measures are of preventive care services. Most of the members are avoiding going to Provider Offices due to the pandemic. The Audit for MCAS MY2020 rates began in November and will continue until July of 2021.

Rates below are not considered typical to our plan because of the reduced services provided during the pandemic.

MY2020 MCAS Rate Tracking Report
As of 12-31-2020 (HEDIS Dashboard)

Hybrid Measures Held to MPL

Measure		Current MY2020 Rate	MY2020 MPL	MY2019 KHS Rate	Current Vs. MY2020 MPL	Current Vs. MY2019 KHS Rate
CCS	Cervical Cancer Screening	49.07	61.31	56.20	-12.24	-7.13
CIS-10	Childhood Immunization Status – Combo 10	17.83	37.47	29.93	-19.64	-12.10
CDC-H9*	HbA1c Poor Control (>9.0%)	64.77	37.47	57.91	-27.30	-6.86
CBP	Controlling High Blood Pressure <140/90 mm Hg	5.13	61.8	38.93	-56.67	-33.80
IMA-2	(meningococcal, Tdap, HPV)	34.75	36.86	41.36	-2.11	-6.61
PPC-Pre	Prenatal & Postpartum Care – Timeliness of Prenatal Care	45.61	89.05	84.18	-43.44	-38.57
PPC-Post	Prenatal & Postpartum Care – Postpartum Care	69.93	76.4	81.02	-6.47	-11.09
WCC-BMI	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents: Body Mass Index Assessment for Children/Adolescents	26.61	80.5	66.42	-53.89	-39.81
WCC-N	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Nutrition	13.43	71.55	N/A	-58.12	N/A
WCC-PA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Physical Activity	12.06	66.79	N/A	-54.73	N/A

* A lower rate indicates better performance

Administrative Measures Held to MPL

Measure		Current MY2020 Rate	MY2020 MPL	MY2019 KHS Rate	Current Vs. MY2020 MPL	Current Vs. MY2019 KHS Rate
AMM - Acute	Antidepressant Medication Management – Acute Phase Treatment	50.11	53.57	50.24	-3.46	-0.13
AMM - Cont.	Antidepressant Medication Management – Continuation Phase Treatment	31.67	38.18	32.64	-6.51	-0.97
AMR	Asthma Medication Ratio	54.03	62.43	48.78	-8.40	5.25
BCS	Breast Cancer screening	51.61	58.82	57.29	-7.21	-5.68
CHL	Chlamydia Screening in Women Ages 16 – 24	55.68	58.44	55.29	-2.76	0.39
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	40.12	82.09	N/A	-41.97	N/A
APM	Metabolic Monitoring for Children and Adolescents	17.65	35.43	N/A	-17.78	N/A

Indicates did not meet MPL
Need 5% or less to meet MPL
Indicates we met or exceeded MPL/ MY2019 rate
Indicates we met the HPL.
N/A' is for measures that were not reported for RY2020
All current rates displayed above are admin(Claims) rates. Medical record abstractions begin after December 2020.
Measue rates for W30 and WCV are pending to be updated by BI in Trending.

V. Policy Updates: There were no new policy updates for 4th quarter 2020.

KAISER REPORTS

(PROPRIETARY AND CONFIDENTIAL)

Available upon Request

Diabetic Exam Reminder Effectiveness Report

Client: KERN HEALTH SYSTEMS - 12049397

Reminder Year:	Reminder Month:	Reminders Sent	Received Exam Within 0-90 Days	Received Exam Within 91-180 Days	Total Exams Within 180 Days
2020	February	503	18	18	36
	March	0	0	0	0
	April	6,190	57	91	148
	May	1,677	35	38	73
	June	1,367	52	59	111
	July	436	27	17	44
	August	554	33	29	62
	September	1,095	42	16	58
	October	3,423	78	6	84
	November	841	30	0	30
	December	1,760	28	0	28
2021	January	518	0	0	0
Totals		**18,364**	**400**	**274**	**674**

LTM Effectiveness* : 4 %

12-Month Effectiveness (Aug 2019 - Jul 2020) : 7 %

* This figure does not include an estimate of those patients who will return within 90 or 180 days.
It solely calculates based upon the patients who have returned to date for letters sent within the last twelve months.

Medical Data Collection Summary Report

Period Covered: February, 2020 through January, 2021
Prepared for: KERN HEALTH SYSTEMS - (12049397)

Overview

This report shows an aggregate view of your members who have received an eye exam during the reporting period. It also shows the number and percentage of your members that have one or more of the health conditions listed below, as reported by VSP doctors. VSP focuses on the six conditions listed below because they represent some of the most frequent and costly health conditions for which early detection and treatment can reduce or prevent vision loss as well as potentially avoid more costly treatment. VSP can work with your health plan or disease management company by providing them with patient-specific information upon request.

Summary of Findings

The left section below shows how many of your members received an eye exam during the reporting period as well as how many of them had each of the conditions listed (as reported by VSP doctors). The percentages represent the number of people with the respective conditions divided by the total number that received an eye exam. The right section below shows the estimated number of cases in your member population. We use health and demographic statistics provided by the Centers for Disease Control and the US Census. Also, because prevalence rates vary by age, we incorporate patient age data from your VSP eye exam claims for the reporting period.

The estimates for diabetes and hypertension are expected to be higher than the reported rates because approximately 30% of people with diabetes and 50% of people with hypertension are unaware of their condition and would not report it to their VSP doctor. The percentages represent the estimated number of people with the conditions divided by your total membership. Note that diabetes and hypertension are self-reported while the other conditions are reported based on the VSP doctor's findings. This report does not indicate if cases are newly diagnosed or existing.

Reported Cases

	Members	
Received Eye Exam:	17,415	
Diabetes[1]:	905	5.2%
Diabetic Retinopathy:	167	1.0%
Glaucoma:	275	1.6%
Hypertension:	627	3.6%
High Cholesterol	254	1.5%
Macular Degeneration:	44	.3%

Estimated Number of Cases

Total Members:	278,987	
Diabetes[1]:	6,826	2.4%
Diabetic Retinopathy:	606	.2%
Glaucoma:	1,147	.4%
Hypertension:	29,420	10.5%
High Cholesterol	42,574	15.3%
Macular Degeneration:	380	.1%

[1] Patients managing their diabetes can avoid medical costs from $2,000 to over $4,000 annually versus those not managing it.

Call Response Summary Report

DECEMBER 2020

Kern Health Systems 12049397
On average, for 1,000 members, VSP receives 27 calls per month

Total Client Calls

426

Category	Reasons For Calling	Client Counts	Client Percent	VSP Percent Book-of-Business
Eligibility	IVR Available Services	113	37.67%	21.06%
	Coverage/Relation	15	5.00%	.00%
	ID Number/ID Card Inquiry	5	1.67%	.00%
	Correcting	4	1.33%	.00%
	Multiple Coverage	1	.33%	.00%
	Not Found	1	.33%	.00%
	Refer to Client	1	.33%	.00%
Category Subtotal - Eligibility		140	46.66%	21.06%
Member Benefits	Available Services	38	12.67%	.00%
	Benefits Description	25	8.33%	.00%
	Glasses Related	3	1.00%	.00%
	Medically Related	1	.33%	.00%
	Retail	1	.33%	.00%
Category Subtotal - Member Benefits		68	22.66%	.00%
Doctor Referral	Email	28	9.33%	.00%
	IVR Doctor Referral	28	9.33%	.90%
	Doctor Access	3	1.00%	.00%
	Verbal or Mail	2	.67%	.00%
Category Subtotal - Doctor Referral		61	20.33%	.90%
Claims	Claim Status	17	5.67%	2.57%
	Payment	2	.67%	.00%
	Status	1	.33%	.00%
Category Subtotal - Claims		20	6.67%	2.57%
Authorizations	Authorizations	4	1.33%	1.60%
Category Subtotal - Authorizations		4	1.33%	1.60%
Language Lines / Miscellaneous	Spanish	2	.67%	.00%
Category Subtotal - Language Lines / Miscellaneous		2	.67%	.00%
Member Website Assistance	Find a Doctor	1	.33%	.00%
	Password Reset	1	.33%	.00%
Category Subtotal - Member Website Assistance		2	.66%	.00%


vsp
SM
Vision care for life

Call Response Summary Report

DECEMBER 2020

Kern Health Systems 12049397
On average, for 1,000 members, VSP receives 27 calls per month

Total Client Calls

426

Category	Reasons For Calling	Client Counts	Client Percent	VSP Percent Book-of-Business
Eligibility Not Online	Check Eligibility	1	.33%	.00%
Category Subtotal - Eligibility Not Online		1	.33%	.00%
Open Access	IVR OON Info	1	.33%	1.53%
Category Subtotal - Open Access		1	.33%	1.53%
TPA/Individual Plan	Change/Cancel	1	.33%	.00%
Category Subtotal - TPA/Individual Plan		1	.33%	.00%
Complaints	None	0	.00%	.00%
Category Subtotal - Complaints		0	.00%	.00%

GRAND TOTAL **300**

2020 4th Quarter Operational Report

4th Quarter 2020 Member Service Indicators

Activity	Goal	3rd Quarter	Status	2nd Quarter	1st Quarter	4th Quarter	3rd Quarter
Incoming Calls		**61,469**		66,882	57,207	77,452	74,441
Abandonment Rate	<5%	**1.19%**		2.6%	1.0%	1.6%	3.2%
Avg. Answer Speed	<2:00	**:11**		:26	:05	:19	:34
Average Talk Time	<8:00	**7:50**		7:52	7:38	7:26	7:24
Top Reasons for Member Calls	Trend	**1. New Member 2. Demographic 3. ID Card 4. PCP Change 5. Referrals**		Same	Same	Same	Same
Outbound Calls	Trend	**63,979**		78,915	86,206	103,634	97,467
# of Walk Ins	Trend	**0**		0	0	545	436
Member Portal Accounts-Q/Total	4%	**2948 33.053 (11.8%)**		3347 30,106 (11.19%)	2500 26,758 (10.3%)	2778 24,257 (9.75%)	2864 21,480

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4th Quarter 2020 Grievance Report

Category	Q4 2020	Status	Issue	Q3 2020	Q2 2020	Q1 2020	Q4 2019
Access to Care	72		Appointment Availability	53	33	53	56
Coverage Dispute	0		Authorizations and Pharmacy	0	0	0	0
Medical Necessity	317		Questioning denial of service	310	246	222	187
Other Issues	14		Miscellaneous	10	11	34	14
Potential Inappropriate Care	200		Questioning services provided. All cases forwarded to Quality Dept.	277	210	273	323
Quality of Service	7		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	5	8	2	0
Total Formal Grievances	610			655	508	584	580
Exempt**	1050		Exempt Grievances-	1091	986	1620	1140
Total Grievances (Formal & Exempt)	1660			1746	1494	2204	1720

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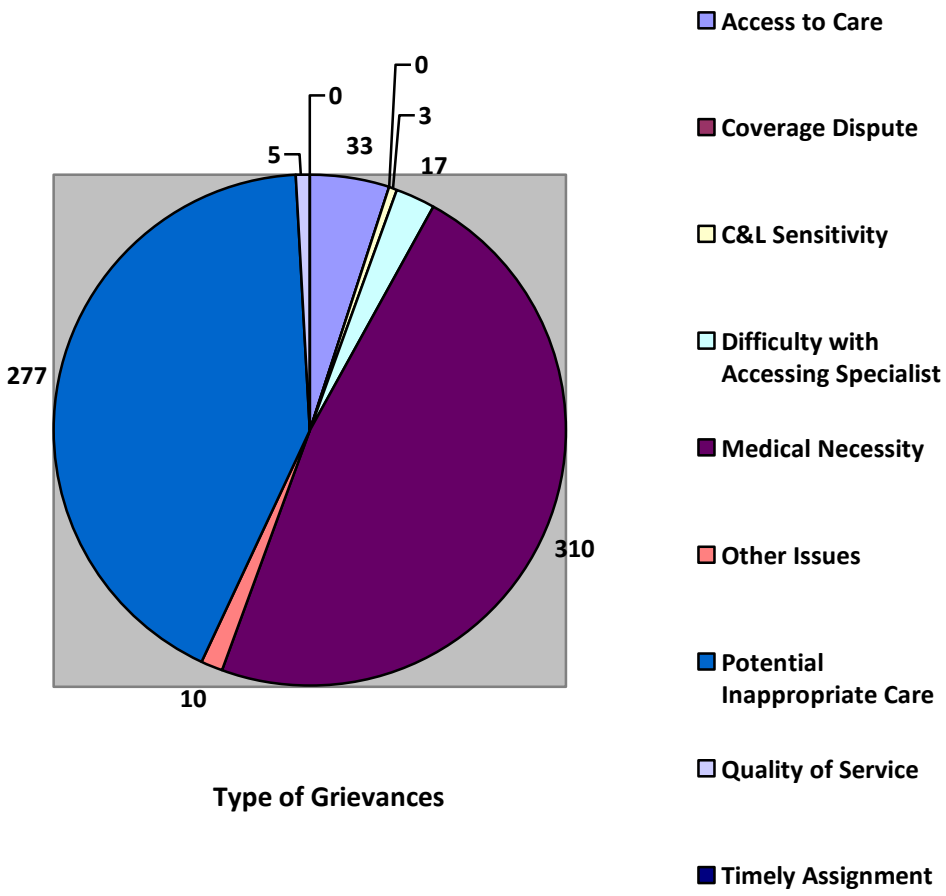
Additional Insights-Formal Grievance Detail

Issue	4th Quarter Grievances	Upheld Plan Decision	Further Review by Quality	Overturned Ruled for Member	Still Under Review
Access to Care	50	30	0	19	1
Coverage Dispute	0	0	0	0	0
Specialist Access	22	15	0	7	0
Medical Necessity	317	184	0	133	0
Other Issues	14	9	0	5	0
Potential Inappropriate Care	200	98	92	10	0
Quality of Service	7	7	0	0	0
Total	610	343	92	174	1

4th Quarter 2020 Grievance Summary

Issue	Number	In Favor of Health Plan	Under Review by Q.I	In favor of Enrollee	Still under review
Access to care	50	31	0	19	0
Coverage dispute	0	0	0	0	0
Cultural and Linguistic Sensitivity	2	2	0	0	0
Difficulty with accessing specialists	22	15	0	7	0
Medical necessity	317	184	0	133	0
Other issues	14	9	0	5	0
Potential Inappropriate care	200	97	93	10	0
Quality of service	5	5	0	0	0
Timely assignment to provider	0	0	0	0	0



Grievances per 1,000 Members =2.20

During the fourth quarter of 2020, there were six hundred and ten formal grievances and appeals received. One hundred seventy-four cases were closed in favor of the Enrollee; three hundred and forty four cases were closed in favor of the Plan. Ninety-two cases have closed and are under review by Quality Improvement. Six hundred and seven cases closed within thirty days. Three cases were pended and closed after thirty days.

4th Quarter 2020 Grievance Summary

Access to Care

There were fifty grievances pertaining to access to care. Thirty-one cases closed in favor of the Plan. Nineteen cases closed in favor of the Enrollee. The following is a summary of these issues:

Twenty-five members complained about the lack of available appointments with their Primary Care Provider (PCP). Fifteen cases closed in favor of the Plan after the response indicated the office provided appropriate access to care based on Access to Care standards. Ten cases closed in favor of the Enrollee after the responses indicated the offices may not have provided appropriate access to care based on Access to Care standards.

Fifteen members complained about the wait time to be seen for a Primary Care Provider (PCP) appointment. Eleven cases closed in favor of the Plan after the response indicated the member was seen within the appropriate wait time for an appointment or the member was there as a walk-in, which are not held to Access to Care standards. Four cases closed in favor of the Enrollee after the responses indicated the members were not seen within the appropriate wait time for an appointment.

Nine members complained about the telephone access with their Primary Care Provider (PCP). Four cases closed in favor of the Plan after the responses indicated the members were provided with the appropriate telephone access. Five cases closed in favor of the Enrollee after the responses indicated the members may not have been provided with the appropriate telephone access.

One member complained about a provider not submitting a referral authorization request in a timely manner. This case closed in favor of the Plan after it was determined the referral authorization request had been submitted timely.

Coverage Dispute

There were no grievances pertaining to a Coverage Dispute issue.

Cultural and Linguistic Sensitivity

There were two grievances pertaining to Cultural and Linguistic Sensitivity. All of the cases closed in favor of the Plan. The following is a summary of these issues:

Two members complained about the lack of interpreting services to assist during their appointments. Both cases closed in favor of the Plan after the responses indicated the members were provided with the appropriate access to interpreting services.

Difficulty with Accessing a Specialist

There were twenty-two grievances pertaining to Difficulty Accessing a Specialist. Fifteen cases closed in favor of the Plan. Seven cases closed in favor of the Enrollee. The following is a summary of these issues:

4th Quarter 2020 Grievance Summary

Ten members complained about the lack of available appointments with a specialist. Five cases closed in favor of the Plan after the responses indicated the members were provided the appropriate access to specialty care based on Access to Care Standards. Five cases closed in favor of the Enrollee after the responses indicated the members may not have been provided appropriate access to care based on the Access to Care Standards for specialty appointments.

Five members complained about the wait time to be seen for a specialist appointment. Four cases closed in favor of the Plan after the responses indicated the offices provided appropriate wait time for an appointment based on Access to Care Standards. One case closed in favor of the Enrollee after the response indicated the member may not have been provided with the appropriate wait time for an appointment based on Access to Care Standards.

Seven members complained about the telephone access with a specialist office. Six cases closed in favor of the Plan after the responses indicated the member was provided with the appropriate telephone access. One case closed in favor of the Enrollee after the response indicated the member may not have been provided with the appropriate telephone access.

Medical Necessity

There were three hundred and seventeen appeals pertaining to Medical Necessity. One hundred eighty-four cases were closed in favor of the Plan. One hundred and thirty-three of the cases closed in favor of the Enrollee. The following is a summary of these issues:

Two hundred and eighty-three members complained about the denial or modification of a referral authorization request. One hundred and fifty-one of the cases were closed in favor of the Plan as it was determined that there was no supporting documentation submitted with the referral authorization requests to support the criteria for medical necessity for the requested specialist or DME item; therefore, the denials were upheld. Three cases were closed in favor of the Plan and modified. One hundred and twenty-nine cases were closed in favor of the Enrollee as it was determined medical necessity was met and the denials were overturned.

Thirty-four members complained about the denial or modification of a TAR. Thirty cases were closed in favor of the Plan, as it was determined there was no supporting documentation submitted with the TAR to support the criteria for medical necessity of the requested medication; therefore, the denials were upheld. Four cases were closed in favor of the Enrollee as it was determined medical necessity was met and the denials were overturned.

Other Issues

There were fourteen grievances pertaining to Other Issues. Nine cases were closed in favor of the Plan after the responses indicated appropriate service was provided. Five cases closed in favor of the Enrollee after the responses indicated appropriate service may not have been provided.

4th Quarter 2020 Grievance Summary

Potential Inappropriate Care

There were two hundred grievances involving Potential Inappropriate Care issues. These cases were forwarded to the Quality Improvement (QI) Department for their due process. Upon review, ninety-seven cases were closed in favor of the Plan, as it was determined a quality of care issue could not be identified. Ten cases were closed in favor of the Enrollee as a potential quality of care issue was identified and appropriate tracking or action was initiated. Ninety-three cases are still pending further review with QI. The following is a summary of these issues:

One hundred and twenty-eight members complained about the potential inappropriate care received from a Primary Care Provider (PCP). All records and/or responses were sent to QI for further review and investigation. Sixty-eight cases closed in favor of the Plan as no inappropriate care issue was identified. Nine cases closed in favor of the enrollee as a potential inappropriate care concern was identified and is still under further review with QI. Fifty-one cases are still under further review with QI.

Fifty-four members complained about the potential inappropriate care received from a specialty provider. All records and/or responses were sent to QI for further review and investigation. Twenty-five cases closed in favor of the Plan as no potential inappropriate care issue was identified. One case closed in favor of the Enrollee as a potential inappropriate care concern was identified and is still under further review with QI. Twenty-eight cases are still under further review with QI.

Sixteen members complained about the potential inappropriate care received from providers staffed by an urgent care, hospital, or a non-hospital affiliated clinic. All records and/or responses were sent to QI for further review and investigation. Three cases closed in favor of the Plan as no potential inappropriate care issue was identified. Thirteen cases are still under further review with QI.

Two members complained about the potential inappropriate care received from a pharmacy. All records and/or responses were sent to QI for further review and investigation. One case closed in favor of the Plan as no potential inappropriate care issue was identified. One case is still under further review with QI.

Quality of Service

There were five grievances involving Quality of Service issues. All cases were closed in favor of the Plan. The following is a summary of these issues:

Four members complained about the service they received from their providers. All cases closed in favor of the Plan after the responses determined the member received appropriate service.

One member complained about the services they received from a provider and staff with a hospital. This case closed in favor of the Plan after the response determined the member received the appropriate service.

4th Quarter 2020 Grievance Summary

Timely Assignment to Provider

There were no grievances pertaining to Timely Assignment to Provider received this quarter.

Kaiser Permanente Grievances and Appeals

During the fourth quarter of 2020, there were seventy grievances and appeals received by KFHC members assigned to Kaiser Permanente. Seven cases closed in favor of the Plan. Sixty-two cases were closed in favor of the Enrollee. One case is still open and pending closure.

Access to Care

There were eleven grievances pertaining to Access to Care. The following is a summary of these issues:

Six members complained about the excessive long wait time to be seen for an appointment. All cases closed in favor of the Enrollee.

Three members complained about the lack of primary care provider availability. All cases closed in favor of the Enrollee.

Two members complained about the lack of facility physical access. One case closed in favor of the Enrollee. One case is open pending closure.

Coverage Dispute

There were nineteen appeals pertaining to Coverage Dispute. The following is a summary of these issues:

Nineteen members complained about a service they requested; however, the requests were not covered. Six cases closed in favor of the Plan and the services were not covered. Thirteen of the cases closed in favor of the Enrollee and the services were provided.

Medical Necessity

There were two cases pertaining to Medical Necessity. The following is a summary of these issues:

Two members complained about a provider's refusal to refer. Both cases closed in favor of the Enrollee.

Quality of Care

There were twenty-one grievances pertaining to quality of care. The following is a summary of these issues:

Three members complained about the quality of care they received from a hospital. All cases closed in favor of the Enrollee.

4th Quarter 2020 Grievance Summary

Fifteen members complained about the quality of care they received from a provider. All cases closed in favor of the Enrollee.

Three members complained about a provider denying treatment. All cases closed in favor of the Enrollee.

Quality of Service

There were seventeen grievances pertaining to a Quality of Service. The following is a summary of these issues.

Seventeen members complained about the services being inadequate at a facility. One case closed in favor of the Plan. Sixteen cases closed in favor of the Enrollee.

KERN HEALTH SYSTEMS
4th Quarter 2020
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Report Date: January 7, 2021

Department: Provider Relations

Monitoring Period: October 1, 2020 through December 31, 2020

Population:

Providers	Credentialed	Recredentialed
MD's	37	72
DO's	1	2
AU's	0	0
DC's	1	1
AC's	0	0
PA's	9	7
NP's	14	24
CRNA's	2	2
DPM's	1	1
OD's	4	3
ND's	0	0
RD's	0	0
BCBA's	7	8
LM's	0	0
Mental Health	4	7
Ocularist	0	0
Ancillary	7	27
OT	0	0
TOTAL	**87**	**154**

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Acupuncture	0	0	0	0
Allergy & Immunology	0	1	1	0
Anesthesiology / CRNA	2	4	6	0
Audiology	0	0	0	0
Autism / Behavioral Analyst	7	8	15	0
Cardiology	2	6	8	0
Chiropractor	1	1	2	0
Colon & Rectal Surgery	0	0	0	0
Critical Care	0	0	0	0
Dermatology	0	0	0	0
Emergency Medicine	0	1	1	0
Endocrinology	2	1	3	0
Family Practice	29	26	55	0
Gastroenterology	0	0	0	0
General Practice	2	4	6	0
General Surgery	1	4	5	0
Genetics	0	0	0	0

KERN HEALTH SYSTEMS
4th Quarter 2020
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Gynecology	0	0	0	0
Gynecology/Oncology	0	0	0	0
Hematology/Oncology	1	2	3	0
Hospitalist	3	0	3	0
Infectious Disease	0	1	1	0
Internal Medicine	8	14	22	0
Mental Health	4	7	11	0
MidWife (Certified)	0	0	0	0
MidWife (Licensed)	0	0	0	0
Naturopathic Medicine	0	0	0	0
Neonatology	0	0	0	0
Nephrology	1	0	1	0
Neurological Surgery	0	0	0	0
Neurology	0	3	3	0
Obstetrics & Gynecology	1	6	7	0
Ocularist	0	0	0	0
Occupational Therapy	0	0	0	0
Ophthalmology	0	0	0	0
Optometry	4	3	7	0
Orthopedic Surgery / Hand Surg	0	2	2	0
Otolaryngology	0	0	0	0
Pain Management	1	3	4	0
Pathology	2	0	2	0
Pediatrics	2	11	13	0
Physical Medicine & Rehab	2	0	2	0
Plastic Sugery	1	0	1	0
Podiatry	1	1	2	0
Psychiatry	2	4	6	0
Pulmonary	0	0	0	0
Radiation Oncology	2	2	4	0
Radiology	1	16	17	0
Registered Dieticians	0	0	0	0
Rheumatology	1	0	1	0
Sleep Medicine	0	0	0	0
Thoracic Surgery	0	0	0	0
Urology	1	0	1	0
Vascular Medicine	0	0	0	0
Vascular Surgery	0	2	2	0
KHS Medical Directors	0	0	0	0
TOTAL	**84**	**133**	**217**	**0**

KERN HEALTH SYSTEMS
4th Quarter 2020
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

ANCILLARY	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Ambulance	0	0	0	0
Cardiac Sonography	0	0	0	0
Comm. Based Adult Services	0	0	0	0
Dialysis Center	0	1	1	0
DME	0	0	0	0
Hearing Aid Dispenser	0	0	0	0
Home Health	0	2	2	0
Home Infusion/Compounding	0	0	0	0
Hospice	1	1	2	0
Hospital	0	3	3	0
Laboratory	0	0	0	0
Lactation Consultant	0	0	0	0
MRI	0	0	0	0
Ocular Prosthetics	0	0	0	0
Pharmacy	1	9	10	0
Pharmacy/DME	0	0	0	0
Physical / Speech Therapy	0	0	0	0
Prosthetics & Orthotics	0	0	0	0
Radiology	0	2	2	0
Skilled Nursing	2	0	2	0
Sleep Lab	0	0	0	0
Surgery Center	0	1	1	0
Transportation	3	3	6	0
Urgent Care	0	5	5	0
TOTAL	**7**	**27**	**34**	**0**

Defer = 0 **Denied = 0**

KERN HEALTH SYSTEMS
4th Quarter 2020
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

KERN HEALTH SYSTEMS
4th Quarter 2020
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Vendor #	Legal Name DBA
	PAC 12/2/2020
PRV029961	Bartz-Altadonna Community Health Center
PRV005731	County of Kern dba: Kern County Public Health Services

Specialty	Address
FQHC / PCP	Bartz-Altadonna Community Health Center 9300 N. Loop Blvd California City CA 93505 P - 661-874-4050 F - 661-874-4051
Mobile Unit / Immunizations Only	County of Kern dba: Kern County Public Health Services Mobile Unit - 1800 Mt Vernon Avenue Bakersfield CA 93306 P - 661-321-3000 F - 661-868-0261

Comments	Contract Effective Date
Group NPI: 1811279763 **TIN: 273261289**	1/1/2021
Group NPI: 1023167541 **TIN: 956000925**	1/1/2021

Kern Health Systems
Board Approved Effective 12/01/20

Legal Name DBA	Specialty	Vendor #	Address	Contract Effective Date
Heather Berry Counseling Inc. dba: Heather Berry Counseling	Clinical Social Worker	PRV064932	14 Sierra Drive Kernville CA 93238 Phone - 760-376-1444 Fax - 760-376-3034	12/1/2020
Jefferson J Lee dba: Lucky Services	Transportation	PRV064912	4949 Buckley Way #110 Bakersfield CA 93309 Phone - 661-446-4229 Fax - 888-350-0867	12/1/2020
Sienna Medical Corporation dba: Sienna Wellness Institute	PCP	PRV013665	6425 Lynch Canyon Drive Lake Isabella CA 93240 Phone - 760-379-8630 Fax - 760-379-7658	12/1/2020
S. Faye Snyder, PsyD	Psychology / Mental Health	PRV056422	6200 Lake Ming Road Ste. A-4 Bakersfield CA 93306 Phone - 661-476-9076 Fax - 661-558-4162	12/1/2020
Yosemite Pathology Medical Group, Inc.	Pathology	PRV013993	***All Locations - Same NPI 1598760985** 3000 Sillect Avenue Bakersfield CA 93308 P-661-366-0622 / F-661-322-0239 2615 Eye Street Bakersfield CA 93301 P- 661-336-0622 / F - 661-336-0784 3001 Sillect Avenue Bakersfield CA 93308 P- 661-336-0622 / F - 661-336-0784 1100 Magellan Drive Tehachapi CA 93563 P- 661-336-0622 / F - 661-336-0784	12/1/2020

NAME	LEGAL NAME/ADDRESS
Jimenez, Arsenio MD	Bartz-Altadonna Community Health Center 9300 N. Loop Blvd California City CA 93505 P - 661-874-4050 F - 661-874-4051
Lopez, Daniel MD	Bartz-Altadonna Community Health Center 9300 N. Loop Blvd California City CA 93505 P - 661-874-4050 F - 661-874-4051
Lyon, Kristopher MD (currently NPAR)	County of Kern dba: Kern County Public Health Services Mobile Unit - 1800 Mt Vernon Avenue Bakersfield CA 93306 P - 661-321-3000 F - 661-868-0261
Brito-Nadjmabadi, Aide PA-C (currently NPAR)	County of Kern dba: Kern County Public Health Services Mobile Unit - 1800 Mt Vernon Avenue Bakersfield CA 93306 P - 661-321-3000 F - 661-868-0261
Avellan, Michael PA-C	Accelerated Urgent Care *All Locations 212 Coffee Road Bakersfield CA 93309
Bains, Jasmeet MD (NEW)	Dignity Health Medical Foundation 3737 San Dimas Street Ste 101 3838 San Dimas Street Ste. B-111 9500 Stockdale Highway Ste. 203 Bakersfield CA
Baro, David PA-C (NEW)	Accelerated Urgent Care *All Locations 212 Coffee Road Bakersfield CA 93309
Cameron, Kathryn NP-C (LOCUM)	Omni Family Health 1451 White Lane Bakersfield CA 93307
Castillo, Fausto MD (LOCUM)	Omni Family Health 1110 West Visalia Road Ste. 102 Exeter CA 860 Sequoia Avenue Lindsay CA
Crisostomo, Christine NP-C (NEW)	Carlos A. Alvarez, MD Inc. 8929 Panama Road Ste. A Lamont CA 801 Santa Fe Way Shafter CA
Gordon, Nicole MD (LOCUM)	Ravi Patel, MD Inc. dba: Comprehensive Blood & Cancer Ctr 6501 Truxtun Avenue Bakersfield CA 93309
Guzman, Kelly PA-C (NEW)	Accelerated Urgent Care *All Locations 212 Coffee Road Bakersfield CA 93309
Patel, Arpit MD (NPAR)	Dignity Health Medical Foundation 3838 San Dimas Street. Ste. B-231 Bakersfield CA 93301
Singh, Sukhmani MD (NEW)	Dignity Health Medical Foundation 3737 San Dimas Street Ste 101 9500 Stockdale Highway Ste. 203 Bakersfield CA

Starley, Denice DO (NEW)	LAGS Spine & Sportscare Medical Ctrs, Inc. 3550 Q Street Ste. 103-105,201,202 Bakersfield CA 93301
Su, Peter MD (NEW)	Accelerated Urgent Care *All Locations 212 Coffee Road Bakersfield CA 93309
Taylor, Douglas DC (LOCUM)	Omni Family Health 912 Fremont Street Delano CA 93215
Thompson, Amanda BCBA (NPAR)	Holdsambeck & Associates, Inc. dba: Holdsambeck Behavioral Health 2535 16th Street Ste. 215 & 210 Bakersfield CA 93301
Yuen, Benny MD (LOCUM)	Ridgecrest Regional Hospital 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555

SPECIALTY	CONTRACT STATUS	PROVIDER PRV #	VENDOR PRV #
Internal Medicine	New Contract	PRV062266	PRV029961
Family Practice	New Contract	PRV063464	PRV029961
General Practice	New Contract	PRV007550	PRV005731
General Practice	New Contract	PRV004428	PRV005731
Family Practice	Existing	PRV065450	All Locations
Family Practice	Existing	PRV043990	PRV012886
Family Practice	Existing	PRV065857	All Locations
Family Practice	Existing	PRV065519	PRV000019
Family Practice	Existing	PRV064782	PRV000019
Internal Medicine	Existing	PRV061020	PRV030784 PRV055424
Surgical Oncology	Existing	PRV064194	PRV013881
Family Practice	Existing	PRV065859	All Locations
General Surgery	Existing	PRV065341	PRV012886
Endocrinology	Existing	PRV065860	PRV012886

Physical Medicine & Rehab / Pain Medicine	Existing	PRV008555	PRV000403
Family Practice	Existing	PRV065858	All Locations
Chiropractic	Existing	PRV064783	PRV000019
Qualified Autism Provider / Behavioral Analyst	Existing	PRV061038	PRV031922
OB/GYN	Existing	PRV057318	PRV000279 PRV038718

PAC APPROVED - EFFECTIVE DATE
Yes Eff 1/1/21
Yes Eff 1/1/21
Yes Eff 1/1/21
Yes Eff 1/1/21
Yes Eff 1/1/21
Yes Eff 1/1/21
Yes Eff 1/1/21
Yes Eff 1/1/21
Yes Eff 1/1/21
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Yes **Eff 1/1/21**
Yes **Eff 1/1/21**
Yes **Eff 1/1/21**
Yes **Eff 1/1/21**
Yes **Eff 1/1/21**

Kern Health Systems
Board Approved Effective 12/01/20

NAME	LEGAL NAME/ADDRESS	SPECIALTY	PROVIDER PRV #	VENDOR PRV #	CONTRACT STATUS	PAC APPROVED - EFFECTIVE DATE
Berry, Heather LCSW	Heather Berry Counseling Inc. 14 Sierra Drive Kernville CA 93238 Phone - 760-376-1444 Fax - 760-376-3034	Clinical Social Worker	PRV011639	PRV064932	New Contract	YesEff 12/1/20
Snyder, S. Faye PsyD	S. Faye Snyder, PsyD 6200 Lake Ming Road Ste. A-4 Bakersfield CA 93306 Phone - 661-476-9076 Fax - 661-558-4162	Psychology	PRV056422	PRV056422	New Contract	YesEff 12/1/20
Flaten, Eric CRNA	Coffee Surgery Center, LLC dba: All Kids Dental Surgery Center 2525 Eye Street Ste. 100 Bakersfield CA 93301	Nurse Anesthestist	PRV048045	PRV000369	Existing	YesEff 12/1/20
Albert, Tyler OD	Omni Family Health 4600 Panama Lane Ste. 102B Bakersfield CA 93313	Optometry	PRV063927	PRV000019	Existing	YesEff 12/1/20
Anderson, Gene MD	Carlos A. Alvarez, MD Inc. 8929 Panama Road Ste. A Lamont CA 801 Santa Fe Way Shafter CA	Family Practice	PRV009824	PRV030784 PRV055424	Existing	YesEff 12/1/20
Chitturi, Chandrika MD	Kern County Hospital Authority 1111 Columbus Street 9330 Stockdale Highway Ste. 400 1700 Mt Vernon Avenue Bakersfield CA	Nephrology	PRV064196	ALL SITES	Existing	YesEff 12/1/20
Escobedo, Gadiel NP-C	Accelerated Urgent Care *All Locations 212 Coffee Road Bakersfield CA 93309	Family Practice	PRV065133	ALL SITES	Existing	YesEff 12/1/20
Estiu Sanchez, Herbert MD	Accelerated Urgent Care *All Locations 212 Coffee Road Bakersfield CA 93309	Family Practice	PRV065132	ALL SITES	Existing	YesEff 12/1/20
Hamzeh, Rabih MD	Ridgecrest Regional Hospital 1111 N China Lake Blvd Ste. 190 1081 N China Lake Blvd Ridgecrest CA 93555	Pediatrics	PRV063650	PRV029495 PRV000279	Existing	YesEff 12/1/20
Howell, Douglas PA-C	Accelerated Urgent Care *All Locations 212 Coffee Road Bakersfield CA 93309	Family Practice	PRV052063	ALL SITES	Existing	YesEff 12/1/20
Lagunda, Mia MD	Clinica Sierra Vista (CSV) 815 Dr. Martin Luther King Jr. Blvd Bakersfield CA 93307	Pediatrics	PRV000434	PRV0000002	Existing	YesEff 12/1/20
Lahip, Johah NP-C	Atul Aggarwal MD Cardiology Clinic 1018 Calloway Drive Bakersfield CA 93312	Cardiovascular Disease	PRV063650	PRV000343	Existing	YesEff 12/1/20
McCluskey, Kristin NP-C	Accelerated Urgent Care *All Locations 212 Coffee Road Bakersfield CA 93309	Family Practice	PRV065142	ALL SITES	Existing	YesEff 12/1/20
Merla, Venkat MD	Clinica Sierra Vista (CSV) 1611 1st Street Bakersfield CA 93304	Internal Medicine	PRV064657	PRV0000002	Existing	YesEff 12/1/20
Ojo, Aderonke DPM	Omni Family Health 912 Fremont Street Delano CA 210 N Chester Avenue Bakersfield CA 4600 Panama Lane Ste. 102B Bakersfield CA 4131 Ming Avenue Bakersfield CA	Podiatry	PRV064656	PRV000019	Existing	YesEff 12/1/20
Pabbathi, Sabitha MD	Clinica Sierra Vista (CSV) 1611 1st Street Bakersfield CA 93304	Internal Medicine	PRV065130	PRV0000002	Existing	YesEff 12/1/20
Perez, Laura BCBA	Nicanor Steven Garcia dba: California Spectrum Services 4865 Truxtun Avenue Bakersfield CA 93309	Qualified Autism Provider /	PRV065144	PRV031975	Existing	YesEff 12/1/20
Ramos, Elena PA-C	Accelerated Urgent Care *All Locations 212 Coffee Road Bakersfield CA 93309	Family Practice	PRV065019	ALL SITES	Existing	YesEff 12/1/20
Rivera, Daniel BCBA	Nicanor Steven Garcia dba: California Spectrum Services 4865 Truxtun Avenue Bakersfield CA 93309	Qualified Autism Provider /	PRV065145	PRV031975	Existing	YesEff 12/1/20
Ruben, Elizabeth NP-C	Clinica Sierra Vista (CSV) 815 Dr. Martin Luther King Jr. Blvd Bakersfield CA 93307	Family Practice	PRV064195	PRV0000002	Existing	YesEff 12/1/20

Setarehshenas, Roya MD	~~Bakersfield Pathology Medical Group~~ Yosemite Pathology Medical Group, Inc. *All Locations - Same NPI 1598760985 3000 Sillect Avenue Bakersfield CA 93308 P-661-366-0622 / F-661-322-0239	Anatomic & Clinical Patholo	PRV040993	PRV013993	Existing	**YesEff 12/1/20**
Shah, Aashini MD	Hospitalist Medicine Physicians of Calif Inc 2615 Chester Avenue Bakersfield CA 93301	Family Practice / Hospitalist	PRV064131	PRV014433	Existing	**Yes** **Eff 12/1/20**
Trapse, Felix MD	Omni Family Health 860 Sequoia Avenue Lindsay CA 93247	Family Practice	PRV035028	PRV000019	Existing	**Yes** **Eff 12/1/20**
United Care Facilities - Macau	United Care Facilities, LLC dba: United Care Macau 2207 Macau Street Bakersfield CA 93313	SNF/CLF	PRV029480	PRV029480	Existing	**Yes** **Eff 12/1/20**
Williams, Lorilea NP-C	Accelerated Urgent Care *All Locations 212 Coffee Road Bakersfield CA 93309	Family Practice	PRV065148	ALL SITES	Existing	**Yes** **Eff 12/1/20**
Wills, Christopher PA-C	Accelerated Urgent Care *All Locations 212 Coffee Road Bakersfield CA 93309	Family Practice	PRV065131	ALL SITES	Existing	**Yes** **Eff 12/1/20**

KERN HEALTH SYSTEMS

Provider Network Management
Network Review
Quarter 4, 2020

- **After-hours Calls**
- **Appointment Availability Survey**
- **Access Grievance Review (Q3, 2020)**
- **Geographic Accessibility & Network Certification**
- **Network Adequacy & Provider Counts**

KERN HEALTH SYSTEMS

After-hours Calls

Quarter 4, 2020

AFTER-HOURS CALLS

Q4, 2020

KERN HEALTH SYSTEMS

Introduction

As required by the Department of Managed Health Care (DMHC) Health & Safety Code 1348.8, Kern Health Systems (KHS) uses an after-hours caller program to assess compliance with access standards for Kern Family Health Care (KFHC) Members. KHS policy requires that:

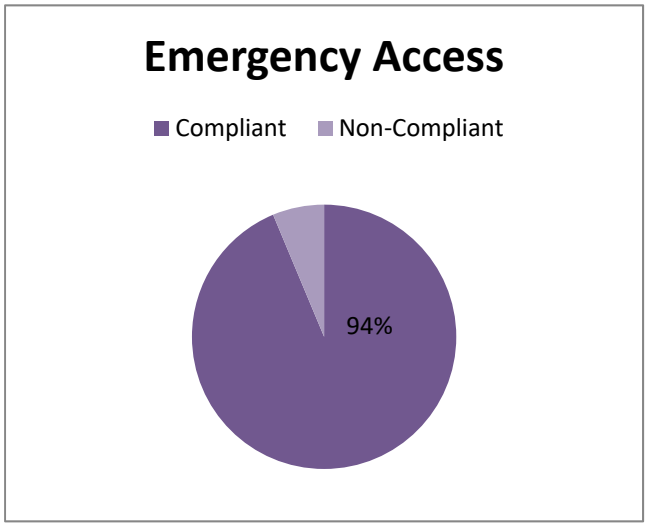
1.) Provider's answering machine or answering service must instruct the member to call 911 if the purpose of the call is a medical emergency.

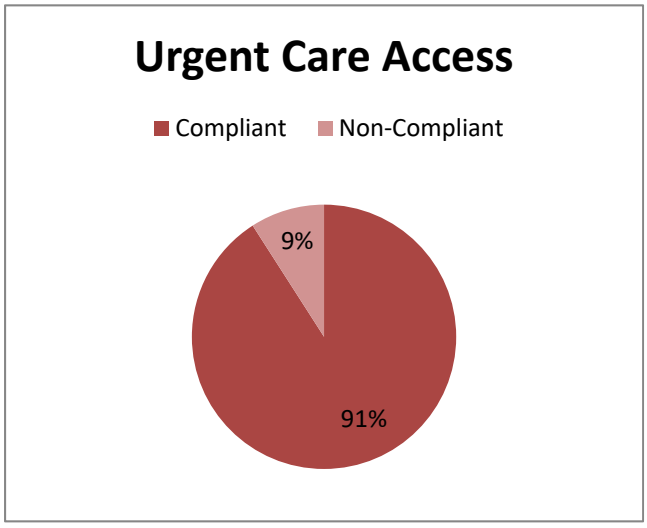
2.) For urgent matters, Provider's answering machine must provide an on-call number. If an answering service is used, the member must receive a call back from an on-call member of your office within 30 minutes of call.

An initial survey is conducted by Health Dialog and then forwarded to the Plan's Provider Network Analysts who make additional calls based on the results received from the survey vendor. Results are to be reported to the KHS QI/UM Committees and to Executive Staff.

Results

143 provider offices were contacted during Q3 2020. Of those offices, 134 were compliant with the Emergency Access Standards and 130 were compliant with the Urgent Care Access Standards.





AFTER-HOURS CALLS

Q4, 2020

Trending / Follow –Up / Outreach

The Plan utilizes the after-hours survey calls to monitor compliance at a network-wide level. The Plan found minimal change in compliance with the emergency and urgent care after-hours access standard when compared to prior quarters, with all percentages remaining at or above 90%.

Compliance with after-hours standard	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020
Emergency Access	98%	98%	96%	96%	97%	94%
Urgent Care Access	93%	95%	93%	92%	90%	91%

While the Plan typically conducts outreach to provider offices to notify them of instances of non-compliance, the Plan did not conduct outreach based on the results of this quarter's survey to limit administrative burden on contracted providers during Kern County's COVID-19 surge.

KERN HEALTH SYSTEMS

Appointment Availability Survey

Quarter 4, 2020

Provider Network Management

Appointment Availability Survey

Q4, 2020

Introduction

As required by the Department of Health Care Services (DHCS) and Title 28 CCR Section 1300.67.2.2, Kern Health Systems (KHS) uses an appointment availability survey to assess compliance with access standards for Kern Family Health Care (KFHC) Members.

KHS policy and Department regulation require that members must be offered appointments within the following timeframes:

1) Non-urgent primary care appointments – **within ten (10) business days of request**.
2) Appointment with a specialist – **within fifteen (15) business days of request.**
3) First prenatal OB/GYN visit – **within the lesser of (10) business days or 2 weeks of request.**

When it is necessary for a provider or enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice and consistent with the objectives of this policy. The standard and monitoring process for the availability of a rescheduled appointment shall be equal to the availability of the initial appointment, such that the measure of compliance shall be shared.

The survey was conducted internally by KHS staff; compliance is determined using the methodology utilized by the DHCS during the 2017 Medical Audit in which they conducted a similar appointment availability survey. Results are to be reported to the KHS QI/UM Committee.

KHS also utilizes these quarterly calls to monitor contracted provider's **Phone Answering Timeliness.** KHS *Policy 4.30-P Accessibility Standards,* requires "contracted providers must answer or design phone systems that answer phone calls within six rings." In conducting the quarterly appointment availability survey, KHS staff count the rings prior to a provider answering to gauge compliance.

Appointment Availability Survey Results

A random sample of 15 primary care provider offices, 15 specialist offices, and 5 OBGYN offices were contacted during Q4 2020.

Of the primary care providers surveyed, the plan compiled the wait time (in days) to determine the Plan's average wait time for a primary care appointment; for Q4 2020, the Plan's average wait time for a primary care appointment was **5.2 days**, and was found to be in-compliance with the 10 business day standard. Of the specialist providers surveyed, the plan compiled the wait time (in days) to determine the Plan's average wait time for a specialist appointment; for Q4 2020, the Plan's average wait time for a specialist appointment was **5.7 days**, and was found to be in-compliance with the 15 business day standard. Of OB/GYN providers surveyed for a first pre-natal visit, the plan compiled the wait time (in days) to determine the Plan's average wait time for a first prenatal visit with an OB/GYN; for Q4 2020 the Plan's average wait time for a first prenatal visit with an OB/GYN was **8.9 days**, and was found to be in-compliance with the 10 day/2 week standard.

Appointment Availability Survey

Q4, 2020

The Plan utilizes the quarterly appointment availability survey to monitor compliance at a network-wide level. The Plan reviewed the results of the Q4 2020 appointment availability survey, and the Plan recognized a decrease in the average wait time amongst primary care and specialist appointments when compared to the prior quarter. The Plan's average wait time remains in compliance with regulatory standard.

Average wait time for appointment (in days)	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020
Primary Care	3.7	3.1	4.4	9.8	9	5.2
Specialist	5.7	5.3	3.1	5.4	8.5	5.7
OB/GYN	N/A	5.4	7	8.8	8	8.9

While the Plan typically conducts outreach to provider offices to notify them of instances of non-compliance, the Plan did not conduct outreach based on the results of this quarter's survey to limit administrative burden on contracted providers during Kern County's COVID-19 surge.

Phone Answering Timeliness Results

Utilizing the methodology outlined above, KHS conducts a phone answering timeliness survey in conjunction with the appointment availability survey. During Q4 2020 calls were answered within an average of **2.2 rings**.

	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020
Average rings before call was answered	2	1.4	1.8	3.8	3.2	2.2

KERN HEALTH SYSTEMS

Access Grievance Review

Quarter 3, 2020

Provider Network Management

Access Grievance Review

Q3, 2020

Q3 2020 – Changes to Categorization

During 2020, the Plan made changes to the categories/subcategories (or "dispositions") in which grievances are labeled. The prior access categories in which the Provider Network Management Department reviewed, "Access to Care" and "Difficulty Accessing a Specialist", are no longer in use. Moving forward, the Plan will review and track access grievances utilizing these newly implemented categories.

KHS Policy and Procedure

The time standards for access to a primary care appointment, specialist appointment, and in-office wait time are outlined in KHS policy 4.30-P *Accessibility Standards.*

Grievance Totals

During Q3 2020 forty-eight (48) access-related grievances were received and reviewed by the KHS Grievance Committee. In twenty-five (25) of the cases, no issues were identified and were closed in favor of the plan. The remaining **twenty-three (23)**, were closed in favor of the enrollee; the KHS Grievance Department sent letters to the providers involved in these cases, notifying them of the outcome.

The twenty-three (23) grievances that were closed in favor of the enrollee were forwarded to the Plan's Provider Network Management Department and were reviewed by the Provider Network Analyst Team. The received access grievances were categorized by the KHS Grievance Department as follows:

Timely Access	**11**
No Subcategorization Provided	6
Access – Wait Time	4
Access – PCP Appointment Availability	1
Technology / Telephone	**7**
No Subcategorization Provided	7
Provider Availability	**5**
Access – PCP Appointment Availability	4
Access – Specialist Appointment Availability	1

Access Grievance Review

Q3, 2020

Tracking and Trending

The Plan utilizes the quarterly access grievance review to monitor Plan access at a network-wide level. Upon review of Q3 2020 access grievances, the Plan identified an increase in grievances when compared to Q2 2020, though in line with grievances counts from Q1 2020 and Q4 2019. The Plan did not identify this increase as an issue or trend due to the count being in line with prior quarters. The Plan will continue to monitor access grievances against the Plan, as well as potential trends, via the quarterly access grievance review.

KERN HEALTH SYSTEMS

Geographic Accessibility & Network Certification

Quarter 4, 2020

Provider Network Management

Geographic Accessibility & Network Certification

Q4, 2020

Background

As required by the Department of Managed Health Care (DMHC) and the Department of Health Care Services (DHCS), Kern Health Systems (KHS) is required to maintain time and distance standards for certain provider types.

Per Section 1300.51 (d)(H) of the California Code of Regulations, KHS shall ensure, "all enrollees have a residence or workplace within **thirty (30) minutes or fifteen (15) miles** of a contracting or plan-operated **primary care provider**" as well as "**within thirty (30) minutes or fifteen (15) miles** of a contracting or plan-operated **hospital**". Further, per Section 1300.67.2.1(b), if "a plan's standards of accessibility […] are unreasonable restrictive […] the plan may propose alternative access standards of accessibility for that portion of its service area.

Per Exhibit A, Attachment 6 of the KHS contract with the DHCS, KHS, "shall maintain a network of **Primary Care Physicians** which are located **within thirty (30) minutes or ten (10) miles** of a member's residence unless [KHS] has a DHCS-approved alternative time and distance standard.

For all geographic areas in which the Plan does not currently meet the regulatory accessibility standard, The Plan monitors and maintains an alternative access standard that has been reviewed and approved by the DMHC or DHCS.

DHCS Annual Network Certification – 2020

DHCS Network Adequacy Standards	
Primary Care (Adult and Pediatric)	10 miles or 30 minutes
Specialty Care (Adult and Pediatric)	45 miles or 75 minutes
OB/GYN Primary Care	10 miles or 30 minutes
OB/GYN Specialty Care	45 miles or 75 minutes
Hospitals	15 miles or 30 minutes
Pharmacy	10 miles or 30 minutes
Mental Health	45 miles or 75 minutes

As a part of the Annual Network Certification requirement, outlined in APL 20-003, the Plan was required to submit geographic access analysis outlining compliance with the above-listed standards. For all zip codes in which the Plan was not compliant with the above standard, the Plan was able to submit alternative access standards to ensure compliance.

The Plan completed required reporting during Q1/Q2 2020. During Q3 2020 a portion of the originally submitted alternative access standard requests were sent back to the Plan to resubmit with additional justification. As of Q4 2020, review of the Plan's compliance with DHCS Network Certification reporting requirements and requested alternative access standards was still ongoing with the DHCS. As part of it's ongoing monitoring the Plan reviews additions/deletions in the provider network against the recently completed geographic accessibility analysis and as of the end of Q4 2020 has not identified any significant changes.

KERN HEALTH SYSTEMS

Network Adequacy & Provider Counts

Quarter 4, 2020

Provider Network Management

Network Adequacy & Provider Counts

Q4, 2020

Introduction

Per CCR § 1300.67.2, Kern Health Systems (KHS) shall maintain, "at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and […] approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees."

During Q3/Q4 2018, KHS, in conjunction with guidance from the Department of Managed Health Care (DMHC), developed and adopted an updated methodology for determining full-time equivalency for contracted providers. KHS memorialized this methodology in Policy 4.30-P *Accessibility Standards;* this policy was submitted to the DMHC and received approval on 12/14/2018.

Per KHS policy, 4.30-P *Accessibility Standards, §4.5 Full-time equivalent (FTE) Provider to Member Ratios,* "Full-time equivalency shall be determined via an annual survey of KHS' contracted providers to determine the percentage of time allocated to Plan's beneficiaries. The results of the survey will be used to calculate an average FTE percentage which will be applied to the Plan's network of providers when calculating the physician-to-enrollee compliance ratios. The methodology for the survey, results of the survey, and network capacity review of above ratios, will be reported annually to the KHS QI/UM Committee. Due to a maximum member assignment of 1,000 Mid-level providers serving in the Primary Care capacity will be counted as .5 of a PCP FTE, prior to percentage calculation."

Survey Methodology and Results

In 2019, KHS contracted with SPH Analytics to conduct our annual Provider Satisfaction Survey; as a part of that survey, responding providers were asked, "*What portion of your managed care volume is represented by Kern Health Systems?"* Outreach for the survey was placed to every contracted provider within the Plan's network. Responses received, and FTE calculations based on those responses, do not account for providers who refuse to participate in the survey. KHS used the responses collected from Primary Care Providers to calculate the FTE for Primary Care Providers, and used the responses collected from Primary Care Providers and Specialists to calculate the FTE for Physicians.

KHS utilized SPH Analytics, an NCQA certified survey vendor, to conduct the survey for 2019. SPH's methodology involved two waves of mail and Internet, with a third wave of phone follow up to administer the survey; for 2019, the provider survey was conducted from March to May.

Based on the results of 2019 survey, KHS calculated a network-wide FTE percentage of **49.06% for Primary Care Providers** and **43.19% for Physicians.**

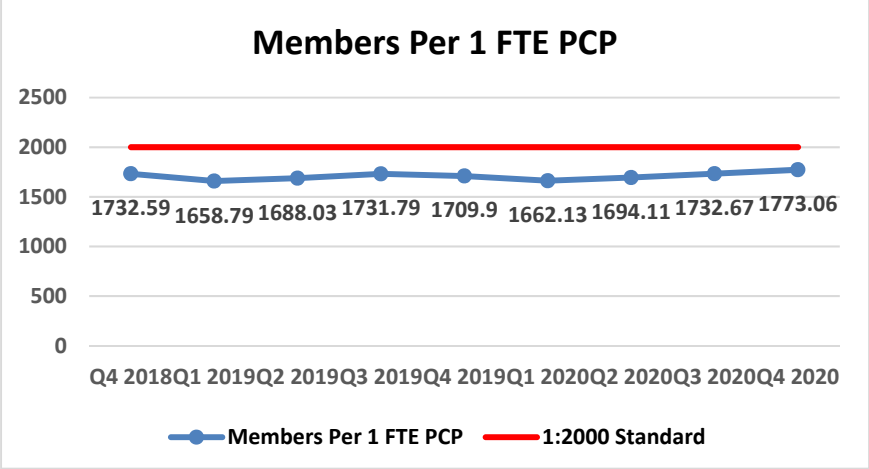
Network Adequacy & Provider Counts

Q4, 2020

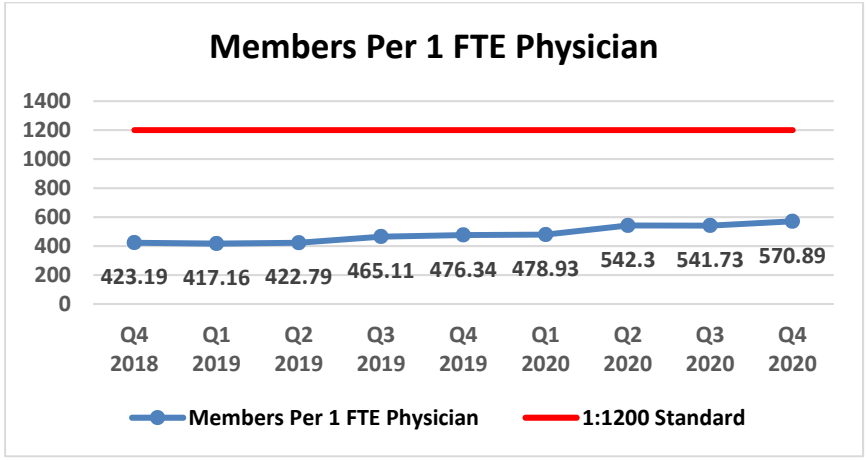
Full Time Equivalency Compliance Calculations

Of KHS' 287,534 membership at the close of Q4 2020, 10,912 were assigned and managed by Kaiser and did not access services through KHS' network of contracted providers; due to this, Kaiser managed membership is not considered when calculating FTE compliance.

