KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Facility Site Review and Medical Record Review	**Policy #**	23.21-P
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Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

The Purpose of this policy is to ensure Kern Health Systems (KHS) is aligned and implementing Department of Health Care Services (DHCS) requirements for the Site Review Program. KHS maintains updates to the Primary Care site review process, which includes Facility Site Reviews (FSR) and Medical Record Reviews (MRR) in accordance with DHCS' All Plan Letters (APLs) and contractual requirements.

II. POLICY

A. Per Department of Health Care Services (DHCS) All Policy Letter (APL) 22-017, Kern Health Systems (KHS) is responsible for oversight of the site review policies whether KHS retains site review functions, delegates them to another Managed Care Plan (MCP), or subcontracts site review. KHS develops and maintains a standardized system-wide process for conducting reviews of provider facility sites and medical records that minimize evaluation criteria and guidelines in compliance with the State Department of Health Care Services (DHCS) contractual requirements. KHS' Chief Medical Officer (CMO) or designee is accountable for the Facility Site Survey process.

Kern Health Systems (KHS) personnel will perform a facility site and medical record review on all contracted primary care providers (PCP) (including OB/GYNs, IPAs, clinics, and hospital ambulatory care clinics serving as PCPs). Physical Access Reviews (PARs) will also be completed for providers who serve a high volume of Seniors and People with Disabilities (SPD) beneficiaries, in accordance with Letters, MMCD Policy Letter 02-02 and 10-016, Title 22, CCR Section 53856, and W & I Code 14182(b)(9).

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).

Only a Certified Master Trainer (CMT) or Certified Site Reviewer (CSR) conduct initial and subsequent site reviews, consisting of a Facility Site Review (FSR) and Medical Records Review (MRR), regardless of a PCP site's other accreditations and certifications.

KHS conducts an initial and subsequent site review, consisting of an FSR and MRR, for all contracted Primary Care Provider (PCP) sites receive regardless of the site's other accreditations and certifications. KHS ensures the following:

1. Each PCP site has passed an initial FSR and, as applicable, corrects all deficiencies in order to close their Corrective Action Plan (CAP) prior to adding the provider(s) to the MCP's network and assigning MCP members to the provider(s).
2. Each PCP completes an initial MRR after the PCP is assigned members, and, as applicable, submits all appropriate documentation to address all deficiencies to close their CAP.
3. Each PCP site completes a periodic subsequent site review, consisting of both an FSR and MRR, at least every three years after the initial FSR.
4. DHCS' most current FSR and MRR tools and standards are being utilized when conducting site reviews.
5. All PCP sites are held to the same standards.
6. The site review status of each contracted PCP site is properly tracked.
7. KHS collaborates with Health Net or any other local MCP to determine how we notify each other of site review statuses and results for shared providers.

KHS issues a Certified Quality Provider Site certificate to providers that successfully pass a site review. This certificate is valid for up to three years and affirms that the site has been deemed a DHCS Certified Quality Provider Site. Certificates are issued and revoked to shared provider sites in coordination with the county collaborative partner.

KHS notifies its providers in advance for scheduled site reviews. However, inspection of an MCP's facilities or other elements of a review may be conducted without prior notice, in conjunction with other medical surveys or as part of an unannounced inspection program[1].

KHS may choose to delegate site review responsibilities to another MCP. However, KHS retains ultimate responsibility for oversight of site review completion, results, any necessary corrective action plan (CAP), and monitoring of assigned PCP sites per county collaboration.

III. DEFINITIONS

TERMS	DEFINITIONS
Ancillary Service Providers	Free standing facilities that provide diagnostic and therapeutic services, such as, but not limited to laboratory, infusion, radiology, imaging, cardiac testing, renal

	dialysis, occupational therapy, speech therapy, physical therapy, pulmonary testing, and cardiac rehabilitation.
High Volume Specialists	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.

IV. PROCEDURES

A. Site Review Process

1. Initial Site Review

An initial site review consists of an initial FSR and an initial MRR. The initial FSR and the initial MRR might not occur on the same date. The FSR is conducted first to ensure the PCP site operates in compliance with all applicable local, state, and federal laws and regulations. KHS does not assign members to providers until their PCP sites receive a passing FSR score and completes all CAPs. An initial FSR is not required when a new provider joins a PCP site that has a current passing FSR score.

A DHCS Site Identification Number ("DHCS Site ID") is a unique identifier and must be assigned by designated MCPs to each PCP site reviewed. DHCS releases sets of DHCS Site ID numbers for each county. In the event of an ownership change at an established PCP site, a new DHCS Site ID will be assigned. The new DHCS Site ID may be the existing Site ID but with a modifier to represent a change of ownership at the site. Local county MCPs collaborate to manage and assign the DHCS Site ID numbers specific to the county.

Once a PCP site passes the initial FSR's and completes all Corrective Action Plans (CAPs), KHS begins assigning members to the PCPs at that site. KHS will complete the initial MRR of a new PCP site within ninety (90) calendar days of the date that KHS first assigns members. KHS may defer this initial MRR for an additional ninety (90) calendar days only if the new PCP does not have enough assigned MCP members to complete the MRR on the required minimum number of medical records (see Subsequent Site Reviews below for details regarding the required minimum number of medical records). If, after 180 days following assignment of members, the PCP still has fewer than the required number of medical records, KHS will complete the MRR using the total number of medical records it has available and adjust the scoring according to the number of medical records reviewed.

KHS may choose to conduct the MRR Review portion of the site review on site or virtually. The virtual process must comply with all applicable Health Insurance Portability Accountability Act (HIPAA) standards at all-times.

There are additional scenarios that require KHS to conduct an initial site review. Examples

of these scenarios include, but are not limited to, instances when:

a. A new PCP site is added to KHS's network.
b. A newly contracted provider assumes a PCP site with a previous failing FSR and/or MRR score within the last three years.
c. A PCP site is returning to the Medi-Cal managed care program and has not had a passing FSR in the last three years.
d. At the discretion of KHS, a separate site review may be conducted for solo practices/organizations.
e. Upon identification of multiple independent practices that occupy the same site, a separate site review must be completed for all PCP practices at that site and a unique alphanumeric DHCS Site ID must be assigned for each independent PCP practice at the site if ownership is different. MCPs must develop processes within their local county collaborative in regard to conducting separate site reviews for shared sites.
f. There is a change of ownership of an existing provider site.
g. A PCP site relocates. When a PCP site relocates, KHS:

    i. Completes an initial FSR within sixty (60) days of notification or discovery of the completed move.
    ii. Allows assigned KHS members to continue to see the provider at the new location, but not assign new Members until the initial site review is completed.
    iii. Upon passing the initial FSR and closing CAPs, if applicable, the following will occur: The PCP site may be formally added to the Network.
    iv. New and established relocating Members can be formally assigned to the new Provider location.

h. If the relocated PCP site does not pass the initial FSR within two attempts, or does not complete required CAPs per established timelines, the following will occur:

    i. The relocated PCP site may not be added to the MCP's Provider Network.
    ii. The previous PCP site must be removed from the Network if the site has closed.
    iii. Current assigned membership must be reassigned to another Network PCP, if the previous site has closed.
    iv. The relocated PCP site may reapply six months from the last FSR survey.

i. Does not assign new members to providers at the site until the PCP site receives passing FSR and MRR scores.
j. If KHS were to expand to a new service area, KHS will complete an initial site review on a specified number of PCP sites as outlined in the bulleted list below. The FSR portion of the initial site review must be completed prior to the start of KHS expanding its operations.

k. Five percent of the PCP sites in KHS' proposed network, or on thirty PCP sites, whichever is greater in number.
l. All remaining proposed PCP sites within the first six months of operation or expansion.
m. All PCP sites in the network if there are thirty or fewer PCP sites in the network.
n. New and/or expanding MCPs may use site reviews of existing county MCPs as evidence of completion of the required initial site reviews.
o. MCPs must submit data and relevant information to DHCS, in a format and timeframe to be specified by DHCS, for the instances described above.

PCP sites that are subject to site reviews must include a variety of PCP types (Family Medicine, Internal Medicine, Pediatric, etc.) and subcontracted entities (solo practice, Medical Group, etc.) from throughout the provider network.

2. Supplemental Facilities

Mobile, Satellite, School Based, and Other Extension Clinics
Supplemental facilities assist in the care delivery of primary care services to geographically remote areas that lack health care services, as well as assist the underserved population in areas where there may be access to care concerns.

a. Supplemental facilities may offer a variety of clinical services including, but not limited to preventive care, immunizations, screenings, and/or chronic care management (excluding specialty services).
b. Mobile clinics are self-contained units including vans, recreational vehicles, and other vehicles that have been repurposed to provide space for various clinic services and may also serve to deliver equipment to locations that operate temporary clinics.
c. In general, supplemental facilities that provide primary care services may serve as an extension of a PCP site, a community-based clinic, a Federally Qualified Health Center (FQHC) county facility, or a standalone clinic with Members assigned.
d. KHS must conduct an initial site review and subsequent site reviews of supplemental facilities at least every three years thereafter, with a focus on areas relevant to the services being provided by the supplemental facilities.
e. KHS must establish a process to complete the oversight of supplemental facilities and collaborate with MCPs within a given county.

3. Subsequent Site Reviews

KHS conducts subsequent site reviews, consisting of an FSR and MRR, at least every three years, beginning no later than three years after the initial FSR. KHS may conduct site reviews more frequently per county collaborative decisions, or when determined necessary based on monitoring, evaluation, or CAP follow-up issues.

4. Scoring

KHS will base FSR and MRR scores on available documented evidence, demonstration of the criteria, and verbal interviews with site personnel. If a site reviewer chooses to review additional criteria not included on the FSR or MRR tools, the site reviewer will not include the additional criteria in the existing scoring method. KHS will not alter scored criteria or assigned weights in any way.

Critical elements have the largest potential for adverse effects on patient health or safety and therefore have a scored weight of two points while all other review elements have a scored weight of one point. The PCP site must correct all critical element deficiencies identified during a site review, focused review, or monitoring visit within ten calendar days of those reviews or visits. KHS will verify that CAPs related to critical elements are completed within 30 calendar days of the site review, focused review, or monitoring visit. KHS will ensure that PCP sites found to be deficient in any critical element during an FSR have fully corrected all deficiencies, regardless of the PCP site's FSR score. Any MRR section score of less than 80 percent requires a CAP for the entire MRR regardless of the total MRR score.

All MRR tool review elements have a scored weight of one-point each. The MRR score is based on a standard review of ten randomly selected KHS member medical records per provider, consisting of five pediatric and five adult or obstetric medical records. For PCP sites serving only pediatric or only adult patients, all ten medical records will be reviewed using the appropriate preventive care criteria. For OB/GYNs acting as PCPs, all medical records will be reviewed using preventive care criteria for adults or pediatrics (pregnant under age 21 years) and obstetrics. During the MRR, site reviewers have the option to request additional medical records for review. If the site reviewer chooses to review additional medical records, KHS will calculate the scores accordingly.

If a PCP site documents patient care performed by multiple PCPs in the same medical record, KHS will consider these medical records as a shared medical record system. KHS will consider shared medical records as those that are not identifiable as separate records belonging to any specific PCP. KHS will review a minimum of ten medical records if two or three PCPs share records, twenty medical records if four to six PCPs share records, and thirty medical records if seven or more PCPs share records. If there are multiple providers in one office that do not share medical records, each PCP will be reviewed separately and receive a separate score. If a minimum number of records are not available for review due to limited patient population, the reviewer will complete the MRR, document the rationale, and adjust the score as needed.

In the event that there are multiple Providers in one office that do not share medical records, each PCP must be reviewed separately and receive a separate score. A minimum of ten medical records must be reviewed per Provider.

During the MRR, site reviewers have the option to request additional medical records for review to ensure adequate review of all Provider specialties, Member populations, etc. If the site reviewer chooses to review additional medical records, the MCP must calculate the scores accordingly.

MCPs may choose to conduct the MRR portion of the site review onsite or virtually. The virtual process must comply with all applicable HIPAA standards at all times, regardless of the chosen method. Both onsite and virtual MRRs may include the review of medical records for Members belonging to another MCP, and may include the viewing, collection, storage, and transmission of Protected Health Information (PHI).

If a PCP site receives a failing score from one MCP, all other MCPs will consider the PCP site as having a failing score. KHS will use the county collaborative process to identify shared providers and to determine methods for sharing site review information, including CAPs and provider terminations (See Policy 4.39 for Provider Terminations).

When a PCP site receives a failing score on an FSR or MRR, KHS will notify the PCP site of the score, all cited deficiencies, and all CAP requirements. KHS may choose to remove any PCP site with a failing FSR or MRR score from its network. If KHS allows a PCP site with a failing FSR or MRR score to remain in its network, KHS will require and verify that the PCP site has corrected the identified deficiencies within the CAP timelines established in this policy. KHS will not assign new members to network PCP sites that receive a failing score on an FSR or MRR until KHS has verified that the PCP site has corrected the deficiencies and the CAP is closed.

PCP sites that receive a failing score on either the FSR or MRR for two consecutive site reviews must receive a minimum passing score on the next FSR and MRR (including PCP sites with open CAPs in place) to remain in the MCP's provider network. If the PCP site fails on its third consecutive attempt, despite KHS' ongoing monitoring and assistance, the PCP site will be removed from KHS' provider network, and its members will be reassigned to other network providers, as appropriate and as contractually required.

5. Corrective Action Plan (CAP)

A CAP is required for all cited deficiencies for PCP sites that have a deficiency in a critical element or receive a conditional passing score on the FSR or MRR tool, on a focused review, or for deficiencies identified by KHS or DHCS through oversight and monitoring activities. CAPs are required as indicated:

Review	Exempted Pass	Conditional Pass	Fail
FSR	a. Score of 90% and above with no deficiencies in critical elements, infection control, or pharmacy b. CAP not required	a. Score of 90% and above with deficiencies in critical elements, infection control, or pharmacy b. Score of 80% and above. c. CAP required	a. Score below 80% b. CAP required
MRR	a. Score of 90% and above, with all section scores at 80% and above b. CAP not required	a. Score of 90% and above with one or more section scores below 80% b. Score of 80% and above c. CAP required.	a. Score below b. 80% c. CAP required
MCPs may require a CAP regardless of score for other findings identified during the survey that require correction.			
MRR	a. Score of 90% and above, with all section scores at 80% and above b. CAP not required	a. Score of 90% and above with one or more section scores below 80% b. Score of 80% and above c. CAP required	a. Score below b. 80% c. CAP required
MCPs may require a CAP regardless of score for other findings identified during the survey that require correction.			

KHS will not assign new Members to Providers who fail to correct site review deficiencies within the established CAP timelines. For Providers that fail to comply with their CAP, the MCP must verify that the PCP site has corrected the deficiencies, and the CAP is closed before assigning new Members. Ultimately, KHS must remove any Provider from their Network that does not come into compliance with review criteria and CAP requirements within the established timelines, and the MCP must expeditiously reassign that Provider's Members to other Network Providers

KHS may decide to provide additional training and give technical assistance when a PCP site fails an FSR prior to contracting with KHS. Precontracted providers who do not pass the initial FSR within two attempts may reapply to KHS after six months.

When conducting the site review, KHS is responsible for follow-up, re-review, closure of CAPs, and monitoring re-reviews. CAP documentation will identify:

a. The specific deficiency,
b. Corrective actions needed,
c. Projected and actual dates of the deficiency correction,
d. Reevaluation of timelines and dates. And
e. Responsible persons

CAPs for non-critical elements may be verified via document submission. CAPs for critical elements will be verified onsite. Closed CAP documentation will include:

a. Documentation of problems in completing corrective actions (if any),
b. Resources and technical assistance provided by the MCP,
c. Evidence of the corrections,
d. Completion and closure dates, and
e. Name and title of the MCP reviewer.

KHS will follow the timeline below for CAP notification and completion:

CAP Timeline	CAP Action(s)
FSR and/or MRR Completion Day	KHS will provide the PCP site a report containing: a. Verbal notification of any CE findings and a signed attestation by the PCP/site designee and KHS staff confirming that a discussion regarding CE findings occurred. (This serves as the start of the CE-CAP timeline.) b. A formal written request for CAPs to address all CEs, if applicable, the day of the site visit but no later than one business day after site visit completion c. The FSR and/or MRR scores site visit but no later than one business day after site visit completion. d. A formal written request for CAPs for all critical elements, if applicable the day of the site visit but no later than one business day after site visit completion
Within ten (10) calendar days of the FSR and/or MRR	a. The PCP site will submit a CAP and evidence of corrections to KHS for all deficient critical elements, if applicable. b. KHS will provide a report to the PCP site containing FSR and/or MRR findings, along with a formal written request for CAPs for all non-critical element deficiencies. c. KHS will provide educational support and technical assistance to PCP sites as needed. d. KHS must review, approve, or request additional information on the submitted CAP(s) for CE findings
Within thirty (30) calendar days from the date of the FSR and/or MRR report	a. KHS will conduct a focused review to verify that CAPs for critical elements are completed. b. The PCP site must submit a CAP for all non-critical element deficiencies to KHS. c. KHS will provide educational support and technical assistance to PCP sites as needed.
Within sixty (60) calendar days from the date of the FSR	a. For those sites that were granted an extension for CE CAPs, the MCP must verify that all CE CAPs are closed

CAP Timeline	CAP Action(s)
Within sixty (60) calendar days from the date of the FSR and/or MRR report	a. KHS will review, approve, or request additional information on the submitted CAP(s) for non-critical findings. b. KHS will continue to provide educational support and technical assistance to PCP sites as needed.
Within ninety (90) calendar days from the date of the FSR and/or MRR report	a. All CAPs must be closed. b. Providers can request a definitive, time-specific extension period to complete the CAP(s), not to exceed 120 calendar days from the date of the initial report of FSR and/or MRR findings.
Beyond 120 days from the date of the FSR and/or MRR report	a. KHS will request approval from DHCS to complete a CAP review for any extenuating circumstances that prevented completion of a CAP within the established timeline. b. KHS will conduct another FSR and/or MRR, as applicable, within 12 months of the applicable FSR and/or MRR date(s).

KHS will not assign new members to providers who do not correct site review deficiencies within the established CAP timelines. KHS will verify that the PCP site has corrected the deficiencies and the CAP is closed. KHS will remove any provider from the network who does not come into compliance with review criteria and CAP requirements within the established timelines, and KHS will appropriately reassign that provider's KHS members to other network providers.

6. Re-Credentialing

For a new provider on a site that has not previously been reviewed, initial provider credentialing and site review will occur simultaneously. Providers at a site are credentialed according to DHCS contractual and policy requirements. A site review shall be completed as part of the initial credentialing process if a new provider at a site that has not previously been reviewed is added to a contractor's provider network. A site review need not be repeated as part of the initial credentialing process if a new provider is added to a provider site that has a current passing site survey score. A site review survey need not be repeated as part of the recredentialing process if the site has a current passing site survey score. A passing Site Review Survey shall be considered "current" if it is dated within the last three years; it need not be repeated until the next scheduled site review survey, which occurs every three years. KHS must conduct post-enrollment site visits for medium-risk Network Providers at least every five years, and their high-risk Network Providers every three years or as necessary.

Per DHCS APL 22-013, KHS must perform site reviews as part of each provider's initial credentialing process when both the site and provider have been added to KHS provider network; thereby, both the site review and credentialing requirements can be completed at the same time. A new site review is not required when new providers join an approved site within three years of the site's previous passing review.

7. Monitoring

KHS will monitor all PCP sites between each regularly scheduled site review. Monitoring methods may include site reviews, but KHS also uses additional methods such as information gathered through established internal KHS systems (e.g., quality improvement), as well as provider and program-specific reports from external sources of information. KHS will monitor and evaluate all critical elements for all PCP sites between scheduled site reviews. When KHS identifies deficiencies through monitoring, KHS will determine the appropriate course of action, such as conducting a site review or additional focused reviews, to educate and correct the deficiencies according to established CAP timelines.

8. Physical Access Reviews (PARS)

The Physical Accessibility Review Survey (Attachment C) assesses the physical accessibility of provider sites for PCPs and high-volume specialist, ancillary, and CBAS providers who serve KHS SPD members. Physical accessibility reviews are available to any contracted provider that request to be evaluated, regardless of whether they are determined to be high volume.

KHS conducts PARs for new PCP sites at the time of initial credentialing or contracting, and every three years thereafter as a requirement for participation in the California State Medi-Cal Managed Care (MMCD) Program. PARS are conducted for PCP sites regardless of the status of other accreditation and/or certifications.

The following types of providers will be excluded from PAR site visits:

a. Non-contracted providers;
b. Transportation providers;
c. Durable Medical Equipment (DME) pick-up sites;
d. Laboratories out of service area;
e. Licensed and State-certified long-term care facilities; and
f. Delegated entities, including Vision Services Plan (VSP), Managed Behavioral Health Services, and Pharmacy Benefit Managers (PBMs).

A PAR will be conducted utilizing the DHCS MMCD Facility Site Survey Tool, APL 15-023 Attachments C, D, or E when appropriate. Assessment includes, but is not limited to, parking, building, elevator and clinic areas, exam rooms, lobbies, and restrooms. Medical equipment assessed may include, but is not limited to, height adjustable exam tables, member accessible weight scales, infusion chairs and/or beds, physical therapy equipment, and

imaging equipment such as for mammography or Magnetic Resonance Imaging (MRI). KHS staff members are trained to conduct the PAR utilizing the requirements and process as described in MMCD PL 12-006 and DHCS APL 15-023.

KHS will utilize the following methodology to identify high-volume specialist, ancillary, and CBAS providers who serve KHS SPD members. 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; at a minimum, the report will include the following data categories:

a. Provider name, NPI number,
b. KHS internal provider ID number;
c. Medi-Cal specialty description.
d. Place of service, and
e. 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.

9. Focused Review

A focused review is a targeted review of one or more specific areas of the FSR or MRR. KHS will not substitute a focused review for a site review. KHS may use focused reviews to monitor providers between site reviews to investigate problems identified through monitoring activities or to follow up on corrective actions. Reviewers may utilize the appropriate sections of the FSR and MRR tools for the focused review, or other methods to investigate identified deficiencies or situations. All deficiencies identified in a focused review require the completion and verification of corrective actions according to CAP timelines established in this policy and procedure.

10. County Collaboration

KHS will collaborate locally within each Medi-Cal managed care county to establish systems and implement procedures for the coordination and consolidation of site reviews for mutually shared PCPs.[2] KHS and Health Net have equal responsibility and accountability for participation in the site review collaborative processes.

The Collaborative Process are:

a. Standardize policy and procedures for FSR’s and MRR’s
b. Standardize tolls for CAP’s

c. Standardize Protocols which will limit access to audit results only to authorized health plan representatives
d. Standardized certified reviewers training and certification programs
e. Standardized protocols for designated vendor's responsibility and reporting if applicable)

KHS submits an initial written description and periodic update reports as requested and instructed by DHCS describing the county collaboration processes, which will include, but are not limited to, the following:

a. Names and titles of each MCP's participating personnel.
b. A work plan that includes goals, objectives, activities, and timelines.
c. Scheduled meeting dates, times, and locations.
d. Meeting processes and outcomes.
e. Communication and information-sharing processes.
f. Roles and responsibilities of each MCP.
g. Delegated activities and use of delegated or sub-delegated entities.
h. Memorandum of Agreement requirements established KHS and Health Net.

KHS will establish policies and procedures to define local collaborative methodology for:

a. Identification of shared providers,
b. Confidentiality, disclosure, and release of shared provider review information and site review results,
c. Site review processes,
d. Issuance of Certified Quality Provider Site certificates,
e. Oversight and monitoring of review processes,
f. Site review personnel and training processes, and
g. Collection and storage of site review results

11. MCP Site Review Personnel

KHS will designate a minimum of one physician, Nurse Practitioner (NP), Physician Assistant (PA), or Registered Nurse (RN), to be certified by DHCS as the MCP's CMT. The CMT has the overall responsibility for the training, supervision, and certification of site reviewers, as well as monitoring site reviews and evaluating site reviewers for accuracy.

KHS will determine the composition of the teams performing site reviews. Each site review will have a designated CSR who is responsible for and signs the FSR and MRR tools. Only physicians, NPs, PAs, or RNs are eligible to become CSRs. A variety of personnel may be part of the site review team, including pharmacists, dietitians, and others to provide assistance and clarification.

a. An RN^3 is the minimal level of site reviewer acceptable for independently performing site reviews. RN reviewers can independently make determinations

regarding implementation of appropriate reporting or referral of abnormal review findings to initiate peer review procedures. An RN can only delegate site review tasks to a subordinate based on the subordinate's legal scope of practice and on the degree of preparation and ability required by the site review tasks that the RN would delegate.

KHS has written policies and procedures that clearly define the duties and responsibilities of all site review personnel. KHS ensures that site review activities established for CSRs comply with the CSR's scope of practice as defined by state law, in accordance with the state licensing and certification agencies and are appropriate to the site reviewers' level of education and training by completing a minimum of 10 FSR's and 10 MRR' s for recertification, attending a DHCS sponsored Inter rated workshop in person every two years, and achieving a 10% variance on FSR and MRR.

12. MCP Site Review Training and Certification

Physicians, NPs, PAs, and/or RNs that are designated by KHS to be CMTs or site reviewers will meet the certification and recertification requirements outlined in the respective table below to be certified as a CMT or CSR. CMT candidates must apply for certification directly to DHCS using Attachments 1-41 of this policy and procedure, Application for DHCS Site Review Master Trainer Certification. Applications will be submitted to KHS's assigned DHCS Nurse Evaluator. Upon certification and recertification, CMTs will receive a certificate signed by DHCS. CMTs must be recertified every three years.

KHS is responsible for ensuring that all site reviewers are appropriately trained, evaluated, certified, and monitored. KHS may collaborate with another MCP to determine local systems for training and certifying site reviewers. Training must include DHCS seminars, KHS classes, individual or small group training sessions provided by a CMT, and self-study learning programs. KHS can only certify physicians, PAs, or RNs as CSRs, and recertify them every three years thereafter. Upon certification and recertification, CSRs will receive written verification of certification by KHS.

13. Inter-rated Review Process

Candidates for CMT and CSR certifications will complete an inter-rater review process as part of both the initial certification and recertification processes. The inter-rater for CMT candidates is a DHCS Nurse Evaluator. The inter-rater review process requires the CMT candidate to concurrently complete and score a site review with the DHCS Nurse Evaluator using the DHCS FSR and MRR tools and standards. The inter-rater for CSR candidates is KHS' CMT. The inter-rater review process requires the CSR candidate to participate with KHS' CMT to concurrently complete and score a site review utilizing the DHCS FSR and MRR tools and standards. The CMT or CSR candidate must achieve the required inter-rater score as described in the tables below to be certified.

If the CMT or CSR candidate does not meet the appropriate inter-rater score variance, they may repeat the process one time. The appropriate inter-rater (DHCS Nurse Evaluator or

KHS' CMT) and the candidate with the failing inter-rater score will jointly assess training needs and implement a training plan prior to conducting the second inter-rater review. CMT and CSR candidates that do not meet the appropriate inter-rater variance score for the second inter-rater review must wait 6 months to reapply for certification.

Initial Certification Requirements	CMT	CSR
Possess a current and valid California RN, Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), NP, or PA license.	X	X
Be employed by or subcontracted with an MCP.	X	X
Submit Attachment A, Application for DHCS Site Review Master Trainer Certification.	X	
Have experience in conducting training in a health-related field, or conducting quality improvement activities such as medical audits, site reviews, or utilization management activities within the past three (3) years.	X	
Complete twenty (20) FSRs and twenty (20) MRRs, and one (1) year of experience as a CSR.	X	
Achieve an inter-rater score within 5% of FSR and 5% of MRR from the DHCS Nurse Evaluator.	X	
Attend didactic site review training or completion of DHCS site review training modules on the current site review tools under supervision of a CMT.		X
Complete ten (10) FSRs and ten (10) MRRs with a CSR or CMT.		X
Achieve an inter-rater score of 10% in FSR and 10% in MRR with designated CMT.		X

Recertification Requirements	CMT	CSR
Possess a current and valid California RN, MD, DO, NP, or PA license.	X	X
Be employed by or subcontracted with an MCP.	X	X

Be responsible for staff training on the most current DHCS site review tools and standards.	X	
Participate in DHCS-sponsored site review trainings as well as site review work group (SRWG) meetings and teleconferences.	X	
Maintain CMT certification.	X	
Complete a minimum of twenty (30) site reviews following initial certification or recertification.	X	X
Attend DHCS-sponsored inter-rater workshops in person or virtually every three years.	X	X
Achieve a 10% variance on the MRR, on the interrater score as defined by the SRWG and DHCS.		X
Achieve an inter-rater score within 5% of FSR and 5% of MRR from the DHCS Nurse Evaluator.	X	

KHS will develop policies and procedures for ongoing supervision and monitoring of site review personnel to ensure reliability of site review findings and data submitted to DHCS. Each MCP must maintain certification records including, but not limited to, site review training activities and supporting documentations to support the certification requirements.

