Facility Site Review and Medical Record Review Preparation Packet

Please read and review this information as it will assist you to have a successful Medi-Cal Managed Care review. You may use these resources now and in the future as part of your own internal monitoring.

IMPORTANT:

If this is not your initial review, there may be some changes to the State regulations since your last audit. Please feel free to contact your Certified Site Reviewer PRIOR to your audit to clarify any of these criteria. Notifying your Certified Site Reviewer is especially important if you have been audited by different health plans, programs, or reviewers in the past.

- This on-site facility review is a requirement and is necessary to participate as a Medi-Cal Managed Care PCP.
- The enclosed Policies and Procedures list should currently be in your office and may be used as staff training if your PCP has signed off that they approve.
    - See signature box at the top of page 1 of each policy.
    - If your PCP prefers to adopt some or all of the enclosed Policies and Procedures, please have them sign the signature page attached and check off which policies/procedures your site has adopted.

Please have everything ready before your scheduled review.

Thank you for your participation.

Simple, functional, written policies that are followed in the office need to be in place. Below is a comprehensive list of policies (if applicable to your practice) that should be in place at the time of audit. Examples of each policy are attached in this packet. If a provider decides to use these specific policies, please check off which (or all) policies and have them sign below to acknowledge use of all attached policies as they are written. Any revisions to a policy can be made and encouraged in order to reflect your office practice. Simply indicate which policies were revised and present the revised policy to the nurse reviewer at the time of the audit. When a revision is made, ensure that the approving provider signs the top right-hand corner of the policy to indicate the implementation of this policy and procedure in the practice. If no revisions are made, continue with signing, indicating no policies have been revised (or writing "none"). Annual review of these policies and procedures should be in place and documented by provider signing the signature page each year.

Policy Description	Check here if implementing the attached P&P(s)
• Site accessibility by individuals with physical disabilities	
• Clean and sanitary environment	
• Fire safety and prevention and emergency non-medical procedures	
• Medical and lab equipment maintenance	
• Emergency health care services	
• Staff qualifications – health care license and certification requirements	
• Non-physician medical practitioners	
• Unlicensed personnel	
• Personnel training	
• Infection Control	
• Bloodborne pathogens and Biohazardous waste management	
• Patient Confidentiality	
• Informed Consent	
• Prior Authorizations	
• Referrals	
• Member Grievances	
• Child/Elder/Domestic Abuse Reporting	
• Sensitive Services & Minor Rights	
• Cultural linguistic & Interpreter Services	
• Disability Rights and Provider Obligations	
• Provisions of Services 24 hours a day	
• Triage	
• Appointments and Patient Recall	
• Pharmaceutical Services	
• Laboratory Services	
• Radiology Services	
• Preventive Health	
• Health Education Services	
• Instrument Sterilization	

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POLICY AND PROCEDURE MANUAL

PROVIDER ACKNOWLEDGEMENT SIGNATURE PAGE

By signing below, I agree that the above checked policies and procedures have been adopted and implemented in my practice. I agree to revise and maintain copies of revisions as policies and procedures in my practice change. When changes are made, I will ensure proper staff training of such changes are shared with staff and documented via a staff in-service training sign in sheet conducted by myself or a designated site personnel such as an office manager or clinic supervisor.

Date	Name of Reviewing Physician(s)	Signature	Review Date	P&P Number(s) Revised – if none, indicate "none"

PRE-AUDIT PREPARATION

Facility Site Review Critical Elements

There are fourteen (14) Critical Elements. (These criteria are worth 2 points each):

1. Exit doors & aisles are unobstructed and egress (escape) accessible

- Accessible pedestrian paths of travel provide a clear circulation path.
- Escape routes are maintained free of obstructions or impediments to full instant use of the path of travel in case of fire or other emergency.
- Building escape routes provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied.
- Cords or other items are not placed on or across walkway areas.

2. Airway Management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag

- Must have a wall oxygen delivery system or portable oxygen tank that is maintained at least ¾ full. Portable oxygen tank must have a flow meter attached and regulated up to 6L of 02/minute, maintained for a minimum of 15 minutes.
- If oxygen tank is less than ¾ full, must have a back-up method for supplying oxygen *and* a scheduled plan for tank replacement.
- Staff must be able to demonstrate proper way of turning oxygen tank on/off.
- There is a method/system in place for oxygen tank replacement.
- There is a nasal cannula/mask available and various sizes of ambu bags appropriate to patient population available on site.

3. Emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia

- Per AAFP, the minimum equipment to manage these emergencies shall include:
    - Epinephrine 1mg/mL (injectable)
    - Diphenhydramine 25mg (oral) or 50 mg/mL (injectable)
    - Naloxone
    - Chewable aspirin 81mg (at least 4 doses)
    - Nitroglycerin spray or tablets
    - Bronchodilator medication (solution for nebulizer or metered dose inhaler)
    - Glucose (any type of glucose containing at least 15 grams)
    - Appropriate sizes of ESIP needles/syringes and alcohol wipes
- Medication dosage chart for all emergency medications must be present and kept in emergency kit. (Package inserts are not acceptable)

4. Only qualified/trained personnel retrieve, prepare or administer medications

- There must be a licensed physician physically present in the treatment facility during the performance of authorized procedures by the Medical Assistant (MA) or documentation which states the supervision of MAs when supervising physician is off premises.
- There must be a process in place and verbalized by the MA(s), at the time of survey, that the pre-labeled medication container/vaccine and prepared dose are shown to the licensed person prior to administration.
- The supervising physician must specifically authorize all medications administered by an MA.

5. Timely physician review & follow-up of referral/consultation reports & diagnostic test results

- Site staff can demonstrate the office referral process from beginning to end; Must include process of tracking results/consult notes and documentation of follow-up efforts.
- There is a documented process of the practitioner's *timely* review of diagnostic tests/consultations and subsequent outreach to follow-up with the patient to communicate results and provide next steps.
- A process for follow-up of missing referral/consultation reports and diagnostic test results is in place.

6. **Only lawfully authorized persons dispense drugs to patients**
   - Drug dispensing complies with all applicable State and Federal laws and regulations.
   - Drugs are dispensed only by a physician, pharmacist, or other persons 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.

7. **Drugs and vaccines are prepared and dawn only prior to administration**
   - **Staff do not routinely prefill syringes**

8. **Personal protective equipment (PPE) for Standard Precautions is readily available for staff use**
   - PPE is readily available for staff use on-site & includes:
     - Water repelling gloves
     - Water repellent clothing barrier/gown
     - Face/eye protection (e.g., face shield or goggles)
     - Respiratory infection protection (e.g., mask).
   - PPE "spill kit" kept together in a bag; readily available, and the storage should be adequate to protect from contamination/damage.

9. **Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport or shipping.**
   - Containers for blood and other potentially infectious materials (OPIM) are closable, leak proof, and labeled and/or color-coded.
   - Double bagging is required only if leakage is possible.
   - A warning label is affixed to red-bagged regulated wastes, sharps containers, fridge/freezers containing blood or OPIM, containers use to store or transport blood or OPIM, and contaminated laundry or equipment for storage or transporting.

10. **Needle stick precautions are practiced on site**
    - Engineered Sharps Injury Protection (ESIP) devices are used on site.
    - Contaminated sharps are discarded immediately.
    - Sharps containers are: 1) located close to the immediate area where sharps are used; 2) inaccessible to unauthorized persons; 3) secured (locked) in patient care areas at ALL times; and 4) not overfilled past manufacturer's designated fill line or more than ¾ full.
    - Supply of containers on hand is adequate to ensure routine change-out when filled.

11. **Cold Chemical Sterilization (if applicable): Staff can 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 locate written directions on site.
    - Product efficacy tests (i.e., test strips) shall be performed according to manufacturer's guidelines.
    - Product manufacturer's directions are strictly followed for instrument pre-soaking treatment, solution preparation, solution exposure procedures, safety precautions (e.g., room temperature, area ventilation), and post-sterilization processes.

12. **Cold Chemical Sterilization (if applicable): Appropriate PPE is available, exposure control plan, Material Safety Data Sheets (MSDS) and clean up instructions in the event of a cold chemical sterilant spill.**
    - Site must have the data sheets for cold chemical sterilants readily available to employees who work with the products to which they could be exposed
    - Staff should attend training classes in safety awareness about the use and exposure to cold chemical sterilants used on site.
    - 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 procedures used on site for chemical spill cleanup

13. Autoclave/Steam Sterilization (if applicable): Spore testing of autoclave/steam sterilizer with documented results (at least monthly)

- Autoclave spore testing is performed at least monthly; (If sterilization is conducted at another location, monthly spore test results must be kept on-site.)
- 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 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.

14. Autoclave/Steam Sterilization (if applicable): Management of positive mechanical, chemical, and biological indicators of the sterilization process.

- The autoclave/steam sterilization procedure should be monitored routinely by using a combination of:
    - Mechanical Indicator: monitor sterilization process with assessment and documentation of cycle time, temperature, and pressure
    - Chemical Indicator: pouches should have external *and* internal indicators (heat/chemical-sensitive inks) that are assessed after each cycle
    - Biological Indicator: spore test results monitored monthly and documented appropriately

Primary Care Provider- Site Review Standards

Purpose: The Facility Site Review Standards provide the instructions, rules, regulations, parameters, and indicators for conducting Facility Site Reviews using the Facility Site Review tool. The site reviewer must use these Standards for measuring, evaluating, assessing, and making decisions.

Scoring: Site reviews include on-site inspection and interviews with site personnel. Reviewers are expected to use reasonable evidence available during the review process to determine if practices and systems on site meet review criteria. Critical Elements have a weight of two (2) points each and non-Critical Elements have a weight of one (1) point on the site review tool. Compliance levels include:

1) Exempted Pass: 90% or above *without deficiencies* in Critical Elements, Pharmaceutical or Infection Control
2) Conditional Pass: 80-89%, or 90% and above with deficiencies in either Critical Elements, Pharmaceutical or Infection Control
3) Fail: 79% and below

A corrective action plan (CAP) is required for a total score less than 90%, *OR* for a total score of 90% or above if there are deficiencies in Critical Elements, Pharmaceutical Services or Infection Control. Compliance rates are based on 170 total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer. Reviewers are expected to determine how to ascertain information needed to complete the review. Review criteria that shall be reviewed *only* by a registered nurse (RN), nurse practitioner (NP), Certified Nurse Midwife (CNM), Licensed Midwife (LM), physician (MD), or physician assistant (PA) is labeled "**RN/NP/CNM/LM/MD/PA".**

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

1) Add the points given in each section.
2) Add points given for all six (6) sections to determine total points given for the site.
3) Subtract all "N/A" items from 170 total possible points to determine the "adjusted" total possible points. If there are no "N/A" items, calculation of site score will be based on 170 points.
4) Divide the total points given by 170 or by the "adjusted" total. Multiply by 100 to calculate percentage rate.

Scoring Example:

Step 1: Add the points given in each section.

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

Example: 31 (Access/Safety)
27 (Personnel)
25 (Office Management)
40 (Clinical Services)
13 (Preventive Services)
34 (Infection Control)
170 (POINTS GIVEN)

Step 3: Subtract "N/A" points from 170 total points possible.

170 (Total points possible)
- 5 (N/A points)
165 ("Adjusted" total points possible)

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

$$\frac{\text{Points given}}{\text{"Adjusted" total}} \quad \text{or} \quad \frac{140}{165} = 0.8485 \times 100 = \mathbf{85\%}$$

Criteria	I. Access/Safety Standards
A. Site is accessible and useable by individuals with physical disabilities.	**Sites must have the following safety accommodations for physically disabled persons:** **<u>Americans with Disabilities Act (ADA) Regulations</u>:** • Site must meet city, county, and state building structure and access ordinances for persons with physical disabilities. A site/facility includes the building structure, walkways, parking lots, and equipment. • All facilities designed, constructed; or altered by, on behalf of, or for the use of a public entity must be readily accessible and usable by individuals with disabilities, if the construction or alteration was begun after January 26, 1992.[1] • Any alteration to a place of public accommodation or a commercial facility, after January 26, 1992, must be made to ensure that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and useable by individuals with disabilities, including individuals who use wheelchairs.[2] **I.A.1) Clearly marked (blue) curb or sign designating disabled-parking space near accessible primary entrance.** **<u>Parking</u>:** • Parking spaces for persons with physical disabilities are located in close proximity to accessible building entrances. • Each parking space reserved for persons with disabilities is identified by a permanently affixed reflectorized sign posted in a conspicuous place. • If the provider has no control over availability of accessible parking within lot or nearby street spaces for persons with disabilities, the provider must have a plan in place for making program services available to persons with physical disabilities. **I.A.2) Pedestrian ramps have a level landing at the top and bottom of the ramp.** **<u>Ramps</u>:** • A clear and level landing is at the top and bottom of all ramps and on each side of an exit door. • Any path of travel is considered a ramp if its slope is greater than a 1-foot rise in 20 feet of horizontal run. • Ramps must be a minimum of 36-inches wide. Some areas require wider ramps.

[1] Title 28, Code of Federal Regulations (CFR), section 35.151. The CFR is searchable at: https://www.ecfr.gov/search.
[2] 28 CFR section 36.402.

Criteria	I. Access/Safety Standards
	• All edges must be protected to keep anyone from slipping off. • All ramps shall have a level top and bottom landings that are 5 feet long. • Ramps must have handrails on both sides if length is longer than 6 feet. **I.A.3) Exit and exam room doorway openings allow for clear passage of a person in a wheelchair.** **<u>Exit Doors</u>:** • All entrances and exterior and interior exit doors, regardless of the occupant load shall be made accessible to persons with disabilities. • Exam room and exit doorways have a minimum opening of 32 inches with the door open at 90 degrees that will allow for passage of wheelchairs. • Door hardware = operable with a single effort without requiring ability to grasp hardware. • Effort to operate doors = a maximum pressure of 5 pounds at interior doors. • Door hardware height = 30” – 44” above floor. • Exit doors include all doors required for access, circulation and use of the building and facilities, such as primary entrances and passageway doors. • Furniture and other items do not obstruct exit doorways or interfere with door swing pathway. **I.A.4) Accessible passenger elevator or reasonable alternative for multi-level floor accommodation.** **<u>Elevators</u>:** • If there is no elevator, a freight elevator may be used to achieve program accessibility if it is upgraded for general passenger use and if passageways leading to and from the elevator are well-lit, neat, and clean. **I.A.5) Clear floor space for wheelchair in waiting area and exam room.** **<u>Clear Floor Space</u>:** • Clear space in waiting/exam areas is sufficient (at least 30-in. x 48-in.) to accommodate a single, stationary adult wheelchair and occupant. • A minimum clear space of 60-inch diameter or square area is needed to turn a wheelchair. **<u>Sanitary Facilities</u>:** **I.A.6) Wheelchair accessible restroom facilities.** • A wheelchair accessible restroom stall allows sufficient space for a wheelchair to enter and permits the door to close.

Criteria	I. Access/Safety Standards
	• Sufficient knee clearance space underneath the sink allows wheelchair users to safely use a lavatory sink for hand washing. • If wheelchair-accessible restrooms are not available within the office site, reasonable alternative accommodation are provided such as a wheelchair-accessible restroom located within the building. Other reasonable alternatives may include, but is not limited to, urinal, bedpan, or bedside commode in a private area. **IA.7) Wheelchair accessible handwashing facilities or reasonable alternative.** • Restroom and hand washing facilities are accessible to able-bodied and physically disabled persons. • If wheelchair-accessible handwashing facilities are not available within the office site, reasonable alternative accommodation are provided such as sanitizers and wheelchair-accessible restroom located within the building. **Note:** • A public entity may not deny the benefits of its program, activities, and services to individuals with disabilities because its facilities are inaccessible.[3] • Every feature need not be accessible, if a reasonable portion of the facilities and accommodations provided is accessible.[4] • Reasonable Portion and/or Reasonable Alternatives are acceptable to achieve program accessibility. • Reasonable Portion applies to multi-storied structures and provides exceptions to the regulations requiring accessibility to all portions of a facility/site. • Reasonable Alternatives are methods other than site structural changes to achieve program accessibility, such as acquisition or redesign of equipment, assignment of assistants/aides to beneficiaries, provision of services at alternate accessible sites, and/or other site-specific alternatives to provide services.[5] • Points shall not be deducted if Reasonable Portion or Reasonable Alternative is made available on site.

[3] 28 CFR sections 35.149 – 35.150.
[4] Title 24, California Code of Regulations (CCR), sections 2-419, California Administrative Code, the State Building Code. CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index.
[5] Title II-5.2000 of the ADA Technical Assistance Manual, available at: https://www.ada.gov/taman2.html.