As of the end of Q4 2020, the plan was contracted with 408 Primary Care Providers, a combination of 228 physicians and 180 mid-levels. Based on the FTE calculation process outlined above, with a 49.06% PCP FTE percentage, KHS maintains a total of **156.01 FTE PCPs**. With a membership enrollment of 276,622 utilizing KHS contracted PCPs, KHS currently maintains a ratio of **1 FTE PCP to every 1773.06 members**; KHS is compliant with state regulations and Plan policy.



As of the end of Q4 2020, the plan was contracted with 1122 Physicians. Based on the FTE calculation process outlined above, with a 43.19% Physician FTE percentage, KHS maintains a total of **484.55 FTE Physicians**. With a total membership enrollment of 276,622 utilizing KHS contracted Physicians, KHS currently maintains a ratio of **1 FTE Physician to every 570.89 members**; KHS is compliant with state regulations and Plan policy.

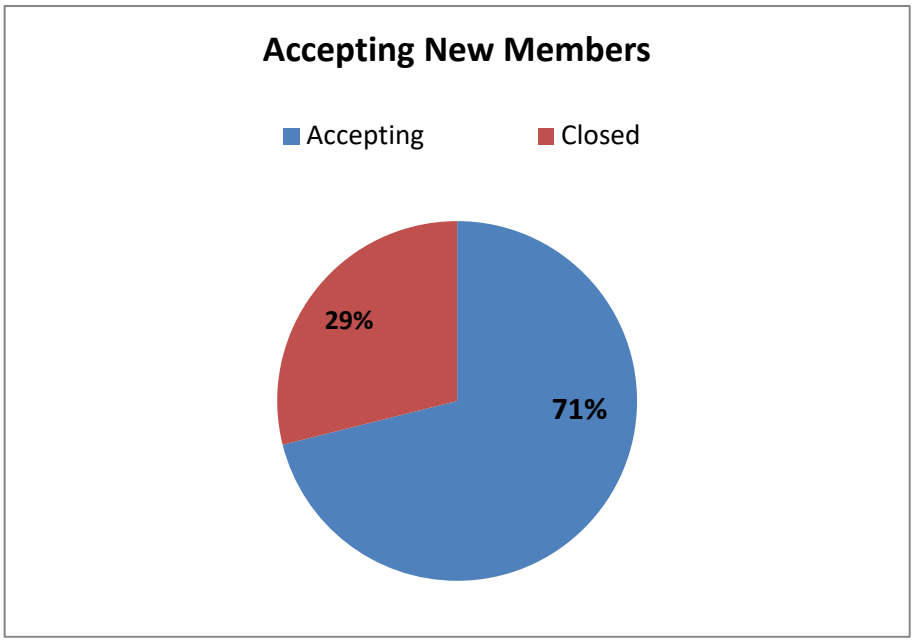


Network Adequacy & Provider Counts

Q4, 2020

Accepting New Members

In addition to the Full Time Equivalency Compliance review conducted above, the Plan monitors adequacy of its Primary Care Network by reviewing the count/percentage of Primary Care Providers (PCP) who are accepting new members. **The Plan calculated that 71% of the network of Primary Care Providers is currently accepting new members at a minimum of one location**. The Plan will continue to monitor this percentage quarterly to ensure it maintains an adequate network of Primary Care Providers.

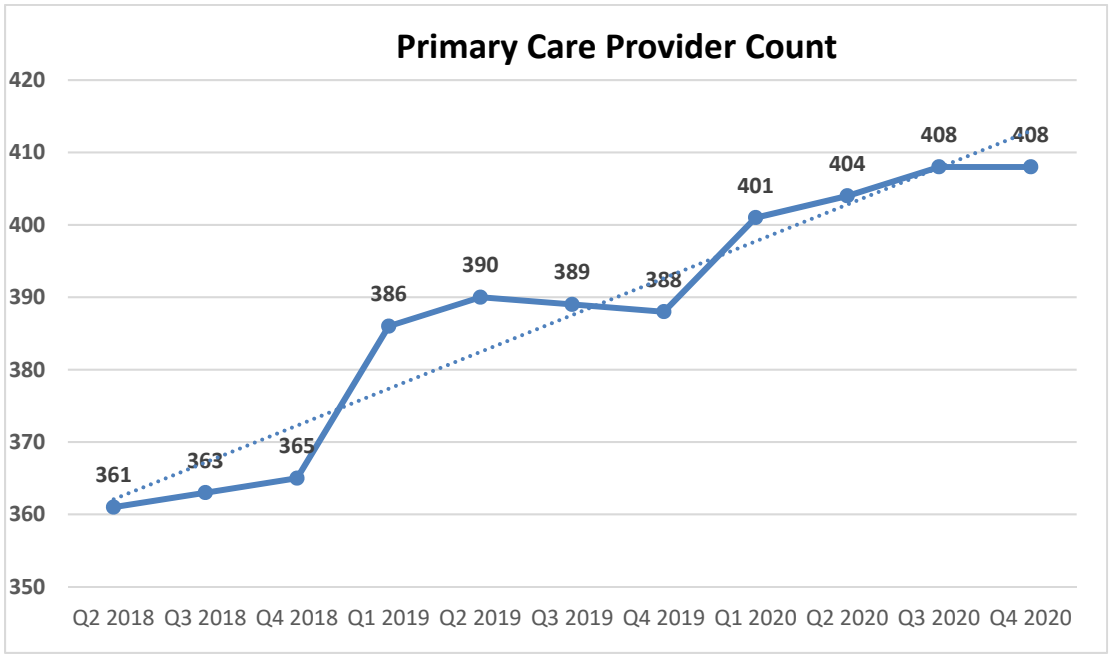


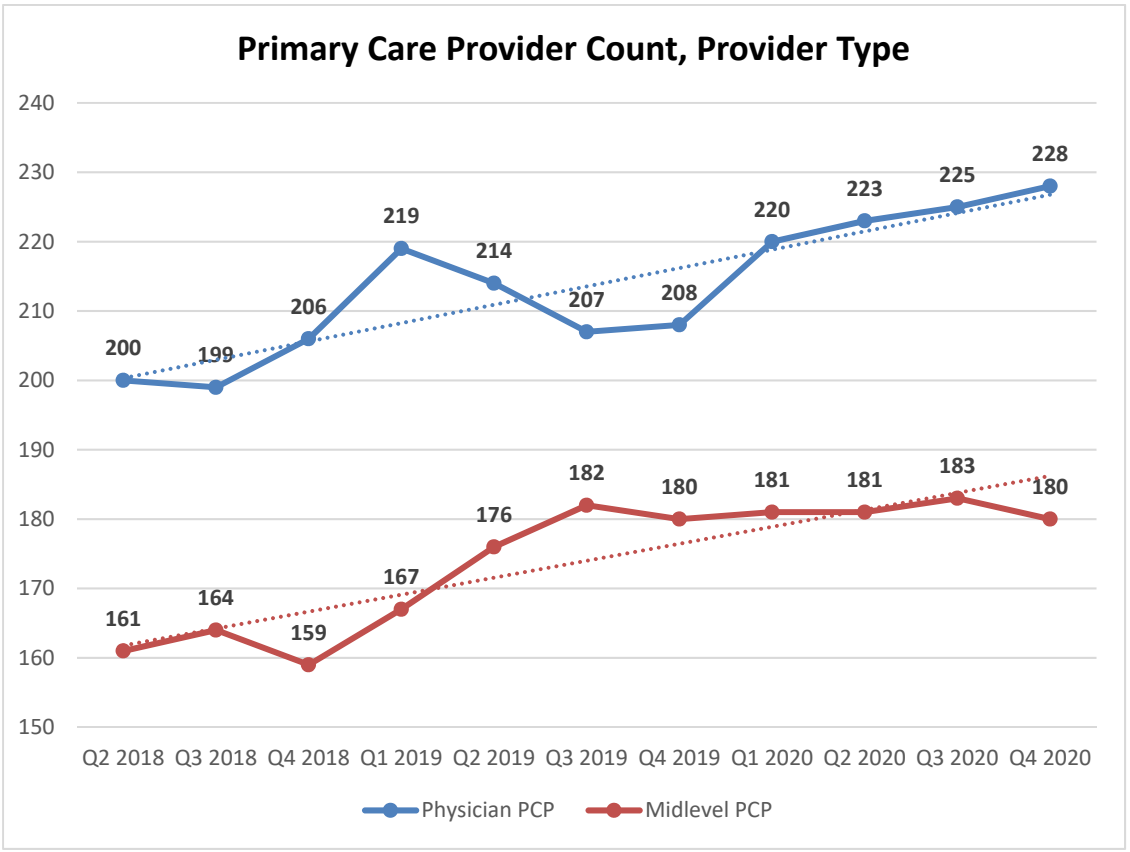
Network Adequacy & Provider Counts

Q4, 2020

KERN HEALTH SYSTEMS

Provider Counts – Primary Care Providers



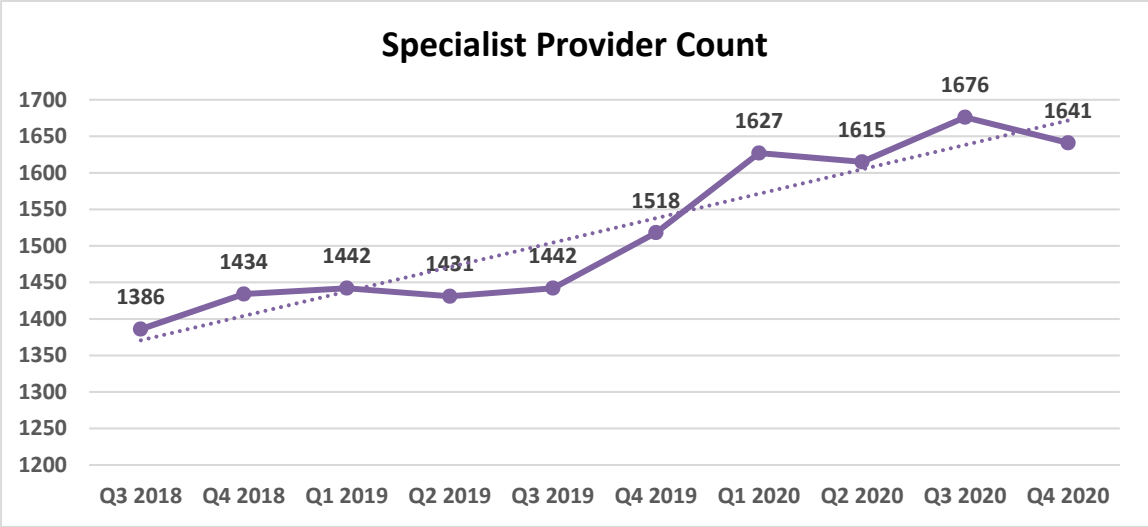


Network Adequacy & Provider Counts

Q4, 2020

KERN HEALTH SYSTEMS

Provider Counts – Specialist Providers



Selected Specialties, Provider Count									
	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020
Cardiology	39	39	39	39	40	40	38	42	44
Dermatology	31	31	31	31	35	33	36	35	36
Endocrinology	17	16	17	19	20	20	19	20	24
Gastroenterology	16	16	16	18	20	20	22	22	22
Hematology	18	18	18	18	18	17	18	18	20
Infectious Disease	11	10	10	12	10	9	10	10	10
Nephrology	23	23	24	22	22	22	21	22	23
Neurology	24	23	22	23	25	25	26	25	25
Oncology	20	21	22	23	23	22	24	24	26
Ophthalmology	28	29	29	30	32	33	32	30	29
Orthopedic Surgery	17	18	20	19	20	21	20	21	20
Pain Medicine	26	25	30	36	38	37	36	36	36
Physical Medicine & Rehab	21	21	23	23	27	27	24	24	24
Plastic Surgery	15	15	14	14	14	15	15	14	14
Podiatry	24	20	20	21	22	22	22	23	23
Psychiatry	45	46	46	48	54	54	53	54	47
Pulmonary Disease	22	22	21	21	21	20	20	20	19
Rheumatology	14	13	16	16	17	10	11	11	12
Urology	9	8	10	12	13	13	15	17	18

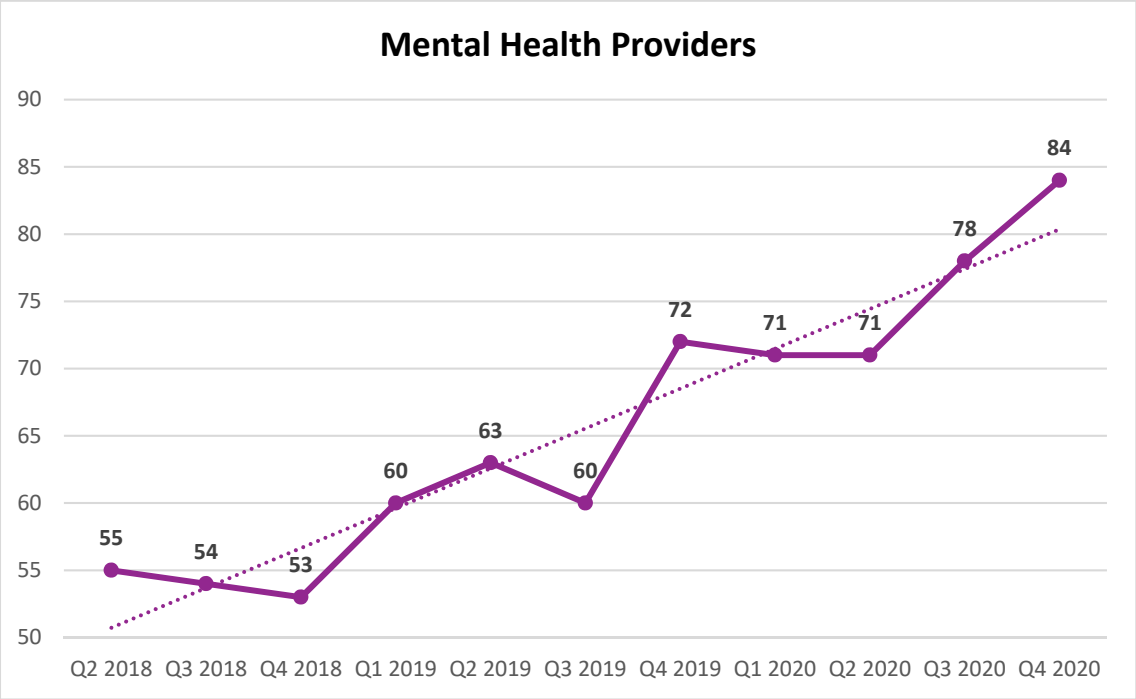
	> 5% Increase		> 5% Decrease
	≤ 5% Increase		≤ 5% Decrease

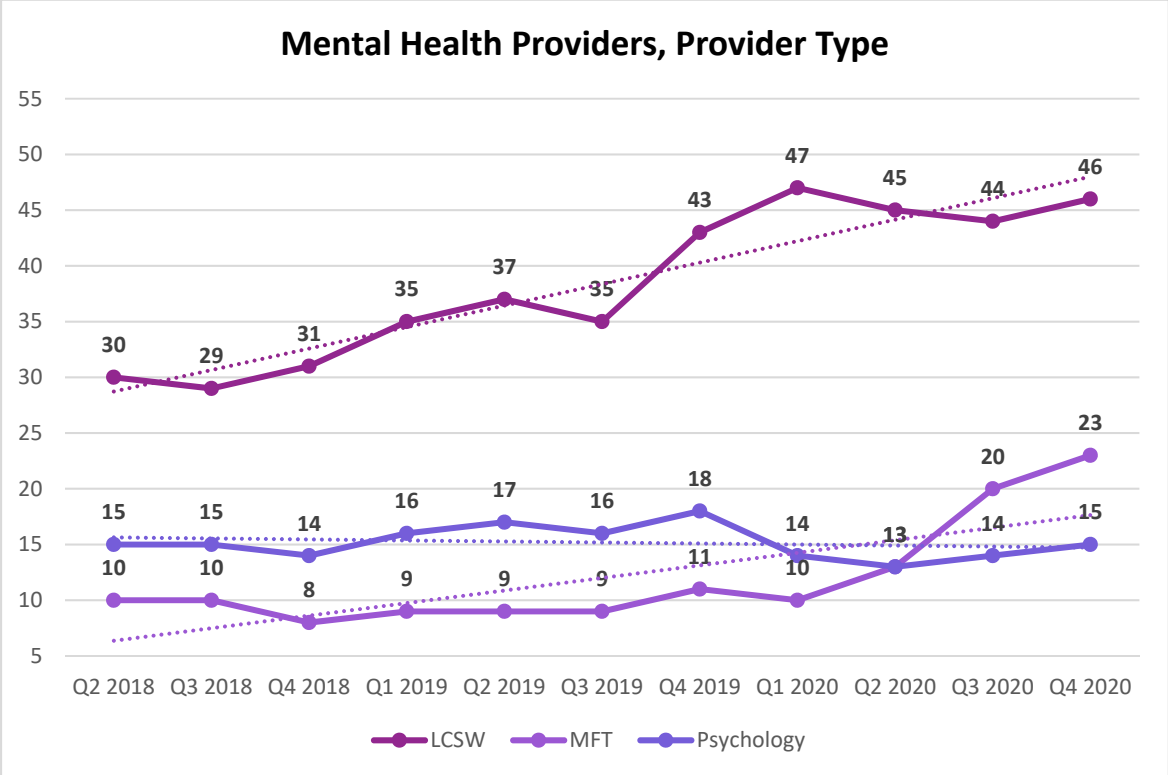
Network Adequacy & Provider Counts

Q4, 2020

KERN HEALTH SYSTEMS

Provider Counts – Mental Health (Psychology, LMFT, LCSW)





Network Adequacy & Provider Counts

Q4, 2020

KERN HEALTH SYSTEMS

Provider Counts – Facilities

	2017	2018	2019	Current
Hospital	18	18	18	18
Surgery Center	19	16	17	19
Urgent Care	13	17	17	17

Provider Counts – Other Provider Types

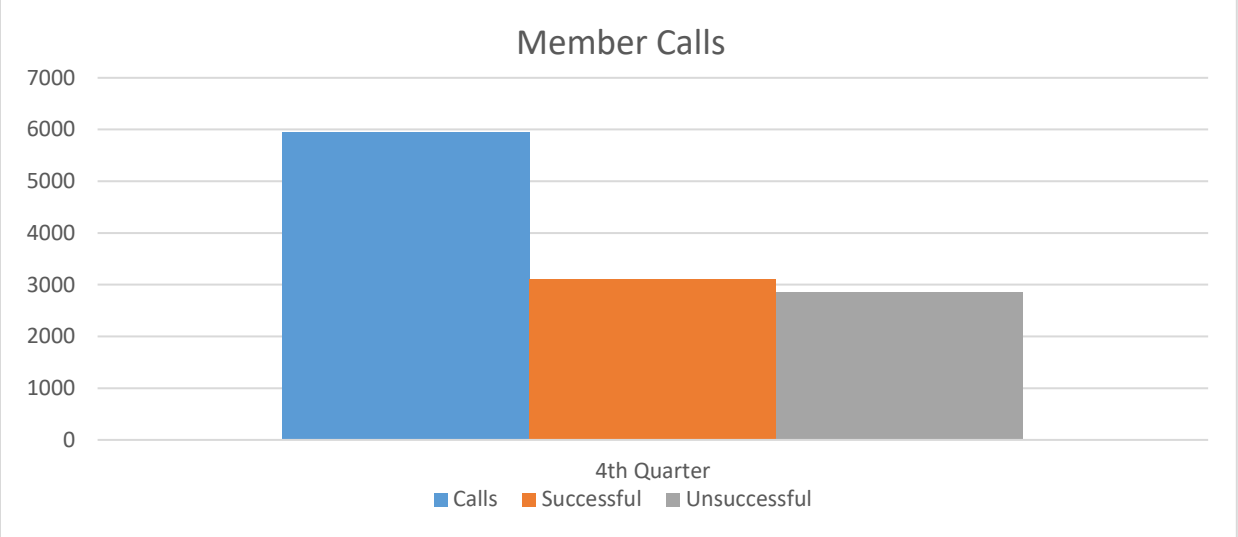
	2017	2018	2019	Current
Ambulance/Transport	15	15	13	17
Dialysis	13	14	16	18
Home Health	13	12	13	13
Hospice	6	7	11	13
Pharmacy	133	136	139	147
Physical Therapy	29	29	29	30

Disease Management Quarterly Report

4th Quarter, 2020

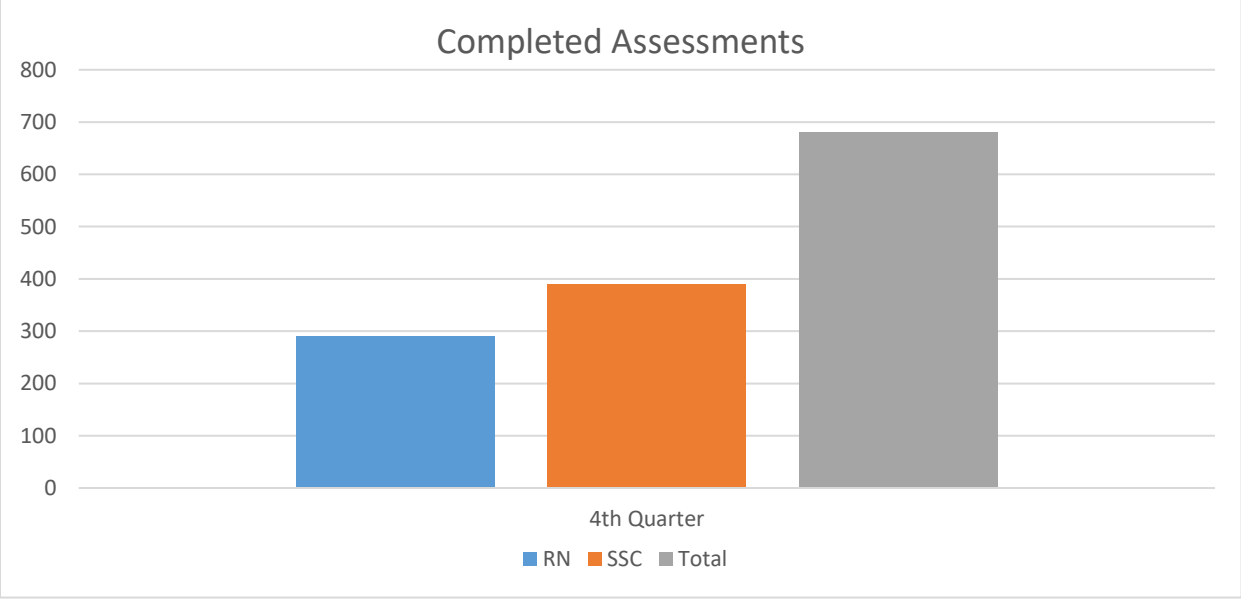
Telephone Calls: A total of 5,955 calls were made by the DM staff during the 4th Quarter, 2020.

Member Calls Attempted	Successful Calls	Unsuccessful Calls	Total Member Calls	% Contacted
RN	1,395	1,326	2,721	51%
SSC	1,703	1,531	3,234	53%
Total	**3.098**	**2,857**	**5,955**	**52%**



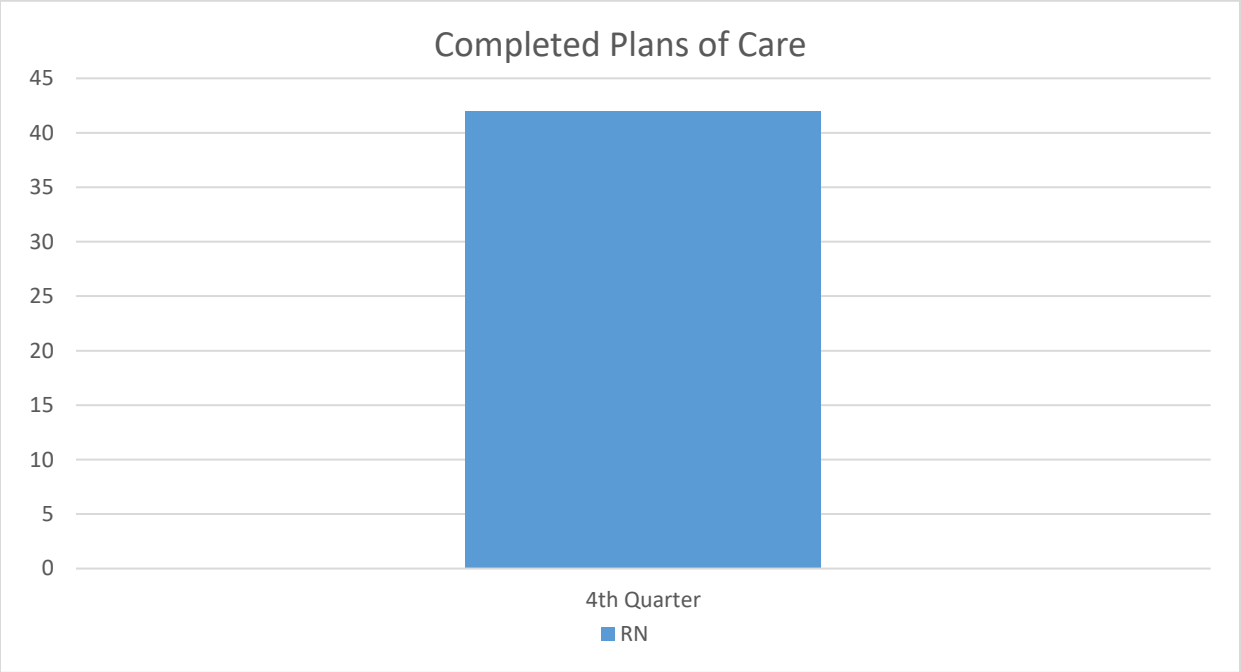
New Assessments Completed.

RN	SSC	Total
290	390	680



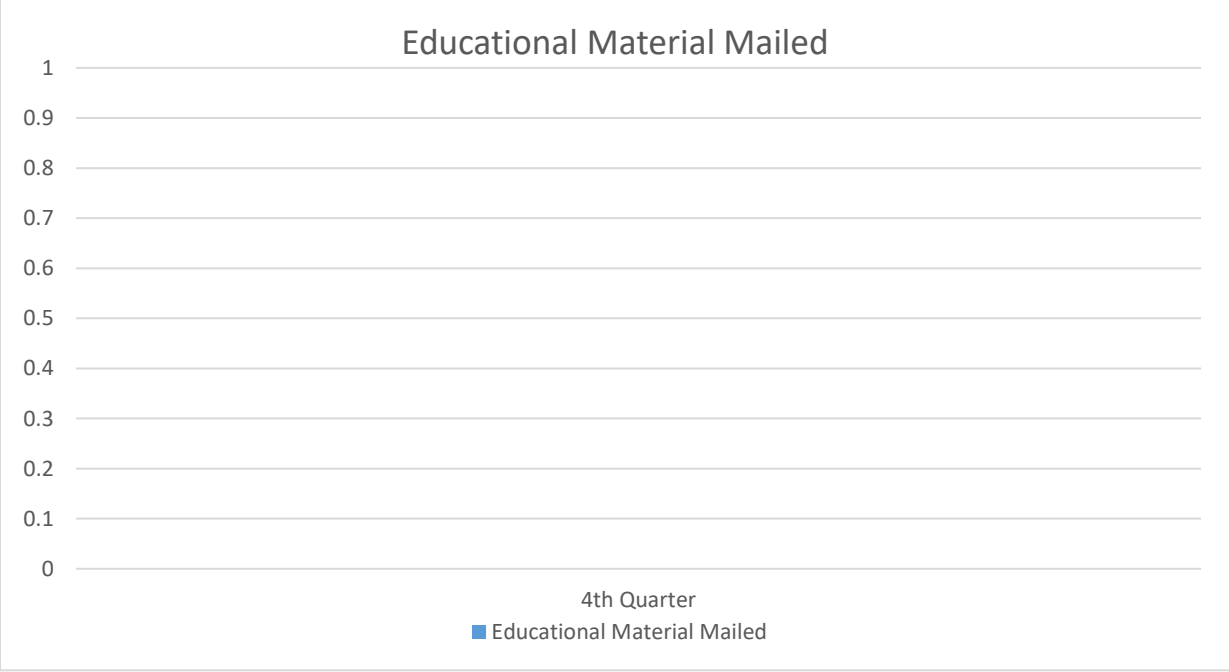
Plans of Care Completed & Closed.

RN
42



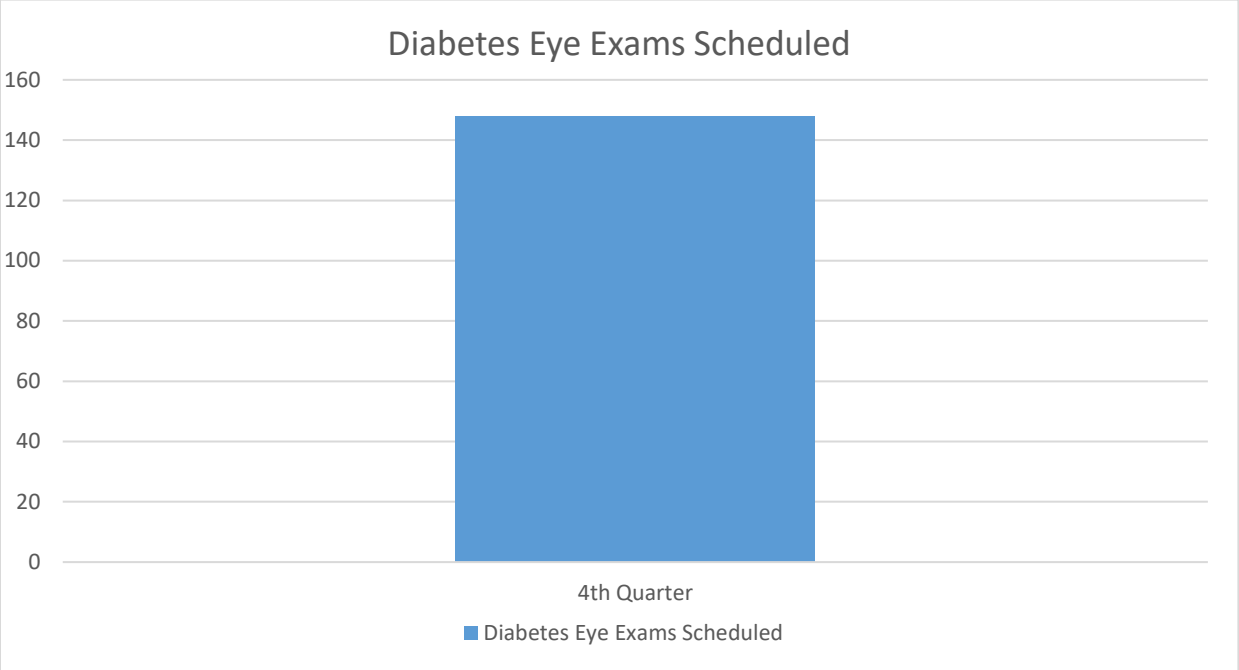
Educational Material Mailed. No educational material being mailed at this time

0



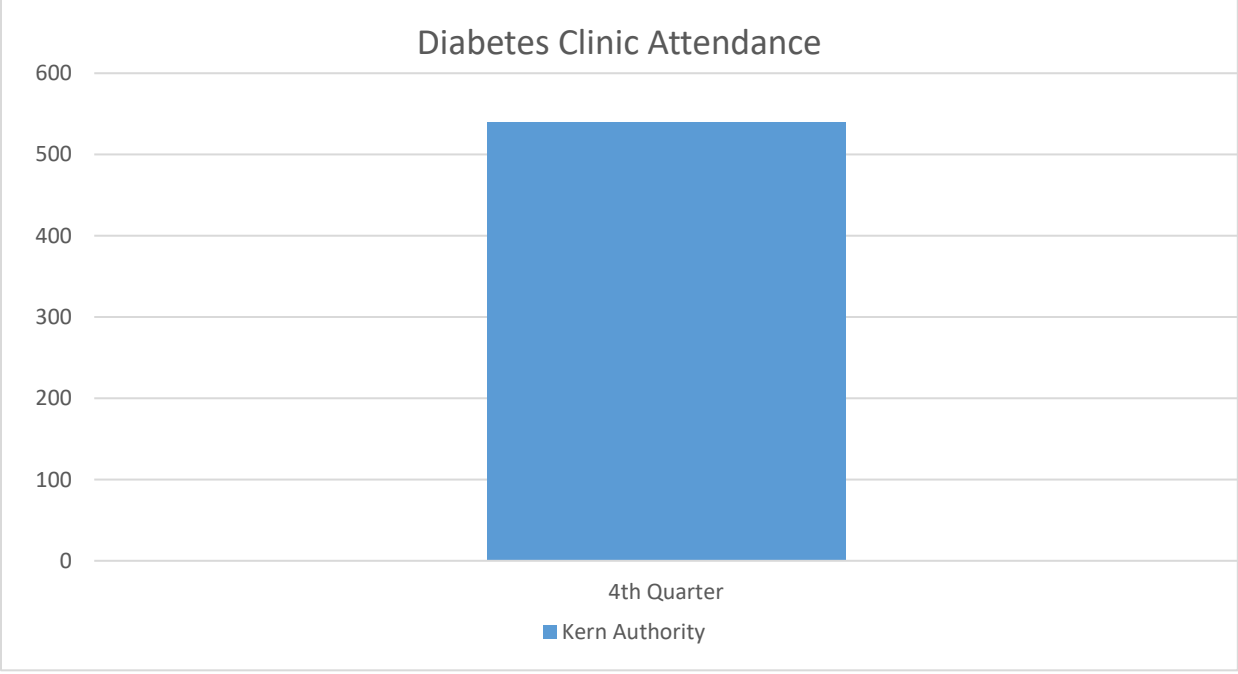
Diabetes Eye Exams Scheduled.

148



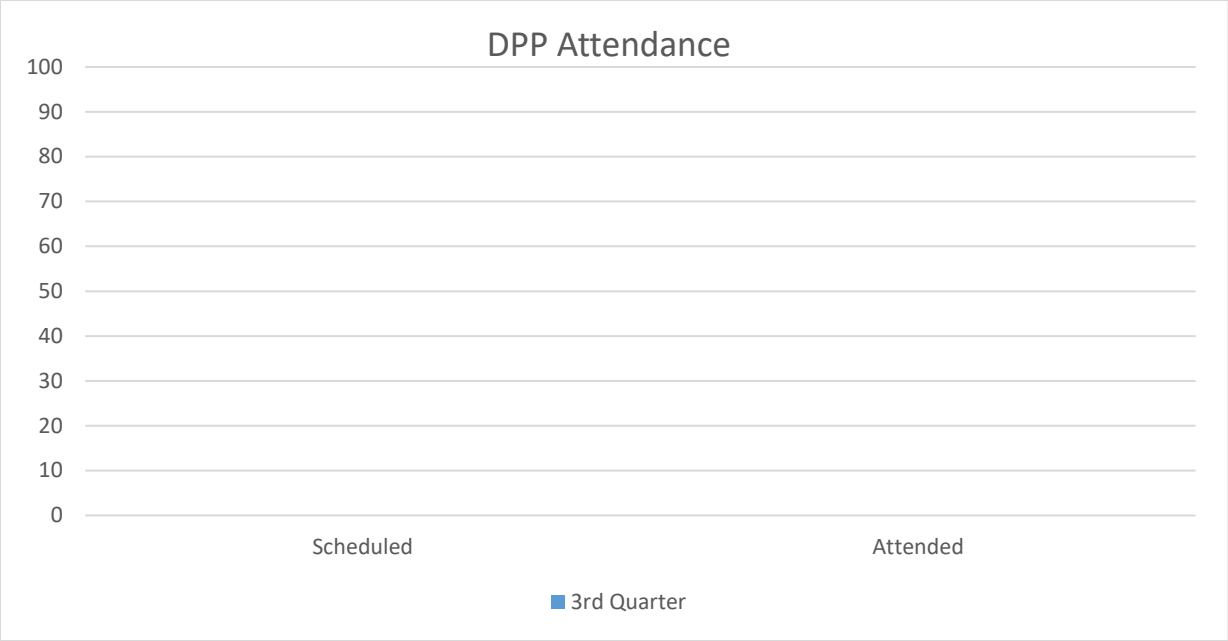
Diabetes Clinic Attendance.

Kern Authority
540



Diabetes Prevention Program: The first DPP program was completed at the end of February, 2020. Of the 48 members who attended the first session on March, 4th, 2019, 22 members completed the 26 sessions. The 2nd cohort has been delayed as a result of COVID19.

Sessions Scheduled to Attend (Jan & Feb)	Actual Sessions Attended (Jan & Feb)
0	0



KERN HEALTH SYSTEMS

Policy and Procedure Review/ Revision

Policy 2.22-P Facility Site Review has been updated and is provided here for your review and approval.

Reviewer	Date	Comment/Signature
Doug Hayward	12/1/20	
Dr. Tasinga	11/20/2020	M Tasinga
Alan Avery	11/13/2020	**Approved without revisions-Alan Avery**
Deb Murr	11/12/2020	Deborah Murr RN
Emily Duran	11/11/2020	Emily Duran
Jane Daughenbaugh	11/10/20	Jane Daughenbaugh

(CEO decision(s))

Board approval required: Yes ___ No ✓ QI/UM Committee approval: Yes ___ No ___
Date approved by the KHS BOD: _____ Date of approved by QI: _____
PAC approval: Yes ___ No ___ Date of approval by PAC: _____
Approval for internal implementation: Yes ___ No ___
Provider distribution date: Immediately _____ Quarterly _____

Effective date: _____
DHCS submission: _____
DMHC submission: _____
Provider distribution: _____

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Facility Site Review				POLICY #: 2.22-P	
DEPARTMENT: Quality Improvement					
Effective Date: 08/1997	Review/Revised Date: 12/01/2020	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Health Services Officer

_____ Date _____
Chief Network Administration Officer

_____ Date _____
Director of Quality Improvement

POLICY:
Kern Health Systems (KHS) personnel will perform a facility site and medical record review on all contracted primary care (including OB/GYNs, IPAs, clinics, and hospital ambulatory care clinics) providers as well as providers who serve a high volume of Seniors and People with Disabilities (SPD) beneficiaries, including facility site Physical Accessibility reviews, in accordance with the Site Reviews Policy Letters, MMCD Policy Letter 02-02 and 10-016, Title 22, CCR Section 53856, and W & I Code 14182(b)(9). Personnel performing the site review are trained by a Medi-Cal Managed Care Division (MMCD) nurse on the required criteria for site compliance. All contracting plans within a county have equal responsibility for the coordination and consolidation of provider site reviews. Site review responsibilities are shared equally by all plans within the county.

KHS will also follow the guidance per Medi-Cal Managed Care Division (MMCD) Policy Letter 14-004 with updated Attachment A and B, PL 12-006 with updated Attachment C and APL 15-023 which introduced Attachment D and E.

KHS makes the results of the FSR Attachment C tool available to members via Provider Directories. The Provider Directories display the accessibility indicator per Medi-Cal Managed Care Division (MMCD) Policy Letter 11-009. The Provider Directories identify whether the provider site has access in the following categories: Parking (P), Exterior Building (EB), Interior Building (IB), Restroom (R), Exam Room (E), and Exam Table/Scale (T).

PROCEDURES:

1.0 FREQUENCY

KHS personnel perform site review on 100% of all primary care provider sites (including OB/GYNs and pediatricians) as well as providers who serve a high volume of SPD beneficiaries as part of the credentialing process. Subsequent reviews are conducted every three (3) years. As providers at a site may change over time, the timeline for provider recredentialing and subsequent site review surveys may become independent processes that are not on a synchronized schedule.

2.0 CRITERIA

Reviewing personnel use the DHCS MMCD Facility Checklist (See Attachment A) when performing the site review and Medical Record Review Survey (See Attachment B) when performing the medical record review. The Department of Health Care Services (DHCS) developed additional requirements for the facility site review for SPD providers: Physical Accessibility Review Survey. (See Attachment C) for reviewing personnel.

The Physical Accessibility Review Survey/Attachment C assesses the physical accessibility of provider sites, including specialist providers that provide to a high volume of SPDs. Physical accessibility reviews are available to any contracted provider that requests to be evaluated, regardless of whether or not they are determined to be high volume.

The results of the Physical Accessibility Review Survey/Attachment C are available on the Kern Family Health Care website listing the level of access met per provider site as either Basic Access or Limited Access and whether the site met the criteria of having Medical Equipment Access. Additional results identify whether or not the site has or does not have access in the following categories: parking, building exterior, building interior, waiting room/reception area, exam room, restroom and medical equipment (height adjustable exam table and patient accessible weight scales). The Physical Accessibility Review Survey/Attachment C does not need to be conducted by a registered nurse or physician.

3.0 Methodology for Identifying Specialists, Ancillary, and CBAS Providers who serve a High Volume of Seniors and People with Disabilities (SPDs) and undergo facility site reviews

At least annually, KHS will use internal claims data from the past 12 months to identify all specialist, Ancillary, and CBAS Providers who served a KHS SPD member, the report is created at a minimum, with the following data categories:

1. Provider name, NPI number, and tax identification number;
2. KHS internal provider ID number;
3. KHS internal vendor ID number;
4. Medi-Cal specialty description;
5. Place of service, and
6. Number of SPD related claims.

KHS will total the number of claims for each specialty types and, determine the average number of claims for all specialties, Ancillary and CBAS Providers as a whole. Specialty, Ancillary and CBAS types, whose claim numbers exceed the established average, will be considered High Volume SPD Specialties, Ancillary and CBAS Providers. The provider sites in each of these specialties will then be required to undergo a Physical Accessibility Review Survey within 90 days of being notified by KHS.

Ownership for the creation of the report based upon the agreed upon methodology resides with KHS Management Information Systems (IT) Department. The IT Department will send the report to the Director of Provider Relations who will review the output and share the report with the Administrative Director of Health Services or designee. The KHS Provider Relations Department will then notify and schedule the facility site reviews with the provider sites identified in the report. Any modification of the stratification methodology will require input and acceptance by the CMO or designee, Chief Health Services Officer or designee, Compliance Director, Provider Relations Director and Quality Improvement Director.

4.0 SCORING

Deficiencies that are identified through Facility Site Reviews resulting in a total score of below 90%, and /or have deficiencies in any of the nine (9) identified Critical Elements, pharmacy and/or infection control require a Corrective Action Plan (CAP). Medical Record Review scoring below 90% require a CAP. A CAP may be required at the discretion of the Reviewer.

5.0 CORRECTIVE ACTION PLANS

The CAP is a standardized, pre-formatted document developed to assist the PCP in meeting MMCD requirements. This CAP includes deficiencies noted during PCP Facility Site and Medical Record Reviews, specified corrective actions, their actions, their evidence of corrections, date corrections, date corrections were implemented, physician or designee responsible for corrective actions and name and title of Reviewer. In addition there is a section for KHS verification of Corrections. The CAP contains three (3) separate sections:

A. Full Scope Facility Site Review
B. Elements Site Review
C. Full Scope Medical Record Review

The CAP includes Disclosure and Release statements regarding CAP submission timeline and authorization to furnish results of the reviews and corrective actions to Health Plans participating in the collaboration, government agencies that have authority over the Health Plans and authorized county entities in the state of California. The CAP informs the PCP that participating Health Plans collaborated for Facility Site and Medical Record Reviews and agree to accept the review findings and to furnish to each other the review and corrective action plans.

The signed Facility Site and Medical Record Review Corrective Action Plan documents are placed in the PCP's file that is maintained by the Health Plan responsible for completing the audit. At a minimum these include:

A. All pages of the CAP with documented deficiencies
B. Signed Facesheet
C. Signed Attestation
D. Evidence of corrections

A CAP is required for a score less than 90%.

The Physical Accessibility Review Survey/Attachment C does not require a corrective action.

5.1 Requirements for the CAP process

The Certified Reviewer will evaluate the Facility Site and Medical Records and document deficiencies on the review tool and CAP. Upon completion of the review, the Certified Reviewer will discuss the findings and the required corrective actions with the PCP or designee as follows:

A. The PCP will submit a CAP that includes implementation dates and evidence of corrections to the health plan within ten (10) days from the date of the request for the CAP.
B. The Critical Element deficiencies must be corrected within ten (10) business days with evidence of correction submitted to the Health Plan.
C. The review findings and CAP information will be shared with collaborative Health Plans.
D. The reviewer shall explain that the PCP/designee signature acknowledges receipt of the CAP and agreement to comply with designated timeframes.

The PCP shall note correction on the CAP as follows:

A. Indicate in the "Corrective Action" required column the corrective action taken.
B. Document the date the correction was implemented; PCP may document additional steps taken in this column.
C. Initial the appropriate column on the CAP (by person responsible for corrective actions).
D. Attach evidence of corrections(s) e.g. in-service sign-in sheet and agenda, invoices forms used.

5.2 CAP follow-up activity

Facility CAPs: CAP verification may be accomplished by PCP submission of appropriate evidence of corrections (e.g. invoice for receipt of safety needles). CAP verification may require an onsite visit forty-five (45) calendar days from date of review if evidence of correction is insufficient or deficiency cannot be verified in writing.

Medical Record Review CAPs: Follow-up action is scheduled at the discretion of the reviewer and may include the following:

A. Score < 80%: On site visit to verify processes implemented.
B. Score 80-89%: Accept documented Corrective Action Plan and/or a CAP verification visit and focused record review may be requested at the reviewer's discretion.
C. Score 90-100%: Exempted Pass without CAP required, however, CAP may be requested at the reviewer's discretion.

5.3 Review and acceptance of the CAP

Following receipt of the completed CAP, the Health Plan shall evaluate and/or verify corrections to approve the CAP. CAP approval is communicated to the PCPs and to the Health Plans through the monthly data exchange of Facility Site and Medical Record Review audit activity.

If the CAP is not accepted by the Health Plan, reviewers will follow-up to assist the PCP with its completion.

6.0 CONTRACTED NETWORK PCP REVIEWS AND CAPS

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

Within ten (10) business days of the survey date providers shall submit a completed CAP with verification for all critical elements, pharmacy and/or infection control and/or other survey deficiencies requiring immediate correction to the requesting plan. Plans shall provide a survey date, findings report and a formal written request for correction of all other (i.e., non-critical, non-immediate) deficiencies to providers.

Within forty-five (45) days of the survey date, plans shall re-evaluate and verify corrections of critical elements and other survey deficiencies requiring immediate correction. Within forty-five calendar days for the date of the written CAP providers shall submit a CAP for all deficiencies (other than critical) to plan and plans shall review/revise/approve CAP and timelines.

Within sixty (60) days from the date of written CAP request providers shall complete all other corrective actions. Plans shall provide educational support and technical assistance as needed, re-evaluate/verify corrections and close the CAP.

Beyond sixty (60) calendar days of the date of written CAP request providers may request a definitive, time-specific extension period (not to exceed 90 calendar days from survey findings report and CAP notification date, unless a longer extension is approved by the Department) to complete corrections if extenuating circumstances that prevented completion of corrections can be clearly demonstrated, and if agreed to by the plan.

Plan shall re-survey any provider site in twelve (12) months that required an extension period beyond ninety (90) calendar days to complete correction prior to closing the CAP.

Enrollment of new members shall not be assigned to PCPs that score below 80%. If the corrections are appropriately made and the CAP is closed, the PCP shall remain in the network and new member assignments shall resume.

7.0 PRE-CONTRACTUAL PCP REVIEWS AND CAPS

New sites scoring 90% and above with no deficiencies in critical elements, infection control, or pharmacy will be allowed to proceed with the credentialing and contracting process for acceptance into the PCP network. A site that scores 90% or above does not require a CAP. However, based on the CSR's clinical judgment, one may be issued if needed.

8.0 PCP NON-COMPLIANCE TO CAP COMPLETION

8.1 Non-compliant CAPs

If a PCP submitted a CAP but continued to be non-compliant with the CAP request, the Health Plan Reviewer will follow up to assist the PCP in providing additional information and assisting with CAP completion.

8.2 Delayed CAP Submission Process

If CAP for the Critical Elements was not completed and submitted within ten (10) business days from the date of the review, a second and final Critical Element CAP request letter is sent to the PCP. Failure to submit required documentation within seventy-two (72) hours of the second notice may result in reassignment of members.

8.3 Other CAP Deficiencies

CAP deficiencies other than critical elements should be received within forty-five (45) calendar days from the date of the request. If the CAP was not received within the first thirty (30) days following the CAP request, the Health Plan will contact the PCP to remind him/her that the CAP is due in fifteen (15) days. Health Plans shall document all contacts in the PCP file.

If a CAP is not received within forty-five (45) days, a concerted effort of communication from collaborative Health Plans will be sent to the PCP requesting CAP completion within seventy-two (72) hours. If the CAP is not received within seventy-two (72) hours, the assigned Health Plan will notify the collaborative Health Plans. Each Health Plan will follow internal escalation procedures.

The Health Plan tracking the CAP process may contact another Health Plan with a mutual contract to meet with the PCP to review deficiencies to make joint efforts to bring the PCP into compliance with MMCD requirements.

PCP failure to submit a CAP within the established CAP timelines requires notification by the assigned Health Plan to the collaborative Health Plans for submission to their appropriate committee for review and action.

As stated in the MMCD Policy 02-02, providers who do not correct survey deficiencies within established CAP timelines, shall not be assigned new members until such time as corrections are verified and the CAP is closed. Any network provider who does not come into compliance with survey criteria within the established timelines shall be removed from

the network and plan members shall be appropriate reassigned to other network providers (*See Policy #5.06 Assignment/Termination of Primary Care Practitioner).*

PCP grievances/complaints resolution process shall be fair and formal (*See Policy #40.02 Practitioner/Provider Grievances on Issues Other than Authorizations and Claims payment).*

PCPs removed from the network may file a formal appeal (*See Policy #4.35 Practitioner/Provider Hearings).*

If verified evidence of corrections is acceptable and the decision is reversed, a full scope survey will be repeated or the current survey and completed CAP will be accepted with a re-survey in 12 months. If the decision is not reversed, the provider may re-apply through the application processes *(See Policy #4.01 Credentialing)*.

9.0 DISCIPLINARY ACTION

If the CAP has not been completed within 45 days, providers will be subject to disciplinary action in accordance with *KHS Policy and Procedure #2.04 - Provider Disciplinary Action*.

10.0 SUBMISSION OF RESULTS TO REGULATORY AGENCIES

KHS submits results of facility site and medical record reviews to the KHS Director of Claims and Provider Relations.

KHS maintains a comprehensive database of the results of facility site and medical record reviews of its total primary care network.

KHS maintains a database that will track and report PCP site reviews as per the Department of Health Care Services (DHCS) data submission requirement.

The Physical Accessibility Review Survey/Attachment(s) C, D and E original documentation is maintained and available for DHCS contract monitoring/auditing purposes.

11.0 COLLECTION OF ADDITIONAL INFORMATION

At KHS's discretion, the reviewer may evaluate other elements of the provider's practice in addition to the information collected on the DHCS mandated tool. This information will be collected during the normal site review process. The information will be used to drive quality and organizational improvement efforts and will be shared internally with other stakeholders in the organization.

Examples of information that may be collected are:

A. Appropriate coordination of complex care such as Diabetes or Asthma.
B. Appropriate coordination of services such as those for members eligible for CCS or EI/DD services
C. Appropriate interventions following positive response during SHA screening
D. Providers who delegate responsibility to provide services such as SBIRT have the appropriate education to supervise their staff in accordance with *Policy 4.01-P Credentialing*. Non-licensed staff providing those services has the necessary training. Supervision of the delegated care provided is performed.

12.0 DELEGATION OF SITE REVIEWS

KHS is responsible for ensuring that all delegates comply with all applicable state and federal law and regulations, contract requirements, and other DHCS guidance including APLs and Dual Plan Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

ATTACHMENTS:

- Attachment A – *Site Review Survey*
- Attachment B – *Medical Record Review Survey*
- Attachment C – *Physical Accessibility Review Survey*
- Attachment D – *Ancillary Services Physical Accessibility Review Survey*
- Attachment E – *CBAS Physical Accessibility Review Survey*

Revision 2020-10: Section 7.0 revised in reference to APL 14-004, updated job titles and added section to address Delectation. **Revision 01/2017:** Retrospective audit conducted by Compliance Department, minor revisions provided to comply with APL 15-023. **Revision 01-2016:** Revised to include reference to PL 12-006, 14-004 and APL 15-023. Attachment C updated. Attachment D and E added. **Revision 09-2014:** SBIRT language for provider requirements removed and added to Policy 4.01-P Credentialing per COO. **Revision 05/2014:** Policy approved by DHCS 5/27/2014 as part of SBIRT services. **Revision 2014-04:** New language added to comply with SBIRT Deliverables. Section 12.0 provides SBIRT training requirements. **Revision 2014-03:** Revised to meet requirements of APL 14-004. Also responsive to section 5.5 Medical Records finding in the DHCS Medical Audit review per QI Supervisor.
Revision 2013-11: Section 3.0 Methodology for Identifying Specialist revised by Provider Relations Supervisor.
Revision 2013-08: **R**evision to policy *Section 2-Criteria* provided by Director of Quality Improvement. Earlier revision removed necessary language describing the criteria for Facility Site Reviews and Physical Accessibility Reviews. New language included for SPD members in Section 1 and 3 by Director of Compliance which provides DHCS MMCD Letters and methodology for identifying high volume providers for SPDs. **Revision 2010-05:** Reviewed by Director of Quality Improvement, Health Education and Disease Management. No substantial changes.
Revision 2005-02: Changes made as requested by QI Manager for DHS contract requirements to submit policies and procedures for performance of Primary Care Provider Site Reviews (03-76165 Attachment 4.10)
[1] Revision 2001-03: Changes made as a result of DHS/DMHC Medical Review (YE 8/31/00). Addition of new Attachments A, B, C, D.

Facility Site Review Survey

Attachment A

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

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

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

_____ **Contact person/title**_____

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

_____

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

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

Site Scores

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

Scoring Procedure

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

_____ ÷ _____ = _____ X 100 = _____%

Points Given / Total / Adjusted Points / Decimal Score / Compliance Rate

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

Compliance Rate

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

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

_____ **Not Pass: Below 80%**

_____ CAP Required

_____ Other follow-up

Next Review Due: _____

Site Review Guidelines

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

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

Scoring: Site survey includes on-site inspection and interviews with site personnel. Reviewers are expected to use reasonable evidence available during the review process to determine if practices and systems on site meet survey criteria. Compliance levels include:

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

A corrective action plan (CAP) is required for a total score less than 90%, *OR* for a total score of 90% or above if there are deficiencies in Critical Elements, Pharmaceutical Services or Infection Control. Compliance rates are based on 150 total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer. Reviewers are expected to determine how to ascertain information needed to complete the survey. Survey criteria to be reviewed only by a R.N. or physician is labeled ☐☐**RN/MD Review only**

Directions: Score full point(s) if survey item is met. Score zero (0) points if item is not met. Do not score partial points for any item. Explain all "N/A" and "No" (0 point) items in the comment section. Provide assistance/consultation as needed for CAPs, and establish follow-up/verification timeline.

