Santa Clara Family Health Plan™

ONSITE PERIODIC FACILITY SITE REVIEW & MEDICAL RECORD REVIEW

Provider Packet 2022

Facility Review Team: FacilitySiteReview@scfhp.com

www.scfhp.com

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40757

Santa Clara Family Health Plan™

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Quality Improvement
Fax: **408-874-1770**
Email: FacilitySiteReview@scfhp.com

Santa Clara Family Health Plan (SCFHP) requests that you share the following documents, policies, and procedures with us as part of your facility site review (FSR) audit.

Please visit our website for FSR updates, resources, and informational videos to help you prepare for the site and medical record review: https://www.scfhp.com/for-providers/quality-improvement-program/tools-and-guidelines-for-fsr-and-mrr/

Policies and Procedures:

All policies and procedures (P&Ps) must be in writing and signed by the provider.

- ☐ Non-medical emergency P&Ps must include an operable employee alarm system for employers with more than 10 employees. Direct voice communication is an acceptable procedure for sounding the alarm for sites with 10 or fewer employees as long as employees can hear the alarm.
  - ☐ Fire
  - ☐ Earthquake
  - ☐ Workplace Violence
  - ☐ Bomb Threat
- ☐ Medical emergency P&Ps
  - ☐ If provider present
  - ☐ If no provider present
- ☐ MAs administration of medications/vaccines indicating the MA confirms with the ordering provider the correct patient, medication, and dosage-prior to administration
- ☐ Tracking referrals or tracking log
- ☐ Interpreter services are made available in identified threshold languages. If bilingual staff are asked to interpret or translate, they should be qualified and languages spoken must be included in written policy. Assessment of ability, training on interpreter ethics and standards, and clear policies that delineate appropriate use of bilingual staff are required.
- ☐ Dispensing sample drugs
  - ☐ Log of sample drugs on site
- ☐ Vaccine protection in case of power outage or malfunction of refrigerator or freezer
- ☐ Isolating a patient with a potentially communicable condition
- ☐ Instrument/equipment sterilization - details from cleaning equipment prior to sterilization through packaging and labeling. Include process followed if failed spore test.
  - ☐ Autoclave/steam sterilization
  - ☐ Cold chemical sterilization

Documents:

- ☐ Emergency phone number list: includes poison control number, local emergency response services (e.g., fire, police/sheriff, ambulance), managers, and annual review date
- ☐ Diploma or certification for the Medical Assistant (MA) from an accredited school or a statement from the supervising physician that certifies the person in writing for specific procedures. If site has RNs and LVNs, have their licensure information readily available. Need to identify they are up to date.

- ☐ Delegation agreement with signature page showing evidence that standardized procedures, delegation agreement, and supervisory guidelines are agreed upon by both supervising physician and non-physician medical practitioner (NPMP)
- ☐ Current Drug Enforcement Administration number (DEA) for each NPMP
- ☐ Evidence of staff training for the following and training materials:
  - ☐ Infection control (annually)
  - ☐ Bloodborne pathogens (annually)
  - ☐ Biohazardous waste handling (annually)
  - ☐ Child, elder, domestic violence, and abuse
  - ☐ Patient confidentiality
  - ☐ Cultural and linguistics (This is a federal requirement)
  - ☐ Disability rights and provider obligations
  - ☐ Informed consent for any and all invasive procedures if performed on site
  - ☐ SCFHP prior authorizations requests
  - ☐ SCFHP grievance/complaint procedure
  - ☐ SCFHP sensitive services and minors' rights
  - ☐ SCFHP referral process, procedures, and resources
- ☐ Receipt of annual service or calibration of equipment, e.g., scales, centrifuge, EKG, audiometer, hemoglobinometer, blood pressure machine, glucometer
- ☐ Receipt or contract with registered hazardous waste hauler
- ☐ Written cleaning schedule with EPA tuberculocidal approved disinfectant, frequency, and by whom for the following:
  - ☐ Housekeeping
  - ☐ Staff
- ☐ Medication dosage chart for all emergency medications in emergency kit
- ☐ Logs showing monthly check of the following operations/expiration:
  - ☐ Oxygen tank PSI
  - ☐ Individual emergency medications
  - ☐ Individual emergency supplies
  - ☐ Medications
  - ☐ Lab test supplies
  - ☐ Vaccines
- ☐ Daily log of refrigerator and freezer temperatures
- ☐ Record release form with expiration date
- ☐ Fax cover page with confidentiality statement
- ☐ Sharps injury log indicating number of sharps injuries per month - even if zero injuries if > 10 employees
- ☐ Lab services - current site-specific CLIA certificate if lab tests are performed on site
- ☐ Radiology services - current CA Radiologic Health Branch Inspection Report and Proof of Registration if there is radiological equipment on site
- ☐ If controlled substances are on site, include dose by dose distribution log
- ☐ Autoclave sterilization - evidence of last three months' spore testing if autoclave is performed on site

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Requested Documents for FSR and Staff Interview Questions

Quality Improvement
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During the site review, office staff will be interviewed. Use this list to prepare your staff for the interview.

Access/Safety

1. If no medically licensed practitioner is present, what do you do in a medical emergency?
2. If a provider is on site, what is your plan of action in a medical emergency?
3. Where do you locate information regarding fire, earthquake, and site evacuation?
    a. Tell me about your procedure to evacuate in case of fire or earthquake.
4. What is the employee alarm system if < 10 employees? (Direct voice communication is acceptable.)
5. What is the employee alarm system if > 10 employees? (Need a system with a distinctive sound.)
6. How are emergency supplies, medications, and equipment restocked after use?
    a. Source to refill oxygen tank as needed?
    b. Demonstrate how to turn on the oxygen tank and set to two liter flow.

Personnel

7. What is your procedure for administering medications?
    a. Must include providing vaccine information statement (VIS) and verifying with the ordering provider that the correct medication, route, and dosage are prepared for the correct patient.
8. Are drugs and vaccines only prepared and drawn prior to administration?
9. If practice has non-physician medical practitioners (NPMP), what is the ratio of supervising physicians to NPMPs? (Ratio cannot exceed 1:4.)
10. Is the supervising physician available in person or by electronic communication at all times when a NPMP is caring for patients?
11. Where is the clinic information or resources about infection control and bloodborne pathogens?
    a. Ask this question if there is no evidence of training done annually.
12. Who do you contact at Santa Clara Family Health Plan (SCFHP) for prior authorization requests and referrals?
13. If a specialist in SCFHP's network is not available, how is this handled?

Office Management

14. If a patient calls for medical advice, how do you handle that phone call?
15. When someone calls for urgent or emergent medical advice, is that advice provided **only** by a Doctor of Medicine (MD), Physician Assistant (PA), or Nurse Practitioner (NP)?
16. Physician coverage:
    a. Are provider office hour schedules available to staff?
    b. When not available, who covers for the physician?
    c. Is the back-up physician in the Santa Clara Family Health Plan (SCFHP) network?
    d. Is contact information for off-site physician(s) available at all times during office hours?
    e. Are after-hours emergency care instructions or telephone information available to patients?
17. Do you have an answering machine or answering service for after hours?
18. Is the telephone system, answering service, or recorded telephone information periodically checked and updated at least monthly?
    a. Do you ever call to check if the answering service works and if the correct information is provided to caller?
19. Are appointments scheduled within timeliness standards?
    a. Urgent within 48 hours

   b. Non-urgent (routine) care within 10 business days
20. Are patients notified of scheduled routine and preventive screening appointments?
21. Is there a process in place to follow up on missed or canceled appointments?
22. Are interpreter services available in threshold languages on-site?
    a. What languages are spoken by staff?
       i. Are staff qualified to translate?
    b. Are you documenting if translator is used or refused?
    c. Are you documenting if patient's family translates?
    d. Is the person who is translating trained in medical interpretation?
23. Medical records:
    a. Are medical records kept on site and easily retrievable for scheduled patient encounters?
    b. How soon are documents or reports filed in chart or scanned into electronic medical record (EMR)?
    c. How soon are EMR office visits completed?
    d. If medical records are paper charts, how long are they kept? (Should be minimum of 10 years.)
24. What steps are taken to ensure confidentiality of patient information?

Clinical Services

25. If you perform vision screening:
    a. Where should the patient stand?
    b. What do you use as an occluder?
    c. How do you clean the occluder after each use?
26. If you perform hearing screening:
    a. Where is the hearing screening performed? (must be a quiet location)
    b. Demonstrate frequencies at 1000 and 8000 Hz
27. How are drugs and hazardous substances disposed of?
28. Who dispenses drugs or sample medications to patients?
29. Does the site utilize CA Immunization Registry (CAIR)? (Must have access to CAIR even if no vaccines are administered.)
30. If lab tests are performed on-site:
    a. Have testing personnel been trained?
31. Is radiology performed on-site?
32. Do you have a pharmacy on-site?
    a. Is it licensed by CA State Board of Pharmacy?

Infection Control

33. If the Medical Assistant (MA) prepares items for sterilization, what is their procedure?
34. Explain your procedure to isolate patients who may be infectious.
35. Contaminated laundry:
    a. Is personal protective equipment (PPE) available on-site?
    b. Are paper patient gowns used?
36. Are surfaces cleaned and decontaminated after contact with blood or other potentially infectious material (PIM)?
    a. What disinfectant is used?
37. Is steam or cold sterilization done on-site?