14. Data Submission Procedures

KHS will submit site review data to DHCS every six months (July 31 for the period January - June, and January 31 for the period July - December) in an approved format uploaded to a designated DHCS secure site. KHS may submit data more frequently than every six months. For preoperational and expansion site reviews, KHS will submit site review data to DHCS at least six weeks prior to site operation. DHCS will make available the database containing all necessary tables and data input forms for the mandatory bi-annual submission of site review data. DHCS will reject site review data if KHS submits it in nonconforming formats.

KHS is required to collect PHI as part of the MRR process and must include the PHI in the bi-annual data submission to DHCS.

15. DHCS-Conducted Site Reviews

DHCS conducts separate site reviews to validate KHS' FSR and MRR processes. Prior to an expansion to a new county by KHS, DHCS conducts initial FSRs, followed by initial

MRRs upon KHS beginning operations and assignment of KHS members, as outlined in APL22-017, of randomly chosen PCP sites in KHS' network. DHCS also conducts subsequent site reviews on PCP sites within KHS networks. DHCS will notify KHS of critical findings in writing via email within 10 business days following the date of the FSR and/or MRR and provide a written report summarizing all of DHCS' review findings within 30 calendar days following the date of the FSR and/or MRR.

Within 30 calendar days from the date of the DHCS-conducted site review report, KHS must provide a CAP to DHCS responding to all cited deficiencies documented in the report. KHS' CAP response must include:

a. The identified deficiency(ies) and
b. A description of action(s) taken to correct the deficiency(ies)

If a deficiency is determined to require long-term corrective action, KHS' CAP response must include indication that KHS has:

a. Initiated remedial action(s)
b. Developed a plan to achieve an acceptable level of compliance, and
c. Documented the date the provider is in full compliance or when full compliance will be achieved.

Additional supporting documentation and remedial action may be required if DHCS determines CAPs are insufficient to correct deficiencies.

KHS will be notified approximately four weeks in advance of DHCS-conducted site reviews. KHS must notify its providers in advance of site reviews, whether the site review is conducted by DHCS or by KHS. However, inspection of KHS' facilities or other elements of a review may be conducted without prior notice, in conjunction with other medical surveys or as part of an unannounced inspection program.

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

All contracting plans within a county have equal responsibility and accountability for the coordination and consolidation of provider site reviews and therefore are expected to participate in these collaborative activities.

All Health Plans within the county shall collaborate to determine processes for scheduling facility site reviews, notification of survey status and/or results on shared providers. Site review responsibilities may be shared equally by all plans within a county, delegated to one or more plans or individual physician practices (e.g., IPA) and/or subcontracted to

other agencies or entities. The Chief Medical Officer or their designee is ultimately responsible for site review activities.

A Full Scope Site Review Survey can be waived for a pre-contracted provider site if the provider or another local plan has documented proof that a current full scope survey with a passing score was completed by the other Health Plan within the past 3 years. Prior to initiating plan operation in a service area, an initial full scope survey shall be completed on 5% of the provider network, or on 30 PCP sites, whichever is greater in number. The 5% or 30 PCP sample sites shall include a variety of providers from throughout the provider network and/or from each subcontracted entity. If there are 30 or fewer PCP sites in the network, 100% of the sites must be completed prior to beginning plan operations. Corrective actions shall be completed per APL 20-006. An initial full scope survey shall be completed on 100% of the remaining proposed PCP sites within the first six (6) months of plan operation or expansion.

The most current site review and medical record surveys shall be shared with and accepted by all Health Plans both intra and inter-county contracting with the provider(s). Each Health Plan is responsible for tracking the survey status of all contracted Medi-Cal managed care provider sites.

Delegation or site review responsibilities are a determination made by each plan. However, each collaborating health plan shall determine the acceptance of surveys completed by the entities delegated or subcontracted by another local plan.

B. Interim Review

Each Health Plan is responsible for systematic monitoring of all PCP sites between each regularly scheduled full scope site review surveys which includes the fourteen (14 critical elements. PCP office self-assessment system may be considered as part of the overall monitoring. Other performance assessments may include previous deficiencies, patient satisfaction, grievance, and utilization management data.

Deficiencies identified during the monitoring process will be noted in a Corrective Action Plan to assist the PCP in meeting requirements. This Corrective Action Plan (CAP) includes deficiencies noted during the monitoring review, 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 Health Plan verification of Corrections.

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 signed Corrective Action Plan documents are placed in the PCP's file that is maintained by the Health Plan responsible for completing the review.

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.

C. Full Scope Site Review

A Full Scope Site Review shall be the system-wide standard for conducting the initial and subsequent periodic reviews of contracted Primary Care Physician sites.

A full scope review consists of the DHCS Facility Site Review Survey and Medical Record Review Survey. Reviewers shall only review criteria that are appropriate to their level of education expertise, training and professional licensing scope of practice as determined by the California statute. The responsible reviewer for each survey shall be at minimum an RN, who shall sign the site review and/or medical record survey.

Facility Site and Medical Record Reviews are performed at least every three (3) years.

1. Initial Site Review

   The initial site review is the first onsite inspection of a site that has not previously had a full scope survey or a PCP site that is returning to the Medi-Cal managed care program and has not had a passing full scope survey within the past three (3) years. It is the responsibility of the Health Plan that performed the Facility Site and Medical Record Review to follow-up and close any provider Corrective Action Plan(s).

   Health Plans may review sites more frequently when determined necessary based on monitoring, evaluation, or corrective action plan (CAP) follow-up issue.

2. Facility Site Review Process

   The Site Reviewer will conduct the Facility Site review with the DHCS Site Review tool and accompanying interpretive guidelines.

   There are fourteen (14) critical survey elements identified to have potential for adverse effect on patient health or safety. The elements include:

   a. Exit doors and aisles are unobstructed and egress (escape) accessible.
   b. Airway management equipment: oxygen delivery system, nasal cannula or mask, bulb syringe, Ambu bag, appropriate to practice and populations served are present on site.
   c. Emergency medicine such as asthma, chest pain, hypoglycemia, and anaphylactic reaction management: Epinephrine 1:1000 (injectable), and Benadryl 25 mg. (oral) or Benadryl 50 mg./ml (injectable), Naloxone, chewable Aspirin 81 mg,

Nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), and glucose. Appropriate sizes of ESIP needles/syringes and alcohol wipes.

d. Only qualified/trained personnel retrieve, prepare or administer medications.
e. Physician review and follow-up or referrals/ consultation reports and diagnostic test results.
f. Only lawfully authorized persons dispense drugs to patients;
g. Drugs and Vaccines are prepared and drawn only prior to administration.
h. Personal protective equipment (PPE) for Standard Precautions is readily available for staff use.
i. Needlestick safety precautions are practiced on-site.
j. Blood, other potentially infectious materials (specimens) and regulated wastes (sharps/biohazardous non-sharps) are placed in appropriate leak-proof, labeled containers for collection, processing, storage, transport, or shipping.
k. Cold chemical sterilization/high level disinfection.
    i. Staff demonstrate/verbalize necessary steps/process to ensure sterility and/or high-level disinfection of equipment.
    ii. Appropriate PPE is available, exposure control plan, MSDS and clean up instructions in the event of a cold chemical sterilant spill.
l. Autoclave steam sterilization Spore testing of autoclave/steam sterilizer is completed (at least monthly), with documented results.
m. Management of positive mechanical, chemical, and/or biological indicators of the sterilization process

The PCP and/or site contact will be notified of all critical element deficiencies found during a full scope site survey, focused survey or monitoring visit.

All critical element deficiencies shall be corrected by the provider within ten (10) business days of the survey date. All corrected critical element deficiencies will be verified as completed by the site reviewer within thirty (30) calendar days of the survey date. Sites found deficient in any critical element during the Full Scope Site Review shall be required to correct 100% of the survey deficiencies regardless of the survey score.

The Site Reviewer will calculate the Facility Site Survey tool score and at the exit interview discuss the findings with the PCP and/or site contact focusing on those area that are critical elements, other areas requiring improvement and the need for a corrective action plan.

V. ATTACHMENTS

Attachment A:	Medical Record Review Standards
Attachment B:	Medical Record Review Tool

Attachment C:	Facility Site Review Standards
Attachment D:	Facility Site Review Tool
Attachment E:	Physical Accessibility Review Survey

VI. REFERENCES

Reference Type	Specific Reference
Other	Department of Health Care Services (DHCS) Policy Letter (PL) 12-006
All Plan Letter(s) (APL)	Department of Health Care Services (DHCS) All-Plan Letter (APL) 15-023
All Plan Letter(s) (APL)	Department of Health Care Services (DHCS) All-Plan Letter (APL) 22-017
All Plan Letter(s) (APL)	DHCS All Plan Letter 15-023 – Facility Site Review Tools for Ancillary Service and Community Based Adult Services Providers
All Plan Letter(s) (APL)	DHCS Medi-Cal Contract Exhibit A, Attachment III, Subsection 5.2.14
Other	[1]See Title 28 CCR, section 1300.80
Other	[2] Health and Safety Code (HSC), section 1342.8.
Other	3 Business and Professions Code (BPC), section 2725.

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Revisions	12-2024	The policy was revised to align with DHCS APL 22-013 and meet requirements for the DHCS 2024 Contract Readiness, R.0025, approved on 12/22/2024. The policy was transferred from Quality Improvement to Quality Performance.	K.C. QP
Revisions	10-2022 to 12-2022	Policy updated to comply with DHCS APL 22-017. The DHCS approved revisions on 2/1/2023.	QI
Revision	10-2022	DMHC Approved, Filing No. 20223599.	-
Revision	9-2022	Policy accepted under the DHCS File and Use	-

		criteria.	
Revision	08-2022	Policy updated to comply with All-Plan Letter (APL) 20-006 and PARs survey.	-
Revision	11-2021	Policy was approved by PAC and QI-UM Committees.	-
Revision	10-2021	Policy created by Director of Quality Improvement and RN, DHCS Certified Master Trainer to comply with DHCS All-Plan Letter (APL) 20-006.	Director of QI

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Quality Improvement/Utilization Management (QI/UM)		11-2021
Physician Advisory Committee (PAC)		11-2021

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Department of Health Care Services (DHCS)	2024 OR R.0025 on 12/9/2025	12/12/2025
Department of Managed Health Care (DMHC)	DMHC Filing No. 20223599.	10-2022
Department of Health Care Services (DHCS)	10-2022 to 12-2022	2/1/2023
Choose an item.		

Chief Executive Leadership Approval *		
Title	**Signature**	**Date Approved**
Chief Executive Officer		
Chief Operating Officer		
Chief Medical Officer		
Choose an item.		
*Signatures are kept on file for reference but will not be on the published copy		

Policy and Procedure Review

KHS Policy & Procedure: 23.21-P Site Review and Medical Record Review Policy.

Last approved version: 02/01/2023

Reason for revision: The policy was revised to align with DHCS APL 22-013 and meet requirements for the DHCS 2024 Contract Readiness, R.0025.

Director Approval		
Title	**Signature**	**Date Approved**
Jake Hall Senior Director of Contracting and Quality Performance		
Kailey Collier Director of Quality Performance		

Date posted to public drive: _____

Date posted to website ("P" policies only): _____

Primary Care Provider-Medical Record Review Standards

Purpose: The Medical Record Review (MRR) Standards provide instructions, rules, regulations, parameters, and indicators for conducting medical record reviews using the MRR Tool. The site reviewer must use these Standards for measuring, evaluating, assessing, and making decisions.

Medical Record Selection: Medical records shall be randomly selected using methodology decided upon by the reviewer. Ten (10) medical records are reviewed for each primary care physician (PCP) site. For sites with *only* adult or *only* pediatric patient members, all ten records reviewed will be in *only* one preventive care criteria. For sites with adult and pediatric members, five (5) adults and five (5) pediatrics preventive criteria will be reviewed. For PCP sites where the OB-GYN providers both specialty and preventive services, based on the age of the patient, reviewer must review either adult or pediatric preventive criteria as well as OB Comprehensive Perinatal Services Program (CPSP) criteria.

PCP sites that document patient care performed by multiple PCPs in the same medical record are considered "shared." The MCP must consider shared medical records as those that are not identifiable as "separate" records belonging to any specific PCP. Scores calculated on shared medical records apply only to PCPs sharing the records. A minimum of ten shared records shall be reviewed for 2-3 PCPs, 20 records for 4-6 PCPs, and 30 records for 7 or more PCPs based on specialty and/or population served.

Example for determining the number of medical records to review:

> A site that has three (3) providers, two (2) providers see only adults and share records, and one (1) only see pediatrics and does not share records, 10 medical records on the two providers who share medical records and 10 medical records on the provider who does not share records will be conducted and scored separately. A total of 20 medical records shall be reviewed for this site. Two (2) scores will be reported for this site.

Reviewers are expected to determine the most appropriate method(s) on each site to ascertain information needed to complete the review. Review criteria that shall be reviewed *only* by a registered nurse (RN), nurse practitioner (NP), physician (MD), physician assistant (PA), Certified Nurse Midwife (CNM), or Licensed Midwife is labeled "  **RN/NP/MD/PA/CNM/LM".**

Reviewers must ensure confidentiality on Protected Health Information (PHI) or Personally Identifiable Information (PII).

Scoring: The review score is based on a review standard of 10 records per individual primary care provider (PCP). Documented evidence found in the hard copy (paper) medical records and/or electronic medical records, including immunization registries, are used for review criteria determinations. Compliance levels are:
An Exempted Pass is 90%.
Conditional Pass is 80-89%.
Failure is 79% and below.

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.

Directions: Score one point if criterion is met. . Score ”R” for documented member refusal, Provider outreach, referral or member non-compliance*. Score zero points if criterion is not met. 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. Do not score partial points for any criterion.

When to use “Documented member refusal”
1. When there is documentation in the record that the site/provider addressed the preventive service and ordered/offered/referred, there was adequate follow up, the member was noncompliant/no-show/nonresponsive and/or the member refused.i.e mammogram ordered, referral given and follow up during the next visit to remind member to get mammogram or ii.mammogram ordered but member declined

2. When there is documentation of the site requesting information, signature/completion of a form or questionnaire and “member refused” or evidence of request/offering is documented. i.e. Requested emergency contact information and member didn’t provide it, “refusal” is documented in the record; Requested completion of privacy notice and member refused to sign, “refusal” is documented in the record

When to use “N/A”
1. When the member is out of the age range or not the same gender for preventive services ie. Blood lead for 8 year old or mammogram for a male

2. When the preventive service is not indicated due to their medical history, 45 year old female with total abdominal hysterectomy or 50 year old male with total colectomyi.e. reviewers may add medical reason in the comment:

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.

Scoring Example:

Step 1: Add the points given in each section.
Step 2: Add the points given (Yes + R) for all six sections.
(Format points given)
(Documentation points given)
(Coordination 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.

$$\frac{\text{Total points given}}{\text{“Adjusted” total points possible}} \qquad \text{Example: } \frac{267}{305} = 0.875 \times 100 = 88\%$$

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

I. Format Criteria	
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.[1] "Family charts" are not acceptable.
A. Member identification is on each Page.	• Member identification includes first and last name, and a unique identifier established for use on clinical site. • Electronically maintained records and printed records from electronic systems must contain member identification.
B. Individual personal biographical information is documented.	Personal biographical information includes: ○ Date of birth ○ Current address ○ Home/work phone numbers ○ 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.
C. Emergency "contact" is identified.	The name and phone number of an "emergency contact" person is identified for all members. Listed emergency contacts may include: ○ 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.

[1] See the U.S. Department of Health and Human Services Summary of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, available at: https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html.

I. Format Criteria	
	• Next of kin category is not considered as an emergency contact. The member's emergency contact may be different from the next of kin.
D. Medical records are maintained and organized	• Contents and format of printed and/or electronic records within the practice site are uniformly organized, securely fastened, attached or bound to prevent medical record loss. • Hard copy printed documents shall belong to the medical record established for each member (e.g., reusing the blank side of printed documents from another member is not acceptable and should be scored a "0"). • Medical Record information should be readily available.
E. Member's assigned and/or rendering PCP is identified.	• The assigned and/or rendering 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. • Various methods can be 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. • If there is only one PCP/Practitioner onsite and is not identified, reviewer may score "N/A".
F. Primary language and linguistic service needs of non-or of limited-English proficiency (LEP) or hearing/speech-impaired persons are prominently noted.	• The primary language is prominently documented at least once in the medical record. • Language documentation is not necessary, score "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.[2]

[2] See All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language assistance Services, or any superseding APL. APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

I. Format Criteria	
G. Person or entity providing medical interpretation is identified.	• Requests for language and/or interpretation services by a non-or limited-English proficient member are documented. • Member refusal of interpreter services may be documented at least once and be accepted throughout the member's care unless otherwise specified. • If bilingual staff are asked to interpret or translate, they should be qualified to do so. Assessment of ability, training on interpreter ethics and standards, and clear policies that delineate appropriate use of bilingual staff, staff or contract interpreters and translators, will help ensure quality and effective use of resources. • Those utilizing the services of interpreters and translators should request information about certification, assessments taken, qualifications, experience, and training. Quality of interpretation should be a focus of concern for all recipients. • Family or friends should not be used as interpreters, unless specifically requested by the member and documented in the member's chart. • Minors (under 18 years old) accompanying member shall not be used as an interpreter. • The Affordable Care Act (ACA) 2010 section 1557: prohibits from using low-quality video remote interpreting services or relying on unqualified staff, translators when providing language assistance services. • Sign language interpreter services may be utilized for medically necessary health care services and related services such as obtaining medical history and health assessments, obtaining informed consents and permission for treatments, medical procedures, providing instructions regarding medications, explaining diagnoses, treatment and prognoses of an illness, providing mental health assessment, therapy or counseling. Various documents can be accepted to document linguistic service needs such as intake form, demographic form, Electronic Medical Record (EMR) fields, consent forms, etc. **Note:** See Commonly Asked Questions and Answers Regarding LEP Individuals, available at: https://www.lep.gov/faq/faqs-rights-lep-individuals/commonly-asked-questions-and-answers-regarding-limited-english. See also Title 22 California Code

I. Format Criteria	
	of Regulations (CCR) Section 51309.5. The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index.
H. Signed Copy of the Notice of Privacy	The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The right to inspect, review and receive a copy of the medical records is covered by the Privacy Rule.[3]

[3] See the U.S. Department of Health and Human Services Understanding of Some of HIPAA's Permitted Uses and Disclosures, available at: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/permitted-uses/index.html.

Rationale: Well-documented records facilitate communication and coordination and promote efficiency and effectiveness of treatment.

RN/NP/MD/PA/CNM/LM

II. Documentation Criteria	
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.[4]
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.[5]
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.[6]
D. Appropriate Consents are present.	1) Consent must be obtained prior to release of patient information.[7] 2) Adults, parents/legal guardians of a minor or emancipated minor may sign consent forms for operative and invasive procedures.[8] Persons under 18 years

[4] 22 CCR 70527 and 28 CCR 1300.80
[5] 22 CCR 70527 and 28 CCR 1300.80
[6] 22 CCR 70527 and 28 CCR 1300.80
[7] 22 CCR 73524, 22 CCR 51009, and Title 45, Code of Federal Regulations Section 164.524. The CFR is searchable at: https://www.ecfr.gov.
[8] 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

II. Documentation Criteria	
	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.[9] **Note:** Human sterilization requires the Department of Health Care Services (DHCS) Consent Form PM 330 if services are performed at the site.
E. Advance Health Care Directive information is offered. (Adults 18 years of 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.[10] The Physician Orders for Life-Sustaining Treatment (POLST) form and Five Wishes are acceptable if appropriately completed and signed by necessary parties.[11] **Note:** Advance Health Care Directive Information is reviewed with the member at least every 5 years and as appropriate to the member's circumstance.
F. All entries are signed, dated and legible.	**Signature** includes: • First initial, last name, and title of health care personnel providing care, including Medical Assistants. • Initials and titles 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. **Dated entries** include: • Month/day/year. • Entries are in reasonably consecutive order by date.

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)

[9] California Law is searchable at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml.

[10] See Probate Code, Section 4701, 42 CFR 422.128, 42 CFR 489.100, and APL 05-010.

[11] See AB 3000, Chapter 266, Statutes of 2008, available at: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=200720080AB3000.

II. Documentation Criteria	
	• 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. Only standard abbreviations are used. All medical record documentation must be in English.[12] **Note:** • In EMR, methods to document signatures (and/or authenticate initials) will vary and must be individually evaluated. • Signature page may be in the member's medical record or available elsewhere onsite and all previous and current employees who document in medical records need to be included on the signature page. • Reviewers should assess the log-in process and may need to request printouts of entries. See the Centers for Medicare and Medicaid Services' (CMS) Guidance on Medicaid Documentation for Medical Office Staff, available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-officestaff-factsheet.pdf.
G. Errors are corrected according to legal medical documentation standards.	• The person that makes the documentation error corrects the error. Example correction methods: • Single line drawn through the error, with the writer's initial and date written above or near the lined-through entry. • Single line and initial.

[12] ACA Section 1557

II. Documentation Criteria	
	• The corrected information is written as a separate entry and includes date of the entry, signature (or initials), and title. There are no unexplained cross-outs, erased entries or use of correction fluid. Both the original entry and corrected entry are clearly preserved. **Note:** Reviewers must determine the method used for error corrections for EMR on a case by case basis. This should include the log-in process and whether the EMR allows for corrections to be made after entries are made.

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

RN/NP/MD/PA/CNM/LM

III. Coordination Criteria	
A. History of present illness or reason for visit is documented.	Each focused visit (e.g., primary care, follow-up ER/urgent care, hospital discharge, etc.) includes a documented history of present illness or reason for visit.
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 or internal investigation per health plan policy 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 or internal investigation per health plan policy 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). • Every visit with the provider shall have follow-up instructions.
E. Unresolved 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.

III. Coordination Criteria	
	• Each problem need not be addressed at every visit as long as the provider documents a reason for deferring the unresolved problem(s) for subsequent visits. • Documentation demonstrates that the practitioner follows up with members about treatment regimens, recommendations, and counseling.
F. There is evidence of practitioner review of specialty/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. Evidence of practitioner review on any page of the report(s) or diagnostic result(s) that have multiple pages is acceptable.
G. There is evidence of follow-up of specialty/consult/referrals made, and results/reports of diagnostic tests, when appropriate.	Documentation includes: • Consultation reports and diagnostic test results for ordered requests. • Abnormal test results/diagnostic reports have explicit notation in the medical record or separate system, 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. If diagnostic appointments or referrals are documented in a separate system from medical records, they must be readily accessible and meet the medical retention requirements. **Note:**

III. Coordination Criteria	
	• Abnormal test results/diagnostic reports without follow-up documentation for specific pediatric or adult preventive screening criteria/diagnostic tests will be scored under this criterion. • If results are normal and there are no missing reports, then the reviewer may score "N/A" for this criterion. • If specific pediatric or adult preventive screenings are ordered and there is no documentation of normal results and/or follow-up, the reviewer shall score this under the appropriate preventive services criteria. • If the provider/staff does not follow up or attempt outreach to the member regarding a missed specialty referral, give a zero "0" score. Reviewer must assess the process of outreach efforts/follow-up contacts and documentation of attempts. The process must include at least one attempt for outreach/follow-up contact.
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. Missed and/or canceled appointments and contact attempts must be documented in the patient's medical record. **Note:** Reviewer must assess the process of outreach efforts/follow-up contacts and documentation of attempts. The process must include at least one attempt for outreach/follow-up contact.

Rationale: Pediatric preventive services are provided to members under 21 years of age in accordance with current American Academy of Pediatrics (AAP) bright future and US Preventive Task Force (USPSTF) recommendations. See the DHCS Boilerplate contract, available at: https://www.dhcs.ca.gov/provgovpart/Documents/2-Plan-Non-CCI-Boilerplate-Final-Rule-Amendment.pdf.

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IV. Pediatric Preventive Criteria	
A. Initial Health Appointment (IHA) includes H&P and Risk Assessment	**New Members** IHA must be completed within 120 days of plan enrollment or PCP effective date (whichever is more recent) or documented within the 12 months prior to Plan enrollment/PCP effective date. The IHA include a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases. A complete IHA 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. References: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-030.pdf or current version
1) Comprehensive History and Physical	**New members** The history must be comprehensive to assess and diagnose acute and chronic conditions it includes: ○ History of present illness ○ Past medical history ○ Social history ○ Review of Organ Systems (ROS) 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.

IV. Pediatric Preventive Criteria	
2) Member Risk Assessment	**New members** Initial Member Risk Assessments related to health and social needs of members, including cultural, linguistic, and health education needs; health disparities and inequities; lack of coverage/access to care; and social drivers of health (SDOH) shall be conducted. An assessment of at least one (1) of the following risk assessment domains within 120 days of the effective date of enrollment into the Plan or PCP effective date (whichever is more recent), or within the 12 months prior to Plan enrollment/PCP effective date meets the standard: • Health Risk Assessment: MCPs will not be required to retain the use of their existing HRA tools. If MCPs decide to retain existing HRA tools, they are encouraged to adapt them to allow delegation to providers • SDOH: The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples of SDOH includes housing instability, food insecurity, transportation needs, utility needs, interpersonal safety, etc. Documented assessments of SDOH in the progress notes or use of the following examples of SDOH screening tools meet the standard: o Social Needs Screening Tool • Adverse Childhood Experiences (ACEs) (birth to 64 years old): Potentially traumatic experiences, such as neglect, experiencing or witnessing violence, having a family member attempt or die by suicide, household with substance use problems, mental health problems and other experiences that occur in childhood that can affect individuals for years and impact their life opportunities. Examples of validated screening tools that meet the standards are as follows: o The Pediatric ACEs and Related Life-Events Screener (PEARLS) is used to screen children and adolescents ages 0-19 for ACEs. o The ACE Questionnaire for Adults is used to screen adults 18 years and older for ACEs. References: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-009.pdf https://www.cdc.gov/about/sdoh/index.html

IV. Pediatric Preventive Criteria	
	https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-017.pdf https://www.cdc.gov/violenceprevention/aces/fastfact.html
B. Subsequent Comprehensive Health Assessment	**Existing/Current Members** The examination must be comprehensive, focus on specific assessments that are appropriate for the child's or adolescent's age, developmental phase, and needs building on the history gathered earlier. The physical examination provides opportunities to identify silent or subtle illnesses or conditions and time for the health care professional to educate children and their parents about the body and its growth and development. See the AAP/Bright Futures Recommendations for Preventive Pediatric Health Care, available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf
1) Comprehensive History and Physical Exam completed at age-appropriate frequency	• Health assessments containing age-appropriate requirements are provided per the most recent AAP periodicity schedule. • Assessments and identified problems are documented in the progress notes. • Follow-up care or referral is provided for identified physical health problems as appropriate. **Note:** The AAP periodicity exam schedule is more frequent than the Child Health and Disability Prevention Program (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.[13]
2) Subsequent Risk Assessment	• Subsequent Member Risk Assessments shall be completed annually or more frequently if any significant changes in health status are identified. An assessment of at least one (1) of the above risk assessment domains (HRA, SDOH and ACEs) meets the standard. • https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf

[13] See the AAP/Bright Futures Recommendations for Preventive Pediatric Health Care, available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

IV. Pediatric Preventive Criteria	
C. Well-child Visit	The Bright Futures/AAP developed a set of comprehensive health guidelines for well-childcare, known as the "periodicity schedule."[14] It is a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence. **Screening** pertains to an assessment of the eligible population for presence of risk factors. • If the patient is positive for risk factors, (e.g., obesity, menstrual status, etc.) age and gender parameters of the criterion the provider shall offer and document appropriate follow-up intervention(s) (e.g., diagnostic testing, counseling, referral to specialist, documentation of patient refusal, etc.). • Providers who fail to document the presence or absence of risk factors shall receive zero points since the patient's risk status could not be determined and the preventive care criterion was not addressed. • Evidence of risk assessments and screenings for other preventive care criteria may be found in the progress notes, comprehensive history forms, or elsewhere in the medical record. **Note:** The AAP does not approve nor endorse any specific tool for screening purposes. Examples of screening tools are available at: https://www.aap.org/en/patient-care/screening-technical-assistance-and-resource-center/screening-tool-finder/?page=1 https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx
1) Alcohol Use Disorder Screening and Behavioral Counseling	Per AAP recommendations, alcohol use disorder screening and behavioral counseling should begin at 11 years of age. If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s). Brief Assessment and Screening

[14] The Bright Futures/AAP periodicity schedule is available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

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	When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use is present. Validated assessment tools may be used without first using validated screening tools. The AAP recommended assessment tool is available at: http://crafft.org. Brief Interventions and Referral to Treatment When brief assessments reveal unhealthy alcohol use, brief misuse counseling with appropriate referral for additional evaluation and treatment options, referrals, or services must be offered. Brief interventions must include the following: • Providing feedback to the patient regarding screening and assessment results; • Discussing negative consequences that have occurred and the overall severity of the problem; • Supporting the patient in making behavioral changes; and • Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated. The AAP/Bright Futures periodicity schedule is available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf For details on Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment, refer to APL 21-014 or any superseding APL. Please refer to the link below to The Medi-Cal Provider Manual: https://www.dhcs.ca.gov/formsandpubs/publications/Pages/Manuals.aspx
2) **Anemia Screening**	Per AAP, perform risk assessment or screening at 4, 15, 18, 24, and 30 months, 3 years old, and then annually thereafter. Test serum hemoglobin at 12 months old. If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s). Acceptable evidence of anemia screening: evaluate patient's diet, nutrition supplement intake, menstrual status, medical history for chronic conditions, etc.