1) Add the points given in each section.
2) Add points given for all six (6) sections to determine total points given for the site.
3) Subtract all "N/A" items from 150 total possible points to determine the "adjusted" total possible points. If there are no "N/A" items, calculation of site score will be based on 150 points.
4) Divide the total points given by 150 or by the "adjusted" total. Multiply by 100 to calculate percentage rate.

Scoring Example:

Step 1: Add the points given in each section.

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

Example:
25 (Access/safety)
22 (Personnel)
23 (Office Management)
34 (Clinical Services)
11 (Preventive Services)
25 (Infection Control)
140 (POINTS)

Step 3: Subtract "N/A" points from 150 total points possible.

150 (Total points possible)
− 5 (N/A points)
145 ("Adjusted" total points possible)

Step 4: Divide total points given by 150 or by the "adjusted" points, then multiply by 100 to calculate percentage rate.

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

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Criteria	I. Access/Safety Reviewer Guidelines
A. Site is accessible and useable by individuals with physical disabilities.	• ADA Regulations: Site must meet city, county and state building structure and access ordinances for persons with physical disabilities. A site/facility includes the building structure, walkways, parking lots, and equipment. All facilities designed, constructed; or altered by, on behalf of, or for the use of a public entity must be readily accessible and usable by individuals with disabilities, if the construction or alteration was begun after January 26, 1992 (28 CFR 35.151). Any alteration to a place of public accommodation or a commercial facility, after January 26, 1992, must be made to ensure that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and useable by individuals with disabilities, including individuals who use wheelchairs (28 CFR 36.402). • Parking: Parking spaces for persons with physical disabilities are located in close proximity to handicap-accessible building entrances. Each parking space reserved for the disabled is identified by a permanently affixed reflectorized sign posted in a conspicuous place. If provider has no control over availability of disabled parking lot or nearby street spaces, provider must have a plan in place for making program services available to persons with physical disabilities. • Ramps: A clear and level landing is at the top and bottom of all ramps and on each side of an exit door. Any path of travel is considered a ramp if its slope is greater than a 1-foot rise in 20 feet of horizontal run. • Exit doors: The width of exit doorways (at least 32-in. or reasonable accommodation) allows for passage clearance of a wheelchair. Exit doors include all doors required for access, circulation and use of the building and facilities, such as primary entrances and passageway doors. Furniture and other items do not obstruct exit doorways or interfere with door swing pathway. • Elevators: If there is no passenger elevator, a freight elevator may be used to achieve program accessibility if it is upgraded for general passenger use and if passageways leading to and from the elevator are well-lit, neat and clean. • Clear Floor Space: Clear space in waiting/exam areas is sufficient (at least 30-in. x 48-in.) to accommodate a single, stationary adult wheelchair and occupant. A minimum clear space of 60-in. diameter or square area is needed to turn a wheelchair. • Sanitary Facilities: Restroom and hand washing facilities are accessible to able-bodied and physically disabled persons. A wheel-chair accessible restroom stall allows sufficient space for a wheelchair to enter and permits the door to close. If wheelchair accessible restrooms are not available within the office site, reasonable alternative accommodations are provided. Alternatives may include: grab bars located behind and/or along the sides of toilet with assistance provided as needed by site personnel; provision of urinal, bedpan, or bedside commode placed in a private area; wheelchair accessible restroom located in a nearby office or shared within a building. Sufficient knee clearance space underneath the sink allows for wheelchair users to safely use a lavatory sink for hand washing. A reasonable alternative may include, but is not limited to, hand washing items provided as needed by site personnel. Note: A public entity may not deny the benefits of its program, activities, and services to individuals with disabilities because its facilities are inaccessible (28 CFR 35.149-35.150). Every feature need not be accessible, if a reasonable portion of the facilities and accommodations provided is accessible (Title 24, Section 2-419, California Administrative Code, the State Building Code). Reasonable Portion and/or Reasonable Alternatives are acceptable to achieve program accessibility. Reasonable Portion applies to multi-storied structures and provides exceptions to the regulations requiring accessibility to all portions of a facility/site. Reasonable Alternatives are methods other than site structural changes to achieve program accessibility, such as acquisition or redesign of equipment, assignment of assistants/aides to beneficiaries, provision of services at alternate accessible sites, and/or other site specific alternatives to provide services (ADA, Title II, 5.2000). Points shall not be deducted if Reasonable Portion or Reasonable Alternative is made available on site. **Specific measurements are provided strictly for "*reference only*" for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.**

I. Access/Safety (continued on next page)

Site Access/Safety Survey Criteria	Yes	No	N/A	Wt.	Site Score
A. Site is accessible and useable by individuals with physical disabilities. 24 CCR (CA Building Standards Code); 28 CFR §35 (American Disabilities Act of 1990, Title II, Title III) Sites must have the following safety accommodations for physically disabled persons:					
1) Clearly marked (blue) curb or sign designating disabled-parking space near accessible primary entrance.	1) ____	1)____	1)____	1	
2) Pedestrian ramps have a level landing at the top and bottom of the ramp.	2)____	2)____	2)____	1	
3) Exit doorway openings allow for clear passage of a person in a wheelchair.	3)____	3)____	3)____	1	
4) Accessible passenger elevator or reasonable alternative for multi-level floor accommodation.	4)____	4)____	4)____	1	
5) Clear floor space for wheelchair in waiting area and exam room.	5)____	5)____	5)____	1	
6) Wheelchair accessible restroom facilities or reasonable alternative.	6)____	6)____	6)____	1	
7) Wheelchair accessible hand washing facilities or reasonable alternative.	7)____	7)____	7)____	1	

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

Criteria	I. Access/Safety Reviewer Guidelines
B. Site environment is maintained in a clean and sanitary condition.	The physical appearance of floors/carpets, walls, furniture, patient areas and restrooms are clean and well maintained. Appropriate sanitary supplies, such as toilet tissue, hand washing soap, cloth/paper towels or antiseptic towelettes are made available for restroom use. Environmental safety includes the "housekeeping" or hygienic condition of the site. Clean means unsoiled, neat, tidy, and uncluttered. Well maintained means being in good repair or condition.
C. Site environment is safe for all patients, visitors and personnel.	• Ordinances: Sites must meet city, county and state fire safety and prevention ordinances. Reviewers should be aware of applicable city and county ordinances in the areas in which they conduct reviews. • Non-medical emergency procedures: Non-medical emergencies include incidents of fire, natural disaster (e.g. earthquakes), workplace violence, etc. Specific information for handling fire emergencies and evacuation procedures is available on site to staff. Personnel know ***where to locate*** information on site, and ***how to use*** information. Evidence of training must be verifiable, and may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • Evacuation Routes: Clearly marked, easy-to-follow escape routes are posted in visible areas, such as hallways, exam rooms and patient waiting areas. The minimum clear passage needed for a single wheelchair is 36 inches along an accessible route, but may be reduced to a minimum of 32 inches at a doorway. • Illumination: Lighting is adequate in patient flow working and walking areas such as corridors, walkways, waiting and exam rooms, and restrooms to allow for a safe path of travel. • Access Aisle: Accessible pedestrian paths of travel (ramps, corridors, walkways, lobbies, elevators, etc.) between elements (seats, tables, displays, equipment, parking spaces, etc.) provide a clear circulation path. Means of egress (escape routes) are maintained free of obstructions or impediments to full instant use of the path of travel in case of fire or other emergency. Building escape routes provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied. Cords (including taped cords) or other items are not placed on or across walkway areas. • Exits: Exit doorways are unobstructed and clearly marked by a readily visible "Exit" sign. • Electrical Safety: Electrical cords are in good working condition with no exposed wires, or frayed or cracked areas. Cords are not affixed to structures, placed in or across walkways, extended through walls, floors, and ceiling or under doors or floor coverings. Extension cords are not used as a substitute for permanent wiring. All electrical outlets have an intact wall faceplate. Sufficient clearance is maintained around lights and heating units to prevent combustible ignition. • Fire Fighting/Protection Equipment: There is fire fighting/protection equipment in an accessible location on site at all times. An accessible location is reachable by personnel standing on the floor, or other permanent working area, without the need to locate/retrieve step stool, ladder or other assistive devices. At least one of the following types of fire safety equipment is on site: 1) Smoke Detector with intact, working batteries. 2) Fire Alarm Device with code and reporting instructions posted conspicuously at phones and employee entrances. 3) Automatic Sprinkler System with sufficient clearance (10-in.) between sprinkler heads and stored materials. 4) Fire Extinguisher in an accessible location that displays readiness indicators or has an attached current dated inspection tag. **Note: Specific measurements are provided strictly for *"reference only"* for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.**

I. Access/Safety (continued on next page)

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

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

RN/MD Review only

Criteria	I. Access/Safety Reviewer Guidelines
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week.	• Site Specific Emergency procedures: Staff is able to describe site-specific actions or procedures for handling medical emergencies until the individual is stable or under care of local emergency medical services (EMS). There is a written procedure for providing immediate emergent medical care on site until the local EMS is on the scene. Although site proximity to emergency care facilities may be considered when evaluating medical emergency procedures, the key factor is the ability to provide immediate care to patients *on site* until the patient is stable or EMS has taken over care/treatment. When the MD or NPMP is not onsite, staff/MA may call 911, and CPR-certified staff may initiate CPR if needed. Non-CPR-certified staff may only call 911 and stay with the patient until help arrives. • Emergency medical equipment: During business hours providers are prepared to provide emergency services for management of emergency medical conditions that occur on site ***until*** the emergent situation is stabilized and/or treatment is initiated by the local 911 Emergency Medical Service (EMS) system. Minimum emergency equipment is available on site to: 1) establish and maintain a patent/open airway, and 2) manage anaphylactic reaction. Emergency equipment and medication, appropriate to patient population, are available in an accessible location. An accessible location is one that is reachable by personnel standing on the floor, or other permanent working area, without locating/retrieving step stool, ladder or other assistive devices. For emergency "Crash" cart/kit, contents are appropriately sealed and are within the expiration dates posted on label/seal. Site personnel are appropriately trained and can demonstrate knowledge and correct use of all medical equipment they are expected to operate within their scope of work. Documented evidence that emergency equipment is checked at least monthly may include a log, checklist or other appropriate method(s). • Emergency phone number list: Posted list includes local emergency response services (e.g., fire, police/sheriff, ambulance), emergency contacts (e.g., responsible managers, supervisors), and appropriate State, County, City and local agencies (e.g., local poison control number). The list should be dated, and updated annually. • Airway management: Without the ability to adequately maintain the patient's airway, all other interventions are futile. Minimum airway control equipment includes a wall oxygen delivery system or portable oxygen tank, oropharyngeal airways, nasal cannula or mask, and Ambu Bag. Various sizes of airway devices appropriate to patient population within the practice are on site. Portable oxygen tanks are maintained at least ¾ full. There is a method/system in place for oxygen tank replacement. If oxygen tanks are less than ¾ full at time of site visit, site has a back-up method for supplying oxygen if needed ***and*** a scheduled plan for tank replacement. Oxygen tubing need not be connected to oxygen tank, but must be kept in close proximity to tank. Health care personnel at the site must demonstrate that they can turn on the oxygen tank. • Anaphylactic reaction management: Severe allergic reaction can cause urticaria (hives), hypotension, bronchospasm, wheezing and pulmonary edema. Minimum equipment includes Epinephrine 1:1000 (injectable), and Benadryl 25 mg. (oral) or Benadryl 50 mg/ml (injectable), appropriate sizes of ESIP needles/syringes*and alcohol wipes. (*If the emergency kit or "crash cart" has only non-safety needles/syringes, score that deficiency in Section VI., Infection Control, criteria B.2. See Infection Control guidelines). There is a current medication administration reference (e.g. medication dosage chart) available for readily identifying the correct medication dosages (e.g. adult, pediatric, infant, etc.). Package inserts are not acceptable as dosage charts. Note: An "emergency medical condition" is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: 1) placing the health of the individual (or unborn child of a pregnant woman) in serious jeopardy, 2) serious impairment to bodily functions, and 3) serious dysfunction of any bodily organ or part. "Emergency services" means those services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death.

I. Access/Safety (continued on next page)

RN/MD Review only

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

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

RN/MD Review only

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

I. Access/Safety (continued from previous page)

RN/MD Review only

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

Criteria	II. Personnel Reviewer Guidelines		
A. Professional health care personnel have current California licenses and certifications.	**Medical Professional**	**License/Certification**	**Issuing Agency**
	Certified Nurse Midwife (CNM)	RN License & Nurse-Midwife Certificate. DEA Registration, *if appropriate*	CA Board of Registered Nursing Drug Enforcement Administration (DEA)
	Certified Radiological Technologist (CRT)	CRT Certificate.	CDPH, Radiologic Health Branch
	Doctor of Osteopathy (DO)	Physician's & Surgeon's Certificate. DEA Registration	Osteopathic Medical Board of CA DEA
	Licensed Vocational Nurse (LVN):	LVN License.	CA Board of Vocational Nursing and Psychiatric Technicians
	Nurse Practitioner (NP)	RN License w/NP Certification & Furnishing Number. DEA Registration, *if appropriate*	CA Board of Registered Nursing DEA
	Pharmacist (Pharm. D)	Pharmacist License	CA State Board of Pharmacy
	Physician/Surgeon (MD)	Physician's & Surgeon's Certificate. DEA Registration	Medical Board of CA DEA
	Physicians' Assistant (PA)	PA License. DEA Registration, *if appropriate*	Physician Assistant Examining Committee/Medical Board of CA, DEA
	Radiological Technician	Limited Permit.	CDPH, Radiologic Health Branch
	Registered Dietitian (RD)	RD Registration Card.	Commission on Dietetic Registration
	Registered Nurse (RN)	RN License.	CA Board of Registered Nursing
	Note: All medical professional licenses and certifications must be current and issued from the appropriate agency for practice in California, and available on site. Although sites with centralized personnel departments are not required to keep documents or copies on site, copies and/or lists of currently certified or credentialed personnel must be readily available when requested by reviewers.		
	Note: Effective June 27, 2010, per CCR, Title 16, 1355.4, mandated by Business and Professions Code section 138, MDs (does not apply to Osteopaths) shall provide notification to each patient that states the MD(s) on site is licensed and regulated by the Board, and includes the following: NOTICE Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322 www.mbc.ca.gov.	Note: Effective August 11, 2011, per CCR, Title 16, 1399.547, mandated by Business and Professions Code section 138, PAs shall provide notification to each patient that states the PA(s) is licensed and regulated by the Physician Assistant Committee, and includes the following: NOTIFICATION TO CONSUMERS Physician Assistants are licensed and regulated by the Physician Assistant Committee (916) 561-8780 www.pac.ca.gov	
	The notice to consumers above shall be provided by one of the following methods: 1) prominently posted sign in an area visible to patients in at least 48-pt Arial font, 2) a written statement signed and dated by the patient (or patient's representative) and kept in the medical record, stating the patient understands that the MD is licensed and licensed and regulated by the board (for PA's, that the PA is licensed and regulated by the PA Committee), or 3) a statement on letterhead, discharge instructions or other document given to the patient (or patient's representative), where the notification is placed immediately above the signature line for the patient in a at least 14-pt font.		
B. Health care personnel are properly identified.	Health care personnel shall disclose, while working, their name and title on a name tag at least 18-point type. It is acceptable for health care personnel in a practice or an office, whose license is prominently displayed, to opt not to wear a nametag. In the interest of public safety and consumer awareness, it shall be unlawful for any person to use the title "nurse" in reference to himself or herself, in any capacity, except for an individual who is a registered nurse, or a licensed vocational nurse. Note: "Health care practitioner" means any person who engages in acts that are the subject of licensure or regulation under the CA B&P Code (Section 680-681). If a health care practitioner or licensed clinical social worker is working in a psychiatric setting or in a setting that is not licensed by the state, the employing entity or agency shall have the discretion to make an exception from the name tag requirement for the individual safety or therapeutic concerns.		

II. Personnel (continued on next page)

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

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

RN/MD Review only

Criteria	II. Personnel Reviewer Guidelines
C. Site personnel are qualified and trained for assigned responsibilities.	• **Medical equipment:** Provider and/or staff are able to demonstrate appropriate operation of medical equipment used in their scope of work. Not all staff is required to be proficient in use of all equipment. • Unlicensed personnel: Medical assistants (MA) are unlicensed health personnel, at least 18 years of age, who perform basic administrative, clerical, and non-invasive routine technical supportive services under the supervision of a licensed physician, surgeon or podiatrist in a medical office or clinic setting. Supervision means the licensed physician must be physically present in the treatment facility during the performance of authorized procedures by the MA. Training may be administered under a licensed physician; or under a RN, LVN, PA, or other qualified medical assistant acting under the direction of a licensed physician. The supervising physician is responsible for determining the training content and ascertaining proficiency of the MA. Training documentation maintained on site for the MA must include the following: A) Diploma or certification from an accredited training program/school, ***or*** B) Letter/statement from the current supervising physician that certifies in writing: date, location, content, and duration of training, demonstrated proficiency to perform current assigned scope of work, and signature. • Medications: Unlicensed staff (e.g. medical assistants) has evidence of appropriate training and supervision in all medication administration methods performed within their scope of work. Medication administration by a MA means the direct application of pre-measured medication orally, sublingually, topically, vaginally or rectally; or by providing a single dose to a patient for immediate self-administration by inhalation or by simple injection. **All medications including vaccines must be verified with (shown to) a licensed person prior to administration.** To administer medications by subcutaneous or intramuscular injection, or to perform intradermal skin tests or venipunctures for withdrawing blood, an MA must have completed at least the minimum number of training-hours established in CCR, Title 16, Section 1366.1. **MAs cannot administer anesthetics, including local anesthetic agents (such as Rocephin hydrated with Xylocaine).** Medical assistants may not place an intravenous needle, start or disconnect the intravenous infusion tube, administer medications or injections into an intravenous line, or administer anesthesia. The supervising physician must specifically authorize all medications administered by an MA. Authorization means a specific written or standing order prepared by the supervising physician. **Note:** Personnel on site must be qualified for their responsibilities and adequately trained for their scope of work. Site staff should have a general understanding of the systems/processes in place, appropriate supervision and knowledge of the available sources of information on site.

II. Personnel (continued on next page)

RN/MD Review only

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

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

RN/MD Review only

Criteria	II. Personnel Reviewer Guidelines
D. Scope of practice for non-physician medical practitioners (NPMP) is clearly defined.	Reviewers are expected to verify that NP and/or CNM standardized procedures, and PA Delegation of Services Agreement and Supervision Physician's Responsibility documentation are present on site. Reviewers are ***not*** expected to make in-depth evaluation of "appropriateness" of the NPMP's scope of practice. Documents may be utilized to determine and/or clarify practice procedures and supervisory processes on site. • Certified Nurse Midwives (CNM): The certificate to practice nurse-midwifery authorizes the holder, under supervision of a licensed physician or surgeon, to attend cases of normal child-birth and to provide prenatal, intrapartum, and postpartum care, including family planning care for the mother, and immediate care for the newborn. The supervising and back-up physician or surgeon for the CNM must be credentialed to perform obstetrical care in the same delivering facility in which the CNM has delivery privileges. • Nurse Practitioners (NP): Nurse practitioners are prepared through education and experience to provide primary care and to perform advanced procedures. The extent of required supervision must be specified in the Standardized Procedures. • Physician Assistants (PA): Every PA is required to have the following documents: 1) Delegation of Services Agreement: Defines specific procedures identified in practice protocols or specifically authorized by the supervising physician, and must be dated and signed by physician and PA. An original or copy must be readily accessible at all practice sites in which the PA works. There is no established time period for renewing the Agreement, but it is expected that the Agreement will be revised, dated and signed whenever any changes occur. Failure to maintain a Delegation of Services Agreement is a violation of the Physician Assistant Regulations and is grounds for disciplinary action by the Medical Board of California against a physician assistant's licensure. 2) Approved Supervising Physician's Responsibility for Supervision of Physician Assistants Agreement: Defines supervision responsibilities and methods required by Title 16, section 1399.545 of the Physician Assistant Regulations, and is signed by the physician. The following procedures must be identified: a) Transport and back-up procedures for when the supervising physician is not on the premises. b) One or more methods for performing medical record review by the supervising physician: c) Responsibility for physician review and countersigning of medical records d) Responsibility of the PA to enter the name of approved supervising physician responsible for the patient on the medical record. • Drug Enforcement Agency (DEA): Each NP, CNM, and PA that prescribes controlled substances is required to have a valid DEA Registration Number. Note: Standardized procedures legally define the expanded scope of nursing practice that overlaps the practice of medicine. CNMs and NPs operate under written Standardized Procedures that are collaboratively developed and approved by the supervising physician, the NP and administration within the organized health care facility/system in which standardized procedures will be used. Standardized Procedures should identify the furnishing of drugs or devices, extent of physician or surgeon supervision, method of periodic review of competence, including peer review, and review of provisions in the Standardized Procedures. Standardized Procedures shall undergo periodic review, with signed, dated revisions completed at each change in scope of work.

II. Personnel (continued on next page)

RN/MD Review only

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

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

RN/MD Review only

Criteria	II. Personnel Reviewer Guidelines
E. Non-physician medical practitioners (NPMP) are supervised according to established standards.	• Non-physician medical practitioners: The Supervising Physician holds ultimate responsibility for the practice of each supervised non-physician medical practitioner. The number of non-physician medical practitioners who may be supervised by a single primary care physician is limited to the full-time equivalent of one of the following: 4 nurse practitioners, 3 nurse midwives, 4 physician's assistants, or 4 of the above individuals in any combination which does not exceed the limit stated. This ratio is based on each physician, not the number of offices. A primary care physician, an organized outpatient clinic or a hospital outpatient department cannot utilize more non-physician medical practitioners than can be supervised within these stated limits. Ref: Assembly Bill 3 Bass, Chapter 376, October 2007, effective January 1, 2008, allows 4 PAs to 1 MD; Business & Professions Code 3516(b); W & I Code 14132.966. Physician Assistant Committee is at: http://www.pac.ca.gov/ or the PAC office at 916-561-8780. • Supervising physician: "Supervising physician" means a physician and/or surgeon licensed by the Medical Board or by the Osteopathic Medical Board of California who supervises one or more physician assistants, possesses a current valid license to practice medicine, and is not currently on disciplinary probation for improper use of a physician assistant. "Supervision" means that a licensed physician and surgeon oversee the activities of, and accept responsibility for, the medical services rendered by a physician assistant. Physicians must comply with all current and/or revised requirements established by the Medical Board of CA for supervising physician assistants.

II. Personnel (continued on next page)

RN/MD Review only

Site Personnel Survey Criteria	Yes	No	N/A	Wt.	Site Score
E. Non-physician medical practitioners (NPMP) are supervised according to established standards. B&P Code 3516(b); W&I Code 14132.966					
The designated supervising physician(s) on site: 1) ratio to number of NPMPs does not exceed established ratios in any combination. a) 1:4 Nurse Practitioners b) 1:3 Certified Nurse Midwives c) 1:4 Physicians Assistants	1)____	1)____	1)____	1	
2) The designated supervising or back-up physician is available in person or by electronic communication at all times when a NPMP is caring for patients.	2)____	2)____	2)____	1	

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

RN/MD Review only

Criteria	II. Personnel Reviewer Guidelines
F. Site personnel receive safety training/information.	• Bloodborne Pathogens: Site personnel treat all blood and other potentially infectious materials (OPIM) as if these *are* infectious. Site personnel who are reasonably anticipated to have eye, skin, mucous membranes and potential exposure to blood and/or other potentially infectious materials (OPIM) receive training as required by the Bloodborne Pathogens Standard, Title 8, CCR, Section 5193. Training occurs ***prior to*** initial exposure to potentially infectious and/or biohazardous materials. Review and re-training sessions occur ***at least annually***. Training content is appropriate (language, educational level, etc.) to personnel on site. Training *minimally* includes the following: ‣ universal/standard precautions ‣ use of personal protective equipment ‣ accessible copy of Bloodborne Pathogens Standard ‣ work practice controls/exposure prevention ‣ modes of transmitting bloodborne pathogens ‣ epidemiology/symptoms of HBV and HIV ‣ recognition of activities with exposure element ‣ handling and labeling of biohazardous waste(s) ‣ Hepatitis B vaccination protocol and requirements ‣ explanation of emergency procedures ‣ post exposure reporting/evaluation/follow-up procedures ‣ decontamination of equipment/work areas ‣ site's written bloodborne pathogen exposure plan ‣ opportunity for discussion/questions Personnel must know ***where to locate*** information/resources on site about infection control, the Bloodborne Pathogens Exposure Plan, and ***how to use*** the information. Evidence of training must be verifiable. Evidence of training may include informal in-services, new staff orientation, external training courses, educational curriculum and participation lists, etc. Training documentation must contain the employee's name, job titles, training date(s), type of training, contents of training session, and names/qualifications of trainers. Records must be kept for three (3) years. • Abuse Reporting: Site personnel have specific knowledge of local reporting requirements, agencies, and procedures, and know *where to locate* information on site and *how to use* information. Note: Health practitioners (e.g., physicians, surgeons, licensed nurses, licensed social workers, paramedics) in a health facility, (e.g., clinic, physician's office, public health clinic) are legally mandated reporters of known or reasonably suspected cases of child abuse, elder abuse and domestic violence. Legally mandated reporters must make telephone and written reports according to timeliness standards established by the designated local law enforcement agencies in each county. "Reasonably suspects" means having objectively reasonable suspicion based upon facts that could cause a reasonable person in a like position, drawing when appropriate on his or her training and experience, to suspect abuse (CA Penal Code 11164). Failure to report by legally mandated reporters can result in criminal or civil prosecutions, punishable by monetary fines and/or county jail confinement. Any person entering employment which makes him/her a mandated reporter must sign a statement, provided and retained by the employer, that the employee has knowledge of the Child Abuse reporting law and will comply with its provision (CA Penal Code 11166.5).

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.

RN/MD Review only

Criteria	II. Personnel Reviewer Guidelines
G. Site personnel receive training and/or information on member rights.	Site personnel have received information and/or training about member rights. Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. If there is no verifiable evidence of staff training, staff is able to locate written member rights information on site and explain how to use information.

II. Personnel (continued from previous page)

RN/MD Review only

Site Personnel Survey Criteria	Yes	No	N/A	Wt.	Site Score
G. Site personnel receive training and/or information on member rights. 22 CCR §51009, §51014.1, §51305.1, §53452, §53858; 28 CCR §1300.68 There is evidence that site staff has received training and/or information on the following:					
1) Patient Confidentiality	1)____	1)____	1)____	1	
2) Informed consent, including Human Sterilization	2)____	2)____	2)____	1	
3) Prior Authorization requests	3)____	3)____	3)____	1	
4) Grievance/Complaint Procedure	4)____	4)____	4)____	1	
5) Sensitive Services/Minors' Rights	5)____	5)____	5)____	1	
6) Health Plan referral process/procedures/resources	6)____	6)____	6)____	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **Totals**					

RN/MD Review only (#B)

Criteria	III. Office Management Reviewer Guidelines
A. Physician coverage is available 24 hours a day, 7 days a week.	Current clinic office hours are posted within the office or readily available upon request. Current site-specific resource information is available to site personnel about physician office hour schedule(s), local and/or Plan-specific systems for after-hours urgent care, emergent physician coverage available 24 hours a day, 7 days per week, and system for providing follow-up care. When a physician is not on site during regular office hours, personnel are able to contact the physician (or covering physician) at all times by telephone, cell phone, pager, etc. Note: One objective of effective clinic office management is to support the provision of appropriate, coordinated health care services. The review of clinic office management is to evaluate if effective systems are in place and whether site personnel appropriately follow established site-specific procedures.
B. There is sufficient health care personnel to provide timely, appropriate health care services.	In addition to the physician, only appropriately licensed medical personnel such as a CNM, NP, RN, or PA handles emergency, urgent, and medical advice/triage telephone calls. The California Board of Vocational Nursing and Psychiatric Technician Examiners has determined that the Licensed Vocational Nurse Practice Act ***does not*** permit the LVN to perform triage independently (MCPB Letter 92-15). The LVN may perform that part of the triage process that includes observation and data collection relative to basic physical assessment. The LVN ***may not*** perform that part of the triage process that includes independent evaluation, interpretation of data, and determination of treatment priorities and levels of care. Unlicensed personnel, such as medical assistants, may provide patient information or instructions only as authorized by the physician (Title 16, §1366 (b)). Note: Telephone triage is the system for managing telephone callers during ***and*** after office hours.

III. Office Management (continued on next page)

RN/MD Review only (#B)

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

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

RN/MD Review only (#C)

Criteria	III. Office Management Reviewer Guidelines
C. Health care services are readily available.	The process established on site provides timely access to appointments for routine care, urgent care, prenatal care, pediatric periodic health assessments/immunizations, adult initial health assessments, specialty care and emergency care. An organized system must be clearly evident (in use) for scheduling appointments appropriately, notifying and reminding members of scheduled appointments, and following up of missed or canceled appointments. Systems, practices and procedures used for making services readily available to patients will vary from site to site. Missed and/or canceled appointments, and contact attempts must be documented in the patient's medical record. Note: Medi-Cal Managed Care Health Plans *require* the following timeliness standards for access to appointments: • Urgent Care: 48 hours • Access to the first Prenatal Visit: 10 business days • Non-urgent (Routine) Care: 10 business days
D. There is 24-hour access to interpreter services for non- or limited-English proficient (LEP) members.	All sites must provide 24-hour interpreter services for all members either through telephone language services or interpreters on site. Site personnel used as interpreters have been assessed for their medical interpretation performance skills/capabilities. A family member or friend may be used as an interpreter if requested by the LEP individual after being informed of their right to use free interpreter services. Note: Assessment of interpreter skills may include written or oral assessment of bilingual skills, documentation of the number of years of employment as an interpreter or translator, documentation of successful completion of a specific type of interpreter training programs (medical, legal, court, semi-technical, etc.), and/or other reasonable alternative documentation of interpreter capability. A request for or refusal of language/ interpreter services must be documented in the member's medical record.

III. Office Management (continued on next page)

RN/MD Review only (#C)

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

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

RN/MD Review only (#E)

Criteria	III. Office Management Reviewer Guidelines
E. Procedures for timely referral/ consultative services are established on site.	An organized, timely referral system is clearly evident for making and tracking referrals, reviewing reports, providing/scheduling follow-up care and filing reports in medical records. Referral informational resources are readily available for use by site personnel. Site staff can demonstrate (e.g., "walk through") the office referral process from beginning to end. Systems, practices and procedures used for handling referrals will vary from site to site.
F. Member grievance/ complaint processes are established on site.	At least one telephone number for filing grievances is posted on site, or is readily available upon request. Complaint forms and a copy of the grievance procedure are readily available on site, and can be provided to members promptly upon request. **Note:** A "grievance" is defined as any written or oral expression of dissatisfaction and shall include any complaint, dispute, request for reconsideration or appeal made by an enrollee or their representative to a Plan or entity with delegated authority to resolve grievances on behalf of the Plan.

III. Office Management (continued on next page)

RN/MD Review only (#E)

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

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

RN/MD Review only (#H)

Criteria	III. Office Management Reviewer Guidelines
G. Medical records are available for the practitioner at each scheduled patient encounter.	The process/system established on site provides for the availability of medical records (paper and electronic), including outpatient, inpatient, referral services, and significant telephone consultations for patient encounters. Medical records are filed that allows for ease of accessibility within the facility, or in an approved health record storage facility off the facility premises (22 CCR, § 75055).
H. Confidentiality of personal medical information is protected according to State and federal guidelines.	• Privacy: Patients have the right to privacy for dressing/undressing, physical examination and medical consultation. Practices are in place to safeguard patient privacy. Because dressing areas and examination room configurations vary greatly, reviewers will make site-specific determinations. • Confidentiality: Personnel follow site policy/procedures for maintaining confidentiality of individual patient information. Individual patient conditions or information is not discussed in front of other patients or visitors, displayed or left unattended in reception and/or patient flow areas. • Electronic records: Electronic record-keeping system procedures have been established to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures, and maintain upkeep of computer systems. Security protection includes an off-site backup storage system, an image mechanism with the ability to copy documents, a mechanism to ensure that recorded input is unalterable, and file recovery procedures. Confidentiality protection may also include use of encryption, detailed user access controls, transaction logs, and blinded files. • Record release: Medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released. The release terms, such as to whom records are released and for what purposes, should also be described. This does not prevent release of statistical or summary data, or exchange of individual identifiable medical information between individuals or institutions providing care, fiscal intermediaries, research entities and State or local official agencies. • Record retention: Hospitals, acute psychiatric hospitals, skilled nursing facilities, *primary care clinics*, psychology and psychiatric clinics must maintain medical records and exposed x-rays for a minimum of 7 years following patient discharge, except for minors (Title 22, CCR, Section 75055). Records of minors must be maintained for at least one year after a minor has reached age 18, but in no event for less than 7 years (Title 22, CCR, Section 75055). Each Plan must maintain all records and documentation (including medical records) necessary to verify information and reports required by statute, regulation or contractual obligation for 5 years from the end of the fiscal year in which the Plan contract expires or is terminated (Title 22, CCR, Section 53861).

III. Office Management (continued from previous page)

RN/MD Review only (#H)

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

Criteria	IV. Clinical Services - Pharmaceutical Reviewer Guidelines
A. Drugs and medication supplies are maintained secured to prevent unauthorized access.	• Deficiencies: All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan. • Controlled substances: Written records are maintained of controlled substances inventory list(s) that includes: provider's DEA number, name of medication, original quantity of drug, dose, date, name of patient receiving drug, name of authorized person dispensing drug, and number of remaining doses. Controlled substances are stored separately from other drugs in a securely locked, substantially constructed cabinet (Control Substances Act, CFR 1301.75). Control substances include all Schedule I, II, III, IV, and V substances listed in the CA Health and Safety Code, Sections 11053-11058, and do not need to be double locked. Personnel with authorized access to controlled substances include physicians, dentists, podiatrists, physician's assistants, licensed nurses and pharmacists. • Security: All drugs for dispensing are stored in an area that is secured at all times (CA B&P Code, §4172). Keys to locked storage area are available only to staff authorized by the physician to have access (16 CCR, Chapter 2, Division 13, Section 1356.3). The Medical Board of California interprets "all drugs" to also include both sample and over-the-counter drugs. The Medical Board defines "area that is secure" to mean a locked storage area within a physician's office. Note: During business hours, the drawer, cabinet or room containing drugs, medication supplies or hazardous substances may remain unlocked ***only*** if there is no access to area by unauthorized persons. Whenever drugs, medication supplies or hazardous substances are unlocked, authorized clinic personnel must remain in the immediate area ***at all times***. At all other times, drugs, medication supplies and hazardous substances must be securely locked. Controlled substances are locked at all times.

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.

RN/MD Review only

Criteria	IV. Clinical Services - Pharmaceutical Reviewer Guidelines
B. Drugs are handled safely and stored appropriately.	• **Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan. • **Drug preparation**: A drug or device is considered "adulterated" if it contains any filthy, putrid, or decomposed substance, or if it has been prepared, packed or held under unsanitary conditions (21 USC, Section 351). A drug is considered contaminated if it has been held under unsanitary conditions that may have been contaminated with filth, or rendered injurious to health. • **Storage**: Medications are kept separate from food, lab specimens, cleaning supplies, and other items that may potentially cause contamination. Drugs are stored under appropriate conditions of temperature, humidity, and light so that the identity, strength, quality, and purity of the drug product are not affected (21 CFR, Section 211.142). Room temperature where drugs are stored does not exceed 30°C (86°F) (Title 22, Section 75037 (d)). • **Immunobiologics**: Vaccines are refrigerated immediately upon receipt on site and stored according to specific instructions on the package insert for each vaccine. Diluent does not need refrigeration if vaccine is administered right after diluent is added. Vaccines are not stored in the doors of refrigerator or freezer. Refrigerator and freezer temperatures are documented at least once a day. Site personnel must be able to verbalize the procedure used to promptly respond to OUT OF RANGE TEMPERATURES. Contacting VFC or manufacturer are acceptable procedures. Refrigerator: Vaccines are kept in a refrigerator **maintained at 2-8°C or 35-46°F,** and include, but are not limited to, DTaP, Td, Tdap, Hepatitis A, Hepatitis B, IPV, Pneumococcal, Rotavirus, Hib, Influenza (inactivated and FluMist), MCV, HPV, Zoster, or any combinations of these listed vaccines. Freezer: Varicella and MMRV vaccines are stored in the **freezer at -15°C or 5°F, or lower,** and are protected from light at all times. MMR may be stored in a refrigerator or freezer; VFC recommends MMR be stored in the freezer with MMRV. If vaccines are in solid state and contain ice crystals on the outside of vial, they are considered appropriately frozen. • **Hazardous substances labeling**: Safety practices are followed in accordance with current/updated CAL-OSHA standards. The manufacturer's label is not removed from a container (bag, bottle, box, can, cylinder, etc.) as long as the hazardous material or residues of the material remain in the container. All portable containers of hazardous chemicals and secondary containers into which hazardous substances are transferred or prepared require labeling. Labels must provide the following information: 1) identity of hazardous substance, 2) description of hazard warning: can be words, pictures, symbols 3) date of preparation or transfer. • **Exception**: Labeling is not required for portable containers into which hazardous chemicals are transferred from labeled containers, and which are intended only for the immediate use of the individual who performs the transfer. **Note**: The purpose of hazard communication is to convey information about hazardous substances used in the work place. A hazardous substance is any substance that is a physical or health hazard. Examples of a physical hazard include substances that are a combustible liquid, a compressed gas, explosive, flammable, an organic peroxide, an oxidizer, pyrophoric, unstable (reactive) or water-reactive. Examples of a health hazard include substances where acute or chronic health effects may occur with exposure, such as carcinogens, toxic or highly toxic agents, irritants, corrosives, sensitizers and agents that damage the lungs, skin, eyes, or mucous membranes.

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.

Criteria	IV. Clinical Services - Pharmaceutical Reviewer Guidelines
C. Drugs are dispensed according to State and federal drug distribution laws and regulations.	• **Deficiencies**: All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan. • **Expiration date**: The manufacturer's expiration date must appear on the labeling of all drugs. All prescription drugs not bearing the expiration date are deemed to have expired. If a drug is to be reconstituted at the time of dispensing, its labeling must contain expiration information for both the reconstituted and unconstituted drug. Expired drugs may not be distributed or dispensed. • **Prescription labeling**: Each prescription medication dispensed is in a container that is not cracked, soiled or without secure closures (Title 22, CCR, Section 75037 (a)). Drug container is labeled with the provider's name, patient's name, drug name, dose, frequency, route, quantity dispensed, and manufacturer's name and lot number. California Pharmacy Law *does not* prohibit furnishing a limited quantity of sample drugs if dispensed to the patient in the package provided by the manufacturer, no charge is made to the patient, and appropriate documentation is made in the patient's medical record (CA Business and Professions Code, Sections 4170, 4171). • **Drug distribution**: Each clinic that provides drug distribution services has written policies and procedures for the safe and effective distribution control, storage, use and disposition of drugs. • **Drug dispensing**: Drug dispensing is in compliance with all applicable State and federal laws and regulations. Drugs are dispensed only by a physician, pharmacist or other persons (e.g., NP, CNM, RN, PA) lawfully authorized to dispense medications upon the order of a licensed physician or surgeon. Personnel such as medical assistants, office managers, and receptionists do not dispense drugs. Drugs are not offered for sale, charged or billed to Medi-Cal members (Business and Professions Code, Article 13, Section 4193). A record of all drugs dispensed is entered in the patient's medical record. • **Vaccine Immunization Statements** (VIS): Since 1994, the National Childhood Vaccine Injury Act, Section 2126 of the Public Health Service Act, mandates that parents/guardians or adult patients be informed before vaccinations are administered. Health care providers must present and offer a copy of the most recent VIS to patients prior to any vaccine.* The date the VIS was given (or presented and offered) *and* the publication date of the VIS must be documented in the patient's medical record. The most current VIS are available from state and local health departments or can be downloaded from the CDC web site at http://www.cdc.gov/vaccines/pubs/vis/default.htm or by calling the CDC Immunization Hotline at (800) 232-2522. The Vaccines for Children (VFC) also contains current VIS and provider notifications at http://www.eziz.org/. *VIS published by CDC is to be provided to the patient/parent/guardian prior to administration of that vaccination. (42USC, 300aa-26(D)(2)). As of 2009, CDC allows providers to present a copy of the current VIS (such as a laminated copy in a binder, etc.) to the patient/parent/guardian and allow time for the patient to read and ask questions. Staff should also *offer* a copy each time (www.cdc.gov/vaccines/pubs/vis/vis-facts.htm). • **Pharmacy**: If a pharmacy is located on site, a licensed pharmacist monitors drug distribution and policies/procedures for medication dispensing/storage. **Note**: "Dispensing" of drugs means the furnishing of drugs or devices directly to a patient or upon a prescription from a physician, dentist, optometrist, podiatrist, veterinarian, or upon an order to furnish drugs or transmit a prescription from a certified nurse midwife, nurse practitioner, physician assistant or pharmacist acting within the scope of his or her practice.

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

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

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

Criteria	IV. Clinical Services – Laboratory Reviewer Guidelines
D. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations.	• CLIA Certificates: All sites that perform laboratory testing for human health assessment, diagnosis, prevention, or treatment of disease has a current, unrevoked, unsuspended site-specific Clinical Laboratory Improvement Amendment (CLIA) certificate, or evidence of renewal. Acceptable documentation such as the original certificate, copy of the original certificate, renewal receipt or other evidence of renewal submission is present on site or readily available upon request. The CLIA certificate or evidence of renewal should include the current site/clinic address. Note: Per 42 CFR, 493.35(b)(1-3), 493.43(b)(1-3) and 493.55(b)(1-3), laboratories must file a separate application for each laboratory location, with the following *exceptions*: 1) Laboratories that are not at a fixed location, that is, laboratories that move from testing site to testing site, such as mobile units providing laboratory testing, health screening fairs, or other temporary testing locations may be covered under the certificate of the designated primary site or home base, using its address, 2) Not-for-profit or Federal, State, or local government laboratories that engage in limited (not more than a combination of 15 moderately complex or waived tests per certificate) public health testing may file a single application, or 3) Laboratories within a hospital that are located at contiguous buildings on the same campus and under common direction may file a single application or multiple applications for laboratory sites within same physical location or street address. The CLIA Certificate on site includes one of the following: A) Certificate of Waiver: Site is able to perform only exempt waived tests. B) Certificate for Provider-Performed Microscopy (PPM): Physicians, dentists, or mid-level practitioners are able to perform PPM procedures and waived tests. C) Certificate of Registration: Allows moderate and/or high complexity lab testing to be conducted until compliance with CLIA regulations are determined by survey. D) Certificate of Compliance: Lab has been surveyed and found in compliance with all applicable CLIA requirements. E) Certificate of Accreditation: Lab is accredited by an accreditation organization approved by the Centers for Medicare & Medicaid Services (CMS). • Waived tests: If only waived tests are performed, site has a current CLIA Certificate of Waiver. There are no specific CLIA regulations regarding the performance of waived tests. Site personnel are expected to follow the test manufacturer's instructions. Laboratories with certificates of waiver may not be routinely inspected by DHCS Laboratory Field Services Division, but may be inspected as part of complaint investigations and on a random basis to determine whether only waived tests are being performed. • Moderate and High complexity tests: Tests not listed as waived are divided into one of two categories, moderate complexity or high complexity, based on the complexity of the testing procedure. CLIA regulations for these categories list specific requirements for laboratory proficiency testing, patient test management, quality control, quality assurance, personnel, and inspections. • Personnel training: Prior to testing biological specimens, personnel have been appropriately trained for the type and complexity of the laboratory services performed. Personnel have demonstrated the ability to perform all testing operations reliably and to report results accurately. Site personnel that perform CLIA waived tests have access to and are able to follow test manufacturer's instructions. When requested, site personnel are able to provide a step-by-step verbal explanation or demonstration of test procedure and how to determine test results. The required training and certification is established by legislation (CA B&P Codes, §1200-1213) for personnel performing moderate and high complexity tests. Reviewers are not expected to complete an in-depth evaluation of personnel performing moderate and high complexity tests. Note: Any site that performs tests or examinations on human biological specimens derived from the human body is, by definition, "laboratories" under State and federal law, and includes locations such as nurses' stations within hospitals, clinics, surgical centers, physician offices, and health fairs. The current listing of waived tests may be obtained at www.fda.gov/cdrh/clia/testswaived.html. CLIA re/certification includes an evaluation every two years (or sooner of complaint driven) by CDPH of personnel licenses/training, laboratory site inspection and demonstration of testing proficiency for moderate and high-complexity test sites. **Contact CDPH Laboratory Field Services (510) 620-3800 for CLIA certification, laboratory license, or personnel questions.**

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.

Criteria	IV. Clinical Services - Radiology Reviewer Guidelines
E. Site meets CDPH Radiological inspection and safety regulations.	• <u>CDPH Radiologic Health Branch (RHB) Inspection Report</u>: If site has ***current*** documentation of one of the following, give the full 9 points and survey items 2-9 will not need to be surveyed. 1) Inspection Report, ***or*** 2) Inspection Report *and* Short Form Sign-off sheet, ***or*** 3) Inspection Report *and* Notice of Violation form *and* approval letter for corrective action plan from the CA RHB. The Radiologic Inspection Report, issued by the RHB, must be present if there is radiology equipment on site. If any violations are found, one of two documents is issued to the site. The "Short Form Sign-off sheet" is issued for minimal problems that are easily corrected. The "Notice of Violation" form, requiring a site corrective action plan, is issued if there are more serious violations. All "Notice of Violation" corrective action plans must be accompanied by an approval letter from the CA RHB. **If documents are not available on site, or if reviewer is uncertain about the "current" status of documents on site, proceed to score all items 1-9.** • <u>Radiological equipment</u>: Equipment inspection, based on a "priority" rating system, is established by legislation (CA H&S Code, Section 115115). 1) Mammography equipment is inspected annually (Mammography Quality Standards Act, 21 CFR, Section 900), and must have federal FDA Certification on site ***and*** CA Mammography X-ray Equipment and Facility Accreditation Certification posted on the machine. 2) High Priority equipment (e.g. fluoroscopy, portable X-ray) is inspected every three years. 3) Medium Priority equipment is inspected every 4-5 years depending on the volume of patients, frequency of x-ray equipment use, and likelihood of radiation exposure. If reviewer is uncertain about the "current" status of equipment inspection, call the Radiological Health Branch. • <u>Radiology Personnel</u>: All certificates/licenses are posted and show expiration dates. If there are a large number of technicians, a list of names, license numbers, and expiration dates may be substituted. The Certified Radiological Technologist (CRT) certificate permits the technologist to perform all radiology films except mammography and fluoroscopy, which require separate certificates. The "Limited Permit" limits the technician to one of the ten (10) x-ray categories specified on the limited certificate: Chest, Dental laboratory, Dermatology, Extremities, Gastrointestinal, Genitourinary, Leg-podiatric, Skull, Torso-skeletal, and X-ray bone densitometry. <u>Note:</u> Per RHB, dexascanners do not require lead aprons or gonadal shields, however, criteria 1-7 are still required. RHB uses the ALARA (<u>A</u>s <u>L</u>ow <u>A</u>s <u>R</u>easonably <u>A</u>chievable) principle, which is the foundation of all radiation safety programs. The ALARA principle means to minimize exposure to radiation doses by employing all *reasonable* methods. Dexascanner manufacturer guidelines do not require gonadal shielding or lead aprons because the amount of radiation is very low, and there is potential for the shield to obscure the area being scanned, which could render the scan non-diagnostic. Operators do not need aprons because the beam is extremely focused, so that the amount of exposure of even "scattered" beams to an operator sitting at a seat near the scanner is about the same level as that found in the natural environment. (A traditional x-ray machine used for bone density testing, that is not a dexascanner, *may* require shielding/apron.) <u>Note</u>: The Radiologic Health Branch of the Food, Drug, and Radiation Safety Division of the CA Department of Public Health enforces the Radiation Control Laws and Regulations designed to protect both the public and employees against radiation hazards. Enforcement is carried out through licensing, registration and periodic inspection of sources of radiation, such as radiation machines. For questions regarding radiologic safety (e.g. expired or no inspection letters on site), call CDPH Radiologic Health Branch at (916) 327-5106, or for general information at (916) 440-7888. For Radiation Emergency Assistance, call 1-800-852-7550. Ref: CCR, Title 17, Chapter 5, Subchapter 4 regulations at <u>www.cdph.ca.gov/programs/Pages/RadiologicHealthBranch.aspx</u>

IV. Clinical Services - Radiology

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

Criteria	V. Preventive Services Reviewer Guidelines
A. Preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases.	• Examination table: A protective barrier that is changed between patient contact is used to cover exam table surface. "Good repair" means clean and well maintained in proper working order. • Scales: Infant scales are marked and accurate to increments of one (1) ounce or less, and have a capacity of at least 35 pounds. Standing floor scales are marked and accurate to increments of one-fourth (1/4) pound or less, and have a capacity of at least 300 pounds. Balance beam or electronic scales are appropriate for clinic use. Balance scales have an adjustment mechanism and zeroing weight to enable routine balancing at zero. Electronic or digital scales have automatic zeroing and lock-in weight features. Spring balance scales (e.g. bathroom scales) are unsatisfactory for clinical use because, over time, the spring counter balance mechanism loses its accuracy. • Measuring devices: Equipment on site for measuring stature (length/height) and head circumference includes: 1) rigid 90° right angle headboard block that is perpendicular to the recumbent measurement surface, or vertical to the wall-mounted standing measurement surface. 2) flat, paper or plastic non-stretchable tape or yardstick, marked to one-eighth (1/8 in. or 1 mm) or less, attached to a firm, flat surface. The "0" of the tape is exactly at the base of the headboard for recumbent measurement, or exactly at foot level for standing measurement. 3) moveable, non-flexible foot board at 90° right angle perpendicular to the recumbent measurement surface, or a flat floor surface for standing. 4) A non-stretchable tape measuring devise marked to one-eighth (1/8 in. or 1 mm) or less for measuring head circumference. • Basic equipment: Exam gown sizes are appropriate to population served on site. • Vision testing: Site has both a literate (e.g., Snellen) and an illiterate eye chart (e.g., "E" Chart, "Kindergarten" chart, Allen Picture Card Test). "Heel" lines are aligned with center of eye chart at a distance of 10 or 20-feet depending on whether the chart is for the 10-foot or 20-foot distance. Eye charts are located in an area with adequate lighting and at height(s) appropriate to use. Disposable eye "occluders" (e.g., Dixie cups or tongue blades with back-to-back- stickers) are acceptable. Non-disposable occluders are cleaned between patients. • Hearing testing: Offices that provide pediatric preventive services should have an audiometer available since audiometric testing is required at preventive health visits starting at 3 years of age. PCP offices (such as Family Practitioners or General Practitioners) with less than 15% of their patients that are pediatric, and that refer all members to another provider for audiometric testing, must have a system in place that clearly demonstrates that the PCP office verifies that audiometric testing has been completed and that those results are returned to the PCP for review. Note: Although patient population varies from site-to-site, screening equipment listed in this section is the standard equipment most often used in performing a physical health screening examination for children and adults.

V. Preventive Services (continued on next page)

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

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

RN/MD Review only

Criteria	V. Preventive Services Reviewer Guidelines
B. Health education services are available to Plan members.	• **Health Education services**: Services may include individual instruction, group classes, family counseling and/or other health educational programs and materials provided to members by the provider, health plan, or community sponsored programs. • **Health Education materials**: Materials must be available in the appropriate threshold languages, and may be located in an accessible area on site (e.g., exam room, waiting room, health education room or area), or provided to members by clinic staff and/or by Plan upon request. Materials may include written information, audio and/or videotapes, computerized programs, and visual presentation aids. General topics for health educational materials may include Immunizations, Pregnancy, Injury Prevention, Smoking Cessation, Dental Health, Nutrition, Physical Activity, STD/HIV Prevention, Family Planning, Asthma, Hypertension, and Diabetes. • **Plan-specific Referral information**: Plan-specific informing materials and/or resources are available on site in languages that are applicable to member population(s) primarily seen on site. For example, if primarily English and Spanish-speaking members are seen on site, then Plan-specific informing materials are available on site in those languages. Although a site may not stock informing materials in *each* threshold language identified for the county, site personnel has access to contact resource information for locating Plan-specific informing materials in threshold languages not typically seen on site. Interpreter services are provided in all identified threshold and concentration standard languages. **Note**: Threshold languages are the primary languages spoken by Limited English Proficient (LEP) population groups residing in a county. A numeric threshold of 3,000 eligible LEP Medi-Cal beneficiaries, or a concentration standard of 1,000 residing in a single ZIP code or 1,500 in two contiguous ZIP codes establishes the threshold languages identified by DHCS for each county.

V. Preventive Services (continued from previous page)

RN/MD Review only

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

RN/MD Review only

Criteria	VI. Infection Control Reviewer Guidelines
A. Infection control procedures for Standard/Universal precautions are followed.	• Deficiencies: All deficiencies related to Infection Control must be addressed in a corrective action plan. • Hand washing facilities: Hand washing facilities are available in the exam room and/or utility room, and include an adequate supply of running potable water, soap and single use towels or hot air drying machines. Sinks with a standard faucet, foot-operated pedals, 4-6-inch wing-type handle, automatic shut-off systems or other types of water flow control mechanism are acceptable. Staff is able to demonstrate infection control "barrier" methods used on site to prevent contamination of faucet handle, door handles and other surfaces until hand washing can be performed. On occasions when running water is not readily available, an antiseptic hand cleanser, alcohol-based hand rub, or antiseptic towelettes is acceptable until running water is available (29 CFR 1919.1030). • Antiseptic hand cleaner: Hand washing prevents infection transmission by removing dirt, organic material and transient microorganisms from hands. Hand washing with plain (non-antimicrobial) soap in any form (e.g., bar, leaflet, liquid, powder, granular) is acceptable for general patient care (Association for Professionals in Infection Control and Epidemiology, Inc., 1995). Antimicrobial agents or alcohol-based antiseptic hand rubs are used for hand washing when indicated to remove debris and destroy transient microorganisms (e.g., before performing invasive procedures, after contact with potentially infectious materials). Plain and antiseptic hand wash products are properly maintained and/or dispensed to prevent contamination. • Waste disposal container: Contaminated wastes (e.g. dental drapes, band aids, sanitary napkins, soiled disposal diapers) are disposed of in regular solid waste (trash) containers, and are maintained to prevent potential contamination of patient/staff areas and/or unsafe access by infants/children. Closed containers are not required for regular, solid waste trash containers. • Isolation procedures: Personnel are able to demonstrate or verbally explain procedure(s) used on site to isolate patients with potentially contagious conditions from other patients. If personnel are unable to demonstrate or explain site-specific isolation procedures *and* cannot locate written isolation procedure instructions, site is considered deficient. Isolation procedures will vary from site to site. Note: Infection Control standards are practiced on site to minimize risk of disease transmission. Site personnel are expected to apply the principles of "Standard Precautions" (CDC, 1996), used for all patients regardless of infection status. Standard precautions apply to blood, all body fluids, non-intact skin, and mucous membranes, which are treated as potentially infectious for HIV, HBV or HCV, and other bloodborne pathogens. "Universal precautions" refer to the OSHA mandated program that requires implementation of work practice controls, engineering controls, bloodborne pathogen orientation/education, and record keeping in healthcare facilities.

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.

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

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

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

• Blood and Other Potentially Infectious Materials (OPIM): OPIM are all human body fluids, any unfixed tissue or organ (other than intact skin) from a human (living or dead), and HIV or HBV-containing blood, cells, tissue, organs, cultures, medium or solutions. Containers for blood and OPIM are closable, leak proof, and labeled and/or color-coded. Double bagging is required only if leakage is possible.

• Labels: A warning label is affixed to red bagged regulated wastes, sharps containers, refrigerators/freezers containing blood or OPIM, containers used to store or transport blood or OPIM, and contaminated laundry or equipment for storage or transporting. The international biohazard symbol with word "BIOHAZARD" *or* the words "Biohazardous Waste" label (fluorescent orange or red-orange with contrasting lettering/symbols) is part of, or affixed to, the container. Sharps containers are labeled with the words "Sharps Waste" or with the international biohazard symbol and the word "BIOHAZARD". Individual containers of blood or OPIM are exempted from warning labels if placed inside a labeled secondary container for storage, transport, or disposal. Alternative marking or color coding may be used to label contaminated laundry or specimen containers if the alternative marking permits employees on site to recognize that container requires compliance with Universal Precautions.