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Facility Site Review (FSR) Survey Preparation Checklist

Quality Improvement

Email: FacilitySiteReview@scfhp.com

This checklist helps with site review survey. All critical element criteria are **bolded in red text and underlined**. Each critical element found deficient during a full scope site survey, focused survey, or monitoring visit shall be corrected by the provider within 10 business days from the survey date. All other criteria shall be corrected by the provider within the CAP timeline.

Access and safety			
Item #	Item	Description	Reviewer comments
A1	Curb sign or sign designating space for disabled parking near accessible primary entrance.	Parking spaces for persons with physical disabilities has to be in close proximity. If that is not possible, provider must have alternative plan to make services available.	
A2	Pedestrian ramps have a level landing at the top and bottom of the ramp.	A clear and level landing is at the top and bottom of all ramps and on each side of an exit door. • Ramp must be 36 inches wide • All edges must be protected • If ramp is longer than 6 feet, it must have handrails • Criteria apply if there is a slope greater than 1 foot in 20 feet of horizontal run	
A3	Exit and exam room doorway opening allow for clear passage of a person in a wheelchair.	• Minimum opening 32 inches and no obstruction • Door opens at 90 degree angle • Effort to open door: 8.8 lbs. at exterior door and 5 lbs. at interior door • Hardware height between 30inches and 44 inches above floor • Doors are not obstructed	
A4	Accessible passenger elevator or reasonable alternative for multiple floor accommodation.	• If the office is on the first floor but bathrooms are on a different floor, it is a requirement • If there is no elevator available to access bathrooms, alternative is required (e.g., bed pan, urinal, commode)	
A5	Clear floor space for wheelchair in waiting room and exam room.	• Space of at least 30x48 inches to fit a wheelchair • 60 inch diameter to turn a wheelchair	
A6	Wheelchair accessible restroom facilities or reasonable alternative.	• Restroom with enough space for wheelchair to turn and door to close • If accessible restroom is not available, alternatives include: an accessible bathroom in the building, urinal, bedpan, or commode in a private room	

Access and safety			
Item #	Item	Description	Reviewer comments
A7	Wheelchair accessible handwashing facilities or reasonable alternative.	• Sufficient knee space under the sink for handwashing or alternative such as hand sanitizer • Highly recommend under-sink drain and supply covers to protect legs and knees of someone with paresthesia or anesthesia of lower extremities	
B1	All patient areas including floor/carpet, walls, and furniture are neat, clean, and well maintained.	Unsoiled, neat, tidy and uncluttered. Everything in good repair or condition.	
B2	Restrooms are clean and contain appropriate sanitary supplies.	Sanitary supplies include: toilet tissues, antiseptic hand washing soap, and cloth/paper towels or antiseptic towelettes.	
C1	Fire safety and prevention.	There is evidence staff has received safety training and/or has safety information available.	
C2	Emergency non-medical procedures (e.g. site evacuation, workplace violence).	There is evidence staff has received safety training and/or know where to locate safety information for non-medical emergencies such as handling fire and evacuation.	
C3	Lighting is adequate in all areas to ensure safety.	Areas include in-patient flow working and walking areas such as corridors, walkways, waiting and exam rooms, and restrooms to allow for a safe path of travel.	
C4	**Exit doors and aisles are unobstructed and egress (escape) accessible.**	All the exits must be unobstructed and egress possible if ambulatory or wheel chair bound. Means of egress (escape routes) are maintained free of obstructions or impediments to full instant use of the path of travel in case of fire or other emergency.	
C5	Exit doors are clearly marked with “Exit” signs.	• Exit doorways are unobstructed and clearly marked by a readily visible “Exit” sign • Strongly recommend that as a patient exits an exam room, they are able to see an exit sign	
C6	Clearly diagram “Evacuation routes” for emergencies are posted in visible location.	Clearly marked and easy-to-follow escape route is posted in a visible location at all elevators, stairs, and exits • Passage of at least 32 inches at doorways and 36 inches along the route	

C7	Electrical cords and outlets are in good working condition.	No cord across walkways, through walls, or under floor covering.	
C8	Firefighting/protection equipment is in an accessible location.	One of the following is required: • A fire extinguisher purchased/service within a year. Doctors can buy new one every year and save the receipt for validation • Smoke detectors with intact batteries • Automatic sprinkling system	
C9	An employee alarm system.	For employers with more than 10 employees, there must be an operable employee alarm system in place to signal for fire or other emergencies. Direct voice communication will suffice for workplaces with 10 or fewer employees, provided all can hear the alarm.	
D1	Personnel are trained in procedures/action plan to be carried out in case of medical emergency on site.	• Staff can describe site procedures for handling emergencies until patient is stable or EMS arrival • Written procedures exist for providing immediate emergent medical care • In absence of non-physician medical practitioner, staff/MA may call 911, CPR certified staff may initiate CPR	
D2	Emergency equipment is stored together in easily accessible location, and is ready to be used.	An accessible location is one that is reachable by personnel standing on the floor, or other permanent working area, without locating/retrieving step stool, ladder, or other assistive devices.	

Access and safety			
Item #	Item	Description	Reviewer comments

D3	Emergency phone number contacts are posted, updated annually, and as changes occur.	• Posted in an accessible area and includes:
		  • Annual review date
		  • Local emergency response services (e.g., fire, police/sheriff, ambulance)
		  • Emergency contacts (e.g., responsible managers, supervisors)
		  • Appropriate State, County, City and local agencies (e.g., local poison control number, Child/Elder/Domestic Violence Abuse)	

D4	**Airway Management: Emergency equipment including oxygen delivery system, nasal cannula or mask, bulb syringe and ambu bag (adult and pediatric).**	• Ambu bag sizes appropriate to patient population within the practice and onsite • Pediatric and adult ambu bag mask and bulb syringe are required. Ambu bag masks should be replaced when they no longer make a solid seal • Oral airways are not required, but highly recommended • O2 tank at least 3/4 full with gauge and flow meter • Oxygen tubing with nasal prongs or mask, not connected but in close proximity. Monthly documented check of O2 tank PSI • Personnel can demonstrate being able to use oxygen tank	
D5	**Emergency medications for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia: Epinephrine 1mg/ml (injectable), and Benadryl 25mg (oral) or Benadryl 50 mg/ml (injectable), Naloxone, chewable Aspirin 81mg, Nitroglycerin spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), and glucose (any type of glucose containing at least 15 grams). Appropriate sizes of ESIP needles/syringes and alcohol wipes.**	• Emergency "crash" cart/kit contents are appropriately sealed and are within the expiration dates posted on label/seal • Site personnel is appropriately trained and can demonstrate knowledge and correct use of all medical equipment they are expected to operate within their scope of work • If medication not available due to shortage a receipt or documentation showing medicine was ordered is acceptable • All needles MUST BE safety needles • Pediatric offices only serving patients under 18 years of age are not required to keep Nitroglycerin in their emergency kit	

D6	Medication dosage chart for all medications included with emergency equipment is kept with emergency medications.	• There is a current medication dosage chart available for the correct medication dosages (e.g. adult, pediatric, infant, etc.) • Package inserts are not acceptable as dosage charts • Keep the medication dosage chart **with** the emergency meds (posting on a wall is not acceptable)	
D7	Document checking of emergency equipment/supplies for expiration and operating status at least monthly.	Documentation may include a log, checklist, or other appropriate method(s).	
D8	Replace/re-stock emergency medication, equipment, and supplies immediately after use.	Receipt to show medications ordered acceptable for any medication shortage.	
E1	Medical equipment is clean.	All medical and laboratory equipment used to measure or assess patient health status/condition is clean.	
E2	Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines.	• There are documented standard operating procedures for routine inspection/maintenance, calibration (or manufacturer guidelines on site if not necessary for specific equipment), repair of failure or malfunction, and testing and cleaning of all specialized equipment have documentation • Written records include calibration or other written logs, work orders, service receipts, dated inspection sticker, etc. • All equipment used to assess patient health status/condition are in properly functioning order	

Personnel criteria			
Item #	Item	Description	Reviewer comments
A1	Professional health care personnel have current California licenses and certifications.	Information includes type of medical professional, license/certification and issuing agency. All licenses must be current and valid.	
A2	Notification is provided to each patient that the MD(s) is licensed and regulated by Medical Board, and that Physician Assistant(s) is licensed and regulated by the Physician Assistant Committee.	Consumer notice (a copy can be sent upon request) shall be provided by one of the following methods: 1. Prominently posted sign in an area visible to patients in at least 48 pt. Arial font 2. Written statement signed and dated by the patient and kept in medical record, stating the patient understands that MD is licensed and regulated by board 3. A statement on letterhead, discharge instruction, or other document given to patient, where the notification is placed immediately above the signature line for the patient in at least 14 pt. font	
B1	ID badges/tags printed with name and title for health care staff OR name on lab coat or uniform.	• Everyone with a license and/or certification must wear ID badge. • Name and title on a name tag must be at least 18 pt. font.	
C1	Documentation of education/training for non-licensed medical personnel is maintained on site.	Training may be administered under a licensed physician; or under an RN, LVN, PA, or other qualified medical assistant acting under the direction of a licensed physician. The supervising physician is responsible for determining the training content and ascertaining proficiency of the MA. Training documentation maintained on site for the MA must include the following: • Diploma or certification from an accredited training program/school, or • Letter/statement from the current supervising physician that certifies in writing: date, location, content, and duration of training, demonstrated proficiency to perform current assigned scope of work, and signature	

C2	**Only qualified/trained personnel retrieve, prepare, or administer medications.**	Medication administration by an MA means the direct application of pre-measured medication orally, sublingually, topically, vaginally, or rectally; or by providing a single dose to a patient for immediate self-administration by inhalation or by simple injection. • All medications including vaccines must be verified with (shown to) a licensed person prior to administration. • Unlicensed staff (e.g. MAs) have evidence of appropriate training and supervision in all medication administration methods performed within their scope of work. • MAs cannot administer anesthetics, including local anesthetic agents (such as Rocephin hydrated with Xylocaine). • The supervising physician must specifically authorize all medications administered by an MA.	
C3	Site has a procedure in place for confirming correct patient, correct medication/vaccine, correct dosage, and correct route prior to administration.	To help reduce the risk of medication errors, staff shall follow procedures in place for medication administration.	
C4	Only qualified/trained personnel operate medical equipment.	Provider and/or staff are properly trained and can demonstrate appropriate operation of medical equipment used in their scope of work. Health care personnel at the site must demonstrate that they can turn on the oxygen tank and tell when an oxygen tank needs to be replaced and/or refilled.	
D1	Standardized Procedures provided for NPs and/or CNMs.	The scope of practice for NPs and CNMs is clearly defined including the delegation of the supervision of MAs when supervising physician is off premises. Must legally define overlap between nursing practice and the practice of medicine.	