Criteria	I. Access/Safety Standards
	Specific measurements are provided strictly for "*reference only*" for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.
B. Site environment is maintained in a clean and sanitary condition.	**I.B.1) All patient areas including floor/carpet, walls, and furniture are neat, clean, and well maintained.** • The physical appearance of floors/carpets, walls, furniture, patient areas, and restrooms are clean and well maintained. **I.B.2) Restrooms are clean and contain appropriate sanitary supplies.** • Appropriate sanitary supplies, such as toilet tissue, hand washing soap, cloth/paper towels or antiseptic towelettes are made available for restroom use. • Environmental safety includes the "housekeeping" or hygienic condition of the site. • Clean means unsoiled, neat, tidy, and uncluttered. • "Well maintained" means being in good repair or condition.
C. Site environment is safe for all patients, visitors and personnel.	**<u>Ordinances</u>:** • Sites must meet city, county, and state fire safety and prevention ordinances. • Reviewers should be aware of applicable city and county ordinances in the areas in which they conduct reviews. **There is evidence staff has received safety training and/or has safety information available on the following:** **I.C.1) Fire safety and prevention.** **I.C.2) Emergency non-medical procedures (e.g. site evacuation, workplace violence).** **<u>Emergency Action Plans</u>:** • Non-medical emergencies include incidents of fire, natural disaster (e.g. earthquakes), workplace violence, etc. • Specific information for handling fire emergencies and evacuation procedures is available on site to staff. Personnel know ***where to locate*** information on site, and ***how to use*** information.[6]

[6] 29 CFR section 1910.38

Criteria	I. Access/Safety Standards
	I.C.3) Lighting is adequate in all areas to ensure safety. **Illumination:** Lighting is adequate in-patient flow working and walking areas such as corridors, walkways, waiting and exam rooms, and restrooms to allow for a safe path of travel. **I.C.4) (CE) Exit doors and aisles are unobstructed and egress (escape) accessible.** **Access Aisle:** • Accessible pedestrian paths of travel (ramps, corridors, walkways, lobbies, elevators, etc.) between elements (seats, tables, displays, equipment, parking spaces, etc.) provide a clear circulation path. • The minimum clear passage needed for a single wheelchair is 36 inches along an accessible route but may be reduced to a minimum of 32 inches at a doorway. • 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 type of emergency. • Building escape routes provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied. • Cords (including taped cords) or other items are not placed on or across walkway areas. **I.C.5) Exit doors are clearly marked with "Exit" signs.** **Exits:** Exit doorways are unobstructed and clearly marked by a readily visible "Exit" sign.[7] **I.C.6) Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location at all elevators, stairs and exits.** **Evacuation Routes**: • Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location at all elevators, stairs and exits.[8] **I.C.7) Electrical cords and outlets are in good working condition.** **Electrical Safety:** • Electrical cords are in good working condition with no exposed wires, frayed or cracked areas. Cords are not affixed to structures, placed in or across walkways, extended through walls, floors, and ceiling, or under doors or floor coverings.

[7] 29 CFR 1910.37
[8] 29 CFR 1910.33-39, 19 CCR 3.09 (a) (1) (B).

Criteria	I. Access/Safety Standards
	• Extension cords are not used as a substitute for permanent wiring. • All electrical outlets have an intact wall faceplate. • Sufficient clearance is maintained around lights and heating units to prevent combustible ignition. **I.C.8) Fire Fighting Equipment in accessible location.** **Firefighting equipment:** **There is firefighting equipment that must be in accessible locations on site. At least one of the following types of fire safety equipment is on site:** • **Fire Extinguisher:** The employer shall provide portable fire extinguishers and shall mount, locate, and identify them so that they are readily accessible. Fire extinguishers are maintained in a fully charged and operable condition and kept in their designated places at all times except during use.[9] • Smoke Detector with intact batteries. • Automatic Sprinkler System With a 10-inch clearance between sprinkler heads and stored materials. **I.C.9) An employee alarm system.** **Employee Alarm System:** • Employers must install and maintain an operable employee alarm system that has a distinctive signal to warn employees of fire or other emergencies, unless employees can promptly see or smell a fire or other hazard in time to provide adequate warning to them.[10] OSHA: For those employers with 10 or fewer employees in a workplace, direct voice communication is an acceptable procedure for sounding the alarm provided all employees can hear the alarm. Such workplaces do not need a back-up system. **Note:** Specific measurements are provided strictly for "*reference only"* for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.

[9] 29 CFR 1910.157
[10] 29 CFR 1910.37

Criteria	I. Access/Safety Standards

D. Emergency health care services are available and accessible 24 hours a day, 7 days a week.
 	
RN/NP/CNM/LM/MD/PA
	I.D. 1) Personnel are trained in procedures/action plan to be carried out in case of medical emergency on site.
	Site Specific Emergency Procedures:
	• Staff can describe site-specific actions or procedures for handling medical emergencies until the individual is stable or under care of local emergency medical services (EMS).
	• There is a written procedure for providing immediate emergent medical care on site until the local EMS is on the scene. Although site proximity to emergency care facilities may be considered when evaluating medical emergency procedures, the key factor is the ability to provide immediate care to patients *on site* until the patient is stable or EMS has taken over care/treatment.
	• When the physician or non-physician medical practitioner (NPMP) is not on site, staff/MA may call 911, and CPR-certified staff may initiate CPR if needed.
	• Non-CPR-certified staff may only call 911 and stay with the patient until help arrives.
	
	I.D.2) Emergency equipment is stored together in easily accessible location and is ready to be used.
	Emergency Medical Equipment:
	During business hours providers are prepared to provide emergency services for management of emergency medical conditions that occur on site ***until*** the emergent situation is stabilized and/or treatment is initiated by the local 911 Emergency Medical Service (EMS) system. Minimum emergency equipment is available on site to:
	  ○ Establish and maintain a patent/open airway.
	  ○ Manage emergency medical conditions.
	
	Emergency equipment and medication, appropriate to patient population served, are available in an accessible location and ready for use.
	• An accessible location is one that is reachable by personnel standing on the floor, or other permanent working area, without locating/retrieving step stool, ladder or other assistive devices.
	• For emergency “Crash” cart/kit, contents are appropriately sealed and are within the expiration dates posted on label/seal.
	• Site personnel are appropriately trained and can demonstrate knowledge and correct use of all medical equipment they are expected to operate within their scope of work.
	
	https://www.aafp.org/afp/2007/0601/p1679.html

Criteria	I. Access/Safety Standards
	I.D. 3) Emergency phone number contacts are posted, updated annually and as changes occur. **Emergency Phone Number list:** Posted in an accessible and prominent location(s) and includes: ○ Local emergency response services (e.g., 911 for fire, police/sheriff, ambulance). ○ Emergency contacts (e.g., responsible managers, supervisors). ○ Appropriate State, County, City, and local agencies (e.g., local poison control number). The list should be dated, and telephone numbers updated annually and as changes occur. **Emergency medical equipment appropriate to practice/patient population is available on site:** **I.D. 4) (CE) Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag:** Without the ability to adequately maintain the patient's airway, all other interventions are futile. Minimum airway control equipment with various sizes of airway devices appropriate to patient population within the practice and examples of oxygen delivery systems include: ○ Wall oxygen delivery system ○ Portable oxygen tank ○ Portable oxygen concentrator (POC) All oxygen delivery systems must be able to be regulated up to 6 liters of oxygen per minute, maintained for a minimum of 15 minutes. This flow rate establishes a minimum total oxygen delivery capacity of 90 liters for these devices:[11] ○ Nasal cannula or mask ○ Bulb syringe ○ Ambu bag as appropriate to patient population served. Mask should be replaced when they no longer make a solid seal.

[11] See the Food and Drug Administration (FDA) guidelines for oxygen generators and oxygen equipment for emergency use, available at: https://www.fda.gov/regulatory-information/search-fda-guidance-documents/review-guidelines-oxygen-generators-and-oxygen-equipment-emergency-use

- Portable oxygen tanks are maintained at least ¾ full. There is a method/system in place for oxygen tank replacement. If oxygen tanks are less than ¾ full at time of site visit, site has a back-up method for supplying oxygen if needed ***and*** a scheduled plan for tank replacement.
- Oxygen tubing does not need be connected to oxygen tank, but must be kept in close proximity to tank.

Oropharyngeal airways are no longer required.

I.D.5) (CE) Emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia:

Severe allergic reaction can cause urticaria (hives), hypotension, bronchospasm, wheezing, and pulmonary edema. Per the American Academy of Family Practice (AAFP), the minimum equipment to manage emergency anaphylactic reaction, asthma exacerbation, chest pain, opioid overdose, and hypoglycemia, based on the patient population served, shall include:

- Epinephrine 1mg/mL (injectable)
- Diphenhydramine 25 mg (oral) or 50 mg/ml (injectable)
- Naloxone[12]
- Chewable aspirin 81 mg[13]
- Nitroglycerin spray/tablet[14]
- Bronchodilator medication (solution for nebulizer or metered dose inhaler)
- Glucose (any type of glucose containing at least 15 grams)
- Appropriate sizes of ESIP needles/syringes[15] and alcohol wipes

- The typical adult strength to address cardiac emergencies is 325 mg (four doses of 81 mg chewable aspirin or one dose of 325 non-enteric coated aspirin).
- If the site is seeing adults, the reviewer shall assess whether the appropriate number of chewable aspirin tablets of 81 mg is available (at least four tablets).

I.D.6) Medication dosage chart for all medications included with emergency equipment (or other method for determining dosage) is kept with emergency medications.

- There is a current medication administration reference (e.g. medication dosage chart) available for readily identifying the correct medication dosages (e.g. adult, pediatric, infant, etc.).
- Package inserts are not acceptable as dosage charts.
- All emergency medications in the emergency kit/ crash cart must have dosage charts.

Score should be either a **Yes or No only**

[12] In 2018, the U.S. Surgeon General issued an advisory emphasizing the importance of health care professionals having naloxone (an opioid antagonist) on hand and being trained in how to use it. The U.S. Surgeon General's advisory is available at: https://www.hhs.gov/surgeongeneral/priorities/opioids-and-addiction/naloxone-advisory/index.html. Also see the FDA's approval of Narcan to reverse opioid overdose: https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/narcan-naloxone-nasal-spray-approved-reverse-opioid-overdose, and articles regarding overdose preparedness for ambulatory clinics, available at: https://www.aafp.org/fpm/2021/0100/p17.html and https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5753997/.

[13] See the American Heart Association's article on Aspirin and Heart Disease, available at: https://www.heart.org/en/health-topics/heart-attack/treatment-of-a-heart-attack/aspirin-and-heart-disease.

[14] Pediatric offices only serving patients under 18 years old are not required to keep Nitroglycerin in their emergency kit. According to the FDA, "The safety and effectiveness of nitroglycerin in pediatric patients (under 18 years old) have not been established." Also see page 8 of an article on Nitrostat, available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2014/021134s007lbl.pdf.

[15] If the emergency kit or "crash cart" has only non-safety needles/syringes, score that deficiency in Section VI., Infection Control, criteria B.2. See Infection Control Standards.

Criteria	I. Access/Safety Standards
	I.D.7) Document checking of emergency equipment/supplies for expiration and operating status at least monthly. Documented evidence that emergency medication and equipment is checked at least monthly may include a log, checklist or other appropriate method(s). **I.D.8) Replace/re-stock emergency medication, equipment, and supplies immediately after use.** A receipt or documentation showing medication is ordered is acceptable for any medication shortage. **Note:** An "emergency medical condition" is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: 1) placing the health of the individual (or unborn child of a pregnant woman) in serious jeopardy 2) serious impairment to bodily functions 3) serious dysfunction of any bodily organ or part "Emergency services" means those services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death.
E. Medical and lab equipment used for patient care is properly maintained. **RN/NP/CNM/LM/MD/PA**	**I.E.1) Medical equipment is clean.** **Medical and Laboratory Equipment:** All equipment used to measure or assess patient health status/condition is clean. **I.E.2) Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines.** **Documentation:** • There is documented evidence that standard operating procedures have been followed for routine inspection/maintenance, calibration, repair of failure or malfunction, and testing and cleaning of all specialized equipment. • Appropriate written records include calibration or other written logs, work orders, service receipts, dated inspection sticker, etc.

Criteria	I. Access/Safety Standards
	• All equipment used to measure or assess patient health status/condition is functioning properly. All specialized equipment (e.g., ultrasonography equipment, electrocardiogram (EKG) machine, defibrillator, audiometer, hemoglobin meter, glucometer, scales, etc.) are adequately maintained according to the specified manufacturer's guidelines for the equipment or is serviced annually by a qualified technician. • Blood pressure cuffs, monitors, and other related equipment need not be calibrated unless required by the manufacturer. Manufacturer guidelines must be available on site, indicating that it is not necessary to calibrate the equipment. **Note:** The term monitor includes, but not limited to, glucometers, EKG, BP monitors, hemocues, and audiometers.

Criteria	II. Personnel Standards		
A.1. Professional health care personnel have current California licenses and certifications.	**Medical Professional**	**License/Certification**	**Issuing Agency**
	Certified Nurse Midwife (CNM)	RN License & Nurse-Midwife Certificate. Drug Enforcement Agency (DEA) Registration, *if appropriate*	CA Board of Registered Nursing DEA
	Certified Radiological Technologist (CRT)	CRT Certificate.	California Department of Public Health (CDPH), Radiologic Health Branch
	Doctor of Osteopathy (DO)	Physician's & Surgeon's Certificate DEA Registration	Osteopathic Medical Board of CA DEA
	Licensed Midwife (LM)	Licensed Midwife Certificate. Drug Enforcement Agency (DEA) Registration, *if appropriate*	Medical Board of CA DEA
	Licensed Vocational Nurse (LVN):	LVN License	CA Board of Vocational Nursing and Psychiatric Technicians
	Nurse Practitioner (NP)	RN License w/NP Certification & Furnishing Number DEA Registration, *if appropriate*	CA Board of Registered Nursing DEA
	Pharmacist (Pharm. D)	Pharmacist License	CA State Board of Pharmacy
	Physician/Surgeon (MD)	Physician's & Surgeon's Certificate DEA Registration	Medical Board of CA DEA
	Physicians' Assistant/ Associate (PA)	PA License DEA Registration, *if appropriate*	Physician Assistant Examining Committee/Medical Board of CA DEA
	Radiological Technician	Limited Permit	CDPH, Radiologic Health Branch

<table>
<tr><th>Criteria</th><th colspan="3">II. Personnel Standards</th></tr>
<tr><td rowspan="4"></td><td>Registered Dietitian (RD)</td><td>RD Registration Card</td><td>Commission on Dietetic Registration</td></tr>
<tr><td>Registered Nurse (RN)</td><td>RN License</td><td>CA Board of Registered Nursing</td></tr>
<tr><td colspan="3">II.A.1) All required Professional Licenses and Certifications, issued from the appropriate licensing/certification agency, are current.
<u>Note</u>: All medical professional licenses and certifications must be current and issued from the appropriate agency for practice in California, and available on site. Although sites with centralized personnel departments are not required to keep documents or copies on site, copies and/or lists of currently certified or credentialed personnel must be readily available when requested by reviewers.</td></tr>
<tr><td rowspan="3">A.2. All required professional licenses and certifications, issued from the appropriate licensing/certification agency, are current.</td><td colspan="2"><u>Note</u>:
Effective June 27, 2010, MDs (does not apply to Osteopaths) shall provide notification to each patient that states the MD(s) on site is licensed and regulated by the Board, and includes the following:[16]

NOTICE
Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov.</td><td><u>Note</u>:
Effective August 11, 2011, PAs shall provide notification to each patient that states the PA(s) is licensed and regulated by the Physician Assistant Board , and includes the following:[17]

NOTIFICATION TO CONSUMERS
Physician Assistants are licensed and regulated by the Physician Assistant Board
(916) 561-8780
www.pab.ca.gov</td></tr>
<tr><td colspan="3">II.A.2) Notification is provided to each member that the MD(s) is licensed and regulated by the Medical Board, and that the Physician Assistant(s) is licensed and regulated by the Physician Assistant Board.

The notice to consumers above shall be provided by one of the following methods:</td></tr>
</table>

[16] 16 CCR 1355.4, as mandated by Business and Professions Code (BPC) section 138.
[17] 16 CCR 1399.547, as mandated by BPC section 138.

Criteria	II. Personnel Standards
	○ Prominently posted sign that includes a QR code in an area visible to patients in at least 48-pt Arial font. ○ A written statement signed and dated by the patient (or patient's representative) and kept in the medical record, stating the patient understands that the MD is licensed and licensed and regulated by the board (for PA's, that the PA is licensed and regulated by the PA Board). ○ A statement on letterhead, discharge instructions or other document given to the patient (or patient's representative), where the notification is placed immediately above the signature line for the patient in at least 14-pt font.
B. Health care personnel are properly identified.	**II.B.1) Health care personnel wear identification badges/tags printed with name and title.** • Health care personnel shall disclose, while working, their name and title on a name tag at least 18-point type. • It is acceptable for health care personnel in a practice or an office, whose license is prominently displayed, to opt not to wear a nametag. **Note:** • In the interest of public safety and consumer awareness, it shall be unlawful for any person to use the title "nurse" in reference themselves, in any capacity, except for an individual who is a registered nurse, or a licensed vocational nurse. • "Health care practitioner" means any person who engages in acts that are the subject of licensure or regulation under Business and Professions Code (Sections 680-681). If a health care practitioner or licensed clinical social worker is working in a psychiatric setting or in a setting that is not licensed by the state, the employing entity or agency shall have the discretion to make an exception from the nametag requirement for the individual safety or therapeutic concerns.
C. Site personnel are qualified and trained for assigned responsibilities. **RN/NP/CNM/LM/MD/PA**	**Unlicensed Personnel:** Medical assistants (MAs) are unlicensed health personnel, at least 18 years of age, who perform basic administrative, clerical, and non-invasive routine technical supportive services under the supervision of a licensed physician, surgeon, or podiatrist in a medical office or clinic setting. • "Supervision" means the licensed physician must be physically present in the treatment facility during the performance of authorized procedures by the MA.