• Needlestick Safety: Contaminated sharps are discarded immediately. Sharps containers are located close to the immediate area where sharps are used, and are inaccessible to unauthorized persons. Sharps are not bent, removed from a syringe, or recapped except by using a one-handed technique. Needleless systems, needles with Engineered Sharps Injury Protection (ESIP) devices, and non-needle sharps are used (incl. in emergency kits), unless exemptions have been approved by Cal/OSHA (8CCR, Section 5193). Security of portable containers in patient care areas is maintained at all times. Any device capable of cutting or piercing (e.g. syringes, hypodermic needles, needleless devices, blades, broken glass, slides, vials) are placed in a closable, puncture-resistant, labeled, leak-proof container. If these requirements are met, containers made of various materials (e.g., cardboard, plastic) are acceptable. Containers are not overfilled past manufacturer's designated fill line, or more than ¾ full. Supply of containers on hand is adequate to ensure routine change-out when filled.

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

• Contaminated Laundry: Contaminated laundry (soiled with blood/OPIM) is laundered by a commercial laundry service, or a washer and dryer on site. Contaminated laundry should not contain sharps, and when transported, should have the appropriate warning label (see Labels bullet above). Manufacturer's guidelines are followed to decontaminate and launder reusable protective clothing. Laundry requirements are "not applicable" if only disposable patient gowns and PPE are used on site.

• Regulated Waste storage: Regulated wastes include: 1) **Biohazardous wastes**, e.g., laboratory wastes, human specimens/tissue, blood/contaminated materials "known" to be infected with highly communicable diseases for humans and/or that require isolation, and 2) **Medical wastes**, e.g., liquid/semi-liquid blood or OPIM, items caked with dry blood or OPIM and capable of releasing materials during handling, and contaminated sharps. Regulated waste is contained separately from other wastes (e.g., contaminated wastes)* *and* placed in red biohazardous bags with Biohazard label, and stored in a closed container that is not accessible to unauthorized persons. If stored outside the office, a lock secures the entry door, gate or receptacle lid, and posted warning sign(s) in English *and* Spanish are visible for 25-feet: "CAUTION-BIOHAZARDOUS WASTE STORAGE AREA- UNAUTHORIZED PERSONS KEEP OUT" or "CUIDADO-ZONA DE RESIDUOUS-BIOLOGICOS PELIGROS-PROHIBIDA LE ENTRADA A PERSONAS NO AUTHORIZADAS." Signs prior to the passage of the Medical Waste Act are permitted for the "life" of the sign.

• Medical Waste disposal: Medical wastes are hauled to a permitted offsite medical waste treatment facility, transfer station, or other registered generator by a registered hazardous waste transporter *OR* person with an approved limited-quantity hauling exemption granted by the CDPH Division of Drinking Water and Environmental Management Branch. Limited-quantity hauling exemptions are renewed annually. A medical waste tracking document that includes the name of the person transporting, number of waste containers, types of medical wastes, and date of transportation, is kept a minimum of 3 years for large waste generators and 2 years for small generators. Medical Waste (including sharps) transported by mail are only acceptable through vendors on the approved CDPH Mail Back Service List at: www.cdph.ca.gov/certlic/medicalwaste/Documents/MedicalWaste/SharpsMailBackList.pdf .

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

*Note: Contaminated wastes include materials soiled with blood during the course of their use but are not within the scope of regulated wastes. Contaminated waste items need not be disposed as regulated waste in labeled red bags, but can be discarded as solid waste in regular trash receptacle.

VI. Infection Control (continued on next page)

RN/MD Review only

Infection Control Survey Criteria	Yes	No	N/A	Wt.	Site Score
B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. 8 CCR §5193 (Cal OSHA Health Care Worker Needlestick Prevention Act, 1999); H& S Code, §117600-118360 (CA Medical Waste Management Act, 1997); 29 CFR §1910.1030.					
1) Personal Protective Equipment is readily available for staff use.	1)____	1)____	1)____	2	
2) **Needlestick safety precautions are practiced on site.**	2)____	2)____	2)____	2	
3) All sharp injury incidents are documented.	3)____	3)____	3)____	1	
4) Blood, other potentially infectious materials and Regulated Wastes are placed in appropriate *leak proof, labeled* containers for collection, handling, processing, storage, transport or shipping.	4)____	4)____	4)____	2	
5) Biohazardous (non-sharp) wastes are contained separate from other trash/waste.	5)____	5)____	5)____	1	
6) Contaminated laundry is laundered at the workplace or by a commercial laundry service.	6)____	6)____	6)____	1	
7) Storage areas for regulated medical wastes are maintained secure and inaccessible to unauthorized persons.	7)____	7)____	7)____	1	
8) Transportation of regulated medical wastes is only by a registered hazardous waste hauler or by a person with an approved limited-quantity exemption.	8)____	8)____	8)____	1	

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

RN/MD Review only

Criteria	VI. Infection Control Reviewer Guidelines
C. Contaminated surfaces are decontaminated according to Cal-OSHA standards.	• **Deficiencies**: All deficiencies related to Infection Control must be addressed in a corrective action plan. • **Routine Decontamination**: Contaminated work surfaces are decontaminated with an appropriate disinfectant (29 CFR 1910.1030). Written "housekeeping" schedules have been established and are followed for regular routine daily cleaning. Staff is able to identify frequency for routine cleaning of surfaces and equipment, the disinfectant used and responsible personnel. • **Spill Procedure**: Staff is able to identify procedures for prompt decontamination of blood/body fluid spills, the disinfectant used, and the responsible person(s). • **Disinfectant Products**: Products used for decontamination have a current EPA-approved status. Effectiveness in killing HIV/HBV/TB is stated on the manufacturer's product label. Decontamination products are reconstituted and applied according to manufacturer's guidelines for "decontamination." • **10% Bleach Solution**: 10% bleach solution that is EPA registered, effective against TB, is changed/reconstituted *every* 24 hours (due to instability of bleach once mixed with water). Surface is cleaned prior to disinfecting (due to presence of organic matter (e.g., dirt, blood, excrement) inactivates active ingredient, sodium hypochlorite). Surface is air dried or allowed appropriate time (stated on label) before drying. Manufacturer's directions, *specific* to every bleach product, are followed carefully. Note: "Contamination" means the presence or reasonably anticipated presence of blood or OPIM on any item or surface. "Decontamination" is the use of appropriate physical or chemical means to remove, inactivate or destroy bloodborne pathogens so that a surface or item is no longer capable of transmitting infectious particles and is rendered safe for handling, use or disposal. Current EPA product lists and information is available from the EPA, Antimicrobial Division at (703) 305-1284, or at www.epa.gov/oppad001/chemreglndex.htm.

VI. Infection Control (continued on next page)

RN/MD Review only

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

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

RN/MD Review only

Criteria	VI. Infection Control Reviewer Guidelines
D. Reusable medical instruments are properly sterilized after each use.	• **Deficiencies**: All deficiencies related to Infection Control must be addressed in a corrective action plan. • **Cleaning prior to sterilization**: Prior to undergoing the sterilization process, soiled instruments/equipment are thoroughly cleaned, rinsed, dried and inspected for the presence of dried blood or other debris. Personnel are able to demonstrate or verbally explain procedure(s) used for cleaning prior to sterilization, and to locate written directions on site. • **Cold/chemical sterilization**: Product manufacturer's directions are strictly followed for instrument pre-soaking treatment, solution preparation, solution exposure procedures, safety precautions (e.g., room temperature, area ventilation), and post-sterilization processes. Sterilization exposure times and solution expiration date/time is communicated to staff. Written procedures for cold sterilization are available on site to staff. • **Autoclave/steam sterilization**: Autoclave manufacturer's directions are strictly followed for instrument pre-cleaning, machine loading, operation safety precautions, minimum time-temperature criteria, and post sterilization processes. Written operating procedures for autoclave are available on site to staff. Documentation of sterilization loads includes: date, time and duration of run cycle, temperature, steam pressure, and operator of each run. If instruments/equipment are transported off-site for sterilization, equipment-handling and transport procedures are available on site to staff. • **Autoclave maintenance**: Autoclave is maintained and serviced according to manufacturer's guidelines. Documentation of maintenance should include: mechanical problems, inspection dates, results/outcome of routine servicing, calibration, repairs, etc. Note: If the manufacturer's guidelines are not present on site, then the autoclave is serviced annually by a qualified technician. A dated sticker on the autoclave or a service receipt is acceptable documentation of appropriate maintenance. • **Spore testing**: Autoclave spore testing is performed *at least monthly*, unless otherwise stated in manufacturer's guidelines. Documentation of biological spore testing includes: date, results, types of spore test used, person performing/documenting test results. Written procedures for performing routine spore testing and for handling positive spore test results are available on site to staff. For positive spore tests, the autoclave is removed from service immediately until inspection is completed and a negative retest occurs. Procedures include: ***report*** problem, ***repair*** autoclave, ***retrieve*** all instruments sterilized since last negative spore test, ***re-test*** autoclave and ***re-sterilize*** retrieved instruments (Report/Repair/Retrieve/Retest/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.

VI. Infection Control (continued from previous page)

RN/MD Review only

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

Attachment B

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
____ Initial Full Scope ____ Monitoring	____ AAAHC ____ JCAHO	____ Family Practice ____ Internal Medicine	____ Primary Care ____ Community
____ Periodic Full Scope ____ Follow-up	____ CHDP ____ NCQA	____ Pediatrics ____ OB/GYN	____ Hospital ____ FQHC
____ Focused Review ____ Ed/TA	____ CPSP ____ None	____ General Practice ____ Specialist	____ Rural Health ____ Other _____ (type)
____ Other _____ (type)	____ Other _____	____ Mid-level (type) _____	____ Solo ____ Group ____ Staff/Teaching

Scoring Procedure

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

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

Medical Record Scores

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

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

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

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

Compliance Rate

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

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

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

__**Not Pass: Below 80%**

__CAP Required

__Other follow-up

Next Review Due: _____

Medical Record Review Guidelines

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

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

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

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

Scoring Example:

Step 1: Add the points given in each section.

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

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

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

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

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

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

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

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

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

I. Format Criteria

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

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

Comments:

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

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

II. Documentation Criteria

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

RN/MD Review only

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

Comments:

7
Pts. Possible

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

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

III. Coordination/Continuity of Care Criteria

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

RN/MD Review only

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

Comments:

8
Pts. Possible

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

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

IV. Pediatric Preventive Criteria (continued on next page)

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

RN/MD Review only Note:

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

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

IV. Pediatric Preventive Criteria (continued from previous page)

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

RN/MD Review only

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

Comments:

19
Pts. Possible

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

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

V. Adult Preventive Criteria (continued on next page)

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

RN/MD Review only

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

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

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

V. Adult Preventive Criteria (continued from previous page)

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

RN/MD Review only

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

Comments:

15
Pts. Possible

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

Criteria	VI. OB/CPSP Preventive Reviewer Guidelines (continued on next page)
A. Initial Comprehensive Assessment (ICA)	Note: Item A.1 assesses the timeframe of a completed ICA. Items A2-9 assess the individual components of the ICA, and can receive a "yes" score - *apart from the timeframe.*
1. ICA completed within 4 weeks of entry to prenatal care	The ICA was completed within 4 weeks of entry to prenatal care.
2. Obstetrical and Medical History	Obstetric/medical: Health and obstetrical history (past/current), LMP, EDD.
3. Physical Exam	Physical exam: includes breast and pelvic exam.
4. Lab tests	Lab tests: hemoglobin/hematocrit, urinalysis, urine culture, ABO blood group, Rh type, rubella antibody titer, STI screen.
5. Nutrition	Nutrition: Anthropometric (height/weight), dietary evaluation, prenatal vitamin/mineral supplementation.
6. Psychosocial	Psychosocial: Social and mental health history (past/current), substance use/abuse, support systems/resources.
7. Health Education	Health education: Language and education needs.
8. Screening for Hepatitis B Virus	All pregnant women are screened for Hepatitis B during their first trimester or prenatal visit, whichever comes first.
9. Screening for Chlamydia Infection	All pregnant women ages 25 and younger, and older pregnant women who are at increased risk, are screened for chlamydia during their first prenatal visit.
B. Second Trimester Comprehensive Re-assessment	Subsequent comprehensive prenatal re-assessments include Obstetric/medical, Nutrition, Psychosocial and Health Education re-assessments are completed during the 2nd trimester.
C. Third Trimester Comprehensive Re-assessment	Subsequent comprehensive prenatal re-assessments include Obstetric/medical, Nutrition, Psychosocial and Health Education re-assessments are completed during the 3rd trimester.
1. Screening for Strep B	All pregnant women are screened for Group B Streptococcus between their 35th and 37th week of pregnancy.
D. Prenatal care visit periodicity according to most recent ACOG standards	ACOG's *Guidelines for Perinatal Care* recommend the following prenatal schedule for a 40-week uncomplicated pregnancy: • First visit by 6-8th week • Approximately every 4 weeks for the first 28 weeks of pregnancy • Every 2-3 weeks until 36 weeks gestation • Weekly thereafter until delivery • Postpartum visit within 4-8 weeks after delivery If the recommended ACOG schedule is not met, documentation shows missed appointments, attempts to contact member and/or outreach activities.

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

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

RN/MD Review only

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

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

Criteria	VI. OB/CPSP Preventive Reviewer Guidelines (continued from previous page)
E. Individualized Care Plan (ICP)	ICP documentation includes specific obstetric, nutrition, psychosocial and health education risk problems/conditions, interventions, and referrals.
F. Referral to WIC and assessment of Infant Feeding status	Pregnant and breastfeeding Plan members must be referred to WIC (Public Law 103-448, Section 203(e)). Referral to WIC is documented in the medical record (Title 42, CFR 431.635). Infant feeding plans are documented during the prenatal period, and infant feeding/breastfeeding status is documented during the postpartum period (MMCD Policy Letter 98-10). Note: Although WIC determines eligibility for program participation, nearly all Medi-Cal beneficiaries are income eligible for WIC. Federal regulations specify that pregnant and breastfeeding women are given the highest priority for WIC Program enrollment.
G. HIV-related services *offered*	The ***offering*** of prenatal HIV information, counseling and HIV antibody testing is documented (CA Health & Safety Code, Section 125107). Practitioners are ***not required*** to document that the HIV test was given or disclose (except to the member) the results (positive or negative) of an HIV test. Offering a prenatal HIV test is not required if a positive HIV test is already documented in the patient's record or if the patient has AIDS diagnosed by a physician. Note: Member's participation is voluntary. Practitioner may provide HIV test or refer to other testing program/site. Documentation or disclosure of HIV related information must be in accordance with confidentiality and informed consent regulations.
H. AFP/Genetic Screening *offered*	The ***offering*** of blood screening tests prior to 20 weeks gestation counting from the first day of the last normal menstrual period is documented (CCR, Title 17, Sections 6521-6532). Genetic screening documentation includes: 1) family history, 2) Triple marker screening tests: Alpha Fetoprotein (AF), unconjugated estriol (UE), human chorionic gonadotropin (HCG), 3) member's consent or refusal to participate. Note: Member's participation is voluntary. Testing occurs through CDPH Expanded AFP Program, and only laboratories designated by CDPH may be used for testing.
I. Domestic Violence/Abuse Screening	Provision of a Domestic Violence Screening is documented. Assessment checklists, body diagrams and/or documentation in progress notes are acceptable. Domestic violence screening includes medical screening, documentation of physical injuries or illnesses attributable to spousal/partner abuse, and referral to appropriate community service agencies (CA Health & Safety Code, Section 1233.5).
J. Family Planning Evaluation	Family Planning counseling, referral or provision of services is documented (MMCD Policy Letter 98-11).
K. Postpartum Comprehensive Assessment	Comprehensive postpartum reassessment includes the 4 components: medical exam, nutrition (mother and infant), psychosocial, health education are completed within 4-8 weeks postpartum (MMCD Policy Letter 96-01). If the postpartum assessment visit is not documented, medical record documents missed appointments, attempts to contact member and/or outreach activities. Infant feeding/breastfeeding status is documented during the postpartum period (MMCD Policy Letter 98-10).

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

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

RN/MD Review only

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

Comments:

20
Pts. Possible

Physical Accessibility Review Survey

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

Provider Name: ☐ PCP ☐ Specialist ☐ Ancillary	Date of Review: Name of Reviewer:
Address: City:	Health Plan Name:
Phone: FAX:	Contact Person Name:
	Level of Access:
Basic Access: Demonstrates facility site access for the members with disabilities to parking, building, elevator, doctor's office, exam room and restroom. To meet Basic Access requirements, all (29) Critical Elements (CE) must be met.	☐ Basic Access
Limited Access: Demonstrates facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, doctor's office, exam room, and restroom. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.	☐ Limited Access
Medical Equipment Access: PCP site has height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus patient). This is noted in addition to level of Basic or Limited Access as appropriate.	☐ Medical Equipment is available

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

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

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

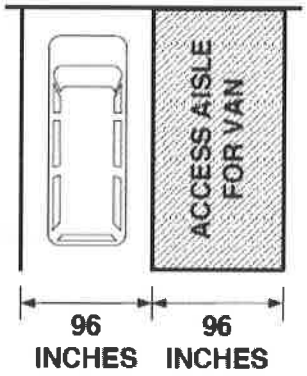
I certify that there have been no changes since the last physical accessibility review:

Name: _____ Signature: _____ Date: _____

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

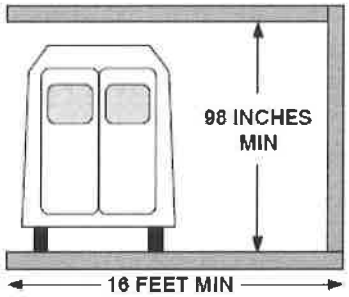
Name: _____ Signature: _____ Date: _____

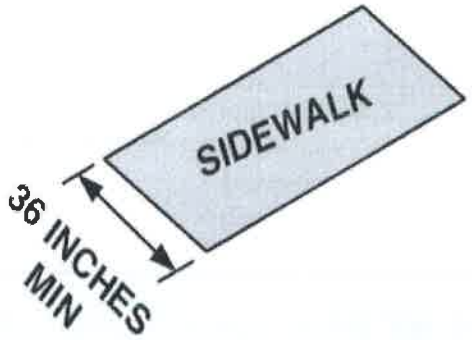
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
PARKING						
1	Is off-street public parking available?	Self explanatory.				
2	Are accessible parking spaces provided in off-street parking?	Self explanatory.				
3 (CE)	**Are the correct number of accessible parking spaces provided?** **1 to 25 total spaces – 1 required** **26 to 50 – 2 required** **51 to 75 – 3 required** **76 to 100 – 4 required** **101 to 150 – 5 required** **151 to 200 – 6 required** **201 to 300 – 7 required** **301 to 400 – 8 required**	If there are 25 total parking spaces or less, at least one accessible space is required. If there are between 26 and 50 total spaces, at least two accessible spaces are required, etc.				

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

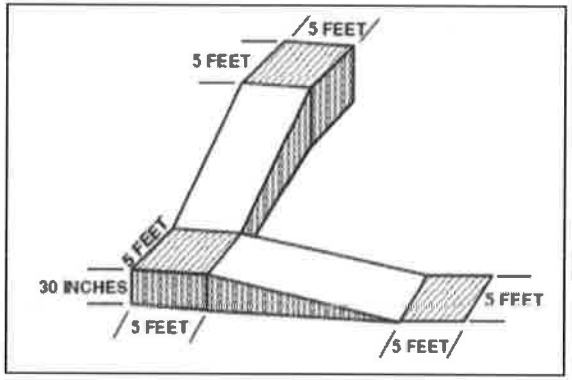
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
7 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the parking locations?**	Pathways should have curb ramps. Without curb ramps, wheelchair users may be required to travel in the street or behind parked cars where drivers cannot see them.				
8 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the drop off locations?**	See above Question # 7.				
9	Does every accessible parking space have a vertical sign posted with the International Symbol of Accessibility?	Symbol in the illustration depicts the International Symbol of Accessibility.  6				

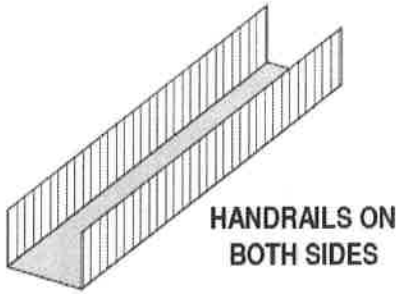
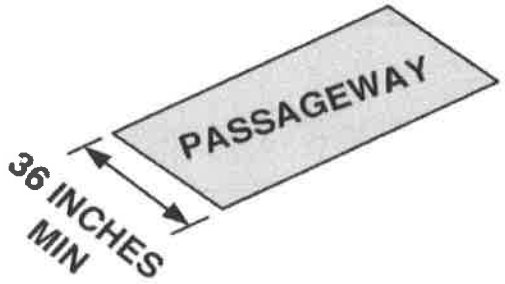
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
10	Are signs mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle?	Signs must be located so a vehicle parked in the space does not obscure them. (Van accessible spaces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

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
13	If van accessible parking is provided in a parking garage, is there at least 8 feet 2 inches (98 inches total) vertical clearance available for full-sized, lift equipped vans?	If there is no parking garage, check NA. If designated accessible parking is located in a garage, the vertical clearance should be at a minimum 8 feet 2 inches (98 inches). Vertical clearance should be posted.  				
EXTERIOR ROUTE (FROM ACCESSIBLE PARKING, PUBLIC TRANSPORTATION, AND PUBLIC SIDEWALK TO THE ENTRANCE)						
14 (CE)	**For exterior routes, if the accessible route crosses a curb, is a curb ramp provided to the building entrance from the following: (Please mark NA for those that do not apply.)**	Self explanatory.				
	a. Parking?					
	b. Public transportation?					

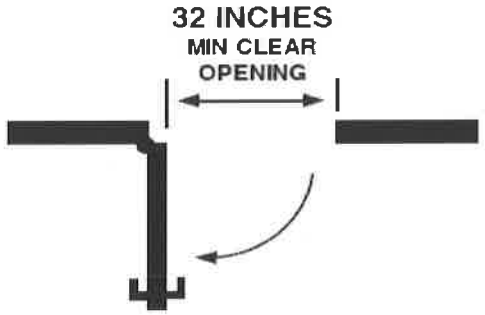
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	c. Public sidewalk?					
15	Is the accessible route to the building entrance at least 36 inches wide for exterior routes from the following: (Please mark NA for those that do not apply.)					
	a. Parking?					
	b. Public transportation?					
	c. Public sidewalk?					
16	Is the accessible route to the building entrance stable, firm, and slip resistant from the following: (Please mark NA for those that do not apply.)	An example of a stable surface is a floor or ground surface without loose elements like gravel or wood chips. Firm surfaces include solid concrete or pavement as opposed to a grassy, graveled or soft soil surface. Avoid glossy or slick surfaces such as ceramic tile.				
	a. Parking?					

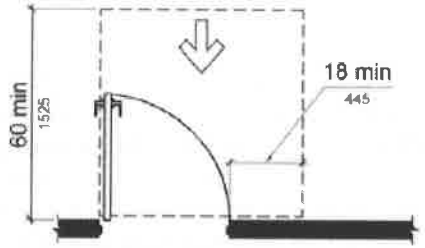
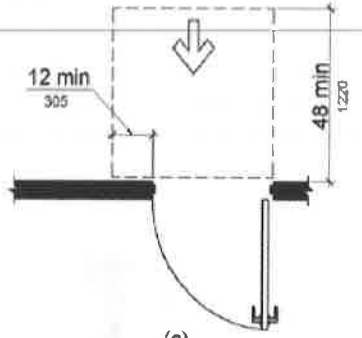
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	b. Public transportation?					
	c. Public sidewalk?					
17	Is there an accessible route that does not include stairs or steps?	Self explanatory.				
18	Is the route to the entrance from the accessible parking spaces,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

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
20 (CE)	**Is each run (leg) of the ramp no longer than 30 feet between landings?**	**Each "run," shown in the white sections in the diagram below, must be no longer than 30 feet.** 				
21	Are 60 inches (5 feet) long, level landings provided at the top and bottom of each ramp run?	See Question 20 diagram above.				

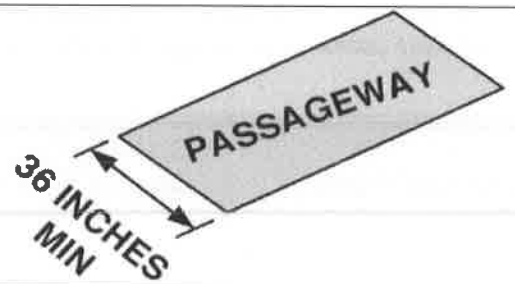
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
22 (CE)	**Are handrails provided on both sides of the ramp that are mounted between 34 and 38 inches above the ramp surface, if it is longer than 6 feet?**	If the ramp is not longer than 6 feet, check NA.  				
23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

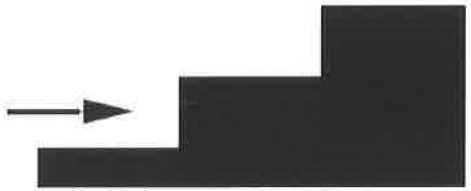
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
BUILDING ENTRANCE						
24	Is the main entrance accessible?	Self explanatory.				
25 (CE)	**If a main entrance is not accessible, is there another accessible entrance?**	Self explanatory.				
26	If a main entrance is not accessible, is there directional signage indicating the location of the accessible entrance?					

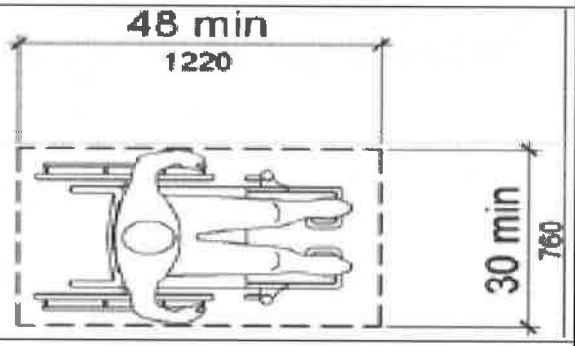
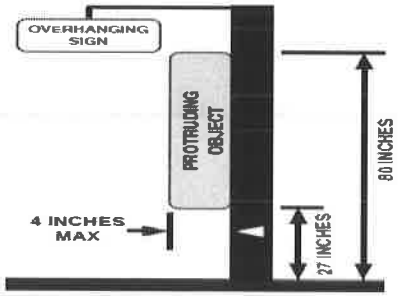
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
27 (CE)	**Do doors have an opening at least 32 inches wide (at the narrowest point below the opening hardware) when opened to 90°?**	When measuring double doors, measure the opening with one door open to 90°.  				
28 (CE)	**Is space available for a wheelchair user to approach, maneuver, and open the door?**	Appropriate space perpendicular and parallel to a doorway permits a wheelchair user, people using walkers and other mobility devices to open the door safely and independently. Following are two common examples of required minimum maneuvering clearances: 1. Approaching the door and pulling it toward you to open requires 60 inches of clear space perpendicular to the doorway and 18 inches parallel to the doorway. 2. Approaching the door and pushing it away from you to open requires 48 inches of clear space perpendicular to the doorway.				

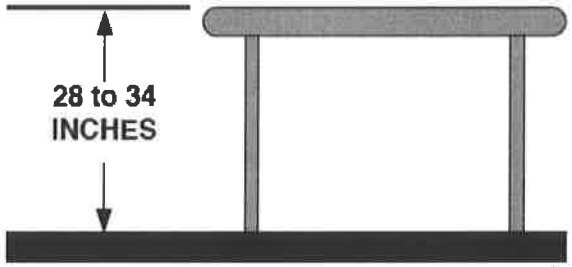
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
		 (a) front approach, pull side				
		 (c) front approach, push side, door provided with both closer and latch				
29	Is the space required to open the door level and clear of movable objects (chairs, trash cans, etc.)?	If there are nonpermanent items such as trash cans, merchandise, etc., located in these areas, they must be removed or relocated.				

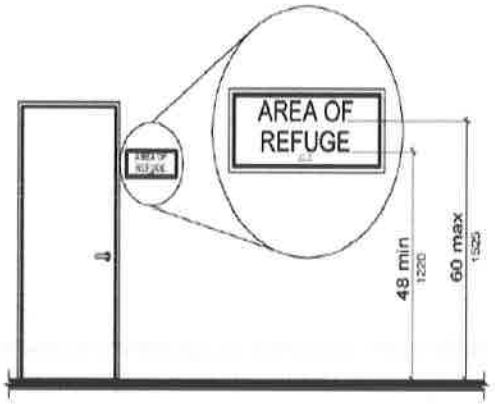
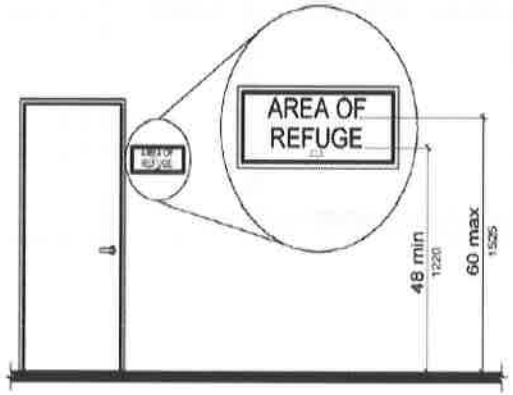
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
30	Are there automatic doors?	Self explanatory.				
31 (CE)	**Do entrance doors have handles that can be opened without grasping, pinching, or twisting of the wrist?**	Can the door be opened by someone with a closed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

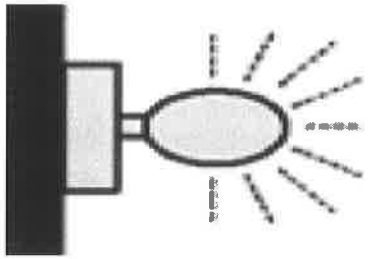
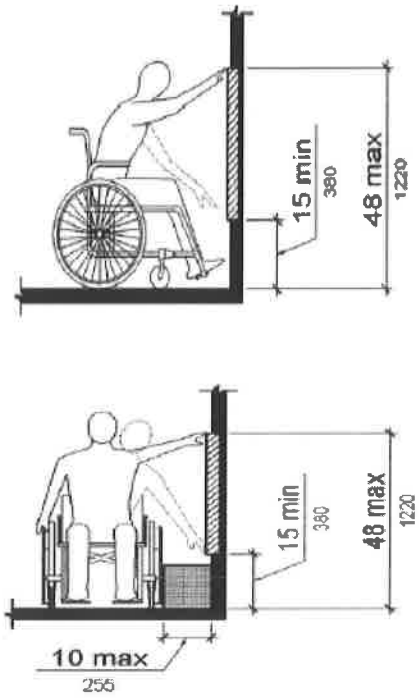
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
33	Is there an interior accessible route to the medical office that does not include stairs or steps?	Floors of a given story are level throughout the building, or connected by ramps, passenger elevators or access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

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

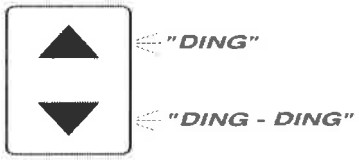
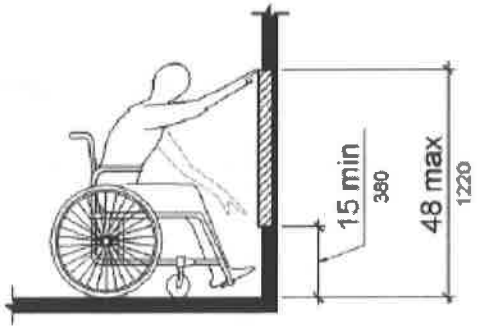
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
41	Does the interior door to the medical office require less than 5 pounds of pressure to open?	If interior door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be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

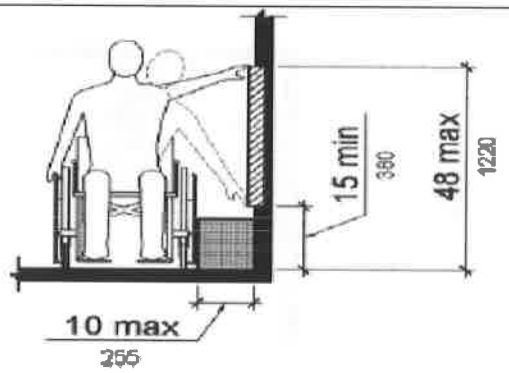
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
44	If floor mats are used, are the edges of floor mats stiff enough or secured so that they do not roll up?	If floor mats are not in use, check NA. Floor mats that are not secured to the floor can roll up or bunch up under walkers or wheelchair casters and cause a tripping hazard.				
45	Is a section of the sign-in/registration counter no more than 34 inches high and at least 36 inches wide and free of stored items.					
46	Does the office have a method, other than a lowered counter, by which people can sign in/register? (If yes, please note this method in comments.)	A medical office may use reasonable alternative methods to meet this need such as a clip board.				

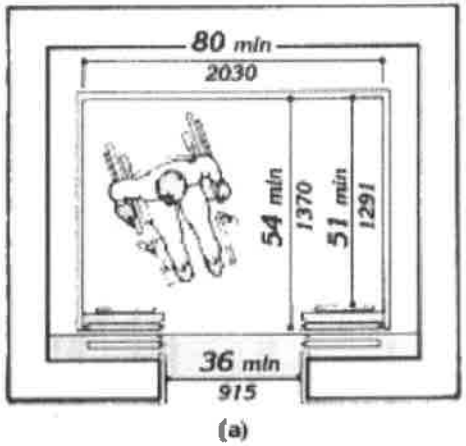
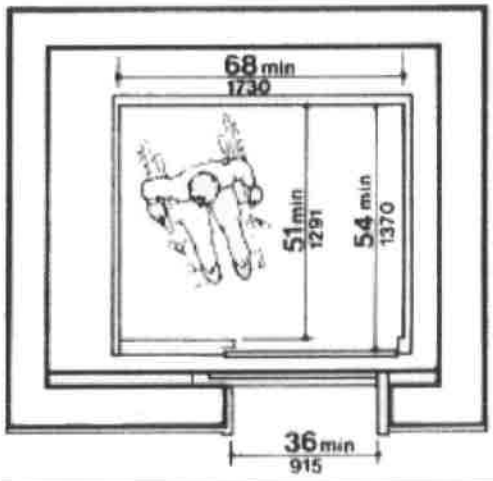
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
47	Do signs identifying permanent rooms and spaces include raised letters and Braille?					
48	Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor?	 Raised letters and Braille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

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
49	If the building has a fire alarm system, are visual signals provided in each public space, including toilet rooms and each room where patients are seen?	If the building does not have a fire alarm system, check NA. 				
50	Are all patient-operated controls (call buttons, self-service literature, brochures, hand sanitizers, etc.) mounted or presented between 15 inches and 48 inches from the floor?					

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

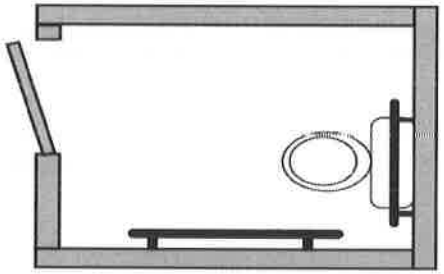
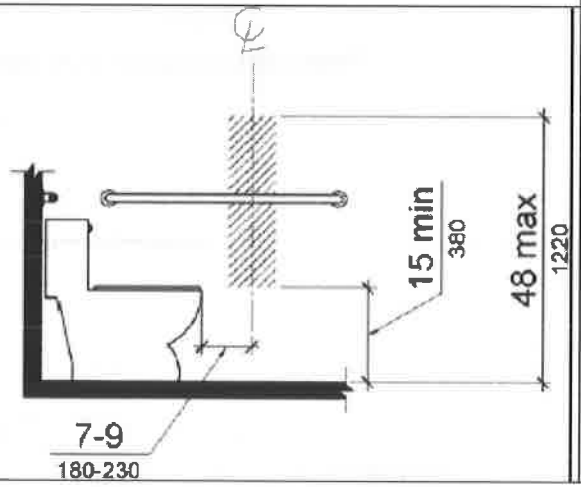
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
54 (CE)	**Is the elevator equipped with both visible and audible door opening/closing and floor indicators?**	A visible and audible signal is required at each elevator entrance to indicate which car is answering a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

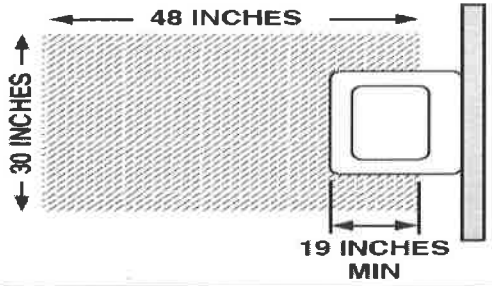
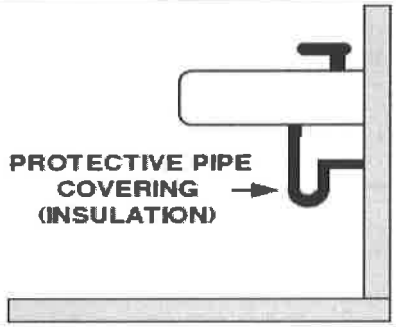
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
						

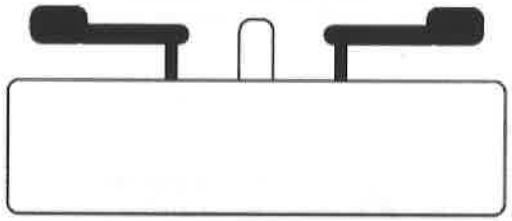
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
57 (CE)	**Is the elevator car large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit?**	The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide, depending on where the door is located.  (a)  				

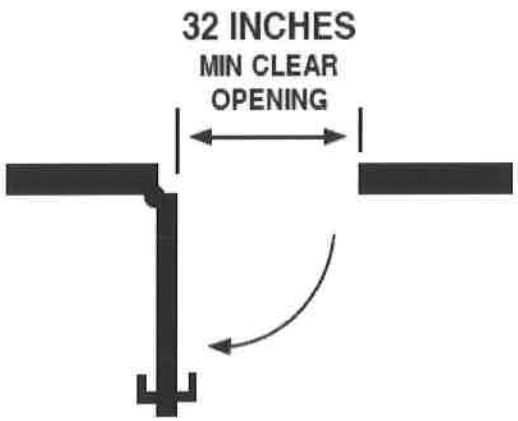
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
58 (CE)	**Do the buttons on the control panel inside the elevator have Braille and raised characters/symbols near the buttons?**	Self explanatory.				
59	Is there an emergency communication system in the elevator?	Self explanatory.				
60	Is the elevator emergency communication system usable without requiring voice communication?	It is essential that emergency communication not be dependent on voice communications alone because the safety of people with hearing or speech impairments could be jeopardized. Visible signal requirement could be satisfied with something as simple as a button that lights when the message is answered, indicating that help is on the way.				

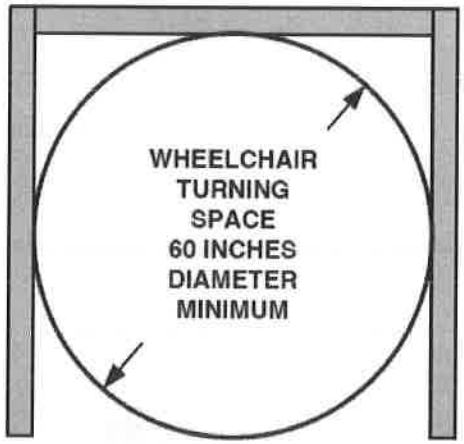
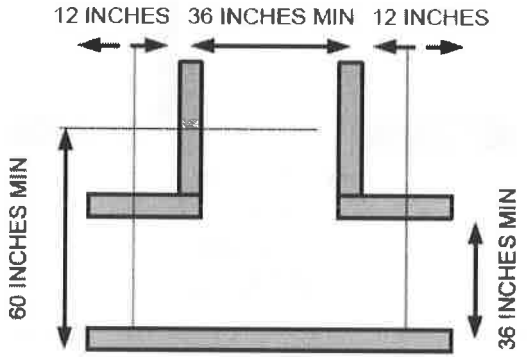
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
61	Do raised letters and Braille identify the emergency intercom in the elevator?	Self explanatory.				
TOILET ROOMS (INCLUDING THOSE USED FOR SPECIMEN COLLECTION)						
ALL TOILET ROOMS:						
62	Is there an accessible toilet room?	Self explanatory.				
63	If there is an inaccessible toilet room, is there directional signage to an accessible toilet room?	Mark NA if there are no inaccessible toilet rooms. Self explanatory.				
64	Does the interior door to the restroom require less than 5 pounds of pressure to open?	If restroom door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the				

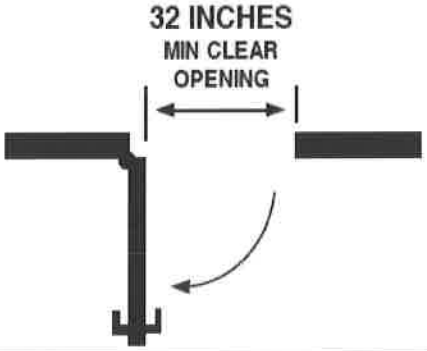
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
		weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
65 (CE)	**For all toilet rooms with and without stalls:** **Are grab bars provided, one on the wall behind the toilet and one on the wall next to the toilet?**	Grab bars should be installed in a horizontal position between 33 and 36 inches above the floor measured to the top of the gripping surface. 				
66	Are all objects mounted at least 12 inches above and 1½ inches below the grab bars?	This includes seat cover dispensers, toilet paper dispensers, sanitizers, trash containers, etc.				
67 (CE)	**Is the toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7 inches and 9 inches in front of the toilet, and at least 15 inches high?**					

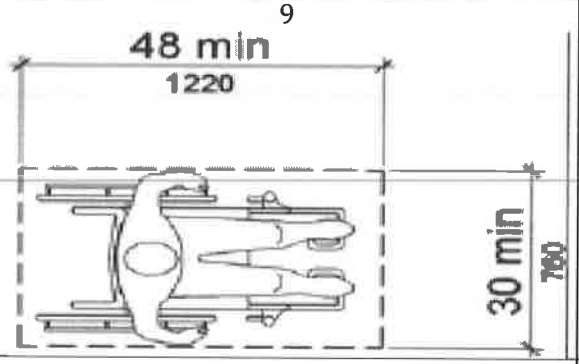
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
68 (CE)	**Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair users to park in front of the sink?**	This space must extend at least 17 inches under the sink from the front edge, although it can extend up to 19 inches underneath. 				
69	Is the space in front of the sink free of trash cans and other movable items?	Self explanatory.				
70	Are the pipes and water supply lines under the sink wrapped with a protective cover?					
71 (CE)	**Are faucet handles operable with one hand and without grasping, pinching, or twisting? (Check Yes if faucets are automatic.)**	A knob handle would not be accessible.				

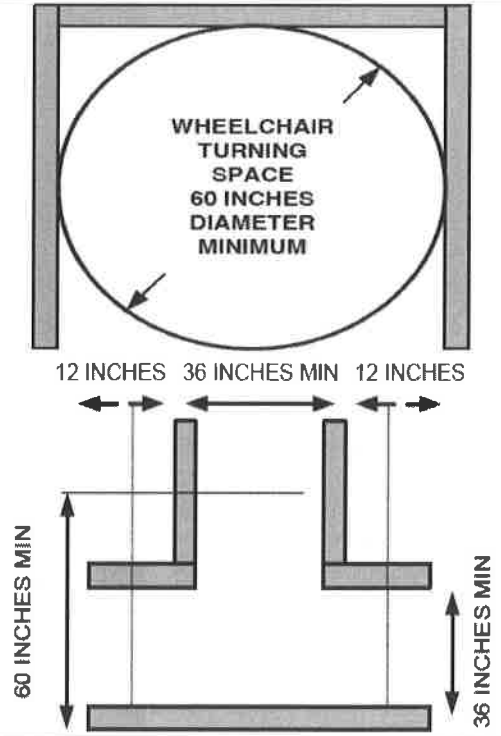
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
		LEVER HANDLES 				
72	Are all dispensers mounted no higher than 40 inches from the floor?	Included are soap dispensers, paper towel dispensers, seat cover dispensers, hand dryers, etc.				
73	Are all dispensers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

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	TOILET ROOM WITHOUT STALLS					
75 (CE)	***Toilet room without stalls:*** **Do toilet room doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**	If there is no toilet room without stalls, check NA. 				
76	Is the space inside the toilet room without stalls clear, without trash cans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	TOILET ROOM WITH STALLS					
77 (CE)	***Toilet Room with stalls:*** **Is there a 60-inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space inside the toilet room with stalls to allow a turn around for wheelchair and scooter users?**	If there is no toilet room with stalls, check NA.  				

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

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
81 (ME)	**Is there a height adjustable exam table that lowers to between 17 inches and 19 inches from the floor to the top of the cushion?**	Self explanatory				
82 (ME)	**Is there space next to the height adjustable exam table for a wheelchair or scooter user to approach, park, and transfer or be assisted to transfer onto the table?**					
83	Does the exam table provide elements to assist during a transfer (such as rails) and support a person while on the table? (If yes, please list in comments.)	Items that could help support a patient while on the table would be armrests, side rails, padded straps, cushions, wedges, etc.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
84	Is a lift available to assist staff with transfers (portable, overhead, or ceiling mounted)?	Self explanatory.				
85 (CE)	**Is there a 60 inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space so that a wheelchair or scooter user can make a 180° turn?**					

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
86 (ME)	**Is a weight scale available within the medical office with a platform to accommodate a wheelchair or scooter and the patient?**	Accessible scales are usable by all people including: wheelchair users, people with activity limitations, and larger people who may exceed a standard weight scale limit. This includes people with conditions that interfere with mobility, walking, climbing, using steps (joint pain, short stature, pregnancy, fatigue, respiratory and cardiac conditions, post surgical conditions, orthopedic injuries); and/or who use mobility devices (e.g. canes, crutches, walkers).				

References

2010 ADA Standards for Accessible Design
U.S Department of Justice
http://www.ada.gov/2010ADAstandards_index.htm

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

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

1133B.4.4 – Striping for the visually impaired (Rev.1-1-2009), and 1115B-1 – Bathing and Toilet Facilities, placement of toilet paper dispensers. These standards can be found in:
2009 California Building Standards Code with California Errata and Amendments
State of California
Department of General Services
Division of the State Architect
Updated April 27, 2010
http://www.documents.dgs.ca.gov/dsa/pubs/access_manual_rev_04-27-10.pdf

Some diagrams are reprinted with permission from the Kentucky Department of Vocational Rehabilitation. These illustrations can also be found in:
"Health Care Usability Profile V3"

Oregon Health & Science University RRTC: Health & Wellness
Authors: Drum, C.E., Davis, C.E., Berardinelli, M., Cline, A., Laing, R., Horner-Johnson, W., & Krahn, G.
Oregon Institute on Disability and Development
Portland, OR 97239
rrtc@ohsu.edu
healthwellness.org

Ancillary Services Physical Accessibility Review Survey

California Department of Health Care Services
Managed Care Quality and Monitoring Division

For purposes of this tool, Ancillary Services refers to Diagnostic and Therapeutic services such as, but not limited to: Radiology, Imaging, Cardiac Testing, Kidney dialysis, Physical Therapy , Occupational therapy , Speech therapy ,Cardiac rehabilitation, Pulmonary testing.

Provider Name: _____ ☐ Radiology ☐ Infusion ☐ Physical Therapy ☐ Other _____	Date of Review: Name of Reviewer:
Address: City:	Health Plan Name:
Phone: FAX:	Contact Person Name:

	Level of Access:
Basic Access: Demonstrates ancillary facility site access for the members with disabilities to parking, building, elevator, restroom, diagnostic and treatment use. To meet Basic Access requirements, all (34) Critical Elements (CE) must be met.	☐ Basic Access
Limited Access: Demonstrates ancillary facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, restroom, diagnostic and treatment use. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.	☐ Limited Access
Medical Equipment: Diagnostic and treatment equipment meet accessibility features for use as indicated the "accessibility indicators". (assistance is available for the equipment used).	☐ Medical Equipment is available ☐ List of Equipment

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

These symbols are in addition to identifying whether the provider office has Basic Access or Limited Access. A provider who has Basic Access will automatically meet the critical elements for the first 5 symbols (P, EB, IB, R, PD).

Accessibility Indicator	Must Satisfy these Criteria	Yes	No	N/A	Comments
P = PARKING	**Critical Elements (CE): 3,7,8,11**				
EB = EXTERIOR BUILDING	**(CE): 14,20,21,22,25**				
IB = INTERIOR BUILDING	**(CE): 28,31,42,43,44,45,46,47**				
R =RESTROOM	**(CE): 53, 55,56,59,62,64**				
PD = PATIENT DIAGNOSTIC AND TREATMENT USE	**(CE): 66,67,70,76,78**				
T = MEDICAL EQUIPMENT	**(T): 72,73,74,77,80,81**				

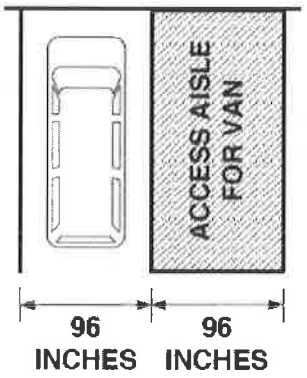
2nd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

Name: _____ Signature: _____ Date: _____

3rd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

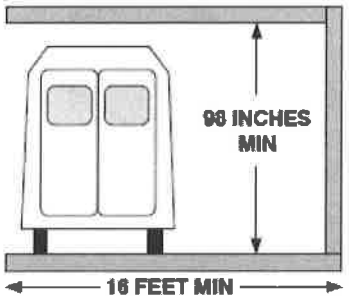
Name: _____ Signature: _____ Date: _____

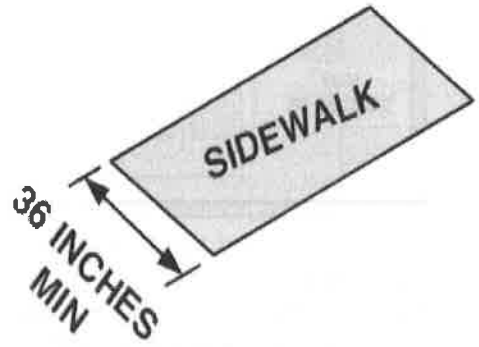
PARKING						
1	Is off-street public parking available?	Self explanatory.				
2	Are accessible parking spaces provided in off-street parking?	Self explanatory.				
3 (CE)	**Are the correct number of accessible parking spaces provided?** **1 to 25 total spaces – 1 required** **26 to 50 – 2 required**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

5	Is there an access aisle next to the accessible space(s)?	The access aisle is the space next to the accessible parking space where a person using the accessible space can load and unload from the vehicle.  				
6	Is the parking space(s) and access aisle(s) free of curb ramps that extend into the space and other obstructions?	If a curb ramp extends into the parking space(s) or access aisle, a person using that space and aisle would not have adequate level space to unload and load from the vehicle.				

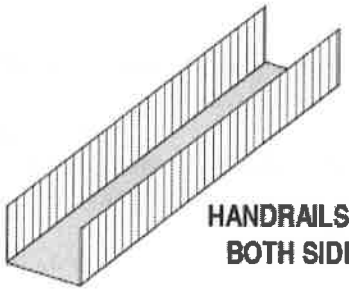
7 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the parking locations?**	**Pathways should have curb ramps. Without curb ramps, wheelchair users may be required to travel in the street or behind parked cars where drivers cannot see them.**				
8 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the drop off locations?**	**See above Question # 7.**				

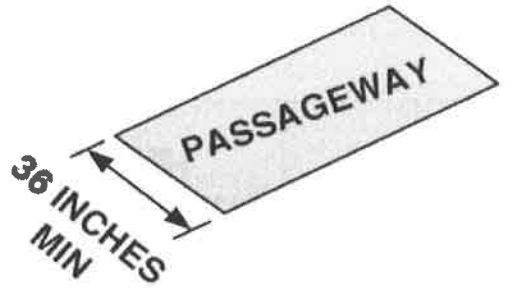
9	Does every accessible parking space have a vertical sign posted with the International Symbol of Accessibility?	Symbol in the illustration depicts the International Symbol of Accessibility. 				
10	Are signs mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle?	Signs must be located so a vehicle parked in the space does not obscure them. (Van accessible spaces must be indicated with an additional sign)				
	Is VAN accessible parking provided?	**1 van space for every 6 standard accessible spaces must be provided, but never less than one. For example, if there are 23 total spaces, at least one accessible space is required and it must be large enough (See Question # 5 for dimensions) to accommodate a van. If there are 201 total parking spaces, at least seven accessible spaces would be required and two of those would have to accommodate vans.**				
12	Is VAN accessible parking signage provided?	Signs must be mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle.				

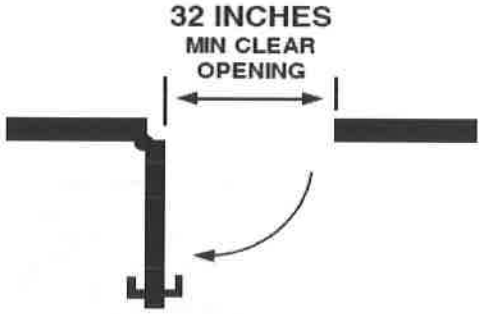
13	If van accessible parking is provided in a parking garage, is there at least 8 feet 2 inches (98 inches total) vertical clearance available for full-sized, lift equipped vans?	If there is no parking garage, check NA. If designated accessible parking is located in a garage, the vertical clearance should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

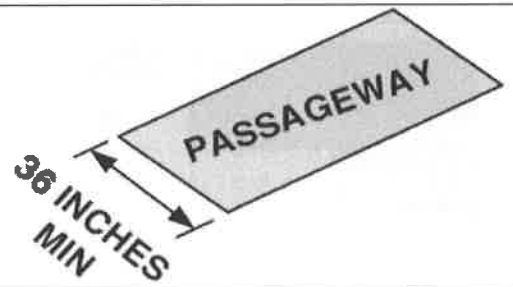
EXTERIOR ROUTE (FROM ACCESSIBLE PARKING, PUBLIC TRANSPORTATION, AND PUBLIC SIDEWALK TO THE ENTRANCE)						
14 (CE)	**For exterior routes, if the accessible route crosses a curb, is a curb ramp provided to the building entrance from the following: (Please mark NA for those that do not apply.)**	**Self explanatory.**				
	a. Parking?					
	b. Public transportation?					
	c. Public sidewalk?					
15	Is the accessible route to the building entrance at least 36 inches wide for exterior routes from the following:(Please mark NA for those that do not apply.)					

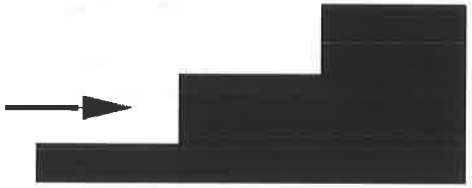
	a. Parking?					
	b. Public transportation?					
	c. Public sidewalk?					
16	Is the accessible route to the building entrance stable, firm, and slip resistant from the following: (Please mark NA for those that do not apply.)	An example of a stable surface is a floor or ground surface without loose elements like gravel or wood chips. Firm surfaces include solid concrete or pavement as opposed to a grassy, graveled or soft soil surface. Avoid glossy or slick surfaces such as ceramic tile.	[redacted]			
	a. Parking?					
	b. Public transportation?					
	c. Public sidewalk?					
17	Is there an accessible route that does not include stairs or steps?	Self explanatory.				