D2	A Practice Agreement defines the scope of services provided by PAs and Supervisory Guidelines define the method of supervision by the Supervising Physician.	• This must be dated and signed by physician and PA with the original copy on site • Must include delegation of the supervision of MAs when supervising physician is off premises • A procedure for emergency transport of patients and back-up procedures (e.g., can call 911, name of hospital to transport patient included in Practice Agreement) for when the supervising physician is not on the premises must be identified.	
D3	Standardized Procedures, Practice Agreements, and Supervisory Guidelines are revised, updated, and signed by the supervising physician and NPMP when changes in scope of services occur.	Standardized Procedures, Practice Agreements shall undergo periodic review, with signed, dated revisions completed at each change in scope of work by supervising physician. Frequency of the review to identify changes in scope of service shall be specified in writing.	
D4	Each NPMP that prescribes controlled substances has a valid DEA Registration.	For NP, CNM and PA.	
E1	Ratio to number of NPMPs does not exceed established ratios in any combination.	The supervising physician holds ultimate responsibility for the practice of each supervised NPMP. The maximum number of NPMPs who may be supervised by a single primary care physician (PCP) is limited to the following at any given time/shift in any of their locations:20 • 4 NPs with furnishing license (there is no limit to the number of NPs the physician may supervise if the NP does not hold a furnishing license) • 4 CNMs • 4 PAs	
E2	The designated supervising or back-up physician is available in person or by electronic communication at all times when a NPMP is caring for patients.	A licensed physician or surgeon oversee the activities of, and accept responsibility for, the medical services rendered by a PA. They are available in person or by electronic communication at all times when a NMPM is caring for patients.	

E3	Evidence of NPMP supervision.	Standardized Procedures for NP or CNM should identify the furnishing of drugs or devices, extent of physician or surgeon supervision, method of periodic review of competence, including peer review, and review of provisions in the Standardized Procedures. Standardized Procedures shall undergo periodic review, with signed, dated revisions completed at each change in scope of work. Evidence of supervision of NPMP(s) are verifiable through on-site observation of supervisory processes, documentation, or supervisor/NPMP's knowledge of the process.	
F	There is evidence that site staff has received training on the following: 1. Infection Control/Universal Precautions (annually) 2. Bloodborne Pathogens Exposure Prevention (annually) 3. Biohazardous Waste Handling (annually)	Training *minimally* includes the following: o Universal/standard precautions o Use of personal protective equipment o Accessible copy of Bloodborne Pathogens Standard o Work practice controls/exposure prevention o Modes of transmitting bloodborne pathogens o Epidemiology/symptoms of HBV and HIV o Recognition of activities with exposure element o Handling and labeling of biohazardous waste(s) o Hepatitis B vaccination protocol and requirements o Explanation of emergency procedures o Post exposure reporting/evaluation/follow-up procedures o Decontamination of equipment/work areas o Site's written bloodborne pathogen exposure plan o Opportunity for discussion/questions Personnel must be able to locate information/resources on site about infection control, the Bloodborne Pathogens Exposure Plan, and how to use the information. Evidence of training must be verifiable and kept for 3 years. Documentation can be: informal in-services, new staff orientation, external training courses, educational curriculum, participation lists, etc. Documentation must include Employee name, job titles, training date(s), type of training, contents of training session, name/qualifications of trainers.	

G1	There is evidence that site staff has received information and/or training on **patient confidentiality**.	Site personnel must receive training on patient confidentiality and protecting information. Evidence is verifiable or staff is able to locate information on site and explain how to use information.	
G2	There is evidence that site staff has received information and/or training on **informed consent, including human sterilization**.	Site personnel must receive training on informed consent including human sterilization. Evidence is verifiable or staff is able to locate information on site and explain how to use information.	
G3	There is evidence that site staff has received information and/or training on **prior authorization requests**.	Site personnel must receive training on prior authorization requests. Evidence is verifiable or staff is able to locate information on site and explain how to use information.	
G4	There is evidence that site staff has received information and/or training on **grievance/ complaints procedure**.	Site personnel must receive training on grievance/ complaints procedure. Evidence is verifiable or staff is able to locate information on site and explain how to use information.	
G5	There is evidence that site staff has received information and/or training on **child/elder/domestic violence abuse**.	Site personnel must have specific knowledge on reporting requirements, agencies, and procedures and know how to locate and use the information.	
G6	There is evidence that site staff has received information and/or training on **sensitive services/minor's rights**.	• Site personnel have received information and/or training on sensitive services/minors' rights. Sensitive Services include family planning, pregnancy, sexually transmitted infections, etc. • PCP sites must have basic information on sensitive services that are appropriate to their practice office and be prepared to provide information to patients when needed. • Minor's Rights: California Family Code provides that a minor may, without parental consent, receive a number of sensitive services including outpatient mental health treatment and counseling for children 12 years and older.	

G7	There is evidence that site staff has received information and/or training on **health plan referral process/procedure/resources**.	Site personnel must receive training on health plan referral process/procedure/resources. Evidence is verifiable or staff is able to locate information on site and explain how to use information.	
G8	There is evidence that site staff has received information and/or training on **cultural and linguistic training**.	Site personnel must receive training on cultural and linguistic training. Evidence is verifiable or staff is able to locate information on site and explain how to use information. Cultural and Linguistic Training- Culturally and Linguistically Appropriate Services (CLAS) mandates are Federal requirements for all recipients of Federal funds	
G9	There is evidence that site staff has received information and/or training on **disability rights and provider obligations**.	Site personnel have received information and/or training on patient rights and provider obligations under the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and/or Section 1557 of the Affordable Care Act Training content should include information about physical access, reasonable accommodations, policy modifications, and effective communication in healthcare settings.	

Office Management criteria			
Item #	Item	Description	Reviewer comments
A1	Clinic office hours are posted or readily available upon request.	Example: available at front desk or posted in front window.	
A2	Provider office hour schedules are available to staff.	Employees know office hours and are able to locate or verbalize them.	
A3	Arrangement/schedule for after-hours, on-call, supervisory back-up physician coverage is available to site staff and members after-hours.	Current site-specific resource information is available to site personnel and members about physician office hour schedule(s), local and/or Plan-specific systems for after-hours urgent care, emergent physician coverage available 24 hours a day, 7 days per week, and system for providing follow-up care.	
A4	Contact information for off-site physician(s) is available at all times during office hours.	Personnel are able to contact the physician (or covering physician) at all times by telephone, cell phone, pager, etc.	
A5	Routine, urgent and after-hours emergency care instructions/telephone information is made available to patients.	Patients will be able to contact the appropriate care depending on severity at all times.	
B1	Appropriate personnel handle emergent, urgent, and medical advice telephone calls.	Only appropriately licensed medical personnel such as a physician, CNM, LM, NP, RN, or PA handles emergency, urgent, and medical advice/triage telephone calls. LVNs cannot independently triage and are limited to observation and data collection. MAs may provide patient information or instructions only as authorized by the physician.	
B2	Telephone answering machine, voice mail system, or answering service is used whenever office staff does not directly answer phone calls.	System in place for managing phone calls during and after office hours.	
B3	Telephone system, answering service, recorded telephone information, and recording device are periodically checked and updated.	Patient needs are met in a timely manner.	