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	Chronic conditions to assess that are associated with anemia: ○ A diet consistently low in iron, vitamin B-12 and folate ○ Heavy Menstruation. See link for signs of heavy menstrual bleeding: https://www.acog.org/womens-health/faqs/heavy-menstrual-bleeding ○ Pregnancy ○ Slow, chronic blood loss from an ulcer; Crohn's disease, celiac disease, cancer, kidney failure, diabetes, etc. The Bright Futures/AAP periodicity schedule is available at: https://www.aap.org/en-us/documents/periodicity_schedule.pdf. See the National Institutes of Health information on Anemia, available at: https://www.nhlbi.nih.gov/health-topics/anemia#:~:text=Some%20people%20are%20at%20a,such%20as%20chemotherapy%20for%20cancer. See the Center for Disease Control and Prevention's (CDC) information on heavy menstrual bleeding, available at: https://www.cdc.gov/ncbddd/blooddisorders/women/menorrhagia.html.
3) Anthropometric measurements	For each well exam: • Infants up to 24 months old: assess for length/height and head circumference (HC). Measurements are plotted in a World Health Organization (WHO) growth chart. • 2-21 years old: assess for height, weight, and body mass index (BMI) measurements are plotted in a CDC growth chart. • Provider should measure and track BMI to identify patient at risk for being overweight, obese, or underweight. Patients identified as overweight and/or obese are provided counseling for nutrition to promote healthy eating habits and regular physical activity. For additional information on anthropometric measurements, refer to the following link: https://www.dhcs.ca.gov/services/chdp/Documents/HAG/4AnthropometricMeasure.pdf

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	Note: Site is deficient if anthropometric measurements are not plotted on the appropriate growth chart.[15]
4) Anticipatory Guidance	• Must be documented at each well child visit. • Is given by the health care provider to assist parents or guardians in the understanding of the expected growth and development of their children. • Specific to the age of the patient, includes information about the benefits of healthy lifestyles and practices that promote injury and disease prevention https://brightfutures.aap.org/Bright%20Futures%20Documents/BF_PreventiveServices_Tipsheet.pdf#search=document%20anticipatory%20document
5) Autism Spectrum Disorder (ASD) Screening	ASD screening must be performed at 18 months and 24 months of age based on AAP periodicity "Bright Futures". If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s). ASD screening tools examples: ○ Ages and Stages Questionnaires (ASQ) ○ Communication and Symbolic Behavior Scales (CSBS) ○ Parents' Evaluation of Developmental Status (PEDS) ○ Modified Checklist for Autism in Toddlers (MCHAT) ○ Screening Tool for Autism in Toddlers and Young Children (STAT) ○ Survey of Well-being of Young Children (SWYC) screening tools (assess three domains of child functioning: developmental domain, emotional/behavioral domain, and family context) Refer to APL 19-014, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21, and APL 19-010, Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21, or any superseding APLs for more information on ASD. Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder"

[15] CDC growth charts are available at: https://www.cdc.gov/growthcharts/.

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	Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening", available at: https://pediatrics.aappublications.org/content/145/1/e20193449. See the AAP publication regarding Identification, Evaluation, and Management of Children with ASD, available at: https://pediatrics.aappublications.org/content/145/1/e20193447. See the Tufts Children's Hospital Survey of Well-being of Young Children, available at: https://www.tuftschildrenshospital.org/The-Survey-of-Wellbeing-of-Young-Children/Overview. See the AAP Screening Tools, available at: https://screeningtime.org/star-center/#/screening-tools
6) Blood Lead Screening	• Children receiving health services through publicly funded programs must receive anticipatory guidance on lead poisoning prevention at each periodic health assessment, starting at 6 months of age and continuing until 72 months of age. • Provider shall offer and document appropriate follow-up intervention(s) for patient whose screen reveals elevated Blood Lead Levels. Medi-Cal managed care health plans (MCPs) must ensure that the providers 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. Childhood Lead Poisoning Prevention Branch (CLPPB) anticipatory guidance includes information about other common sources of lead exposure for children.[16]

[16] The CLPPB Guidance is available at: https://vchca.org/images/public_health/VCCHDP/Chapter6.pdf.

<table>
<tr><th colspan="2">IV. Pediatric Preventive Criteria</th></tr>
<tr><td></td><td>Spanish version:
https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/CDPH%20Document%20Library/CLPPB-antguid(S).pdf.

Order or perform blood lead screening tests on all child members in accordance with the following:
• At 12 months and at 24 months of age.
• 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.
• 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.
• At any time, a change in circumstances has, in the professional judgement of the network provider, put the child member at risk.
• If requested by the parent or guardian.

Follow the CDC Recommendations for Post-Arrival Lead Screening of Refugees contained in the CLPPB issued guidelines.[17]

<u>Note</u>: Network providers are not required to perform a blood lead screening test if either of the following applies:
• 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.
• If a parent, guardian, or other person with legal authority to withhold consent for the child refuses to consent to the screening.

Evidence of provider compliance of blood lead screening test if not performed:
• The provider 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, the provider must obtain a signed statement of voluntary refusal by parent or guardian.</td></tr>
</table>

[17] The CDC Recommendations are available at: https://www.cdc.gov/immigrantrefugeehealth/guidelines/lead-guidelines.html.

If the provider is unable to obtain a signed statement of voluntary refusal because the party that withheld consent, refuses or declines to sign it, or is unable to sign it (e.g., when services are provided via telehealth modality), it is acceptable for the provider to document the refusal.

See APL 20-016, Blood Lead Screening of Young Children, or any superseding APL for more information.

Please refer to California Department of Public Health (CDPH) CLPPB and the CDC for recommended actions based on BLL levels:

- Information on how to report blood lead screening test results to CLPPB can be found at: https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/report_results.aspx.
- Health care providers using a point-of-care device are considered laboratories and must report.[18]
- See the CDC Guidance on Childhood Lead Poisoning Prevention, available at: https://www.cdc.gov/nceh/lead.
- See the California Management Guidelines on Childhood Lead Poisoning for Health Care Providers publication, available at: https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/prov.aspx
- For children at risk of lead exposure, see “Prevention of Childhood Lead Toxicity”, available at: https://publications.aap.org/pediatrics/article-pdf/138/1/e20161493/929122/peds_20161493.pdf, and “Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention”, available at: https://www.cdc.gov/nceh/lead/acclpp/final_document_030712.pdf

[18] See Health and Safety Code Section 124130. State law is searchable at: https://leginfo.legislature.ca.gov/faces/home.xhtml.

IV. Pediatric Preventive Criteria	
7) Blood Pressure Screening	• Per AAP, blood pressure screening starts at 3 years old. • In infants and children with specific risk conditions, blood pressure measurements should be performed at visits before age 3 years. • Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveals elevated blood pressure. In persons aged 3-18 years, the prevalence of hypertension is 3.6 %. Evidence suggests that elevated blood pressure in childhood increases the risk for adult Hypertension and Metabolic Syndrome. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents", available at: http://pediatrics.aappublications.org/content/140/3/e20171904 See the Bright Futures Medical Screening Reference Table, available at: https://brightfutures.aap.org/Bright%20Futures%20Documents/MSRTable_InfancyVisits_BF4.pdf. See the AAP guidance on Clinical Practice Guidelines for Screening and Management of High Blood Pressure in Children and Adolescents, available at: https://publications.aap.org/pediatrics/article/140/3/e20171904/38358/Clinical-Practice-Guideline-for-Screening-and
8) Dental/Oral Health Assessment	• Per DHCS contracts, the provider is responsible for ensuring that dental screening/oral health assessment for all members are included as part of the IHA.[19] • Inspection of the mouth, teeth, and gums is performed at every health assessment visit and refer to a dentist if a dental problem is detected or suspected. • Per AAP, referral to a dental home begins at 12 months. If patients do not have an established dental home after 12 months, continue performing an oral health risk assessment and refer to a dental home.[20]

[19] For additional information, see the MCP Contract, Exhibit A, Attachment 11, Provision 15.
[20] See the AAP Oral Health Practice Tools, available at: https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/.

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	• Documentation of “HEENT” is acceptable. See the Caries-risk Assessment and Management for Infants, Children, and Adolescents, available at: https://www.aapd.org/media/Policies_Guidelines/BP_CariesRiskAssessment.pdf See the AAP guidance on Fluoride Use in Caries Prevention in the Primary Care Setting, available at: http://pediatrics.aappublications.org/content/134/3/626.
a. Fluoride Supplementation	• The AAP and USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride. • Parents or legal guardian should be encouraged to check with local water utility agency if water has fluoride. • If local water does not contain fluoride, provider may recommend the purchase of fluoridated water or give prescription for fluoride drops or tablets. • Per AAP, fluoride supplementation for all children ages 6 months until their fifth-year birthday (age range according to the most current AAP periodicity schedule) whose daily exposure to systemic fluoride is deficient. For the fluoridation status of a community water supply, contact the local water department or the link for “My Water’s Fluoride”, available at: https://nccd.cdc.gov/doh_mwf/default/default.aspx See the AAP’s guidance on Maintaining and Improving the Oral Health of Young Children, available at: http://pediatrics.aappublications.org/content/134/6/1224. See the USPSTF guidance on Dental Caries in Children Younger Than 5 Years, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1 Comment: USPSTF changed their recommendation as of 12/7/21 which is what AAP is referencing in the AAP periodicity schedule footnote 35 and 36.

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	See guidance on fluoride supplementation, available at: https://publichealth.nc.gov/oralhealth/library/includes/IMBresources/2020-FluorideSupplementation.pdf#:~:text=Pediatric%20Dentistry%20%28AAPD%29%20recommend%20the%20daily%20administration%20of,years%20of%20age%20to%20provide%20the%20maximum%20benefits.
b. Fluoride Varnish	• Fluoride varnish is a dental treatment that can help prevent tooth decay, slow it down, or stop it from getting worse by strengthening the tooth enamel (outer coating on teeth). • AAP recommends that fluoride varnish be applied to the teeth of infants and children starting at tooth eruption until their fifth-year birthdate (age range according to the most current AAP periodicity schedule). All children in this category should receive fluoride varnish application at least once every 3-6 months in the primary care or dental office. **Note:** Documentation of "seeing a dentist" without specific notation that fluoride varnish was applied at the dentist office does not meet the criterion. Not all dentists routinely apply fluoride varnish during routine dental visits. See the USPSTF guidance on Dental Caries in Children Younger Than age 5 Years, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1. See APL 19-010, Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21, for additional guidance on fluoride varnish. See the AAP publication on Maintaining and Improving the Oral Health of Young Children, available at: https://publications.aap.org/pediatrics/article/134/6/1224/33112/Maintaining-and-Improving-the-Oral-Health-of-Young.

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9) Depression Screening	• AAP recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 20 years. • Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up if screening is positive and a follow up plan is documented. • Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening is positive for depression. • Depression screening must be done using a validated screening tool. Per AAP, screen using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit, and available at: https://downloads.aap.org/AAP/PDF/Mental_Health_Tools_for_Pediatrics.pdf and https://www.aap.org/en/patient-care/screening-technical-assistance-and-resource-center/screening-tool-finder/?page=1
a) Suicide Risk Screening	Anyone who screens positive on a suicide risk screening tool should be followed up with a brief suicide safety assessment. Age Recommendations for Screening: • Universal Screening for children 12 years and older • Patients ages 8-11 should be screened for suicide risk when they are presenting with behavioral health chief complaints, if the patient or parent raises a concern, if there is a reported history of suicidal ideation or behavior, or if the patient displays warning signs of suicide. • Youth under age 8: Screening not indicated. Assess for suicidal thoughts/behaviors if warning signs are present ○ Warning signs of suicide risk that requires further evaluation in children under age 8 include (but not limited to): ○ Talking about wanting to die or wanting to kill oneself ○ Actions such as grabbing their throat in a “choking” motion, or placing their hands in the shape of a gun pointed toward their head ○ Engaging in self-harming behaviors ○ Acting with impulsive aggression ○ Giving away treasured toys or possessions

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	Examples of Screening Tools: • Ask Suicide-Screening Questions (ASQ) • Suicide Behavior Questionnaire-Revised (SBQ-R) • Other publicly available tools that are commonly used in primary care settings: • Columbia Suicide Severity Rating Scale (C-SSRS) – Triage Version • Patient Health Questionnaire – 9 Adolescent Version (PHQ-9A) • Patient Safety Screener – 3 (PSS-3) References: • https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/strategies-for-clinical-settings-for-youth-suicide-prevention/screening-for-suicide-risk-in-clinical-practice/ • https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/strategies-for-clinical-settings-for-youth-suicide-prevention/conducting-a-brief-suicide-safety-assessment/
b) Maternal Depression Screening	• Maternal mental health condition is defined as a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression. • Maternal depression screen at 1-, 2-, 4-, and 6-month visits. • Maternal depression screening must be done using a validated screening tool, such as the Edinburgh Postnatal Depression Scale (EPDS), Postpartum Depression Screening Scale, or Patient Health Questionnaire (PHQ) 9.[21] • As with any screening test, results should be interpreted within the clinical context and when appropriate referral to the PCP and/or to mental health care providers for follow up.[22] • Provider shall offer and document appropriate follow-up intervention(s) for women whose screening is positive for maternal depression.

[21] See the American College of Obstetricians and Gynecologists (ACOG) guidance on Screening for Perinatal Depression, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/11/screening-for-perinatal-depression.

[22] For additional resources on perinatal depression, see: http://www.acog.org/More-Info/PerinatalDepression.

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	Assembly Bill (AB) 2193 requires provider who provides prenatal or postpartum care for a patient to offer to screen or appropriately screen a mother for maternal mental health conditions.[23] It also requires interpregnancy care providers to do the same when the patient has experienced a stillbirth or miscarriage. (Health and Safety Code, section 123640 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=123640.&lawCode=HSC), with the most recent version effective 1/1/2022, as amended by AB 1477. Per AAP, "screening should occur per 'Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice', available at: https://pediatrics.aappublications.org/content/143/1/e20183259 See the ACOG Frequently Asked Questions on Postpartum Depression, available at: https://www.acog.org/Patients/FAQs/Postpartum-Depression. See the USPSTF recommendation on Screening Depression in Adults, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening1 See the U.S. Department of Health and Human Services guidance on Postpartum Depression, available at: https://www.womenshealth.gov/mental-health/mental-health-conditions/postpartum-depression.
10) Developmental Disorder Screening	• Screen for developmental disorders at the 9th, 18th, and 30th month visits. • 30th month screening can be done at 24 months. • Providers must use an AAP validated screening tool that must also be a global, not domain specific, consistent with criteria set forth in the CMS Technical Specifications. • Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening is positive for developmental disorder.

[23] AB 2193 (Chapter 755, Statutes of 2018) is available at: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB2193.

IV. Pediatric Preventive Criteria	
	• The CMS Technical Specifications are consistent with age recommendations and use of a validated screening tool; however, tech spec excludes MCHAT tool which AAP allows. CMS determined that the ASQ: SE and M-CHAT screening tools were too specific because they screen for a domain-specific condition (social emotional development or autism, respectively), rather than a full, general assessment of developmental delays. For detailed information on the CMS Technical Specifications please refer to the link: https://www.medicaid.gov/license/form/6466/4391. The developmental screening measure starts on page 65. Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children with Developmental Disorders Through Developmental Surveillance and Screening", available at: https://pediatrics.aappublications.org/content/145/1/e20193449.
11) Developmental Surveillance	Developmental surveillance is a component of every well care visit. If the patient is positive for potential delays, provider shall offer and document appropriate follow-up intervention(s).
12) Drug Use Disorder Screening and Behavioral Counseling	Per AAP recommendations, drug use screening and behavioral counseling should begin at 11 years of age. Provider shall offer and document appropriate follow-up interventions for patient whose screening reveals unhealthy drug use. Brief Assessment and Screening When a screening is positive, validated assessment tools should be used to determine if unhealthy drug use is present. Validated drug assessment tools may be used without first using validated screening tools. The AAP recommended assessment tool is available at: http://crafft.org. Brief Interventions and Referral to Treatment When brief assessments reveal unhealthy drug use, brief misuse counseling with appropriate referral for additional evaluation and treatment options, referrals, or services must be offered.

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	Brief interventions must include the following: • Providing feedback to the patient regarding screening and assessment results; • Discussing negative consequences that have occurred and the overall severity of the problem; • Supporting the patient in making behavioral changes; and • Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated. See APL 21-014 or any superseding APL for details on Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment. See the AAP guidance on Substance Use Screening, Brief Intervention, and Referral to Treatment, available at: https://pediatrics.aappublications.org/content/138/1/e20161211.
13) Dyslipidemia Screening	Family history of obesity, diabetes, hypertension, and heart disease is commonly associated with a combined dyslipidemia. Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveals dyslipidemia. Per AAP perform a risk assessment at: ○ 2, 4, 6, and 8 years old, then annually thereafter. ○ Order one lipid panel between 9 and 11. ○ Perform again between 17 and 21 years old to identify children with genetic dyslipidemia or more lifestyle-related dyslipidemia. For more information see “Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents”, available at: https://www.nhlbi.nih.gov/health-topics/integrated-guidelines-for-cardiovascular-health-and-risk-reduction-in-children-and-adolescents For more information on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents, see: https://www.nhlbi.nih.gov/node/80308 https://brightfutures.aap.org/Pages/default.aspx

IV. Pediatric Preventive Criteria	
14) Hearing Screening	Per AAP audiometric screenings are performed at: ○ Birth to 2 months old, 4, 5, 8, and 10 years old ○ Once between 11-14 years old ○ Once between 15-17 years old ○ Once between 18-21 years old Per AAP, clinicians must confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs", available at: http://pediatrics.aappublications.org/content/120/4/898.full. 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, the primary care provider must make a referral to a specialist. • Non-audiometric assessments shall be performed at each health assessment visit until the child reaches 21 years old and includes an assessment of birth/family history (hearing loss in the family), history of ear infection and the signs and symptoms of hearing loss (i.e. does not startle at loud noises, does not turn to the source of a sound after 6 months of age, speech is delayed and unclear, often says, "Huh?", turns the TV volume up too high, etc.). • Audiometric testing is performed using a newborn hearing screening test (e.g. Automated Auditory Brainstem Response [AABR] or Otoacoustic Emission [OAE] technology) at the birth hospital or specialty facility; or a Behavioral Audiometry Evaluation with an audiometer at the primary care facility starting at 4 years old and includes follow-up care as appropriate. See the AAP periodicity schedule, available at: www.aap.org/periodicityschedule. See the CDC recommendations and guidelines on Hearing Loss in Children, available at: https://www.cdc.gov/ncbddd/hearingloss/recommendations.html. See the CDC guidance on Hearing Screenings for Children, available at: https://www.cdc.gov/ncbddd/hearingloss/screening.html.

IV. Pediatric Preventive Criteria	
	For more information on Hearing Loss in Children, see: https://www.cdc.gov/ncbddd/hearingloss/facts.html.
15) Hepatitis B Virus Infection Screening	Chronic HBV infection in children is typically asymptomatic and blood tests for liver enzymes may be normal. Appropriate screening, postexposure, prophylaxis and vaccination are the keys to prevention. • Evidence of serum HBsAg, along with anti-HBs, which is the most effective screening tool for HBV infection. A lack of anti-HBs identifies susceptible children who need vaccination. Children found to be HBsAg-positive should be retested 6 months later to document chronic infection • The CDC recommends: o children born in the United States to immigrant parents from endemic areas be screened o children born to HBsAg-positive mothers should be tested (generally at 1 year of age) o children who live in a household with a known HBsAg-positive person(s) should be screened References: https://www.cdc.gov/hepatitis/hbv/testingchronic.htm https://publications.aap.org/pediatrics/article/124/5/e1007/72122/Recommendations-for-Screening-Monitoring-and https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/Immunization/PerinatalHepB-PediatricProviderQuicksheet.pdf
16) Hep C Virus Infection Screening	• Per AAP, all individuals 18 and older should be assessed for risk of hepatitis C virus (HCV) infection. • Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveal potential for Hepatitis C Virus infection. • Per USPSTF and CDC, test at least once between the ages of 18 and 79. Persons with increased risk of HCV infection, including those who are persons with past or

IV. Pediatric Preventive Criteria	
	current injection drug use, should be tested for HCV infection and reassessed annually.[24] . For more information refer to Hepatitis C Virus Infection in Adolescents and Adults: Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening.
17) HIV Screening	• Per AAP, risk assessment for HIV shall be completed at each well child visit starting at 11 years old. • Adolescents should be tested for HIV according to the USPSTF recommendations once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent.[25] • Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually. If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s). Recommendations for STD screening are listed in Box 3 at: https://www.cdc.gov/mmwr/volumes/68/rr/rr6805a1.htm#B3_down. Additional information on screening recommendations is available at: https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm; https://stacks.cdc.gov/view/cdc/82088. The CDC Recommendations for Providing Quality STD Clinical Services is available at: https://www.cdc.gov/mmwr/volumes/68/rr/rr6805a1.htm. For additional information on clinical considerations for risk assessment, screening intervals, treatment, and prevention, see: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening

[24] See the USPSTF recommendations on HCV screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening, and the CDC recommendations on HCV screening, available at: https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm.
[25] See the USPSTF recommendation on HIV screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening

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	The AAP periodicity schedule is available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf For those at risk, look for documented evidence that pre-exposure prophylaxis (PrEP) was offered.
18) Psychosocial/Behavioral Assessment	• Psychosocial/Behavior Assessment should be done at each well child visit. • This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. • **Note: Social Determinants Of Health (SDOH)** • Per AAP, social determinants of health (SDOH) are the web of interpersonal and community relationships experienced by children, parents, and families. • Per CDC, social determinants of health (SDOH) are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality of life risks and outcomes. https://brightfutures.aap.org/Bright%20Futures%20Documents/BF_IntegrateSDoH_Tipsheet.pdf https://www.cdc.gov/socialdeterminants/about.html See the AAP publication titled "Promoting Optimal Development: Screening for Behavioral and Emotional Problems", available at: http://pediatrics.aappublications.org/content/135/2/384. See the AAP publication titled "Poverty and Child Health in the United States", available at: http://pediatrics.aappublications.org/content/137/4/e20160339 https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.
19) Sexually Transmitted Infections	Per AAP, adolescents should be screened for STIs per recommendations in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases. • Sexual activity shall be assessed at every well child visit starting at 11 years old.

<table>
<tr><th colspan="2">IV. Pediatric Preventive Criteria</th></tr>
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If adolescents are identified as sexually active the provider shall offer and provide contraceptive care with the goals of helping teens reduce risks and negative health consequences associated with adolescent sexual behaviors, including unintended pregnancies and STIs.
For adolescents that have been pregnant, provider should engage in a discussion of counseling on inter-pregnancy intervals and contraceptive care, such as moderately and most effective contraceptive options.

Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveals STI.AAP refers to CDC for full list of STIs, available at:

https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm
https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/California-STI-Treatment-Guidelines.aspx

Risk assessments for Adolescents and 24 years and younger: Annual chlamydia and gonorrhea screenings should be done for sexually active women under age 25 as well as older women who are at risk. Screening for syphilis, HIV, chlamydia, and Hepatitis B should be given to all pregnant women, and gonorrhea screening for all pregnant women.[26]
Men Who Have Sex with Men (MSM): These men have higher rates of STIs, such as HIV and syphilis and should be tested for these as well as chlamydia, and gonorrhea.
Men Who Have Sex with Women: There is insufficient evidence for screening among heterosexual men who are at low risk for infection, however, screening young men can be considered in high prevalence clinical settings (adolescent clinics, correctional facilities, and STI/sexual health clinic).
Sex Workers: This population is at higher risk for HIV and other STIs than others, and should be tested at least annually for HIV.
Transgender and Gender Diverse Persons: Screening recommendations should be adapted based on anatomy, (i.e., annual, routine screening for Chlamydia in cis-gender women < 25 years old should be extended to all transgender men and

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[26] See the AAP guidance on Screening and Nonviral STIs in Adolescents and Young Adults: https://publications.aap.org/pediatrics/article/134/1/e302/62344/Screening-for-Nonviral-Sexually-Transmitted, the AAP periodicity schedule, available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf, and the AAP guidance on Adolescent Sexual Health, available at: https://www.aap.org/en/patient-care/adolescent-sexual-health/.

	gender diverse people with a cervix. Consider screening at the rectal site based on reported sexual behaviors and exposure. **Persons with HIV**: For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter. More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology. **Syphilis** • People who are pregnant • Male adolescents and young adults in settings with high prevalence rates (e.g. jails or juvenile correction facilities) • MSM at least annually (every 3 to 6 months if high risk because of multiple or anonymous partners, sex in conjunction with illicit drug use, or having sex partners who participated in these activities) See the AAP guidance on Adolescent Sexual Health, available at: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/adolescent-sexual-health/Pages/default.aspx See the DHCS webpage on the Staying Healthy Assessment, available at: https://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx. For information on chlamydia and gonorrhea screening. see: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/chlamydia-and-gonorrhea-screening. For USPSTF information on syphilis screening, see: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/syphilis-infection-in-nonpregnant-adults-and-adolescents. Senate Bill (SB) 306 (Pan, Chapter 486, Statutes of 2021) https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB306 https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=120685&lawCode=HSC
20) Sudden Cardiac Arrest	SCA and SCD screening should be performed for all children (athlete or not) at the same time as the Pediatric Physical Examination or at a minimum of every 3 years or on entry into middle or junior high school and into high school. AAP recommended 4

<table>
<tr><th colspan="2">IV. Pediatric Preventive Criteria</th></tr>
<tr><td></td><td>questions directed toward SCA and SCD detection for which a positive response suggested an increased risk for SCA and SCD
• Have you ever fainted, passed out, or had an unexplained seizure suddenly and without warning, especially during exercise or in response to sudden loud noises, such as doorbells, alarm clocks, and ringing telephones?
• Have you ever had exercise-related chest pain or shortness of breath?

• Has anyone in your immediate family (parents, grandparents, siblings) or other, more distant relatives (aunts, uncles, cousins) died of heart problems or had an unexpected sudden death before age 50? This would include unexpected drownings, unexplained auto crashes in which the relative was driving, or SIDS

• Are you related to anyone with HCM or hypertrophic obstructive cardiomyopathy, Marfan syndrome, ACM, LQTS, short QT syndrome, BrS, or CPVT or anyone younger than 50 years with a pacemaker or implantable defibrillator?