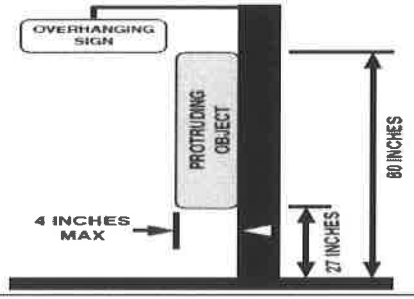
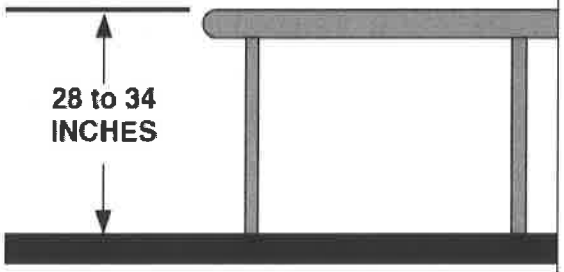
18	Is the route to the entrance from the accessible parking spaces, including transitions at curb ramps, free of grates, gaps, and openings that are both greater than ½ inch wide and over ¼ inch deep?	Self explanatory.				
RAMPS:						
19	Is an access ramp present?	If there is more than one ramp, select the one that appears to be the primary access ramp.				
20 (CE)	**Are handrails provided on both sides of the ramp that are mounted between 34 and 38 inches above the ramp surface, if it is longer than 6 feet?**	**If the ramp is not longer than 6 feet, check NA.**  **HANDRAILS ON BOTH SIDES**				

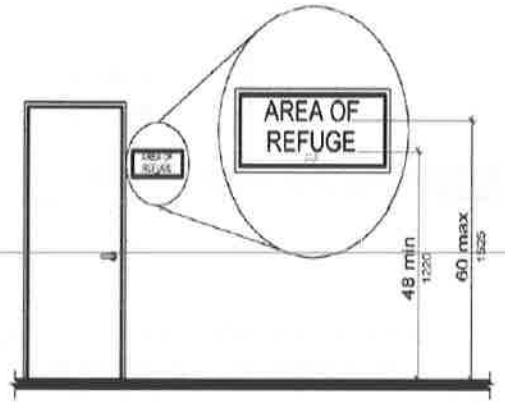
21 (CE)	**Are all ramps at least 36 inches wide?**					

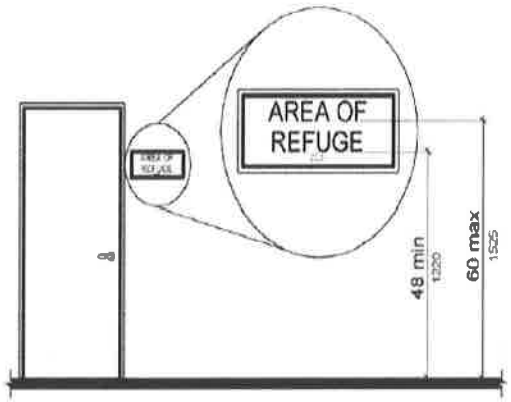
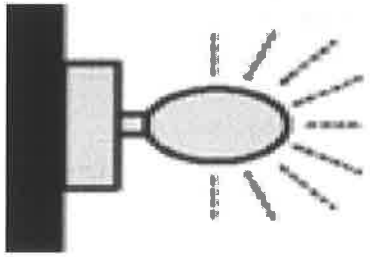
BUILDING ENTRANCE						
22 CE	**Is the main entrance accessible?**	**Self explanatory.**				
23	If a main entrance is not accessible, is there another accessible entrance?	Self explanatory.				
24	If a main entrance is not accessible, is there directional signage indicating the location of the accessible entrance?					
25 (CE)	**Do doors have an opening at least 32 inches wide (at the narrowest point below the opening hardware) when opened to 90°?**	**When measuring double doors, measure the opening with one door open to 90°.** 				

26	Are there automatic doors?	Self explanatory.				
INTERIOR ROUTE (FROM THE BUILDING ENTRANCE, TO THE REGISTRATION COUNTER/WINDOW, AND THROUGH TO THE PARTICIPANT AREAS						
27	Is there an interior route to the patient area?	Some patient areas are accessed directly from the street or drop off rather than being located within a larger building or complex, therefore they do not have interior routes.				
	Are <u>ALL</u> interior paths of travel at least 36 inches wide?					
29	Is the interior accessible route stable, firm, and slip resistant?	Avoid unsecured carpeting or other loose elements. It is easier for people using walkers, wheelchairs and other aids to walk or push on surfaces that have low pile carpeting without a pad underneath. Glossy or slick surfaces such as ceramic tile or marble can be slippery.				

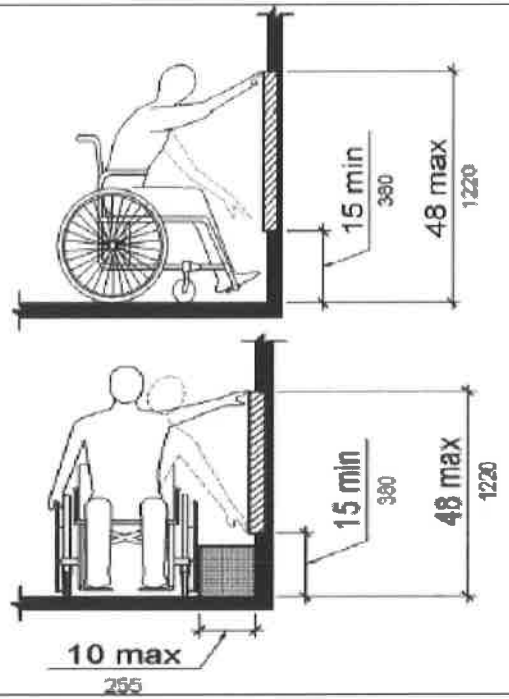
30	Is the interior accessible route well lighted?	A brightly lit corridor will help avoid falls.				
31 (CE)	**If there are stairs on the accessible route, are there handrails on each side?**	**If there are no stairs, check NA.**				
32	If there are stairs, are all stair risers closed that are on the accessible route?					
33	If there are stairs, are all stair treads marked by a stripe providing a clear visual contrast to assist people with visual impairments?	Contrast striping must be provided on the upper approach and lower tread for interior stairs and on the upper approach and all treads for exterior stairs. Stripes must be 2" to 4" wide placed parallel to and no more than 1" from the nose of the step or upper approach. The stripe must extend the full width of the step or upper approach and should be made of material that is at least as slip resistant as the other stair treads (a painted stripe is acceptable).				

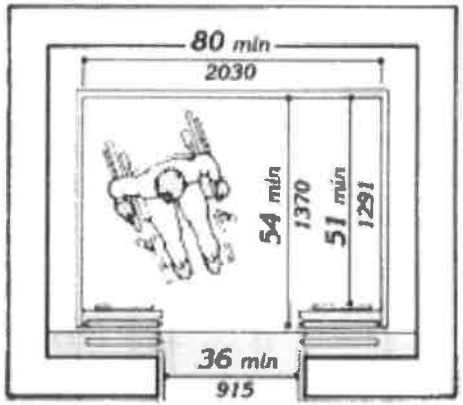
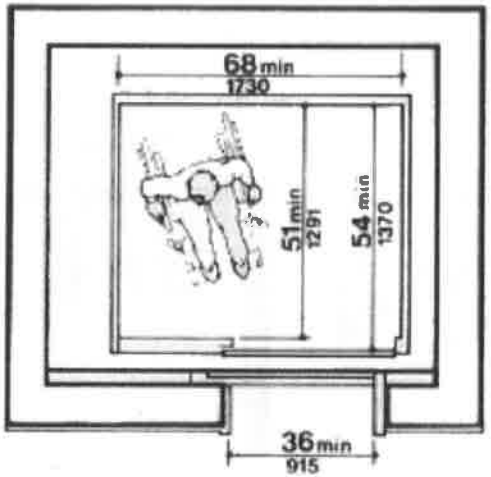
34	Is the path through the facility free of any objects that stick out into the circulation path that a blind person might not detect with a cane?	If an object protrudes more than 4 inches and is located between 27 inches above the walking surface and below 80 inches, a blind person walking with a cane will not detect it.  				
35	If floor mats are used, are the edges of floor mats stiff enough or secured so that they do not roll up?	If floor mats are not in use, check NA. Floor mats that are not secured to the floor can roll up or bunch up under walkers or wheelchair casters and cause a tripping hazard.				
36	Is a section of the sign-in/registration counter no more than 34 inches high and at least 36 inches wide and free of stored items?	 				

37	Does the office have a method, other than a lowered counter, by which people can sign in/register? (If yes, please note this method in comments.)	A medical office may use reasonable alternative methods to meet this need such as a clip board.				
38	Do signs identifying permanent rooms and spaces include raised letters and Braille?					

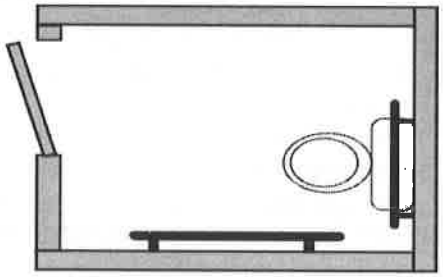
39	Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor?	 Raised letters and Braille signs are either on the latch side of doors or on the face of doors and are mounted between 48 inches and 60 inches from the floor.				
40	If the building has a fire alarm system, are visual signals provided in each public space, including toilet rooms and Participant Areas?	If the building does not have a fire alarm system, check NA. 				

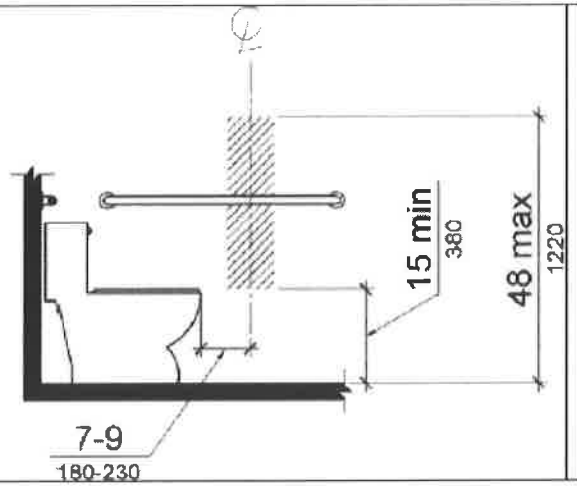
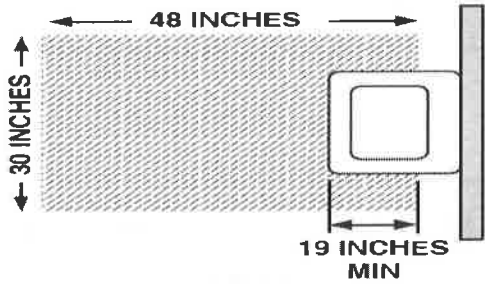
ELEVATORS						
41	Is there an elevator?	Self explanatory.				
42 (CE)	**If needed, is the elevator available for public/patient use during business hours?**	**Self explanatory.**				
43 (CE)	**Is the elevator equipped with both visible and audible door opening/closing and floor indicators?**	**A visible and audible signal is required at each elevator entrance to indicate which car is answering a call. An audible signal would be a "ding" or a verbal announcement.** 				
44 (CE)	**Is there a raised letter and Braille sign on each side of each elevator jamb?**	**These signs allow everyone to know which floor they are on before entering or exiting the elevator.**				

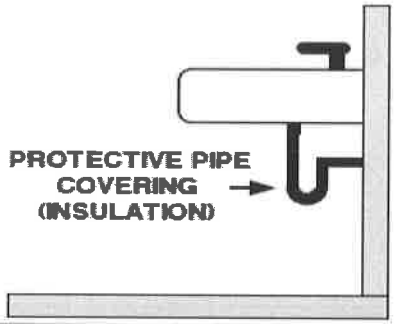
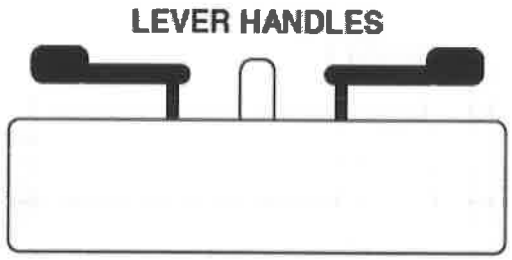
45 (CE)	**Are the hall call buttons for the elevator no higher than 48 inches from the floor?**					

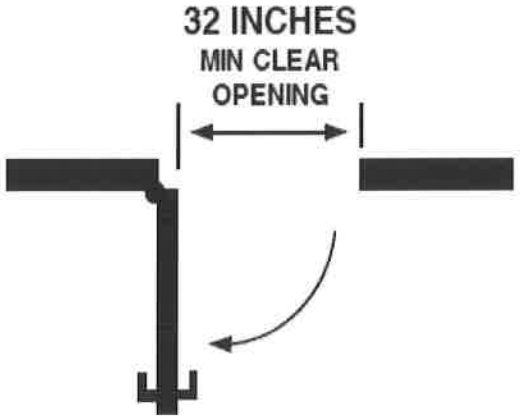
46 (CE)	Is the elevator car large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit?	The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide, depending on where the door is located.  (a)  				
	Do the buttons on the control panel inside the elevator have Braille and raised characters/symbols near the buttons?	Self explanatory.				

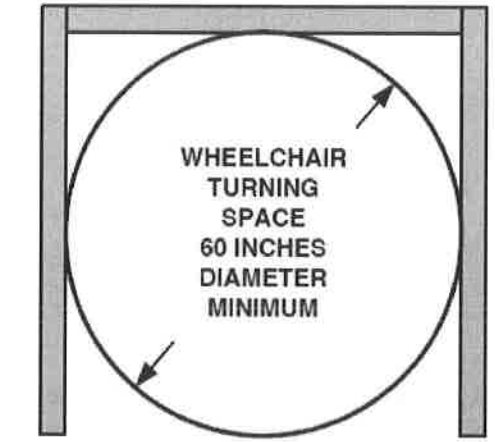
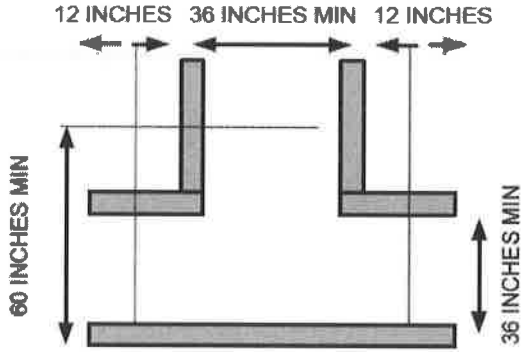
48	Is there an emergency communication system in the elevator?	Self explanatory.				
49	Is the elevator emergency communication system usable without requiring voice communication?	It is essential that emergency communication not be dependent on voice communications alone because the safety of people with hearing or speech impairments could be jeopardized. Visible signal requirement could be satisfied with something as simple as a button that lights when the message is answered, indicating that help is on the way.				
50	Do raised letters and Braille identify the emergency intercom in the elevator?	Self explanatory.				

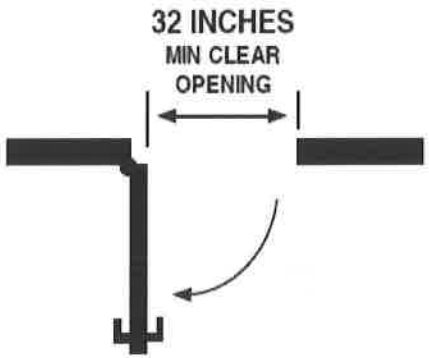
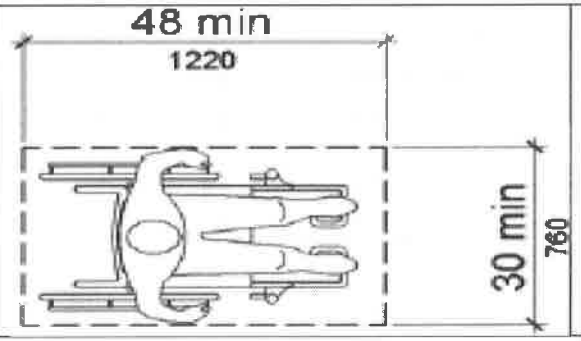
ALL RESTROOMS/TOILET ROOMS (WITH AND WITHOUT STALLS):						
51	Is there an accessible restroom/toilet room?	Self explanatory.				
52	Does the interior door to the restroom require less than 5 pounds of pressure to open?	If restroom door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
53 (CE)	**Are grab bars provided, one on the wall behind the toilet and one on the wall next to the toilet?**	**Grab bars should be installed in a horizontal position between 33 and 36 inches above the floor measured to the top of the gripping surface.** 				
54	Are all objects mounted at least 12 inches above and 1½ inches below the grab bars?	This includes seat cover dispensers, toilet paper dispensers, sanitizers, trash containers, etc.				

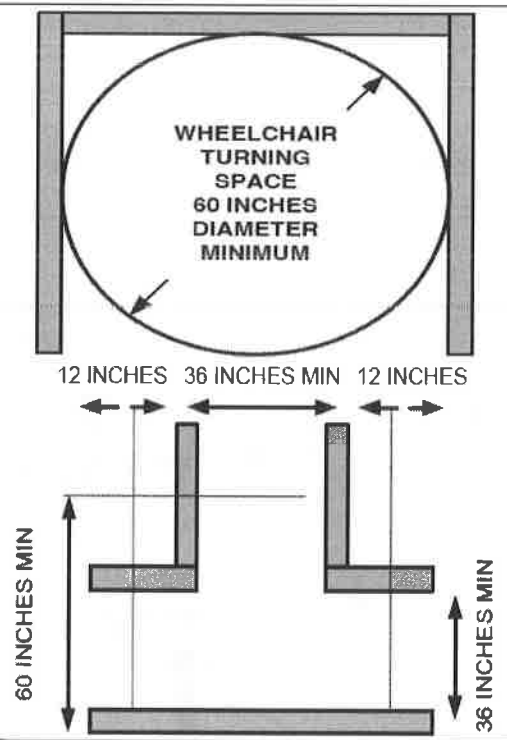
55 (CE)	**Is the toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7 inches and 9 inches in front of the toilet, and at least 15 inches high?**					
56 (CE)	**Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair users to park in front of the sink?**	**This space must extend at least 17 inches under the sink from the front edge, although it can extend up to 19 inches underneath.** 				
57	Is the space in front of the sink free of trashcans and other movable items?	Self explanatory.				

58	Are the pipes and water supply lines under the sink wrapped with a protective cover?					
59 (CE)	**Are faucet handles operable with one hand and without grasping, pinching, or twisting? (Check Yes if faucets are automatic.)**	**A knob handle would not be accessible.** 				
60	Are all dispensers mounted no higher than 40 inches from the floor?	Included are soap dispensers, paper towel dispensers, seat cover dispensers, hand dryers, etc.				
61	Are all dispensers (soap, paper towel, etc.) operable with one hand and without grasping, pinching, or twisting?	Self explanatory.				

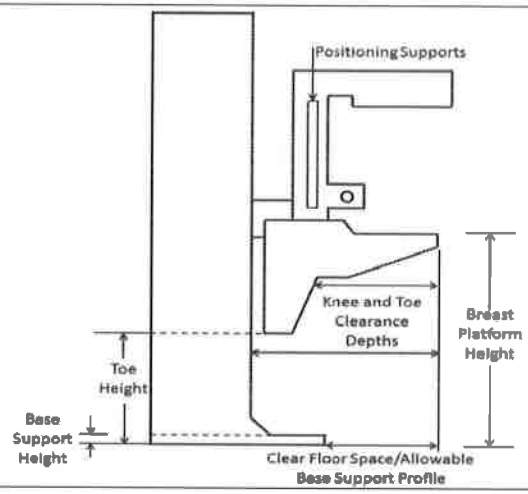
62 (CE)	**Do restroom doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**					
63	Is the space inside the restroom clear, without trashcans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				

64 (CE)	**Is there a 60-inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space inside the restroom to allow a turn around for wheelchair and scooter users?**	 				
65	Can the hardware on the stall door be operated without grasping, pinching, or twisting of the wrist?	Handles, pulls, latches, locks, and other operating devices on accessible doors shall have a shape that is easy to grasp with one hand and does not require tight grasping, tight pinching, or twisting of the wrist to operate.				

PATIENT AREAS (DIAGNOSTIC & TREATMENT, ROOMS)						
	Do doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?					
	Is there space next to the equipment for a wheelchair or scooter user to approach, park, and transfer or be assisted to transfer onto following?					
	a. Equipment (such as PT)?					
	b. Diagnostic apparatus?					
	c. Patient activity areas (such as OT, dining)?					
	d. Infusion (chairs, beds for chemo, dialysis)?					

68	Patient Dressing Rooms are accessible (all bullet points need to be present) • Doorways are at least 32 inches • Turning Radius is 60x60 inches • Seating 17-19 inches from the floor • Grab bars	If there are reasonable alternative for dressing room accommodations, this measure is met.				
69	In the diagnostic/treatment area, is there a 60 inch diameter turning circle or a 60 inch x 60 inch "T" shaped space so that a wheelchair or scooter user can make a 180° turn?					
70 (CE)	**If any diagnostic equipment or treatment tables/chairs are used, is there a patient pre-assessment process (i.e. phone, prior to appointment) to verify that the necessary services can be provided?**	Self explanatory.				

71	Does the Diagnostic Table have a weight limit?	Document weight limit : □ MRI _____ □ CT _____ □ Fluoroscopy_____ □ PET _____ □ Bone Density/Dexascan _____ □ Ultrasound _____ □ Nuclear Medicine_____ □ Xray_____ □ _____ □ _____				
72 (T)	**Is there height adjustable equipment (chairs and tables) that lowers between 17 inches and 19 inches from the floor to the top of the cushion?**	Score each appropriate equipment that do or do not lower 17 to 19 inches from the floor to the top of the cushion:				
	a. MRI					
	b. CT					
	c. Fluoroscopy					
	d. PET					
	e. Bone Density/Dexascan					
	f. Ultrasound					
	g. Nuclear Medicine					
	h. Xray					
	i. Physical Therapy Table					
	j. Dialysis Chair					
	k. Other					
	l. Other					
73 (T)	**Mammography machine can accommodate wheelchair users with knee and foot clearance under the breast plate allowing technologist to take quality**	The top of breast platform needs to go to 26 inches above the floor to accommodate an individual seated in a wheelchair.				

	images.					
74 (T)	**A Mammography chair is available for patients who must be seated.** ***Example:*** *persons with balance difficulties, or cannot stand for any length of time.*	The chair's footrests must accommodate and ride over the base support.				
75	Are transfer and positioning supports available?	Examples include: • Positioning supports while on the equipment as pillows, wedges, strapping, transfer supports Please list elements in comments.				
76 (CE)	**Does staff provide patient transfer assistance on and off of equipment (this includes use of lift equipment when needed).**	**Self Explanatory**				

77 (T)	**Is lift equipment available to assist staff with transfers (portable, overhead, or ceiling mounted)?**	**Self Explanatory**				
78 (CE)	**Is staff trained yearly on safe transfer techniques?**	**Self explanatory**				

WEIGHT MEASUREMENT						
79	Are patients normally weighed at this provider site?	Self explanatory				
80 (T)	**Is a weight scale available that can be used by a wheelchair or scooter user, obese patients whose weight exceeds the weight limits for standard scales, and for patients that cannot step onto a standard scale?**	**Accessible scale platform dimensions should be a minimum of 32x 36 inches**				
81 (T)	**If there is no accessible scale, are other methods to weigh the patient in place?**	**Examples of other methods to weigh the patient are: weight scales integrated into examination tables, chairs, stretchers, and lifts, or an accessible scale located in a nearby office, within the same building.**				

References

2010 ADA Standards for Accessible Design
U.S Department of Justice
http://www.ada.gov/2010ADAstandards_index.htm

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

Two questions in the FSR Attachment C were drawn from Title 24, Part 2 of the California Building Standards Code. These are 1133B.4.4 – Striping for the visually impaired (Rev.1-1-2009), and 1115B-1 – Bathing and Toilet Facilities, placement of toilet paper dispensers. These standards can be found in:

2009 California Building Standards Code with California Errata and Amendments
State of California
Department of General Services
Division of the State Architect
Updated April 27, 2010
http://www.documents.dgs.ca.gov/dsa/pubs/access_manual_rev_04-27-10.pdf

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

"Health Care Usability Profile V3"
© Copyright 2008
Oregon Health & Science University RRTC: Health & Wellness
Authors: Drum, C.E., Davis, C.E., Berardinelli, M., Cline, A., Laing, R., Horner-Johnson, W., & Krahn, G.
Oregon Institute on Disability and Development
Portland, OR 97239
rrtc@ohsu.edu
healthwellness.org

Community Based Adult Services (CBAS) Physical Accessibility Review Survey

California Department of Health Care Services
Managed Care Quality and Monitoring Division

Provider Name: ☐ CBAS ☐ Other	Date of Review: Name of Reviewer:
Address: City:	Health Plan Name:
Phone: FAX:	Contact Person Name:
	Level of Access:
Basic Access: Demonstrates facility site access for the members with disabilities to parking, building, elevator, Participant Areas, and restroom. To meet Basic Access requirements, all (24) Critical Elements (CE) must be met.	☐ Basic Access
Limited Access: Demonstrates facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, participant areas, and restroom. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.	☐ Limited Access

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

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

Accessibility Indicator	Must Satisfy these Criteria	Yes	No	N/A	Comments
P = PARKING	Critical Elements (CE): 6,7,8				
EB = EXTERIOR BUILDING	(CE): 9,15,16,17,20				
IB = INTERIOR BUILDING	(CE): 23,26,36,37,38,39,40,41				
R=RESTROOM	(CE): 47,49,50,53,56,58				
PA= PARTICIPANT AREAS	(CE): 60,61				

2nd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

Name: _____ Signature: _____ Date: _____

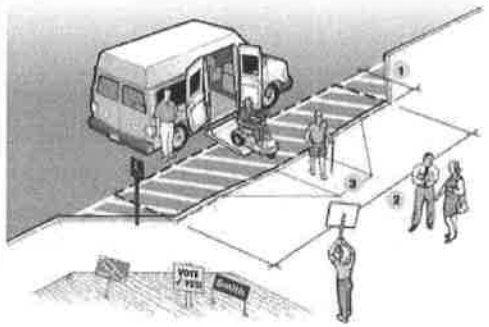
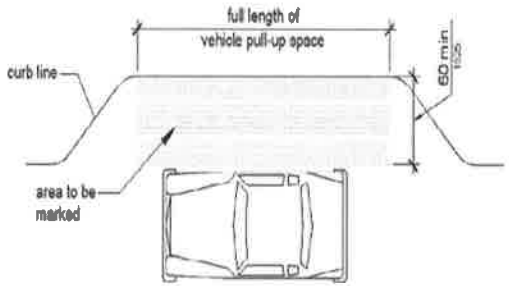
3rd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

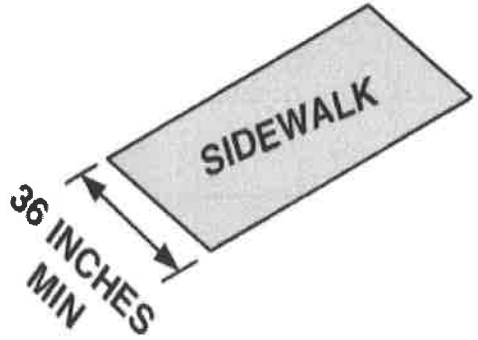
Name: _____ Signature: _____ Date: _____

PARKING						
1	Are accessible parking spaces provided in the designated parking area?	Self explanatory.				
2	Are the correct number of accessible parking spaces provided? 1 to 25 total spaces – 1 required 26 to 50 – 2 required 51 to 75 – 3 required 76 to 100 – 4 required 101 to 150 – 5 required 151 to 200 – 6 required 201 to 300 – 7 required 301 to 400 – 8 required	If there are 25 total parking spaces or less, at least one accessible space is required. If there are between 26 and 50 total spaces, at least two accessible spaces are required, etc.				
3	Is the accessible parking space(s) closest to the main entrance?	The accessible parking space (s) should afford the shortest route of travel from adjacent parking to the accessible entrance.				

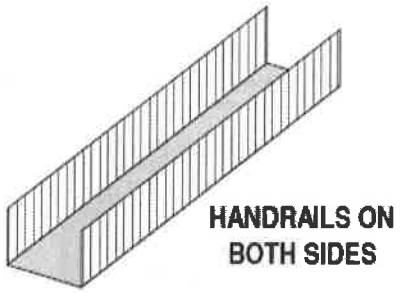
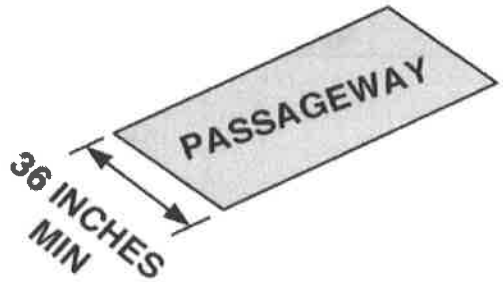
4	Does every accessible parking space have a vertical sign posted with the International Symbol of Accessibility?	Symbol in the illustration depicts the International Symbol of Accessibility. 				
5	Are signs mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle?	Signs must be located so a vehicle parked in the space does not obscure them. (Van accessible spaces must be indicated with an additional sign)				

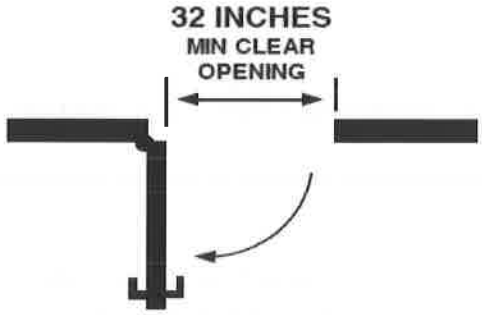
6 (CE)	**Is a passenger loading zone provided with a vehicular pull-up space.**	The vehicular pull-up space dimension is a minimum of 96 inches wide and 20 feet long				

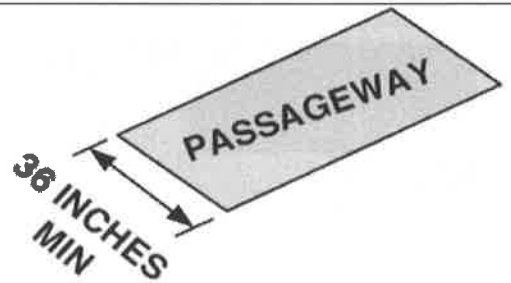
7 (CE)	**Is there an access aisle that adjoins an accessible route and does not overlap the Vehicular way /driveway?**	**Access aisles serving vehicle pull-up *spaces* shall be a minimum of 60 inches wide.**  				
8 (CE)	**Do curbs on the route have curb ramps at the drop off locations?**	**Pathways should have curb ramps. Without curb ramps, wheelchair users may be required to travel in the street or behind parked cars where drivers cannot see them.**				

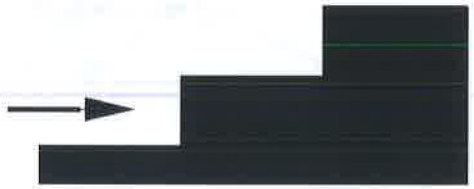
EXTERIOR ROUTE (FROM DROP OFF AND PICK UP LOCATIONS TO THE ENTRANCE)						
9 (CE)	**For exterior routes, if the accessible route crosses a curb, is a curb ramp provided to the building entrance from the following: (Please mark NA for those that do not apply.)**	**Self explanatory.**				
	a. Public Transportation					
	b. Public sidewalk?					
	c. Drop off?					
10	Is the accessible route to the building entrance at least 36 inches wide for exterior routes from the following: (Please mark NA for those that do not apply.)					
	a. Public Transportation					
	b. Public sidewalk?					
	c. Drop off?					
11	Is the accessible route to the	An example of a stable surface is a floor or				

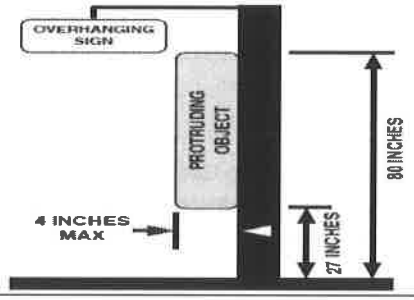
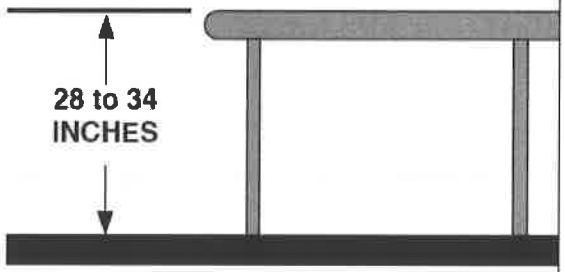
	building entrance stable, firm, and slip resistant from the following: (Please mark NA for those that do not apply.)	ground surface without loose elements like gravel or wood chips. Firm surfaces include solid concrete or pavement as opposed to a grassy, graveled or soft soil surface. Avoid glossy or slick surfaces such as ceramic tile.				
	a. Public Transportation					
	b. Public sidewalk?					
	c. Drop off?					
12	Is there an accessible route that does not include stairs or steps?	Self explanatory.				
13	Is the route to the entrance from drop off, free of grates, gaps, and openings that are both greater than ½ inch wide and over ¼ inch deep?	Self explanatory.				

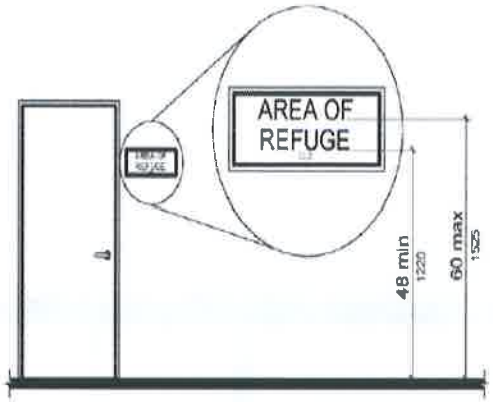
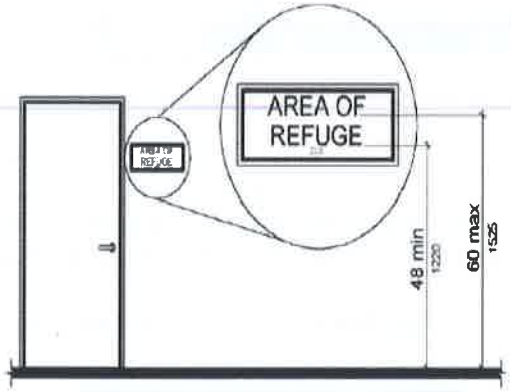
RAMPS:						
14	Is an access ramp present?	If there is more than one ramp, select the one that appears to be the primary access ramp.				
15 (CE)	**Are handrails provided on both sides of the ramp that are mounted between 34 and 38 inches above the ramp surface, if it is longer than 6 feet?**	**If the ramp is not longer than 6 feet, check N/A.** 				
16 (CE)	**Are all ramps at least 36 inches wide?**					

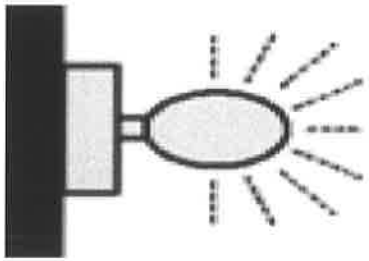
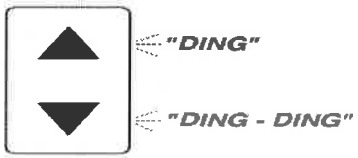
BUILDING ENTRANCE						
	Is the main entrance accessible?	**Self explanatory.**				
18	If a main entrance is not accessible, is there another accessible entrance?	Self explanatory.				
19	If a main entrance is not accessible, is there directional signage indicating the location of the accessible entrance?					
	Do doors have an opening at least 32 inches wide (at the narrowest point below the opening hardware) when opened to 90°?	**When measuring double doors, measure the opening with one door open to 90°.** 				

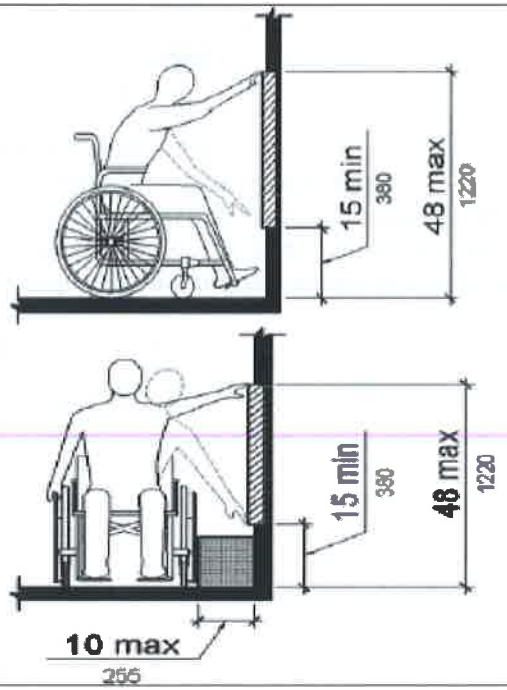
21	Are there automatic doors?	Self explanatory.				
INTERIOR ROUTE (FROM THE BUILDING ENTRANCE, TO THE REGISTRATION COUNTER/WINDOW, AND THROUGH TO THE PARTICIPANT AREAS						
22	Is there an interior route to the participant area?	Some participant areas are accessed directly from the street or drop off rather than being located within a larger building or complex, therefore they do not have interior routes.				
23 (CE)	**Are <u>ALL</u> interior paths of travel at least 36 inches wide?**					
24	Is the interior accessible route stable, firm, and slip resistant?	Avoid unsecured carpeting or other loose elements. It is easier for people using walkers, wheelchairs and other aids to walk or push on surfaces that have low pile carpeting without a pad underneath. Glossy or slick surfaces such as ceramic tile or marble can be slippery.				

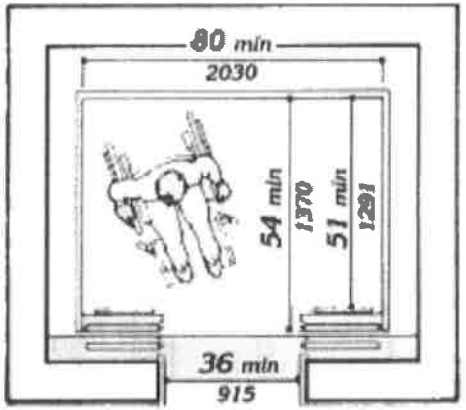
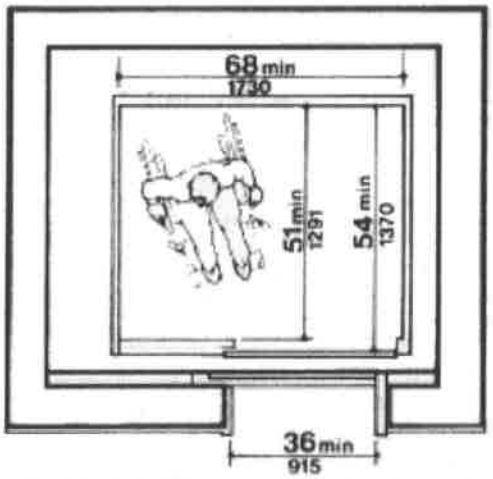
25	Is the interior accessible route well lighted?	A brightly lit corridor will help avoid falls.				
26 (CE)	**If there are stairs on the accessible route, are there handrails on each side?**	**If there are no stairs, check N/A.**				
27	If there are stairs, are all stair risers closed that are on the accessible route?					
28	If there are stairs, are all stair treads marked by a stripe providing a clear visual contrast to assist people with visual impairments?	Contrast striping must be provided on the upper approach and lower tread for interior stairs and on the upper approach and all treads for exterior stairs. Stripes must be 2" to 4" wide placed parallel to and no more than 1" from the nose of the step or upper approach. The stripe must extend the full width of the step or upper approach and should be made of material that is at least as slip resistant as the other stair treads (a painted stripe is acceptable).				

29	Is the path through the facility free of any objects that stick out into the circulation path that a blind person might not detect with a cane?	If an object protrudes more than 4 inches and is located between 27 inches above the walking surface and below 80 inches, a blind person walking with a cane will not detect it.  				
30	If floor mats are used, are the edges of floor mats stiff enough or secured so that they do not roll up?	If floor mats are not in use, check NA. Floor mats that are not secured to the floor can roll up or bunch up under walkers or wheelchair casters and cause a tripping hazard.				
31	Is a section of the sign-in/registration counter no more than 34 inches high and at least 36 inches wide and free of stored items.	 				

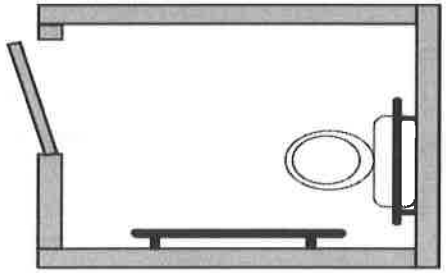
32	Do signs identifying permanent rooms and spaces include raised letters and Braille?					
33	Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor?	 Raised letters and Braille signs are either on the latch side of doors or on the face of doors and are mounted between 48 inches and 60 inches from the floor.				

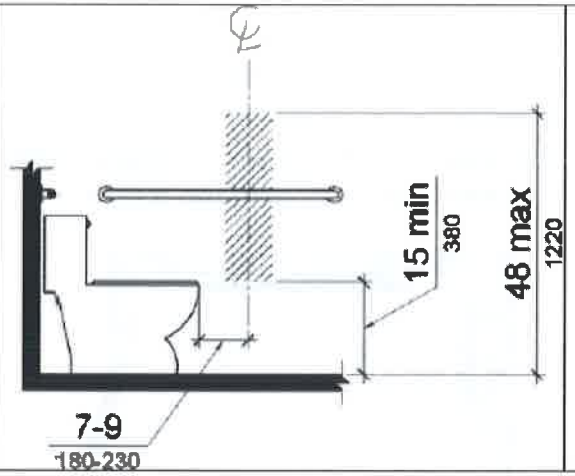
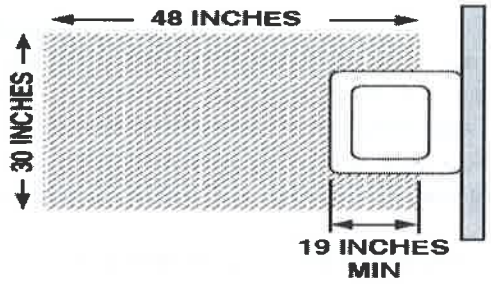
34	If the building has a fire alarm system, are visual signals provided in each public space, including toilet rooms and Participant Areas?	If the building does not have a fire alarm system, check NA. 				
ELEVATORS						
35	Is there an elevator?					
36 (CE)	**If needed, is the elevator available for public/patient use during business hours?**	**Self explanatory.**				
37 (CE)	**Is the elevator equipped with both visible and audible door opening/closing and floor indicators?**	**A visible and audible signal is required at each elevator entrance to indicate which car is answering a call. An audible signal would be a "ding" or a verbal announcement.** 				

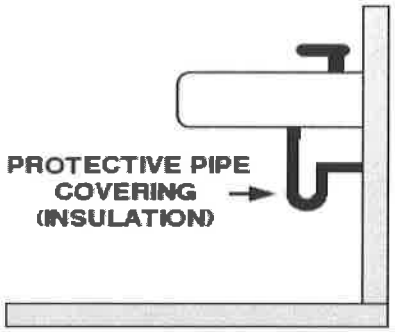
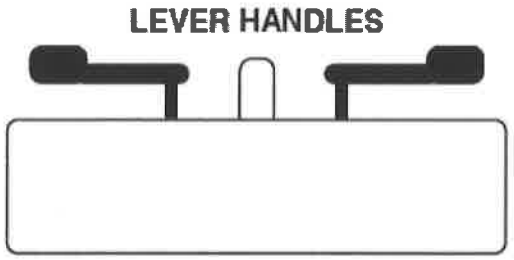
38 (CE)	**Are there raised letter and Braille sign on each side of each elevator jamb?**	**These signs allow everyone to know which floor they are on before entering or exiting the elevator.**				
39 (CE)	**Are the hall call buttons for the elevator no higher than 48 inches from the floor?**					

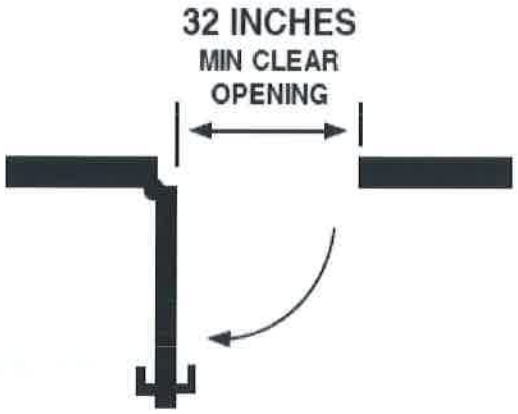
40 (CE)	Is the elevator car large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit?	The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide, depending on where the door is located.  (a)  				
41 (CE)	Do the buttons on the control panel inside the elevator have Braille and raised characters/symbols near the buttons?	Self explanatory.				

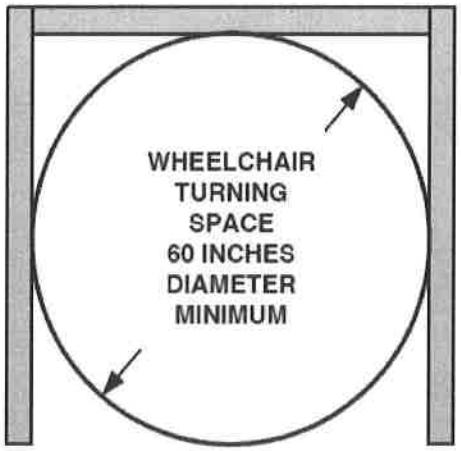
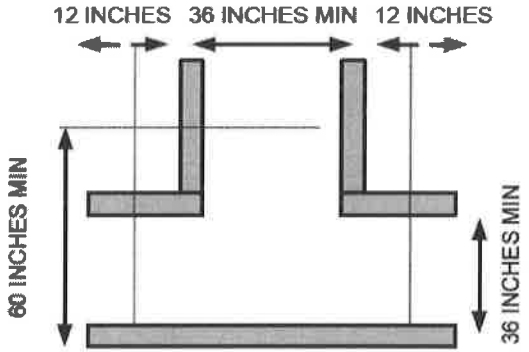
42	Is there an emergency communication system in the elevator?	Self explanatory.				
43	Is the elevator emergency communication system usable without requiring voice communication?	It is essential that emergency communication not be dependent on voice communications alone because the safety of people with hearing or speech impairments could be jeopardized. Visible signal requirement could be satisfied with something as simple as a button that lights when the message is answered, indicating that help is on the way.				
44	Do raised letters and Braille identify the emergency intercom in the elevator?	Self explanatory.				

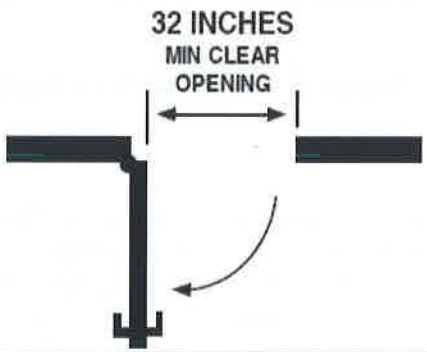
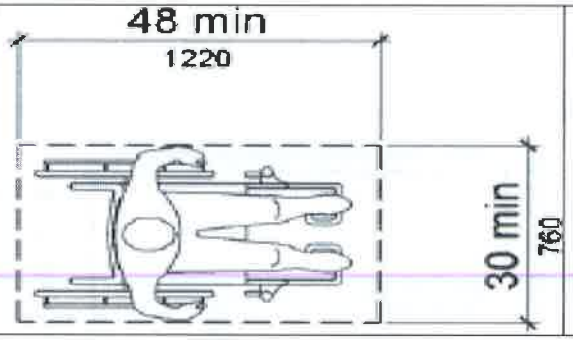
ALL RESTROOMS/TOILET ROOMS (WITH AND WITHOUT STALLS):						
45	Is there an accessible restroom/toilet room?	Self explanatory.				
46	Does the interior door to the restroom require less than 5 pounds of pressure to open?	If restroom door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
47 (CE)	**Are grab bars provided, one on the wall behind the toilet and one on the wall next to the toilet?**	**Grab bars should be installed in a horizontal position between 33 and 36 inches above the floor measured to the top of the gripping surface.** 				
48	Are all objects mounted at least 12 inches above and/or 1½ inches below the grab bars?	This includes seat cover dispensers, toilet paper dispensers, sanitizers, trash containers, etc.				

49 (CE)	**Is the toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7 inches and 9 inches in front of the toilet, and at least 15 inches high?**					
50 (CE)	**Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair users to park in front of the sink?**	**This space must extend at least 17 inches under the sink from the front edge, although it can extend up to 19 inches underneath.** 				
51	Is the space in front of the sink free of trashcans and other movable items?	Self explanatory.				

52	Are the pipes and water supply lines under the sink wrapped with a protective cover?					
53 (CE)	**Are faucet handles operable with one hand and without grasping, pinching, or twisting? (Check Yes if faucets are automatic.)**	**A knob handle would not be accessible.** 				
54	Are all dispensers mounted no higher than 40 inches from the floor?	Included are soap dispensers, paper towel dispensers, seat cover dispensers, hand dryers, etc.				
55	Are all dispensers (soap, paper towel, etc.) operable with one hand and without grasping, pinching, or twisting?	Self explanatory.				

56 (CE)	**Do restroom doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**					
57	Is the space inside the restroom clear, without trashcans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				

58 (CE)	**Is there a 60-inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space inside the restroom to allow a turn around for wheelchair and scooter users?**	 				
59	Can the hardware on the stall door be operated without grasping, pinching, or twisting of the wrist?	Handles, pulls, latches, locks, and other operating devices on accessible doors shall have a shape that is easy to grasp with one hand and does not require tight grasping, tight pinching, or twisting of the wrist to operate.				
PARTICIPANT AREAS (QUIET ROOM/THERAPY ROOM S-PT/OT, ACTIVITY AREA)						

60 (CE)	**Do doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**					
61 (CE)	**There is space in the following areas for a wheelchair or scooter user to approach and park for participation in activities or use of exercise equipment:**					
	a. Quiet room?					
	b. Physical Therapy Room {PT}?					
	c. Occupational Therapy {OT}?					
	d. Activity Area					

62	Is there a bed that is between 17 inches and 19 inches from the floor to the top of the cushion?	Self explanatory				

References

2010 ADA Standards for Accessible Design
U.S Department of Justice
http://www.ada.gov/2010ADAstandards_index.htm

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

Two questions in the FSR Attachment C were drawn from Title 24, Part 2 of the California Building Standards Code. These are 1133B.4.4 – Striping for the visually impaired (Rev.1-1-2009), and 1115B-1 – Bathing and Toilet Facilities, placement of toilet paper dispensers. These standards can be found in:

2009 California Building Standards Code with California Errata and Amendments
State of California
Department of General Services
Division of the State Architect
Updated April 27, 2010
http://www.documents.dgs.ca.gov/dsa/pubs/access_manual_rev_04-27-10.pdf

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

"Health Care Usability Profile V3"
© Copyright 2008
Oregon Health & Science University RRTC: Health & Wellness
Authors: Drum, C.E., Davis, C.E., Berardinelli, M., Cline, A., Laing, R., Horner-Johnson, W., & Krahn, G.
Oregon Institute on Disability and Development
Portland, OR 97239
rrtc@ohsu.edu
healthwellness.org

KERN HEALTH SYSTEMS

Policy and Procedure Review/ Revision

Policy 3.01-P Excluded Services has been updated and is provided here for your review and approval.

Reviewer	Date	Comment/Signature
Doug Hayward	12/8/20	
Dr. Tasinga	11/9/2020	M Tasinga
Alan Avery	10/23/2020	**Approved without changes-Alan Avery**
Deb Murr	11/9/2020	Deborah C Murr RN
Robin Dow-Morales	10/20/2020	**Approved without changes – Robin Dow-Morales**
Nate Scott	9/16/2020	**Approved without changes. – Nate Scott**
Louis Iturriria	9/16/2020	**Approved without changes. – Louis Iturriria**
Shannon Miller	9/15/20	**Approved without changes. – Shannon Miller**

(CEO decision(s))

Board approval required: Yes ___ No ✓ QI/UM Committee approval: Yes ___ No ___
Date approved by the KHS BOD: _____ Date of approved by QI: _____
PAC approval: Yes ___ No ___ Date of approval by PAC: _____
Approval for internal implementation: Yes ___ No ___
Provider distribution date: Immediately _____ Quarterly _____

Effective date: _____
DHCS submission: _____
DMHC submission: _____
Provider distribution: _____

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Excluded Services				POLICY #: 3.01-P	
DEPARTMENT: Utilization Management					
Effective Date: 01/31/1996	Review/Revised Date: 12/08/2020	DMHC	X	PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Health Services Officer

_____ Date _____
Director of Claims

_____ Date _____
Director of Member Services

_____ Date _____
Director of Marketing

_____ Date _____
Director of Utilization Management

POLICY:
Kern Health Systems (KHS) covers benefits in accordance with the following legislative, regulatory, and contractual requirements[2]:

- The Knox-Keene Act
- CCR Title 10 §2699.6700 through 2699.6703
- CCR Title 22 §§ 51301through 51365
- CCR Title 22 §§ 59998 through 59999
- KHS Medi-Cal Product contract with the Department of Health Services (DHS)

All other services and benefits are excluded unless specifically included as a result of the decision of the KHS Board of Directors.

PROCEDURE:

The following table identifies excluded benefits and limitations. In addition to those limitations included in the table, services are subject to utilization controls and prior authorization requirements.

Benefit/Services	Exclusions or Limitations
Audiological Services	Services are limited to 2 visits per calendar month. Additional services can be considered based on medical necessity.
California Children's Services (CCS)	Services that are eligible for coverage under the CCS program are carved out of KHS' contract with DHS and are therefore excluded. KHS works to ensure CCS services are coordinated and provided as described in *KHS Policy and Procedure #3.16-P: California Children's Services.*
Childhood Lead Poisoning Case Management	Childhood lead poisoning case management is carved out of KHS' contract with DHS and is therefore excluded. Members are referred to the Kern County Department of Public Health Lead Poisoning Prevention Program for case management. KHS is responsible to ensure contracted providers who perform periodic health assessments on children between the ages of six months to six years, comply with current federal and state laws and industry guidelines for health care providers issued by CLPPB, including any future updates or amendments. *Referenced APL-18-007.*
Chiropractic Services	Chiropractic services are reimbursable only to FQHCs and RHCs providing chiropractic services through KHS. *Referenced APL-15-003*
Common Household Items[3]	Common household items and articles of clothing are excluded.
Covered by Other Insurance[4]	Services, which are eligible for reimbursement by insurance or covered under any other insurance or health care service plan when member has a source of insurance are excluded. KHS shall provide the services at the time of need, and the member shall cooperate to assure that KHS is reimbursed for such benefits.

Benefit/Services	Exclusions or Limitations
Covered by Workers' Compensation	Treatment for any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit, or gain for which benefits are provided or payable under any Worker's Compensation benefit plan are excluded.
Dental Services	Dental services are carved out of KHS' contract with DHS and are therefore excluded. KHS is responsible to provide limited services related to dental conditions as described in *KHS Policy and Procedure #3.06-P: Dental Services*. Anesthesia for dental procedures may be covered under KHS benefits if medically necessary.
Developmental Disabilities	Medicaid Home services are carved out of KHS' contract with DHS and are therefore excluded. KHS works with members to encourage treatment as described in *KHS Policy and Procedure #3.03-P: Kern Regional Center Services (Developmental Disabilities and Early Intervention)*. Behavioral Health and Intervention Treatment for both Autism Spectrum Disorder/Non Autism Spectrum Disorder are covered benefits as described in KHS *Policy and Procedure #3.72-I Behavioral Health Therapy.*
Durable Medical Equipment	❖ The following items are excluded: ➢ Modification of automobiles or other highway motor vehicles ➢ Books or other items primarily educational in nature ➢ Air conditioners, air filters, or heaters ➢ Food blenders ➢ Reading lamps, or other lighting devices ➢ Bicycles, tricycles, or exercise equipment ➢ Television sets ➢ Orthopedic mattresses, recliners, rockers, seat lift chairs, or other furniture items ➢ Waterbeds ➢ Stairway chairlifts, or other devices which are temporarily or permanently affixed to, or installed in, any part of a home, for the purpose of transporting persons between floors.
Emergency Services for Non-Emergency Conditions[5]	❖ Emergency services for non-emergency conditions are excluded.