C1	Appointments are scheduled according to patient's stated clinical needs within the timeliness standards established for Plan members.	Medi-Cal Managed Care Health Plans require the following timeliness standards for access to appointments: • Urgent Care: 48 hours • Access to the first Prenatal Visit: 10 business days • Non-urgent (Routine) Care: 10 business days	
C2	Patients are notified of scheduled routine and/or preventive screening appointments.	There is a site-specific system/practice and procedures in place to provide timely access to appointments for routine care, urgent care, prenatal care, pediatric periodic health assessments/immunizations, adult initial health assessments, specialty care, and emergency care.	
C3	There is a process in place verifying follow-up on missed and canceled appointments.	An organized system must be in use for scheduling appointments appropriately, notifying, and reminding members of scheduled appointments, and following up on missed or canceled appointments. Outreach attempts must be documented.	
D1	Interpreter services are made available in identified threshold languages specified for location of site.	Sites must provide 24-hour interpreter services for all members either through telephone language services or interpreters on site.	
D2	Persons providing language interpreter services, including sign language on site, are trained in medical interpretation.	Site personnel used as interpreters have been assessed (information about certifications, assessments taken, qualifications, experiences, training, etc.) for their medical interpretation performance skills and capabilities. A request for or refusal of language/interpreter services must be documented in the member's medical record. Must not rely on family and friends as interpreters unless specifically requested by member. Sign language interpreter may be used for medically necessary health care services.	
E1	Office practice procedures allow timely provision and tracking of: processing internal and external referrals, consultant reports, and diagnostic test results.	• An organized, timely referral system is evident • Referral informational resources are readily available for use by site personnel • Site staff can provide a walk-through of the office referral process from beginning to end	

E2	**Physician Review and follow-up of referral/consultation reports and diagnostic test results.**	• There is a documented process of the practitioner review of diagnostic tests/consultations and subsequent outreach to follow-up with the patient to communicate results and provide next steps. • Practitioner review is evidenced by date and signature/initials on the report of the reviewing practitioner.	
F1	Phone number(s) for filing grievances/complaints are located on site.	At least one telephone number is posted on site or is readily available upon request.	
F2	Complaint forms and a copy of the grievance procedure are available on site.	• Complaint forms and a copy of the grievance procedure are readily available on site and can be provided to members promptly upon request • Includes The Department of Managed Health Care Help Center 1-888-466-2219 and Ombudsman 1-888-452-8609	
G1	Medical records are readily retrievable for scheduled patient encounters.	The process/system established on site provides for the availability of medical records (paper and electronic), including outpatient, inpatient, referral services, and significant telephone consultations for patient encounters.	
G2	Medical documents are filed in a timely manner to ensure availability for patient encounters.	Must allow for ease of accessibility within the facility or in an appropriate health record storage facility if stored off-premises.	
H1	Exam rooms and dressing areas safeguard patients' right to privacy.	Patients have the right to privacy for dressing/undressing, physical examination, and medical consultation.	

H2	Procedures are followed to maintain the confidentiality of personal patient information.	• PHI will not be discussed around others and information will not be left in areas accessible to others • There must be a confidentiality agreement between the provider and the cleaning service agency/persons if the medical records are kept in an open space and/or are unsecured • Electronic record-keeping system procedures have been established to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures, and maintain upkeep of computer systems (may include encryption, detailed user access control, transaction logs, blinded files, etc) • Security protection includes an off-site backup storage system, an image mechanism with the ability to copy documents, a mechanism to ensure that recorded input is unalterable, and file recovery procedures	
H3	Medical record release procedures are compliant with State and federal guidelines.	• Medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released. • The release terms, such as to whom records are released and for what purposes, and the expiration date of the consent to medical record release should also be described.	
H4	Storage and transmittal of medical records preserves confidentiality and security.	Storage and transmittal: • Records of health care services rendered shall be confidentially and securely kept and maintained • FAX cover sheet shall have confidentiality statement.	
H5	Medical records are retained for a minimum of 10 years.	Records required to be kept and maintained under this section (including minors under 18 years old) shall be retained by the provider for a period of 10 years from the final date of the contract period between the plan and the provider, from the date of completion of any audit, or from the date the service was rendered, whichever is later.	

Clinical services			
Item #	Item	Description	Reviewer comments
A1	Drugs are stored in specifically designated cupboards, cabinets, closets, or drawers.	Drugs must be stored in locked cabinets, closets, drawers, or cupboards.	
A2	Prescription drugs, drug samples, over-the-counter drugs, hypodermic needles/syringes, all medical sharp instruments, and prescription pads are securely stored in a lockable space within the office/clinic.	Drugs, hypodermic needles, prescription pads, and medical supply must be stored in a lockable space within office/clinic.	
A3	Controlled drugs (if on site) are stored in lockable space accessible only to authorized personnel.	Control drugs must store in a lockable space accessible to only authorized personnel.	
A4	A dose-by-dose controlled substance distribution log is maintained.	Written records are maintained of controlled substances inventory list(s) that includes: 1) Provider's DEA number 2) Name of medication 3) Original quantity of drug 4) Dose 5) Date 6) Name of patient receiving drug 7) Name of authorized person dispensing drug and 8) Number of remaining doses Only appropriate personnel have access including physicians, dentists, podiatrists, PAs, licensed nurses, and pharmacists and specifically authorized employees.	
A5	Written site-specific policy/procedure for dispensing of sample drugs are available on site.	A list of drugs available for use in clinic must be maintained. Each clinic that provides drug distribution services shall have written policy and procedures for the safe and effective distribution, control, storage, use, and disposition of drugs.	
B1	Drugs are prepared in a clean area or "designated clean" area if prepared in a multi-purpose room.	Must not be adjacent to potential sources of contamination including water sources. Area must be regularly disinfected and cleaned.	

B2	Drugs for external use are stored separately from drug for internal use. In sample medication closet, separate oral medications from inhalants and dermatologic.	Drugs should be stored separated by route of administration, especially ophthalmic and otic prescriptions. Vaccines and other drugs should be stored separately from food, lab specimens, human specimens, cleaning supplies, and other items that may potentially cause contamination.	
B3	Items other than medications in refrigerator/freezer are kept in a secured, separate compartment from drugs.	Items other than medications must be kept separate in refrigerator/freezer.	
B4	Read the refrigerator thermometer temperature.	Refrigerator thermometer temperature should be 36-46 degrees Fahrenheit or 2-8 degrees Celsius.	
B5	Read the freezer thermometer temperature.	Freezer thermometer temperature should be 5 degrees Fahrenheit or -15 degrees Celsius.	
B6	Site utilized drugs/vaccine storage units must be able to maintain required temperature. If temperature device is used, must be calibrated every two years.	Do not store vaccine in a dorm-style or bar-style refrigerator unit under any circumstances.	
B7	Daily temperature readings of drugs/vaccines refrigerator and freezer are documented.	Refrigerator and freezer temperatures are documented at least once a day (required twice daily for VFC providers). The use of data-downloadable digital data loggers required with accuracy of +/- 1°F (0.5°C) and buffered probe, calibrated every 2 years. Must have a backup on hand.	
B8	Has a written plan for vaccine protection in case of power outage or malfunction of the refrigerator or freezer.	Site personnel must be able to respond to out of range temperatures appropriately.	
B9	Drugs and vaccines are stored separately from test reagents, germicides, disinfectants, and other household substances.	Away from potential contaminants.	
B10	Hazardous substances are appropriately labeled.	Biohazard sign on leak-proof hazardous substance container with a lid.	

B11	Site has method(s) in place for drug and hazardous substance disposal.	Safety practices are followed in accordance with current/updated CAL-OSHA standards and 29 CFR 1910.1030. Containers comply with United States Department of Transportation requirements when prepared for transport offsite from facility. Must keep completed tracking document from hazardous waste transporter. All portable containers of hazardous chemicals and secondary containers must have labels with: • Identity of hazardous substance • Description of hazard warning: can be words, pictures, or symbols • Date of preparation or transfer **Exception**: Labeling is not required for portable containers into which hazardous chemicals are transferred from labeled containers, and which are intended only for the immediate use of the individual who performs the transfer.	

Clinical services			
Item #	Item	Description	Reviewer comments
C1	There are no expired drugs on site.	• If no expiration date is shown on the label, assume they are expired • If a drug is reconstituted at time of dispensing, label should have reconstituted and reconstituted expiration info	
C2	Site has a procedure to check expiration date of all drugs (including vaccines and samples), and infant and therapeutic formulas.	Completed at least monthly for all drugs and infant/therapeutic formula.	
C3	All stored and dispensed prescription drugs are appropriately labeled.	Drug container is labeled with the provider's name, patient's name, drug name, dose, frequency, route, quantity dispensed, and manufacturer's name and lot number.	
C4	**Only lawfully authorized persons dispense drugs to patients.**	• Drugs are dispensed only by a physician, pharmacist, or other persons (e.g., NP, CNM, RN, PA) lawfully authorized to dispense medications upon the order of a licensed physician or surgeon. • Personnel such as MAs, office managers, and receptionists do not dispense drugs. • A record of all drugs and formulas dispensed shall be entered in the patient's medical record.	
C5	**Drugs and Vaccines are prepared and drawn only prior to administration.**	• Advisory Committee on Immunization Practices (ACIP) discourages the routine practice of providers' prefilling syringes.	
C6	Current Vaccine Information Sheets (VIS) for distribution to patients are present on site.	• Patients or parents/guardians must be informed before vaccine administration. • Date VIS was given and publication date of VIS must be documented • Allowed up to 6 months for a new VIS to be used	

C7	If pharmacy on site, see copy of license by CA State Board of Pharmacy.	• If a pharmacy is located on site and owned by the clinic, the license issued by the CA State Board of Pharmacy must be present on site • A licensed pharmacist monitors drug distribution and policies and procedures for medication dispensing and storage • Every pharmacy that dispenses a controlled substance must be registered with the DEA and be licensed by the CA State Board of Pharmacy	
C8	Site utilizes California Immunization Registry (CAIR) or the most current version.	If immunizations not offered at clinic, site staff must have access to the member's immunization record through the registry.	
D1	Laboratory test procedures are performed according to current site-specific CLIA certificate.	• Sites performing laboratory testing must have valid CLIA or evidence of renewal available on-site (including mobile units, multi-site, same physical location, public health testing, etc). • May be certificate of waiver, certificate for PPM, certificate of registration, certificate of compliance, and certificate of accreditation.	
D2	Testing personnel performing clinical lab procedures have been trained.	Personnel performing labs have been appropriately trained based on complexity of tests and can properly provide step-by-step instruction of procedure and how to accurately determine test results.	
D3	Lab supplies are inaccessible to unauthorized persons.	Must be either locked or in inaccessible room.	
D4	Lab test supplies are not expired.	Supplies disposed of by manufacturer's expiration date.	
D5	Site has a procedure to check expiration date and a method to dispose of expired lab test supplies.	At minimum monthly.	