A positive response from the 4 questions above or an abnormal ECG should prompt further investigation that may include referral to a pediatric cardiologist or pediatric electrophysiologist.

https://www.aap.org/en/news-room/news-releases/aap/2021/american-academy-of-pediatrics-all-children-should-be-screened-for-potential-heart-related-issues/

https://publications.aap.org/pediatrics/article/148/1/e2021052044/179969/Sudden-Death-in-the-Young-Information-for-the</td></tr>
<tr><td>21)Tobacco Use Screening</td><td>Tobacco Use Screening, Prevention, and Cessation Services

• Screen all children 11 years and older at each well child visit for tobacco products use.</td></tr>
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IV. Pediatric Preventive Criteria	
	• Tobacco products include but not limited to smoked cigarettes, chewed tobacco, electronic cigarette, and vaping products use, and/or exposure to secondhand smoke. • At any time the PCP identifies a potential tobacco use problem, then the provider shall document prevention and/or cessation services to potential/active tobacco users. • Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveal tobacco use. Tobacco cessation services must be documented in the patient's medical record as follows: 1) Initial and annual assessment of tobacco (e-cigarette, vaping products, and/or secondhand smoke) use for each adolescent (11-21 years of age). 2) FDA-approved tobacco cessation medications (for non-pregnant adults of any age). 3) Individual, group, and telephone counseling for members of any age who use tobacco products. 4) Services for pregnant tobacco users. 5) Prevention of tobacco use in children and adolescents (including counseling and pharmacotherapy). For information on comprehensive tobacco prevention and cessation services for Medi-Cal beneficiaries is available at, see APL 16-014, Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries, or any superseding APL. The AAP recommended assessment tool is available at: http://crafft.org.
22) Tuberculosis Screening	• Per AAP, Committee on Infectious Diseases, published in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases, testing should be performed on recognition of high-risk factors. • All children are assessed for risk of exposure to tuberculosis (TB) at 1, 6, and 12-months old and annually thereafter.

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	• Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveals positive risk factors for TB. • Two tests that are used to detect TB bacteria in the body: the TB skin test (TST) (Mantoux) and TB blood tests QuantiFERON-TB Gold Plus. A positive TB skin test or TB blood test only tells that a person has been infected with TB bacteria. 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). • Providers are required to follow current CDC and American Thoracic Society guidelines for TB diagnosis and treatment. The California Pediatric Tuberculosis Risk Assessment tool is available at: https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-Pediatric-TB-Risk-Assessment.pdf. CDC guidance on TB testing and diagnosis is available at: https://www.cdc.gov/tb/topic/testing/default.htm.
23) Vision Screening	• Age-appropriate visual screening occurs at each health assessment visit, with referral to optometrist/ophthalmologist as appropriate. • Per AAP, visual acuity screenings using optotypes (figures or letters of different sizes used for vision screening) are to be performed at ages 3 (if cooperative), 4, 5, 6, 8, 10, 12, and 15 years old. • Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. • Documentation of “PERRLA” is acceptable for children below the age of 3 years. • If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s). • AAP recommended eye charts are: ○ LEA Symbols (3-5 years old)

IV. Pediatric Preventive Criteria	
	○ HOTV Chart (3-5 years old) ○ Sloan Letters (preferred) or Snellen Letters (over 5 years old) See the AAP publications titled "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" available at: http://pediatrics.aappublications.org/content/137/1/e20153596 and "Procedures for the Evaluation of the Visual System by Pediatricians", available at: http://pediatrics.aappublications.org/content/137/1/e20153597. **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, ophthalmoscopy red reflex examination, or corneal penlight evaluation. Visual acuity screening usually begins at age 3 years. AAP guidance on Visual System Assessment in Infants, Children, and Young Adults by Pediatricians is available at: https://pediatrics.aappublications.org/content/137/1/e20153596.
D) Childhood Immunizations	Every visit should be an opportunity to update and complete a child's immunizations. Childhood Immunizations Schedules, per the AAP Committee on Infectious Diseases, are available at: https://redbook.solutions.aap.org/SS/immunization_Schedules.aspx. For reference, see the CDC's ACIP webpage, available at: https://www.cdc.gov/vaccines/acip/index.html, also see APL 18-004, Immunization Requirements, or any superseding APL For details on Immunization Requirements.
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 ACIP guidelines, unless medically contraindicated, vaccine shortage or refused by the parent. Refer to the following link for more information on ACIP Vaccine Recommendations and Guidelines: https://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

IV. Pediatric Preventive Criteria	
2) Vaccine administration documentation	The name, manufacturer, date of administration, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries, in accordance with the National Childhood Vaccine Injury Act. For additional details on the National Childhood Vaccine Injury Act, refer to: https://www.congress.gov/bill/99th-congress/house-bill/5546
3) Vaccine Information Statement (VIS) documentation	• VISs are information sheets produced by the CDC that explain both the benefits and risks of a vaccine to the vaccine recipients. • Federal law requires that healthcare staff provide a VIS to a patient, parent, or legal representative before each dose of certain vaccines. VIS documentation in the medical/electronic record, medication logs, or immunization registries include the date the VIS was given or presented/offered *and* the VIS publication date. Refer to the following link from the CDC for the current VISs: https://www.cdc.gov/vaccines/hcp/vis/current-vis.html. **Note:** Federal law allows up to 6 months for the updated VIS to be distributed.

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/NP/MD/PA/CNM/LM

V. Adult Preventive Criteria	
A. Initial Health Appointment (IHA): Includes H&P and Risk Assessment	**New Members** IHA must be completed within 120 days of plan enrollment or PCP effective date (whichever is more recent) or documented within the 12 months prior to Plan enrollment/PCP effective date. The IHA include a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases. https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-030.pdf or current version
1) Comprehensive History and Physical	**New members**: The history must be comprehensive to assess and diagnose acute and chronic conditions it includes: o History of present illness o Past medical history o Social history o Review of Organ Systems (ROS) including dental assessment Referrals for any abnormal findings must be documented. 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. A review of the organ systems that include documentation of "inspection of the mouth" or "seeing dentist" meets the criteria for dental assessment during a comprehensive history and physical.
	New members:

V. Adult Preventive Criteria	
2) Member Risk Assessment	Initial Member Risk Assessments related to health and social needs of members, including cultural, linguistic, and health education needs; health disparities and inequities; lack of coverage/access to care; and social drivers of health (SDOH) shall be conducted. An assessment of at least one (1) of the following risk assessment domains within 120 days of the effective date of enrollment into the Plan or PCP effective date (whichever is more recent), or within the 12 months prior to Plan enrollment/PCP effective date meets the standard: • Health Risk Assessment: MCPs will not be required to retain the use of their existing HRA tools. If MCPs decide to retain existing HRA tools, they are encouraged to adapt them to allow delegation to providers • SDOH: The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples of SDOH includes housing instability, food insecurity, transportation needs, utility needs, interpersonal safety, etc. Documented assessments of SDOH in the progress notes or use of the following examples of SDOH screening tools meet the standard: o Social Needs Screening Tool • Cognitive Health Assessment (65 years and older): Annual cognitive assessment for Medi-Cal members to identify whether the patient has signs of Alzheimer's disease or related dementias. Examples of validated screening tools that meet the standard are as follows: o General Practitioner Assessment of Cognition (GPCOG) o Mini-Cog o Eight-item Informant Interview to Differentiate Aging and Dementia • Adverse Childhood Experiences (ACEs) (birth to 64 years old): Potentially traumatic experiences, such as neglect, experiencing or witnessing violence, having a family member attempt or die by suicide, household with substance use problems, mental health problems and other experiences that occur in childhood that can affect individuals for years and impact their life opportunities. Examples of validated screening tools: o The ACE Questionnaire for Adults is used to screen adults 18 years and older for ACEs. References: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf

V. Adult Preventive Criteria	
	https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-025.pdf https://mini-cog.com/wp-content/uploads/2022/03/Standardized-English-Mini-Cog-1-19-16-EN_v1-low-1.pdf https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-009.pdf https://www.cdc.gov/about/sdoh/index.html https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-025.pdf https://www.alz.org/media/documents/gpcog-screening-test-english.pdf
B. Periodic Health Evaluation according to most recent USPSTF guidelines	The type, quantity, and frequency of preventive services is based on the most recent USPSTF recommendations.
1) Comprehensive History and Physical Exam completed at age-appropriate frequency.	• Periodic health evaluations occur in accordance with the frequency that is appropriate for individual risk factors. • 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.
2) Subsequent Risk Assessment	• Risk Assessment including social, cultural and health education needs, is completed by the member or parent/guardian must be completed annually or any significant change of health status. An assessment of at least one (1) of the above risk assessment domains (HRA, SDOH, CHA and ACEs) meets the standard. •https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Program-Guide-a11y.pdf •https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf • https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-030.pdf or current version

V. Adult Preventive Criteria	
C. Adult Preventive Care Screenings	The following adult preventive care screenings are based on USPTSF Grade A and B recommendations. • If the patient falls within the eligible condition (e.g. obesity, post-menopausal, etc.), age and gender parameters of the criterion, the provider shall assess for risk factors. • If the patient is positive for risk factors, the provider shall offer and document follow-up intervention(s). • Providers who fail to document the presence or absence of risk factors shall receive zero (0) points. • An "NA" score is warranted if the patient falls outside of the eligible condition, age and gender parameters of the specific criterion. If specific preventive care screening tests are ordered, but results are not found in the member's record, and no documentation of follow-up is documented, these deficiencies will be cited under the appropriate preventive care criteria. The Follow-up of Specialty Referrals criteria pertain to referrals/lab tests that are not specified under preventive care criteria (i.e. ophthalmology, nephrology, etc.).
1) Abdominal Aneurysm Screening	Assess all individuals during well adult visits for past and current tobacco use. USPSTF recommends that medical providers should perform a one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked 100 or more cigarettes in their lifetime. Indirect evidence shows that smoking is the strongest predictor of Abdominal Aortic Aneurysm (AAA) prevalence, growth, and rupture rates.[27] There is a dose-response relationship, as greater smoking exposure is associated with an increased risk for AAA. The USPSTF Grade A and B Recommendations are available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

[27] See the USPSTF recommendation on AAA Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/abdominal-aortic-aneurysm-screening.

V. Adult Preventive Criteria	
2) Alcohol Use Disorder Screening and Behavioral Counseling	Assess all adults at each well visit for alcohol misuse. If at any time the PCP identifies a potential alcohol misuse problem , the provider shall: • Refer any member identified with possible alcohol use disorders to the alcohol and drug program in the county where the member resides for evaluation and treatment. • Use the Alcohol Use Disorder Identification Test (AUDIT) or Alcohol Use Disorder Identification Test-Consumption (AUDIT-C). • Complete at least one expanded screening, using a validated screening tool every year and additional screenings can be provided in a calendar year if medical necessity is documented by the member's provider. • Offer behavioral counseling intervention(s) to those members that a provider identifies as having risky or hazardous alcohol use on the expanded screening tool. Behavioral counseling intervention(s) typically include one to three sessions, 15 minutes in duration per session, offered in-person, by telephone, or by telehealth modalities. See the NIH guidance on Screening Tests, available at: https://pubs.niaaa.nih.gov/publications/arh28-2/78-79.htm See APL 21-014, Alcohol and Drug Screenings, Assessment, Brief Interventions and Referral to Treatment, or any superseding APL, for additional information. The USPSTF uses the term "unhealthy alcohol use" to define a spectrum of behaviors, from risky drinking to alcohol use disorder (AUD) (e.g., harmful alcohol use, abuse, or dependence). Risky or hazardous alcohol use means drinking more than the recommended daily, weekly, or per-occasion amounts, resulting in increased risk for adverse health consequences but not meeting criteria for AUD (e.g. the National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines "risky use" as exceeding the recommended limits of 4 drinks per day (56 g/d based on the US standard of 14 g/drink) or 14 drinks per week (196 g/d) for healthy adult men aged 21 to 64 years or 3 drinks per day or 7 drinks per week (42 g/d or 98 g/week) for all adult women of any age and men 65 years or older).

V. Adult Preventive Criteria	
	Screening Unhealthy alcohol use screening must be done with validated screening tools. The US Surgeon General, NIAAA, CDC, and ASAM recommend routinely screening adult patients for unhealthy alcohol use and providing them with appropriate interventions, https://www.niaaa.nih.gov/guide Brief Assessment When a screen is positive, providers should use validated assessment tools to determine if an alcohol use disorder is present. Validated alcohol assessment tools may be used without first using validated screening tools. Validated assessment tools include, but are not limited to: • CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) • NIDA-modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST) • Alcohol Use Disorders Identification Test (AUDIT) Brief Interventions and Referral to Treatment For recipients with brief assessments revealing alcohol misuse, brief misuse counseling should be offered. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment (MAT), should be offered to recipients whose brief assessment demonstrates probable alcohol use disorder. Alcohol brief interventions includes alcohol misuse counseling and counseling a member regarding additional treatment options, referrals, or services. Brief interventions must include the following: • Providing feedback to the patient regarding screening and assessment results. • Discussing negative consequences that have occurred and the overall severity of the problem. • Supporting the patient in making behavioral changes. • Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated. Documentation Requirements Member medical records must include the following:

V. Adult Preventive Criteria	
	• The service provided, for example: screen and brief intervention. • The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record). • The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record). • If and where a referral to an alcohol or substance use disorder program was made. A recommended substance abuse assessment tool is available at http://crafft.org. Please refer to the following link to The Medi-Cal Provider Manual: https://www.dhcs.ca.gov/formsandpubs/publications/Pages/Manuals.aspx.
3) 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.[28]
4) Cervical Cancer Screening	• Screen for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years. • Women ages 30 to 65 years who want to lengthen the screening interval, screen with a combination of cytology and human papillomavirus (HPV) co-testing every 5 years OR with high-risk human papillomavirus (hrHPV) testing alone every 5 years. • Follow-up of abnormal test results are documented. Routine Pap testing may not be required for the following: • Women who have undergone hysterectomy in which the cervix is removed (TAH - Total Abdominal Hysterectomy), unless the hysterectomy was performed because of invasive cancer. • Women 66 years and older who have had regular previous screening in which the Pap result have been consistently normal.

[28] See the USPSTF recommendation on Breast Cancer Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening.

V. Adult Preventive Criteria	
	The USPSTF recommendation on Cervical Cancer Screening is available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening.
5) Colorectal Cancer Screening	All adults are screened for colorectal cancer beginning at age 45 years old and concluding at age 75 years to include: • High sensitivity gFOBT or FIT every year • sDNA-FIT every 1 to 3 years • CT colonography every 5 years • Flexible sigmoidoscopy every 5 years • Flexible sigmoidoscopy every 10 years + FIT every year • Colonoscopy screening every 10 years. When abnormal results are found on flexible sigmoidoscopy or CT colonography, follow-up with colonoscopy is needed for further evaluation. Rates of colorectal cancer incidence are higher in Black adults and American Indian and Alaskan Native adults, persons with a family history of colorectal cancer (even in the absence of any known inherited syndrome such as Lynch syndrome or familial adenomatous polyposis), men, and persons with other risk factors (such as obesity, diabetes, long-term smoking, and unhealthy alcohol use. The decision to screen for colorectal cancer in adults **aged 76 to 85 years** should be an individual one,taking into account the patient's overall health and prior screening history. The USPSTF recommendation on Colorectal Cancer Screening is available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening.
6) Depression Screening	• Per USPSTF, screen for depression in the general adult population, including pregnant and postpartum women. • Screening should be implemented at each well visit with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

V. Adult Preventive Criteria	
	• Providers should screen all adults who have not been previously screened using a validated screening tool. If the depression screening is positive, a follow up plan must be documented. • Providers should use clinical judgment in consideration of risk factors, comorbid conditions, and life events to determine if additional screening of high-risk patients is warranted. Recommended screening tools include: ○ Patient Health Questionnaire (PHQ) in various forms ○ Hospital Anxiety and Depression Scales in adults ○ Geriatric Depression Scale in older adults ○ The Edinburgh Postnatal Depression Scale (EPDS) pregnant and postpartum The USPSTF Grade A and B Recommendations are available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations The USPSTF recommendation on Screening for Depression in Adults is available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-adults-screening.
7) Diabetic Screening and Comprehensive Care	• Per USPSTF, screen for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 35 to 70 years who are overweight or obese. • Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity. • Glucose abnormalities can be detected by measuring HbA1c or fasting plasma glucose or with an oral glucose tolerance test. • Hemoglobin A1C (HbA1c) is a measure of long-term blood glucose concentration and is not affected by acute changes in glucose levels due to stress or illness. HbA1c measurements do not require fasting, they are more convenient than using a fasting plasma glucose or oral glucose tolerance test. The oral glucose tolerance

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<tr><td>7.a)</td><td>test is done in the morning in a fasting state; blood glucose concentration is measured 2 hours after ingestion of a 75-g oral glucose load.

• The diagnosis of IFG, IGT, or type 2 diabetes should be confirmed; repeated testing with the same test on a different day is the preferred method of confirmation.

See the USPSTF recommendation on Prediabetes and Type 2 Diabetes Screening, available at: https://uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-prediabetes-and-type-2-diabetes.

See APL 18-018, Diabetes Prevention Program, or any superseding APL for additional information.

• When reviewing medical records of patients with a diagnosis of Diabetes, the reviewer should score based on documented routine comprehensive diabetic care/screening: retinal exams, podiatry, nephrology, etc.
• Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life. With support from health care providers, patients can manage their diabetes with self-care, taking medications as instructed, eating a healthy diet, being physically active, and quitting smoking.

See the National Community for Quality Assurance guidance on Comprehensive Diabetes Care, available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/.

See the USPSTF recommendation on Prediabetes and Type 2 Diabetes Screening, available at: https://uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-prediabetes-and-type-2-diabetes.</td></tr>
<tr><td></td><td>Assess all adults at each well visit for drug misuse. If at any time the PCP identifies a potential drug use problem the provider shall:</td></tr>
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V. Adult Preventive Criteria	
8) Drug Use Disorder Screening and Behavioral Counseling	• Refer any member identified with possible drug use disorders to the drug treatment program in the county where the member resides for evaluation and treatment. • Complete at least one expanded screening, using a validated screening tool, every year and additional screenings can be provided in a calendar year if medical necessity is documented by the member's provider. • Offer behavioral counseling intervention(s) to those members that a provider identified as having risky or hazardous drug use on the expanded screening tool. Behavioral counseling intervention(s) typically include one to three sessions, 15 minutes in duration per session, offered in-person, by telephone, or by telehealth modalities. See APL 21-014, Alcohol and Drug Screenings, Assessment, Brief Interventions and Referral to Treatment, or any superseding APL, for additional information. The term "unhealthy drug use" is defined as the use of illegally obtained substances, excluding alcohol and tobacco, or the use of nonmedical prescription medications that differ than the parameters for which they were prescribed such as duration, frequency, and amount. <u>Brief Assessment</u> When a screen is positive, providers should use validated assessment tools to determine if a drug use disorder is present. Validated drug assessment tools may be used without first using validated screening tools. Validated assessment tools include, but are not limited to: • CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) • NIDA-modified Alcohol, Smoking, and Substance Involvement Screening Test (NM-ASSIST) • Drug Abuse Screening Test (DAST-20) <u>Brief Interventions and Referral to Treatment</u> For recipients with brief assessments revealing drug misuse, brief misuse counseling should be offered. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment (MAT), should be offered to

<table>
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<tr><td></td><td>recipients whose brief assessment demonstrates probable substance use disorder. Drug brief interventions includes misuse counseling and counseling a member regarding additional treatment options, referrals, or services. Brief interventions must include the following:
• Providing feedback to the patient regarding screening and assessment of results.
• Discussing negative consequences that have occurred and the overall severity of the problem.
• Supporting the patient in making behavioral changes.
• Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated.

<u>Documentation Requirements</u>
Member medical records must include the following:
• The service provided, for example: screen and brief intervention.
• The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electric health record).
• The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record).
• If and where a referral to an alcohol or substance use disorder program was made.

A recommended substance abuse assessment tool is available at: http://crafft.org.

Please refer to the following link to the Medi-Cal Provider Manual: https://www.dhcs.ca.gov/formsandpubs/publications/Pages/Manuals.aspx.</td></tr>
<tr><td>9) Dyslipidemia Screening</td><td>USPSTF recommends that adults without a history of cardiovascular disease (CVD) (e.g., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all the following criteria are met:
1) They are aged 40 to 75 years;
2) They have one or more CVD risk factors (e.g., dyslipidemia, diabetes, hypertension, or smoking); and</td></tr>
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V. Adult Preventive Criteria	
	3) They have a calculated 10-year risk of a cardiovascular event of 10% or greater. Screen universal lipids at every well visit for those with increased risk of heart disease and at least every 6 years for healthy adults. The USPSTF Grade A and B Recommendations are available at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.
10) Folic Acid Supplementation	• The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.[29] • USPSTF and WHO categorize women in the age range of 12-49 years as "women who are capable of becoming pregnant".
11) Hepatitis B Virus Screening	Assess all adults for risk of acquiring Hepatitis B Virus (HBV) at each well visit. Screening those at risk should include testing to three HBV screening seromarkers (HBsAg, antibody to HBsAg [anti-HBs], and antibody to hepatitis B core antigen [anti-HBc]) so that persons can be classified into the appropriate hepatitis B category and properly recommended to receive vaccination, counseling, and linkage to care and treatment. Important risk groups for HBV infection with a prevalence of ≥2% that should be screened include: • Persons born in countries and regions with a high prevalence of HBV infection (≥2%), such as sub-Saharan Africa and Central and Southeast Asia (Egypt, Algeria, Morocco, Libya, Afghanistan, Vietnam, Cambodia, Thailand, Philippines, Malaysia, Indonesia, Singapore, etc.). • U.S.-born persons not vaccinated as infants whose parents were born in regions with a very high prevalence of HBV infection (≥8%).

[29] See the USPSTF recommendation on Folic Acid to Prevent Neural Tube Defects, available at: https://www.uspreventiveservicestaskforce.org/uspstf/draft-update-summary/folic-acid-supplementation-prevent-neural-tube-defects

V. Adult Preventive Criteria	
	• HIV-positive persons • Injection drug users • MSM • Household contacts or sexual partners of persons with HBV infection See the CDC guidance on Viral Hepatitis, available at: https://www.cdc.gov/hepatitis/hbv/hbvfaq.htm
12) Hepatitis C Virus Screening	• All adults 18 to 79 years old shall be assessed for risk of Hepatitis C Virus (HCV) exposure at each well visits. • Testing should be initiated with anti-HCV. For those with reactive test results, the anti-HCV test should be followed with an HCV RNA. Persons for whom HCV Testing is recommended: • All Adults ages 18 to 79 years should be tested once. • Currently, or had history of, ever injecting drugs. • Medical Conditions: Long term hemodialysis, persons who received clotting factor concentrates produced before 1987; HIV infection; Persistent abnormal alanine aminotransferase levels (ALT). • Prior recipients of transfusions or organ transplant before July 1992 or donor who later tested positive for HCV infection. Persons with continued risk for HCV infection (e.g., injection drug users) should be screened periodically. There is limited information about the specific screening interval that should occur in persons who continue to be at risk for new HCV infection or how pregnancy changes the need for additional screening. See the USPSTF recommendation on Screening for HCV in Adolescents and Adults Practice Considerations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening#bootstrap-panel--6. See the CDC Recommendations for Hepatitis C Screening Among Adults in the United States, available at: https://www.cdc.gov/hepatitis/hcv/guidelinesc.htm.

V. Adult Preventive Criteria	
	See the USPSTF Grade A and B Recommendations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations
13) High Blood Pressure Screening	• All adults 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. See the USPSTF Grade A and B Recommendation, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hypertension-in-adults-screening.
14) HIV Screening	USPSTF recommends risk assessment shall be completed at each well visit for patients 65 years old and younger: • Those at high risk (regardless of age) i.e., having intercourse without a condom or with more than one sexual partner whose HIV status is unknown. • IV drug users. • MSM. All shall be tested for HIV and offered pre-exposure prophylaxis (PrEP). [30] Lab results are documented. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening
	• Per the USPSTF, clinicians shall screen for Intimate Partner Violence (IPV) on asymptomatic women of reproductive age, which is defined across studies as

[30] See the USPSTF recommendation on Prevention of HIV Infection, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis.

V. Adult Preventive Criteria	
15) Intimate Partner Violence Screening for Women of Reproductive Age	ranging from 12 to 49 years, with most research focusing on women age 18 years or older. • Provide or refer those who screen positive to ongoing support services. Per USPSTF the following instruments accurately detect IPV in the past year among adult women: ○ Humiliation, Afraid, Rape, Kick (HARK) ○ Hurt, Insult, Threaten, Scream (HITS) ○ Extended–Hurt, Insult, Threaten, Scream (E-HITS) ○ Partner Violence Screen (PVS) ○ Woman Abuse Screening Tool (WAST) The USPSTF A and B recommendations are the minimum that is required by DHCS. The term “intimate partner violence” describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy. See the CDC guidance on IPV, available at: https://www.cdc.gov/violenceprevention/intimatepartnerviolence/
16) Lung Cancer Screening	• Assess all individuals during well adult visits for past and current tobacco use. • Per USPSTF, screen annually for lung cancer with low-dose computed tomography in adults ages 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. • Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. See the USPSTF recommendation on Lung Cancer Screening, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/lung-cancer-screening.

V. Adult Preventive Criteria	
17) Obesity Screening and Counseling	• USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. • Documentation shall include weight and BMI • There is fair to good evidence that high-intensity counseling—about diet, exercise, or both—together with behavioral interventions aimed at skill development, motivation, and support strategies produces modest, sustained weight loss (typically 3-5 kg for 1 year or more) in adults who are obese (as defined by BMI ≥ 30 kg/m2). Although the USPSTF did not find direct evidence that behavioral interventions lower mortality or morbidity from obesity, the USPSTF concluded that changes in intermediate outcomes, such as improved glucose metabolism, lipid levels, and blood pressure, from modest weight loss provide indirect evidence of health benefits. See the USPSTF recommendation on Screening and Counseling for Obesity in Adults, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/obesity-in-adults-screening-and-counseling-2003.
18) Osteoporosis Screening	Assess all postmenopausal women during well adult visits for risk of osteoporosis. USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, or who have at least one risk factor, as determined by a formal clinical risk assessment tool.[31] These risk factors include: • Parental history of hip fracture • Smoking • Excessive alcohol consumption • Low body weight.

[31] See the USPSTF recommendations on Screening for Osteoporosis to Prevent Fractures, available at: https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/osteoporosis-screening.

V. Adult Preventive Criteria	
	USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older. For postmenopausal women younger than 65 years who have at least 1 risk factor, a reasonable approach to determine who should be screened with bone measurement testing is to use a clinical risk assessment tool.
19) Sexually Transmitted Infection (STI) Screening and Counseling	Assess all individuals during well adult visits for risk of STI.[32] Chlamydia & Gonorrhea: • Test all sexually active women under 25 years old • Older women who have new or multiple sex partners • MSM regardless of condom use or persons with HIV shall be tested at least annually Syphilis: • MSM or persons with HIV shall be screened at least annually Trichomonas: • Sexually active women seeking care for vaginal discharge • Women who are IV drug users • Exchanging sex for payment • HIV+, have History of STD, etc. Herpes: • Men and women requesting STI evaluation who have multiple sex partners shall be tested. • HIV+ • MSM w/ undiagnosed genital tract infection.

[32] See the USPSTF recommendation on STIs: Behavioral Counseling, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/sexually-transmitted-infections-behavioral-counseling.

V. Adult Preventive Criteria	
	Intensive behavioral counseling for adults who are at increased risk for STIs includes counseling on use of appropriate protection and lifestyle.
20) Skin Cancer Behavioral Counseling	USPSTF recommends that young adults 24 years and younger should be counseled to minimize exposure to Ultraviolet (UV) radiation to reduce their risk of skin cancer.[33]
21)Tobacco Use: Screening, Counseling, and Intervention	• Assess all individuals during well adult visits for tobacco use and document prevention and/or counseling services to potential/active tobacco users. ○ Per USPSTF, providers can document any combination of the following since not all may apply especially to pregnant tobacco users: tobacco cessation services, behavioral counseling and/or pharmacotherapy. See APL 16-014, Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries, or any superseding APL, for additional information. If the PCP identifies tobacco use, documentation that the provider offered tobacco cessation services, behavioral counseling, and/or pharmacotherapy to include any or a combination of the following must be in the patient's medical record: • FDA-approved tobacco cessation medications (for non-pregnant adults of any age). • Individual, group, and telephone counseling for members of any age who use tobacco's products. • Services for pregnant tobacco users. See APL 16-014, Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries, or any superseding APL, for additional information.
22) Tuberculosis Screening	• Adults are assessed for TB risk factors or symptomatic assessments upon enrollment and at periodic physical evaluations.

[33] See the USPSTF Grade A and B Recommendations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/skin-cancer-counseling.

	• The Mantoux skin test, or other approved TB infection screening test,[34] 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, for example: ○ Further medical evaluation ○ Chest x-ray ○ Diagnostic laboratory studies ○ Referral to specialist Practitioners are required to follow current CDC and American Thoracic Society guidelines for TB diagnosis and treatment. See the CDPH guidance on California Adult TB Risk Assessment, available at: https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-TB-Risk-Assessment-and-Fact-Sheet.pdf. See the USPSTF recommendation on Latent TB Infection Screening, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/latent-tuberculosis-infection-screening. See the CDC publications on TB, available at: www.cdc.gov/tb/publications//.
D) Adult Immunizations	

[34] 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).