Benefit/Services	Exclusions or Limitations
Experimental, Investigational, Outmoded, or Non-Efficacious Services[6]	Those medical, surgical (including implants), or other health care procedures, services products, drugs or devices which are either experimental or investigational, not recognized in accordance with generally accepted medical standards as being safe and effective for use in the treatment in question, or outmoded or not efficacious are excluded. In exception to the above, the following experimental and/or investigational treatments are covered: ➢ Those that Independent Medical Review determine must be covered as described in *KHS Policy and Procedure #14.51-P – Independent Medical Review* ➢ Cancer clinical trials as described in *KHS Policy and Procedure #3.53 – Cancer Treatment Services* ➢ Investigational services that meet the requirements of CCR Title 22 §51303 (h)
Hearing Aids	Replacement hearing aids are covered only if the prior hearing aid has been lost, stolen, or irreparably damaged due to circumstances beyond the member's control. With the exception of those batteries covered under the EPSDT Supplemental Services program, replacement hearing aid batteries are not covered.
Hospice Care	An individual who voluntarily elects hospice care waives the right to payment for all non-hospice services related to the terminal condition.[7] The election may be revoked at any time.
Infertility Treatment[8]	Diagnosis of infertility is not covered unless provided in conjunction with covered gynecological services. Treatments of medical conditions of the reproductive systems are not excluded.
Inpatient Hospital Services	Personal or comfort items or a private room in a hospital are excluded unless medically necessary.
Local Education Agency (LEA) Services	Local Education Agency (LEA) assessment services provided to any student and any (LEA) services provided pursuant to an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) are excluded.
Long Term Care and Skilled Nursing Care	KHS is responsible to provide limited long term care as described in *KHS Policy and Procedure #3.42-P: Nursing Facility Services and Long Term Care.*

Benefit/Services	Exclusions or Limitations
Medications	Non-formulary medications are covered under limited circumstances as described in *KHS Policy and Procedure #13.01-P: Drug Utilization and Non-Formulary Treatment Requests*. Certain drugs for the treatment of HIV/AIDS, alcohol and substance abuse, and mental health conditions are carved out of KHS' contract with DHS and are therefore excluded. These drugs may be reimbursable by the Medi-Cal Program at the fee for service (FFS) rate. See *KHS Policy and Procedure #3.14-P: Mental Health Services* for a list of excluded psychotherapeutic drugs. See Attachment A for a list of excluded drugs for the treatment of HIV/AIDS. See Attachment B for a list of excluded drugs for the treatment of alcohol and substance abuse.[9]
Not Medically Necessary[10]	Services, supplies, items, procedures, or equipment, which are not medically necessary as determined by KHS are excluded. Services deemed to be not medically necessary include but are not limited to the following: ➢ Drugs or medications for cosmetic purposes[11] ➢ Examinations at frequencies unrelated to medical needs including: the member's desire for medical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses or insurance.[12] ➢ Eyeglasses used primarily for protective, cosmetic, occupational or vocational purposes or eyeglasses prescribed for other than the correction of refractive errors or binocularity anomalies[13] ➢ Hysterectomy performed solely for the purpose of rendering a woman permanently sterile or when there is more than one purpose for the procedure and the hysterectomy would not be performed except for the purpose of rendering the woman permanently sterile[14]
Not Ordered by Primary Care Practitioner (PCP)	Most services not ordered by the member's PCP are excluded. Exceptions include: ➢ Emergency services ➢ Family planning ➢ Indian Health Center services ➢ Pregnancy services ➢ STD/HIV/AIDS services

Benefit/Services	Exclusions or Limitations
Not Primarily Medical in Purpose[15]	Services and supplies not primarily medical in purpose are excluded. These include but are not limited to[16]: ➢ Articles of clothing ➢ Toothbrushes, toothpaste, and denture cleaners ➢ Shaving soap and lotions ➢ Cigarettes, cigars, pipes, and tobacco ➢ Cosmetics ➢ Hair combs and brushes ➢ Tissue wipes ➢ Cotton, adhesive tapes, and elastic bandages
Occupational Therapy	KHS does not limit services for occupational therapy. Frequency of services are based on medical necessity.
Orthoptics	Orthoptics are excluded.
	❖
Physical Therapy	Services do not include the use of Roentgen rays or radioactive materials or the use of electricity for surgical purposes including cauterization.Services are limited to treatment immediately necessary to prevent or reduce anticipated hospitalization or to continue a necessary plan of treatment after discharge from the hospital.
Pleoptics	Pleoptics are excluded.
Podiatry Services	Routine nail trimming is not covered. KFHC does not limit services for podiatry services. KHS may review for medical necessity on a case-by-case basis.
Prior to Effective Date	Any services which are received prior to the subscriber's effective date of coverage are excluded.
Reconstructive Surgery[17]	Cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance are excluded. Reconstructive surgery to restore and achieve symmetry incident to a mastectomy is not excluded.
Speech Pathology	KHS does not limit services for speech pathology. Frequency of services are based on medical necessity.
Spiritual Healing and Prayer	Healing by prayer or spiritual means are carved out of KHS' contract with DHS and are therefore excluded. Services may be reimbursable directly from the Medi-Cal Program.

Benefit/Services	Exclusions or Limitations
Substance Abuse Treatment	Substance abuse treatment is carved out of KHS' contract with DHS and is therefore excluded. KHS works with members to encourage treatment as described in *KHS Policy and Procedure #3.10-P: Alcohol and Substance Abuse Treatment Services*.
Transplants	KHS is responsible to provide limited transplant services as described in *KHS Policy and Procedure #3.02-P: Major Organ Transplant*.
Transportation	Transportation is covered in accordance with medical necessity determinations.
Tuberculosis Treatment	Direct Observed Therapy (DOT) for treatment of tuberculosis is carved out of KHS' contract with DHS and is therefore excluded. KHS works with members to encourage treatment as described in *KHS Policy and Procedure #3.46 – Tuberculosis Treatment*.
Vision Supplies	Replacement eye appliances are covered only if the prior appliance has been lost, stolen, or significantly damaged due to circumstances beyond the member's control. The following supplies are not covered: ➢ Double segment bifocal or no-line multifocal lenses ➢ Multifocal contact lenses Eye appliances to supplement an existing eye appliance, regardless of the source of the existing appliance are limited to the following: ➢ Two pairs of single vision glasses, one for distance vision and one for near vision, in lieu of multifocal eyeglasses when there are indications that multifocal lenses cannot be worn satisfactorily ➢ Low vision aids, including single vision eyeglasses prescribed as a low vision aid ➢ Ptosis crutches, occluders, bandage contact lenses, prosthetic eyes, and prosthetic scleral shells ➢ Overcorrection single vision or bifocal eyeglasses for concurrent use with contact lenses. Prescription eyeglasses for alternative use by a person who has and is able to wear contact lenses are not covered. Contact lenses shall not subsequently be covered after a member has been provided prescription eyeglasses because the patient could not wear contact lenses.

1.0 DELEGATION MONITORING AND OVERSIGHT

KHS is responsible for ensuring that all delegates comply with all applicable state and federal law and regulations, contract requirements, and other DHCS guidance including APLs and Dual Plan Letters. These requirements must be communicated by KHS to all delegated entities and

subcontractors.

ATTACHMENTS:

- **Attachment A:** *Excluded Drugs for the Treatment of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)*
- **Attachment B:** *Excluded Drugs for Alcohol and Heroin (Opioid)Dependence Treatment*

REFERENCE:

Revision 2020-10: Routine review of policy. References to APL-18-007 Blood Lead Testing and APL 15-003 Chiropractic Services in addition to Policy and Procedure #3.72-I Behavioral Health Therapy Developmental Disabilities by Chief Health Services Officer. **Revision 2016-12:** Reference to acupuncture was removed. Acupuncture is a covered benefit. **Revision 2016-09:** Revision to Chiropractic Services regarding reimbursement. Corrected reference to policy on page four. No requested revision by DMHC during audit review. **Revision 2014-11:** Policy submitted as part of DMHC Material Modification. Policy approval pending as of 08/2014. Policy revised to comply with Mental Health Carve-In (12-2013). Healthy Families language removed due to transition to Medi-Cal. **Revision 2006-10:** Routine revision. Revised per DHS Workplan Comments 7c (4/26/06). **Revision 2003-06**: Revised per DHS comment 03-04-03. **Revision 2002-11:** Routine Revision. **Formerly:** #3.05 – Excluded Services. Number changed due to P&P manual revision.

[2]DHS Contract §6.7.1.1

[3] CCR Title 22 §51303 (I) and §51320 (b) and §59998 (a)(7)(A)

[5] CCR Title 10 §2699.6703 (a)(6)

[6] CCR Title 22 §51303 (g) and (h); CCR Title 10 §2699.6700 (a)(4) and §2699.6703 (a)(5)

[7] CCR Title 22 §51349 (f)

[8] CCR Title 10 §2699.6703 (a)(8)

[9] DHS Contract 03-76165 A03, Exhibit A, Attachment 11-A.

[10] CCR Title 10 §2699.6703 (a)(3)

[11] CCR Title 10 §2699.6700 (a)(4)

[12] CCR Title 10 §2699.6700 (a)(2)(D)

[13] CCR Title 22 §51317 (a)(4)

[14] CCR Title 22 §51305.6 (a)

[15] CCR Title 22 §51303 (I)

[16] CCR Title 22 §59998 (a)(7)

[17] CCR Title 22 §51305 (I) (l); CCR Title 10 §2699.6700 (a)(23) and §2699.6703 (a)(13)

EXCLUDED DRUGS FOR THE TREATMENT OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)[1]

Generic Name

Abacavir Sulfate
Abacavir Sulfate/Lamivudine/Zidovudine
Abacavir/Lamivudine
Amprenavir
Atazanavir Sulfate
Emtricitabine
Enfuvirtide
Indinavir Sulfate
Efavirenz
Lamivudine
Saquinavir
Lopinavir/Ritonavir
Ritonavir
Delavirdine Mesylate
Saquinavir Mesylate
Tenofovir Disoproxil/Emtricitabine
Tenofovir Disoproxil Fumarate
Nelfinavir Mesylate
Nevirapine
Stavudine
Zidovudine/Lamivudine
Fosamprenavir Calcium

[1] 03-76165 A-01

EXCLUDED DRUGS FOR ALCOHOL AND HEROIN (OPIOID) DEPENDENCE TREATMENT[2]

Generic Name

Buprenorphine HCL
Buprenorphine HCL and Naloxone HCL dihydrate

[2] 03-76165 A-03

KERN HEALTH SYSTEMS

Policy and Procedure Review/ Revision

Policy 3.13-P EPSDT Supplemental Services and Targeted Case Management (TCM) has been updated and is provided here for your review and approval.

Policy approved by DHCS 9/11/2020.

Reviewer	Date	Comment/Signature
Doug Hayward		
Dr. Tasinga	11/9/2020	M Tasinga
Deb Murr	10/23/2020	**Added delegated oversight language** Deborah C Murr RN
Michael Pitts	10/21/2020	**Michael Pitts, RN**
Shannon Miller	10/19/2020	**Shannon Miller, RN**

(CEO decision(s))

Board approval required: Yes ___ No ____ QI/UM Committee approval: Yes ___ No ___
Date approved by the KHS BOD: _____ Date of approved by QI: _____
PAC approval: Yes ___ No ___ Date of approval by PAC: _____
Approval for internal implementation: Yes ___ No ___
Provider distribution date: Immediately _____ Quarterly _____

Effective date: _____
DHCS submission: _____
DMHC submission: _____
Provider distribution: _____

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: EPSDT Supplemental Services and Targeted Case Management (TCM)				POLICY #: 3.13-P	
DEPARTMENT: Utilization Management					
Effective Date: 08/1997	Review/Revised Date: 11/12/2020	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Health Services Officer

_____ Date _____
Director of Case and Disease Management

_____ Date _____
Director of Utilization Management

POLICY:

KHS is required to cover and ensure the provision of screening, preventive, and medically necessary diagnostic and treatment services for members under the age of 21, including EPSDT Supplemental Services. The EPSDT benefit includes case management and targeted case management services designed to assist members in gaining access to necessary medical, social, educational, and other services. KHS will ensure that comprehensive case management is provided to each member. KHS must maintain procedures for monitoring the coordination of care provided to members, including but not limited to all medically necessary services delivered both within and outside KHS's provider network. If KHS determines that case management services are medically necessary and not otherwise available, KHS will provide, or arrange and pay for, the case management services for its

members who are eligible for EPSDT services (Title 22, CCR, and Section 51340(k)). KHS will ensure the provision and referral of appropriate Early and Periodic Screening, Diagnostic and Treatment (EPSDT) in accordance with the following statutory, regulatory, and contractual requirements:

- Title 22, CCR, Section 51184 and 51340(k)
- DHCS Contract Exhibit A – Attachment 10 Provision 4(F) and Attachment 11 Provision 2
- DHCS APL14-011 Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder
- DHCS APL 20-012 Private Duty Nursing Case Management Responsibilities For Medi-Cal Eligible Members Under the Age of 21
- Pursuant section 1905(a)(4)(B) of the Social Security Act (the Act) for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT)
- Section 1374.73 of the Health and Safety Code
- Pursuant to Section 14132.56 of the Welfare & Institutions Code

DEFINITIONS:

EPSDT Case Management Services[2]	Services that will assist EPSDT-eligible individuals in gaining access to needed medical, social, educational, and other services. "Case Management Services" means those services furnished to assist individuals eligible under the Medi-Cal State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, education, and other services in accordance with 42 Code of Federal Regulations (CFR) sections 441.18 and 440.169. The assistance that case managers provide in assisting eligible individuals is set forth in 42 CFR 14 section 440.169(d) and (e), and 22 California Code of Regulations (CCR) section 51184(d), (g) (5) and (h). SA Pg. Pg. 3, para. 1.
EPSDT Diagnosis and Treatment Services[3]	Only those services provided to persons under 21 years of age that: 1. Are identified in section 1396d(r) of Title 42 of the United States Code, 2. Are available under CCR Title 22 Chapter 3 of Division 3 Subdivision 1, ccr.oal.ca.gov without regard to the age of the recipient or that are provided to persons under 21 years of age pursuant to any provision of federal Medicaid law other than section 1396d(a)(4)(B) and section 1396a(a)(43) of Title 42 of the United States Code, and 3. Meet the standards and requirements of CCR Title 22 Sections 51003 and 51303, ccr.oal.ca.gov and any specific requirements applicable to a particular service that are based on the standards and requirements of those sections.
EPSDT Services	EPSDT Services means Early and Periodic Screening, Diagnostic and Treatment services, a benefit of the State's Medi-Cal program that provides comprehensive, preventative, diagnostic, and treatment services to eligible children under the age of 21, as specified in section 1905(r) of the Social Security Act. (42 U.S.C. §§ 1396a (a)(10)(A),

	1396a(a)(43), 1396d(a)(4)(B), 1396d(r).)
Private Duty Nursing	Private Duty Nursing (PDN) means nursing services provided in a Medi-Cal beneficiary's home by a registered nurse or a licensed practical nurse, under the direction of a beneficiary's physician, to a Medi-Cal beneficiary who requires more individual and continuous care than is available from a visiting nurse. (42 CFR. § 440.80.)
Home Health Agency	Home Health Agency as defined in Health and Safety Code section 1727(a) and used herein, means a public or private organization licensed by the State which provides skilled nursing services as defined in Health and Safety Code section 1727(b), to persons in their place of residence.
Individual Nurse Provider	Individual Nurse Provider (INP) means a Medi-Cal enrolled Licensed Vocational Nurse or Registered Nurse who independently provides Private Duty Nursing services in the home to Medi-Cal beneficiaries.

PROCEDURES:

1.0 PROGRAM DESCRIPTION

The EPSDT benefit provides comprehensive screening, diagnostic, treatment, and preventive health care services for individuals under the age of 21 who are enrolled in Medi-Cal and is key to ensuring that members who are eligible for EPSDT services receive appropriate preventive, dental, mental health, developmental, and specialty services.

Section 1905(r) of the Social Security Act (SSA) defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic, and treatment services for low-income individuals under 21 years of age. States are required to provide any Medicaid covered services listed in section 1905(a) of the SSA for members who are eligible for EPSDT services when the services are determined to be medically necessary to correct or ameliorate any physical or behavioral conditions.

In accordance with Title 42 of the Code of Federal Regulations (CFR), Section 440.130(c), services must also be provided when medically necessary to prevent disease, disability, and other health conditions or their progression, to prolong life, and to promote physical and mental health and efficiency.

The EPSDT benefit is more robust than the Medi-Cal benefit package provided to adults and is designed to ensure that eligible members receive early detection and preventive care in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible.

All members under the age of 21 must receive EPSDT screenings designed to identify health and developmental issues, as early as possible. The EPSDT benefit also includes medically

necessary diagnostic and treatment services for members with developmental issues, when a screening examination indicates the need for further evaluation of a child's health. The member should be appropriately referred for diagnosis and treatment without delay.

Pursuant to Title 22, CCR, Section 51340, speech therapy, occupational therapy, and physical therapy services are exempt from the benefit limitations set forth under Title 22, CCR, and Section 51304. KHS may not impose service limitations. In addition, KHS is required to provide speech therapy, occupational therapy, and physical therapy services when medically necessary to correct or ameliorate defects discovered by screening services, whether or not such services or items are covered under the state plan unless otherwise specified in the applicable KHS contract with DHCS.

2.0 ACCESS

Title 42 of the United States Code (USC), Section 1396d(r), defines EPSDT services as including the following:

1) Screening services provided at intervals which meet reasonable standards of medical and dental practice and at other intervals indicated as medically necessary to determine the existence of physical or mental illnesses or conditions. Screening services must include, at a minimum, a comprehensive health and developmental history (including assessment of both physical and mental health development); a comprehensive unclothed physical exam; appropriate immunizations; laboratory tests (including blood lead level assessment appropriate for age and risk factors); and health education (including anticipatory guidance).

2) Vision services provided at intervals which meet reasonable standards of medical practice and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Vision services must include, at a minimum, diagnosis and treatment for defects in vision, including eyeglasses.

3) Dental services provided at intervals which meet reasonable standards of dental practice and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Dental services must include, at a minimum, treatment for relief of pain and infections, restoration of teeth, and maintenance of dental health.

4) Hearing services provided at intervals which meet reasonable standards of medical practice and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Hearing services must include, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids.

5) Other necessary health care, diagnostic services, treatment, and measures, as described in 42 USC 1396d (a), to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are listed in the state plan or are covered for adults.

6) Blood Lead Anticipatory Guidance and Screening Requirements

Federal law requires states to screen children enrolled in Medicaid for elevated blood lead levels (BLLs) as part of required prevention services offered through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Accordingly, the Centers for Medicare and Medicaid Services (CMS) released an informational bulletin in November 2016 that provides an overview of blood lead screening requirements for children enrolled in Medicaid. In addition, KHS is contractually required to cover and ensure that network providers provide blood lead screening tests in accordance with the California Code of Regulations (CCR).

The CCR imposes specific responsibilities on doctors, nurse practitioners, and physician's assistants conducting periodic health assessments (PHAs) on children between the ages of six months and six years. The California Department of Public Health's Childhood Lead Poisoning Prevention Branch (CLPPB) issues guidance for all California providers pursuant to the CCR.6 The CLPPB sets forth required blood lead standards of care, including Blood Lead and Anticipatory Guidance developed by the Department of Health Care Services (DHCS) related to children enrolled in Medi-Cal.

In accordance with APL 20-016, KHS will ensure that their contracted providers (i.e. physicians, nurse practitioners, and physician's assistants), who perform periodic health assessments on children between the ages of six months to six years (i.e. 72 months), comply with current federal and state laws and industry guidelines for health care providers issued by CLPPB, including any future updates or amendments.

KHS will ensure that their contracted providers:

1) Provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child member that, at a minimum, includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age.8 This anticipatory guidance must be provided to the parent or guardian at each PHA, starting at 6 months of age and continuing until 72 months of age.
2) Order or perform blood lead screening tests on all child members in accordance with the following:
    a) At 12 months and at 24 months of age.
    b) When the network provider performing a PHA becomes aware that a child member who is 12 to 24 months of age has no documented evidence of a blood lead screening test taken at 12 months of age or thereafter.
    c) When the network provider performing a PHA becomes aware that a child member who is 24 to 72 months of age has no documented evidence of a blood lead screening test taken.
    d) At any time a change in circumstances has, in the professional judgement of the network provider, put the child member at risk.
    e) If requested by the parent or guardian.
3) Follow the CDC Recommendations for Post-Arrival Lead Screening of Refugees contained in the CLPPB issued guidelines.

Network providers are not required to perform a blood lead screening test if either of the following applies:

1) In the professional judgment of the network provider, the risk of screening poses a greater risk to the child member's health than the risk of lead poisoning.
2) If a parent, guardian, or other person with legal authority to withhold consent for the child refuses to consent to the screening.

Network providers must document the reason(s) for not performing the blood lead screening test in the child member's medical record. In cases where consent has been withheld, KHS must ensure that the network provider documents this in the child member's medical record by obtaining a signed statement of voluntary refusal. If the network provider is unable to obtain a signed statement of voluntary refusal because the party that withheld consent declines to sign or is unable to sign (e.g., when services are provided via telehealth modality), the network provider must document the reason for the not obtaining a signed statement in the child's medical record. KHS will consider these documented efforts that are noted in the child's medical record as evidence of compliance with blood lead screening test requirements.

Current CLPPB-issued guidelines include minimum standards of care a network provider must follow when conducting blood lead screening tests, interpreting blood lead levels, and determining appropriate follow-up. KHS must ensure network providers follow these CLPPB-issued guidelines. According to current CLPPB guidelines, blood lead screening tests may be conducted using either the capillary (finger stick) or venous blood sampling methods; however, the venous method is preferred because it is more accurate and less prone to contamination. All confirmatory and follow-up blood lead level testing must be performed using blood samples taken through the venous blood sampling method. While the minimum requirements for appropriate follow-up activities, including referral, case management and reporting, are set forth in the CLPPB guidelines, a provider may determine additional services that fall within the EPSDT benefit are medically necessary. KHS must ensure that members under the age of 21 receive all medically necessary care as required under EPSDT.

In addition to ensuring network providers meet requirements for testing, follow-up care, and documentation, as described above, KHS is required to identify, on at least a quarterly basis all child members between the ages of six months to six years (i.e. 72 months) who have no record of receiving a blood lead screening test required by Title 17 CCR section 37100. KHS must identify the age at which the required blood lead screenings were missed, including children without any record of a completed blood lead screening at each age. KHS must notify the network provider who is responsible for the care of an identified child member of the regulatory requirements to test that child and provide the required written or oral anticipatory guidance to the parent/guardian of that child member. KHS must also maintain records, for a period

of no less than 10 years, of all child members identified quarterly as having no record of receiving a required blood lead screening test and provide those records to DHCS, at least annually as well as upon request, for auditing and compliance purposes.

2.1 Medical Necessity Standards

Specifically, for members under the age of 21, KHS is required to provide and cover all medically necessary services with the following exceptions:

A. Dental services provided by dental personnel covered by the Medi-Cal Denti-Cal Program (Policy Letter 13-002);
B. Non-medical services provided by Regional Centers (RCs) to members with developmental disabilities, including, but not limited to, respite, out-of-home placement, and supportive living. However, KHS will monitor and coordinate all medical services with RC staff;
C. Alcohol and substance use disorder treatment services available under the Drug Medi-Cal Program and outpatient heroin detoxification services, including all medications used for treatment of alcohol and substance use disorder covered by DHCS, as well as specific medications not currently covered by DHCS, but reimbursed through Medi-Cal fee-for-service (FFS);
D. Specialty mental health services listed in Title 9, CCR, Section 1810.247 for members that meet medical necessity criteria as specified in Title 9, CCR, Sections 1820.205, 1830.205, or 1830.210, which must be provided by a mental health plan (APLs 13-018 and 17-018);
E. CCS services not included in the KHS capitated rate. The EPSDT services determined to be medically necessary for treatment or amelioration of the CCS-covered condition, including private duty nursing related to a CCS-eligible condition, must be case managed and have obtained prior authorization by the CCS program (on a FFS basis) (Title 22, CCR, Section 51013);8
F. Services for which prior authorization is required but are provided without obtaining prior authorization; and
G. Other services listed as services that are not "Covered Services" under KHS's Contract with DHCS, such as Pediatric Day Health Care services.

Where another entity—such as a local education agency (LEA), RC, or local governmental health program—has overlapping responsibility for providing services to a member under the age of 21, KHS will assess what level of medically necessary services the member requires, determine what level of service (if any) is being provided by other entities, and then coordinate the provision of services with the other entities to ensure that KHS and the other entities are not providing duplicative services.

KHS has the primary responsibility to provide all medically necessary services, including services which exceed the amount provided by LEAs, RCs, or local governmental health programs. However, these other entities must continue to meet their own requirements regarding provision of services. KHS should not rely on a LEA program, RC, CCS, Child Health and Disability Prevention Program, local governmental health program, or other entities as the primary provider of medically necessary services. KHS is the primary provider of such medical services except for those services that have been expressly carved out. KHS is required to provide case management and coordination of care to ensure that members can access medically necessary medical services as determined by the KHS provider. For example, when

school is not in session, KHS will cover medically necessary services that were being provided by the LEA program when school was in session.

3.0 REPORTING

According to the November 2016 CMS informational bulletin, there is concern that not all blood lead screening tests are coded correctly to be included in Medicaid screening data. Network providers, including laboratories, should utilize appropriate Common Procedure Terminology coding to ensure accurate reporting of all blood lead screening tests.

In order to comply with Health Insurance Portability and Accountability Act requirements, KHS must utilize the CMS-1500/UB-04 claim forms, or their electronic equivalents (837-P/837-I), to report confidential screening/billing to DHCS.

DHCS currently utilizes encounter data submitted through national standard file formats (837-P/837-I) for tracking the administration of blood lead screening. KHS is required to submit complete, accurate, reasonable, and timely encounter data consistent with our DHCS contract and APLs 14-019 and 17-005.12 Additionally, KHS must ensure that blood lead screening encounters are identified using the appropriate indicators, as outlined in the most recent DHCS Companion Guide for X12 Standard File Format, which can be obtained by emailing the Encounter Data mailbox at: MMCDEncounterData@dhcs.ca.gov.

California law requires laboratories performing blood lead analysis on blood specimens drawn in California to electronically report all results to CLPPB. This reporting must include specified patient demographic information, the ordering physician, and analysis data on each test performed. KHS must ensure that network providers are reporting blood lead screening test results to CLPPB, as required.

4.0 MONITORING

KHS will provide training to ALL laboratories and health care providers performing blood lead analysis and monitor through quarterly reporting reconciliation for members less than 6 years of age. Providers will be notified of compliance with this requirement through various communication channels and ongoing auditing of screenings performed.

5.0 PRIVATE DUTY NURSING

As outlined in DHCS APL 20-012 and the I.N. Settlement Agreement, KHS is required to provide Case Management Services as set forth in its Medi-Cal contract to all plan enrolled Medi-Cal beneficiaries who are EPSDT eligible and for whom Medi-Cal Private Duty Nursing services have been approved, including, upon a plan member's request, Case Management Services to arrange for all approved Private Duty Nursing services desired by the plan member, even when the Plan is not financially responsible for paying for the approved Private Duty Nursing services. Medi-Cal Private Duty Nursing services include Private Duty Nursing services approved by the California Children's Services Program (CCS).

KHS shall use one or more Home Health Agencies, Individual Nurse Providers, or any combination thereof, in providing Case Management Services as set forth in the Medi-Cal contract to plan enrolled EPSDT eligible Medi-Cal beneficiaries approved to receive Private Duty Nursing services, including, upon that member's request, Case Management Services to arrange for all approved Private Duty Nursing services desired by the member, even when the

Plan is not financially responsible for paying for the approved Private Duty Nursing services.

When KHS has approved EPSDT eligible Medi-Cal beneficiary to receive Private Duty Nursing services, the Managed Care Plan has primary responsibility to provide Case Management for approved Private Duty Nursing services. When CCS has approved a CCS participant who is an EPSDT eligible Medi-Cal beneficiary to receive Private Duty Nursing services for treatment of a CCS condition, the CCS Program has primary has primary responsibility to provide Case Management for approved Private Duty Nursing services.

Regardless of which Medi-Cal program entity has primary responsibility for providing Case Management for the approved Private Duty Nursing services, an EPSDT eligible Medi-Cal beneficiary approved to receive Medi-Cal Private Duty Nursing services, and/or their personal representative, may contact any Medi-Cal program entity that the beneficiary is enrolled in (which may be KHS, CCS, or the Home and Community Based Alternatives Waiver Agency) to request Case management for Private Duty Nursing services. The contacted Medi-Cal program entity must then provide Case Management Services as described above to the beneficiary and work collaboratively with the Medi-Cal program entity primarily responsible for Case Management.

KHS obligations to enrolled EPSDT eligible members who are approved to receive Private Duty Nursing services who request Case Management Services for their approved Private Duty Nursing services include, but are not limited to:

a) providing the member information about the number of Private Duty Nursing hours that they are approved to receive.
b) contacting enrolled Home Health Agencies and enrolled Individual Nurse Providers to seek approved Private Duty Nursing services on the member's behalf;
c) identifying and assisting potentially eligible Home Health Agencies and Individual Nurse Providers with navigating the process of enrolling to be a Medi-Cal provider;
d) working with Home Health Agencies and enrolled Individual Nurse Providers to jointly provide Private Duty Nursing services to the member as needed.

The California Code of Regulations (CCR) further clarifies the parameters of California's implementation of the EPSDT program. Pursuant to Title 22 of the CCR, Section 51184(a)(3), screening services include any other encounter with a licensed health care provider that results in the determination of the existence of a suspected illness or condition or a change or complication in a condition. Screening services must identify developmental issues as early as possible.

KHS is required to provide appointment scheduling assistance and necessary transportation, including non-emergency medical transportation and non-medical transportation, to and from medical appointments for the medically necessary services that KHS is responsible for providing, including carved out services, pursuant to the contract with DHCS.

KHS is responsible for determining whether a member requires Targeted Case Management (TCM) services, and refers members who are eligible for TCM services to a Regional Center or local governmental health program as appropriate for the provision of TCM services.[4] If members under age 21 are not accepted for TCM services, KHS ensures the member has access to services comparable to EPSDT TCM services.[5] Such services would be provided through

the County Health System if not otherwise available.

If a Member is receiving TCM services as specified in Title 22, CCR, Section 51351, KHS is responsible for coordinating the member's health care with the TCM Provider and for determining the medical necessity of covered diagnostic and treatment services recommended by the TCM provider.[6]

6.0 DELEGATION

KHS is responsible for ensuring that our delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Dual Plan Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

REFERENCE:

Revision 2020-10 Policy updated by Director of Utilization Management to comply with APL 20-016.
Revision 2020-07: Policy approved by DHCS 9/11/2020. Policy updated by Director of Utilization Management to comply with APL 20-012 and I.N. Settlement Agreement.
Revision 2018-11: Policy updated by Administrative Director of Health Services to comply with APL 18-017.
Revision 2018-04: Policy updated by Director of Health Services to comply with APL 18-007.
Revision 2016-02: Removed language on the transition from Kern Regional Center**. Revision 2014-11:** Policy updated by Director of Health Services to comply with ABA Autism requirements. **Revision 2014-01:** Revision provided by Director of Health Services. Healthy Families language removed. **Revision 2005-10:** Routine review. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004).

References:
CCR Title 17 Section 37100
CCR Title 22 Section 51184(g)
CCR Title 22 Section 51184(b)
DHS Contract A-11 2
DHS Contract A-11 2
DHS Contract A-11 2

KERN HEALTH SYSTEMS

Policy and Procedure Review/ Revision

Policy 11.21-I Population Needs Assessment (previously 2.11-I GNA) has been updated and is provided here for your review and approval.

Note: Policy to go to QI/UM Committee for approval in February 2021.

Reviewer	Date	Comment/Signature
Doug Hayward	1/11/21	
Dr. Tasinga	1/7/2021	
Deb Murr	12/18/2020	
Isabel Silva	12/17/20	

(CEO decision(s))

Board approval required: Yes ___ No ✓ QI/UM Committee approval: Yes ___ No ___
Date approved by the KHS BOD: _____ Date of approved by QI: _____
PAC approval: Yes ___ No ___ Date of approval by PAC: _____
Approval for internal implementation: Yes ___ No ___
Provider distribution date: Immediately _____ Quarterly _____

Effective date: _____
DHCS submission: _____
DMHC submission: _____
Provider distribution: _____

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Population Needs Assessment				POLICY #: 11.21	
DEPARTMENT: Health Services – Health Education					
Effective Date: 04/2005	Review/Revised Date: 01/11/2021	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	X
		BOD		FINANCE COMMITTEE	

_____ Date_____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Health Services Officer

_____ Date _____
Director of Health Education, Cultural and Linguistics

POLICY:

Kern Health System (KHS) will identify health education, cultural and linguistic (C&L) needs of members through a Population Needs Assessment (PNA). KHS' contract with the Department of Health Care Services (DHCS) identifies the PNA as the Group Needs Assessment. The goal of the PNA is to improve health outcomes for members and ensure that KHS is meeting the needs of all of its members by:

- Identifying member health needs and health disparities
- Evaluating health education, C&L and quality improvement (QI) activities and available resources to address identified health concerns
- Implementing targeted strategies for health education, C&L and QI programs and services.

The PNA will facilitate the development and implementation of effective health education and promotion programs as well as cultural and linguistic services. Additionally, KHS will identify community health education and promotion resources, which will assist in the delivery of culturally competent and linguistically appropriate programs and services.

The PNA will be used for the continuous development and improvement of contractually required health education, cultural and linguistic programs and services.

PROCEDURES:

1.0 INITIAL PLANNING

KHS will complete a PNA report and action plan annually. DHCS will provide ongoing instruction and guidance on the PNA format and submission deadlines.

Oversight and administration of the PNA is conducted by a full-time health educator with a master's degree in community or public health education (MPH) within the KHS Health Education department.

2.0 PNA DESIGN AND INFORMATION COLLECTION

For each specific PNA, a PNA team is assembled which includes, but is not limited to department representatives from Health Education, Cultural and Linguistics, Marketing, Member Services, Quality Improvement and IT. Additionally, input is solicited from the Public Policy/Community Advisory Committee (PP/CAC).

The PNA identifies the following for KHS members:

A. Demographic profile
B. Member health status and disease prevalence
C. Access to Care
D. Member health disparities
E. Health Education, Cultural and Linguistic, and/or Quality Improvement program gap analysis
F. Community health education, cultural and linguistic program and resources
G. Unique needs of KHS member, including:
    - Seniors and Persons with Disabilities
    - Children with Special Health Care Needs
    - Members with limited English proficiency
    - Members from diverse cultural and ethnic backgrounds

In addition the PNA assesses the internal systems in place to address the cultural and linguistic needs of members, including but not limited to, assessing KHS's capacity to provide linguistically appropriate services.

2.1 Data Sources

KHS uses reliable data sources to conduct the PNA. Data sources will include the most recently available Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results and the KHS specific health disparities data provided by DHCS. KHS evaluates the most recent results from the CAHPS survey, including response to the CAHPS survey supplemental questions selected by DHCS when conducting the PNA and the development of an action plan.

KHS' Health Education department may use other DHCS recommended data sources that include but are not limited to member surveys, Centers for Medicare and Medicaid Services (CMS) Adult and Child Core Set performance measurement results, claims and encounter data, analysis of focus groups, key informant interviews, local health department and county data,

member grievance and appeals data, and compliance findings such as the DHCS Timely Access Survey results.

Research on state and county census data, such as demographic characteristics, geographic distribution, and health status indicators are compared with KHS' membership profile. The membership database is used to profile member's age, gender, race, and language. The top five inpatient and outpatient claims diagnoses for members are assessed through analysis of claims and encounter data. The top five medications for members is also assessed through analysis of pharmacy data. Previously completed community needs assessments are collected to supplement the development of the PNA. Existing needs assessment and reports are reviewed for health indicators, priority needs and gaps in health service for low-income populations. National objectives such as, Healthy People 203and/or 0, are used as a source of information on areas of health promotion, health protection and preventative services.

KHS will provide the Public Policy/Community Advisory Committee (PP/CAC) an opportunity to provide input through the PP/CAC survey. The PP/CAC survey solicits information of health needs and barriers to services for members. (See Attachment B). KHS reports the PNA findings to the PP/CAC, discusses improvement opportunities and updates the PP/CAC on progress made towards the PNA goals through the quarterly PP/CAC meetings.

When possible KHS will make a good faith effort to work in close collaboration with policy level committees, the public health department and community based organizations in implementing the needs assessment.

2.2 Additional Consumer/Member Input

Additional member input is obtained through the KHS contracted 24-hour advice nurse and triage service. The contracted 24-hour advice nurse and triage service submits monthly reports of all calls received from members, the reason for the call and the call disposition. This information is indicative of the health needs of KHS members.

3.0 INFORMATION TABULATION AND ANALYSIS

Once all the data has been collected, the Health Education department tabulates and analyzes the data.

4.0 PRIORITY SETTING AND PROGRAM DEVELOPMENT

The PNA findings and action plan provide the substantive foundation for key decisions which become the basis for continuous program planning in Health Education, C&L services and QI activities. The PNA team convenes and decides on steps or actions to be planned based on the PNA findings to address the overall needs of members and the needs of CSHCN, SPDs, LEP members and other member subgroups from diverse cultural and ethnic backgrounds. KHS' specific health disparities data provided by DHCS is taken into consideration when selecting and evaluating strategies targeting health disparities. Input from the PP/CAC is also solicited at this planning stage.

The results of the PNA will also be considered in the development of any Marketing materials prepared by KHS.

5.0 PROVIDER & KHS STAFF TRAINING

Providers will receive pertinent information regarding the PNA findings and KHS' action plan to address the overall identified needs of members, as well as the specific needs of CSHCN, SPDs, members with LEP, and other member subgroups from diverse cultural and ethnic backgrounds through provider bulletins, the provider portal, and/or the PP/CAC and QI/UM committee. KHS staff trainings will be provided as necessary.

6.0 REPORTING

Upon completion of the PNA, a PNA Report and action plan are submitted to DHCS for approval annually (See Attachment A). The PNA report shows a clear link between data sources, key data findings, and identified opportunities for improvement. The PNA Report will include the following:

A. PNA Overview
B. Data sources
C. Key Data Assessment Findings
    a. Member demographics
    b. Member health status, disease prevalence, access to care, and health disparities
    c. Gap analysis of health education, cultural and linguistic, and/or quality improvement programs
D. Action Plan
E. Stakeholder Engagement

7.0 DELEGATION OVERSIGHT

KHS is responsible for ensuring that our delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, and Dual Plan Letters. These requirements must be communicated by KHS to all delegate entities and subcontractors.

ATTACHMENTS:

- Attachment A: PNA Report Template
- Attachment B: PP/CAC Survey

REFERENCE:

Revisions 2020-11: Policy updated to comply with APL 19-011. Policy renamed and renumbered to fit under Health Education section as requested by the Director of Health Education Cultural and Linguistics Services. **Revision 2018-06:** Policy updated to comply with APL 17-002. **Revision 2017-01:** Policy updated by Health Education & Disease Management Manager. **Revision 2013-07:** Major revision provided by Quality Improvement Department. Policy should be reviewed in its entirety. **Revision 2010-05:** Routine review provided by Director of Quality Improvement, Health Education and Disease Management. **Revision 2009-07:** Revised by Director of Quality Improvement, Health Education and Disease Management. **Revision 2008-04:** Routine revision. Not reviewed by the AIS Department. **Revision 2005-04:** Revised to comply with DHS Contract 03-76165 (Effective May 1, 2004). Formulary #30.01renumbered to fit in new numbering scheme. **Revision 2002-02:** Created for NCQA compliance.

[1] References: DHS Contract §6.7.7.7; MMCD Policy Letter 99-02; and MRMIB Contract § III C (3)

Population Needs Assessment REPORT TEMPLATE

[Managed Care Health Plan Name]

[Report Year]

Responsible Health Education and/or Cultural and Linguistics Staff
Name:
Title:
Email:

Name:
Title:
Email:

This is a suggested template for the Population Needs Assessment (PNA) report. Regardless of the template used, all sections must be included in order to meet the standards for approval*.

Table of Contents

1. Population Needs Assessment Overview

Summarize PNA report including data sources used, key findings, and objectives for developing health education, culturally competent and linguistically appropriate services, and continuous quality improvement programs.

2. Data Sources

Data Sources—*List and provide a brief description of each data source used in the PNA including year of data. Data sources must include the most recently available Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results and the Department of Health Care Services managed care health plan (MCP) specific health disparities data. Other recommended data sources may include but are not limited to member surveys/assessments, Centers for Medicare and Medicaid Services (CMS) Adult and Child Core Sets, claims and encounter data, analysis of focus groups, key informant interviews, county data, provider data, and compliance findings such as the DHCS Timely Access Survey results. Provide an overview of procedures, resources, and methodologies used to conduct the PNA.*

3. Key Data Assessment Findings

Membership/Group Profile--*Describe membership characteristics for the MCP. Include member demographic elements which may include age, gender, race/ethnicity, geographic distribution, education level, members with Limited English Proficiency (LEP), members of a vulnerable group (i.e. LGBT, homeless), and seniors and persons with disabilities (SPD). The MCP is expected to incorporate this information when available.*

Health Status and Disease Prevalence—*Describe health status, disease prevalence, and key health issues of members and include data and information sources that support these findings.*

Access to Care—*Describe identified issues related to access to care and include data and information sources that support these findings, including any relevant provider data.*

Health Disparities—*Describe health disparities identified through this assessment and include data and information sources that support these findings.*

Health Education, C&L, and/or Quality Improvement Program Gap Analysis—*Describe gaps in services as they relate to access to care, language needs, cultural and linguistic competency, and health education, as well as gaps in quality improvement efforts identified in this assessment.*

Other—*Describe other key findings from this PNA that are important to the MCP's work or membership.*

4. Action Plan

The PNA Action Plan is a review and update of the health education, C&L, and QI activities and available resources to address identified member needs. The Action Plan must outline health education, C&L, and QI efforts taken and planned to improve health outcomes for members. The data assessment must be used to identify health education, C&L, and QI program targeted strategies including those designed to impact health disparities. MCPs must use reliable data sources to make any necessary adjustments to strategies annually.

Based on the data assessment findings above, list objectives for the next year, and strategies to reach them, including at least one objective targeting a health disparity.

Objectives must be SMART (Specific, Measurable, Attainable, Realistic, Timed) and can be single year, or multi-year. Indicate data sources used to inform the objectives and to measure progress.

Strategies are approaches or plans of action to make progress toward or achieve an objective.

Action Plan Table

Use the reporting table below to identify objectives and strategies that will be acted upon in the next year. Replicate and complete for each objective.

Objective: *Reduce the percentage of members reported having trouble with completing health forms by themselves from 40% to 30%.* **Data Source:** *(CAHPS Data)*
Strategies
1.) *Increase the number of health education classes, shared-decision making tools, and resources that enhance Members' health literacy.*
2.) *Publish all health education self-management materials and tools (with instructions) to the Member Portal with an option to be emailed.*

Action Plan Review and Update Table

Use the reporting table below to report the progress made toward Action Plan objectives and strategies in this reporting period. Progress towards objectives must be supported by data. Replicate and complete for each objective.

Objective 1.) *(Enter Objective 1 from last year's Action Plan. [i.e. increase the rate of BLANK by 30% from 43% to 60%])*	**Progress Measure:** *(i.e. increased the rate of BLANK by 30%, from 43% to 56%)* **Data source:** *(i.e. 2021 claims data) If new data is not available, please indicate.*

Data source: *(i.e. 2020 claims data)*	**Progress Toward Objective:** *Provide a narrative description of progress toward objective, including any barriers or facilitators.*
Strategies	
Strategy 1.) *(i.e. Enter Strategy 1 from last year's Action Plan)*	**Progress Discussion:** *Provide a narrative description of progress toward strategy.*
Strategy 2.)	**Progress Discussion:**
Strategy 3.)	**Progress Discussion:**

5. Stakeholder Engagement

Describe how the Community Advisory Committee (CAC) and/or other community advisory groups are engaged to provide input into the PNA.

Describe the process for educating contracted health care providers, practitioners, and allied health care personnel regarding pertinent information regarding the PNA findings and member needs.

***Alternative Submissions**

If the MCP already produces reports as required by National Committee for Quality Assurance (NCQA) Accreditation, sections of the required accreditation reports may be submitted to meet this PNA Report requirement as long as required data sources are referenced. To be a complete submission MCP must provide the following sections (A-D) below:

A. The Population Health Management Strategy section of the Population Health Management Report;
B. The Population Identification section of the Population Health Management Report;

C. The Population Health Management Impact section of the Population Health Management Report; and
D. The Program Structure section of the Quality Management and Improvement Report.

Data sources referenced in sections A-D must include the most recently available Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results and the Department of Health Care Services health disparities data. Sections A-D must outline health education, C&L, and QI efforts taken and planned to improve health outcomes for members.

KFHC Population Needs Assessment
Public Policy and Community Advisory Committee Survey

1. What are top issues in our community that impact the health of KFHC members?

2. What are the major challenges that KFHC members face when trying to access health care services?

3. What are the major challenges that KFHC members face when trying to access health education services, such as health education classes, phone calls, and printed material?

4. What are the top reasons members may not attend health education classes? Select all that apply.

    A. Lack of transportation or the classes are too far
    B. The class times are not convenient
    C. Members are too busy
    D. The class incentives are not attractive or valuable
    E. The class topics are not useful
    F. Other (specify): _____

5. What are the major challenges that KFHC members face when trying to access language interpretation services?

6. How can we encourage more KFHC members to use our language interpretation services?

7. How can we encourage more KFHC members to use each of the following services:
    - Preventive health care screenings
    - Prenatal and Postpartum Care
    - Immunizations
    - Health education programs for Asthma, Diabetes, Nutrition, and Tobacco Cessation

8. What should KFHC do to better meet the needs of the different races/ethnicities and languages in our communities?

9. How can we improve our engagement and understanding of the different cultures in Kern County? [Culture refers to integrated patterns of human behavior that includes language, thoughts, actions, customs, beliefs, values, and institutions that unite a group of people.]

10. Which of the following are effective health education services or programs that can help our members stay healthy? Select all that apply.

    A. Virtual or online classes
    B. In person classes
    C. Gym memberships
    D. Free exercise classes (such as Zumba classes)
    E. Individual counseling
    F. Discounts or gift cards for grocery stores and restaurants that have healthy options
    G. Walking groups
    H. Other (specify): _____

11. What should KFHC do to help improve community health conditions? Select all that apply.
    a. Offer grants to schools to help them start or grow student wellness programs.
    b. Open community resource centers that offer health education and disease management programs.
    c. Help members access or pay for affordable and healthy housing.
    d. Work with local policymakers and government officials on ways to plan safer, healthier, and more walkable communities, such as adding more sidewalks, parks, bike paths, public transit, public art, and grocery stores.
    e. Other (specify): _____

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
Fourth Quarter 2020

Report Date: January 12, 2021

OVERVIEW

Kern Health Systems' Health Education department provides comprehensive, culturally and linguistically competent services to plan members with the intent of promoting healthy behaviors, improving health outcomes, reducing risk for disease and empowering plan members to be active participants in their health care.

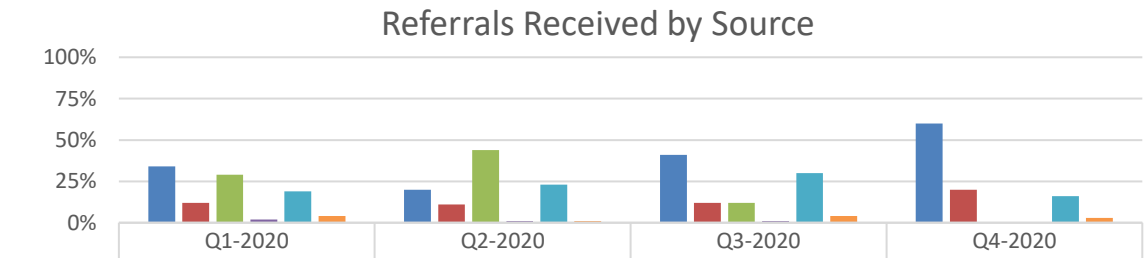
The following pages reflect statistical measurements for the Health Education department detailing the ongoing activity for the 4th quarter 2020.

- Asthma Mitigation Project
- Prenatal and Postpartum Care – Baby Steps Program
- Virtual Health Education Classes

Respectfully submitted,
Isabel Silva, MPH, CHES
Director of Health Education, Cultural and Linguistic Services

REFERRALS FOR HEALTH EDUCATION SERVICES

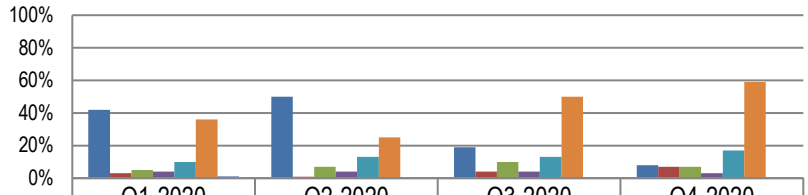
The Health Education Department (HE) receives referrals from various sources. Internal referrals are received from the Kern Health Systems (KHS) Utilization Management (UM), Disease Management (DM), Case Management (CM), Member Services (MS), and Member Portal. Externally, KHS providers submit referrals for health education services according to the member's diagnosis and members can also self-refer for health education services through the Member Portal or by calling Member Services.



	Q1-2020	Q2-2020	Q3-2020	Q4-2020
Provider	34%	20%	41%	60%
Member	12%	11%	12%	20%
HE	29%	44%	12%	0%
DM	2%	1%	1%	0%
UM	19%	23%	30%	16%
CM	4%	1%	4%	3%

During this quarter, 707 referrals were received which is a 0.4% decrease in comparison to the previous quarter.

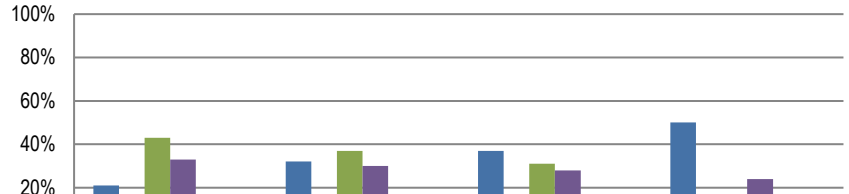
Referrals Received by Topic



	Q1-2020	Q2-2020	Q3-2020	Q4-2020
Asthma	42%	50%	19%	8%
Diabetes	3%	1%	4%	7%
Other Nutritional Counseling	5%	7%	10%	7%
Tobacco Cessation	4%	4%	4%	3%
Weight Mgmt - Adult	10%	13%	13%	17%
Weight Mgmt - Ped/Teen	36%	25%	50%	59%
Educational Material	1%	0%	0%	0%

The HE department receives referrals for various health conditions. This quarter, referrals for Ped/Teen weight management education increased from 50% to 59% due to an increase in provider referrals.

Referrals by Status



	Q1-2020	Q2-2020	Q3-2020	Q4-2020
*Accepted Services	21%	32%	37%	50%
Disenrolled	2%	0%	0%	0%
Declined Services	43%	37%	31%	16%
Unable to Contact	33%	30%	28%	24%
Withdrawn	1%	1%	2%	3%
Deceased	0%	0%	0%	0%

The rate of members who accepted to receive health education services increased from 37% in the 3rd quarter to 50% in the 4th quarter of 2020.

HEALTH EDUCATION SERVICE PROVIDERS

The HE department offers various types of services through KHS or through community partnerships. These services are currently being provided in a virtual setting or have been placed on hold due to COVID-19.

Kern Family Health Care (KFHC):

- Healthy Eating and Active Lifestyle Workshop
  - Intro to Gardening
  - Rethink Your Drink
  - Funxercise
  - Healthy Cooking
- Breathe Well Asthma Workshop

Bakersfield Memorial Hospital (BMH):

- Diabetes Management Classes (English and Spanish)
- Heart Healthy Classes
- Individual Nutrition Counseling
- Small Steps to a Healthy Weight Classes (English and Spanish)

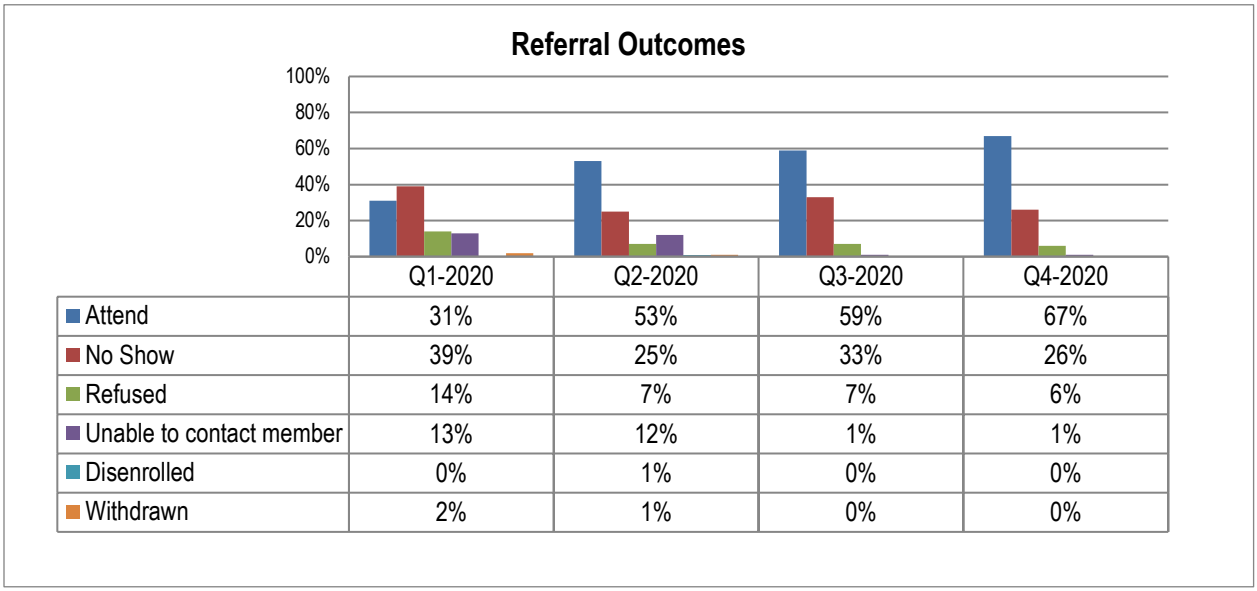
Clinica Sierra Vista (CSV) WIC:

- Diabetes Management Classes
- Heart Healthy Classes

California Smokers' Helpline (CSH):

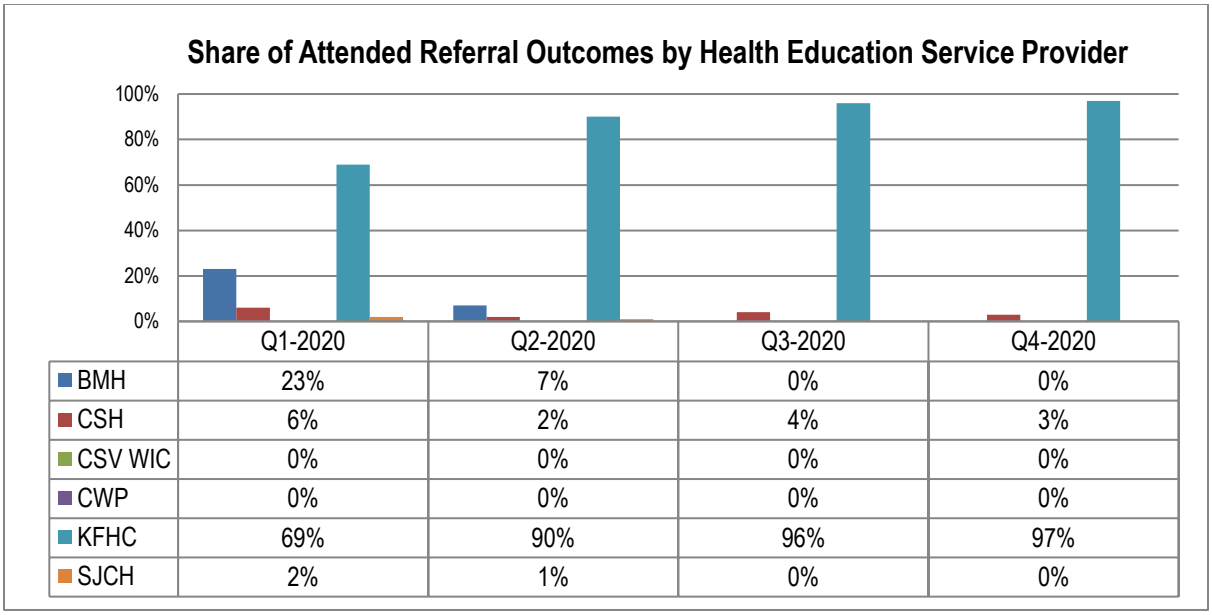
- Telephone Smoking Cessation Counseling

REFERRAL OUTCOMES



	Q1-2020	Q2-2020	Q3-2020	Q4-2020
Attend	31%	53%	59%	67%
No Show	39%	25%	33%	26%
Refused	14%	7%	7%	6%
Unable to contact member	13%	12%	1%	1%
Disenrolled	0%	1%	0%	0%
Withdrawn	2%	1%	0%	0%

During this quarter, the rate of members who received health education services out of all members who accepted services increased from 59% to 67%.