If radiology is on site, the following documents are posted on site:			
E1	Site has current CA Radiologic Health Branch Inspection Report and Proof of Registration if there is radiological equipment on site.	• Inspection Report and Proof of Registration, or • Inspection Report and Proof of Registration and Short Form Sign-off sheet, or • Inspection Report and Proof of Registration and Notice of Violation form and approval letter for corrective action plan from the CA RHB	
E2	Current copy of California Code of Regulation Title 17.	Posted on site.	
E3	Radiation safety operating procedures posted in highly visible location.	If site has x-ray machine, it has to be registered. If site has a radiology machine but the site does not use it, site has to prove that it has been deactivated.	
E4	Notice to employees posted in highly visible location.	Posted on site.	
E6	Physician supervisor/operator certificate posted and within current expiration date.	All certificates/licenses are posted and show expiration dates.	
E7	Technologist certificate posted and within current expiration date.	If there are large number of technicians, a list of names, license numbers, and expiration dates may be substituted.	
If radiology is on site, the following radiology protective equipment are present on site:			
E8	Operator protection devices: radiological equipment operator must use lead apron or lead shield.	Lead apron or lead shield must be available in radiology site.	
E9	Gonadal shield for patient procedures in which gonads are in direct beam.	Gonadal shield 0.5 mm. or greater lead equipment must be available in radiology site.	

Preventive services: Following examination of equipment appropriate for primary care services and availability on site.			
Item #	Item	Description	Reviewer comments
A1	Exam tables and lights are in good repair.	A protective barrier that is changed between patient contacts is used to cover exam table surface. "Good repair" means clean and well-maintained in proper working order.	
A2	Stethoscope and sphygmomanometer with various cuffs size	Various cuffs sizes available to serve patient population. E.g., child, adult, and obese/thigh.	
A3	Thermometer with numeric reading		
A4	Basic equipment: percussion hammer, tongue blades, patient gowns	Exam gown sizes are appropriate to population served on site.	
A5	Standing scale and infant scales	• Bathroom scales are not allowed • Scales must have capacity for 300 pounds (adults) • Electronic or digital scales must have automatic zeroing and lock-in weight features	
A6	Measuring devices for height/length and head circumference	• For adults, a wall-mounted stadiometer is best • Rigid 90-degree right angle headboard block • Flat, paper or plastic non-stretchable tape or yardstick • Movable, non-flexible foot board • Non-stretchable tape measuring devices	
A7	Eye chart and occluder for vision testing	• Site has both a literate (e.g., Snellen and HOTV) and illiterate eye chart (e.g., LEA symbols) • "Heel" line is aligned with center of eye chart at a distance of 10 or 20 foot marker depending on the chart. Patient is to stand with heels on the 10 or 20 foot marker—not toes	
A8	Ophthalmoscope	In good working condition.	
A9	Otoscope with adult and pediatric ear speculums	Otoscope with multi-size ear speculums appropriate to the population served.	
A10	Audiometer	A pure tone, air conduction audiometer is located in a quiet location for testing. If not, system in place to demonstrate audiometric testing referred out was performed and results shared with the office. Testing should be available for patients age four and above.	

B1	Health education materials and Plan-specific resource information are readily accessible on site or are made available upon request.	May include instruction, group classes, family counseling and/or other health educational programs and materials.	
B2	Applicable to the practice and population served on site.	Site specific with general topics for health educational materials such as: Immunizations, Pregnancy, Injury Prevention, Smoking Cessation, Dental Health, Nutrition, Physical Activity, STD/HIV Prevention, Family Planning, Asthma, Hypertension, and Diabetes. Must meet readability and suitability requirements and in accessible format which may include written information, audio and/or videotapes, computerized programs, and visual presentation aids for people with disabilities.	
B3	Available in threshold languages identified for county and/or area of site location.	Site specific and available/accessible on site.	

Infection control			
Item #	Item	Description	Reviewer comments
A1	Soap or antiseptic hand cleaner and running water are available in exam and/or treatment areas for hand washing.	Hand-washing facilities are available in the exam room and/or utility room, and include an adequate supply of running potable water, soap, and single use towels or hot air drying machines.	
A2	Waste disposal containers are available in exam rooms, procedure/treatment rooms, and restrooms.	Contaminated wastes (e.g., dental drapes, band aids, sanitary napkins, and soiled disposable diapers) are disposed of in regular solid waste containers, and are maintained to prevent potential contamination of patient/staff area and/or unsafe access by infants/children.	
A3	Site has procedure for effectively isolating infectious patients with potential communicable conditions.	Personnel can demonstrated or verbally explain procedures to isolate patients with potentially contagious conditions; procedure can be located on site.	
B1	**Personal protective equipment (PPE) for Standard Precautions is readily available for staff use.**	• PPE is available for staff • PPE includes gowns, glove, goggles/face shield, and masks.	
B2	**Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak-proof, labeled containers for collection, handling, processing, storage, transport, or shipping.**	Regulated wastes include biohazard wastes (e.g., laboratory wastes, human specimens/tissue etc.) and medical wastes (e.g., liquid/semiliquid blood or OPIM, items caked with dry blood etc.) are contained separately from other wastes and placed in red biohazardous bags with biohazard label, and stored in a closed container that is not accessible to unauthorized persons.	
B3	**Needle stick safety precautions are practiced on site.**	Only safety needles are used.	
B4	All sharp injury incidents are documented.	The Sharps Injury Log must contain, at a minimum, information about the injury, the type and brand of device involved in the injury (if known), the department or work area where the exposure occurred, and an explanation of how the incident occurred. Incident must be recorded within 14 business days of incident date and reported with confidentiality maintained. Sites with 10 or fewer employees are exempt from keeping a log.	

B5	Biohazardous wastes are contained separate from other trash/waste.	Red biohazard bag used with biohazard symbol separate from other waste.	
B6	Storage areas for regulated medical wastes are maintained secure and inaccessible to unauthorized persons.	If stored outside the office, a lock secures the entry door, gate or receptacle lid, and posted warning sign(s) in English and Spanish are visible for 25-feet: "CAUTION-BIOHAZARDOUS WASTE STORAGE AREA-UNAUTHORIZED PERSONS KEEP OUT" and CUIDADO-ZONA DE RESIDUOUS-BIOLOGICOS PELIGOROS-PROHIBIDA LE ENTRADA A PERSONAS NO AUTHORIZADAS".	
B7	Contaminated laundry is laundered at the workplace or by a commercial laundry service.	Manufacturer's guidelines must be followed and must have appropriate warning label when transported.	
B8	Transportation of regulated medical wastes is only by a registered hazardous waste hauler or to a central location of accumulation in limited quantities (up to 35.2 pounds).	• All medical waste transporters must carry paperwork issued by CDPH while transporting medical waste to permitted offsite medical waste treatment facilities, transfer stations, or other registered generator. • Limited-quantity exemption is not required for Small Quantity Generator (up to 35.2 pounds). A medical waste-tracking document that includes the name of the person transporting, number of waste containers (e.g., three sharps containers, or five biohazard bags), types of medical wastes, and date of transportation, is kept a minimum of 3 years for large waste generators and 2 years for small generators.	
C1	Equipment and work surfaces are appropriately cleaned and decontaminated after contact with blood or other potentially infectious material.	Staff can identify cleaning and disinfection of surfaces and equipment, the disinfectant used and responsible personnel in between patients use.	

C2	Routine cleaning and decontamination of equipment/work surfaces is completed according to site-specific written schedule.	Written "housekeeping" schedules for routine cleaning include: • Area cleaned/decontaminated • Frequency of cleaning/decontamination • Employee responsible for determining and implementing the written schedule All equipment and environmental and work surfaces shall be cleaned and decontaminated after contact with blood or OPIM no later than at the end of the shift with appropriate cleaner. Spill Procedure: Personnel can identify procedures for prompt decontamination of blood/body fluid spills, the disinfectant used, and the responsible person(s).	
C3-C4	Disinfectant solutions used on site are: - Approved by the Environment Protection Agency (EPA) - Effective in killing HIV/HBV/TB	Disinfectant solutions used are according to the EPA Tuberculocidal approved products.	
C5	Follow manufacturer instructions for disinfection.	Decontamination products are used according to manufacturer's guidelines for decontamination and contact times. 10% Bleach Solution: • 10% bleach solution that is EPA registered and effective against TB, is changed/reconstituted every 24 hours • Surface is cleaned prior to disinfecting • Surface is air-dried or allowed appropriate time (stated on label) before drying.	
D1	Written site-specific policy/procedures or manufacturer's instructions for instrument/equipment sterilization are available to staff.	If autoclave or cold sterilization is performed, site shall have specific policy/procedures or manufacturer's instructions addressing instrument/equipment pre-treatment, cleaning and preparation, the management of chemical solutions, autoclave loading and operation, safety guidelines and precautions, and other required processes available to staff.	