Criteria	II. Personnel Standards
	• Per Business and Professions Code Section 2069 (a) (1), a supervising physician and surgeon at a "community clinic" licensed under Health and Safety Code section 1204(a) may, at their discretion, in consultation with the nurse practitioner, nurse midwife, or physician assistant provide written instructions to be followed by a medical assistant in the performance of tasks or supportive services. • The written instructions may provide that the supervisory function for the medical assistant in performing these tasks or supportive services may be delegated to the nurse practitioner, nurse midwife, or physician assistant and that those tasks may be performed when the supervising physician and surgeon is not on site. **II.C.1) 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, NP, 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. • For facilities that have pediatric patients (under 21 years old) obtain evidence of completed training (valid for 4 years) in: ○ Audiometric screening ○ Vision screening ○ Anthropometric measurements, including obtaining Body Mass Index (BMI) percentile ○ Dental screening and fluoride varnish application • **C.2) (CE) 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.**

Criteria	II. Personnel Standards
	• Unlicensed staff (e.g. MAs) have evidence of appropriate training and supervision in all medication administration methods performed within their scope of work. • To administer medications by subcutaneous or intramuscular injection, or to perform intradermal skin tests or venipunctures for withdrawing blood, an MA must have completed at least the minimum number of training-hours established in CCR, Title 16, Section 1366.1. **Note:** • **MAs cannot administer anesthetics, including local anesthetic agents (such as Rocephin hydrated with Xylocaine).** [18] • MAs may not place an intravenous needle, start or disconnect the intravenous infusion tube, administer medications or injections into an intravenous line, or administer anesthesia. • The supervising physician must specifically authorize all medications administered by an MA. "Authorization" means a specific written or standing order prepared by the supervising physician. **II.C.3) 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 for confirming the correct patient, correct medication/vaccine, correct dosage, and correct route prior to administration. **II.C.4) Only qualified/trained personnel operate medical equipment.** **Medical Equipment:** • Provider and/or staff can demonstrate appropriate operation of medical equipment used in their scope of work. Not all staff is required to be proficient in use of all equipment but at any given time, a staff must be prepared to operate equipment that is not routinely needed by every patient such as patient lifts and accessible scales. 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.

[18] 16 CCR 1366.3(a) (1), also see information from the Medical Board of California on Medical Assistants, available at: https://www.mbc.ca.gov/Licensing/Physicians-and-Surgeons/Practice-Information/Medical-Assistants.aspx. https://www.mbc.ca.gov/FAQs/?cat=Licensees&topic=Medical%20Assistants

Criteria	II. Personnel Standards
	• For facilities that see pediatric patients (under 21 years old), the facility staff responsible for conducting hands on preventive screening, specifically: audiometric screening, vision screening, anthropometric measurements, including obtaining Body Mass Index (BMI) percentile, dental screening and fluoride varnish application, must demonstrate competency and appropriate application of these screenings/services. o Reviewers may interview site personnel regarding the appropriate use of equipment and/or request demonstrated use of equipment, as appropriate. o Reviewers may utilize CHDP Health Assessment Guidelines for ▪ Audiometric screening ▪ Vision screening ▪ Anthropometric measurements, including obtaining Body Mass Index (BMI) percentile ▪ Dental screening and fluoride varnish application ▪ https://www.dhcs.ca.gov/services/chdp/Pages/HAG.aspx **Note:** • Personnel on site must be qualified for their responsibilities and adequately trained for their scope of work. • Site staff should have a general understanding of the systems/processes in place, appropriate supervision, and knowledge of the available sources of information on site. • Family members and personal care assistants, whether paid or unpaid, are not "unlicensed personnel" or otherwise captured within the scope of this tool.
D. Scope of practice for non-physician medical practitioners (NPMP) is clearly defined. **RN/NP/CNM/LM/MD/PA**	**II.D.1) 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. • Documents may be utilized to determine and/or clarify practice procedures and supervisory processes on site. • Reviewers are expected to verify that NP and/or CNM standardized procedures, and PA Practice Agreement and Supervision Physician's Responsibility documentation are present on site. • Reviewers are ***not*** expected to make in-depth evaluation of "appropriateness" of the NPMP's scope of practice.

Criteria	II. Personnel Standards
	NPs: • NPs are prepared through education and experience to provide primary care and to perform advanced procedures. • The extent of required supervision must be specified in the Standardized Procedures. • Standardized procedures legally define the expanded scope of nursing practice that overlaps the practice of medicine. • Standardized Procedures should identify the furnishing of drugs or devices, extent of physician or surgeon supervision, method of periodic review of competence, including peer review, and review of provisions in the Standardized Procedures. **CNM:** • The certificate to practice nurse-midwifery authorizes the holder, under supervision of a licensed physician or surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family planning care for the mother, and immediate care for the newborn. • The supervising and back-up physician or surgeon for the CNM must be credentialed to perform obstetrical care in the same delivering facility in which the CNM has delivery privileges. **Note:** CNMs and NPs operate under written Standardized Procedures that are collaboratively developed and approved by the supervising physician, the NP and administration within the organized health care facility/system in which standardized procedures will be used. **II.D.2) A Practice Agreement defines the scope of services provided by PAs and Supervisory Guidelines define the method of supervision by the Supervising Physician.** **PA:** • Practice Agreement: a) Defines specific procedures identified in practice protocols or specifically authorized by the supervising physician, and must be dated and signed by physician and PA. b) The delegation of the supervision of MAs when supervising physician is off premises. c) An original or copy must be readily accessible at all practice sites in which the PA works.

Criteria	II. Personnel Standards
	d) Failure to maintain a Practice Agreement is a violation of the PA Regulations and is grounds for disciplinary action by the Medical Board of California against a physician assistant's licensure. • Supervising Physician's Responsibility for Supervision of PAs' Practice Agreement: Defines supervision responsibilities and methods required by Title 16, section 1399.545 of the Physician Assistant Regulations, and is signed by the physician. The following procedures must be identified: ○ 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. **Note:** • A Delegation of Services Agreement (DSA) in effect prior to January 1, 2020, shall be updated to meet the current requirements.[19] • DSAs that still reflect components that are no longer required by BPC section 3502.3 should be enforced since the DSA is the currently established agreement between the PA and the supervising physician. • The reviewer should assess the site's process for compliance with the DSA. • Any deficiency shall result in a CAP requesting the site to adhere to the DSA components or establish a new Practice Agreement. **II.D.3) 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. **II.D.4) Each NPMP that prescribes controlled substances has a valid DEA Registration Number.** **DEA:**

[19] BPC 3502.3

Criteria	II. Personnel Standards
	Each NP, CNM, and PA that prescribes controlled substances is required to have a valid DEA Registration Number.

E. Non-physician medical practitioners (NPMP) are supervised according to established standards.  **RN/NP/CNM/LM/MD/PA**	**The designated supervising physician(s) on site:**
	
	II.E.1) Ratio to number of NPMPs does not exceed established ratios in any combination.
	NPMPs:
	• 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; and
	  ○ 4 PAs.
	
	This ratio is based on each physician, not the number of offices. A PCP, an organized outpatient clinic, or a hospital outpatient department cannot utilize more NPMPs than can be supervised within these stated limits.
	
	Physician Assistant Board (PAB) is at https://www.pab.ca.gov/ or the PAB office at 916-561-8780.
	
	II.E.2) The designated supervising or back-up physician is available in person or by electronic communication at all times when a NPMP is caring for patients.
	Supervising Physician:
	• "Supervision" means that a licensed physician and surgeon oversee the activities of, and accept responsibility for, the medical services rendered by a PA.
	• Supervising or back-up physician is available in person or by electronic communication at all times when a NPMP is caring for patients.

[20] BPC 3516(b), Welfare and Institutions Code (WIC) section 14132.966

Criteria	II. Personnel Standards
	II.E.3) Evidence of NPMP supervision. **<u>Evidence of NPMP Supervision:</u>** • 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.[21] • 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. Site personnel receive safety training. **RN/NP/CNM/LM/MD/PA**	**II.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 occurs ***prior to*** initial exposure to potentially infectious and/or biohazardous materials. Review and re-training sessions occur ***<u>at least annually</u>***. Training content is appropriate (language, educational level, etc.) to personnel on site. Training *minimally* includes the following: ○ Universal/standard precautions ○ Use of personal protective equipment ○ Accessible copy of Bloodborne Pathogens Standard ○ Work practice controls/exposure prevention ○ Modes of transmitting bloodborne pathogens ○ Epidemiology/symptoms of HBV and HIV ○ Recognition of activities with exposure element ○ Handling and labeling of biohazardous waste(s) ○ Hepatitis B vaccination protocol and requirements ○ Explanation of emergency procedures ○ Post exposure reporting/evaluation/follow-up procedures ○ Decontamination of equipment/work areas ○ Site's written bloodborne pathogen exposure plan ○ Opportunity for discussion/questions

[21] BPC 2834

Criteria	II. Personnel Standards
	Personnel must know ***where to locate*** information/resources on site about infection control, the Bloodborne Pathogens Exposure Plan, and ***how to use*** the information. Evidence of training must be verifiable. Evidence of training may include: o Informal in-services o New staff orientation o External training courses o Educational curriculum o Participation lists, etc. Training documentation must contain: 1) Employee's name 2) Job titles 3) Training date(s) 4) Type of training 5) Contents of training session 6) Names/qualifications of trainers Records must be kept for three (3) years. **Note:** Site personnel treat all blood and other potentially infectious materials (OPIM) as if these *are* infectious. Site personnel who are reasonably anticipated to have eye, skin, mucous membranes and potential exposure to blood and/or OPIM receive training as required by the Bloodborne Pathogens Standard.[22]
G. Site personnel receive training on member rights. **RN/NP/CNM/LM/MD/PA**	**II.G. There is evidence that site staff has received information and/or training on the following:** **II.G.1) Patient Confidentiality** • Site personnel have received information and/or training about patient confidentiality and must be prepared to provide information on how patient confidentiality is protected at the site.

[22] 8 CCR 5193

Criteria	II. Personnel Standards
	• Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written patient confidentiality information on site and explain how to use information. **II.G.2) Informed Consent, including Human Sterilization** • Site personnel have received information and/or training on informed consent, including human sterilization. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written informed consent, including human sterilization information on site and explain how to use information. **II.G.3) Prior Authorization Requests** • Site personnel have received information and/or training on prior authorization requests. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written prior authorization requests information on site and explain how to use information. **II.G.4) II.F.4) Grievance/Complaint Procedure** • Site personnel have received information and/or training on grievance/complaint procedure. Staff must be prepared to provide information to patient when requested. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written grievance/complaint procedures information on site and explain how to use information. **II.G.5) Child/Elder/Domestic Violence Abuse**

Criteria	II. Personnel Standards
	Abuse Reporting: Site personnel have specific knowledge of local reporting requirements, agencies, and procedures, and know *where to locat*e information on site and *how to use* information. **Note:** • Health practitioners (e.g., physicians, surgeons, licensed nurses, licensed social workers, paramedics) in a health facility, (e.g., clinic, physician's office, public health clinic) are legally mandated reporters of known or reasonably suspected cases of child abuse, elder abuse and domestic violence. • Legally mandated reporters must make telephone and written reports according to timeliness standards established by the designated local law enforcement agencies in each county. "Reasonably suspected" means having objectively reasonable suspicion based upon facts that could cause a reasonable person in a like position, drawing when appropriate on his or her training and experience, to suspect abuse (CA Penal Code 11164). • Failure to report by legally mandated reporters can result in criminal or civil prosecutions, punishable by monetary fines and/or county jail confinement. Any person entering employment, which makes him/her a mandated reporter, must sign a statement, provided and retained by the employer, that the employee has knowledge of the Child Abuse reporting law and will comply with its provision.[23] **II.G.6) Sensitive Services/Minors' 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. **II.G.7) Health Plan Referral Process/Procedures/Resources**

[23] Penal Code section 11166.5

Criteria	II. Personnel Standards
	• Site personnel have received information and/or training on health plan referral process/procedures/resources. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written health plan referral process/procedures/resources information on site and explain how to use information. **II.G.8) Cultural and Linguistic Training** • Site personnel have received information and/or training on cultural and linguistic appropriate services. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written cultural and linguistic 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.[24] **II.G.9) 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. **https://www.hhs.gov/sites/default/files/ocr/civilrights/resources/factsheets/504.pdf** **https://www.hhs.gov/sites/default/files/section-1557-final-rule-faqs.pdf** **https://www.hhs.gov/sites/default/files/1557-fs-lep-508.pdf**

[24] See the National Standards on CLAS, available at: https://www.health.pa.gov/topics/Documents/Health%20Equity/CLAS%20Standards%20FactSheet.pdf.

Criteria	III. Office Management Standards
A. Physician coverage is available 24 hours a day, 7 days a week.	**III.A.1) Clinic office hours are posted or readily available upon request.** Current clinic office hours are posted within the office or readily available upon request. **III.A.2) Provider office hour schedules are available to staff.** **III.A.3) 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. **III.A.4) Contact information for off-site physician(s) is available at all times during office hours.** When a physician is not on site during regular office hours, personnel are able to contact the physician (or covering physician) at all times by telephone, cell phone, pager, etc. **III.A.5) Routine, urgent and after-hours emergency care instructions/telephone information is made available to patients.** **Note:** One objective of effective clinic office management is to support the provision of appropriate, coordinated health care services. The review of clinic office management is to evaluate if effective systems are in place and whether site personnel appropriately follow established site-specific procedures.
B. There are sufficient health care personnel to provide timely, appropriate health Care services. **RN/NP/CNM/LM/MD/PA**	**III.B.1) Appropriate personnel handle emergent, urgent, and medical advice telephone calls.** • In addition to the physician, only appropriately licensed medical personnel such as a CNM, LM, NP, RN, or PA handles emergency, urgent, and medical advice/triage telephone calls.

Criteria	III. Office Management Standards
	• The California Board of Vocational Nursing and Psychiatric Technician Examiners has determined that the Licensed Vocational Nurse Practice Act does not permit the LVN to perform triage independently.[25] • The LVN may perform that part of the triage process that includes observation and data collection relative to basic physical assessment. • The LVN may not perform that part of the triage process that includes independent evaluation, interpretation of data, and determination of treatment priorities and levels of care. • Unlicensed personnel, such as medical assistants, may provide patient information or instructions only as authorized by the physician.[26] **Note:** Telephone triage is the system for managing telephone calls during ***and*** after office hours. **III.B.2) Telephone answering machine, voice mail system, or answering service is used whenever office staff does not directly answer phone calls.** • Telephone answering machine, voice mail system, or answering service is used whenever office staff does not directly answer phone calls. **III.B.3) Telephone system, answering service, recorded telephone information, and recording device are periodically checked and updated.** • Telephone system, answering service, recorded telephone information, and recording device are periodically checked and updated.
C. Health care services are readily available. **RN/NP/CNM/LM/MD/PA**	**III.C.1) Appointments are scheduled according to patients stated clinical needs within the timeliness standards established for Plan members.** **Note:** Medi-Cal Managed Care Health Plans *require* the following timeliness standards for access to appointments: ○ Urgent Care: 48 hours ○ Access to the first Prenatal Visit: 10 business days ○ Non-urgent (Routine) Care: 10 business days

[26] 16 CCR 1366(b)

Criteria	III. Office Management Standards
	III.C.2) Patients are notified of scheduled routine and/or preventive screening appointments. • The process established on site provides timely access to appointments for routine care, urgent care, prenatal care, pediatric periodic health assessments/immunizations, adult initial health assessments, specialty care, and emergency care. • Systems, practices, and procedures used for making services readily available to patients will vary from site to site. **III.C.3) There is a process in place verifying follow-up on missed and canceled appointments.** • An organized system must be evident (in use) for scheduling appointments appropriately, notifying, and reminding members of scheduled appointments, and following up on missed or canceled appointments. • Missed and/or canceled appointments and contact attempts must be documented in the patient's medical record.
D. There is 24-hour access to interpreter services for non- or limited-English proficient (LEP) members.	**III.D.1) 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. **III.D.2) Persons providing language interpreter services, including sign language on site, are trained in medical interpretation.** • Site personnel used as interpreters have been assessed for their medical interpretation performance skills/capabilities. • Reviewer should ask for a written policy which includes the languages spoken by bilingual providers and staff. **Note:** https://www.lep.gov; 22 CCR 51309.5 • If bilingual staff are asked to interpret or translate, they should be qualified to do so. Assessment of ability, training on interpreter ethics and standards, and clear policies that delineate appropriate use of bilingual staff, staff or contract interpreters and translators, will help ensure quality and effective use of resources.

Criteria	III. Office Management Standards
	• Those utilizing the services of interpreters and translators should request information about certification, assessments taken, qualifications, experience, and training. Quality of interpretation should be a focus of concern for all recipients. • Family or friends should not be used as interpreters, unless specifically requested by the member's circumstances. Minors, under 18 years old, accompanying members shall not be used as interpreters. • The Affordable Care Act of 2010, Section 1557: prohibits from using low-quality video remote interpreting services or relying on unqualified staff, translators when providing language assistance services. • A request for or refusal of language/interpreter services must be documented in the member's medical record. Sign language interpreter services may be utilized for medically necessary health care services and related services such as: ○ Obtaining medical history and health assessments ○ Obtaining informed consents and permission for treatments ○ Medical procedures ○ Providing instructions regarding medications ○ Explaining diagnoses ○ Treatment and prognoses of an illness ○ Providing mental health assessment ○ Therapy or counseling
E. Procedures for timely referral/ consultative services are established on site.  **RN/NP/CNM/LM/MD/PA**	**Office practice procedures allow timely provision and tracking of:** **III.E.1) Processing internal and external referrals, consultant reports, and diagnostic test results.** • An organized, timely referral system is evident for making and tracking referrals, reviewing reports, providing/scheduling follow-up care and filing reports in medical records. • Referral informational resources are readily available for use by site personnel. • Site staff can demonstrate (e.g., "walk through") the office referral process from beginning to end Systems, practices, and procedures used for handling referrals will vary from site-to-site.

Criteria	III. Office Management Standards
	III.E.2 (CE) 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.
F. Member grievance/ complaint processes are established on site.	**III.F.1) Phone number(s) for filing grievances/complaints are located on site.** • At least one telephone number for filing grievances is posted on site or is readily available upon request. **III.F.2) 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. **Note:** A "grievance" is defined as any written or oral expression of dissatisfaction and shall include any complaint, dispute, and request for reconsideration or appeal made by an enrollee or their representative to a Plan or entity with delegated authority to resolve grievances on behalf of the Plan.
G. Medical records are available for the practitioner at each scheduled patient encounter.	**III.G.1) 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.