V. Adult Preventive Criteria	
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 ACIP guidelines, unless medically contraindicated or refused by the member.[35] Vaccination status must be assessed for the following: ○ Td/Tdap (every 10 years) ○ Flu (annually) ○ Pneumococcal (ages 65 and older; or anyone with underlying conditions) ○ Zoster (starting at age 50) ○ Varicella and MMR Documented evidence of immunity (i.e. titers, childhood acquired infection) in the medical record meets the criteria for Varicella and MMR. The name of the vaccines and date the member received the vaccines must be documented as part of the assessment. See APL 18-004, Immunization Requirements, or any superseding APL for additional information.
2) Vaccine administration documentation	The name, manufacturer, date of administration, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries, in accordance with the National Childhood Vaccine Injury Act.
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.

[35] See the CDC ACIP Guidance on Immunization Schedules, available at: https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html.

Rationale: Perinatal assessments are provided according to the current American College of Obstetrics and Gynecologists (ACOG) standards and Comprehensive Perinatal Services Program (CPSP) Guidelines.[36] Reviewers please note, if the OB-GYN provider is also acting as the member's PCP and the member is/was pregnant during the review period (e.g. the last three years), the appropriate preventive services criteria, based on the members' age, i.e. Pediatric or Adult shall ALSO be reviewed and scored.

RN/NP/MD/PA/CNM/LM

VI. OB/CPSP Preventive Criteria	
A. Initial Comprehensive Prenatal Assessment (ICA)	**Initial Prenatal Visit - First entry to OB Care:** During the initial Comprehensive assessment, provider gathers baseline information on the pregnant woman, such as: ○ Obstetric and medical history, including medical documentation from prior visits with other providers. ○ Nutrition status ○ Health education ○ Psychosocial needs Based on the information gathered, the provider and the pregnant woman develop an individualized care plan (ICP) to meet her unique needs. Documentation of ICP services received, or reasons why not received, must be provided. See VI, B, below, for the First Trimester Comprehensive Assessment, which may be completed over more than one visit during the trimester. See the CDPH CPSP Provider Handbook, available at: https://custom.cvent.com/C506006261F8428CB7CCB91AAA9A05B4/files/8a01c5b0dd744c0aa06f0dece9dec3f1.pdf.
1) Initial Prenatal Visit	Documentation of initial prenatal visit completed within four weeks of entry to prenatal care. Optimally within the first trimester.
2) Obstetrical and Medical History	**Obstetric/medical:** The H&P exam must be consistent with the most recent ACOG Guidelines for Perinatal Care.[37]

[36] See the CDPH webpage on CPSP, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx
[37] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.

VI. OB/CPSP Preventive Criteria	
3) Physical Exam	Physical exam: includes breast and pelvic exam and calculation of estimated date of delivery. https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx
4) Dental Assessment	Dental Screening and referral as indicated must be documented. Oral health problems are associated with other diseases including heart disease, diabetes, and respiratory infections.[38]
5) Healthy Weight Gain and Behavior Counseling	The USPSTF recommends that clinicians offer pregnant women effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.[39] Effective behavioral counseling interventions promotes healthy weight gain and decreases risk of gestational diabetes mellitus, emergency cesarean delivery, infant macrosomia, and LGA infants.
6) Lab tests	
a) Bacteriuria Screening	USPSTF recommends screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at their first prenatal visit, if later.[40]

[38] See the ACOG guidance on Oral Health Care During Pregnancy and Through the Lifespan, available at: https://www.acog.org/en/Clinical/Clinical%20Guidance/Committee%20Opinion/Articles/2013/08/Oral%20Health%20Care%20During%20Pregnancy%20and%20Through%20the%20Lifespan

[39] See the USPSTF recommendation on Healthy Weight and Weight Gain in Pregnancy, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/healthy-weight-and-weight-gain-during-pregnancy-behavioral-counseling-interventions

[40] See the USPSTF recommendation on Screening for Asymptomatic Bacteria in Adults, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/asymptomatic-bacteriuria-in-adults-screening.

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	Urine culture is recommended for bacteriuria screening in pregnancy and is the method for diagnosis. Pregnant women with asymptomatic bacteriuria usually receive antibiotic therapy, based on urine culture results and follow-up monitoring.
b) Rh Incompatibility Screening	• Rh incompatibility screening: 24-28 weeks gestation.[41] • Rh incompatibility is a condition that occurs during pregnancy if a woman has Rh-negative blood and her baby has Rh-positive blood.
c) Diabetes Screening	USPSTF recommends screening for gestational diabetes mellitus **(**GDM**)** in asymptomatic pregnant women after 24 weeks of gestation.[42] • In the two-step approach: the 50-g OGCT is performed between 24 and 28 weeks of gestation. A diagnosis of GDM is made when two or more glucose values fall at or above the specified glucose thresholds. • One-step approach: a 75-g glucose load is administered after fasting and plasma glucose levels are evaluated after 1 and 2 hours. Gestational diabetes is diagnosed if 1 glucose value falls at or above the specified glucose threshold. Self-monitoring of blood glucose can be a useful tool in the management of pregnant woman with pre-existing and with gestational diabetes.
d) Hepatitis B Virus Screening	All pregnant women are screened for Hepatitis B during their first trimester or prenatal visit, whichever comes first.[43] The screening tests for detecting maternal HBV infection is the serologic identification of HBsAg. Screening should be performed in each pregnancy, regardless of previous HBV vaccination or previous negative HBsAg test results.

[41] See the USPSTF recommendation on Rh(D) Incompatibility Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/rh-d-incompatibility-screening, and the NIH guidance on Rh Incompatibility, available at: https://www.nhlbi.nih.gov/health-topics/rh-incompatibility.
[42] See the USPSTF recommendation on Gestational Diabetes Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/gestational-diabetes-screening.
[43] See the USPSTF recommendation on HBV Infection in Pregnant Women, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-in-pregnant-women-screening.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2864180/

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	Following referral required for women with positive HBV: • Case management during pregnancy • HBV DNA viral load testing • Referral to specialty care for counseling and medical management of HBV infection. See Hepatitis B information on the CDC website, available at: https://www.cdc.gov/hepatitis/hbv/index.htm.
e) Hepatitis C Virus Screening	Per ACOG all pregnant women should receive Hepatitis C screening with blood assessment during the first prenatal visit. Pregnant woman with newly diagnosed HCV infection and abnormal serum aminotransferase and/or platelet levels should be referred for further medical assessment to rule out liver fibrosis or injury and so antiviral treatment can be initiated at the appropriate time. Providers should report HCV infection in a pregnant person to infant's health care provider so that follow-up HCV testing can be conducted at the recommended time, and to the local health department so that ongoing risk factors can be assessed and relevant contacts can receive hepatitis A and hepatitis B testing and vaccination, as indicated, and can be linked, as appropriate, to preventive services. https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2021/05/routine-hepatitis-c-virus-screening-in-pregnant-individuals
f) Chlamydia Infection Screening	Per CDC, All pregnant women under 25 years old and older women with increased risk such as new or multiple sex partners, or a sex partner who has an STD, should be tested for chlamydia at their first prenatal visit pregnant women with chlamydial infection should have a test-of-cure four weeks after treatment and be retested within three months. Retest during the 3rd trimester for women under 25 years of age or at risk.

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	See the CDC guidance on Chlamydia, available at: https://www.cdc.gov/std/chlamydia. See the CDC guidance on STD Tests, available at: https://www.cdc.gov/std/prevention/screeningreccs.htm. See the USPSTF recommendation on Chlamydia and Gonorrhea Screening, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/chlamydia-and-gonorrhea-screening.
g) Syphilis Infection Screening	Per CDC, all pregnant women should be tested for syphilis at the first prenatal visit.[44] High risk women need to be tested again during the third trimester (28 weeks gestation) and at delivery. This includes women who live in areas of high syphilis morbidity, are previously untested, had a positive screening test in the first trimester, or are at higher risk for syphilis (i.e., multiple sex partners, drug use, transactional sex, late entry into prenatal care or no prenatal care, meth or heroin use, incarceration themselves or of sex partners, unstable housing, or homelessness).
h) Gonorrhea Infection Screening	All pregnant women under 25 years old, and older pregnant women who are at increased risk, are screened for gonorrhea during their first prenatal visit.[45] Specific microbiologic diagnosis of *N. gonorrhea* infection should be performed for all women at risk for or suspected of having gonorrhea. See the CDC guidance on Gonococcal Infections Among Adolescents and Adults, available at: https://www.cdc.gov/std/treatment-guidelines/gonorrhea-adults.htm.

[44] See the CDC information on syphilis, available at: https://www.cdc.gov/std/syphilis/stdfact-syphilis-detailed.htm.
[45] See the CDC guidance on Gonococcal Infections Among Adolescents and Adults, available at: https://www.cdc.gov/std/treatment-guidelines/gonorrhea-adults.htm, and the USPSTF recommendation on Chlamydia and Gonorrhea Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/chlamydia-and-gonorrhea-screening.

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i) Human Immunodeficiency Virus (HIV) Screening	Per ACOG, all pregnant women should be informed that HIV test is part of the routine panel of the prenatal tests.[46] If woman declines HIV testing this should be documented in the medical record. Repeat testing in the third trimester is recommended for woman known to be at high risk of acquiring HIV infection, and women who declined testing earlier in pregnancy.
B. First Trimester Comprehensive Assessment	A Comprehensive Perinatal Assessment must be completed each trimester and during the postpartum period. A Comprehensive Assessment tool must be used and updated every trimester and during the 12-month post-pregnancy period. The assessment tool must be consistent with CDPH's template tool, as confirmed by the local county or city Perinatal Health Coordinator.[47] See the CPSP Integrated Initial 1, 2, and 3 Trimester Assessments and ICP, available link bottom of the page.
1) Individualized Care Plan (ICP)	ICP documentation includes specific obstetric, nutrition, psychosocial, and health education risk problems/conditions, interventions, and referrals. **ICP must be developed based on the comprehensive assessment in each trimester and during the 12-month post-pregnancy period. The ICP must be updated based on the Comprehensive Assessments in each trimester, during the 12-month post-pregnancy period, and more frequently as needed. Documentation must be provided of the services offered and whether received.**
2) Nutrition Assessment	A complete initial nutrition assessment should be performed at the initial visit or within four weeks thereafter and should be documented in the

[46] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx, and the USPSTF recommendation on HIV Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening

[47] See the CDPH CPSP webpage, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx, and the Title 22 CPSP regulations, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-Title22CPSPRegulations.pdf

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	pregnant woman medical record: • anthropometric data • biochemical data • clinical data • dietary data
3) Psychosocial Assessment	The psychosocial screening should be performed on a regular basis and documented in the woman's prenatal record.[48] The assessment should include the following: ○ Depression assessment ○ Social and mental history ○ Substance use Disorder including alcohol and tobacco ○ Unintended pregnancy ○ Support systems ○ Documentation of referral as appropriate. See the proposed changes for the 20202 Prenatal and Postpartum care HEDIS measures, available at: https://www.ncqa.org/wp-content/uploads/2019/02/20190208_08_Perinatal_Depression.pdf.
a) Maternal Mental Health Screening	Screening for maternal mental health conditions must be part of the Comprehensive Assessments at each trimester. Identified needs must be incorporated into the Individualized Care Plan and follow up services documented. *Health and Safety Code (HSC) Section 123640: and* AB-1477 Maternal mental *health: Licensed health care practitioner who provides prenatal, postpartum or interpregnancy care for a patient shall ensure that the mother is offered screening or is appropriately screened for maternal mental health conditions.* Counselling, referrals, or any interventions is documented.

[48] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx, and the CDPH CPSP Provider Handbook, available at: https://custom.cvent.com/C506006261F8428CB7CCB91AAA9A05B4/files/8a01c5b0dd744c0aa06f0dece9dec3f1.pdf.

<table>
<tr><th colspan="2">VI. OB/CPSP Preventive Criteria</th></tr>
<tr><td></td><td>“Maternal mental health condition” means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

• USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women.
• CMS Technical Specifications include screening using validated tools and documentation of a follow-up plan if the depression screening is positive that aligns with USPSTF's referral and documentation of counseling or interventions with those found at risk for perinatal depression.
• Patient is screened for depression on the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen.

Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record.
• Edinburgh Postnatal Depression Scale (EPDS),
• Patient Health Questionnaire (PHQ) 9

Follow-Up Plan – Documented follow-up for a positive depression screening must include one or more of the following:
• Additional evaluation or assessment for depression
• Suicide Risk Assessment
• Referral to a practitioner who is qualified to diagnose and treat depression
• Pharmacological interventions
• Other interventions or follow-up for the diagnosis or treatment of depression

Additional information on CMS Technical Specifications, is available at: https://www.medicaid.gov/license/form/6466/4391.</td></tr>
</table>

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	See the USPSTF Grade A and B Recommendations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations
b) Social Needs Assessment	The comprehensive Assessments in each trimester must also provide social needs assessment includes housing, food, transportation, unintended pregnancy, support system available.[49] Identified needs must be incorporated into the Individualized Care Plan, and follow up services documented
c) Substance Use Disorder Assessment	• All pregnant women should be routinely asked about their use of alcohol, tobacco and drug, including prescription opioids and other medications used for nonmedical reasons. • If the woman acknowledges the use of alcohol, cocaine, opioids, amphetamines, or other mood-altering drugs or if chemical dependence is suspected, she should be counseled about the perinatal implications of their use during pregnancy and offered referral to an appropriate treatment program. See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx.
4) Breastfeeding and other Health Education Assessment	• Health Education including breast feeding, preparation to breastfeed, language, cultural competence. And education needs must be assessed at least once during each trimester and more frequently as needed. Identified needs must be incorporated into the Individualized Care Plan, and follow up services documented. • Materials must be available in the appropriate threshold languages and must meet readability and suitability requirements for educational material distributed to Medi-Cal members.[50]

[49] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx.

[50] See APL 18-016, Readability and Suitability of Written Health Education Materials, or any superseding APL.

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5) Preeclampsia Screening	USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.[51]
6) Intimate Partner Violence Screening	• USPSTF recommends that clinicians screen IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services.[52] • 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 • Documentation of illnesses attributable to spousal/partner abuse • Referral to appropriate community service agencies[53]
C. Second Trimester Comprehensive Assessment	See the CDPH CPSP webpage, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx. See the Title 22 CPSP Regulations, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-Title22CPSPRegulations.pdf.
1) Individualized Care Plan (ICP)	ICP documentation includes specific obstetric, nutrition, psychosocial, and health education risk problems/conditions, interventions, and referrals. ICP must be updated every trimester and more frequently as needed

[51] See the USPSTF recommendation on Preeclampsia Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/preeclampsia-screening.
[52] See the USPSTF recommendation on IPV, Elder Abuse, and Abuse of Vulnerable Adults Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening.
[53] HSC 1233.5

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2) Nutrition Assessment	A nutrition reassessment using updated information should be offered to each client at least once every trimester and the individualized care plan should be revised accordingly. Nutrition ICP component should address: • The prevention and/or resolution of nutrition problems. • The support and maintenance of strengths and habits oriented toward optimal nutritional status • Dispensing, as medically necessary, prenatal vitamin/mineral supplement to each pregnant woman. • Treatment and intervention directed toward helping the patient understand the importance of, and maintain good nutrition during pregnancy and lactation, with referrals as appropriate.
3) Psychosocial Assessment	The psychosocial screening should be performed on a regular basis and documented in the woman's prenatal record. The assessment should include the following: ○ Depression assessment ○ Social and mental history ○ Substance use/abuse including alcohol and tobacco ○ Unintended pregnancy ○ Support systems ○ Documentation of referrals as appropriate. See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx. https://www.ncqa.org/wp-content/uploads/2019/02/20190208_08_Perinatal_Depression.pdf
a) Maternal Mental Health Screening	Screening for maternal mental health conditions must be part of the Comprehensive Assessments at each trimester. Identified needs must be incorporated into the Individualized Care Plan and follow up services documented.

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	Health and Safety Code (HSC) Section 123640 and AB-1477 Maternal Mental Health: Licensed health care practitioner who provides prenatal, postpartum or interpregnancy care for a patient shall ensure that the mother is offered screening or is appropriately screened for maternal mental health conditions. Counseling, referrals or any interventions is documented. *"Maternal mental health condition" means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.* • USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. • CMS Technical Specifications includes screening using validated tools and documentation of a follow-up plan if the depression screening is positive that aligns with USPSTF's referral and documentation of counseling or interventions with those found at risk for perinatal depression. • Patient screened for depression on the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen. • Edinburgh Postnatal Depression Scale (EPDS), • Patient Health Questionnaire (PHQ) 9 Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. Follow-Up Plan – Documented follow-up for a positive depression screening must include one or more of the following: o Additional evaluation or assessment for depression • Suicide Risk Assessment • Referral to a practitioner who is qualified to diagnose and treat depression • Pharmacological interventions

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	• Other interventions or follow-up for the diagnosis or treatment of depression For additional information on CMS Technical Specifications, see: https://www.medicaid.gov/license/form/6466/4391. See the USPSTF Grade A and B recommendations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations
b) Social Needs Assessment	Social needs assessment including housing, food, transportation, unintended pregnancy, support system available.[54]
c) Substance Use Disorder Assessment	• All pregnant women should be routinely asked about their use of alcohol, tobacco, and drugs, including prescription opioids and other medications used for nonmedical reasons. • If the woman acknowledges the use of alcohol, cocaine, opioids, amphetamines, or other mood-altering drugs or if chemical dependence is suspected, she should be counseled about the perinatal implications of their use during pregnancy and offered referral to an appropriate treatment program. See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx See the USPSTF Grade A and B Recommendations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations.
4) Breastfeeding and Other Health Education Assessment	• Health Education including breast feeding, language, cultural competence, and education needs must be assessed. • Materials must be available in the appropriate threshold languages and must meet readability and suitability requirements for educational material distributed to Medi-Cal members.[55]

[54] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx.

[55] See APL 18-106, Readability and Suitability of Written Health Education Materials, or any superseding APL.

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5) Preeclampsia Screening	USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.[56]
a) Low Dose Aspirin	The Provider should advise on the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.[57]
6) Intimate Partner Violence Screening	• USPSTF recommends that clinicians screen for IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services.[58] • 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. • Referral to appropriate community service agencies.[59]

[56] See the USPSTF recommendation on Preeclampsia Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/preeclampsia-screening.
[57] See the USPSTF Grande A and B recommendations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations.
[58] See the USPSTF recommendation on IPV, Elder Abuse, and Abuse of Vulnerable Adults Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening.
[59] HSC 1233.5

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7) Diabetes Screening	The **USPSTF** recommends screening for **gestational diabetes** mellitus **(GDM)** in asymptomatic pregnant women after 24 and 28 weeks of gestation.[60] • In the 2-step approach, the 50-g OGCT is performed between 24 and 28 weeks of gestation in a non-fasting state. If the screening threshold is met or exceeded, patients receive the oral glucose tolerance test (OGTT). A diagnosis of GDM is made when 2 or more glucose values fall at or above the specified glucose thresholds. • 1-step approach, a 75-g glucose load is administered after fasting and plasma glucose levels are evaluated after one and two hours. Gestational diabetes is diagnosed if 1 glucose value falls at or above the specified glucose threshold.
D. Third Trimester Comprehensive Assessment	See the CDPH CPSP webpage, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx. See the Title 22 CPSP Regulations, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-Title22CPSPRegulations.pdf.
1) Individualized Care Plan (ICP) Update and Follow Up	ICP documentation includes specific obstetric, nutrition, psychosocial and health education risk problems/conditions, interventions, and referrals. See the CPSP Integrated Initial 1, 2, and 3 Trimester Assessments and ICP, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-CombinedInitialandTrimesterAssessmentandCarePlan.pdf. See the CPCP Postpartum Assessment and ICP, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-PostpartumAssessmentandCarePlan.pdf.

[60] See the USPSTF recommendation on Gestational Diabetes Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/gestational-diabetes-screening.

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2) Nutrition Assessment	A nutrition reassessment using updated information should be offered to each client at least once every trimester and the individualized care plan should be revised accordingly. Nutrition ICP component should address: • The prevention and/or resolution of nutrition problems. • The support and maintenance of strengths and habits oriented toward optimal nutritional status. • Dispensing, as medically necessary, prenatal vitamin/mineral supplement to each pregnant woman. • Treatment and intervention directed toward helping the patient understand the importance of, and maintain good nutrition during pregnancy and lactation, with referrals as appropriate. https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-Title22CPSPRegulations.pdf
3) Psychosocial Assessment	Psychosocial assessment must be performed on a regular basis and documented in the woman's prenatal record. The assessment should include the following: • Depression Assessment • Social and Mental History • Substance use/abuse including alcohol and tobacco; unintended pregnancy • Support systems • Documentation of referrals as appropriate See the CDPH CPSP Provider Handbook, available at: https://custom.cvent.com/C506006261F8428CB7CCB91AAA9A05B4/files/8a01c5b0dd744c0aa06f0dece9dec3f1.pdf. See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx
	Practitioner who provides prenatal, interpregnancy, or postpartum care for a patient shall ensure that the mother is offered screening or is appropriately screened for

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a) Maternal Mental Health Screening	*maternal mental health conditions.* Counselling, referrals or any interventions is documented. *"Maternal mental health condition" means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.*[61] • USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. • CMS Technical Specifications includes screening using validated tools and documentation of a follow-up plan if the depression screening is positive that aligns with USPSTF's referral and documentation of counseling or interventions with those found at risk for perinatal depression. • Patient screened for depression on the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen. Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. • Edinburgh Postnatal Depression Scale (EPDS), • Patient Health Questionnaire (PHQ) 9 Follow-Up Plan – Documented follow-up for a positive depression screening must include one or more of the following: • Additional evaluation or assessment for depression • Suicide Risk Assessment • Referral to a practitioner who is qualified to diagnose and treat depression • Pharmacological interventions • Other interventions or follow-up for the diagnosis or treatment of depression

[61] HSC 123640

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	For additional information on CMS Technical Specifications, see: https://www.medicaid.gov/license/form/6466/4391. See the USPSTF recommendation on Screening Depression in Adults, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-adults-screening. The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.[62]
b) Social Needs Assessment	The comprehensive assessments in each trimester must also provide social needs assessment including housing, food, transportation, unintended pregnancy, support system available.[63] Identified needs must be incorporated into the Individualized Care Plan, and follow up services documented
c) Substance Use Disorder Assessment	• All pregnant women should be routinely asked about their use of alcohol, tobacco and drug, including prescription opioids and other medications used for nonmedical reasons. • If the woman acknowledges the use of alcohol, cocaine, opioids, amphetamines, or other mood-altering drugs or if chemical dependence is suspected, she should be counseled about the perinatal implications of their use during pregnancy and offered referral to an appropriate treatment program. The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.

[62] See the USPSTF recommendation on Perinatal Depression, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/perinatal-depression-preventive-interventions.
[63] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx.

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	See APL 21-014, Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment, or any superseding APL for additional information. The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco.[64] See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx. See the USPSTF Grade A and B Recommendations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations.
4) Breastfeeding and other Health Education Assessment	• Health Education including breast feeding, preparation to breastfeed, language, cultural competence, and education needs must be assessed at least once during each trimester and more frequently as needed. Identified needs must be incorporated into the Individualized Care Plan and follow up services documented. • Materials must be available in the appropriate threshold languages and must meet readability and suitability requirements for educational material distributed to Medi-Cal members.[65]
5) Preeclampsia Screening	USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.[66]

[64] See the USPSTF recommendation on Tobacco Smoking Cessation in Adults, Including Pregnant Persons, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions.
[65] See APL 18-016, Readability and Suitability of Written Health Education Materials, or any superseding APL.
[66] See the ACIP recommendations on Routine Vaccination of Infants, Children, Adolescents, Pregnant Women, and Adults, available at: https://www.cdc.gov/vaccines/vpd/dtap-tdap-td/hcp/recommendations.html.

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a) Low-Dose Aspirin	USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.[67]
6) Intimate Partner Violence Screening	• USPSTF recommends that clinicians screen for IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services.[68] • 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. • Referral to appropriate community service agencies.[69]
7) Diabetic Screening	The **USPSTF** recommends screening for **gestational diabetes** mellitus **(GDM)** in asymptomatic pregnant women after 24 and 28 weeks of gestation.[70] • In the 2-step approach, the 50-g OGCT is performed between 24 and 28 weeks of gestation in a non-fasting state. If the screening threshold is met or exceeded, patients receive the oral glucose tolerance test (OGTT). A diagnosis of GDM is made when 2 or more glucose values fall at or above the specified glucose thresholds.

[67] See the USPSTF recommendation on Aspirin Use to Prevent Preeclampsia and Related Morbidity and Mortality, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/low-dose-aspirin-use-for-the-prevention-of-morbidity-and-mortality-from-preeclampsia-preventive-medication.
[68] See the USPSTF recommendation on IPV, Elder Abuse, and Abuse of Vulnerable Adults Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening.
[69] HSC 1233.5
[70] See the USPSTF recommendation on Screening for Gestational Diabetes, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/gestational-diabetes-screening.

VI. OB/CPSP Preventive Criteria	
	• 1-step approach, a 75-g glucose load is administered after fasting and plasma glucose levels are evaluated after one and two hours. Gestational diabetes is diagnosed if 1 glucose value falls at or above the specified glucose threshold. • Self-monitoring of blood glucose can be a useful tool in the management of pregnant woman with pre-existing and with gestational diabetes.
8) Screening for Strep B	All pregnant women are screened for Group B Streptococcus (GBS) between their 35th and 37th week of pregnancy. Vaginal or rectal swab cultures at 36 – 37 weeks of gestation are positive for GBS, they should receive appropriate intrapartum antibiotic prophylaxis unless a prelabor cesarean birth is performed in the setting of intact membranes. Please refer to the following link for ACOG Frequently Asked Questions on Group B Streptococcus and pregnancy: https://www.acog.org/womens-health/faqs/group-b-strep-and-pregnancy. See the ACOG guidance on Prevention of Group B Streptococcal Early-Onset Disease in Newborns, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/02/prevention-of-group-b-streptococcal-early-onset-disease-in-newborns?utm_source=vanity&utm_medium=web&utm_campaign=clinical.
9) Screening for Syphilis	Pregnant women with high risk for syphilis and women who live in areas with high syphilis morbidity should be re-tested for syphilis between 28 and 32 weeks and at delivery. Stat RPR should be performed at delivery for women with no prenatal care. https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/CS_Eval_Management_pregnant%20women.pdf
10) Tdap Immunization	• Pregnant women should receive a single dose of Tdap during every pregnancy, preferably at 27 through 36 weeks gestation.

VI. OB/CPSP Preventive Criteria	
	• Tdap is recommended only in the immediate postpartum period before discharge from the hospital or birthing center for new mothers who have never received Tdap before or whose vaccination status is unknown. • Practitioners are required to ensure the provision of immunizations according to CDC's most recent ACIP guidelines, unless medically contraindicated or refused by the member. See the CDC's ACIP recommendations on Routine Vaccination of Infants, Children, Adolescents, Pregnant Women, and Adults, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/preeclampsia-screening1. See the CDC's ACIP guidelines on vaccines, available at: https://www.cdc.gov/vaccines/hcp/acip-recs/index.html. Please note-the administration of pertussis is eligible for the Valued Based Payment (VBP) program. Please consult with the MCP for details.
E. 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: 1) First visit by 6-8th week 2) Approximately every 4 weeks for the first 28 weeks of pregnancy 3) Every 2-3 weeks until 36 weeks gestation 4) Weekly thereafter until delivery If the recommended ACOG schedule is not met, documentation shows missed appointments, attempts to contact member and/or outreach activities. Refer the following link to ACOG for further details: https://www.acog.org/clinical
F. Influenza Vaccine	CDC and ACIP recommend that pregnant women gets vaccinated during any trimester of their pregnancy. Refer to the following link for further information on vaccination schedules:

VI. OB/CPSP Preventive Criteria	
	https://www.cdc.gov/vaccines/pregnancy/hcp-toolkit/guidelines.html https://www.cdc.gov/vaccines/hcp/acip-recs/rec-vac-preg.html See CDC guidance on pregnancy and vaccination, available at: https://www.cdc.gov/vaccines/pregnancy/pregnant-women/index.html See APL 18-004, Immunization Requirements, or any superseding APL for additional information.
G. COVID Vaccine	The American College of Obstetricians and Gynecologists (ACOG) recommends that all eligible persons greater than age 12 years, including pregnant and lactating individuals, receive a COVID-19 vaccine or vaccine series. Provider should document the discussion in the medical record if pregnant woman refused to receive the vaccine. During the subsequent office visits, obstetrician–gynecologists should address ongoing questions and concerns and offer vaccination again. https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2020/12/covid-19-vaccination-considerations-for-obstetric-gynecologic-care
H. Referral to Special Supplemental Nutrition Program for Women, Infants, and Children (**WIC) and assessment of Infant Feeding Status**	Pregnant and breastfeeding mothers must be referred to WIC.[71] • Referral to WIC is documented in the medical record.[72] • Infant feeding plans are documented during the prenatal period. • Infant feeding/breastfeeding status is documented during the postpartum period.[73] Refer to the following link for information on the WIC program: https://www.myfamily.wic.ca.gov/

[71] Public Law 103-448, Section 203(e)
[72] 42 CFR 431.635
[73] PL 98-010, Breastfeeding Promotion

VI. OB/CPSP Preventive Criteria	
	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.
I. HIV-related services *offered*	Per ACOG, repeat testing in the third trimester is recommended for women known to be at high risk of acquiring HIV infection, and women who declined testing earlier in pregnancy. • The ***offering*** of prenatal HIV information, counseling, and HIV antibody testing is documented.[74] • 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. See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx. See the CDC STI Screening Recommendations, available at: https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm. See the ACOG guidance on Prenatal and Perinatal HIV Testing, available at: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Prenatal-and-Perinatal-Human-Immunodeficiency-Virus-Testing?IsMobileSet=false. See the USPSTF recommendation on HIV Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening.