D2	Staff adheres to site-specific policy and/or manufacturer/product label directions for cleaning reusable instruments/equipment prior to sterilization	Prior to undergoing the sterilization process, soiled instruments/equipment are thoroughly cleaned using enzymatic detergent, rinsed, dried, and inspected for the presence of dried blood or other debris.	
D3a	**Staff demonstrate/verbalize necessary steps/process to ensure sterility and/or high-level disinfection of equipment.**	• Personnel can demonstrate or verbally explain procedure(s) used for cleaning prior to sterilization, and to locate written directions on site. • Product efficacy tests (i.e. test strips) shall be performed according to manufacturer's guidelines. • Written procedures for cold sterilization and/or high-level disinfection is available on site to staff.	
D3b	Confirmation from manufacturer item(s) is/are heat sensitive.	• The use of a liquid chemical sterilant should be restricted to reprocessing devices that are heat-sensitive and incompatible with other sterilization methods. All other items should be heat sterilized or disposable.	
D3c	**Appropriate PPE is available, exposure control plan, Material Safety Data Sheets, and clean up instructions in the event of a cold chemical sterilant spill.**	• Personnel are familiar with and can recognize signs and symptoms of exposure to cold chemical sterilants used on site. • Staff must be aware of the procedures for clean up in the event of spillage. • Staff can demonstrate or verbally explain procedure(s) used on site for chemical spill cleanup.	
D4a	Spore testing of autoclave/steam sterilizer with documented results (at least monthly)	• Documentation of biological spore testing includes: o Date o Results o Types of spore test used o Person performing/documenting test results • For positive spore tests, the autoclave is removed from service immediately until inspection is completed and a negative retest occurs. • Documentation of monthly spore testing must be maintained onsite even for sterilization that is performed offsite.	

D4b	Autoclave maintenance per manufacturer's guidelines.	Documentation of maintenance should include: • Mechanical problems • Inspection dates • Results/outcome of routine servicing • Calibration • Repairs, etc.	
D4c	**Spore testing of autoclave/steam sterilizer with documented results (at least monthly).**	Documentation of biological spore testing includes: • Date • Results • Types of spore test used • Person performing/documenting test results Written procedures for performing routine spore testing and for handling positive spore test results are available on site to staff. For positive spore tests, the autoclave is removed from service immediately until inspection is completed and a negative retest occurs. Procedures include: • Report problem • Repair autoclave • Retrieve all instruments sterilized since last negative spore test • Re-test autoclave • Re-sterilize retrieved instruments	

D4d	**Management of positive mechanical, chemical, and biological indicators of the sterilization process.**	• Staff should adhere to site-specific protocol and/or manufacturer/product label for management of positive indicator(s). • Mechanical Indicator: monitor sterilization process with a daily assessment of cycle time and temperature by examining the temperature record chart and an assessment of pressure via the pressure gauge (e.g., graphs, gauges, printouts) • Chemical Indicator: are usually either heat-or chemical-sensitive inks that change color when one or more sterilization parameters (e.g., steam-time, temperature, and/or saturated steam; ETO-time, temperature, relative humidity and/or ETO concentration) are present. • Biological: spore test – an indicator to evaluate the sterilizing conditions and indirectly the microbiologic status of the processed items	
D4e	Sterilized packages are labeled with sterilization date and load identification information.	• Must follow aseptic technique. Sterilized package labels include: • Date of sterilization • Load run identification information • Initials of staff member • General contents (e.g. suture set) each item in a sterile package need not be listed on the label if a master list of package contents is available elsewhere on site	
D4f	Storage of sterilized packages.	• Must be stored in areas that are clean, dry and separated from non-sterile items by a functional barrier • Not considered sterile if package is opened, wet/moist, discolored or damaged, and should be kept removed from sterile package storage area. • Site has a process for routine evaluation of sterilized packages.	

Medical Record Review Preparation Checklist

Quality Improvement
Fax: 1-408-874-1770
Email: FacilitySiteReview@scfhp.com

Purpose: The Medical Record Review (MRR) preparation checklist is used to conduct an internal review of your own practice to determine your readiness level for your upcoming MRR. Please reference the most current California Department of Health Care Services (DHCS) Medical Record Review Standards and the embedded governing entity website links below for more detailed information. All new DHCS criteria are in red text of the new standards effective July 1, 2022. The MRR Standards provide instructions, rules, regulation parameters, and indicators for the MRR. Not all criteria below may be applicable to your clinic. Please provide a brief explanation to the nurse reviewer before or during your site review for all criteria that are not applicable.

I. FORMAT CRITERIA		
Item	**Description**	**Reviewer Comments**
An individual medical record is established for each member.	Practitioners are able to readily identify each individual treated. "Family charts" are not acceptable. https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html	
A. Member identification is on each page.	Member identification includes first and last name, and/or a unique identifier established for use on clinical site.	
B. Individual personal biographical information is documented.	Personal biographical information includes date of birth, current address, home/work phone numbers, and name of parent(s)/legal guardian if member is a minor. If member refused to provide information, "refused" is documented in the medical record.	
C. Emergency "contact" is identified.	The name and phone number of an "emergency contact" person is identified for all members. If the patient is a minor, the primary emergency contact must be a parent or legal guardian.	
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. Medical Record information should be readily available.	
E. Member's assigned and/or rendering primary care physician (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.	
F. Primary language and linguistic service needs of non-or limited- English proficient (LEP), or hearing/speech-impaired persons are prominently noted.	The primary language is prominently documented at least once in the medical record. https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx	

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 must be documented in medical record. Family or friends should not be used as interpreters, unless requested by the member and documented in the member's chart. https://www.lep.gov/faq/faqs-rights-lep-individuals/commonly-asked-questions-and-answers-regarding-limited-english. See also Title 22 California Code 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	https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/permitted-uses/index.html	
II. DOCUMENTATION		
Item	**Description**	**Reviewer Comments**
A. Allergies are prominently noted.	Allergies and adverse reactions are listed in a prominent, easily identified, and consistent location in the medical record. If member has no allergies or adverse reactions, "No Known Allergies" (NKA), "No known Drug Allergies" (NKDA), or ∅ is documented.	
B. Chronic problems and/or significant conditions are listed.	Documentation may be on a separate "problem list," or a clearly identifiable problem list in the progress notes. This list should contain only current long-term, on-going conditions with slow or little progress.	
C. Current continuous medications are listed.	Documentation may be on a separate "medication list," or a clearly identifiable medication list in the progress notes. List of current, on-going medications identifies the medication name, strength, dosage, route (if other than oral), and frequency. Discontinued medications are noted on the medication list or in progress notes.	

D. Appropriate Consents are present:		
1. Release of medical record	Consent also must be obtained prior to release of patient information. The consent must have an expiration date.	
2. Signed informed consents are present when any invasive procedure is performed.	Adults, parents/legal guardians of a minor or emancipated minors may sign consent forms for operative and invasive procedures. Note: human sterilization requires 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). Reviewed at least every 5 years.	Adult medical records include documentation of whether the member has been offered information or has executed an Advance Health Care Directive. Advance Health Care Directive Information is reviewed with the member at least every 5 years and as appropriate to the member's circumstance. (See Probate Code, Section 4701, 42 CFR 422.128, 42 CFR 489.100, and APL 05-010.)	
F. All entries are signed, dated, and legible.	Signature includes the first initial, last name, and title of health care personnel providing care, including Medical Assistants. Stamped signatures are acceptable, but must be authenticated, meaning the stamped signature can be verified, validated, confirmed, and is countersigned or initialed. Any signature is acceptable if it is identified elsewhere in the medical record, e.g. a signature page. 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. One correction method is (single line drawn through the error, with the writer's initial and date written above or near the lined-through entry). Similar variations (such as single line and initial) are also used. The corrected information is written as a separate entry and includes date of the entry, signature (or initials), and title. In EMRs, corrections, additions, and deletions are ideally made via a signed, dated addendum.	

III. COORDINATION/CONTINUITY OF CARE CRITERIA		
Item	**Description**	**Reviewer Comments**
A. History of present illness 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.	
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.	
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.	
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. Documentation demonstrates that the practitioner follows up with members about treatment regimens, recommendations, and counseling.	
F. There is evidence of practitioner *review* of consult/referral reports and diagnostic test results.	There is documented evidence of practitioner review of records such as diagnostic studies, lab tests, X ray reports, consultation summaries, inpatient/discharge records, emergency and urgent care reports, and all abnormal and/or "STAT" reports. Evidence of review may include the practitioner's initials or signature on the report, notation in the progress notes, or other site-specific method of documenting practitioner review.	
G. There is evidence of *follow-up* of specialty referrals made, and results/reports of diagnostic tests, when appropriate.	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	
H. Missed primary care appointments and outreach efforts/follow-up contacts are documented.	Documentation includes incidents of missed/broken appointments, cancellations, or "no shows" with the PCP office. Attempts to contact the member or parent/guardian and the results of follow-up actions are documented in the medical record.	