Criteria	III. Office Management Standards
	III.G.2) Medical documents are filed in a timely manner to ensure availability for patient encounters. • Medical records are filed in a timely manner that allows for ease of accessibility within the facility or in an appropriate health record storage facility if stored off-premises.[27]
H. Confidentiality of personal medical information is protected according to State and federal guidelines. **RN/NP/CNM/LM/MD/PA**	**III.H.1) Exam rooms and dressing areas safeguard patients' right to privacy.** **Privacy:** • Patients have the right to privacy for dressing/undressing, physical examination, and medical consultation. • Practices are in place to safeguard patient privacy. • Because dressing areas and examination room configurations vary greatly, reviewers will make site-specific determinations. **III.H.2) Procedures are followed to maintain the confidentiality of personal patient information.** **Confidentiality:** • Personnel follows site policy/procedures for maintaining confidentiality of individual patient information. • Individual patient conditions or information is not discussed in front of other patients or visitors, displayed or left unattended in reception and/or patient flow areas (this includes unattended electronic devices, patient registration sign-in sheets with more than one unique patient identifier). • 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 Records:** • Electronic record-keeping system procedures have been established to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures, and maintain upkeep of computer systems.

[27] 22 CCR 75055

Criteria	III. Office Management Standards
	• Security protection includes an off-site backup storage system, an image mechanism with the ability to copy documents, a mechanism to ensure that recorded input is unalterable, and file recovery procedures. • Confidentiality protection may also include use of encryption, detailed user access controls, transaction logs, and blinded files. **III.H. 3) Medical record release procedures are compliant with State and federal guidelines.** **<u>Record Release</u>:** • 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. • This does not prevent release of statistical or summary data, or exchange of individual identifiable medical information between individuals or institutions providing care, fiscal intermediaries, research entities and State or local official agencies.[28] **III.H.4) Storage and transmittal of medical records preserves confidentiality and security.** **<u>Storage and transmittal:</u>** • Health care services rendered under the Medi-Cal program or any other health care program administered by the department or its agents or contractors, shall confidentially and securely keep and maintain records of each service rendered under the Medi-Cal program or any other health care program administered by the department or its agents or contractors, the beneficiary or person to whom rendered, the date the service was rendered, and any additional information as the department may by regulation require. • FAX cover sheet shall have confidentiality statement. **III.H.5) Medical records are retained for a minimum of 10 years.** **<u>Record Retention:</u>** • 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

[28] 45 CFR 164.524

Criteria	III. Office Management Standards
	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, in accordance with 42 CFR 438.3(u).[29]

[29] WIC 14124.1

Criteria	IV. Clinical Services - Pharmaceutical Standards
A. Drugs and medication supplies are maintained secured to prevent unauthorized access.	**Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, disposition, etc.) must be addressed in a corrective action plan. **IV.A.1) Drugs are stored in specifically designated cupboards, cabinets, closets or drawers.** **Security**: • All drugs for dispensing are stored in an area that is secured at all times.[30] The Medical Board defines "area that is secure" to mean a locked storage area within a physician's office. • Keys to locked storage area are available only to staff authorized by the physician to have access.[31] • The Medical Board of California interprets "all drugs" to also include both sample and over-the-counter drugs.[32] **IV.A.2) Drugs, drug samples, and over-the-counter drugs, hypodermic needles/syringes, all medical sharp instruments, hazardous substances and prescription pads are securely stored in a lockable space (cabinet or room) within the office/clinic.** • All drugs (including sample and over the counter), medication supplies, hazardous substances and prescription pads are securely stored in a lockable space (room, closet, cabinet, drawer) within the office/clinic.[33] (CA B&P Code, 4051.3) • A secure area means that drugs and biologicals are stored in a manner to prevent unmonitored access by unauthorized individuals. Drugs and biologicals must not be stored in areas that are readily accessible to unauthorized persons. (42 CFR 482.13-CMS Manual System; 42 CFR Part 482.25) • Keys to the locked storage area are available only to staff authorized by the physician to have access.[34] (16 CCR, Chapter 2, Division 3, Section 1356.32) • During business hours, the lockable space may remain unlocked ONLY if there is no access to

[30] BPC 4172
[31] 16 CCR 1356.3
[32] 22 CCR 75032 and 75033
[33] BPC 4051.3
[34] 16 CCR 1356.32

Criteria	IV. Clinical Services - Pharmaceutical Standards
	this area by unauthorized persons and authorized clinic personnel remain in the immediate area at all times. At all other times, all drugs (including sample and over the counter), medication supplies, prescription pads and hazardous substances must be securely locked. **IV.A.3) Controlled drugs are stored in a locked space accessible only to authorized personnel.** **<u>Controlled substances</u>**: • Controlled substances are stored separately from other drugs in a securely locked, substantially constructed cabinet accessible only to authorized personnel.[35] **IV.A.4) 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 • Control substances include all Schedule I, II, III, IV, and V substances listed in the CA Health and Safety Code, Sections 11053-11058, and do not need to be double locked. • Personnel with authorized access to controlled substances include physicians, dentists, podiatrists, PAs, licensed nurses, and pharmacists and specifically authorized employees.[36] **IV.A.5) Written site-specific policy/procedure for dispensing of sample drugs are available on site.** • A list of drugs available for use in the clinic shall be maintained. Site should have written site-specific policies and procedures (P&Ps) for use of sample medications including governing activities of pharmaceutical manufacturers' representatives American Society of hospital

[35] 21 CFR 1301.75
[36] 21 CFR 1301.72

Criteria	IV. Clinical Services - Pharmaceutical Standards
	pharmacist (ASHP) Guidelines: Minimum Standard for pharmaceutical services in ambulatory care).[37] • Each clinic, which provides drug distribution services, shall have written policy and procedures for the safe and effective distribution, control, storage, use and disposition of drugs. **Note:** During business hours, the drawer, cabinet or room containing drugs, medication supplies or hazardous substances may remain unlocked ***only*** if there is no access to area by unauthorized persons. Whenever drugs, medication supplies or hazardous substances are unlocked, authorized clinic personnel must ***always remain*** in the immediate area. At all other times, drugs, medication supplies, and hazardous substances must be securely locked. Controlled substances are ***always locked***.
B. Drugs are handled safely and stored appropriately. **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan (CAP). **IV.B.1) Drugs are prepared in a clean area or "designated clean" area if prepared in a multi-purpose room.** **Drug Preparation:** Drugs shall be drawn up in a designated clean medication preparation area that is not adjacent to potential sources of contamination, including sinks or other water sources. The drug preparation area should be cleaned and disinfected on a regular basis. CDC guidelines for drug preparation and safety: https://www.cdc.gov/injectionsafety/providers/provider_faqs_med-prep.html **IV.B.2) Drugs for external use are stored separately from drugs for internal use.** **Storage:** • Drugs shall be separated by route of administration, especially ophthalmic and otic preparations. • Vaccines and other drugs should be stored separately from food, lab specimens, human specimens, cleaning supplies, and other items that may potentially cause contamination.

[37] The ASHP Guidelines for Minimum Standard for Ambulatory Care Pharmacy Practice is available at: https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/anticoagulation/guidelines-minimum-standard-ambulatory-care-pharmacy.ashx?la=en&hash=ABF816352CAF1AB846B7C339A45AA74D80F820A6.

Criteria	IV. Clinical Services - Pharmaceutical Standards

	• The Center for Disease Control (CDC) recommends avoiding storing other medications and biological products such as lab specimens/human specimens in a vaccine storage unit.
	
	IV.B.3) Items other than medications in refrigerator/freezer are kept in a secured, separate compartment from drugs.
	• Storing food, other medications, and biological products with vaccines put vaccines at risk for temperature fluctuation, excessive light exposure, administration errors, and contamination.
	  ○ If food, other medications and biological products must be stored in the same refrigerator with vaccines, they must be in the sealed containers and stored below vaccines on the different shelves.
	• Drugs are stored under appropriate conditions of temperature, humidity, and light so that the identity, strength, quality, and purity of the drug product are not affected.[38]
	• Room temperature where drugs are stored does not exceed 30ºC (86ºF).[39]
	• A drug or device is considered "adulterated" if it contains any filthy, putrid, or decomposed substance, or if it has been prepared, packed or held under unsanitary conditions.[40]
	• A drug is considered contaminated if it has been held under unsanitary conditions that may have been contaminated with filth or rendered injurious to health.
	• Drugs that are unused are considered by the Environmental Protection Agency (EPA) to be toxic wastes and must be disposed in accordance with 40 CFR, part 261.
	
	American College of Physician guidelines state sound management procedures include:
	  ○ Routinely checking for expiration dates.
	  ○ Keeping medicines off the floor.
	  ○ Labeling the sample medicines or writing prescribing information directly on the sample package.
	  ○ Keeping a log of sample medicines given. In case of a recall, keeping a log allows to track down a patient to whom the recalled drug had been prescribed.
	  ○ When a medication sample is given to a patient, the name and strength of the medication, instructions for use and the quantity or duration of therapy is always documented in the patient's chart.

[38] 21 CFR 211.142
[39] 22 CCR 75037(d)
[40] Title 21, United States Code (USC), section 351. USC is searchable at: https://uscode.house.gov/search/criteria.shtml.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	ASHP guidelines for minimum standard for pharmaceutical services in ambulatory care: ○ Site should have written site-specific policies and procedures (P&Ps) for use of sample medications including governing activities of pharmaceutical manufacturers' representatives. ○ Each clinic, which provides drug distribution services, shall have written policy and procedures for the safe and effective distribution, control, storage, use and disposition of drugs.[41] **Immunobiologics:**[42] • Sites should have a written Vaccine Management Plan for routine and emergency vaccine management (required for Vaccines for Children (VFC) providers). • Vaccines are refrigerated immediately upon receipt on site and stored according to specific instructions on the package insert for each vaccine. • Diluent does not need refrigeration if vaccine is administered right after diluent is added. • Vaccines are not stored in the doors, floors, vegetable bins, or under or near cooling vents of a refrigerator or freezer. **IV.B.4) Refrigerator thermometer temperature is 36º-46º Fahrenheit or 2º-8º Centigrade (at time of site visit).** **Refrigerator:** Vaccines are kept in a refrigerator **maintained at 2-8ºC or 36-46ºF,** and include, but are not limited to, DTaP, Td, Tdap, Hepatitis A, Hepatitis B, IPV, Pneumococcal, Rotavirus, Hib, Influenza (inactivated and FluMist), MCV, HPV, recombinant Zoster, or any combinations of these listed vaccines.[43] **IV.B. 5) Freezer thermometer temperature is 5º Fahrenheit or –15º Centigrade, or lower (at time of site visit).**

[41] The ASHP Guidelines for Minimum Standard for Ambulatory Care Pharmacy Practice is available at: https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/anticoagulation/guidelines-minimum-standard-ambulatory-care-pharmacy.ashx?la=en&hash=ABF816352CAF1AB846B7C339A45AA74D80F820A6.
[42] See the FDA's webpage on Vaccines, available at: https://www.fda.gov/vaccines-blood-biologics/vaccines/questions-about-vaccines.
[43] See the CDC Vaccine Recommendation and Guidelines of the Advisory Committee on Immunization Practices, available at: https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/storage.html, and the CDC Vaccine Storage and Handling Toolkit, available at: https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	Freezer: Varicella and MMRV vaccines are stored in the **freezer at -15ºC or 5ºF, or lower,** and are always protected from light. ○ MMR may be stored in a refrigerator or freezer; VFC recommends MMR be stored in the freezer with MMRV. ○ Never freeze vaccine diluents. **IV.B. 6) Site utilizes drugs/vaccine storage units that are able to maintain required temperature.** CDC recommends for both temporary and long-term storage refrigerators and freezers using: ○ Purpose-built units designed to either refrigerate or freeze (can be compact, under-the counter style or large units). ○ Stand-alone household units. ○ Units dedicated to storage of biologics. Measures should be in place to ensure that vaccine storage units are not accidentally physically disconnected from the power supply, such as "Do Not Disconnect" labels and not plugging units into surge protectors with an on/off switch. **Do not store any vaccine in a dormitory-style or bar-style combined refrigerator/freezer unit under any circumstances.**[44] **IV.B. 7) 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). CDC recommends use of a continuous temperature monitoring device (digital data loggers). ○ Digital data loggers (DDL) should have a minimum accuracy of +/- 1°F (0.5°C) ○ Equipped with buffered probe ○ Active temperature display outside of the unit ○ Capacity for continuous monitoring and recording where the data can be routinely downloaded ○ Calibrated at least every 2 years, to monitor vaccine storage unit temperatures

[44] See the CDC Vaccine & Immunization webpage, available at: https://www.cdc.gov/vaccines/.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	At least one back-up device should be readily available for emergency vaccine transport or when primary DDL is sent in for calibration. **IV.B. 8) Has a written plan for vaccine protection in case of power outage or malfunction of the refrigerator or freezer.** • A written plan for vaccine protection in case of power outage or malfunction of the refrigerator or freezer is required. www.cdc.gov; https://www.fda.gov/vaccines-blood-biologics/safety-availability-biologics/impact-severe-weather-conditions-biological-products • Site personnel must be able to verbalize the procedures in the plan used to promptly respond to OUT OF RANGE TEMPERATURES. • Quarantine vaccines until guidance is obtained. • Action is taken when temperatures are identified to be outside of the recommended range. • Contacting VFC (http://eziz.org/vfc/overview/) or manufacturer are acceptable procedures. • For VFC providers, follow program requirements for documentation and reporting. Consultation with CDC is available when necessary.[45] www.cdc.gov **IV.B. 9) Drugs and vaccines are stored separately from test reagents, germicides, disinfectants, and other household substances.** • As these items may potentially cause contamination to verify that drugs are stored separately from test reagents, germicides, disinfectants, and other household substances. **IV.B.10) Hazardous substances are appropriately labeled.** **IV.B.11) Site has method(s) in place for drug and hazardous substance disposal.** **Hazardous Substances Labeling and Disposal**: • Safety practices are followed in accordance with current/updated CAL-OSHA standards and 29 CFR 1910.1030.

[45] See the CDC General Best Practice Guidelines for Immunization: Best Practices Guidance of the ACIP, available at: https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/storage.html, the CDC Vaccine Storage and Handling Toolkit, available at: https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf, the FDA Questions about Vaccines, available at: https://www.fda.gov/vaccines-blood-biologics/vaccines/questions-about-vaccines, and the CDC webpage on Vaccines and Immunizations, available at: https://www.cdc.gov/vaccines/.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	• The manufacturer's label is not removed from a container (bag, bottle, box, can, cylinder, etc.) only if the hazardous material or residues of the material remain in the container. • Containers for biohazard waste shall comply with United States Department of Transportation requirements when prepared for transport offsite from the facility. • A hazardous waste transporter transporting medical waste shall maintain a completed tracking document and provide a copy of that document to the medical waste generator (clinic, etc.). All portable containers of hazardous chemicals and secondary containers into which hazardous substances are transferred or prepared require labeling. Labels must provide the following information: 1) Identity of hazardous substance 2) Description of hazard warning: can be words, pictures, symbols 3) Date of preparation or transfer **Exception**: Labeling is not required for portable containers into which hazardous chemicals are transferred from labeled containers, and which are intended only for the immediate use of the individual who performs the transfer. **Note:** The purpose of hazard communication is to convey information about hazardous substances used in the workplace. A hazardous substance is any substance that is a physical or health hazard.
C. Drugs are dispensed according to State and federal drug distribution laws and regulations. **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan. **IV.C.1) There are no expired drugs on site.** **Expiration Date:** • The manufacturer's expiration date must appear on the labeling of all drugs and formulas. • All prescription drugs not bearing the expiration date are deemed to have expired. • If a drug is to be reconstituted at the time of dispensing, its labeling must contain expiration information for both the reconstituted and unreconstituted drug. • Expired drugs may not be distributed or dispensed. • Per CDC – Medication Vials should be discarded whenever sterility is compromised or questionable.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	• Per CDC "If a multi-dose has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial". • Per VFC "For multi-dose vials that do not require reconstitution, doses that remain after withdrawal of a dose can be administered until the expiration date printed on the vial unless otherwise specified by the manufacturer (Polio, meningococcal polysaccharide vaccine (MPSV4), PPSV, TIV, IPV, and yellow fever that are available in multi-dose vials)".[46] Both CDC and VFC recommend to follow the manufacturer's product information. **IV.C.2) Site has a procedure to check expiration date of all drugs (including vaccines and samples), and infant and therapeutic formulas.** • Site has a procedure to check expiration date of all drugs (including vaccines and samples) and infant and therapeutic formula AT LEAST monthly. **IV.C.3) All stored and dispensed prescription drugs are appropriately labeled.** **Prescription Labeling**: • Labels shall be carefully preserved, and all medications shall be stored in their original containers. • Each prescription medication dispensed is in a container that is not cracked, soiled, or without secure closures.[47] • Each commercial container of a controlled substance shall have printed on the label the symbol designating the schedule in which such controlled substance is listed. • Drug container is labeled with the provider's name, patient's name, drug name, dose, frequency, route, quantity dispensed, and manufacturer's name and lot number. • California Pharmacy Law *does not* prohibit furnishing a limited quantity of sample drugs if dispensed to the patient in the package provided by the manufacturer, no charge is made to the patient, and appropriate documentation is made in the patient's medical record.[48]

[46] See the CDC Frequently Asked Questions regarding Multi-dose vials, available at: https://www.cdc.gov/injectionsafety/providers/provider_faqs_multivials.html, and the CDC Vaccine Storage and Handling Toolkit, available at: https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf.
[47] 22 CCR 75037(A)
[48] BPC 4170 and 4171

Criteria	IV. Clinical Services - Pharmaceutical Standards
	Drug Distribution: • Each clinic that provides drug distribution services has written policies and procedures for the safe and effective distribution control, storage, use and disposition of drugs. • In order to prevent inadvertent exposure to out-of-range temperatures, vaccines should never be re-distributed beyond the manufacturer/distributer-to-clinic distribution chain unless during an emergency. • In the event of necessary vaccine transport (emergency/power outage), vaccines must be packaged following CDC recommendations and include temperature monitoring devices during transport (approval is required for VFC providers prior to any vaccine transfer). **IV.C.4) (CE) Only lawfully authorized persons dispense drugs to patients.** **Drug Dispensing:** • Drug dispensing complies with all applicable State and federal laws and regulations. • Drugs are dispensed only by a physician, pharmacist, or other persons (e.g., NP, CNM, RN, PA) lawfully authorized to dispense medications upon the order of a licensed physician or surgeon. • Personnel such as MAs, office managers, and receptionists do not dispense drugs. • Drugs are not offered for sale, charged or billed to Medi-Cal members.[49] • A record of all drugs and formulas dispensed shall be entered in the patient's medical record. **Drug Administration:** • Basic safe practices for medication/vaccine administration, assess and document: 1) Patient's identity 2) Correct medication 3) Correct dose 4) Correct route 5) Appropriate time CMS Manual System;[50] • Proper preparation is critical for maintaining the integrity of the vaccine during transfer from the vial to the syringe.