[74] HSC 125107

VI. OB/CPSP Preventive Criteria	
J. 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.[75] Genetic screening documentation includes: • Family history • Triple marker screening tests: Alpha Fetoprotein (AF), unconjugated estriol (UE), human chorionic gonadotropin (HCG) • Member's consent or refusal to participate For information on the Alpha-Fetoprotein Test, see: https://americanpregnancy.org/prenatal-testing/alpha-fetoprotein-test **Note:** Member's participation is voluntary. Testing occurs through CDPH Expanded AFP Program, and only laboratories designated by CDPH may be used for testing.
K. Family Planning Evaluation	• Women should be counseled about the risks and benefits of repeat pregnancy sooner than 18 months which have been associated with adverse perinatal outcomes, including preterm birth, low birth weight, and small size of gestational age, as well as adverse maternal outcomes. • All postpartum women can be considered at risk for unintended pregnancy for that period of time. Family Planning counseling, including counseling of interpregnancy intervals, contraceptive care, referral or provision of services is documented.[76] Prenatal discussions should include the woman's reproductive life plans, including the desire for and timing of any future pregnancies. See the HHS guidance on Contraceptive Care Measures, available at: https://opa.hhs.gov/research-evaluation/title-x-services-research/contraceptive-care-measures

[75] 17 CCR 6521-6532
[76] See PL 98-011, Family Planning Services in Medi-Cal Managed Care, or any superseding APL for additional information.

<table>
<tr><th colspan="2">VI. OB/CPSP Preventive Criteria</th></tr>
<tr><td></td><td>See DHCS' Office of Family Planning webpage, available at: https://www.dhcs.ca.gov/services/ofp/Pages/OfficeofFamilyPlanning.aspx

See APL 18-019, Family Planning Services Policy for Self-Administered Hormonal Contraceptives, or any superseding APL for additional information.</td></tr>
<tr><td>L. Comprehensive Postpartum Assessment</td><td>The weeks following birth are a critical period for a woman and her infant, setting the stage for long-term health and well-being. To optimize the health of women and infants, postpartum care should become an ongoing process, rather than a single encounter, with services and support tailored to each woman's individual needs.
As of April 1, 2022, Medi-Cal's postpartum period is extended from 60 to 365 days, regardless of how the pregnancy ends.

• Per ACOG, women should contact their OB-GYN or other obstetric care providers within the first three weeks postpartum.
• The comprehensive postpartum visit should be scheduled between four weeks and six weeks after delivery.
• This initial postpartum assessment should be followed up with ongoing care as needed throughout the 12 month postpartum period, including with a comprehensive postpartum visit no later than 12 weeks after birth.

The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being, including the following domains:
○ Mood and emotional well-being
○ Infant care and feeding
○ Sexuality
○ Contraception
○ Birth spacing
○ Sleep and fatigue
○ Physical recovery from birth
○ Chronic disease management
○ Health maintenance</td></tr>
</table>

VI. OB/CPSP Preventive Criteria	
	Women with chronic medical conditions such as hypertensive disorders, obesity, diabetes, thyroid disorders, renal disease, and mood disorders should be counseled regarding the importance of timely follow-up with their OB-GYN or primary care providers for ongoing coordination of care. During the postpartum period, the woman and her OB-GYN or other obstetric care provider should identify the health care provider who will assume primary responsibility for her ongoing care in her primary medical home. See the ACOG guidance on Optimizing Postpartum Care, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care. See the ACOG guidance on Postpartum Care, available at: https://www.acog.org/news/news-releases/2018/04/acog-redesigns-postpartum-care See the CDPH CPSP Postpartum Assessment and ICP, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-PostpartumAssessmentandCarePlan.pdf. https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/I21-13.pdf#:~:text=Individuals%20in%20Medi-Cal%20with%20a%20SOC%20may%20be,for%20the%20rest%20of%20pregnancy%20and%20postpartum%20period. See PL 12-003, Obstetrical Care-Perinatal Services, or any superseding APL for additional information. See ACOG information on Optimizing Postpartum Care, available at: https://www.acog.org/More-Info/OptimizingPostpartumCare. **Note:** Postpartum care is eligible for the VBP program. Please consult with the MCP for details.

VI. OB/CPSP Preventive Criteria	
	For screening: If the postpartum assessment visit is not documented a point will not be given. A point can be given if there is documentation in the medical record of missed appointments and attempts to contact member and/or outreach activities. If appointments are documented in a separate system from medical records, they must be readily accessible and meet the medical retention requirements.
1) Individualized Care Plan (ICP)	ICP documentation includes specific obstetric, nutrition, psychosocial and health education risk problems/conditions, interventions, and referrals. **ICP must be developed based on the comprehensive assessment in each trimester and post-partum.** See the CDPH CPSP Integrated Initial 1st, 2nd, and 3rd Trimester Assessments and ICP, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-CombinedInitialandTrimesterAssessmentandCarePlan.pdf. See the CDPH CPSP Postpartum Assessment and ICP, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-PostpartumAssessmentandCarePlan.pdf.
2) Nutrition Assessment	• USPSTF recommends providing interventions during pregnancy and after birth to support breastfeeding. Nutrition Assessment should include mother and infant including support for breast feeding.[77] • Any needed interventions must be noted. • Documentation of referrals as indicated. Infant feeding/breastfeeding status is documented during the postpartum period.[78] See the ACOG guidance on Optimizing Support for Breastfeeding as Part of Obstetric Practice, available at: https://www.acog.org/Clinical-Guidance-and-

[77] See the USPSTF recommendation on Breastfeeding: Primary Care Interventions, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breastfeeding-primary-care-interventions.

[78] See PL 98-010, Breastfeeding Promotion, or any superseding APL for additional information.

VI. OB/CPSP Preventive Criteria	
	Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Support-for-Breastfeeding-as-Part-of-Obstetric-Practice?IsMobileSet=false. https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-PostpartumAssessmentandCarePlan.pdf
3) Psychosocial Assessment	Psychosocial Assessment includes mood and emotional wellbeing; sleep and fatigue.[79] See the ACOG guidance on Optimizing Postpartum Care, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care.
a) Maternal Mental Health Screening/Postpartum Depression screening	*Practitioner who provides prenatal or postpartum care for a patient shall ensure that the mother is offered screening or is appropriately screened for maternal mental health conditions.* Counselling and intervention must be documented. • USPSTF recommends that clinicians provide or refer postpartum persons who are at increased risk of postpartum depression to counseling interventions.[80] • CMS Technical Specifications includes screening using validated tools and documentation of a follow-up plan if the depression screening is positive that aligns with USPSTF's referral and documentation of counseling or interventions with those found at risk for postpartum depression. • Patient screened for depression on the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen. Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record.

[79] See the ACOG guidance on Optimizing Postpartum Care, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care?utm_source=redirect&utm_medium=web&utm_campaign=otn.
[80] See the USPSTF recommendation on Perinatal Depression, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/abdominal-aortic-aneurysm-screening.

VI. OB/CPSP Preventive Criteria	
	Follow-Up Plan – Documented follow-up for a positive depression screening must include one or more of the following: ○ Additional evaluation or assessment for depression ○ Suicide Risk Assessment ○ Referral to a practitioner who is qualified to diagnose and treat depression ○ Pharmacological interventions ○ Other interventions or follow-up for the diagnosis or treatment of depression For additional information on CMS Technical Specifications, see: https://www.medicaid.gov/license/form/6466/4391. Edinburgh Postnatal Depression Scale (EPDS) is most commonly used and has been translated in 50 different languages.[81]
b) Social Needs Assessment	Social and Mental History (past and current). Follow up on pre-existing mental health disorders and social care needs such as housing, food, and transportation refer as appropriate.
c) Substance Use Disorder Assessment	Screen for tobacco and alcohol use and provide counseling; Screen for substance use disorder and refer as indicated. USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.[82] See APL 21-014, Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment, or any superseding APL for additional information.

[81] HSC 123640
[82] See the USPSTF recommendation on Unhealthy Alcohol Use in Adolescents and Adults, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions.

VI. OB/CPSP Preventive Criteria	
	USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco.[83]
4) Breastfeeding and other Health Education Assessment	• Health Education on infant care and feeding including breast feeding, contraception, and birth spacing. • Materials must be in threshold language and must meet readability and suitability requirements for educational material distributed to Medi-Cal members.[84] See the USPSTF recommendation on Breastfeeding, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breastfeeding-primary-care-interventions. See APL 18-019, Family Planning Services Policy for Self-Administered Hormonal Contraceptives, or any superseding APL for additional information.
5) Comprehensive Physical Exam	The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being, including the following domains: • Mood and emotional well-being • Infant care and feeding • Sexuality • Contraception • Birth spacing • Sleep and fatigue • Physical recovery from birth • Chronic disease management • Health maintenance

[83] See the USPSTF recommendation on Tobacco Smoking Cessation in Adults, Including Pregnant Persons, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions

[84] See APL 18-016, Readability and Suitability of Written Health Education Materials, or any superseding APL for additional information.

VI. OB/CPSP Preventive Criteria	
	Women with chronic medical conditions such as hypertensive disorders, obesity, diabetes, thyroid disorders, renal disease, and mood disorders should be counseled regarding the importance of timely follow-up with their OB-GYN or primary care providers for ongoing coordination of care. During the postpartum period, the woman and her OB-GYN or other obstetric care provider should identify the health care provider who will assume primary responsibility for her ongoing care in her primary medical home. It is recommended that all women have contact with their OB-GYN or other obstetric care providers within the first three weeks postpartum. This initial assessment should be followed up with ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth. See the ACOG guidance on Optimizing Postpartum Care, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care

Primary Care Provider-Medical Record Review Tool

Health Plan: _____

Site ID: _____ **Site NPI:** _____

Address: _____

City and Zip Code: _____

Phone: _____ **Fax:** _____

Review Date: _____

Reviewer name/title: _____

Reviewer name/title: _____

Reviewer name/title: _____

Reviewer name/title: _____

Collaborating MCP(s): 1. _____

2. _____

No. of Physicians: _____

Contact person/title: _____

Provider Name	Credentials (MD, NP, PA, CNM, LM)	NPI

Electronic Medical Record (EMR): Yes (#)___ No(#) __

Medical Record Review: Onsite _____ Remote Access _____

Paper/Hard Copy Medical Records: Yes ___ No___ Shared Medical Records: Yes_____ No_____

Number of Records Reviewed: _____

Visit Purpose	Site-Specific Certification(s)	Provider Type	Clinic Type
_____Initial Full Scope _____Monitoring _____Periodic Full Scope _____Follow-up _____Focused Review _____Technical Assistance ____Other_____ (type)	_____ AAAHC _____ JC _____ CHDP _____ NCQA _____ CPSP _____ None _____ PCMH _____ Other _____	_____ Family Practice _____ Internal Medicine _____ General Practice _____ Pediatrics _____ OB/GYN as PCP_____ _____ Certified Nurse Midwife _____ Licensed Midwife	_____ Primary Care _____ Community _____ Hospital _____ FQHC _____ Rural Health _____ Solo _____ Group _____ Staff/Teaching _____ Other (Type)_____

Medical Record Scores

Note: Score "R" for Documented Member Refusal (due to member non-compliance with evidence showing provider outreach, referrals, lab orders, awaiting results.)
When scoring for OB/CPSP Preventive, score the Adult or Pediatric Preventive criteria for the same record.

	Points possible	Yes Pts. Given	R Pts. Given	No's	N/A's	Section Score %
I. Format	**(8) x 10 = 80**					
II. Documentation	**(8) x 10 = 80**					
III. Coordination of Care	**(8) x 10 = 80**					
IV. Pediatric Preventive	**(34) x # of records**					
V. Adult Preventive	**(30) x # of records**					
VI. OB/CPSP Preventive	**(59) x # of records**					
	Points Possible	**Yes Pts. Given**	**R Pts. Given**	**No's**	**N/A's**	

Scoring Procedure

Scoring is based on <u>10</u> 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-34, Adult-30, OB/CPSP-59, the <u>total points possible</u> will differ from site to site, depending on the number of *types* of records that are selected. The "No's" 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%)

____ **Fail: 79% and Below**

____ CAP Required

____ Other follow-up

Next Review Due: _____

Medical Records Reference:

Medical Record	CIN	Age Year/Month	Gender	Member's Health Plan Code or Name	Member's Enrollment Date in MCP or Effective Date PCP Assigned to Member*
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

* Whichever is more recent

I. Format Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.) Criteria not met: 0 points Criteria not applicable: N/A	Wt.	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
Individual Medical Record is established for each member.												
A. Member identification is on each page.	1											
B. Individual personal biographical information is documented.	1											
C. Emergency "contact" is identified.	1											
D. Medical records are maintained and organized.	1											
E. Member's assigned and/or rendering primary care physician (PCP) is identified.	1											
F. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing/speech-impaired persons are prominently noted.	1											
G. Person or entity providing medical interpretation is identified.	1											
H. Signed Copy of the Notice of Privacy.	1											
Comments:	**Yes**											
	R											
	No											
	NA											

II. Documentation Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point **Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.)** **Criteria not met: 0 points** **Criteria not applicable: N/A**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Allergies are prominently noted.	**1**											
B. Chronic problems and/or significant conditions are listed.	**1**											
C. Current *continuous* medications are listed.	**1**											
D. Appropriate consents are present:												
1) Release of Medical Records	**1**											
2) Informed Consent for invasive procedures	**1**											
E. Advance Health Care Directive Information is offered.	**1**											
F. All entries are signed, dated, and legible.	**1**											
G. Errors are corrected according to legal medical documentation standards.	**1**											
Comments:	**Yes**											
	R											
	No											
	N/A											

III. Coordination of Care Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point **Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.)** **Criteria not met: 0 points** **Criteria not applicable: N/A**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. History of present illness or reason for visit 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 specialty/consult/referral reports and diagnostic test results.	**1**											
G. There is evidence of *follow-up* of specialty consult/referrals made, and results/reports of diagnostic tests, when appropriate.	**1**											
H. Missed primary care appointments and outreach efforts/follow-up contacts are documented.	**1**											
Comments:	**Yes**											
	R											
	No											
	N/A											

IV. Pediatric Preventive Criteria **NOTE: * denotes** Pending AAP guidance.

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.) Criteria not met: 0 points Criteria not applicable: N/A	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Initial Health Appointment (IHA) includes H&P and Risk Assessment												
1) Comprehensive History and Physical	**1**											
2) Member Risk Assessment	**1**											
B. Subsequent Comprehensive Health Assessment												
1) Comprehensive History and Physical exam completed at age-appropriate frequency	**1**											
2) Subsequent Risk Assessment	**1**											
C. Well-child visit												
1) Alcohol Use Disorder Screening and Behavioral Counseling	**1**											
2) Anemia Screening	**1**											
3) Anthropometric Measurements	**1**											
4) Anticipatory Guidance	**1**											
5) Autism Spectrum Disorder Screening	**1**											
6) Blood Lead Screening	**1**											
7) Blood Pressure Screening	**1**											
8) Dental/Oral Health Assessment	**1**											
a) Fluoride Supplementation	**1**											
b) Fluoride Varnish	**1**											
9) Depression Screening	**1**											

IV. Pediatric Preventive Criteria **NOTE: * denotes** Pending AAP guidance.

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.) Criteria not met: 0 points Criteria not applicable: N/A	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
a) Suicide-Risk Screening	**1**											
b) Maternal Depression Screening	**1**											
10) Developmental Disorder Screening	**1**											
11) Developmental Surveillance	**1**											
12) Drug Use Disorder Screening and Behavioral Counseling	**1**											
13) Dyslipidemia Screening	**1**											
14) Hearing Screening	**1**											
15) Hepatitis B Virus Infection Screening	**1**											
16) Hepatitis C Virus Infection Screening	**1**											
17) Human Immunodeficiency Virus (HIV) Infection Screening	**1**											
18) Psychosocial/Behavioral Assessment	**1**											
19) Sexually Transmitted Infections (STIs) Screening and Counseling	**1**											
20) Sudden Cardiac Arrest and Sudden Cardiac Death Screening	**1**											
21) Tobacco Use Screening, Prevention, and Cessation Services	**1**											
22) Tuberculosis Screening	**1**											
23) Vision Screening	**1**											
D. Childhood Immunizations												
1) Given according to Advisory Committee on Immunization Practices (ACIP) guidelines	**1**											

IV. Pediatric Preventive Criteria **NOTE: * denotes** Pending AAP guidance.

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point **Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.)** **Criteria not met: 0 points** **Criteria not applicable: N/A**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
2) Vaccine administration documentation	**1**											
3) Vaccine Information Statement (VIS) documentation	**1**											
Comments:	**Yes**											
	R											
	No											
	N/A											

V. Adult Preventive Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point **Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.)** **Criteria not met: 0 points** **Criteria not applicable: N/A**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Initial Health Appointment (IHA) includes H&P and Risk Assessment												
1) Comprehensive History and Physical	**1**											
2) Member Risk Assessment	**1**											
B. Periodic Health Evaluation according to most recent United States Preventive Services Taskforce (USPSTF) Guidelines												
1) Comprehensive History and Physical Exam completed at age-appropriate frequency	**1**											
2) **Subsequent** Risk Assessment	**1**											
C. Adult Preventive Care Screenings												
1) Abdominal Aneurysm Screening	**1**											
2) Alcohol Use Disorder Screening and Behavioral Counseling	**1**											
3) Breast Cancer Screening	**1**											
4) Cervical Cancer Screening	**1**											
5) Colorectal Cancer Screening	**1**											
6) Depression Screening	**1**											
7) Diabetic Screening	**1**											
a) Comprehensive Diabetic Care	**1**											
8) Drug Use Disorder Screening and Behavioral Counseling	**1**											
9) Dyslipidemia Screening	**1**											
10) Folic Acid Supplementation	**1**											

V. Adult Preventive Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point **Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.)** **Criteria not met: 0 points** **Criteria not applicable: N/A**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
11) Hepatitis B Virus Screening	**1**											
12) Hepatitis C Virus Screening	**1**											
13) High Blood Pressure Screening	**1**											
14) HIV Screening	**1**											
15) Intimate Partner Violence Screening for Women of Reproductive Age	**1**											
16) Lung Cancer Screening	**1**											
17) Obesity Screening and Counseling	**1**											
18) Osteoporosis Screening	**1**											
19) Sexually Transmitted Infection (STI) Screening and Counseling	**1**											
20) Skin Cancer Behavioral Counseling	**1**											
21) Tobacco Use Screening, Counseling, and Intervention	**1**											
22) Tuberculosis Screening	**1**											
D. Adult Immunizations												
1) Given according to ACIP guidelines	**1**											
2) Vaccine administration documentation	**1**											
3) Vaccine Information Statement (VIS) documentation	**1**											
Comments:	**Yes**											
	R											

V. Adult Preventive Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point **Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.)** **Criteria not met: 0 points** **Criteria not applicable: N/A**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
	No											
	N/A											

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.) Criteria not met: 0 points Criteria not applicable: N/A	Wt.	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
A. Initial Comprehensive Prenatal Assessment (ICA)												
1) Initial prenatal visit	1											
2) Obstetrical and Medical History	1											
3) Physical Exam	1											
4) Dental Assessment	1											
5) Healthy Weight Gain and Behavioral Counseling	1											
6) Lab tests												
a) Bacteriuria Screening	1											
b) Rh Incompatibility Screening	1											
c) Diabetes Screening	1											
d) Hepatitis B Virus Screening	1											
e) Hepatitis C Virus Screening	1											
f) Chlamydia Infection Screening	1											
g) Syphilis Infection Screening	1											
h) Gonorrhea Infection Screening	1											
i) Human Immunodeficiency Virus (HIV) Screening	1											
B. First Trimester Comprehensive Assessment												
1) Individualized Care Plan (ICP)	1											

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point **Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.)** **Criteria not met: 0 points** **Criteria not applicable: N/A**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
2) Nutrition Assessment	**1**											
3) Psychosocial Assessment												
a) Maternal Mental Health Screening	**1**											
b) Social Needs Assessment	**1**											
c) Substance Use Disorder	**1**											
4) Breast Feeding and other Health Education Assessment	**1**											
5) Preeclampsia Screening	**1**											
6) Intimate Partner Violence Screening	**1**											
C. Second Trimester Comprehensive assessment												
1) ICP	**1**											
2) Nutrition Assessment	**1**											
3) Psychosocial Assessment												
a) Maternal Mental Health Screening	**1**											
b) Social Needs Assessment	**1**											
c) Substance Use Disorder Assessment	**1**											
4) Breast Feeding and other Health Education Assessment	**1**											
5) Preeclampsia Screening	**1**											
a) Low Dose Aspirin	**1**											

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.) Criteria not met: 0 points Criteria not applicable: N/A	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
6) Intimate Partner Violence Screening	**1**											
7) Diabetes Screening	**1**											
D. Third Trimester Comprehensive assessment												
1) ICP Update and Follow Up	**1**											
2) Nutrition Assessment	**1**											
3) Psychosocial Assessment												
a) Maternal Mental Health Screening	**1**											
b) Social Needs Assessment	**1**											
c) Substance Use Disorder Assessment	**1**											
4) Breastfeeding and other Health Education Assessment	**1**											
5) Preeclampsia Screening	**1**											
a) Low Dose Aspirin	**1**											
6) Intimate Partner Violence Screening	**1**											
7) Diabetic Screening	**1**											
8) Screening for Strep B	**1**											
9) Screening for Syphilis	**1**											
10) Tdap Immunization	**1**											
E. Prenatal care visit periodicity according to most recent American College of Obstetricians and Gynecologists (ACOG) standards	**1**											

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point **Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.)** **Criteria not met: 0 points** **Criteria not applicable: N/A**	**Wt.**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
F. Influenza Vaccine	**1**											
G. COVID Vaccine	**1**											
H. Referral to Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and assessment of Infant Feeding Status	**1**											
I. HIV-related services *offered*	**1**											
J. AFP/Genetic Screening offered	**1**											
K. Family Planning Evaluation	**1**											
L. Comprehensive Postpartum Assessment												
1) ICP	**1**											
2) Nutrition Assessment	**1**											
3) Psychosocial Assessment												
a) Maternal Mental Health Screening/Postpartum Depression screening	**1**											
b) Social Needs Assessment	**1**											
c) Substance Use Disorder Assessment	**1**											
4) Breastfeeding and other Health Education Assessment	**1**											
5) Comprehensive Physical Exam	**1**											
Comments:	**Yes**											
	R											
	No											

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

Criteria met: Give one (1) point Documented Member Refusal: R Give (1) point and score "R" for instances of member non-compliance. (Evidence showing provider outreach, order, referral, pending results.) Criteria not met: 0 points Criteria not applicable: N/A	Wt.	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
	N/A											

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				

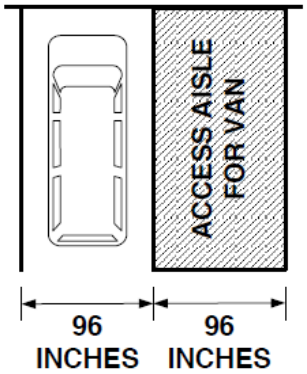
I certify that there have been no changes since the last physical accessibility review:

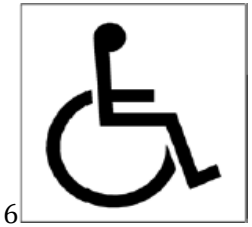
Name: _____ Signature: _____ Date: _____

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

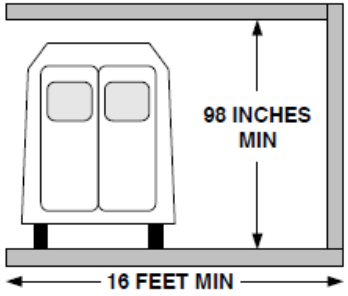
Name: _____ Signature: _____ Date: _____

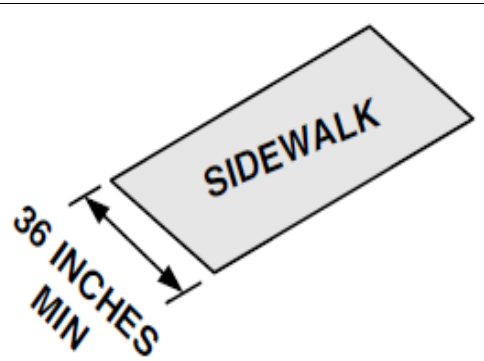
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
PARKING						
1	Is off-street public parking available?	Self explanatory.				
2	Are accessible parking spaces provided in off-street parking?	Self explanatory.				
3 (CE)	**Are the correct number of accessible parking 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.				

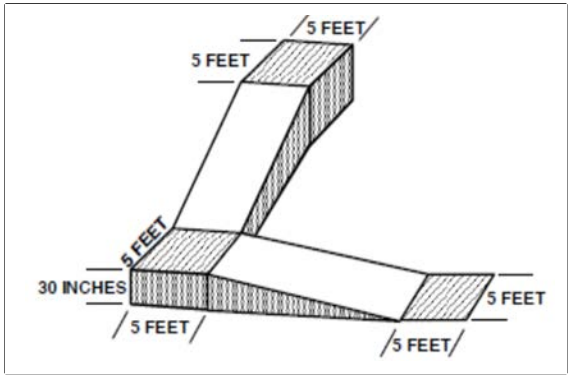
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
7 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the parking locations?**	Pathways should have curb ramps. Without curb ramps, wheelchair users may be required to travel in the street 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				

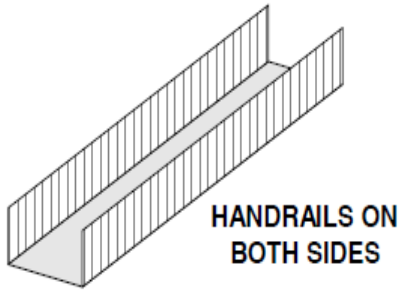
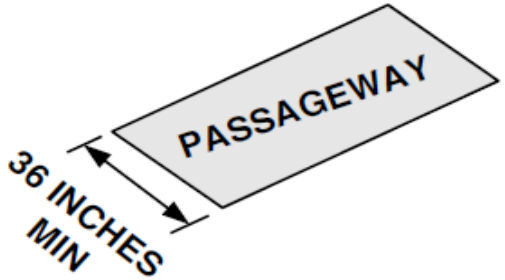
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
10	Are signs mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle?	Signs must be located so a vehicle parked in the space does not obscure them. (Van accessible spaces 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?					

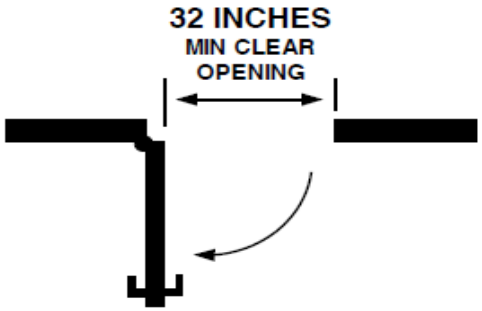
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	c. Public sidewalk?					
15	Is the accessible route to the building entrance at least 36 inches wide for exterior routes from the following: (Please mark NA for those that do not apply.)					
	a. Parking?					
	b. 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?					