IV. Pediatric Preventive Criteria		
Item	**Description**	**Reviewer Comments**
A. Initial Health Assessment (IHA) includes H&P and IHEBA/SHA	New members: The IHA (comprehensive history, and IHEBA) enables the PCP to assess current acute, chronic, and preventive needs and to identify those members whose health needs require coordinated services with appropriate community resources/other agencies not covered by the Plan. IHA must be completed within 120 days of plan enrollment, or documented within the 12 months prior to Plan enrollment. (References: IHA PL 08 – 003 or current version; IHEBA PL 13-001 or current version).	
1. Comprehensive History and Physical (H&P)	New members: the history must be comprehensive to assess and diagnose acute and chronic conditions which includes history of present illness; past medical history; social history, review of organ systems. If H&P not completed, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to schedule appointment are documented. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL%202008/PL08-003.PDF https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2013/PL13001.pdf	
2. Individual Health Education Behavioral Assessment (IHEBA)	New Members: An age-appropriate IHEBA (“Staying Healthy Assessment,” SHA) or other DHCS-approved tool (such as AAP Bright Future) is completed by the member or parent/guardian 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. Staff may assist. SHA Questionnaires: http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx	

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.	
1. Comprehensive History and Physical exam completed at age appropriate frequency	Health assessments containing age-appropriate requirements are provided according to the most recent AAP periodicity schedule for pediatric preventive health care. Assessments and identified problems are documented in the progress notes. https://www.aap.org/en-us/Documents/periodicity_schedule.pdf	
2. Subsequent Periodic IHEBA	An age-appropriate IHEBA is re-administered when the member has reached the next specific age interval designated by the Managed Care Quality and Monitoring Division (MCQMD). The PCP must review previously completed SHA questionnaires with parent, guardian or adolescent annually before reaching the next age group. SHA Questionnaires: http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx	
C. Well-child visit	The Bright Futures/AAP developed a set of comprehensive health guidelines for well-childcare, known as the "periodicity schedule." 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. https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx	

1. Alcohol/Drug Misuse: Screening and Behavioral Counseling	Per AAP, screen all children 11 years and older at each well visit for alcohol/drug misuse. If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s). Brief Assessment and Screening 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. 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:	
2. Anemia Screening	Perform risk assessment or screening at 4, 15, 18, 24, 30 months and 3 years old, then annually thereafter; and serum hemoglobin at 12 months old. 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.	
3. Anthropometric measurements	Head circumference for 2 years and younger, length/height and weight for 0-20 years old are documented and plotted in a WHO growth chart if under 2 years old and CDC growth chart if 2-21 years old. https://www.cdc.gov/growthcharts/.	
4. Anticipatory guidance	Includes age appropriate counseling/health education provided to parent or pediatric member and must be documented at each well child visit. https://brightfutures.aap.org/Bright%20Futures%20Documents/BF_PreventiveServices_Tipsheet.pdf#search=document%20anticipatory%20document	

5. Autism Spectrum Disorder Screening	Autism Spectrum Disorder Screening must be performed at 18 months and 24 months based on AAP periodicity "Bright Futures". The Autism Spectrum Disorder Screening tools that may be used are: a. Ages and Stages Questionnaires (ASQ) b. Communication and Symbolic Behavior Scales (CSBS) c. Parents' Evaluation of Developmental Status (PEDS) d. Modified Checklist for Autism in Toddlers (MCHAT) e. Screening Tool for Autism in Toddlers and Young Children (STAT) 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. https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx	
6. Blood Lead Screening Test	Blood Lead Level (BLL) testing preferably using venous blood as follows: • At 12 month and 24 months of age, • Between 12 months and 24 months of age if there is no documented evidence of BLL testing at 12 months or thereafter, and • Between 24 months and 72 months of age if there is no documented evidence of BLL testing at 24 months or thereafter. See APL 20-016, Blood Lead Screening of Young Children, or any superseding APL for more information. https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx 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.	

7. Blood Pressure Screening	Blood pressure screening starts at 3 years of age. 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. https://publications.aap.org/pediatrics/article/140/3/e20171904/38358/Clinical-Practice-Guideline-for-Screening-and?autologincheck=redirected	

8. Dental Assessment	Inspection of the mouth, teeth and gums is performed at every health assessment visit. Documentation of "HEENT" is acceptable. Children are referred to a dentist at any age 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. https://www.aapd.org/media/Policies_Guidelines/BP_CariesRiskAssessment.pdf	
8a) Dental Home	Establish a dental home by 12 months of age and refer to a dentist annually regardless of whether a dental problem is detected or suspected. See the AAP Oral Health Practice Tools, available at: https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/.	
8b) 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. 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	

8c) Fluoride Varnish	Fluoride varnish applied on children 5 years old and younger once teeth have erupted. All children in this category should receive fluoride varnish application at least once every 3-6 months in the primary care or dental office. Documentation of "seeing a dentist" without specific notation that fluoride varnish was applied at the dentist office does not meet the criterion since not all dentists routinely apply fluoride varnish during routine dental visits. 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. https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx	
9. Depression screening	USPSTF 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. 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://screeningtime.org/star-center/#/screening-tools.	
9a) Suicide-Risk Screening	Until the AAP Periodicity Schedule is finalized, please follow current recommendations from AAP on Suicide Risk Screening: Starting at 12 years old, screen at each well visit using Ask Suicide-Screening Questions (ASQ), PHQ-9 Modified for Teens (PHQ9A) or other validated screening tools that consist of 3 suicide-related items ("thoughts of death," "wishing you were dead," and "feeling suicidal" within the past month). Refer patients at risk to behavioral health (psychotherapy, psychodynamic or interpersonal therapy). 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/	

9b) Maternal Depression Screening	Assembly Bill (AB) 2193 would require provider who provides prenatal or postpartum care for a patient to offer to screen or appropriately screen a mother for maternal mental health conditions. Maternal depression screening at 1-, 2-, 4-, and 6-month visits. "Screening should occur per 'Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice'. https://pediatrics.aappublications.org/content/143/1/e20183259 https://www.acog.org/Patients/FAQs/Postpartum-Depression https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening1 https://www.womenshealth.gov/mental-health/mental-health-conditions/postpartum-depression.	
10. Developmental Disorder Screening	Developmental screening for developmental disorders at the 9th, 18th and 30th month visits (30 month screening can be done at 2 year well child check). 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. 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.	
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.	

13. Dyslipidemia Screening	Per AAP, a risk assessment at 2, 4, 6, and 8 years old, then annually thereafter; one lipid panel between 9 and 11, and again at 17 and 21 years old to identify children with genetic dyslipidemia or more lifestyle-related dyslipidemia. https://www.nhlbi.nih.gov/node/80308 https://brightfutures.aap.org/Pages/default.aspx	
14. Hearing Screening	Non-audiometric screening for infants/children (2 months to 3 years) includes family and medical history, physical exam and age appropriate screening. Audiometric screening for children and young adults (3 -20) is done at each health assessment visit and includes follow-up care as appropriate. Per AAP audiometric screenings are performed at: Birth to 2 months old, 4, 5, 8, and 10 years old o Once between 11-14 years old o Once between 15-17 years old o Once between 18-21 years old A failed audiometric screening is followed up with a repeat screening at least two weeks and no later than 6 weeks after the initial screening. If the second screening also fails, there is a referral to a specialist. See the AAP periodicity schedule, available at: www.aap.org/periodicityschedule. https://www.cdc.gov/ncbddd/hearingloss/recommendations.html.	

15. Hepatitis B Virus Infection Screening	USPSTF recommends screening for hepatitis B virus (HBV) infection in persons at high risk for infection:- 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%), such as sub-Saharan Africa and central and Southeast Asia - HIV-positive persons – Injection drug users - Men who have sex with men - Household contacts or sexual partners of persons with HBV infection. https://www.cdc.gov/hepatitis/hbv/index.htm	
16. Hepatitis C Virus Infection Screening	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 current injection drug use, should be tested for HCV infection and reassessed annually. 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. CDC recommendations on HCV screening, available at: https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm	

17. HIV Infection screening	Per AAP, risk assessment for HIV shall be completed at each well child visit starting at 11 years old. Adolescents should be screen for HIV according to the USPSTF recommendations once between the ages of 15 and 18. Those at high risk (i.e. those who are sexually active, IV drug users, MSM) shall be tested for HIV and offered pre-exposure prophylaxis (PrEP). 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. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening	
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. 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.	

19. Sexual Transmitted Infection (STI) Screening and Counseling	Sexual activity shall be assessed at every well child visit starting at 11 years old. STI screening on all sexually active adolescents. https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm 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.	
20. Sudden Cardiac Arrest and Sudden Cardiac Death Screening	Until the AAP Periodicity Schedule is finalized, please follow current recommendations from AAP on Sudden Cardiac Arrest and Sudden Cardiac Death Screening: Starting at 11 years old, screen at each well visit and refer to a pediatric cardiologist or electrophysiologist if positive for any of the following: Fainting, passing out, or sudden unexplained seizure(s) without warning, especially during exercise or in response to sudden loud noises, such as doorbells, alarm clocks, and ringing telephones; exercise-related chest pain or shortness of breath; family history of death from 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; or 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. https://publications.aap.org/pediatrics/article/148/1/e2021052044/179969/Sudden-Death-in-the-Young-Information-for-the	

21. Tobacco Use Screening, Prevention, and Cessation Services	Screen individuals 11 years and older annually with documented interventions counseling, pharmacotherapy, etc., if high risk — see Adolescent SHA Q19 - 20 or Adult SHA Q17 - 18. Tobacco products include but are not limited to smoked cigarettes, chewed tobacco, electronic cigarettes and vaping products, exposure to secondhand smoke. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-014.pdf	
22. Tuberculosis Screening	Risk assessment at each well visit; TB skin test for those at high risk (i.e. TST or Quantiferon).All children are assessed for risk of exposure to tuberculosis (TB) at 1, 6, and 12-months old and annually thereafter. 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. Documentation of "PERRLA" is acceptable for children below the age of 3 years. • AAP recommended eye charts are: o LEA Symbols (3-5 years old) o HOTV Chart (3-5 years old) o Sloan Letters (preferred) or Snellen Letters (over 5 years old) Follow AAP recommendations: https://pediatrics.aappublications.org/content/137/1/e20153596	

D. Childhood Immunizations		
1. Given according to ACIP guidelines	Immunization status is assessed at each health assessment visit. Practitioners are required to ensure the provision of immunizations according to CDC's most recent Advisory Committee on Immunization Practices (ACIP) guidelines, unless medically contraindicated, vaccine shortage, or refused by the parent. DHCS requires documentation of immunizations in the California Immunization Registry (CAIR). Refer to the following link for more information on ACIP Vaccine Recommendations and Guidelines: https://www.cdc.gov/vaccines/hcp/acip-recs/index.html.	
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	Vaccine Information Statements (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. Refer to the following link from the CDC for the current VISs: https://www.cdc.gov/vaccines/hcp/vis/current-vis.html.	
V. ADULT PREVENTIVE CRITERIA		
Item	**Description**	**Reviewer Comments**
A. Initial Health Assessment (IHA) includes H&P and IHEBA	New members: The IHA (comprehensive history and IHEBA "Staying Healthy Assessment" or other DHCS-approved tool) 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. 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. Reference: PLs 08–003 and 13-001, or any superseding APL.	