[49] BPC 4193
[50] 42 CFR 482.23(c)

Criteria	IV. Clinical Services - Pharmaceutical Standards
	• Personnel can demonstrate or verbally explain procedure(s) used on site to confirm correct patient, medication/vaccine, dosage and route and vaccine are prepared and drawn only prior to administration. • Proper vaccine administration is critical to ensure that vaccination is safe and effective. • CDC recommends that all health care personnel who administer vaccines receive comprehensive, competency-based training on vaccine administration policies and procedures before administering vaccines. • Comprehensive, skills-based training should be integrated into existing staff education programs such as new staff orientation and annual education requirements. **IV.C.5) Drugs and Vaccines are prepared and drawn only prior to administration.** ACIP discourages the routine practice of providers' prefilling syringes. • Vaccines have a similar appearance after being drawn into a syringe, prefilling may result in administration errors. • Unused, provider prefilled syringes must be discarded if not used within the same day that they are filled. • Unused syringes that are prefilled by the manufacturer and activated (i.e., syringe cap removed, or needle attached) should be discarded at the end of the clinic day. In certain circumstances in which a single vaccine type is being used (e.g., in preparation for a community influenza vaccination campaign), filling a small number (10 or fewer) of syringes may be considered (*5*). The doses should be administered as soon as possible after filling, by the same person who filled the syringes. (**IV.C.6) Current Vaccine Information Sheets (VIS) for distribution to patients are present on site.** **Vaccine Immunization Statements**:

[51] See the CDC's Vaccine Recommendations and Guidelines of the ACIP, available at: https://www.cdc.gov/vaccines/hcp/acip-recs/generalrecs/administration.html.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	• Since 1994, the National Childhood Vaccine Injury Act, Section 2126 of the Public Health Service Act, mandates that parents/guardians or adult patients be informed before vaccinations are administered. • Health care providers must present and offer a VIS to patients prior to any vaccine.[52] As of 2009, CDC allows providers to present a current VIS (such as a laminated copy in a binder, etc.) to the patient/parent/guardian and allow time for the patient to read and ask questions. Staff should also offer a copy each time.[53] • The date the VIS was given (or presented and offered) *and* the publication date of the VIS must be documented in the patient's medical record. • Federal law allows up to 6 months for a new VIS to be used. The most current VIS are available from state and local health departments or can be downloaded from the CDC web site at: http://www.cdc.gov/vaccines/pubs/vis/default.htm or by calling the CDC Immunization Hotline at (800) 232-2522. VFC contains current VIS and provider notifications at: http://www.eziz.org/ **IV.C.7) If there is a pharmacy on site, it is licensed by the CA State Board of Pharmacy.** **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. • Every pharmacy that dispenses a controlled substance must be registered with the DEA and be licensed by the CA State Board of Pharmacy. • A licensed pharmacist monitors drug distribution and policies and procedures for medication dispensing and storage. **Note:** "Dispensing" of drugs means the furnishing of drugs or devices directly to a patient or upon a prescription from a physician, dentist, optometrist, podiatrist, veterinarian, or upon an order to furnish drugs or transmit a prescription from a certified nurse midwife, nurse practitioner, physician assistant or pharmacist acting within the scope of his or her practice. **IV.C.8) Site utilizes California Immunization Registry (CAIR) or the most current version.**

[52] 42 USC 300aa-26(D)(2)
[53] See the CDC's Facts about VIS, which is available at: https://www.cdc.gov/vaccines/hcp/vis/about/facts-vis.html.

Criteria	IV. Clinical Services - Pharmaceutical Standards
	<u>Immunization Registry Utilization</u>: Scoring must be No or Yes. • DHCS requires documentation of immunizations in the California CAIR or the local registry. • If the clinic does not offer vaccines administration, the site staff shall be able to utilize the registry to access the member's immunization record. Contractor shall ensure that member-specific immunization information is periodically reported to an immunization registry (is) established in the Contractor's Service Area(s) as part of the Statewide Immunization Information System. Reports shall be made following the Member's initial health assessment and all other health care visits which result in an immunization being provided. Reporting shall be in accordance with all applicable State and Federal laws. DHCS Contract; CDC Recommendations at: www.cdc.gov/vaccines.

Criteria	IV. Clinical Services – Laboratory Review
D. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations.	**IV.D.1) Laboratory test procedures are performed according to current site-specific CLIA certificate.** **<u>CLIA Certificates</u>**: • All sites that perform laboratory testing for human health assessment, diagnosis, prevention, or treatment of disease has a current, unrevoked, unsuspended site-specific Clinical Laboratory Improvement Amendment (CLIA) certificate, or evidence of renewal. • Acceptable documentation such as the original certificate, copy of the original certificate, renewal receipt or other evidence of renewal submission is present on site or readily available upon request. The CLIA certificate or evidence of renewal should include the current site/clinic address. **<u>Note</u>:** Per 42 CFR, 493.35(b)(1-3), 493.43(b)(1-3) and 493.55(b)(1-3), laboratories must file a separate application for each laboratory location, with the following *<u>exceptions</u>*: 1) Laboratories that are not at a fixed location, that is, laboratories that move from testing site to testing site, such as mobile units providing laboratory testing, health screening fairs, or other temporary testing locations may be covered under the certificate of the designated primary site or home base, using its address. 2) Not-for-profit or Federal, State, or local government laboratories that engage in limited (not more than a combination of 15 moderately complex or waived tests per certificate) public health testing may file a single application, or 3) Laboratories within a hospital that are located at contiguous buildings on the same campus and under common direction may file a single application or multiple applications for laboratory sites within same physical location or street address. 4) A multi-site CLIA waiver can be used at all affiliated locations. A copy of the CLIA waiver must be at each individual location with the address of the main location on the waiver. A copy of the CLIA application must be reviewed by the CSR to verify the locations included for old and new locations. The CLIA Certificate on site includes one of the following: ○ Certificate of Waiver: Site can perform only exempt waived tests ○ Certificate for Provider-Performed Microscopy (PPM): Physicians, dentists, or NPMPs can perform PPM procedures and waived tests

Criteria	IV. Clinical Services – Laboratory Review
	○ Certificate of Registration: Allows moderate and/or high complexity lab testing to be conducted until compliance with CLIA regulations are determined by survey ○ Certificate of Compliance: Lab has been surveyed and found in compliance with all applicable CLIA requirements ○ Certificate of Accreditation: Lab is accredited by an accreditation organization approved by CMS **Waived Tests**: • If only waived tests are performed, site has a current CLIA Certificate of Waiver. • There are no specific CLIA regulations regarding the performance of waived tests. • Site personnel are expected to follow the test manufacturer's instructions. • Laboratories with certificates of waiver may not be routinely inspected by DHCS Laboratory Field Services Division but may be inspected as part of complaint investigations and on a random basis to determine whether only waived tests are being performed. **Moderate and High Complexity Tests:** Tests not listed as waived are divided into one of two categories, moderate complexity or high complexity, based on the complexity of the testing procedure. CLIA regulations for these categories list specific requirements for laboratory proficiency testing, patient test management, quality control, quality assurance, personnel, and inspections. **IV.D.2) Testing personnel performing clinical lab procedures have been trained.** **Personnel Training:** • Prior to testing biological specimens, personnel have been appropriately trained for the type and complexity of the laboratory services performed. • Personnel have demonstrated the ability to perform all testing operations reliably and to report results accurately. • Site personnel that perform CLIA waived tests have access to and can follow test manufacturer's instructions. • When requested, site personnel can provide a step-by-step verbal explanation or demonstration of test procedure and how to determine test results.

Criteria	IV. Clinical Services – Laboratory Review
	• The required training and certification are established by legislation for personnel performing moderate and high complexity tests.[54] Reviewers are not expected to complete an in-depth evaluation of personnel performing moderate and high complexity tests. **IV.D.3) Lab supplies (e.g. vacutainers, vacutainer tubes, culture swabs, test solutions) are inaccessible to unauthorized persons.** **IV.D.4) Lab test supplies are not expired.** Lab supplies are disposed of by manufacturer's expiration date. **IV.D.5) Site has a procedure to check expiration date and a method to dispose of expired lab test supplies.** **Note:** Any site that performs tests or examinations on human biological specimens derived from the human body is, by definition, "laboratories" under State and federal law, and includes locations such as nurses' stations within hospitals, clinics, surgical centers, physician offices, and health fairs. The current listing of waived tests may be obtained at www.cms.gov or www.fda.gov includes an evaluation every two years (or sooner of complaint driven) by CDPH of personnel licenses/training, laboratory site inspection and demonstration of testing proficiency for moderate and high-complexity test sites. **Contact CDPH Laboratory Field Services (510) 620-3800 or LFSrecep@cdph.ca.gov for CLIA certification, laboratory license, or personnel questions.**

[54] BPC 1200-1213

Criteria	IV. Clinical Services – Radiology Review
E. Site meets CDPH Radiological inspection and safety regulations	**IV.E.1) Site has current CA Radiologic Health Branch Inspection Report and Proof of Registration if there is radiological equipment on site.** **<u>CDPH Radiologic Health Branch (RHB) Inspection Report</u>**: If site has ***current*** documentation of one of the following, give the full 9 points and survey items 2-9 will not need to be surveyed. Acceptable documentation is: ○ 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 The Radiologic Inspection Report and Proof of Registration (receipt of payment or cancelled check), issued by the RHB, must be present if there is radiology equipment on site. If any violations are found, one of two documents are issued to the site: ○ "Short Form Sign-off sheet" is issued for minimal problems that are easily corrected. ○ "Notice of Violation" form, requiring a site corrective action plan, is issued if there are more violations that are serious. All "Notice of Violation" corrective action plans must be accompanied by an approval letter from the CA RHB. **If documents are not available on site, or if reviewer is uncertain about the "status of documents on site, proceed to score all items 1-9.** **The following documents are posted on site:** **IV.E.2) Current copy of Title 17 with a posted notice about availability of Title 17 and its location.** **IV.E.3) "Radiation Safety Operating Procedures" posted in highly visible location.** **IV.E.4) "Notice to Employees Poster" posted in highly visible location.** **IV.E.5) "Caution, X-ray" sign posted on or next to door of each room that has X-ray equipment.** **IV.E.6) Physician Supervisor/Operator certificate posted and within current expiration date.**

Criteria	IV. Clinical Services – Radiology Review
	IV.E.7) Technologist certificate posted and within current expiration date. **The following radiological protective equipment is present on site:** **IV.E.8) Operator protection devices: radiological equipment operator must use lead apron or lead shield.** **IV.E.9) Gonadal shield (0.5 mm or greater lead equivalent): for patient procedures in which gonads are in direct beam.** **Radiological Equipment:** Equipment inspection, based on a "priority" rating system, is established by legislation. https://blink.ucsd.edu/_files/safety-tab/rad/Title-17-CCR.pdf • Mammography equipment is inspected annually, and must have federal FDA Certification on site ***and*** CA Mammography X-ray Equipment and Facility Accreditation Certification posted on the machine.[55] • High Priority equipment (e.g. fluoroscopy, portable X-ray) is inspected every three years. • Medium Priority equipment is inspected every 4-5 years depending on the volume of patients, frequency of x-ray equipment uses, and likelihood of radiation exposure. If reviewer is uncertain about the "status of equipment inspection, call the RHB. **Radiology Personnel:** • All certificates/licenses are posted and show expiration dates. • If there are many technicians, a list of names, license numbers, and expiration dates may be substituted. • The Certified Radiological Technologist (CRT) certificate permits the technologist to perform all radiology films except mammography and fluoroscopy, which require separate certificates. • The "Limited Permit" restricts the technician to one of the ten-(10) x-ray categories specified on the limited certificate: Chest, Dental laboratory, Dermatology, Extremities, Gastrointestinal, Genitourinary, Leg-podiatric, Skull, Torso-skeletal, and X-ray bone densitometry.

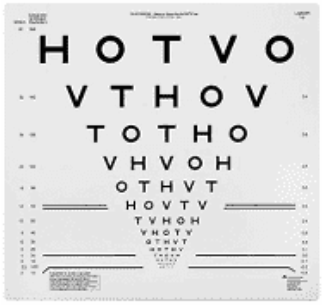
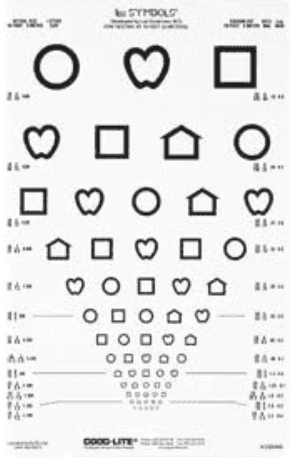
[55] 21 CFR 900

Criteria	IV. Clinical Services – Radiology Review
	Note: • Per RHB, dexascanners do not require lead aprons or gonadal shields, however, criteria 1-7 are still required. • RHB uses the ALARA (As Low As Reasonably Achievable) principle, which is the foundation of all radiation safety programs. The ALARA principle means to minimize exposure to radiation doses by employing all *reasonable* methods. • Dexascanners manufacturer guidelines do not require gonadal shielding or lead aprons due to very low radiation output, and potential for the shield to obscure the area being scanned, possibly rendering the scan non-diagnostic. With the focused beam, operators do not need aprons, the amount of exposure of "scattered" beams to an operator seated near the scanner is about the same level as that found in the natural environment. A traditional x-ray machine used for bone density testing, is not a dexascanner, and *may* require shielding/apron. **Note:** The RHB of the Food, Drug, and Radiation Safety Division of CDPH enforces the Radiation Control Laws and Regulations designed to protect both the public and employees against radiation hazards. Enforcement is carried out through licensing, registration and periodic inspection of sources of radiation, such as radiation machines. For questions regarding radiologic safety (e.g. expired or no inspection letters on site), call CDPH RHB at (916) 327-5106. For Radiation Emergency Assistance, call 1-800-*852*-7550. Ref: CCR, Title 17, Chapter 5, Subchapter 4 regulations at https://www.cdph.ca.gov/rhb

Criteria	V. Preventive Services Standards
A. Preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases.	**Examination equipment, appropriate for primary care services, is available on site:** **V.A.1) Exam tables and lights are in good repair.** **<u>Examination Table and Lights</u>:** • Lights and exam tables shall be in good repair. "Good repair" means clean and well maintained in proper working order. • Examination tables must have a protective barrier such as paper which is changed between patients, to cover the exam surface. **V.A.2) Stethoscope and sphygmomanometer with various size cuffs (e.g. child, adult, obese, thigh).** **V.A.3) Thermometer with a numeric reading.** **V.A.4) Basic exam equipment: in addition to items mentioned above, offices should have the following:** ○ Percussion hammer ○ Tongue blades ○ Patient gowns **V.A.5) Scales: Standing balance beam and infant scales.** **<u>Scales:</u>** • Infant scales are marked and accurate to increments of one (1) ounce or less and have a capacity of at least 35 pounds. • Standing floor scales are marked and accurate to increments of one-fourth (1/4) pound or less and have a capacity of at least 300 pounds. • Balance beam scales have an adjustment mechanism and zeroing weight to enable routine balancing at zero. • Electronic or digital scales have automatic zeroing and lock-in weight features. • Spring balance scales (e.g. bathroom scales) are unsatisfactory for clinical use as, over time, the spring counterbalance mechanism loses its accuracy.

Criteria	V. Preventive Services Standards
	V.A.6) Measuring devices for stature (height/length) measurement and head circumference measurement. **Measuring Devices:** Equipment on site for measuring stature (length/height) and head circumference includes: ○ Rigid 90º right angle headboard block that is perpendicular to the recumbent measurement surface. ○ Vertical to the wall-mounted standing measurement surface. ○ Flat, paper or plastic non-stretchable tape or yardstick, marked to one-eighth (1/8 in. or 1 mm) or less, attached to a firm, flat surface. The "0" of the tape is exactly at the base of the headboard for recumbent measurement, or exactly at foot level for standing measurement. ○ Moveable, non-flexible footboard at 90º right angle perpendicular to the recumbent measurement surface, or a flat floor surface for standing. ○ A non-stretchable tape measuring device marked to one-eighth (1/8 in. or 1 mm) or less for measuring head circumference (re-usable measuring device must be appropriately cleaned in between use). **V.A.7) Eye charts (literate and illiterate) and occluder for vision testing.** **Vision Testing:**[56] • Site has both literate (e.g., Snellen) and illiterate eye charts • The current preferred optotypes (figures or letters of different sizes) for patients who cannot distinguish letters are the LEA or HOTV symbols (see figures below)

[56] See the Procedures for the Evaluation of the Visual System by Pediatricians, available at: https://pediatrics.aappublications.org/content/137/1/e20153597. Also see the American Association for Pediatric Ophthalmology and Strabismus Vision Screening Committee's Pediatric Screening Guidance during the COVID-19 Pandemic, available at: https://aapos.org/education/allied-health/covid.