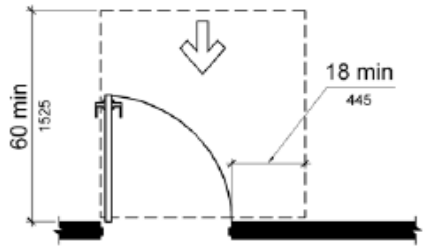
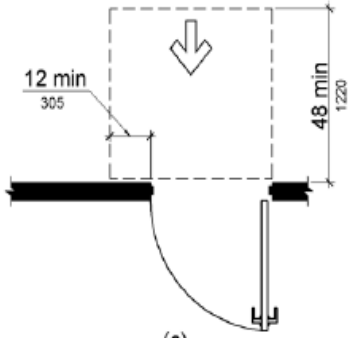
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	b. Public transportation?					
	c. Public sidewalk?					
17	Is there an accessible route that does not include stairs or steps?	Self explanatory.				
18	Is the route to the entrance from the accessible parking spaces, 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.				

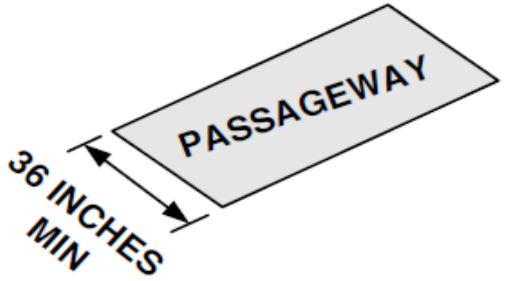
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
22 (CE)	**Are handrails provided on both sides of the ramp that are mounted between 34 and 38 inches above the ramp surface, if it is longer than 6 feet?**	If the ramp is not longer than 6 feet, check NA.  				
23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

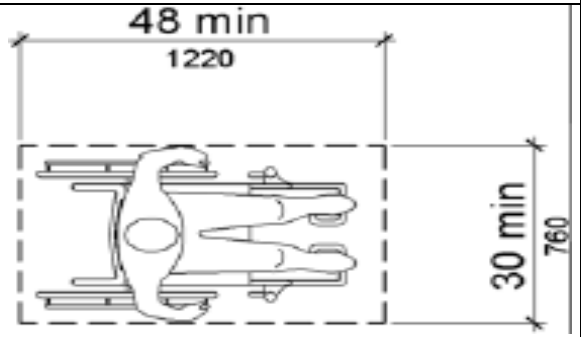
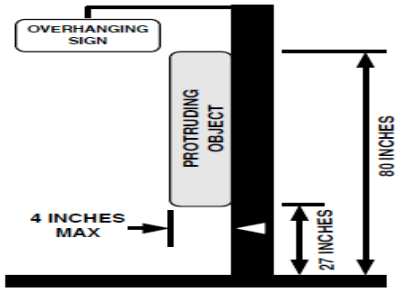
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
27 (CE)	**Do doors have an opening at least 32 inches wide (at the narrowest point below the opening hardware) when opened to 90°?**	When measuring double doors, measure the opening with one door open to 90°.  				
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.				

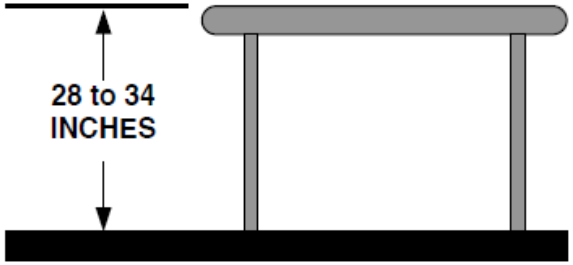
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
		 (a) front approach, pull side  (c) front approach, push side, door provided with both closer and latch				
29	Is the space required to open the door level and clear of movable objects (chairs, trash cans, etc.)?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

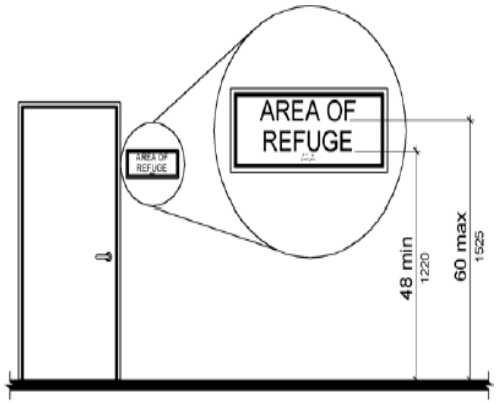
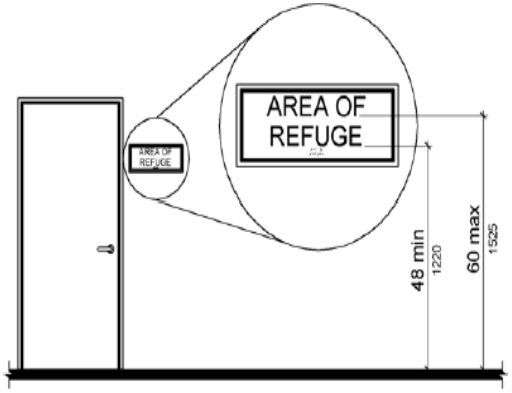
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
30	Are there automatic doors?	Self explanatory.				
31 (CE)	**Do entrance doors have handles that can be opened without grasping, pinching, or twisting of the wrist?**	Can the door be opened by someone with a closed 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.				

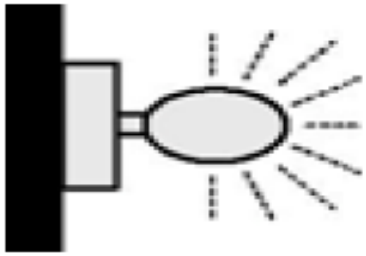
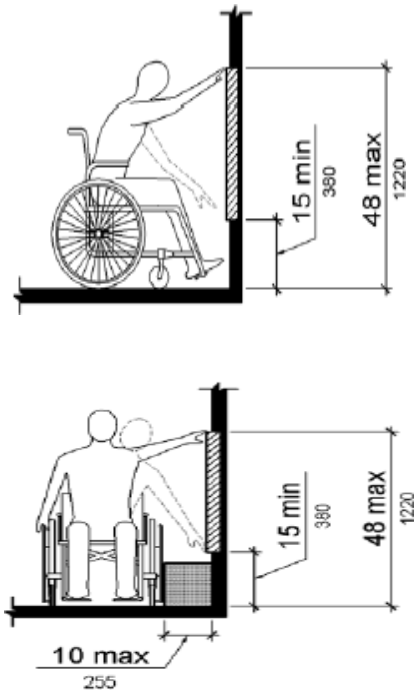
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
33	Is there an interior accessible route to the medical office that does not include stairs or steps?	Floors of a given story are level throughout the building, or connected by ramps, passenger elevators or access 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.				

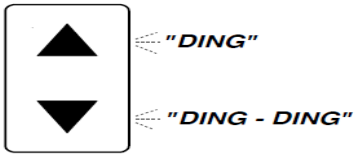
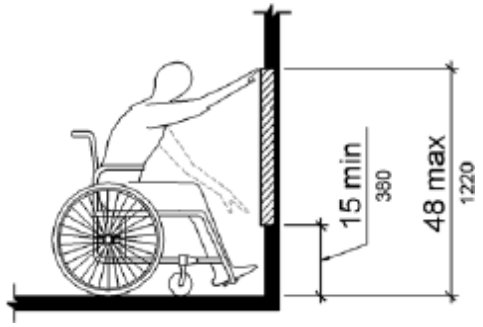
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
41	Does the interior door to the medical office require less than 5 pounds of pressure to open?	If interior door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 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. 				

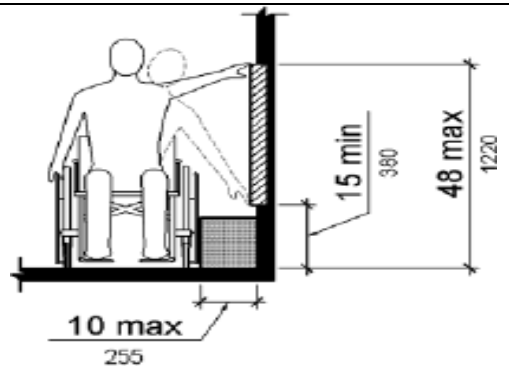
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
44	If floor mats are used, are the edges of floor mats stiff enough or secured so that they do not roll up?	If floor mats are not in use, check NA. Floor mats that are not secured to the floor can roll up or bunch 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.				

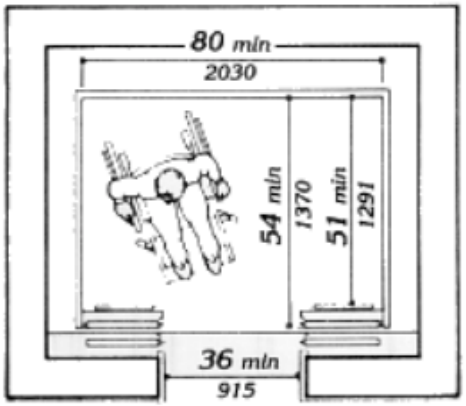
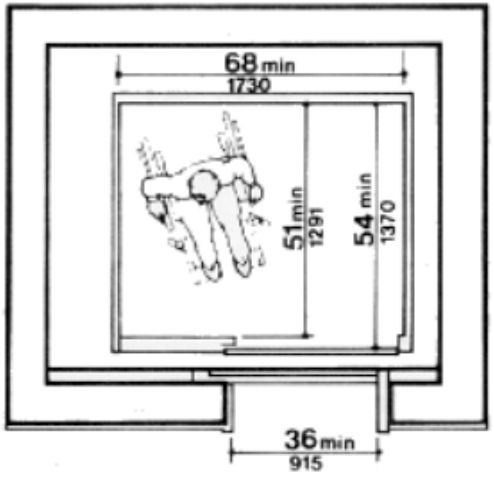
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
47	Do signs identifying permanent rooms and spaces include raised letters and Braille?					
48	Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor?	 Raised letters and Braille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

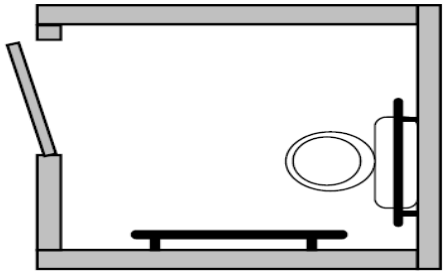
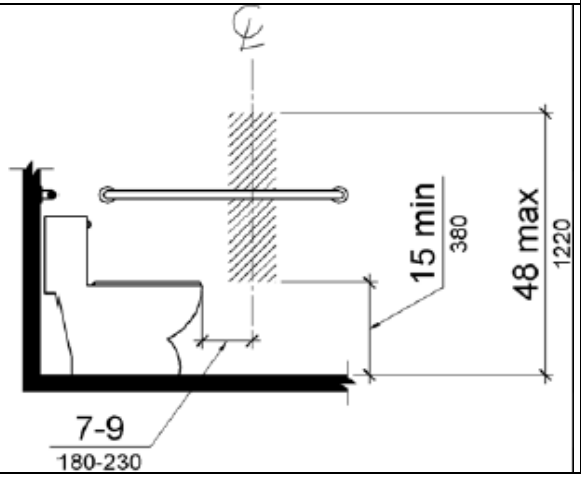
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
54 (CE)	**Is the elevator equipped with both visible and audible door opening/closing and floor indicators?**	A visible and audible signal is required at each elevator entrance to indicate which car is answering a 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?**					

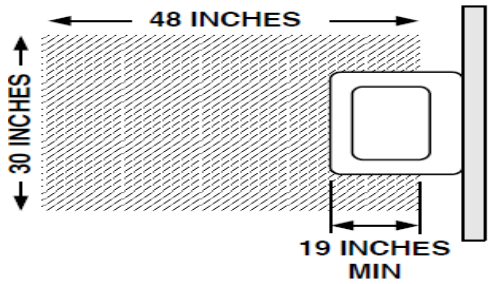
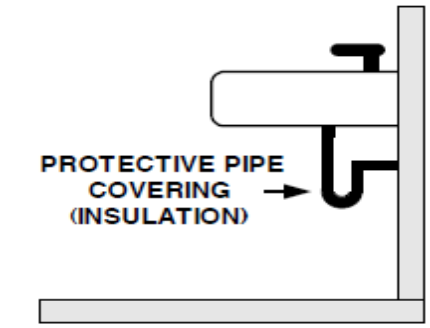
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
						

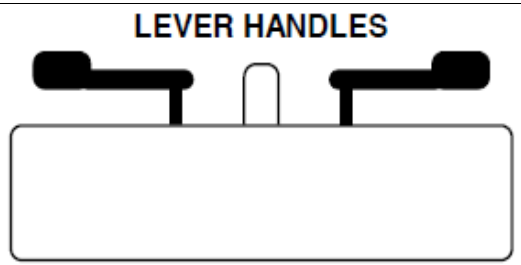
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
57 (CE)	**Is the elevator car large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit?**	The doorway should be at least 36 inches wide and the floor area should be at least 51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

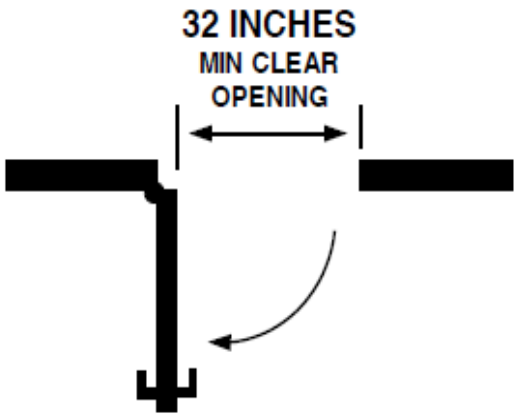
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
58 (CE)	**Do the buttons on the control panel inside the elevator have Braille and raised characters/symbols near the buttons?**	Self explanatory.				
59	Is there an emergency communication system in the elevator?	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.				

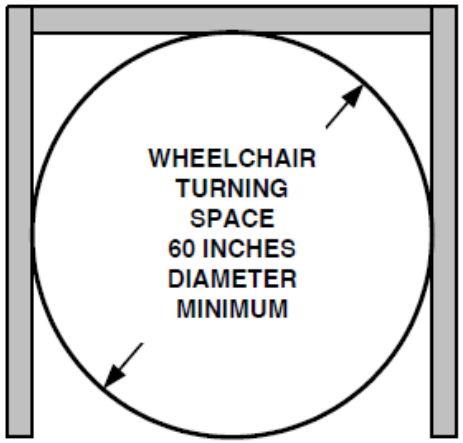
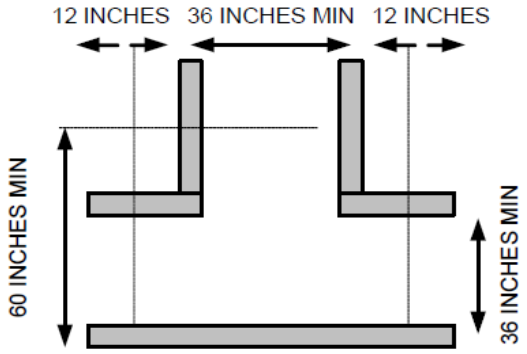
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
61	Do raised letters and Braille identify the emergency intercom in the elevator?	Self explanatory.				
TOILET ROOMS (INCLUDING THOSE USED FOR SPECIMEN COLLECTION)						
ALL TOILET ROOMS:						
62	Is there an accessible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

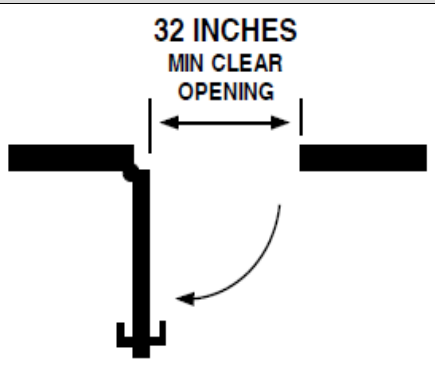
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
		weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
65 (CE)	**For all toilet 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?**					

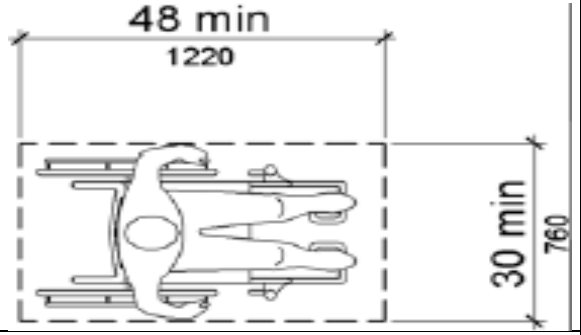
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
68 (CE)	**Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair users to park in front of the sink?**	This space must extend at least 17 inches under the sink from the front edge, 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.				

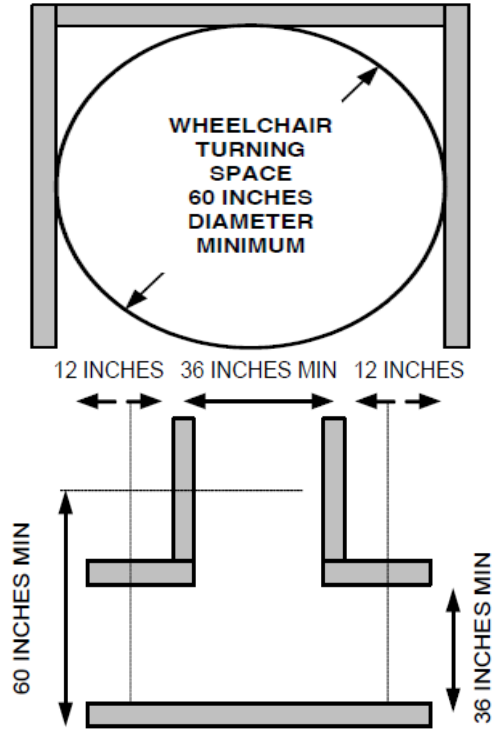
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
						
72	Are all dispensers mounted no higher than 40 inches from the floor?	Included are soap dispensers, paper towel dispensers, seat cover dispensers, hand dryers, etc.				
73	Are all dispensers (soap, paper towel, 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?**	9 				
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.
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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**				

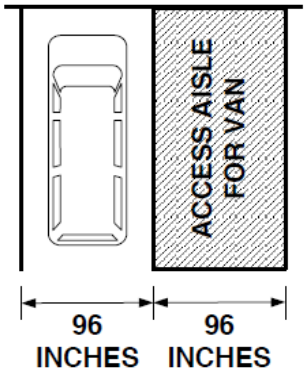
2nd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

Name: _____ Signature: _____ Date: _____

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

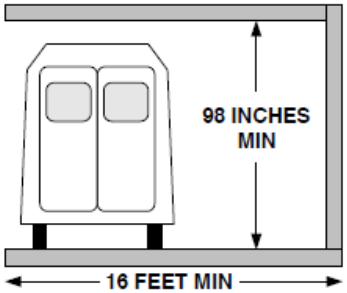
Name: _____ Signature: _____ Date: _____

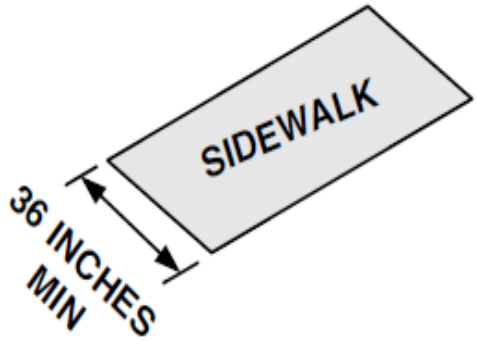
PARKING						
1	Is off-street public parking available?	Self explanatory.				
2	Are accessible parking spaces provided in off-street parking?	Self explanatory.				
3 (CE)	**Are the correct number of accessible parking spaces provided?** **1 to 25 total spaces – 1 required** **26 to 50 – 2 required** **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.				

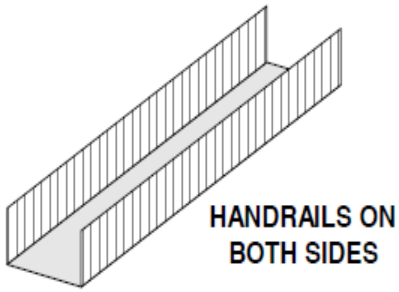
7 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the parking locations?**	**Pathways should have curb ramps. Without curb ramps, wheelchair users may be required to travel in the street or behind parked cars where drivers cannot see them.**				
8 (CE)	**Do curbs on the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

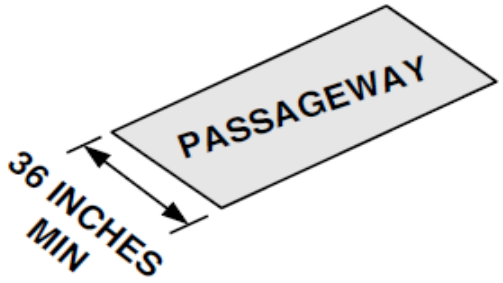
9	Does every accessible parking space have a vertical sign posted with the International Symbol of Accessibility?	Symbol in the illustration depicts the International Symbol of Accessibility. 				
10	Are signs mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked 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)				
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.				

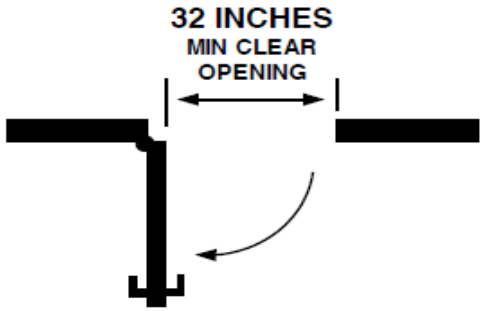
13	If van accessible parking is provided in a parking garage, is there at least 8 feet 2 inches (98 inches total) vertical clearance available for full-sized, lift equipped vans?	If there is no parking garage, check NA. If designated accessible parking is located in a garage, the vertical clearance should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

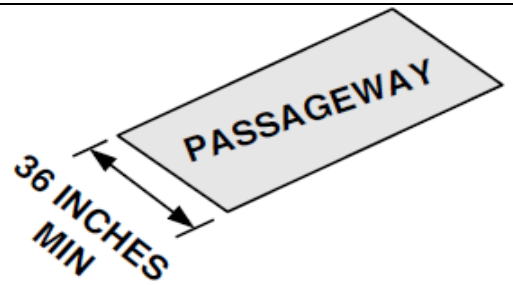
EXTERIOR ROUTE (FROM ACCESSIBLE PARKING, PUBLIC TRANSPORTATION, AND PUBLIC SIDEWALK TO THE ENTRANCE)						
14 (CE)	**For exterior routes, if the accessible route crosses a curb, is a curb ramp provided to the building entrance from the following: (Please mark NA for those that do not apply.)**	**Self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

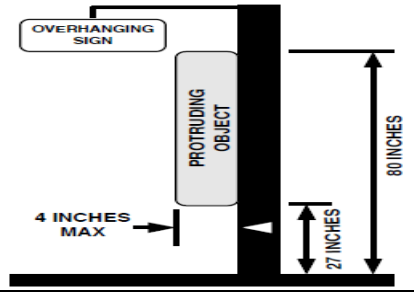
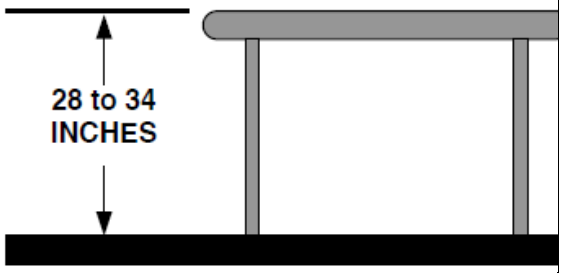
18	Is the route to the entrance from the accessible parking spaces, including transitions at curb ramps, free of grates, gaps, and openings that are both greater than ½ inch wide and over ¼ inch deep?	Self explanatory.				
RAMPS:						
19	Is an access ramp present?	If there is more than one ramp, select 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.**  				

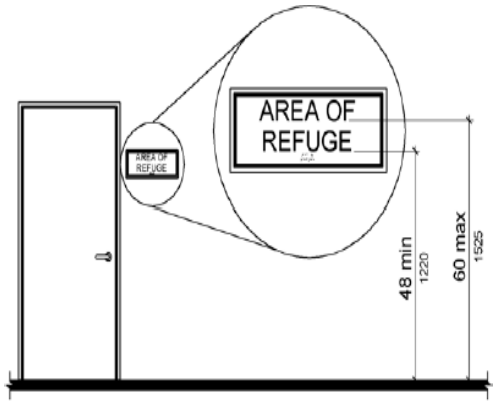
21 (CE)	**Are all ramps at least 36 inches wide?**					

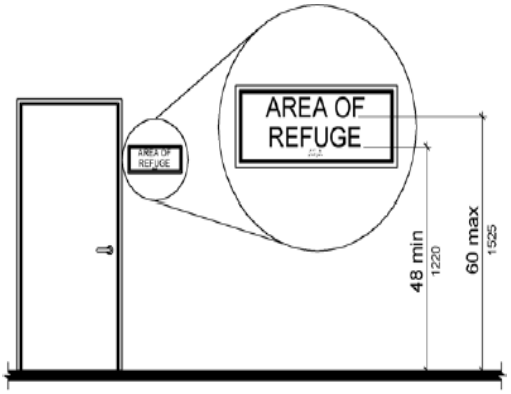
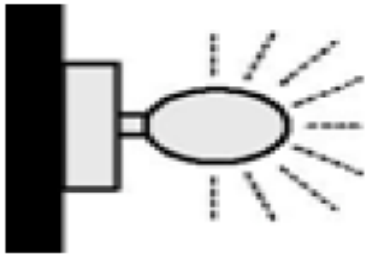
BUILDING ENTRANCE						
22 CE	**Is the main entrance accessible?**	**Self explanatory.**				
23	If a main entrance is not accessible, is there another accessible entrance?	Self explanatory.				
24	If a main entrance is not accessible, is there directional signage indicating the location of the accessible 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°.** 				

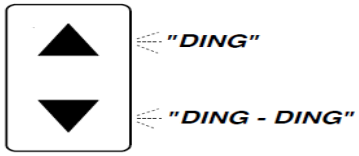
26	Are there automatic doors?	Self explanatory.				
INTERIOR ROUTE (FROM THE BUILDING ENTRANCE, TO THE REGISTRATION COUNTER/WINDOW, AND THROUGH TO THE PARTICIPANT AREAS						
27	Is there an interior route to the patient area?	Some patient areas are accessed directly from the street or drop off rather than being located within a larger building or complex, therefore they do not have interior routes.				
28 (CE)	**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.				

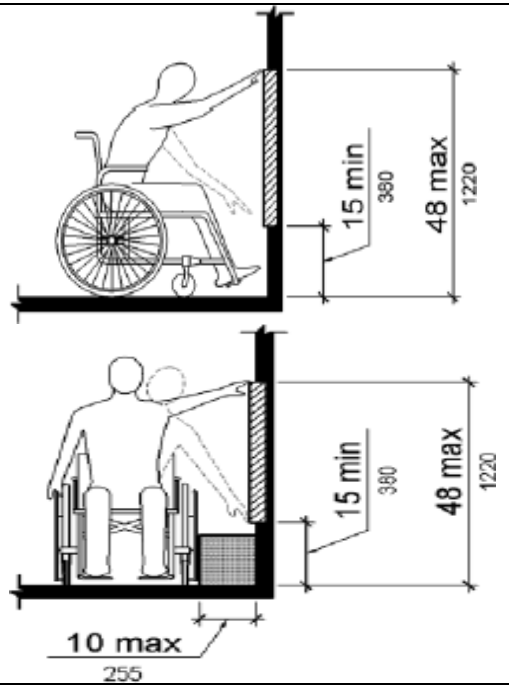
30	Is the interior accessible route well lighted?	A brightly lit corridor will help avoid falls.				
31 (CE)	**If there are stairs on the accessible route, are there handrails on each side?**	**If there are no stairs, check NA.**				
32	If there are stairs, are all stair risers closed that are on the 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).				