1. Comprehensive History and Physical	New members: The history must be comprehensive to assess and diagnose acute and chronic conditions which includes: history of present illness, past medical history, social history, review of organ systems (ROS) including dental assessment. 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. Referrals for any abnormal findings must be documented. IF H&P is not found in medical record, the reasons (e.g. member/parent refusal, missed appointment) and contact attempts to reschedule are documented. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL%202008/PL 08-003.PDF https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPol icyLetters/PL2013/PL13001.pdf	
2. Individual Health Education Behavioral Assessment (IHEBA)	New member: An age-appropriate IHEBA ("Staying Healthy" or other DHCS-approved tool) is completed by the member within 120 days of the effective date of enrollment into the Plan or PCP effective date (whichever is more recent), or within the 12 months prior to Plan enrollment/PCP effective date. Staff may assist. If an initial IHEBA is not found in the medical record, the reasons (e.g., member's refusal, missed appointment) and contact attempts to reschedule are documented. The IHEBA has evidence of practitioner review: printed name, signature, date, and interventions which may be documented on the IHEBA form, in progress notes, or other areas of the paper or electronic medical record system. SHA Questionnaires are available at: http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx	

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.	
2. Subsequent Periodic IHEBA	The adult or senior assessment must be re-administered every 3 to 5 years, at a minimum. The PCP must review previously completed SHA questionnaires with the patient every year, except years when the assessment is re-administered. Documentation requirements are the same as the initial IHEBA. For subsequent annual reviews, PCP must sign, print name, and date "SHA Annual Review" section (last page) to verify the annual review was conducted and discussed with the patient. SHA Questionnaires are available at: http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx	
C. Adult Preventative 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). 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.		
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. See the USPSTF recommendation on AAA Screening: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/abdominal-aortic-aneurysm-screening.	

2. Alcohol Use Disorder Screening and Behavioral Counseling	Assess all adults at each well visit for alcohol misuse. **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:** Alcohol brief interventions includes alcohol misuse counseling and counseling a member regarding additional treatment options, referrals, or services **Documentation Requirements:** 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 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 See APL 21-014, Alcohol and Drug Screenings, Assessment, Brief Interventions and Referral to Treatment, or any superseding APL, for additional information. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-014.pdf See the NIH guidance on Screening Tests, available at: https://pubs.niaaa.nih.gov/publications/arh28-2/78-79.htm 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.as	

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. USPSTF link: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening	
4. Cervical Cancer Screening	Screening for cervical cancer in women age 21 to 65 years with cytology (Pap smear) every 3 years or, for women age 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. Follow-up of abnormal test results is documented. Routine Pap testing may not be required for the following: 1) women who have undergone hysterectomy in which the cervix is removed (total abdominal hysterectomy), unless hysterectomy was performed because of invasive cancer, 2) women 66 years and older who have had regular previous screening in which the smears have been consistently normal. USPSTF link: 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. USPSTF link: 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 at each well visit with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. 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 IHEBA forms when used solely for depression screening do not have psychometric properties and may not be reliable screening tools for depression. The USPSTF Grade A and B Recommendations are available at: https://www.uspreventiveservicestaskforce.org/Page/Name/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	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. Glucose abnormalities can be detected by measuring HbA1c or fasting plasma glucose or with an oral glucose tolerance test. 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.	
7a. Comprehensive Diabetic Care	Offer or refer patients with glucose abnormalities to intensive behavioral counseling interventions to promote a healthful diet and physical activity. 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 https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-018.pdf See the National Community for Quality Assurance guidance on Comprehensive Diabetes Care, available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/.	

8. Drug Use Disorder Screening and Behavioral Counseling	Assess all adults at each well visit for drug misuse. 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) If at any time the PCP identifies a potential drug use problem (e.g., patient answered "yes" to the drug use questions in the IHEBA), the provider shall: 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 as having risky or hazardous drug use. A member responds affirmatively to the drug use questions in the IHEBA. Member provides responses on the expanded screening that indicate hazardous use, or when otherwise identified See APL 21-014, Alcohol and Drug Screenings, Assessment, Brief Interventions and Referral to Treatment, or any superseding APL, for additional information. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-014.pdf 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.	

9. Dyslipidemia Screening	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 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. USPSTF Link: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.	
10. Folic Acid Supplementation	The USPSTF recommends all women who are planning or capable of pregnancy are to take 0.4-0.8 mg daily of folic acid. USPSTF and WHO categorize women in the age range of 12-49 years as “women who are capable of becoming pregnant”. USPSTF Link: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/folic-acid-for-the-prevention-of-neural-tube-defects-preventive-medication	

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]). 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%). HIV-positive persons, injection drug users, MSM, and 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	The USPSTF recommends screening for Hepatitis C Virus (HCV) exposure in adults ages 18 to 79 years old. Screen individuals for risk factors and TEST FOR HCV if one of the following risk factors is identified: 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 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.	

13. High Blood Pressure Screening	All adults 18 years and older including those without known hypertension are screened. A blood pressure (B/P) measurement for the normotensive adult is documented at least once every 2 years if the last systolic reading was below 120 mmHg and the diastolic reading was below 80 mmHg.B/P is measured annually if the last systolic reading was 120 to 139 mmHg and the diastolic reading was 80 to 89 mmHg. USPSTF Link: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hypertension-in-adults-screening.	
14. HIV Screening	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). Lab results are documented. USPSTF Link: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening USPSTF recommendation on Prevention of HIV Infection: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis	

15. Intimate Partner Violence Screening for Women of Reproductive Age	Per the USPSTF, clinicians shall screen for Intimate Partner Violence (IPV) on asymptomatic women of reproductive age, which is defined across studies as 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. The SHA is an incomplete tool to screen for IPV, however, per USPSTF the following instruments accurately detect IPV in the past year among adult women: o Humiliation, Afraid, Rape, Kick (HARK) o Hurt, Insult, Threaten, Scream (HITS) o Extended–Hurt, Insult, Threaten, Scream (E-HITS) o Partner Violence Screen (PVS) o Woman Abuse Screening Tool (WAST) The USPSTF A and B recommendations are the minimum that is required by DHCS: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening 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. USPSTF Link: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/lung-cancer-screening.	

17. Obesity Screening and Counseling	Documentation shall include weight and body mass index (BMI). The 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 (BMI > 30). USPSTF Link: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/obesity-in-adults-screening-and-counseling-2003.	
18. Osteoporosis Screening	Bone measurement testing for women 65 years and older or postmenopausal women younger than 65 with one of the following risk factors: parental history of hip fracture, smoking, excessive alcohol consumption, and low body weight. USPSTF Link: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/osteoporosis-screening	
19. Sexually Transmitted Infection (STI) Screening and Counseling	Risk assessment shall be completed at each well visit. Chlamydia and Gonorrhea: test all sexually active women under 25 years old and 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: test MSM or persons with HIV shall be screened at least annually Trichomonas: test 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: test men and women requesting STI evaluation who have multiple sex partners shall be tested, HIV+, and MSM with undiagnosed genital tract infection Intensive behavioral counseling for adults who are at increased risk for STIs includes counseling on use of appropriate protection and lifestyle. USPSTF Link: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/sexually-transmitted-infections-behavioral-counseling	

20. Skin Cancer Behavioral Counseling	USPSTF recommends that young adults and parents of young children should be counseled to minimize exposure to Ultraviolet (UV) radiation for persons aged 6 months to 24 years to reduce their risk of skin cancer. USPSTF Link: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/skin-cancer-counseling	
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. If the PCP identifies tobacco use (e.g. Patient answered "Yes" on IHEBA): o 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 o 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. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-014.pdf	

22. Tuberculosis Screening	Adults are assessed for tuberculosis (TB) risk factors or symptomatic assessments upon enrollment and at periodic physical evaluations. The Mantoux skin test, or other approved TB infection screening test, is administered to all asymptomatic persons at increased risk of developing TB irrespective of age or periodicity if they had not had a test in the previous year. Adults already known to have HIV or who are significantly immunosuppressed require annual TB testing. 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		
1. Given according to ACIP guidelines	Immunization status is assessed at each periodic health evaluations. Practitioners are required to ensure the provision of immunizations according to CDC's most recent Advisory Committee on Immunization Practices (ACIP) guidelines, unless medically contraindicated or refused by the parent. DHCS requires documentation of immunizations in the California Immunization Registry (CAIR). 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. See the CDC ACIP Guidance on Immunization Schedules, available at: https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html	
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	Vaccine Information Statements (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. The date the VIS was given (or presented and offered) and the VIS publication date are documented in the medical record.	

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