Criteria	V. Preventive Services Standards
	  • Wall mounted eye charts should be height adjustable and positioned at the eye-level of the patient • Examiners shall stand their patients with their heels to the line unless the eye chart that is being used to screen specifically instructs the patient to be positioned elsewhere. “Heel” lines are aligned with center of eye chart at 10 or 20-feet depending on whether the chart is for the 10-foot or 20-foot distance. • Eye charts are in an area with adequate lighting and at height(s) appropriate to use • Effective occlusion, such as with tape or an occlusive patch of the eye not being tested, is important to eliminate the possibility of peeking. **V.A.8) Ophthalmoscope.** Ophthalmoscope is in good working condition. **V.A.9) Otoscope with adult and pediatric ear speculums.** Otoscope with multi-size ear speculums appropriate to the population served. **V.A.10) A pure tone, air conduction audiometer is located in a quiet location for testing.**

Criteria	V. Preventive Services Standards

	Hearing Testing:[57]
	• The pure tone audiometer must have the minimum ability to:
	  ○ Produce intensities between 0 to 80 dB
	  ○ Have a headset with right and left earphones
	  ○ Be operated manually
	  ○ Produce frequencies at 1000, 2000, 3000, 4000, 6000, and 8000 Hz
	• Offices that provide pediatric preventive services should have a pure tone; air conduction audiometer available, audiometric testing is required at preventive health visits starting at 4 years of age.
	• PCP offices (such as Family Practitioners or General Practitioners) that refer all members to another provider for audiometric testing, must have a system in place that clearly demonstrates that the PCP office verifies that audiometric testing has been completed and that those results are returned to the PCP for review.

B. Health education services are available to Plan members.	**Health Education Services:** Services may include individual instruction, group classes, family counseling and/or other health educational programs and materials provided to members by the provider, health plan, or community sponsored programs. **Health education materials and Plan-specific resource information are:** **V.B.1) Readily accessible on site or are made available upon request.** **V.B.2) Applicable to the practice and population served on site.** **V.B.3) Available in threshold languages identified for county and/or area of site location.** **Health Education Materials:**

[57] See the American Speech-Language-Hearing Association's guidance on Audiograms, available at: https://www.asha.org/public/hearing/audiogram/.

Criteria	V. Preventive Services Standards
	• Must be available in the appropriate threshold languages and may be located in an accessible area on site (e.g., exam room, waiting room, health education room or area), or provided to members by clinic staff and/or by Plan upon request. • Must be available in accessible format which may include written information, audio and/or videotapes, computerized programs, and visual presentation aids for people with disabilities. • Should include general topics for health educational material such as: Immunizations, Pregnancy, Injury Prevention, Smoking Cessation, Dental Health, Nutrition, Physical Activity, STD/HIV Prevention, Family Planning, Asthma, Hypertension, and Diabetes. • Must meet the Medi-Cal Managed Care readability and suitability requirements for educational material distributed to Medi-Cal members.[58] **Plan-Specific Referral Information:** Plan-specific informing materials and/or resources are available on site in languages that are applicable to member population(s) primarily seen on site. ○ For example, if primarily English and Spanish-speaking members are seen on site, then Plan-specific informing materials are available on site in those languages. ○ Although a site may not stock informing materials in each threshold language identified for the county, site personnel has access to contact resource information for locating Plan-specific informing materials in threshold languages not typically seen on site. ○ Interpreter services are provided in all identified threshold and concentration standard languages. **Note:** Threshold languages are the primary languages spoken by Limited English Proficient (LEP) population groups residing in a county. A numeric threshold of 3,000 eligible LEP Medi-Cal beneficiaries or a concentration standard of 1,000 residing in a single ZIP code or 1,500 in two contiguous ZIP codes establishes the threshold languages identified by DHCS for each county.

[58] See All Plan Letter (APL) 18-016, "Readability and Suitability of Written Health Education Materials". APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

Criteria	VI. Infection Control Standards
A. Infection control procedures for Standard/Universal precautions are followed. 🗁 **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan (CAP). **Hand Washing Facilities:**[59] • Hand washing facilities are available in the exam room and/or utility room, and include an adequate supply of running potable water, soap and single use towels or hot air-drying machines. • Sinks with a standard faucet, foot-operated pedals, 4-6-inch wing-type handle, automatic shut-off systems or other types of water flow control mechanism are acceptable. • Staff can demonstrate infection control "barrier" methods used on site to prevent contamination of faucet handle, door handles and other surfaces until hand washing can be performed. • On occasions when running water is not readily available, an antiseptic hand cleanser, alcohol-based hand rub, or antiseptic towelettes is acceptable until running water is available.[60] **VI.A.1) Soap or antiseptic hand cleaner and running water are available in exam and/or treatment areas for hand washing.** **Soap or Antiseptic Hand Cleaner:** Hand washing prevents infection transmission by removing dirt, organic material and transient microorganisms from hands. ○ Hand washing with plain (non-antimicrobial) soap in any form (e.g., bar, leaflet, liquid, powder, granular) is acceptable for general patient care (Association for Professionals in Infection Control and Epidemiology, Inc., 1995). ○ Antimicrobial agents or alcohol-based antiseptic hand rubs are used for hand washing when indicated to remove debris and destroy transient microorganisms (e.g., before performing invasive procedures, after contact with potentially infectious materials). ○ Plain and antiseptic hand wash products are properly maintained and/or dispensed to prevent contamination.

[59] See the World Health Organization's Hand Hygiene guidelines, available at: https://cdn.who.int/media/docs/default-source/integrated-health-services-(ihs)/infection-prevention-and-control/hand-hygiene-why-how-and-when-brochure.pdf?sfvrsn=dc8a0810_2

[60] 29 CFR 1919.1030

Criteria	VI. Infection Control Standards
	VI.A.2) A waste disposal container is available in exam rooms, procedure/treatment rooms, and restrooms. **Waste Disposal Container:**[61] • Contaminated wastes (e.g. dental drapes, band-aids, sanitary napkins, soiled disposable diapers) are disposed of in regular solid waste (trash) containers, and are maintained to prevent potential contamination of patient/staff areas and/or unsafe access by infants/children. • Closed containers are not required for regular, solid waste trash containers. **VI.A.3) Site has procedure for effectively isolating infectious patients with potential communicable conditions.** **Isolation Procedures**:[62] • Personnel can demonstrate or verbally explain procedure(s) used on site to isolate patients with potentially contagious conditions from other patients. • If personnel are unable to demonstrate or explain site-specific isolation procedures *and* cannot locate written isolation procedure instructions, site is considered deficient. • Isolation procedures may vary from site to site. **Note:** • Infection Control standards are practiced on site to minimize risk of disease transmission. • Site personnel are expected to apply the principles of "Standard Precautions" (CDC, 1996), used for all patients regardless of infection status. • Standard precautions apply to blood, all body fluids, non-intact skin, and mucous membranes, which are treated as potentially infectious for HIV, HBV or HCV, and other bloodborne pathogens. • "Universal precautions" refer to the OSHA mandated program that requires implementation of work practice controls, engineering controls, bloodborne pathogen orientation/education, and record keeping in healthcare facilities.

[61] HSC 118275-118320. Also see the OSHA Standards for Bloodborne Pathogens, available at: https://www.hercenter.org/rmw/osha-bps.php.

[62] See the CDC's Guidelines for Isolation Precautions, available at: https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html.

Criteria	VI. Infection Control Standards
B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. 🗘🗁 **RN/NP/CNM/LM/MD/PA**	**<u>Deficiencies</u>:** All deficiencies related to Infection Control must be addressed in a corrective action plan. **<u>VI.B.1) (CE) Personal Protective Equipment for Standard Precautions is readily available for staff use.</u>** **<u>Personal Protective Equipment (PPE)</u>:** PPE must be readily available.[63] PPE for protection against bloodborne pathogen hazards is available on site and must include: 1) Gloves 2) Water repellent clothing barrier/gown 3) Face/eye protection (e.g., goggles/face shield) 4) Respiratory infection protection (e.g., mask) PPE does not include general work clothes (e.g., uniforms, cloth lab coats) that will permit liquid to soak through. • The storage of PPE should be adequate to protect the PPE from contamination, loss, damage, water or sunlight. • Proper storage often requires a dry and clean place that is not subject to temperature extremes. **<u>VI.B.2) (CE) Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport or shipping.</u>** **<u>Blood and Other Potentially Infectious Materials (OPIM)</u>:** • OPIM are all human body fluids, any unfixed tissue or organ (other than intact skin) from a human (living or dead), and HIV or HBV-containing blood, cells, tissue, organs, cultures, medium or solutions. • Containers for blood and OPIM are closable, leak proof, and labeled and/or color-coded. • Double bagging is required only if leakage is possible.

[63] 29 CFR 1910.1030

Criteria	VI. Infection Control Standards
	Labels: • A warning label is affixed to red-bagged regulated wastes, sharps containers, refrigerators/freezers containing blood or OPIM, containers used to store or transport blood or OPIM, and contaminated laundry or equipment for storage or transporting. • The international biohazard symbol with word "BIOHAZARD" *or* the words "Biohazardous Waste" label (fluorescent orange or red orange with contrasting lettering/symbols) is part of, or affixed to, the container. • Sharps containers are labeled with the words "Sharps Waste" or with the international biohazard symbol and the word "BIOHAZARD". • Individual containers of blood or OPIM are exempted from warning labels if placed inside a labeled secondary container for storage, transport, or disposal. • Alternative marking or color coding may be used to label contaminated laundry or specimen containers if the alternative marking permits employees on site to recognize that container requires compliance with Universal Precautions. **VI.B.3) (CE) Needlestick safety precautions are practiced on site.** **Needlestick Safety:**[64] • Contaminated sharps are discarded immediately. • Sharps containers are located close to the immediate area where sharps are used and are inaccessible to unauthorized persons. • Sharps are not bent, removed from a syringe, or recapped. Recapping, bending, or removing contaminated needles is permissible only if there is no feasible alternative or if such actions are required for a specific medical procedure. If recapping, bending, or removal is necessary, employers must ensure that workers use either a mechanical device or a one-handed technique. Needleless systems, needles with Engineered Sharps Injury Protection (ESIP) devices, and non-needle sharps are used (incl. in emergency kits), unless exemptions have been approved by Cal/OSHA.[65] • Security of portable containers in patient care areas is always maintained.

[64] See the OSHA Needlestick Safety Frequently Asked Questions, available at: , and the OSHA Standards for Bloodborne Pathogens, available at: https://www.osha.gov/bloodborne-pathogens https://www.hercenter.org/rmw/osha-bps.php.

[65] 8 CCR 5193

Criteria	VI. Infection Control Standards
	• Any device capable of cutting or piercing (e.g. syringes, hypodermic needles, needleless devices, blades, broken glass, slides, vials) are placed in a closable, puncture-resistant, labeled, leak-proof container. If these requirements are met, containers made of various materials (e.g., cardboard, plastic) are acceptable. • Containers are not overfilled past the manufacturer's designated fill line, or more than ¾ full. • Supply of containers on hand is adequate to ensure routine change-out when filled. **VI.B.4) All sharp injury incidents are documented.** **Sharps Injury Documentation:**[66] • Site has a method in place to document sharps injuries. • 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. • The incident must be recorded in the log within 14 business days of the date the incident is reported to the employer and maintained in such a manner to protect the confidentiality of the injured employee (e.g., removal of personal identifiers) and follow-up care is documented within 14 days of injury incident. • Sites with 10 or fewer employees are exempt from OSHA recordkeeping requirements and are exempt from recording and maintaining a Sharps Injury Log, however, it is recommended to have a method in place to document sharps injuries regardless of the number of employees. **Regulated Waste Storage:** Regulated wastes include: ○ **Biohazardous wastes**, e.g., laboratory wastes, human specimens/tissue, blood/contaminated materials "known" to be infected with highly communicable diseases for humans and/or that require isolation. ○ **Medical wastes**, e.g., liquid/semi-liquid blood or OPIM, items caked with dry blood or OPIM and capable of releasing materials during handling, and contaminated sharps. **VI.B.5) Biohazardous (non-sharp) wastes are contained separate from other trash/waste.**

[66] See 8 CCR 5193, and the National Institute for Occupational Safety and Health's guidance on Preventing Needlesticks and Sharps Injuries, available at: https://www.cdc.gov/niosh/topics/bbp/sharps.html.

Criteria	VI. Infection Control Standards
	VI.B.6) Storage areas for regulated medical wastes are maintained secure and inaccessible to unauthorized persons.[67] • Regulated waste is contained separately from other wastes (e.g., contaminated wastes)* and placed in red biohazardous bags with Biohazard label and stored in a closed container that is not accessible to unauthorized persons. • If stored outside the office, a lock secures the entry door, gate or receptacle lid, and posted warning sign(s) in English and Spanish are visible for 25-feet: "CAUTION-BIOHAZARDOUS WASTE STORAGE AREA- UNAUTHORIZED PERSONS KEEP OUT" and CUIDADO-ZONA DE RESIDUOUS-BIOLOGICOS PELIGOROS-PROHIBIDA LE ENTRADA A PERSONAS NO AUTHORIZADAS". See HSC Sections 117915-117946, 49 CFR, Section 173.6; Core Infection Prevention and Control Practices -Centers for Disease Control and Prevention (CDC) The Healthcare Infection Control Advisory Committee (HICPAC), 2016. **VI.B.7) Contaminated laundry is laundered at the workplace or by a commercial laundry service.** **<u>Contaminated Laundry</u>:** • Contaminated laundry (soiled with blood/OPIM) is laundered by a commercial laundry service, or a washer and dryer on site. • Contaminated laundry should not contain sharps, and when transported, should have the appropriate warning label. • Manufacturer's guidelines are followed to decontaminate and launder reusable protective clothing. • Ensure that laundry areas have handwashing facilities and products and appropriate PPE available for staff. • Laundry requirements are "not applicable" if only disposable patient gowns and PPE are used on site.

[67] HSC 117600-118360, 29 CFR 1910.1030, CDC Guidelines for Isolating Precautions: Preventing Transmission of Infection Agents in Healthcare Settings, available at: https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html.

Criteria	VI. Infection Control Standards
	VI.B.8) 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). **Medical Waste Disposal:** California adopted statutes into HSC affecting medical waste transporters in October 1993.[68] • Only medical waste transporters listed with CDPH can transport medical waste. • All medical waste transporters must carry paperwork issued by CDPH in each vehicle while transporting medical waste. • Medical wastes are hauled to a permitted offsite medical waste treatment facility, transfer station, or other registered generator by a registered hazardous waste transporter. • Limited-quantity exemption is not required for Small Quantity Generator (up to 35.2 pounds). However, 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. For the CDPH list of current medical waste transporters, visit: https://www.cdph.ca.gov/Programs/CEH/DRSEM/CDPH%20Document%20Library/EMB/MedicalWaste/Haulist_012921.pdf For information on the United States Postal Service mailability standards for medical waste (including sharps) refer to the Domestic Mail Manual, section 601.10.17: https://pe.usps.com/Archive/HTML/DMMArchive20100607/601.htm CDPH Medical Waste Management Program: https://www.cdph.ca.gov/Programs/CEH/DRSEM/Pages/EMB/MedicalWaste/MedicalWaste.aspx CDPH Medical Waste Management Program Transporter Checklist: https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8660.pdf CDPH Medical Waste Transporter Annual Verification: https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8668.pdf

[68] HSC 117600-11836

Criteria	VI. Infection Control Standards
	CDPH Medical Waste Transfer Stations and Offsite Treatment Facilities: https://www.cdph.ca.gov/Programs/CEH/DRSEM/Pages/EMB/MedicalWaste/Transfer-and-Treatment.aspx CDPH Medical Waste Transporters Data Submission Protocol: https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8666.pdf Department of Toxic Substances Control-Managing Hazardous Waste Transporters Registration https://dtsc.ca.gov/transporters/ ***Note:** Contaminated wastes include materials soiled with blood during their use but are not within the scope of regulated wastes. Contaminated waste items need not be disposed as regulated waste in labeled red bags but can be discarded as solid waste in regular trash receptacle.
C. Contaminated surfaces are decontaminated according to Cal-OSHA standards. **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan (CAP). **VI.C.1) Equipment and work surfaces are appropriately cleaned and decontaminated after contact with blood or other potentially infectious material.** **Routine Decontamination:** ○ Contaminated work surfaces are decontaminated with an appropriate disinfectant.[69] ○ Written "housekeeping" schedules have been established and are followed for regular routine daily cleaning. ○ Staff can identify cleaning and disinfection of surfaces and equipment, the disinfectant used and responsible personnel in between patients use. **VI.C.2) Routine cleaning and decontamination of equipment/work surfaces is completed according to site-specific written schedule.** **The written schedule for cleaning and decontamination of the work site as follows:** ○ **Area cleaned/decontaminated**

[69] 29 CFR 1910.1030

Criteria	VI. Infection Control Standards
	○ **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. Cleaning and decontamination of equipment and work surfaces is required more often as specified below: ○ Location within the facility ○ Type of surface or equipment to be treated ○ Type of soil or contamination present ○ Tasks or procedures being performed in the area Contaminated work surfaces shall be cleaned and decontaminated with an appropriate disinfectant immediately or as soon as feasible when: ○ Surfaces become overtly contaminated. ○ There is a spill of blood or OPIM. ○ Procedures are completed. ○ At the end of the work shift if the surface may have become contaminated since the last cleaning. **Spill Procedure:** Personnel can identify procedures for prompt decontamination of blood/body fluid spills, the disinfectant used, and the responsible person(s). **Disinfectant solutions used on site are:** **VI.C.3) Approved by the Environmental Protection Agency (EPA).** **VI.C.4) Effective in killing HIV/HBV/TB.** **VI.C.5) Follow manufacturer instructions.** **Disinfectant Products:** ○ Products used for decontamination have a current EPA-approved status. ○ Effectiveness in killing HIV/HBV/TB is stated on the manufacturer's product label. ○ Decontamination products are used according to manufacturer's guidelines for decontamination and contact times.