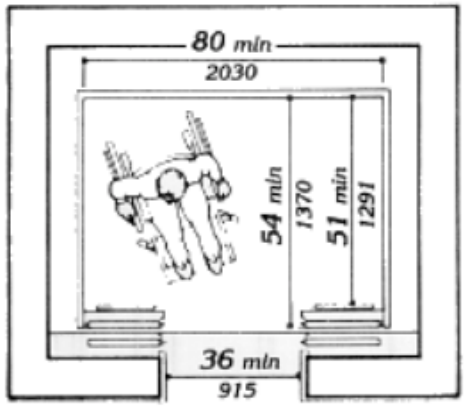
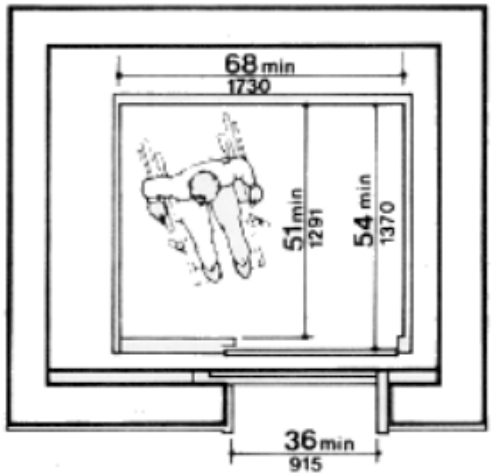
34	Is the path through the facility free of any objects that stick out into the circulation path that a blind person might not detect with a cane?	If an object protrudes more than 4 inches and is located between 27 inches above the walking surface and below 80 inches, a blind person walking with a cane 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?					

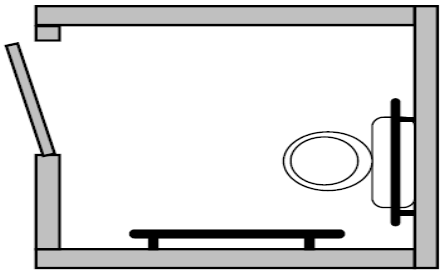
39	Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor?	 Raised letters and Braille signs are either on the latch side of doors or on the face of doors and are mounted between 48 inches and 60 inches from the floor.				
40	If the building has a fire alarm system, 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. 				

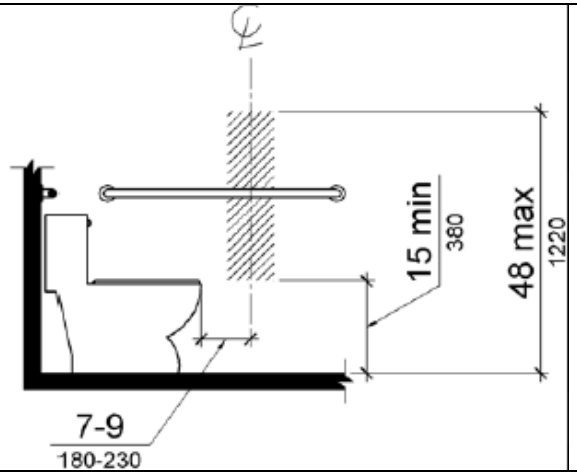
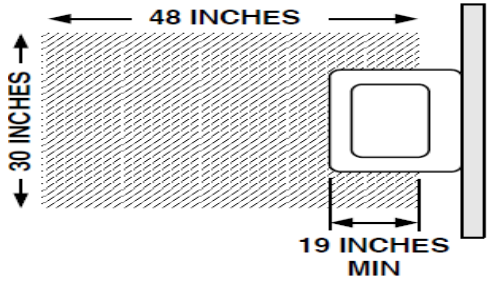
ELEVATORS						
41	Is there an elevator?	Self explanatory.				
42 (CE)	**If needed, is the elevator available for public/patient use during business hours?**	**Self explanatory.**				
43 (CE)	**Is the elevator equipped with both visible and audible door opening/closing and floor indicators?**	**A visible 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.**				

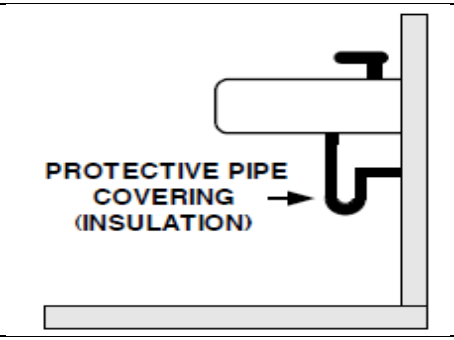
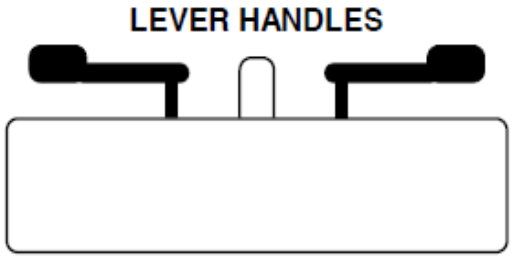
45 (CE)	**Are the hall call buttons for the elevator no higher than 48 inches from the floor?**					

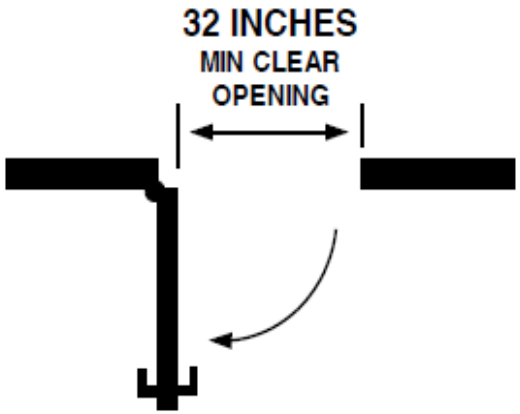
46 (CE)	**Is the elevator car large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit?**	**The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide, depending on where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

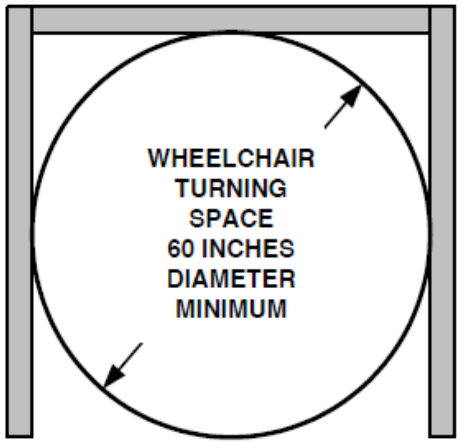
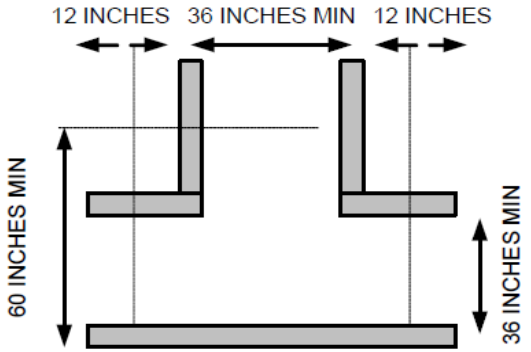
48	Is there an emergency communication system in the elevator?	Self explanatory.				
49	Is the elevator emergency communication system usable without requiring voice communication?	It is essential that emergency communication not be dependent on voice communications alone because the safety of people 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.				

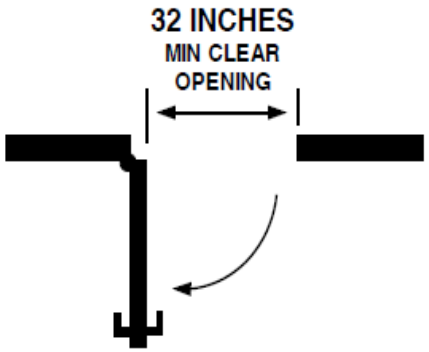
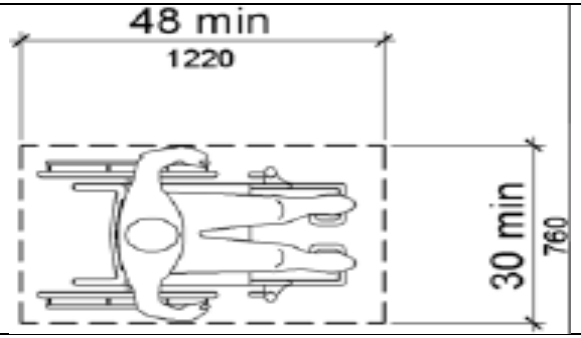
ALL RESTROOMS/TOILET ROOMS (WITH AND WITHOUT STALLS):						
51	Is there an accessible restroom/toilet room?	Self explanatory.				
52	Does the interior door to the restroom require less than 5 pounds of pressure to open?	If restroom door is a fire door, check NA. For interior doors (not fire doors), labor 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.				

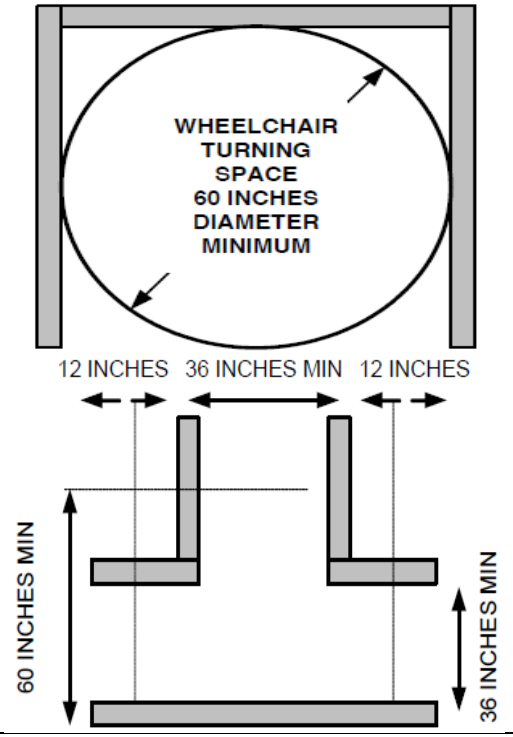
55 (CE)	**Is the toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7 inches and 9 inches in front of the toilet, and at least 15 inches high?**					
56 (CE)	**Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair 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.				

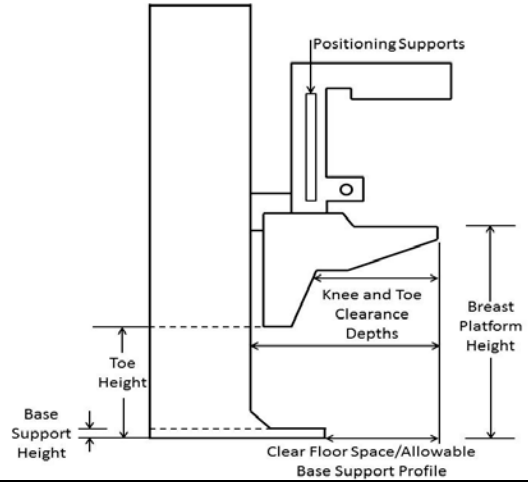
62 (CE)	**Do restroom doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**					
63	Is the space inside the restroom clear, without trashcans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				

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)						
66 (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?**					
67 (CE)	**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"

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:	Health Plan Name:
City:	
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: _____

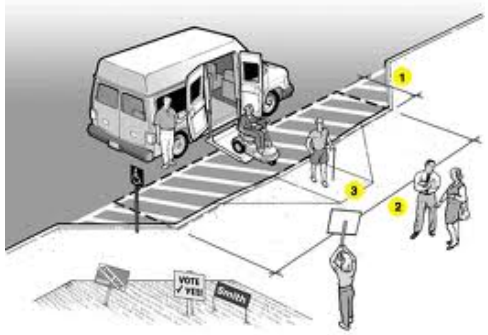
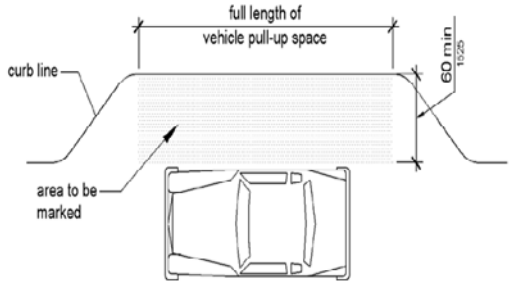
3rd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

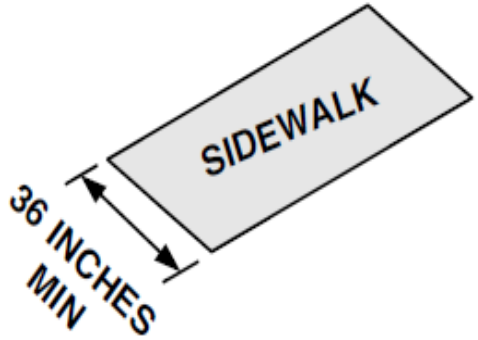
Name: _____ Signature: _____ Date: _____

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.				

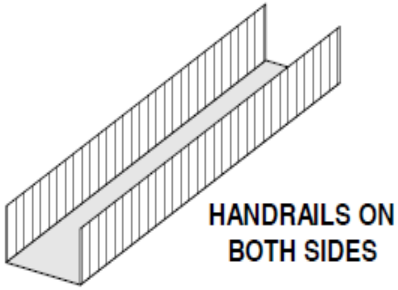
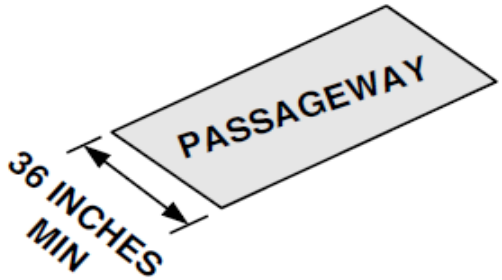
4	Does every accessible parking space have a vertical sign posted with the International Symbol of Accessibility?	Symbol in the illustration depicts the International Symbol of Accessibility. 				
5	Are signs mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked 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)				

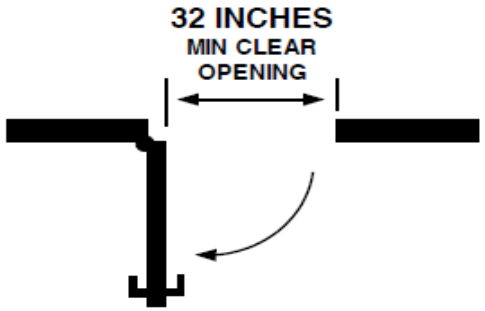
6 (CE)	**Is a passenger loading zone provided with a vehicular pull-up space.**	The vehicular pull-up space dimension is a minimum of 96 inches wide and 20 feet long				

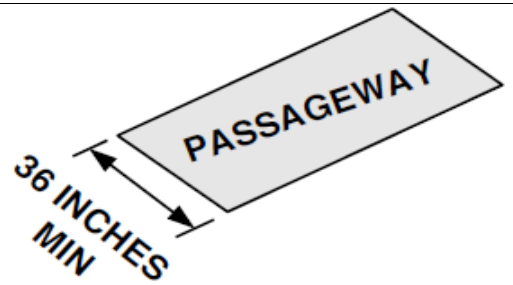
7 (CE)	**Is there an access aisle that adjoins an accessible route and does not overlap the Vehicular way /driveway?**	**Access aisles serving vehicle pull-up *spaces* shall be a minimum of 60 inches wide.**  				
8 (CE)	**Do curbs on the route have curb ramps at the drop off locations?**	**Pathways 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				

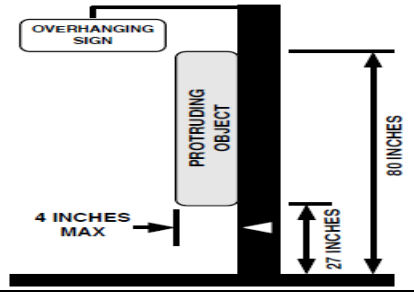
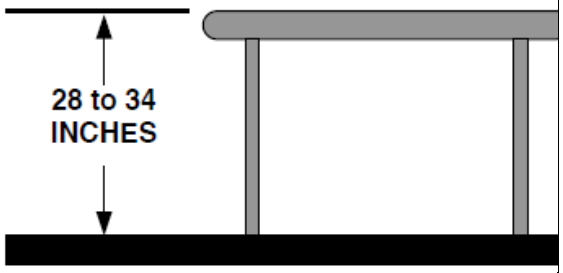
	building entrance stable, firm, and slip resistant from the following: (Please mark NA for those that do not apply.)	ground surface without loose elements like gravel or wood chips. Firm surfaces include solid concrete or pavement as opposed to a grassy, graveled or soft soil surface. Avoid glossy or 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.				

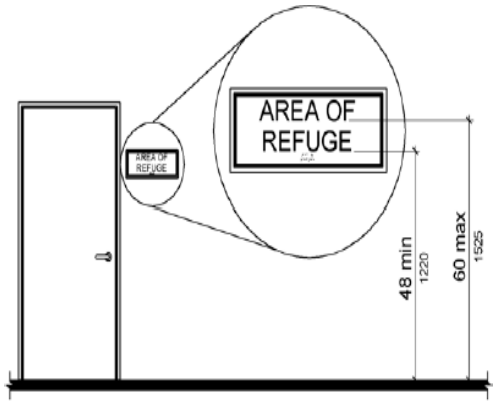
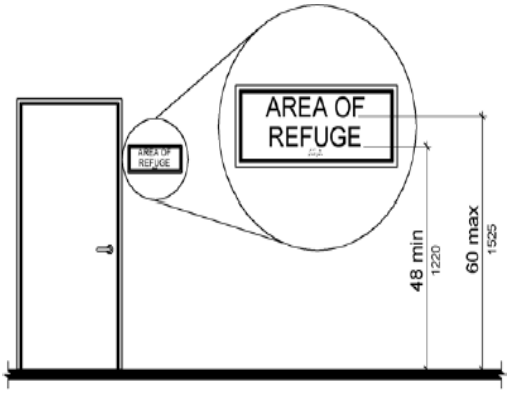
RAMPS:						
14	Is an access ramp present?	If there is more than one ramp, select the one that appears to be the primary access ramp.				
15 (CE)	**Are handrails provided on both sides of the ramp that are mounted between 34 and 38 inches above the ramp surface, if it is longer than 6 feet?**	**If the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

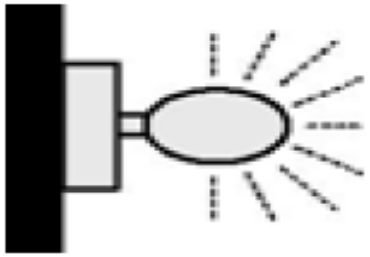
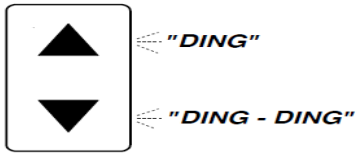
BUILDING ENTRANCE						
17 (CE)	**Is the main entrance accessible?**	**Self explanatory.**				
18	If a main entrance is not accessible, is there another accessible entrance?	Self explanatory.				
19	If a main entrance is not accessible, is there directional signage indicating the location of the accessible entrance?					
20 (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°.** 				

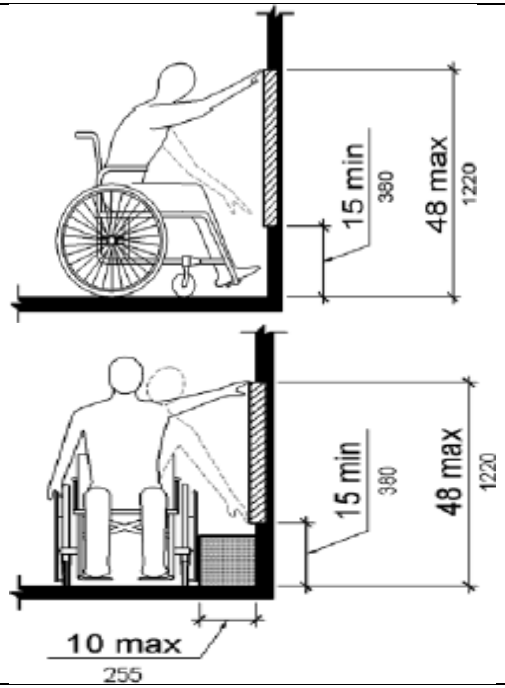
21	Are there automatic doors?	Self explanatory.				
INTERIOR ROUTE (FROM THE BUILDING ENTRANCE, TO THE REGISTRATION COUNTER/WINDOW, AND THROUGH TO THE PARTICIPANT AREAS						
22	Is there an interior route to the participant area?	Some participant areas are accessed directly from the street or drop off 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.				

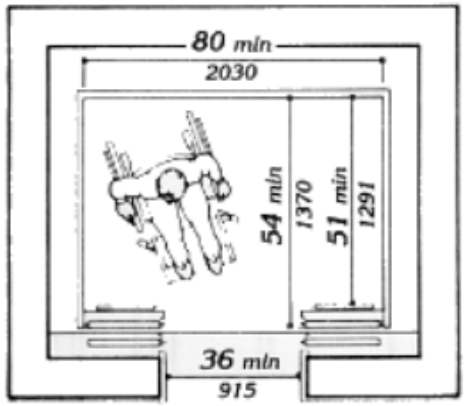
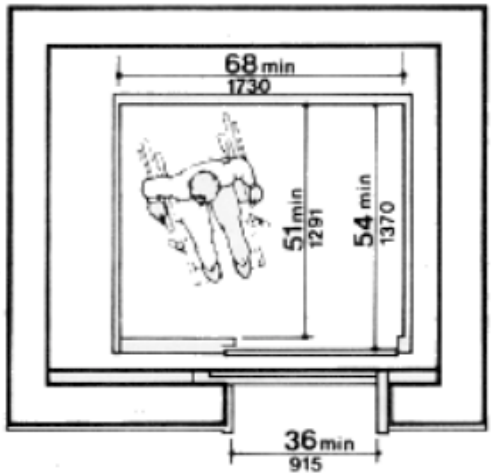
25	Is the interior accessible route well lighted?	A brightly lit corridor will help avoid falls.				
26 (CE)	**If there are stairs on the accessible route, are there handrails on each side?**	**If there are no stairs, check N/A.**				
27	If there are stairs, are all stair risers closed that are on the 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.	 				

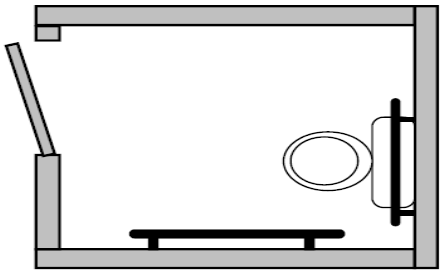
32	Do signs identifying permanent rooms and spaces include raised letters and Braille?					
33	Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor?	 Raised letters and Braille signs are either on the latch side of doors or on the face of doors and are mounted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

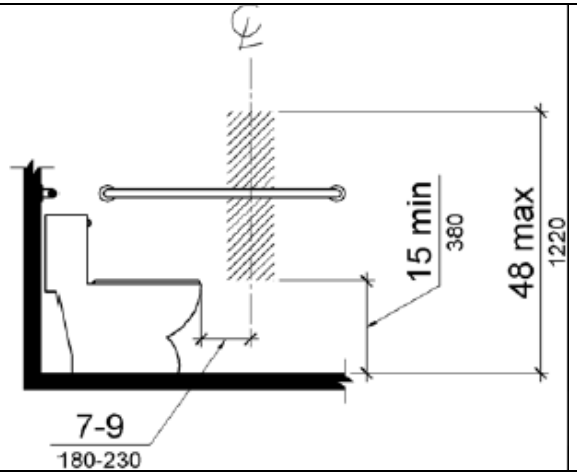
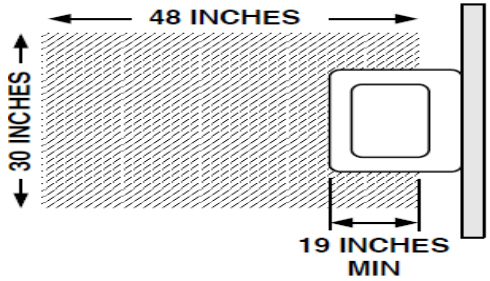
34	If the building has a fire alarm system, are visual signals provided in each public space, including toilet rooms and Participant Areas?	If the building does not have a fire alarm system, check NA. 				
ELEVATORS						
35	Is there an elevator?					
36 (CE)	**If needed, is the elevator available for 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.** 				

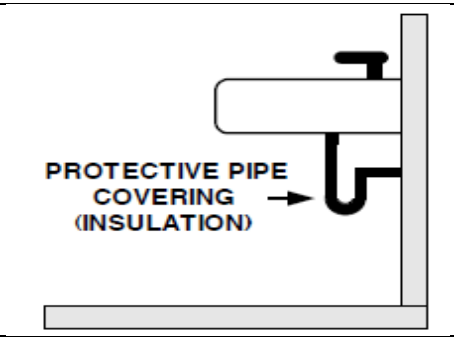
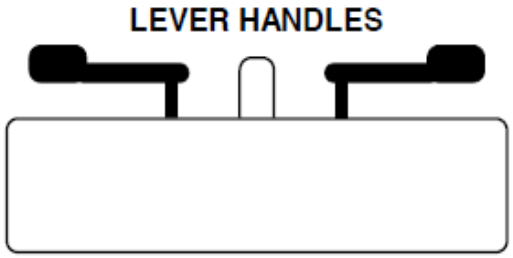
38 (CE)	**Are there raised letter and Braille sign on each side of each elevator jamb?**	**These signs allow everyone to know which floor they are on before entering or exiting the elevator.**				
39 (CE)	**Are the hall call buttons for the elevator no higher than 48 inches from the floor?**					

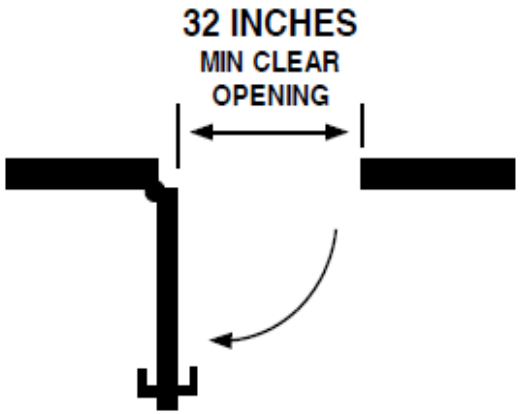
40 (CE)	**Is the elevator car large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit?**	**The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide, depending on where 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.**				

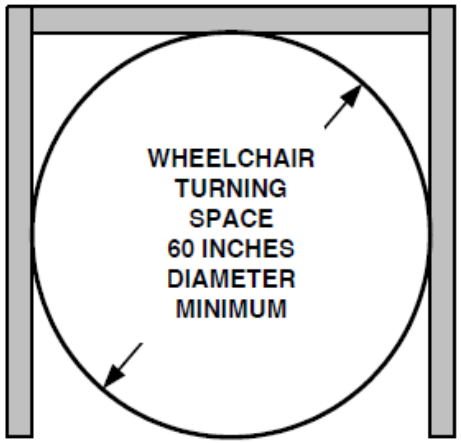
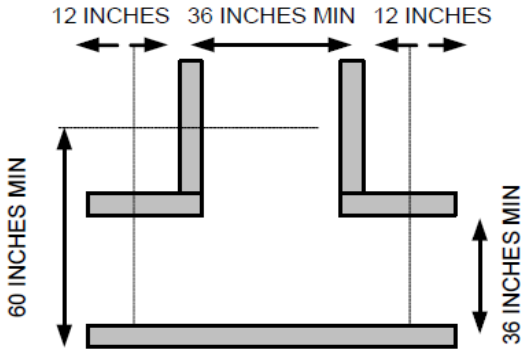
42	Is there an emergency communication system in the elevator?	Self explanatory.				
43	Is the elevator emergency communication system usable without requiring voice communication?	It is essential that emergency communication not be dependent on voice communications alone because the safety of people 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.				

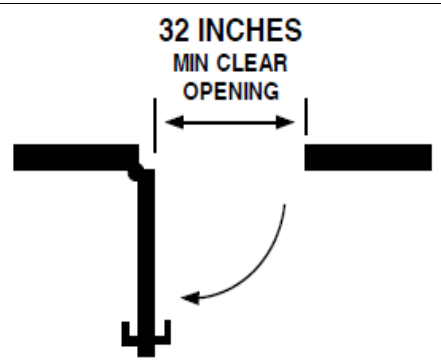
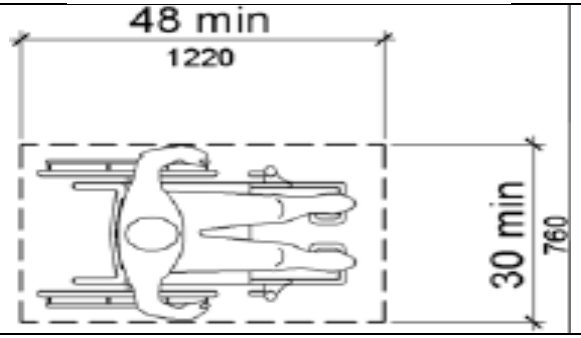
ALL RESTROOMS/TOILET ROOMS (WITH AND WITHOUT STALLS):						
45	Is there an accessible restroom/toilet room?	Self explanatory.				
46	Does the interior door to the restroom require less than 5 pounds of pressure to open?	If restroom door is a fire door, check NA. For interior doors (not fire doors), labor 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"

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