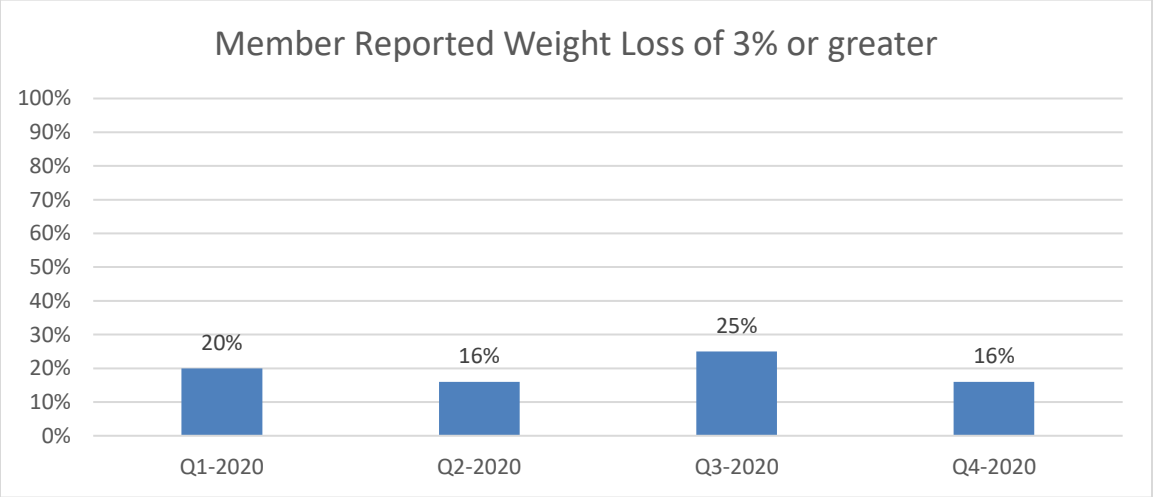


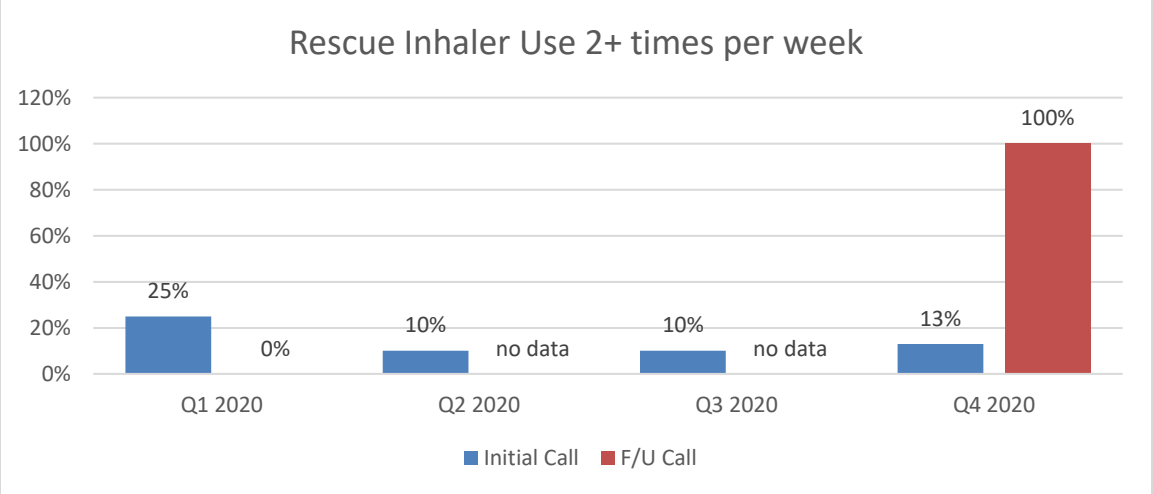
	Q1-2020	Q2-2020	Q3-2020	Q4-2020
BMH	23%	7%	0%	0%
CSH	6%	2%	4%	3%
CSV WIC	0%	0%	0%	0%
CWP	0%	0%	0%	0%
KFHC	69%	90%	96%	97%
SJCH	2%	1%	0%	0%

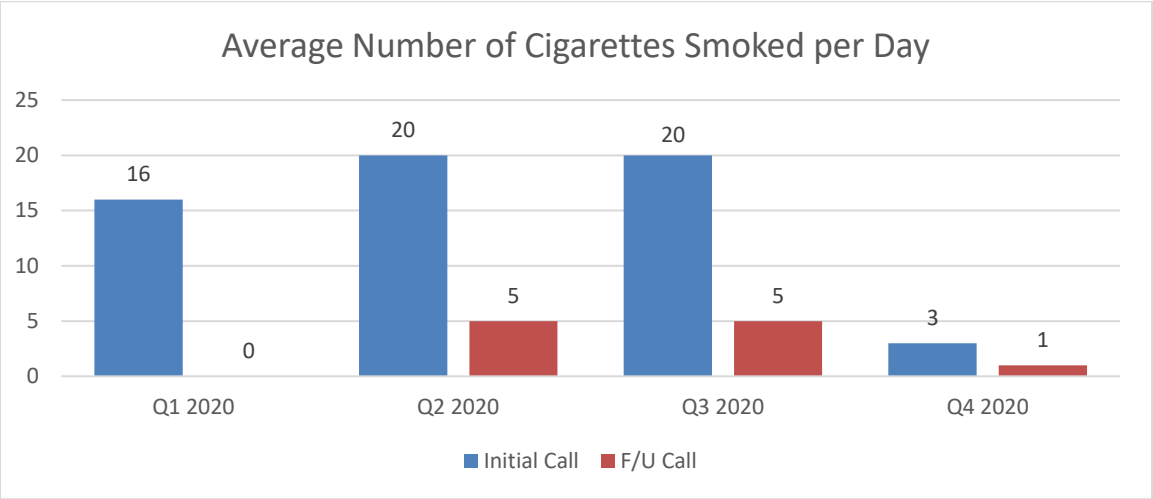
Services through KFHC demonstrates to be the largest share of referral outcomes. This quarter KFHC showed an increase from 96% in the 3rd quarter to 97% in the 4th quarter of 2020.

Effectiveness of Health Education Services

To evaluate the effectiveness of the health education services provided to members, a 3-month follow up call was conducted on members who received services during the prior quarter. Of the 16 members who participated in the 3 month follow up call, 14 received weight management education 1 received smoking cessation education and 1 received asthma management education. All findings are based on self-reported data from the member.

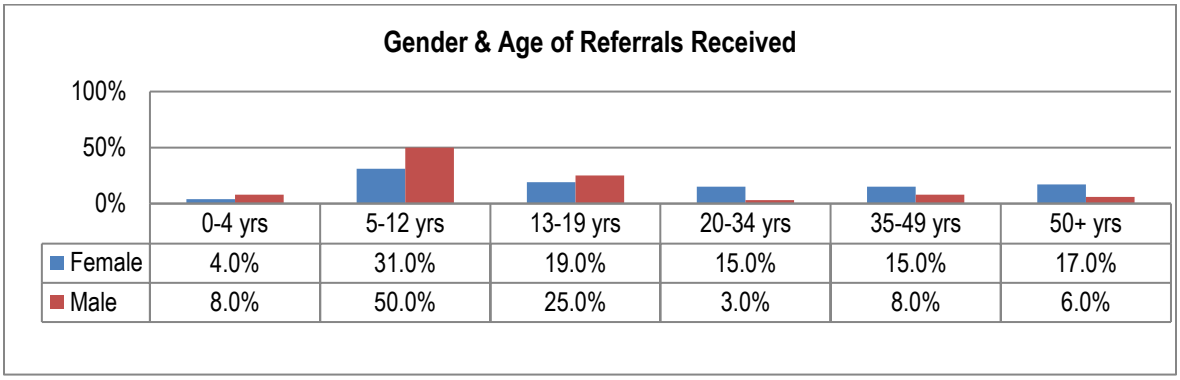






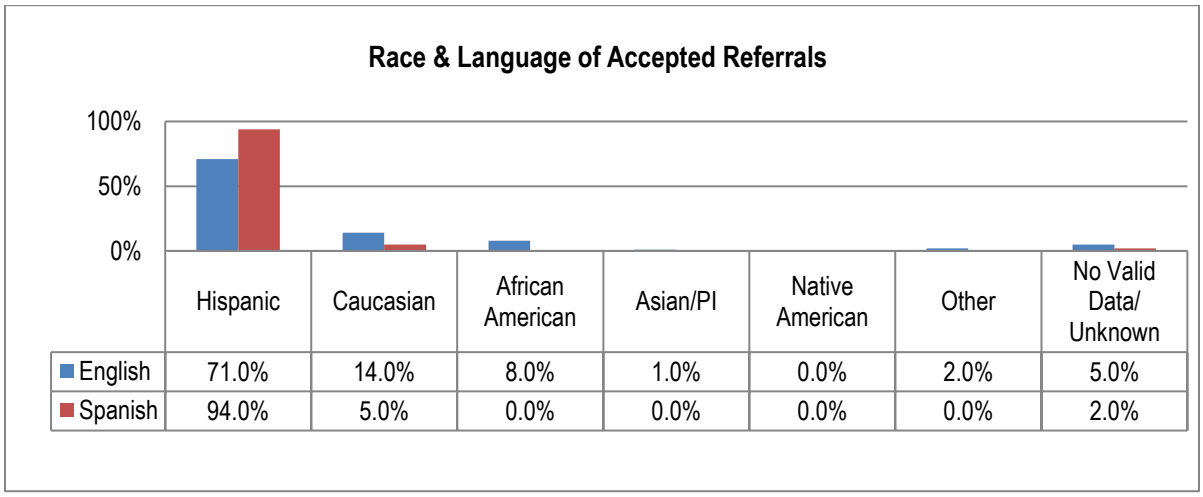
Demographics of Members

KHS' provides services to a culturally and linguistically diverse member population. KHS' language threshold is English and Spanish, and all services and materials are available in these languages.



	0-4 yrs	5-12 yrs	13-19 yrs	20-34 yrs	35-49 yrs	50+ yrs
Female	4.0%	31.0%	19.0%	15.0%	15.0%	17.0%
Male	8.0%	50.0%	25.0%	3.0%	8.0%	6.0%

Out of the members who were referred for health education services, the largest gender-age groups were male ages 5-12 years and female ages 5-12 years.



A breakdown of member classifications by race and language preferences revealed that the majority of members who accepted services are Hispanic and the majority preferred to speak Spanish.

Referrals Accepted by Top Bakersfield Zip Codes			
Q1-2020	**Q2-2020**	**Q3-2020**	**Q4-2020**
93307	93307	93307	93307
93306	93306	93306	93304
93304	93304	93305	93306
93309	93308	93313	93313
93305	93309	93309	93309

KHS serves members in the Kern County area. During this quarter, 79% of the members who accepted services reside in Bakersfield and the highest concentration of members were in the 93307 area.

Referrals Accepted by Top Outlying Areas			
Q1-2020	**Q2-2020**	**Q3-2020**	**Q4-2020**
Delano	Delano	Delano	Arvin
McFarland	Lamont	Wasco	Delano
Tehachapi	Arvin	Arvin	Lamont
Lamont	Shafter	Shafter	McFarland
Arvin	Tehachapi	Lamont	Taft

Additionally, 21% of the members who accepted services reside in the outlying areas of Kern County and the highest concentration of members reside in Arvin.

Health Education Mailings

In addition to referrals, the HE department mails out a variety of educational material in an effort to assist members with gaining knowledge on their specific diagnosis or health concern. During this quarter, the HE department was not able to provide material by mail due to COVID-19 limitations. Members were directed to access digital information available on the Kern Family Health Care website.

Educational Mailings				
	Q1-2020	**Q2-2020**	**Q3-2020**	**Q4-2020**
Anemia	0	0	0	0
Asthma	305	0	0	0
High Cholesterol	6	0	0	0
Diabetes	20	0	0	0
Gestational Diabetes	2	0	0	0
High Blood Pressure	13	0	0	0
COPD	2	0	0	0
Postpartum Care	564	0	0	0
Prenatal Care	120	0	0	0
Smoking Cessation	12	0	0	0
Weight Management	357	0	0	0
WIC	245	0	0	0
Total	**1,646**	**0**	**0**	**0**

INTERPRETER REQUESTS

Face-to-Face Interpreter Requests

During this quarter, there were 130 requests for face-to-face interpreting services received, which was a decrease in comparison to the previous quarter. KHS employs qualified staff interpreters in Spanish and contracts with the interpreting vendor, CommGap. During this quarter, the majority of these requests were for a Spanish interpreter.

Top Languages Requested			
Q4-2019	**Q1-2020**	**Q2-2020**	**Q3-2020**
Spanish	Spanish	Spanish	Spanish
Punjabi	Punjabi	Punjabi	Punjabi
Mandarin	Mandarin	Arabic	Cantonese
Arabic	Arabic	Cantonese	Arabic
Cantonese	Cantonese	Vietnamese	Thai
Vietnamese	Persian		

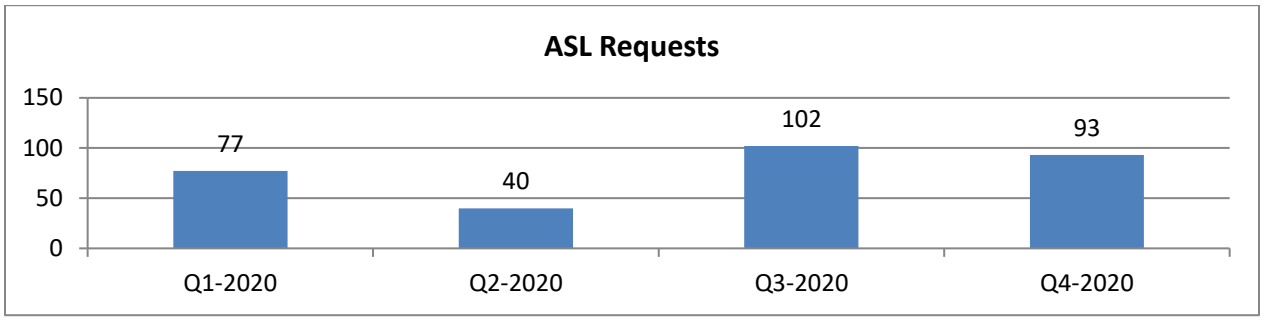
Telephonic Interpreter Requests

During this quarter, there were 595 requests for telephonic interpreting services through KHS' interpreting vendor, Language Line Solutions, which was a decrease in comparison to the previous quarter. During this quarter, the majority of these requests were for a Spanish interpreter.

Top Languages Requested			
Q1-2020	**Q2-2020**	**Q3-2020**	**Q4-2020**
Spanish	Spanish	Spanish	Spanish
Punjabi	Punjabi	Punjabi	Punjabi
Arabic	Arabic	Arabic	Arabic
Mandarin	Tagalog	Vietnamese	Vietnamese
Tagalog	Vietnamese	Cantonese	Mandarin
			Thai

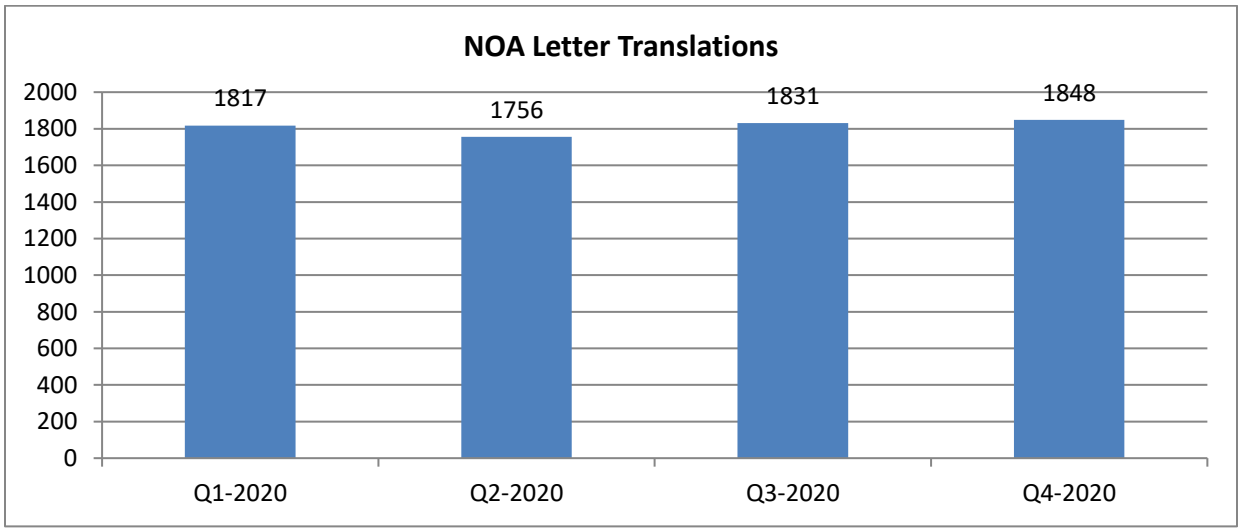
American Sign Language (ASL) Requests

During this quarter, there were a total of 93 requests received for an American Sign Language interpreter, which was a decrease in comparison to the previous quarter.



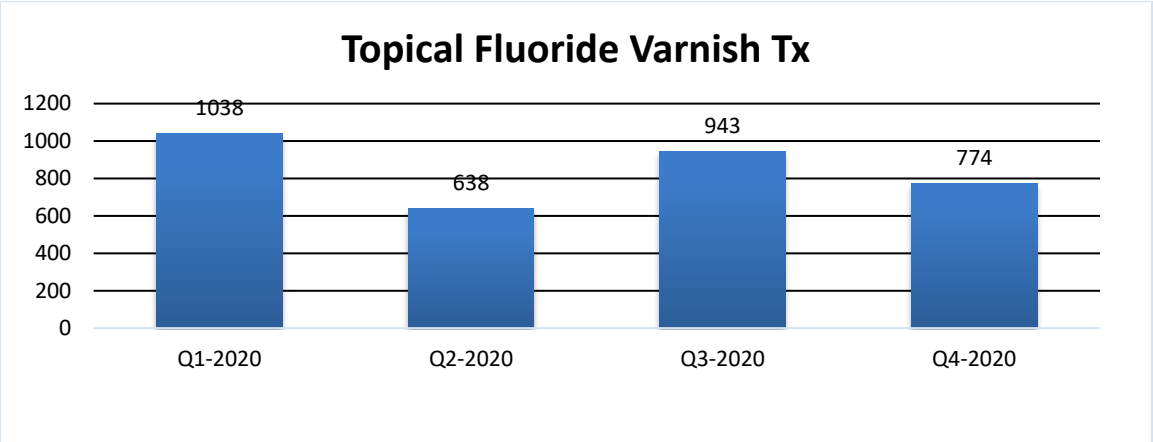
DOCUMENT TRANSLATIONS

The Health Education department coordinates the translation of written documents for members. Translations are performed in-house by qualified translators or outsourced through a contracted translation vendor. During this quarter, 1,848 Notice of Action letters were translated in-house into Spanish for the UM and Pharmacy departments.



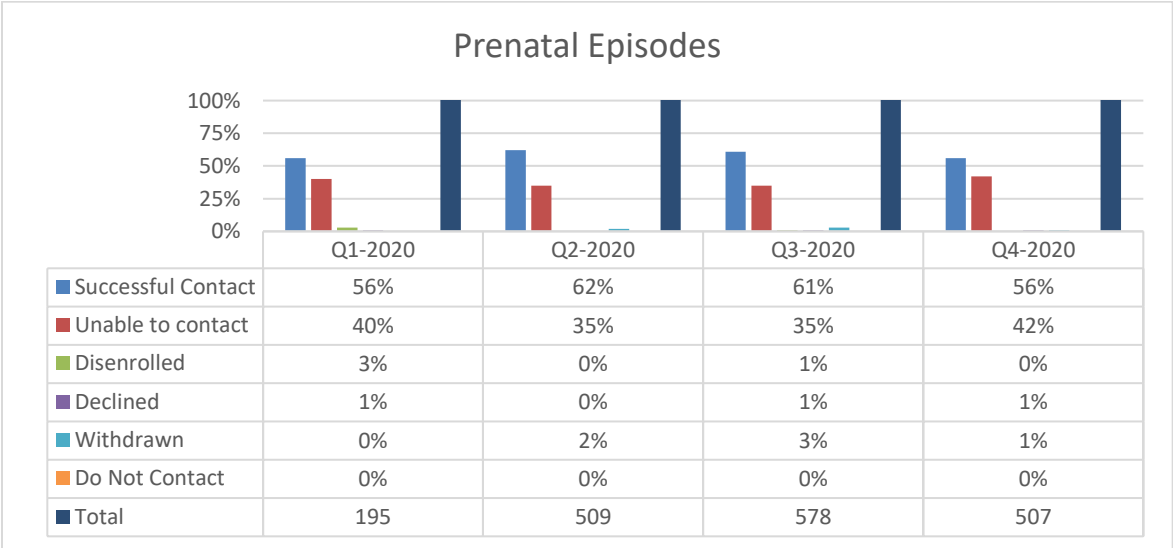
TOPICAL FLUORIDE VARNISH TREATMENTS

Fluoride varnish treatments are effective in preventing tooth decay and more practical and safer to use with young children. KHS covers up to three topical fluoride varnish treatments in a 12-month period for all members younger than 6 years.



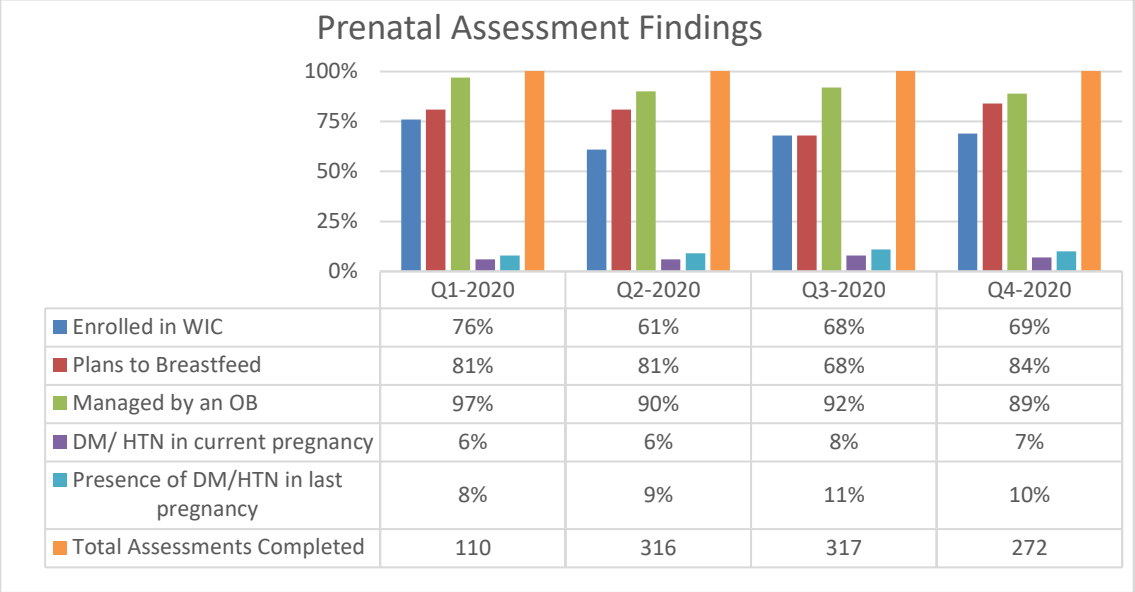
PERINATAL OUTREACH AND EDUCATION

The HE department performs outreach education calls to all members identified as being pregnant in the 1st trimester, a pregnant teen (under age 18), or postpartum due to a C-section or teen pregnancy delivery.



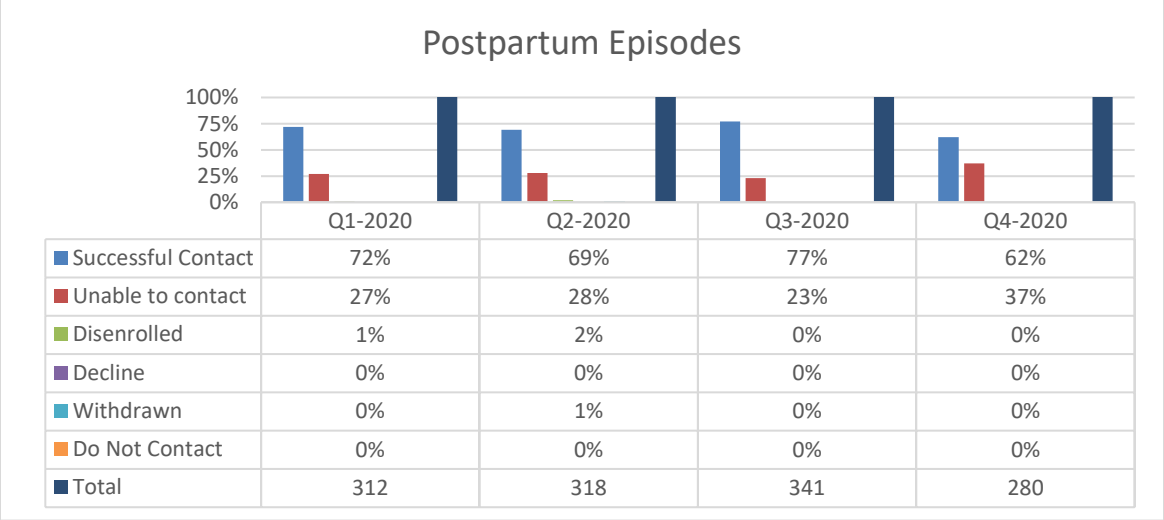
	Q1-2020	Q2-2020	Q3-2020	Q4-2020
Successful Contact	56%	62%	61%	56%
Unable to contact	40%	35%	35%	42%
Disenrolled	3%	0%	1%	0%
Declined	1%	0%	1%	1%
Withdrawn	0%	2%	3%	1%
Do Not Contact	0%	0%	0%	0%
Total	195	509	578	507

During the 4th quarter of 2020, 507 episodes for pregnant members were completed and the rate of successful contacts decreased from 61% to 56%.



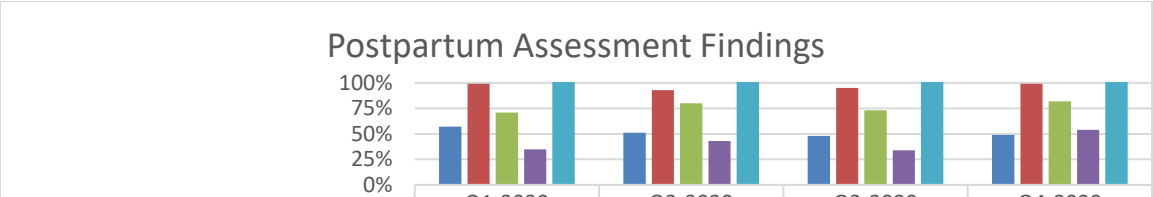
	Q1-2020	Q2-2020	Q3-2020	Q4-2020
Enrolled in WIC	76%	61%	68%	69%
Plans to Breastfeed	81%	81%	68%	84%
Managed by an OB	97%	90%	92%	89%
DM/ HTN in current pregnancy	6%	6%	8%	7%
Presence of DM/HTN in last pregnancy	8%	9%	11%	10%
Total Assessments Completed	110	316	317	272

The total prenatal assessments completed decreased from 3rd quarter to the 4th quarter. Although there was a slight increase in the percentage of members reporting that they were enrolled in WIC, the percentage of members who planned to breastfeed increased from 68% in the 3rd quarter to 84% in the 4th quarter.



	Q1-2020	Q2-2020	Q3-2020	Q4-2020
Successful Contact	72%	69%	77%	62%
Unable to contact	27%	28%	23%	37%
Disenrolled	1%	2%	0%	0%
Decline	0%	0%	0%	0%
Withdrawn	0%	1%	0%	0%
Do Not Contact	0%	0%	0%	0%
Total	312	318	341	280

During the 4th quarter 2020, 280 postpartum episodes were closed and the rate of successfully contacts decreased from 77% to 62%.



	Q1-2020	Q2-2020	Q3-2020	Q4-2020
Currently Brestfeeding	57%	51%	48%	49%
Newborn saw a doctor after leaving hospital	99%	93%	95%	99%
Newborn added to Medi-Cal case	71%	80%	73%	82%
Aware of Family Planning /Birth Control Options	35%	43%	34%	54%
Total Assessments Completed	225	221	261	174

Postpartum assessments completed decreased from 261 assessments in the 3rd quarter to 174 assessments completed in the 4th quarter of 2020. The percentage of members who reported adding their newborn to their Medi-Cal case increased by 9 percentage points and the percentage of members who reported that they were aware of their family planning options increased by about 20 percentage points.

MEMBER WELLNESS BASED INCENTIVES AND CHRONIC CONDITION TOOLS

During the 4th quarter of 2020, KHS continued to offer wellness based incentives for members. In January 2020, the postpartum care incentive was modified to align with the new MCAS measure where the time frame to complete this visit is now 1-12 weeks following delivery. Additionally, the well child 12-23 months incentive program was discontinued in April and will be replaced with another incentive program that better aligns with the new MCAS measures.

- **Initial Health Assessment (IHA)** – newly enrolled members who complete the IHA visit within 120 days of enrollment are mailed a $10 gift card.
- **Early Prenatal Care** – pregnant members who complete prenatal care during the 1st trimester will receive a $30 gift card.
- **2019 Postpartum Care** – members who delivered in 2019 and complete the postpartum visit within 21-56 days following delivery will receive a $30 gift card.

- **2020 Postpartum Care** – members who delivered in 2020 and complete the postpartum visit within 1-12 weeks following delivery will receive a $30 gift card.
- Well Child 0-15 Months – members between 0-15 months of age who complete a series of well baby visits will receive a $10 gift card for each visit up to 6 visits.
- **Well Child Care 3-6 Years** – members between the ages of 3-6 years old who complete a well child visit will receive a $15 gift card.
- **Well Child Care 12-21 Years** – members between 12-21 years of age who complete a well child visit will receive a $20 gift card.

Member Incentive Fulfillment

	Q1-2020	Q2-2020	Q3-2020	Q4-2020
IHA Incentive	2,345	1,569	1,760	1,382
Early Prenatal Care Incentive	71	126	70	40
2019 Postprtum Care Incentive*	386	0	0	0
2020 Postpartum Care Incentive	383	807	862	563
Well Child 12-23 Mos Incentive**	1,787	924	26	0
Well Child 0-15 Mos Incentive	0	0	0	11,941
Well Child 3-6 Years Incentive	0	0	0	7,503
Well Child 12-21 Years Incentive	0	0	0	2,864

*Discontinued as of 1/1/2019. Incentive fulfilled due to claims lag.

**Discontinued as of 4/1/2020. Incentives fulfilled due to claims lag.

Health Services Quarterly Committee Reporting- Reporting Period October 1, 2020 thru December 31, 2020

Health Services Overview

The 2020 membership enrollment reached 289,000 in Q4 2020. Additional benefit coverage and broadening interdisciplinary collaboration to support the membership growth will continue into 2021.

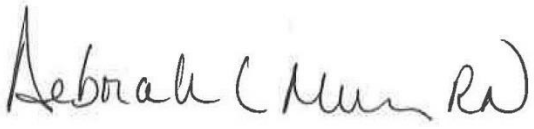
- Pharmacy Carve Out State Managed Benefit on hold for 4/1/2021
  - Discharge Coordination
  - Medication transition to Outpatient

- Cal Aim-Multiyear implementation for MCAL benefits
  - Social Determinants of Health
  - Enhanced Care Management
  - In Lieu of Services
  - Population Health

- COVID impact

The following pages reflect statistical measurements for Utilization Management, Case Management and Disease Management detailing the ongoing compliance activity for the 4th Quarter 2020.

Respectfully submitted,



Deborah Murr RN, BS-HCM
Chief Health Services Officer
Kern Health System

Utilization Management Reporting

Timeliness of Decision Trending

Summary:

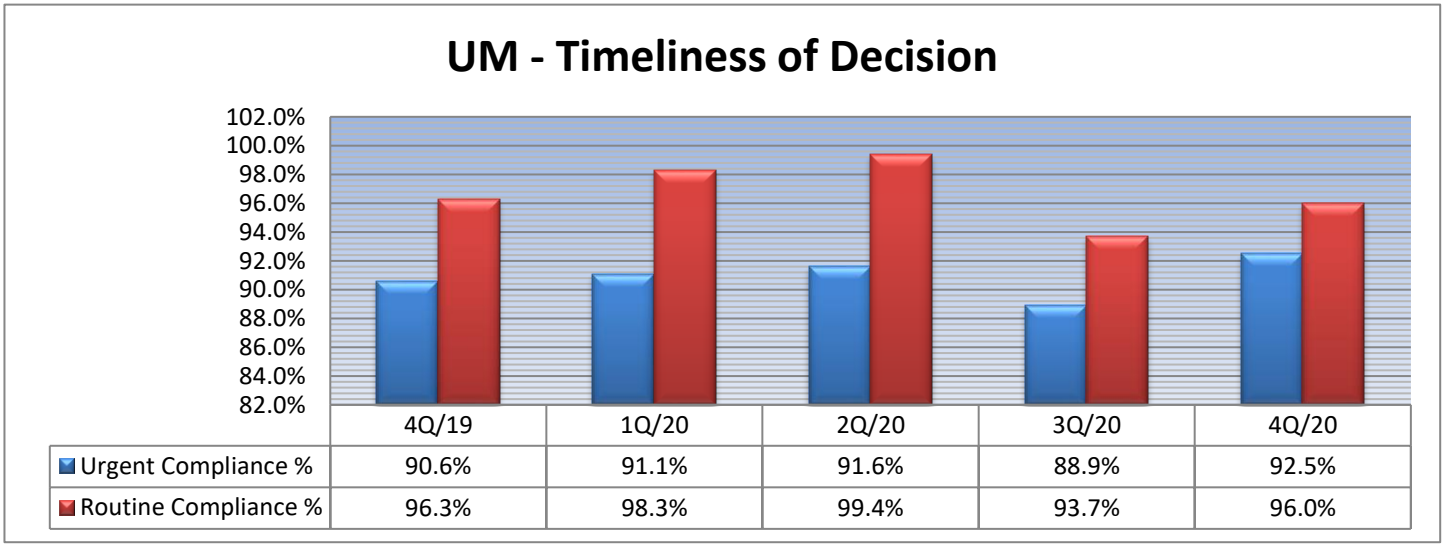
Quarterly audits are conducted to ensure compliance with DMHC requirements, KHS Contractual Agreement with the Department of Health Services, and KHS Policy and Procedures. Referrals are submitted and have specific turn-around-times set for each type of referral.

Providers may indicate 'Urgent' on the referrals indicating a decision needs to be made within 3 business days. Routine/non-emergent referrals must be processed within 5 business days. Once an urgent referral has been reviewed it may be downgraded for medical necessity at which time the provider will be notified via letter that the referral has been re-classified as a routine and nurse will clearly document on the referral "re-classified as routine". Random referrals are reviewed every quarter to observe timeliness. 10% of referrals received are reviewed monthly.

For those referrals that are found to be out of compliance with turn-around-timelines, the case manager and support staff are notified, and importance of timeframes discussed to help ensure future compliance.

Urgent: Response back to Provider in 3 business days
Routine: Response back to Provider in 5 business day

There were 47,595 referrals processed in the 4th quarter 2020 of which 4,297 referrals were reviewed for timeliness of decision. In comparison to the 3rd quarter's processing time, routine referrals increased from the 3rd quarter which was 93.7% and urgent referrals increased from the 3rd quarter which was 88.9% to 92.5%.

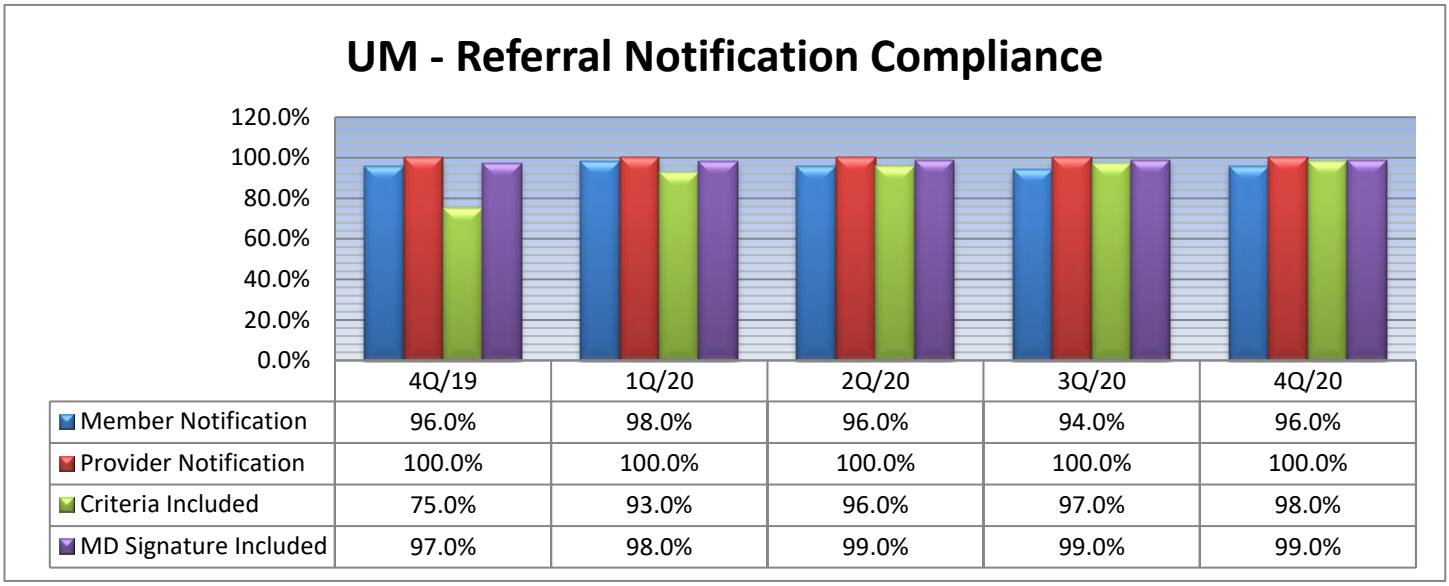


	4Q/19	1Q/20	2Q/20	3Q/20	4Q/20
Urgent Compliance %	90.6%	91.1%	91.6%	88.9%	92.5%
Routine Compliance %	96.3%	98.3%	99.4%	93.7%	96.0%

Audit Criteria:

- Member Nofication: Letter of referral decision sent to member within 24 hours
- Provider Notification: Referral is faxed back to the provider with 24 hours of decision

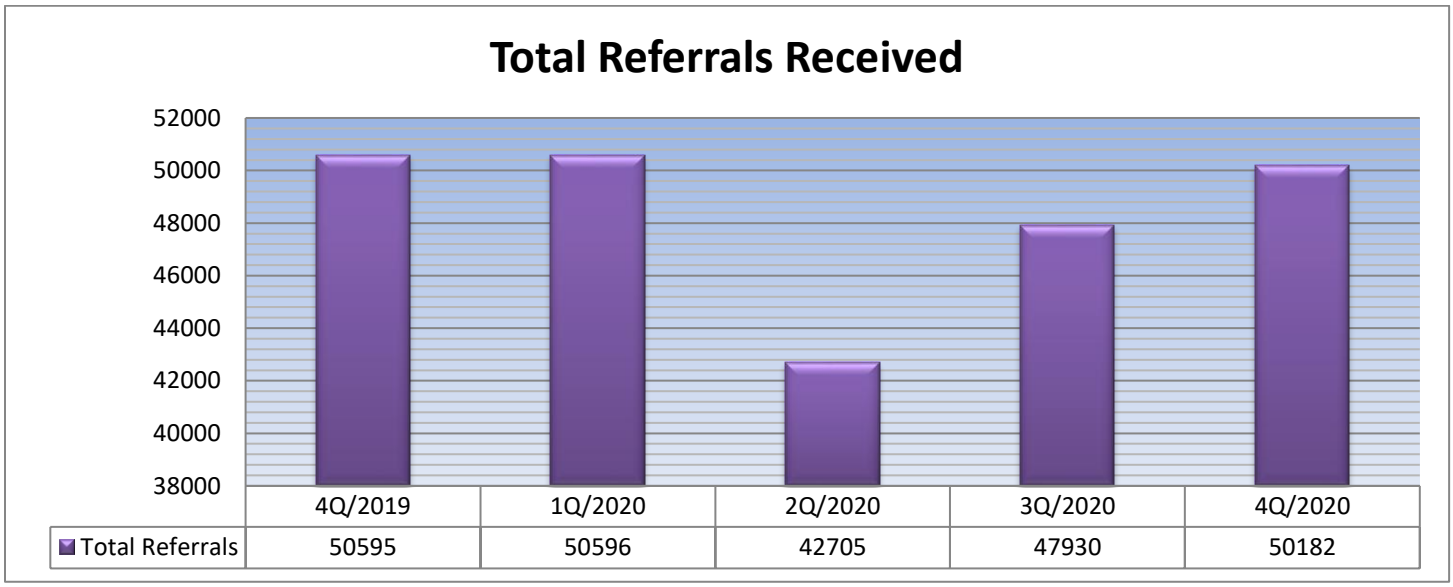
- Criteria Included: Criteria provided to provider on denial reason
- MD Signature: MD Signature included all referrals/NOA letters upon denial

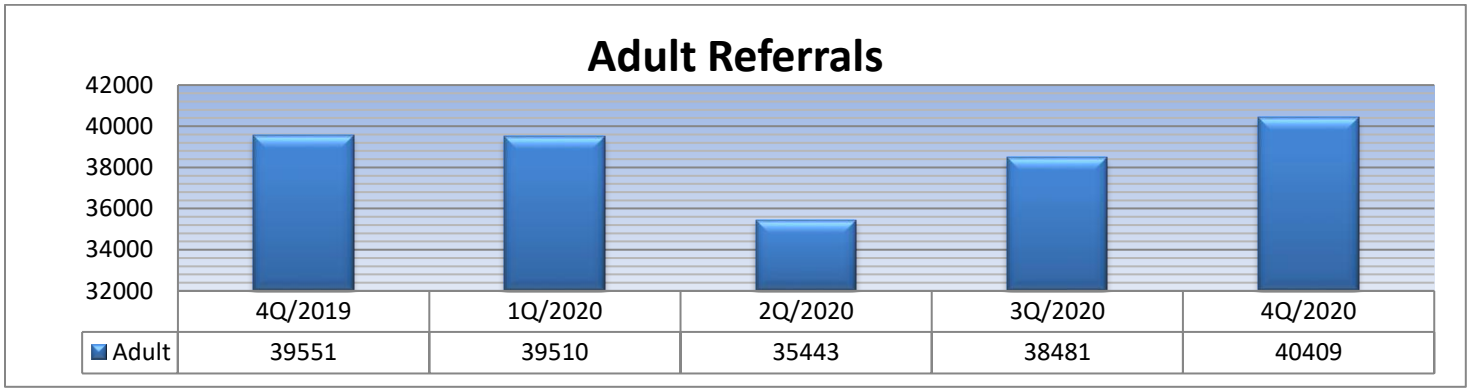


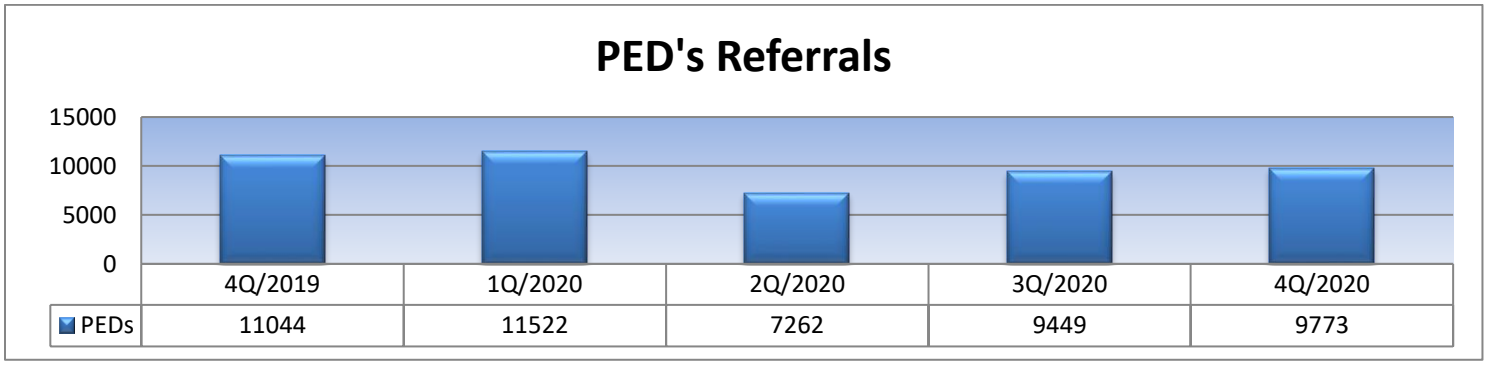
	4Q/19	1Q/20	2Q/20	3Q/20	4Q/20
Member Notification	96.0%	98.0%	96.0%	94.0%	96.0%
Provider Notification	100.0%	100.0%	100.0%	100.0%	100.0%
Criteria Included	75.0%	93.0%	96.0%	97.0%	98.0%
MD Signature Included	97.0%	98.0%	99.0%	99.0%	99.0%

Summary: Overall compliance rate from the 4th Qtr. of 2020 is 98% which remained the same from the 3rd Qtr. which was 98%.

Outpatient Referral Statistics





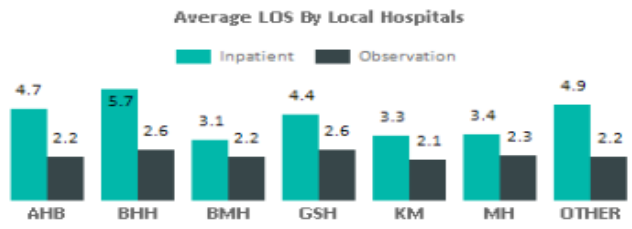


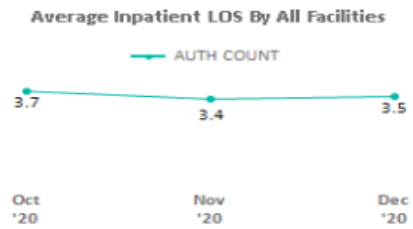
4th Quarter Inpatient and LOS Report

Report captures Adult Admissions(Inpatient/Observation)

Dates of Discharge Between : 10/1/2020-12/31/2020

Adult Admission(Inpatient/Observation)





Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
	3	7	2.33
ADVENTIST HEALTH BAKERSFIELD S	600	2468	4.11
ADVENTIST HEALTH COMMUNITY CAR	9	18	2.00
ADVENTIST HEALTH MEDICAL CENTE	12	36	3.00
ANTELOPE VALLEY HOSPITAL	7	59	8.43
BAKERSFIELD HEART HOSPITAL	98	542	5.53
BAKERSFIELD MEMORIAL HOSPITAL	857	2503	2.92
DELANO REGIONAL MEDICAL CENTER	85	266	3.13
GOOD SAMARITAN HOSPITAL	126	527	4.18
KECK HOSPITAL OF USC	53	246	4.64
KERN COUNTY MEDICAL AUTHORITY	734	2283	3.11
KERN VALLEY HEALTHCARE DIST RH	1	2	2.00
KERN VALLEY HEALTHCARE DISTRIC	13	33	2.54
MERCY HOSPITAL	647	1976	3.05
RIDGECREST REGIONAL HOSPITAL	6	14	2.33
SANTA MONICA UCLA MC AND ORTHO	9	63	7.00
TEHACHAPI HOSPITAL	1	1	1.00
UCLA MEDICAL CENTER	17	57	3.35
UNITED CARE FACILITIES	1	7	7.00
USC NORRIS CANCER HOSPITAL	1	4	4.00
USC VERDUGO HILLS HOSPITAL	2	26	13.00
VENTURA COUNTY MEDICAL CENTER	1	3	3.00
Total	**3283**	**11141**	**3.39**

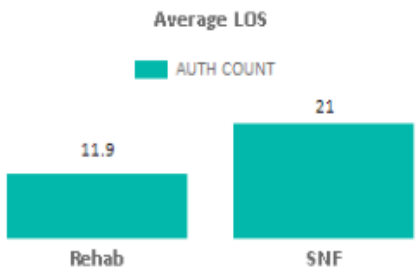
Non Participating Providers

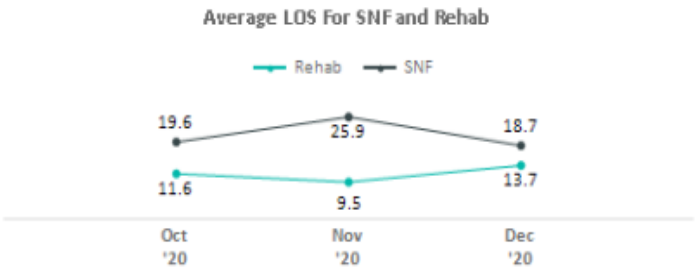
Provider Name	Admit Count	LOS	Avg LOS
ANTELOPE VALLEY HOSPITAL	35	195	5.57
LANCASTER HOSPITAL CORPORATION	9	74	8.22
HENRY MAYO NEWHALL	7	41	5.86
HARBOR - UCLA MEDICAL CENTER	7	66	9.43
GLENDALE ADVENTIST	6	55	9.17
PACIFICA HOSPITAL OF THE VALLE	5	76	15.20
FRESNO COMMUNITY HOSPITAL AND	5	39	7.80
CEDARS SINAI MEDICAL CENTER	5	36	7.20
SOUTHERN CALIFORNIA HOSPITAL	4	26	6.50
SIERRA VIEW MEDICAL CENTER	4	18	4.50
Total	**182**	**1081**	**5.94**

Report captures Adult Admissions(SNF/Rehabilitation)

Dates of Discharge Between : 10/1/2020-12/31/2020

Adult Admissions (SNF/Rehab)





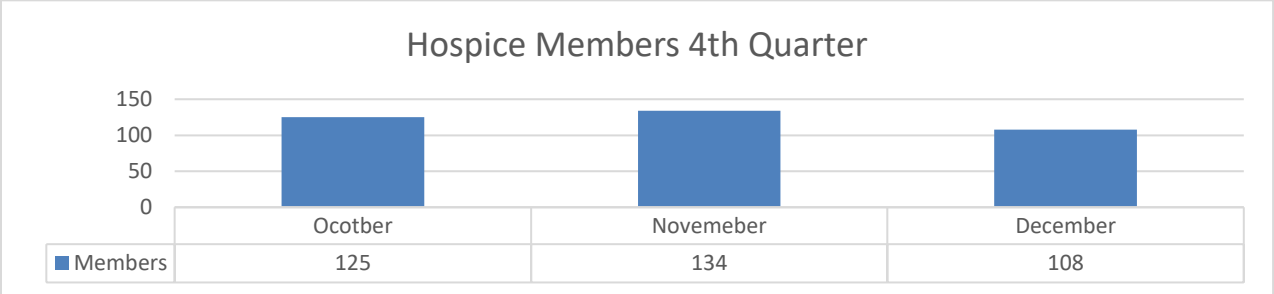
Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
BELLAGIO IN THE DESERT	3	61	20.33
CAPRI IN THE DESERT	1	8	8.00
DELANO POSTACUTE CARE	3	116	38.67
ENCOMPASS HEALTH REHABILITATIO	33	393	11.91
GGNSC SHAFTER LP	23	414	18.00
GOOD SAMARITAN HOSPITAL	9	130	14.44
PARKSIDE CONGREGATE LIVING, IN	11	150	13.64
ROSE DESERT CONGREGATE	3	65	21.67
SORRENTO IN THE DESERT	16	477	29.81
UNITED CARE FACILITIES	74	1269	17.15
VFP HOMES	14	313	22.36
Total	**190**	**3396**	**17.87**

Non Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
TLC CONGREGATE LIVING I, INC.	2	105	52.50
LINK TO CARE CONGREGATE HOME	2	111	55.50
SF VALLEY CONGREGATE LIVING, I	2	106	53.00
WEST VALLEY CONGREGATE HEALTH	2	85	42.50
PARADISE CONGREGATE LIVING	1	36	36.00
HOME OF COMPASSION #2 INC.	1	27	27.00
ROYAL HAVEN LLC	1	36	36.00
MONTROSE COMFORT LIVING AND CA	1	35	35.00
ANTELOPE VALLEY HOSPITAL	1	12	12.00
QUALITY CLHF, INC.	1	3	3.00
PROCARE HOSPICE LLC	1	74	74.00
COMMUNITY SUBACUTE AND TRANSIT	1	17	17.00
ROYAL OAK RESIDENCE INC	1	62	62.00
Total	**46**	**1268**	**27.57**

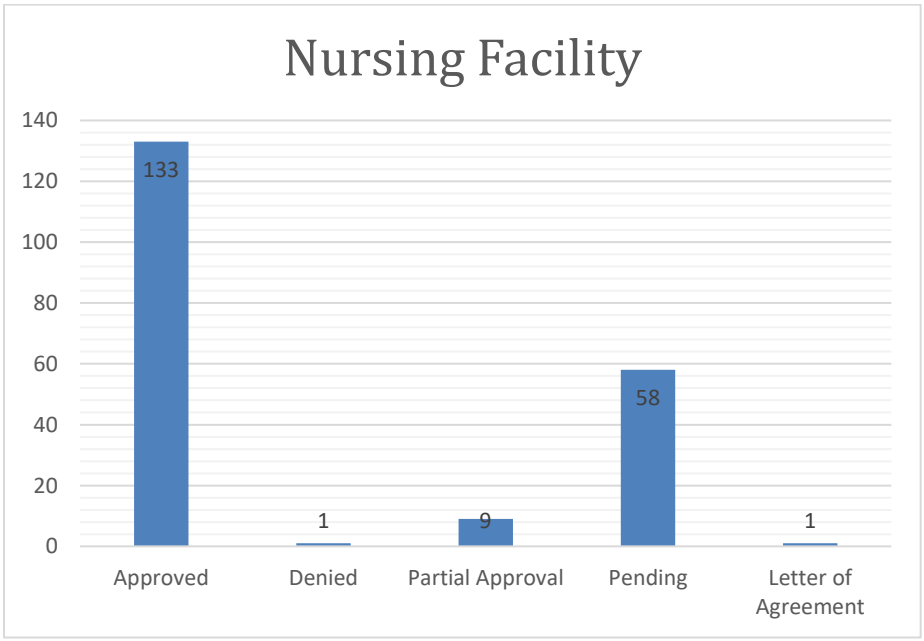
Disclaimer: SNF/LTC should not be calculated in the acute hospital LOS and PAR/NPAR not accurately reflected--report under revision.