Criteria	VI. Infection Control Standards
	<u>10% Bleach Solution</u>: ○ 10% bleach solution that is EPA registered and effective against TB, is changed/reconstituted ***every*** 24 hours (due to instability of bleach once mixed with water). ○ Surface is cleaned prior to disinfecting (due to presence of organic matter (e.g., dirt, blood, excrement) inactivates active ingredient, sodium hypochlorite). ○ Surface is air-dried or allowed appropriate time (stated on label) before drying. ○ Manufacturer's directions, *specific* to every bleach product, are followed carefully. **<u>Note</u>:** "Contamination" means the presence or reasonably anticipated presence of blood or OPIM on any item or surface. "Decontamination" is the use of appropriate physical or chemical means to remove, inactivate or destroy bloodborne pathogens so that a surface or item is no longer capable of transmitting infectious particles and is rendered safe for handling, use or disposal.[70] Current EPA product lists and information is available from the EPA, Antimicrobial Division at (703) 305-1284, or at 29 CFR 1910.1030.
D. Reusable medical instruments are properly sterilized after each use. **RN/NP/CNM/LM/MD/PA**	**<u>Deficiencies</u>:** All deficiencies related to Infection Control must be addressed in a corrective action plan (CAP). **VI.D.1) Written site-specific policy/procedures or manufacturer's instructions for instrument/equipment sterilization are available to staff.** If site uses an autoclave or cold chemical solution to achieve sterilization and/or high level disinfection (HLD) of instruments/equipment, 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, which are available to staff to follow. **Staff adheres to site-specific policy and/or manufacturer/product label directions for the following procedures:** **VI.D.2) Cleaning reusable instruments/equipment prior to sterilization.** **Cleaning Prior to Sterilization:**

[70] 8 CCR 5193. Also see CalOSHA's Best Practices Approach for Reducing Bloodborne Pathogen Exposure, available at:

https://www.dir.ca.gov/dosh/dosh_publications/BBPBest1.pdf.

Criteria	VI. Infection Control Standards
	• 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. **Cold chemical sterilization/high level disinfection:** **VI.D.3a) (CE) 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. **Cold Chemical Sterilization/High Level disinfection:** • Product manufacturer's directions are strictly followed for instrument pre-soaking treatment, solution preparation, solution exposure procedures, safety precautions (e.g., room temperature, area ventilation), and post-sterilization processes. • Sterilization and or high-level disinfection exposure times and solution expiration date and time are available to staff. • Written procedures for cold sterilization and/or high-level disinfection is available on site to staff. **VI.D.3b) Confirmation from manufacturer item(s) is/are heat sensitive.** • Per CDC,[71] the use of liquid chemical germicides to sterilize instruments ("cold sterilization") are limited. Sterility is not verified or assured with cold chemical sterilization. The first choice is always heat sterilization. The CDC refers to heat sterilization as "the method of choice when sterilizing instruments and devices. If an item is heat sensitive, it is preferable to use a heat-stable alternative or disposable item". • 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.

[71] See the CDC Guidelines for Disinfection and Sterilization, available at: https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf. Also see the CDC's Guidelines on other sterilization methods, available at: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/sterilization/other-methods.html.

Criteria	VI. Infection Control Standards
	VI.D.3c) (CE) Appropriate PPE is available, exposure control plan, Material Safety Data Sheets (MSDS) and clean up instructions in the event of a cold chemical sterilant spill. **Cold Chemical Sterilants Spillage:** The OSHA Hazard Communication Standard requires manufacturers and importers of hazardous chemicals to develop MSDS for each chemical or mixture of chemicals.[72, 73] ○ Employers must have the data sheets for cold chemical sterilants readily available to employees who work with the products to which they could be exposed. ○ Staff should attend training classes in safety awareness about the use and exposure to cold chemical sterilants used on site. ○ 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. ○ If personnel are unable to demonstrate or explain site-specific chemical spill cleanup procedures *and* cannot locate written chemical spill cleanup procedure instructions, site is considered deficient. ○ Cleanup procedures may vary from site to site depending on the cold chemical sterilants used. ○ The appropriate PPE for cold chemical sterilants clean up must be readily available. National Institute for Occupational Safety and Health (NIOSH) with the Centers for Disease Control and Prevention. Environmental Health and Safety guidelines for disinfectants and sterilization methods. MSDS for cold chemical sterilants. The American National Standard (ANSI)/Advancing Safety in Medical Technology (AAMI) ST58:2013. Control Methods and Work Practices: are in place to prevent or reduce exposure to the cold chemical sterilants. Cold chemical sterilants have toxic properties and are hazardous.

[72] 29 CFR 1910.1200, 1915.99, 1917.28, 1918.90, 1926.59, and 1928.21.

[73] See CDC guidelines on sterilizing heat sensitive dental instruments, available at: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/healthcare-equipment.html l/ 29 CFR 1910.1030(d)(3)(i), 29 CFR 1910.1030(d)(3)(ii), 29 CFR 1910.1030(d)(4)(ii)(A), 29 CFR 1910.1030(d)(4)(iii)(B), 29 CFR 1910.132, 29 CFR 1910.134. See the CDC Guidelines for Disinfection and Sterilization in Healthcare Facilities, available at: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/sterilization/index.html.

Criteria	VI. Infection Control Standards
	• Cold chemical sterilants must be used strictly in accordance with the manufacturer's directions. Always consult the manufacturer for safety precautions and MSDS information. • The appropriate PPE must be used to avoid inhalation or skin contact exposure to during the cold chemical sterilization/high level disinfection process. Examples of cold chemical sterilants include: ○ Glutaraldehyde (Cidex) ○ Peracetic acid ○ Hydrogen peroxide-based solutions Glutaraldehyde is a common cold chemical sterilants. Exposure to glutaraldehyde can cause the following health effects: throat and lung irritation, breathing difficulty, nose irritation, nosebleed, burning eyes and conjunctivitis, rash, hives, headaches, and nausea. Exposure to glutaraldehyde may be prevented or reduced by using the following control methods and work practices: ○ Use local exhaust ventilation. ○ Keep glutaraldehyde baths under a fume hood where possible.[74] ○ Avoid skin contact (use appropriate PPE-gloves and aprons made of nitrile or butyl rubber wear goggles and face shields). ○ Use only enough sterilants to perform the required sterilization procedure. ○ Seal or cover all containers holding the sterilants. ○ Attend training classes. **Autoclave/Steam Sterilization:** **VI.D.4a) Staff demonstrate/verbalize necessary steps/process to ensure sterility.** • Autoclave manufacturer's directions are strictly followed for instrument pre-cleaning, machine loading, operation safety precautions, minimum time-temperature criteria, and post sterilization processes. • Written operating procedures for autoclave are available on site to staff. • Documentation of sterilization loads include date, time and duration of run cycle, temperature, steam pressure, and operator of each run.

[74] For more information on glutaraldehyde exposure and safety tips, refer to the CDC guidance, available at: https://www.cdc.gov/niosh/docs/2001-115/default.html.

Criteria	VI. Infection Control Standards
	• If instruments/equipment are transported off-site for sterilization, equipment handling, and transport procedures are available on site to staff. • Documentation of instruments and personnel transporting must be maintained. **VI.D.4 b) Autoclave maintenance per manufacturer's guidelines.** **<u>Autoclave Maintenance</u>:** Autoclave is maintained and serviced according to manufacturer's guidelines. Documentation of maintenance should include: o Mechanical problems o Inspection dates o Results/outcome of routine servicing o Calibration o Repairs, etc. **<u>Note</u>:** If the manufacturer's guidelines are not present on site, then the autoclave is serviced annually by a qualified technician. A dated sticker on the autoclave or a service receipt is acceptable documentation of appropriate maintenance. **<u>VI.D.4c) (CE) Spore testing of autoclave/steam sterilizer with documented results (at least monthly).</u>** **<u>Spore Testing</u>:** • Autoclave spore testing is performed *at least monthly*, unless otherwise stated in manufacturer's guidelines. • Documentation of biological spore testing includes: o Date o Results o Types of spore test used o Person performing/documenting test results • Written procedures for performing routine spore testing are available on site to staff **Note: Documentation of monthly spore testing must be maintained onsite even for sterilization that is performed offsite.**

Criteria	VI. Infection Control Standards
	VI.D.4.d) (CE) Management of positive mechanical, chemical, and biological indicators of the sterilization process. **Autoclave/Steam Sterilization Mechanical, Chemical, and Biological Indicators:[75]** • Sterilization failure can occur for reasons such as slight variation in the resistance of the spores, improper use of the sterilizer, and laboratory contamination during the culture. • Per CDC, the autoclave/steam sterilization procedure should be monitored routinely by using a combination of: o 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) o 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. o Biological: spore test – an indicator to evaluate the sterilizing conditions and indirectly the microbiologic status of the processed items o Staff should adhere to site-specific protocol and/or manufacturer/product label for management of positive indicator(s). • Written procedures for 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: o Report problem o Repair autoclave o Retrieve all instruments sterilized since last negative spore test o Re-test autoclave o Re-sterilize retrieved instruments • Biologic spore test products vary and are designed for use based on specific autoclave type. Biologic control testing challenges the autoclave sterilization cycle with live, highly resistant, nonpathogenic spores. If spores are killed during processing, it is assumed that all other microorganisms are also killed and that the autoclave load is sterile.

See the CDC Guidelines for Disinfection and Sterilization in Healthcare Facilities, available at: https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf

Criteria	VI. Infection Control Standards

	VI.D.4.e) Sterilized packages are labeled with sterilization date and load identification information.
	Package and storage of sterilized items:
	• Following the sterilization process, medical and surgical devices must be handled using aseptic technique in order to prevent contamination.
	• Storage areas for sterilized packages are clean, dry and separated from non-sterile items by a functional barrier (e.g., shelf, cabinet door, and drawer).
	• Sterilized package labels include:
	  ○ Date of sterilization
	  ○ Load run identification information
	  ○ 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
	
	VI.D.4.f) Storage of sterilized packages.
	Storage of sterilized packages:[76]
	• Storage areas for sterilized packages are clean, dry and separated from non-sterile items by a functional barrier (e.g., shelf, cabinet door, and drawer).
	• Maintenance of sterility is event related, not time related.
	• Sterilized items are considered sterile until use, unless an event causes contamination.
	• Sterilized items are not considered sterile if package is opened, wet/moist, discolored or damaged, and should be kept removed from sterile package storage area.
	• Site has a process for routine evaluation of sterilized packages.

[76] See the CDC Summary of Recommendations regarding Disinfection and Sterilization, available at: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html, and the CDC Guidelines for Disinfection and Sterilization in Healthcare Facilities, available at: https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf.

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

January 1, 2024

Primary Care Provider- Site Review Tool

Date: _____ **Health Plan Name or Code:** _____ **IPA:** _____

Last Review Date: _____ **Site ID:** _____ **Site NPI:** _____

Reviewer name/title: _____ **Provider Address:** _____

Reviewer name/title: _____ **City and Zip Code:** _____

Reviewer name/title: _____ **Phone:** _____ **Fax:** _____ **Current Fire Clearance:** _____

Contact person/title: _____

No. of staff on site: _____ **Physician** _____ **NP** _____ **CNM** _____ **LM** _____ **PA** _____ **RN** _____ **LVN** _____ **MA** _____ **Clerical** _____ **other**

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

Site Scores

	Total Points Poss.	Points Given	No Points	N/As	CE*
I. Access/Safety	**31**				
II. Personnel	**27**				
III. Office Management	**25**				
IV. Clinical Services	**40**				
V. Preventive Services	**13**				
VI. Infection Control	**34**				
Totals	**170**				

*CE = Critical Elements. Indicate any CEs for easy reference to generate a CAP.

Scoring Procedure

1) Add points given in each section.
2) Add total points given for all six sections.
3) Adjust score for "N/A" criteria (if needed), by subtracting N/A points from 170 total points possible.
4) Divide total points given by "adjusted" total points.
5) Multiply by 100 to get the compliance (percent) rate.

170 - _____ = _____
N/A Points **Adjusted Points**

_____ ÷ _____ = _____ X 100 = _____%
Points Given **Total / Adjusted Points** **Decimal Compliance Score** **Rate**

Compliance Rate

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

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

_____ **Fail: 79% and Below**

_____ CAP Required

_____ Other follow-up

Next Site Review Due: _____

I. Access/Safety Criteria	Yes	No	N/A	Wt.	Site Score
A. Site is accessible and useable by individuals with physical disabilities. Title 24, California Code of Regulations (CCR) (CA Building Standards Code); Title 28 Code of Federal Regulations (CFR) §35 (American Disabilities Act of 1990, Title II, Title III) All facilities designed, altered, or constructed after January 26, 1992, for the use of public entity must be readily accessible and usable by persons with disabilities. Sites must have the following safety accommodations for physically disabled persons:					
1) Clearly marked (blue) curb or sign designating disabled-parking space near accessible primary entrance.	1)	1)	1)	1	
2) Pedestrian ramps have a level landing at the top and bottom of the ramp.	2)	2)	2)	1	
3) Exit and exam room doorway openings allow for clear passage of a person in a wheelchair.	3)	3)	3)	1	
4) Accessible passenger elevator or reasonable alternative for multi-level floor accommodation.	4)	4)	4)	1	
5) Clear floor space for wheelchair in waiting area and exam room.	5)	5)	5)	1	
6) Wheelchair accessible restroom facilities.	6)	6)	6)	1	
7) Wheelchair accessible handwashing facilities or reasonable alternative.	7)	7)	7)	1	

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

I. Access/Safety Criteria, continued	Yes	No	N/A	Wt.	Site Score
B. Site environment is maintained in a clean and sanitary condition. 28 CCR §1300.80; 22 CCR §75062					
1) All patient areas including floor/carpet, walls, and furniture are neat, clean, and well maintained.	1)	1)	1)	1	
2) Restrooms are clean and contain appropriate sanitary supplies.	2)	2)	2)	1	
C. Site environment is safe for all patients, visitors, and personnel. 8 CCR §3220, §2299-2989; 22 CCR §53230; 24 CCR, §2, §3, §9; 28 CCR §1300.80; 29 CFR §1910.37, §1910.38, §1910.157, §1910.301, §1926.34 There is evidence staff has received safety training and/or has safety information available on the following:					
1) Fire safety and prevention.	1)	1)	1)	1	
2) Emergency non-medical procedures (e.g. site evacuation, workplace violence).	2)	2)	2)	1	
3) Lighting is adequate in all areas to ensure safety.	3)	3)	3)	1	
4) <u>Exit doors and aisles are unobstructed and egress (escape) accessible.</u>	**4)**	**4)**	**4)**	**2**	
5) Exit doors are clearly marked with “Exit” signs.	5)	5)	5)	1	
6) Clearly diagramed “Evacuation Routes” for emergencies are posted in a visible location at all elevators, stairs and exits.	6)	6)	6)	1	
7) Electrical cords and outlets are in good working condition.	7)	7)	7)	1	
8) Fire Fighting Equipment in accessible location	8)	8)	8)	1	
9) An employee alarm system.	9)	9)	9)	1	

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

RN/NP/CNM/LM/ MD/PA only

I. Access/Safety Criteria, continued	Yes	No	N/A	Wt.	Site Score
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week. 8 CCR §3220; 22 CCR §51056, §53216, §75031; 28 CCR §1300.67, §1300.80; American Academy of Family Practice (AAFP)					
1) Personnel are trained in procedures/action plan to be carried out in case of medical emergency on site.	1)	1)	1)	1	
2) Emergency equipment is stored together in easily accessible location and is ready to be used.	2)	2)	2)	1	
3) Emergency phone number contacts are posted, updated annually, and as changes occur.	3)	3)	3)	1	
Emergency medical equipment appropriate to practice/patient population is available on site:					
4) **Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag.**	**4)**	**4)**	**4)**	**2**	
5) Emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia. Epinephrine 1mg/ml (injectable) and Diphenhydramine (Benadryl) 25 mg (oral) or Diphenhydramine (Benadryl) 50 mg/ml (injectable), Naloxone, chewable Aspirin 81 mg, Nitroglycerine 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.	**5)**	**5)**	**5)**	**2**	
6) Medication dosage chart for all medications included with emergency equipment (or other method for determining dosage) is kept with emergency medications.	6)	6)	6)	1	
There is a process in place on site to:					
7) Document checking of emergency medication, equipment and supplies for expiration and operating status at least monthly.	7)	7)	7)	1	
8) Replace/re-stock emergency medication, equipment and supplies immediately after use.	8)	8)	8)	1	