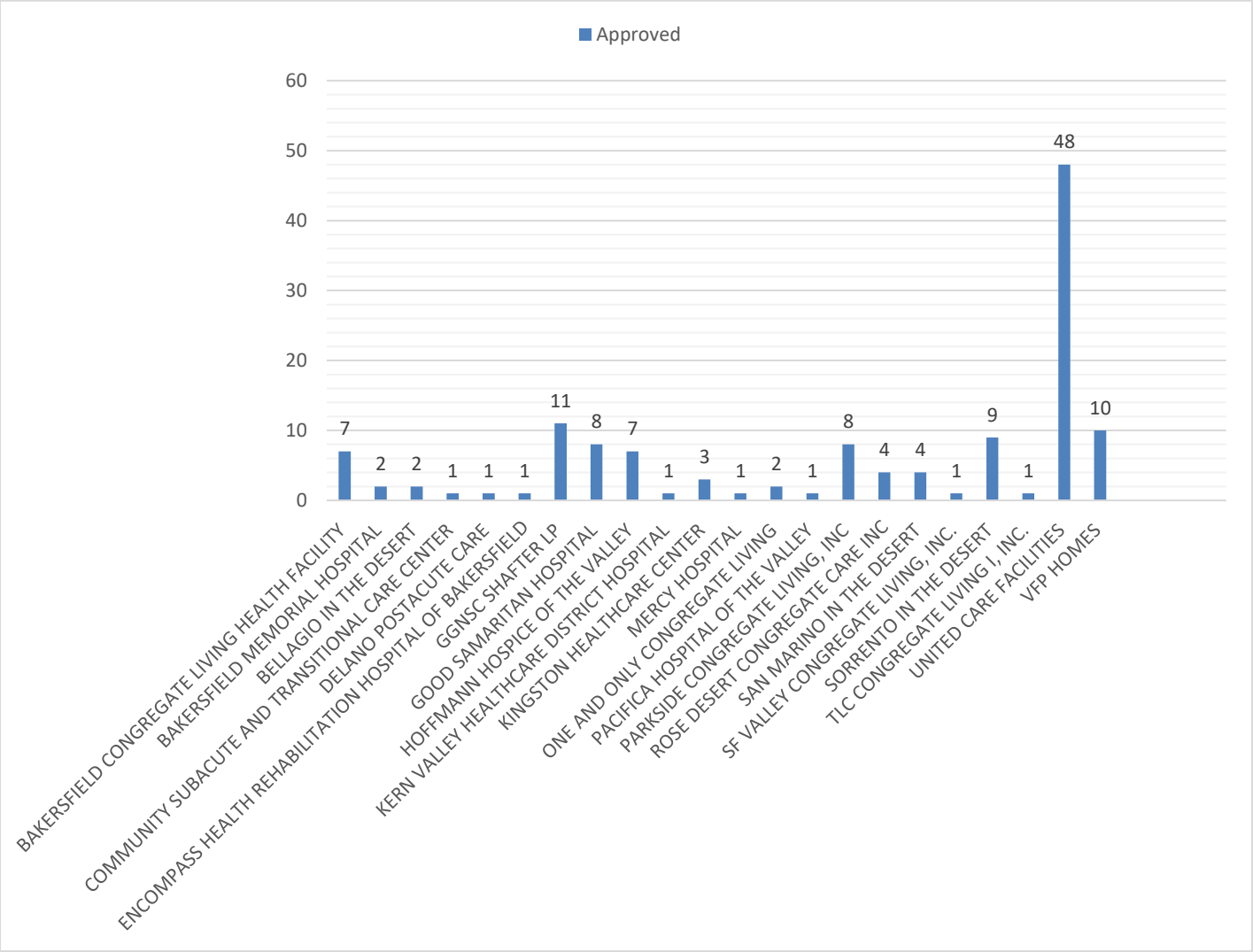


Nursing Facility Services Report

Purpose: Kern Health Systems covers medically necessary Nursing Facility Services for eligible members. KHS members requiring Nursing Facility Services are identified and placed in health care facilities, which provide the level of care most appropriate to the member's medical needs. For members requiring long-term care, KHS coordinates the members care and initiates disenrollment per DHCS criteria. Monthly and quarterly reporting is completed as per Policy 3.42, Sec. 5, for nursing facility services and to identify any current trends.

Summary: Summary: During the 4th quarter 2020, there were 205 referrals for Nursing Facility Services. The average length of stay was 29.8 days for these members. During the 3rd quarter there was only 2 denials of the 196 referrals.




Approved
60
50
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30
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7
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2
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11
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7
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3
1
2
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8
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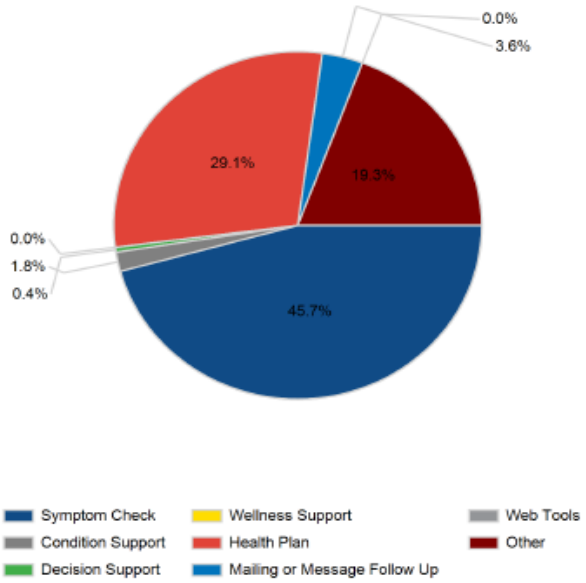
4
1
9
1
48
10
BAKERSFIELD CONGREGATE LIVING HEALTH FACILITY
BAKERSFIELD MEMORIAL HOSPITAL
BELLAGIO IN THE DESERT
COMMUNITY SUBACUTE AND TRANSITIONAL CARE CENTER
DELANO POSTACUTE CARE
ENCOMPASS HEALTH REHABILITATION HOSPITAL OF BAKERSFIELD
GGNSC SHAFTER LP
GOOD SAMARITAN HOSPITAL
HOFFMANN HOSPICE OF THE VALLEY
KERN VALLEY HEALTHCARE DISTRICT HOSPITAL
KINGSTON HEALTHCARE CENTER
MERCY HOSPITAL
ONE AND ONLY CONGREGATE LIVING
PACIFICA HOSPITAL OF THE VALLEY
PARKSIDE CONGREGATE LIVING, INC
ROSE DESERT CONGREGATE CARE INC
SAN MARINO IN THE DESERT
SF VALLEY CONGREGATE LIVING, INC.
SORRENTO IN THE DESERT
TLC CONGREGATE LIVING I, INC.
UNITED CARE FACILITIES
VFP HOMES

Health Dialog Report

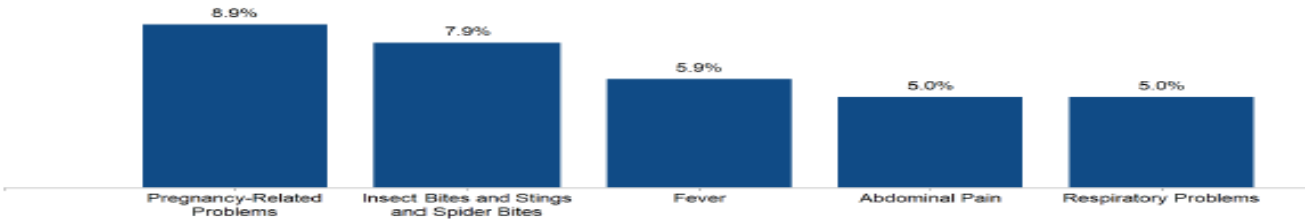
October:

Member Inbound Call Reasons (Oct-2020)

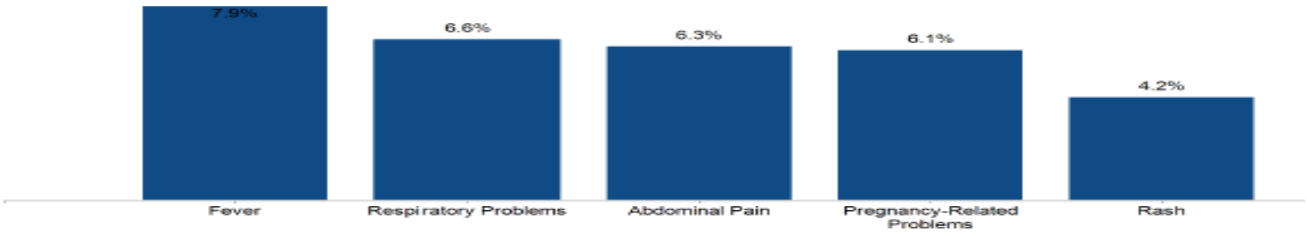


REASON	NUMBER
Symptom Check	102
Condition Support	4
Decision Support	1
Wellness Support	0
Health Plan	65
Mailing or Message Follow Up	8
Web Tools	0
Other	43

Most Frequent Symptoms - Inbound Symptom Check Calls (Oct-2020)

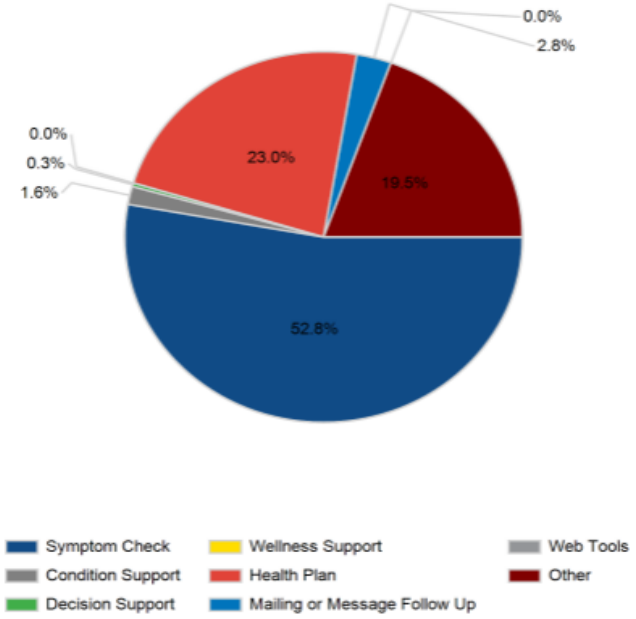


Most Frequent Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)



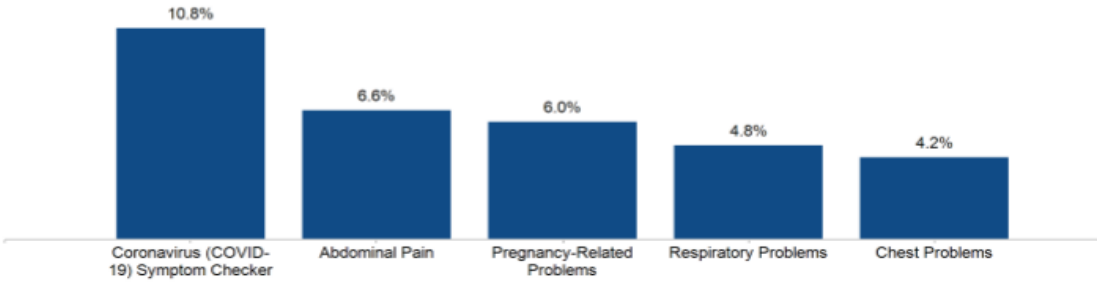
November:

Member Inbound Call Reasons (Nov-2020)

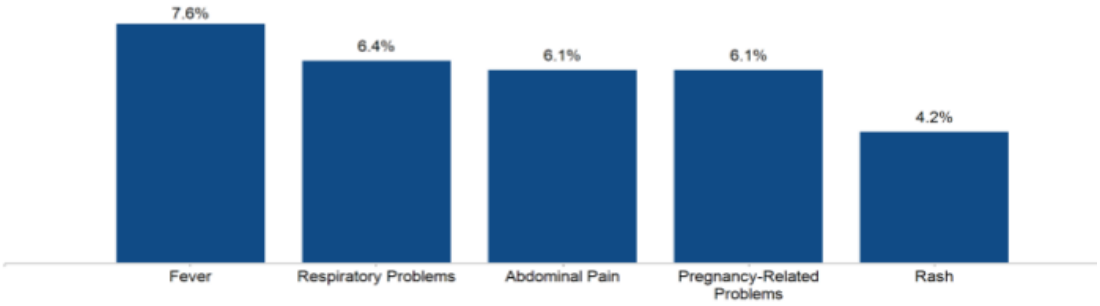


REASON	NUMBER
Symptom Check	168
Condition Support	5
Decision Support	1
Wellness Support	0
Health Plan	73
Mailing or Message Follow Up	9
Web Tools	0
Other	62

Most Frequent Symptoms - Inbound Symptom Check Calls (Nov-2020)

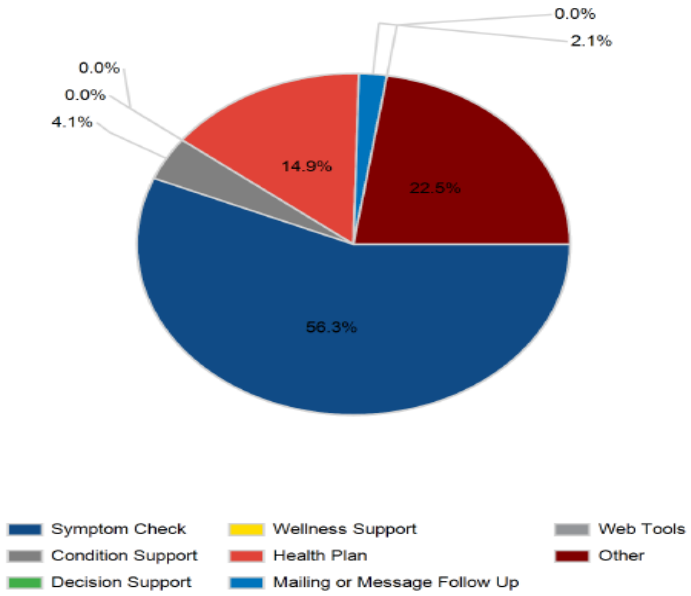


Most Frequent Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)



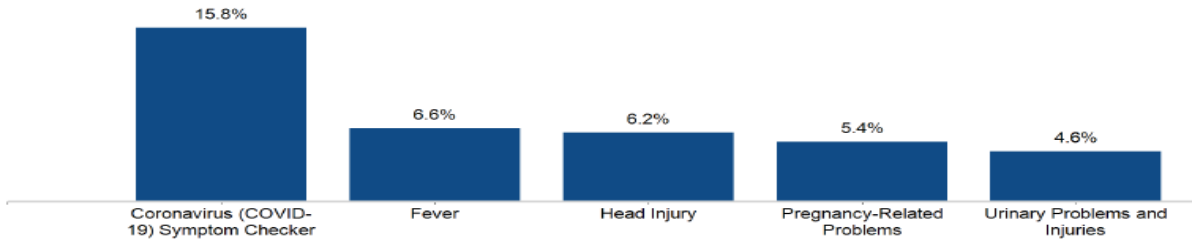
December:

Member Inbound Call Reasons (Dec-2020)

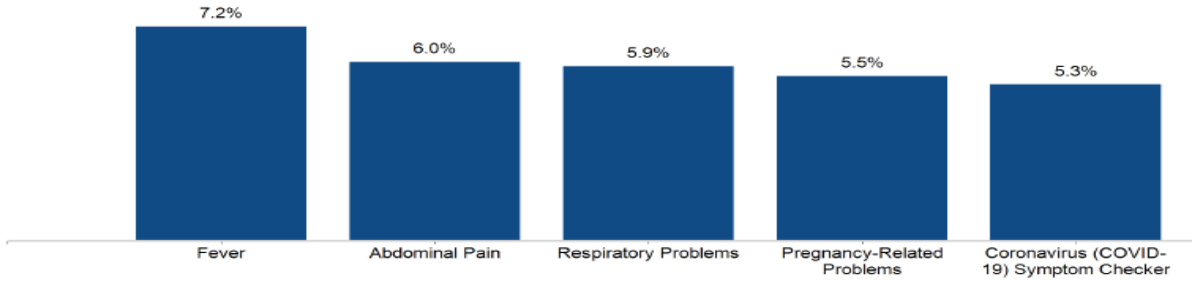


REASON	NUMBER
Symptom Check	245
Condition Support	18
Decision Support	0
Wellness Support	0
Health Plan	65
Mailing or Message Follow Up	9
Web Tools	0
Other	98

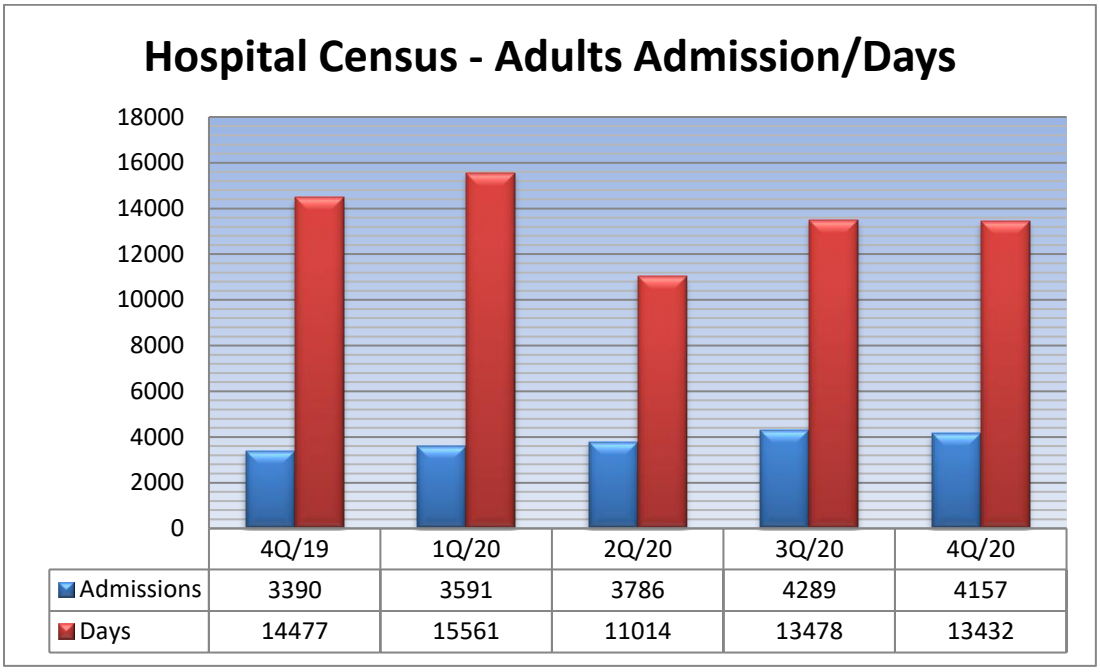
Most Frequent Symptoms - Inbound Symptom Check Calls (Dec-2020)



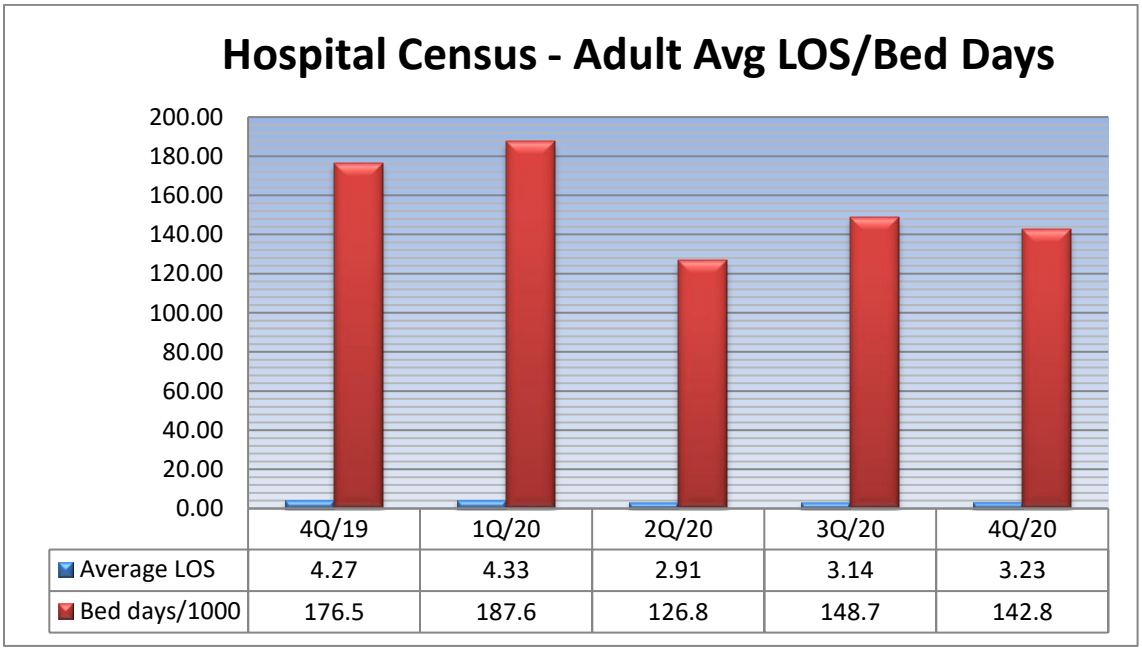
Most Frequent Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)



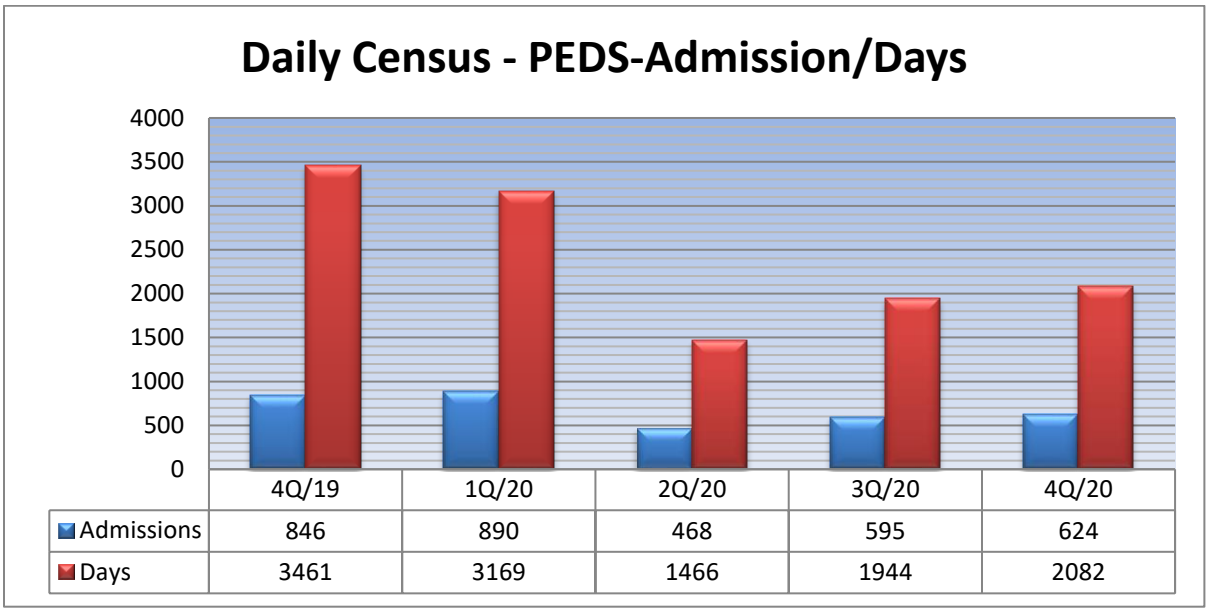
Inpatient 4th Quarter Trending



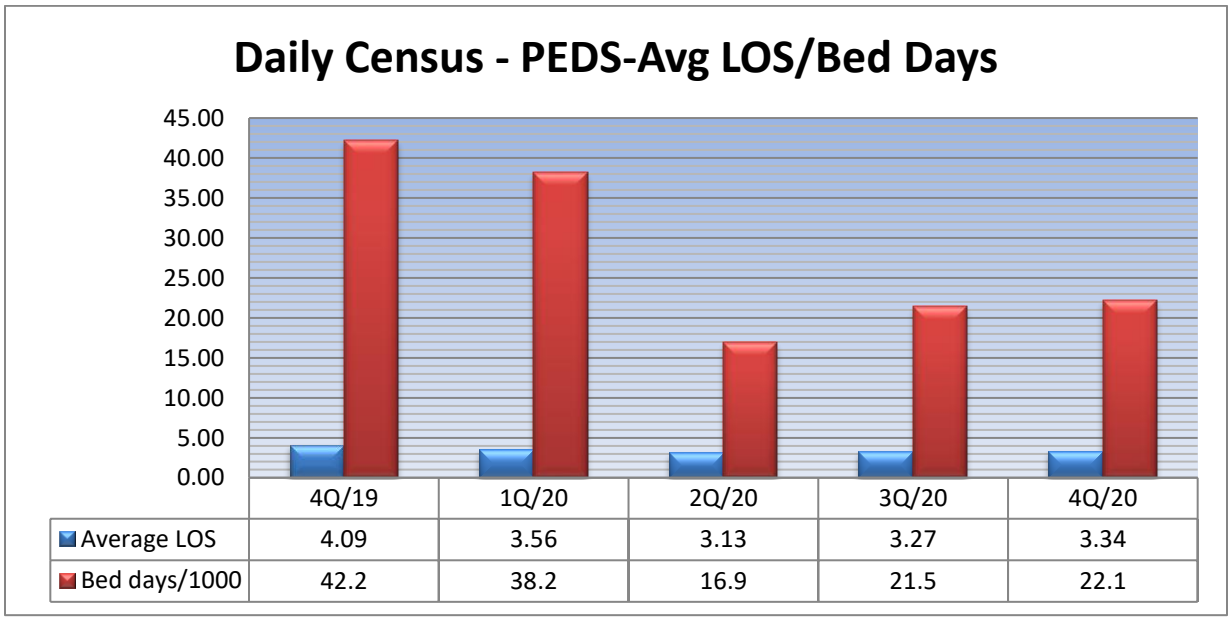
	4Q/19	1Q/20	2Q/20	3Q/20	4Q/20
Admissions	3390	3591	3786	4289	4157
Days	14477	15561	11014	13478	13432



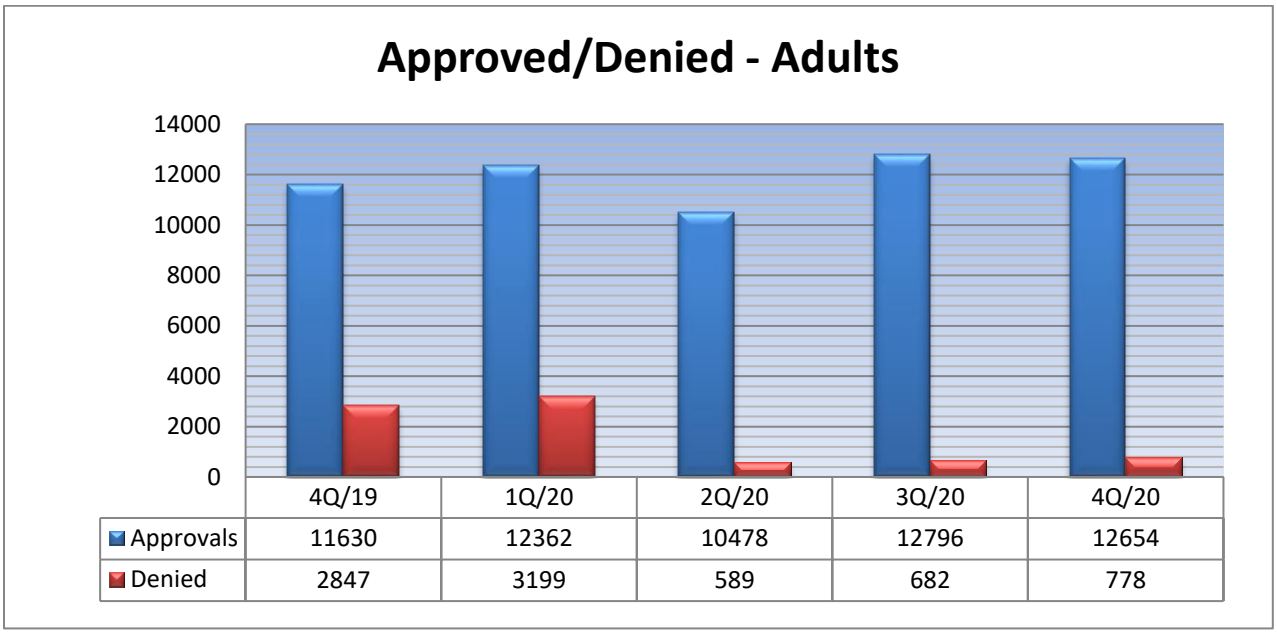
	4Q/19	1Q/20	2Q/20	3Q/20	4Q/20
Average LOS	4.27	4.33	2.91	3.14	3.23
Bed days/1000	176.5	187.6	126.8	148.7	142.8



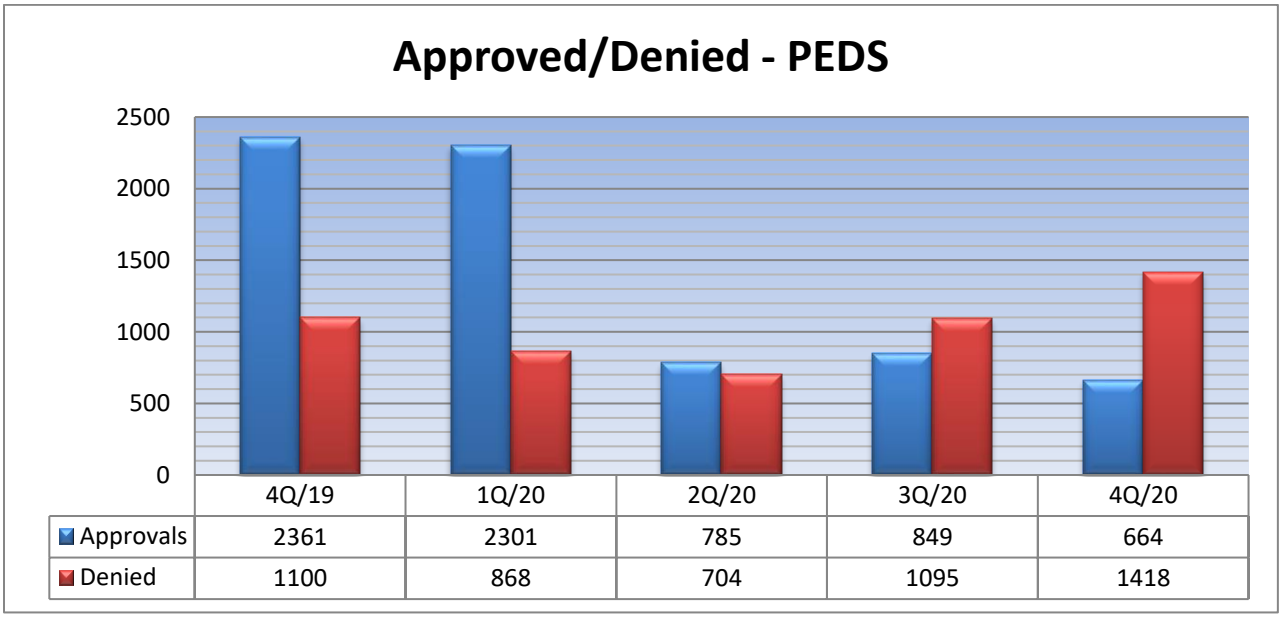
	4Q/19	1Q/20	2Q/20	3Q/20	4Q/20
Admissions	846	890	468	595	624
Days	3461	3169	1466	1944	2082



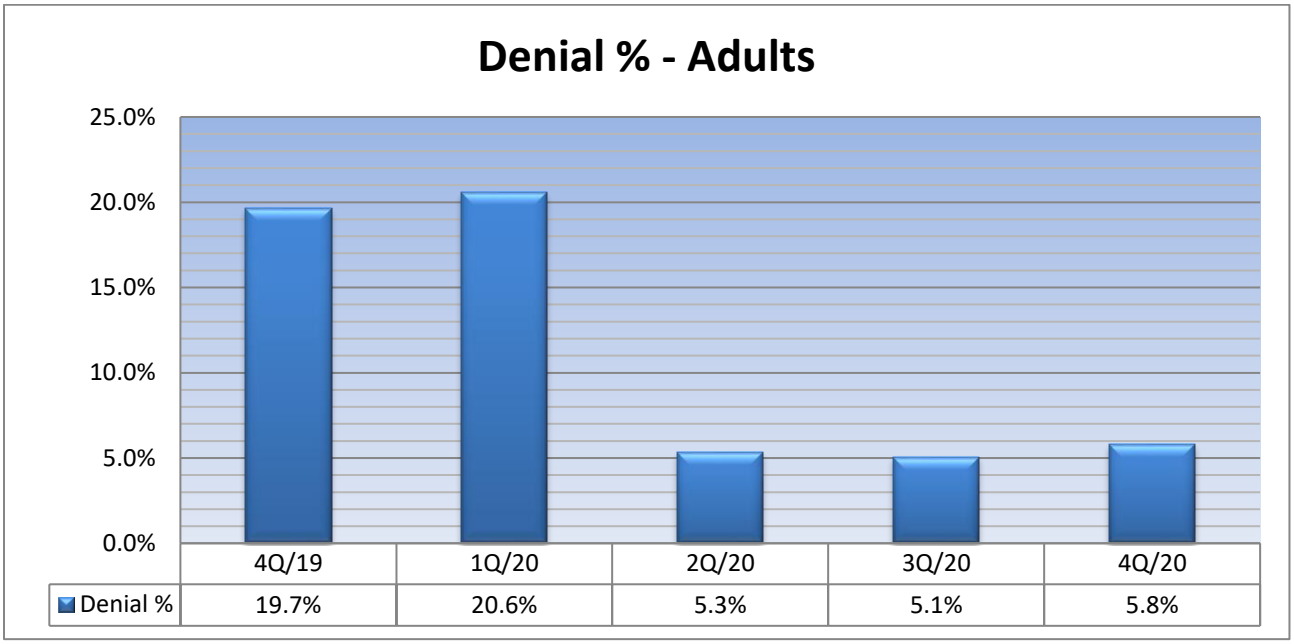
	4Q/19	1Q/20	2Q/20	3Q/20	4Q/20
Average LOS	4.09	3.56	3.13	3.27	3.34
Bed days/1000	42.2	38.2	16.9	21.5	22.1

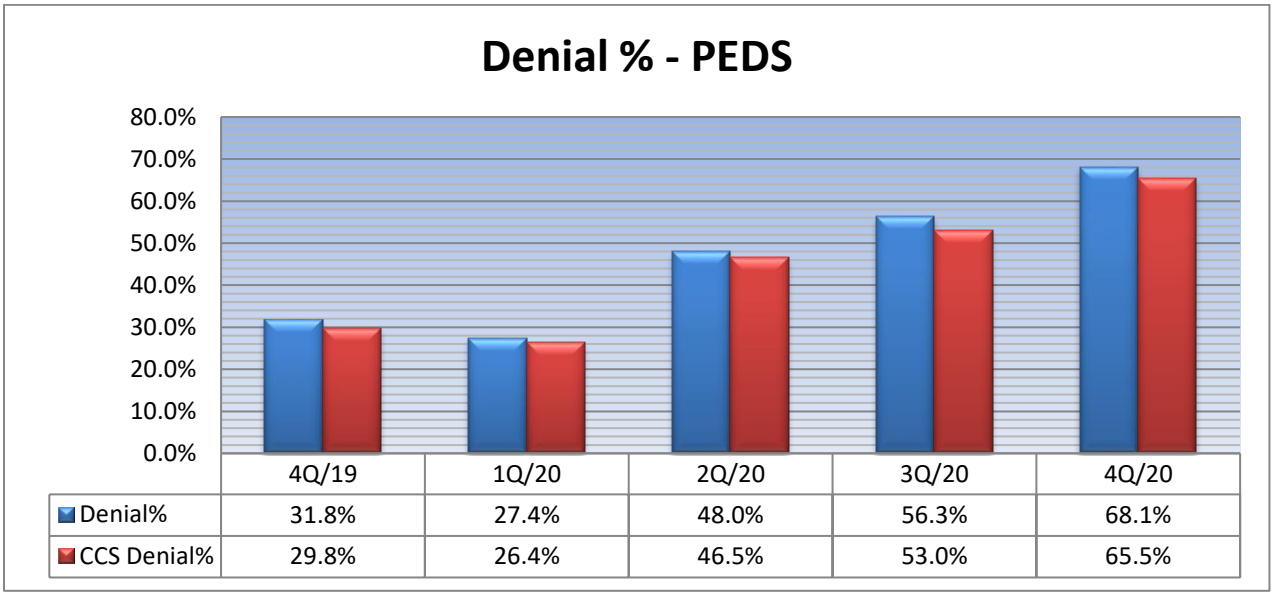


	4Q/19	1Q/20	2Q/20	3Q/20	4Q/20
Approvals	11630	12362	10478	12796	12654
Denied	2847	3199	589	682	778



	4Q/19	1Q/20	2Q/20	3Q/20	4Q/20
Approvals	2361	2301	785	849	664
Denied	1100	868	704	1095	1418





Continuity of Care

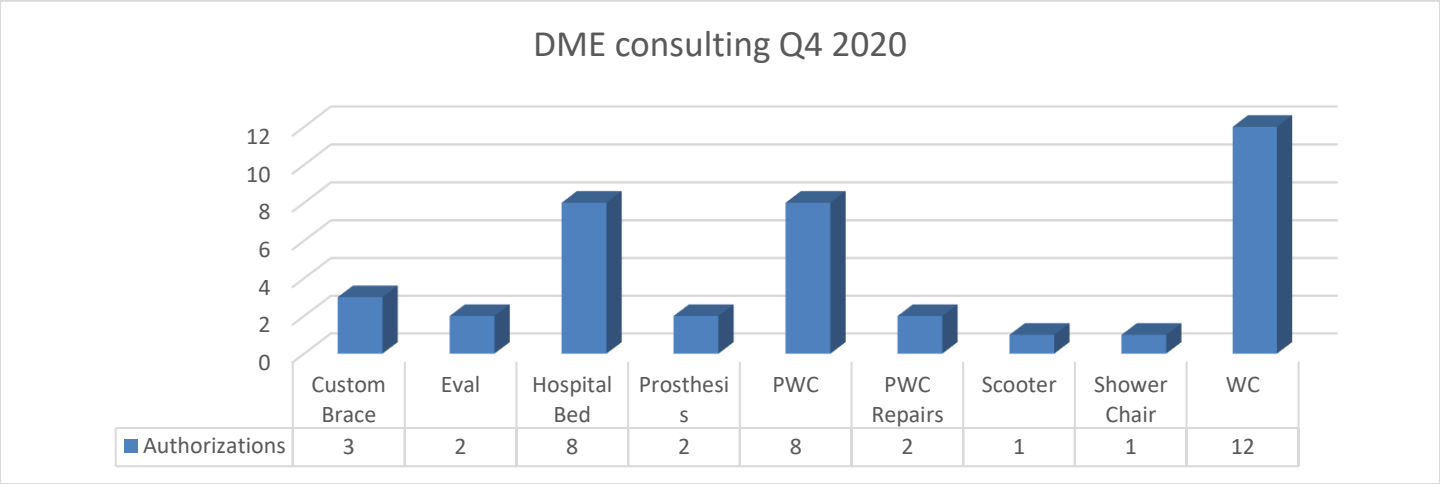
Total Referral – 3

Total Approval – 3

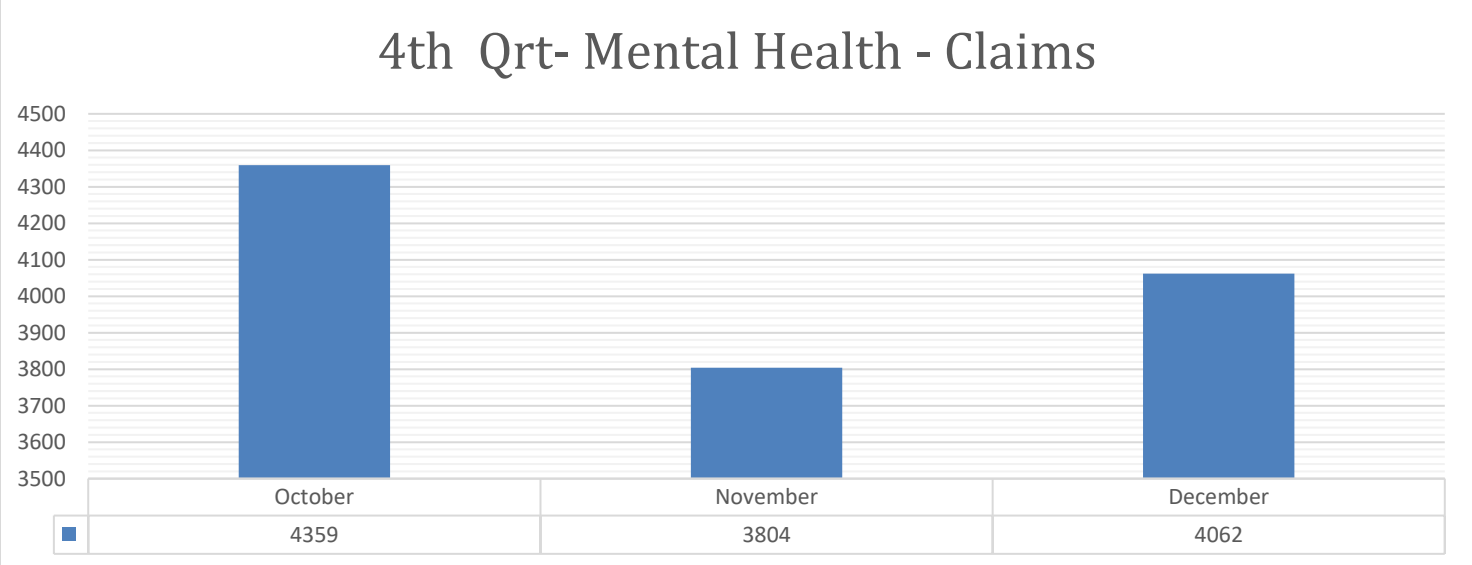
Total Denial - 0

Total SPD COC -1

DME Consulting



Mental Health



ABA Services

UNIQUE CASES		Mild	Moderate	Severe	Pending Dx	Total
MEMBER COUNT		75	90	18	71	254
Severity %		29.53%	35.43%	7.09%	28%	100%
SEVERITY	Oct	Nov	Dec	Total		
MILD	17	25	33	75		
MODERATE	32	25	33	90		
SEVERE	7	4	7	18		
Approved FBA	60	46	73	179		
Approved Treatment	58	50	74	182		
PENDING DX	30	19	22	71		
	Oct	Nov	Dec	Total		
AGE 7 OR LESS	56	50	48	154		
AGE 8 OR GREATER	30	23	37	90		
TOTAL	86	73	85	244		
% < 7	65.12%	68.49%	56.47%	63.11%		
% > 8	34.88%	31.51%	43.53%	36.89%		

Diabetic Exam Reminder Effectiveness Report

Client: KERN HEALTH SYSTEMS - 12049397

Reminder Year:	Reminder Month:	Reminders Sent	Received Exam Within 0-90 Days	Received Exam Within 91-180 Days	Total Exams Within 180 Days
2020	January	878	52	10	62
	February	503	18	18	36
	March	0	0	0	0
	April	6,190	57	91	148
	May	1,677	35	37	72
	June	1,367	52	54	106
	July	436	27	11	38
	August	554	33	8	41
	September	1,095	40	3	43
	October	3,423	60	0	60
	November	841	10	0	10
	December	1,760	6	0	6
Totals		**18,724**	**390**	**232**	**622**

LTM Effectiveness* : 3 %

12-Month Effectiveness (Jul 2019 - Jun 2020) : 7 %

Medical Data Collection Summary Report

Period Covered: January, 2020 through December, 2020
Prepared for: KERN HEALTH SYSTEMS - (12049397)

Reported Cases

	Members	
Received Eye Exam:	17,588	
Diabetes[1]:	924	5.3%
Diabetic Retinopathy:	166	.9%
Glaucoma:	272	1.5%
Hypertension:	688	3.9%
High Cholesterol	275	1.6%
Macular Degeneration:	49	.3%

Estimated Number of Cases

Total Members:	276,973	
Diabetes[1]:	6,766	2.4%
Diabetic Retinopathy:	602	.2%
Glaucoma:	1,136	.4%
Hypertension:	29,188	10.5%
High Cholesterol	42,241	15.3%
Macular Degeneration:	379	.1%

KERN HEALTH SYSTEMS
CASE MANAGEMENT DEPARTMENT MONTHLY REPORT

Reporting Period: October1st, 2020- December 31st, 2020

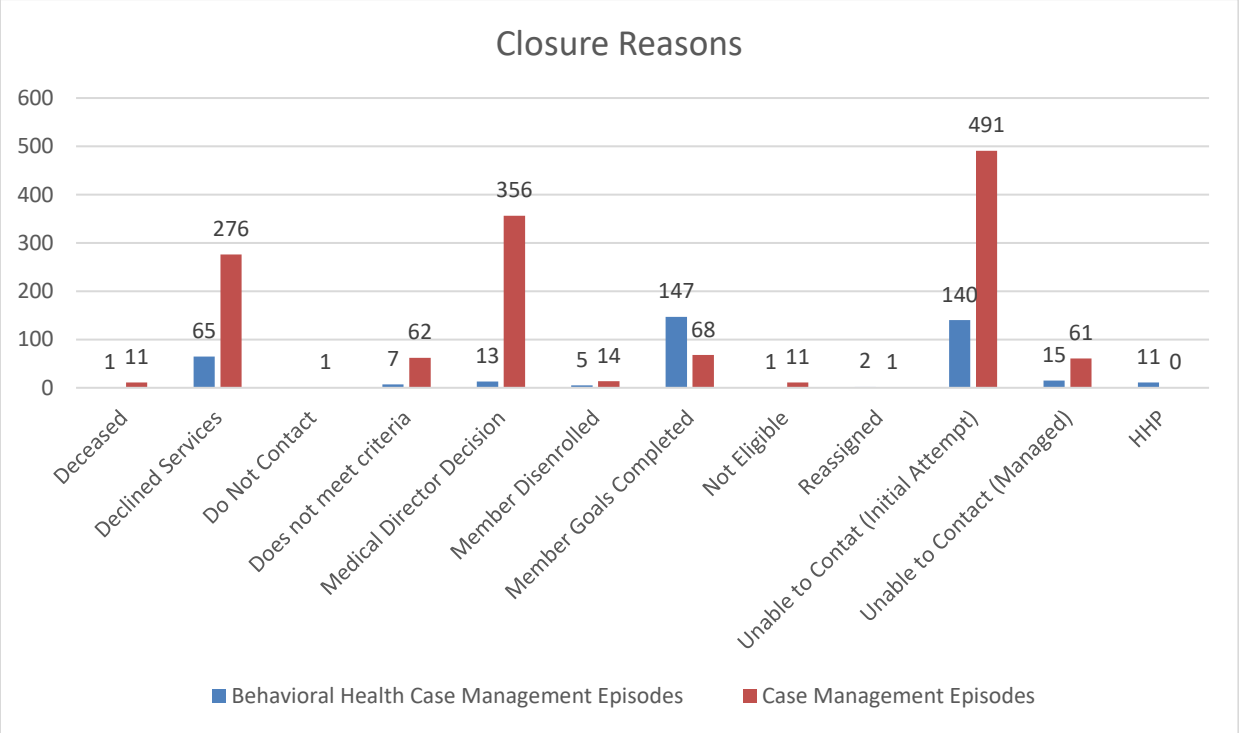
During the months of October thru December, a total of 1,938 members were managed by the Case Management Department.

Episode Type	Closed Episodes	Open Episodes	Referral Episodes	Total
Case Management	1,035	255	25	1,315
Behavioral Health Case Management	488	124	11	623

Episode Source other than ACG Modeler	Behavioral Health Management Episodes	*Percentage*	Case Management Episodes	*Percentage*
All Internally Generated Claims	1	0.2%	0	0.0%
All Internally Generated Complex Case Management	16	3.1%	190	52.5%
All Internally Generated Grievance	1	0.2%	6	1.7%
All Internally Generated Hospital Discharge	0	0.0%	19	5.2%
All Internally Generated Medical Director	2	0.4%	17	4.7%
All Internally Generated Member Request	8	1.5%	11	3.0%
All Internally Generated UM Generated	17	3.3%	7	1.9%
BH Homeless	1	0.2%	0	0.0%
BH Mental Health	35	6.8%	0	0.0%
CM DM HE Facility Based Social Worker	1	0.2%	0	0.0%
CM DM HE Health Education	4	0.8%	1	0.3%
CM DM HE Member Services	21	4.1%	10	2.8%
CM DM HE Provider	6	1.2%	6	1.7%
CM DM High ER Utilizer	150	29.0%	0	0.0%
Critical High-Risk SPD	0	0.0%	1	0.3%
DM HE Social Worker Case Management	3	0.6%	10	2.8%

HE Postpartum Claim	21	4.1%	0	0.0%
HE Prenatal Claim	25	4.8%	0	0.0%
High Risk SPD	205	39.7%	83	22.9%
QR Provider Relations	0	0.0%	1	0.3%

A total of 1,759 Episodes were closed during the months of October thru December 2020. With 407 BH-CM Episode Type closed and 1,352 CM Episode Type closed.



Members Closed and Referred to HHP	Behavioral Health Case Management Episodes	Case Management Episodes
HHP	23	12

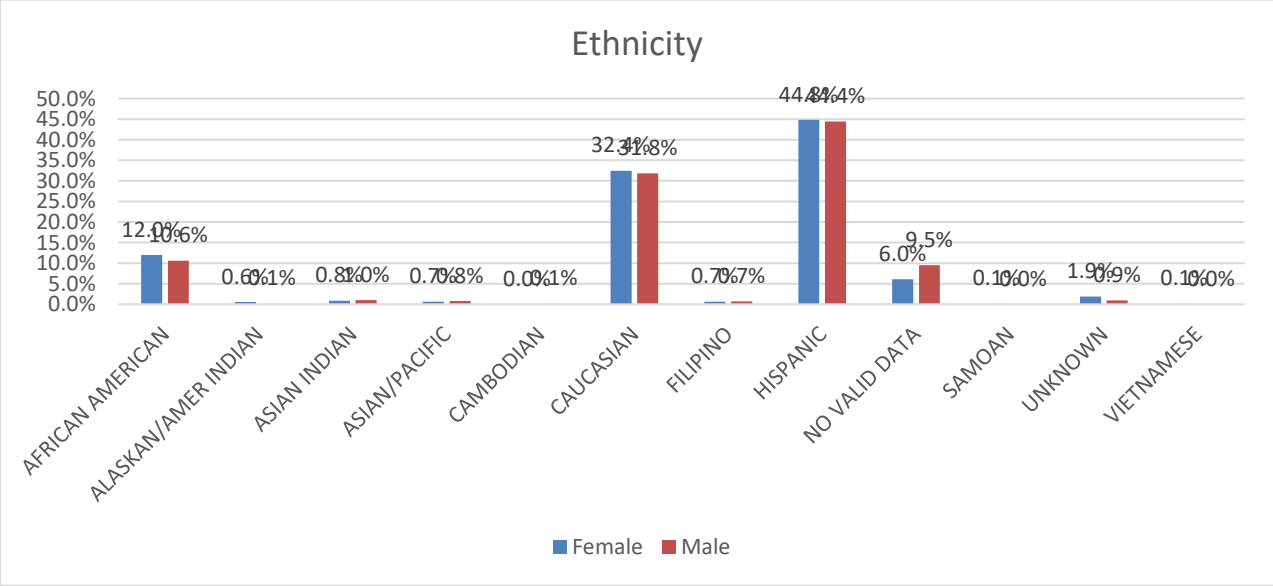
Closed Episodes with Admits within 30 days after Closure	Total
Behavioral Health Case Management	25
Case Management	64
Percentage of closed cases Readmitted	3%

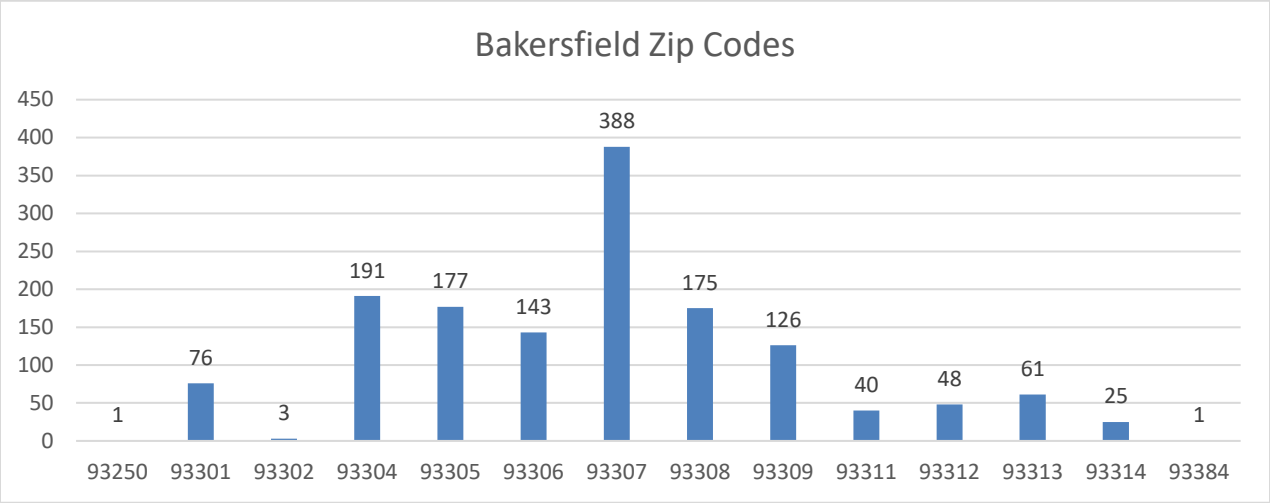
Assessments/Plan of Care	Behavioral Health Case Management Episodes	Case Management Episodes	Total
Assessments	135	236	371
Plan of Care	134	241	375

During the months of October thru December, 94% of the members managed were 65 years of age or younger.

Age	<18	18-40	41-65	>65	Total
Case Management	13	285	928	89	1,315
Behavioral Case Management	56	268	275	24	623

Of the 1,938 members managed during the months of October thru December, most members were female at 56%. The majority of members' ethnicity was Hispanic at 45%.





Outlying Areas

City	Total
ARVIN	46
BODFISH	6
BORON	5
BUTTONWILLOW	2
CALIF CITY	20
DELANO	82
EL MONTE	1
FELLOWS	2
FRAZIER PARK	8
GLENNVILLE	1
HANFORD	1
KERNVILLE	1
LAKE ISABELLA	19
LAMONT	43
LEBEC	2
LOS ANGELES	1
LOST HILLS	4
MARICOPA	6
MARYSVILLE	1
MC FARLAND	26
MOJAVE	11
N/A	18
POMONA	1

ROSAMOND	7
SHAFTER	37
TAFT	34
TEHACHAPI	48
WASCO	38
WELDON	5
WOFFORD HTS	7

Notes Completed

Note Source	Behavioral Case Management Episodes	Case Management Episodes
Activity Note	1462	1301
Add Episode Note	85	71
Care Plan Problem Note	270	518
Change Status Note	1585	2967
Edit Episode Note	39	265
Episode Note	78	260
Goals	253	368
Interventions	790	519

Letters

Letter Template	Behavioral Health Case Management Episodes	Case Management Episodes
Appointment Letter English	41	67
Appointment Letter Spanish	7	20
Consent Form English	5	15
Consent Form Spanish	3	11
Discharge English	14	3
Discharge Spanish	3	2
Educational Material	6	0
Mental Health Alert to PCP	3	0
Suicide Hospital Letter to MD	2	0
Unable to Contact	393	818
Welcome Letter Bilingual	136	275

Activities Completed

Activities Completed	Total
CMA's	2,865
Nurses	1,495
Social Workers	652

Activity Type

Activity Type	Behavioral Health Case Management Episodes	Case Management Episodes
Clinical Engagement	0	15
Education	0	29
Fax	146	218
Letter Contact	267	354
Member Services	39	51
Phone Call	1308	2476

Activity Name

Activity Name	Behavioral Health Case Management Episodes	Case Management Episodes
Appointment Reminder Calls	34	61
Close Episode for CEG	0	5
Close Episode for UTC	31	23
Community Resources	5	10
Contact Member	345	394
Contact Pharmacy	1	29
Contact Provider	128	395
COVID-19 Education	0	37
Create Work Item	44	63
Follow-up with PCP.	0	1
HHP	0	2
Homeless	3	2
ICT	27	46
Incoming Call	0	16
Inpatient Discharge Follow Up	25	140
Language Line	98	185
Mail Appointment Letter	47	46
Mail Authorization	0	2

Mail Consent Letter	7	21
Mail Discharge Letter	83	120
Mail Educational Material	2	0
Mail Provider Directory	2	2
Mail Unable to contact letter	60	147
Mail Urgent Care Pamphlet	15	0
Mail Welcome Letter	4	1
Mental Health Alert to PCP	5	0
Palliative Care	2	0
Plan of care	134	147
Request Medical Records	33	147
Return Mail	2	8
Schedule Physician Appointment	74	89
Transportation	1	14
Verbal consent to be received	548	990

Seniors and Persons with Disabilities (SPDs):

SPD Members are identified for Complex Case Management through use of the John Hopkins Predictive Modeler, through Health Risk Assessments and other sources including member requests and outside and internal requests.

The SPD population represents a total of 44 percent (844) of the Complex Group during the months of October thru December 2020.

The John Hopkins Predictive Modeler identified SPD's represent 49% percent of the SPD's identified in the Complex Group during the months of October thru December 2020. HRA identified SPD members represent 32% and other sources of SPD members represent 19%.