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

RN/NP/CNM/LM/MD/PA only

I. Access/Safety Criteria, continued	Yes	No	N/A	Wt.	Site Score
E. Medical and lab equipment used for patient care is properly maintained. 28 CCR §1300.80; 21 CFR §800-1299; 22 CCR §75062; §53230					
1) Medical equipment is clean.	1)	1)	1)	1	
2) Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines.	2)	2)	2)	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **TOTALS**					

RN/NP/CNM/LM/MD/PA only

II. Personnel Criteria	Yes	No	N/A	Wt.	Site Score
A. Professional health care personnel have current California licenses and certifications. CA Business & Professional Code (BPC) §2050, §2099.5, §2506**,** §2725, §2746, §2835, §3500, §4110; CCR, Title 16, §1355.4, §1399.547					
1) All required Professional Licenses and Certifications, issued from the appropriate licensing/certification agency, are current.	1)	1)	1)	1	
2) Notification is provided to each member that the MD(s) is licensed and regulated by the Medical Board, and that the Physician Assistant(s) is licensed and regulated by the Physician Assistant Committee.	2)	2)	2)	1	
B. Health care personnel are properly identified. BPC §680					
1) Health care personnel wear identification badges/tags printed with name and title.	1)	1)	1)	1	
C. Site personnel are qualified and trained for assigned responsibilities. BPC §2069; 16 CCR §1366 - 1366.4					
1) Documentation of education/training for non-licensed medical personnel is maintained on site.	1)	1)	1)	1	
2) Only qualified/trained personnel retrieve, prepare, or administer medications.	**2)**	**2)**	**2)**	**2**	
3) Site has a procedure in place for confirming correct patient/medication/vaccine dosage and route prior to administration.	3)	3)	3)	1	
4) Only qualified/trained personnel operate medical equipment.	4)	4)	4)	1	

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

RN/NP/CNM/LM/MD/PA only

II. Personnel Criteria, continued	Yes	No	N/A	Wt.	Site Score
D. Scope of practice for non-physician medical practitioners (NPMP) is clearly defined. 16 CCR §1379, §1399.540, §1399.545, §1474; BPC §2725, §2746.5, §2746.51, §2836.1					
1) Standardized Procedures provided for Nurse Practitioners (NP) and/or Certified Nurse Midwives (CNM).	1)	1)	1)	1	
2) A Practice Agreement defines the scope of services provided by Physician Assistants (PA) and Supervisory Guidelines define the method of supervision by the Supervising Physician.	2)	2)	2)	1	
3) Standardized Procedures, Practice Agreements and Supervisory Guidelines are revised, updated and signed by the supervising physician and NPMP when changes in scope of services occur.	3)	3)	3)	1	
4) Each NPMP that prescribes controlled substances has a valid Drug Enforcement Administration Registration Number.	4)	4)	4)	1	
E. NPMPs are supervised according to established standards. BPC §3516(b); Welfare and Institutions Code (WIC) 14132.966; 16 CCR §1379; §1399.545					
The designated supervising physician(s) on site: 1) Ratio to number of NPMPs does not exceed established ratios in any combination. a) 1:4 NPs b) 1:4 CNMs c) 1:4 PAs	1)	1)	1)	1	
2) The designated supervising or back-up physician is available in person or by electronic communication at all times when a NPMP is caring for patients.	2)	2)	2)	1	
3) Evidence of NPMP supervision.	3)	3)	3)	1	

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

RN/NP/CNM/LM/MD/PA only

II. Personnel Criteria, continued	Yes	No	N/A	Wt.	Site Score
F. Site personnel receive safety training annually 8 CCR §5193; CA Health and Safety Code (HSC) §117600; CA Penal Code §11164, §11168; 29 CFR §1910.1030, 8 CCR §3342					
There is evidence that site staff has received **annual** training on the following:					
1) Infection Control/Universal Precautions (annually)	1)	1)	1)	1	
2) Blood Borne Pathogens Exposure Prevention (annually)	2)	2)	2)	1	
3) Biohazardous Waste Handling (annually)	3)	3)	3)	1	
G. Site personnel receive training on member rights. 22 CCR §51009, §51305.1, §53452, §53858; 28 CCR §1300.68; 42 CFR §438.206 (6); 42 CFR §438.224; 42 CFR §438.10 (g); HSC 124260, 1374.16; CA Penal Code §11164, §1166.5, §11168, Family Code 6920, 6924, 6930; National Youth law					
There is evidence that site staff has received training on the following:					
1) Patient confidentiality	1)	1)	1)	1	
2) Informed Consent, including human sterilization	2)	2)	2)	1	
3) Prior Authorization requests	3)	3)	3)	1	
4) Grievance/Complaint Procedure	4)	4)	4)	1	
5) Child/Elder/Domestic Violence Abuse	5)	5)	5)	1	
6) Sensitive Services/Minors' Rights	6)	6)	6)	1	
7) Health Plan referral process/procedures/resources	7)	7)	7)	1	
8) Cultural and linguistics	8)	8)	8)	1	
9) Disability Rights and Provider Obligations	9)	9)	9)	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **TOTALS**					

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

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

RN/NP/CNM/LM/MD/PA only

III. Office Management Criteria, continued	Yes	No	N/A	Wt.	Site Score
C. Health care services are readily available. 22 CCR §56000(2); 28 CCR §1300.67.2.2					
1) Appointments are scheduled according to patients stated clinical needs within the timeliness standards established for Plan members.	1)	1)	1)	1	
2) Patients are notified of scheduled routine and/or preventive screening appointments.	2)	2)	2)	1	
3) There is a process in place verifying follow-up on missed and canceled appointments.	3)	3)	3)	1	
D. There is 24-hour access to interpreter services for non- or limited-English proficient (LEP) members. 22 CCR §53851; 28 CCR 1300.67.04					
1) Interpreter services are made available in identified threshold languages specified for location of site.	1)	1)	1)	1	
2) Persons providing language interpreter services, including sign language on site, are trained in medical interpretation.	2)	2)	2)	1	
E. Procedures for timely referral/consultative services are established on site. 22 CCR §53851; 28 CCR §1300.67, §1300.80					
Office practice procedures allow timely provision and tracking of:					
1) Processing internal and external referrals, consultant reports, and diagnostic test results.	1)	1)	1)	1	
2) **Physician Review and follow-up of referral/consultation reports and diagnostic test results.**	**2)**	**2)**	**2)**	**2**	
F. Member Grievance/Complaint processes are established on site. 22 CCR §53858, §56260					
1) Phone number(s) for filing grievances/complaints are located on site.	1)	1)	1)	1	
2) Complaint forms and a copy of the grievance procedure are available on site.	2)	2)	2)	1	

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

III. Office Management Criteria, continued	Yes	No	N/A	Wt.	Site Score
G. Medical records are available for the practitioner at each scheduled patient encounter. 22 CCR §75055; 28 CCR §1300.80					
1) Medical records are readily retrievable for scheduled patient encounters.	1)	1)	1)	1	
2) Medical documents are filed in a timely manner to ensure availability for patient encounters.	2)	2)	2)	1	
H. Confidentiality of personal medical information is protected according to State and federal guidelines.					
1) Exam rooms and dressing areas safeguard patients' right to privacy.	1)	1)	1)	1	
2) Procedures are followed to maintain the confidentiality of personal patient information.	2)	2)	2)	1	
3) Medical record release procedures are compliant with State and federal guidelines.	3)	3)	3)	1	
4) Storage and transmittal of medical records preserves confidentiality and security.	4)	4)	4)	1	
5) Medical records are retained for a minimum of 10 years.	5)	5)	5)	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **TOTALS**					

IV. Clinical Services: Pharmaceutical Services Criteria	Yes	No	N/A	Wt.	Site Score
A. Drugs and medication supplies are maintained secure to prevent unauthorized access. BPC §4172; 22 CCR §75032, §75033, §75037(a-g), §75039; 21 CFR §1301.72, §1301.75, §1301.76, §1302; 16 CCR §1356.3; HSC §11053-11058					
1) Drugs are stored in specifically designated cupboards, cabinets, closets or drawers.	1)	1)	1)	1	
2) Prescription drug samples, and over-the-counter drugs, hypodermic needles/syringes, all medical sharp instruments, hazardous substances, and prescription pads are securely stored in a lockable space (cabinet or room) within the office/clinic.	2)	2)	2)	1	
3) Controlled drugs are stored in a locked space accessible only to authorized personnel.	3)	3)	3)	1	
4) A dose-by-dose controlled substance distribution log is maintained.	4)	4)	4)	1	
5) Written site-specific policy/procedure for dispensing of sample drugs are available on site.	5)	5)	5)	1	

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

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IV. Clinical Services: Pharmaceutical Services Criteria, continued	Yes	No	N/A	Wt.	Site Score
B. Drugs are handled safely and stored appropriately. 22 CCR §75037(a-g), §75039; 21 CFR §211.137; 21 USC §351; HSC §117600-118360; 40 CFR, part 261; Current CDC Recommendations					
1) Drugs are prepared in a clean area or "designated clean" area if prepared in a multi-purpose room.	1)	1)	1)	1	
2) Drugs for external use are stored separately from drugs for internal use.	2)	2)	2)	1	
3) Items other than medications in refrigerator/freezer are kept in a secured, separate compartment from drugs.	3)	3)	3)	1	
4) Refrigerator thermometer temperature is 36º-46º Fahrenheit or 2º-8º Centigrade (at time of site visit).	4)	4)	4)	1	
5) Freezer thermometer temperature is 5º Fahrenheit or –15º Centigrade, or lower (at time of site visit).	5)	5)	5)	1	
6) Site utilizes drugs/vaccine storage units that are able to maintain required temperature.	6)	6)	6)	1	
7) Daily temperature readings of drugs/vaccines refrigerator and freezer are documented.	7)	7)	7)	1	
8) Has a written plan for vaccine protection in case of power outage or malfunction of the refrigerator or freezer.	8)	8)	8)	1	
9) Drugs and vaccines are stored separately from test reagents, germicides, disinfectants, and other household substances.	9)	9)	9)	1	
10) Hazardous substances are appropriately labeled.	10)	10)	10)	1	
11) Site has method(s) in place for drug and hazardous substance disposal.	11)	11)	11)	1	

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

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IV. Clinical Services: Pharmaceutical Services Criteria, continued	Yes	No	N/A	Wt.	Site Score
C. Drugs are dispensed according to State and federal drug distribution laws and regulations. BPC §4024, §4076, §4170, §4171, §4173, §4174; 22 CCR §75032, §75033, §75036, §75037(a-g), §75038, §75039; 16 CCR §1718.1; 21 CFR §211.137; 42 USC 6A §300AA-26; CDC Recommendations; DHCS Contract; All Plan Letter 18-004; BPC §4000 et seq (Pharmacy Law); §4170; HSC §11000-11651 (Uniform Controlled Substances Act)					
1) There are no expired drugs on site.	1)	1)	1)	1	
2) Site has a procedure to check expiration date of all drugs (including vaccines and samples), and infant and therapeutic formulas.	2)	2)	2)	1	
3) All stored and dispensed prescription drugs are appropriately labeled.	3)	3)	3)	1	
4) **Only lawfully authorized persons dispense drugs to patients.**	**4)**	**4)**	**4)**	**2**	
5) **Drugs and Vaccines are prepared and drawn only prior to administration.**	**5)**	**5)**	**5)**	**2**	
6) Current Vaccine Information Sheets (VIS) for distribution to patients are present on site.	6)	6)	6)	1	
7) If there is a pharmacy on site, it is licensed by the CA State Board of Pharmacy.	7)	7)	7)	1	
8) Site utilizes California Immunization Registry (CAIR) or the most current version.	8)	8)	8)	1	

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

IV. Clinical Services: Laboratory Services Criteria	Yes	No	N/A	Wt.	Site Score
D. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations. 22 CCR §51211.2, §51137.2; BPC §1200-1214, §1229, §1220; 42 USC 263a; Public Law 100-578; www.cms.gov; www.fda.gov					
1) Laboratory test procedures are performed according to current site-specific CLIA certificate.	1)	1)	1)	1	
2) Testing personnel performing clinical lab procedures have been trained.	2)	2)	2)	1	
3) Lab supplies (e.g. vacutainers, vacutainer tubes, culture swabs, test solutions) are inaccessible to unauthorized persons.	3)	3)	3)	1	
4) Lab test supplies are not expired.	4)	4)	4)	1	
5) Site has a procedure to check expiration date and a method to dispose of expired lab test supplies.	5)	5)	5)	1	

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

IV. Clinical Services: Radiology Services Criteria	Yes	No	N/A	Wt.	Site Score
E. Site meets CDPH Radiological inspection and safety regulations. 17 CCR §30110, §30111, §30255, §30305, §30404, §30405; https://www.cdph.ca.gov/rhb or (916) 327-5106					
1) Site has current CA Radiologic Health Branch Inspection Report and Proof of Registration if there is radiological equipment on site.	1)	1)	1)	1	
The following documents are <u>posted</u> on site: 2) Current copy of Title 17 with a posted notice about availability of Title 17 and its location.	2)	2)	2)	1	
3) "Radiation Safety Operating Procedures" posted in highly visible location.	3)	3)	3)	1	
4) "Notice to Employees Poster" posted in highly visible location.	4)	4)	4)	1	
5) "Caution, X-ray" sign posted on or next to door of each room that has X-ray equipment.	5)	5)	5)	1	
6) Physician Supervisor/Operator certificate posted *and* within current expiration date.	6)	6)	6)	1	
7) Technologist certificate posted *and* within current expiration date.	7)	7)	7)	1	
The following radiological protective equipment is present on site: 8) Operator protection devices: radiological equipment operator must use lead apron or lead shield.	8)	8)	8)	1	
9) Gonadal shield (0.5 mm or greater lead equivalent): for patient procedures in which gonads are in direct beam.	9)	9)	9)	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **TOTALS**					

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

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

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

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VI. Infection Control Criteria	Yes	No	N/A	Wt.	Site Score
A. Infection control procedures for Standard/Universal precautions are followed. 8 CCR §5193; 22 CCR §53230; 29 CFR §1910.1030; Federal Register 1989, §54:23042					
1) Soap or antiseptic hand cleaner and running water are available in exam and/or treatment areas for hand washing.	1)	1)	1)	1	
2) A waste disposal container is available in exam rooms, procedure/treatment rooms, and restrooms.	2)	2)	2)	1	
3) Site has procedure for effectively isolating infectious patients with potential communicable conditions.	3)	3)	3)	1	
B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. 8 CCR §5193 (Cal OSHA Health Care Worker Needlestick Prevention Act, 1999); HSC, §117600-118360 (CA Medical Waste Management Act, 1997, updated January 2017); 29 CFR §1910.1030; 49 CCR §173.6; 49 CFR, Section 173.6; CDC Core Infection Prevention and Control Practices -Centers for Disease Control and Prevention (CDC) The Healthcare Infection Control Advisory Committee (HICPAC), 2016; 2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare settings.					
1) **Personal Protective Equipment (PPE) for Standard Precautions is readily available for staff use.**	**1)**	**1)**	**1)**	**2**	
2) Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport or shipping.	**2)**	**2)**	**2)**	**2**	
3) **Needlestick safety precautions are practiced on site.**	**3)**	**3)**	**3)**	**2**	
4) All sharp injury incidents are documented.	4)	4)	4)	1	
5) Biohazardous (non-sharp) wastes are contained separate from other trash/waste.	5)	5)	5)	1	
6) Storage areas for regulated medical wastes are maintained secure and inaccessible to unauthorized persons.	6)	6)	6)	1	
7) Contaminated laundry is laundered at the workplace or by a commercial laundry service.	7)	7)	7)	1	
8) 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).	8)	8)	8)	1	

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

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VI. Infection Control Criteria, continued	Yes	No	N/A	Wt.	Site Score
C. Contaminated surfaces are decontaminated according to Cal-OSHA Standards. 8 CCR §5193; HSC §118275					
1) Equipment and work surfaces are appropriately cleaned and decontaminated after contact with blood or other potentially infectious material.	1)	1)	1)	1	
2) Routine cleaning and decontamination of equipment/work surfaces is completed according to site-specific written schedule.	2)	2)	2)	1	
Disinfectant solutions used on site are: 3) Approved by the Environmental Protection Agency (EPA).	3)	3)	3)	1	
4) Effective in killing HIV/HBV/TB.	4)	4)	4)	1	
5) Follow manufacturer instructions.	5)	5)	5)	1	

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

RN/NP/CNM/LM/MD/PA only

VI. Infection Control Criteria, continued	Yes	No	N/A	Wt.	Site Score
D.Reusable medical instruments are properly sterilized after each use. 22 CCR §53230, §53856; CDC guideline for disinfection and sterilization; Food and Drug Administration: Reprocessing medical equipment in health care setting.					
1) Written site-specific policy/procedures or manufacturer's instructions for instrument/equipment sterilization are available to staff.	1)	1)	1)	1	
Staff adheres to site-specific policy and/or manufacturer/product label directions for the following procedures: 2) Cleaning reusable instruments/equipment prior to sterilization.	2)	2)	2)	1	
3) Cold chemical sterilization/high level disinfection: **a) Staff demonstrate/verbalize necessary steps/process to ensure sterility and/or high-level disinfection of equipment.**	**3a)**	**3a)**	**3a)**	**2**	
b) Confirmation from manufacturer item(s) is/are heat sensitive.	3b)	3b)	3b)	1	
c) Appropriate PPE is available, exposure control plan, Material Safety Data Sheets and clean up instructions in the event of a cold chemical sterilant spill.	**3c)**	**3c)**	**3c)**	**2**	
4) Autoclave/steam sterilization. a) Staff demonstrate/verbalize necessary steps/process to ensure sterility.	4a)	4a)	4a)	1	
b) Autoclave maintenance per manufacturer's guidelines.	4b)	4b)	4b)	1	
c) **Spore testing of autoclave/steam sterilizer with documented results (at least monthly).**	**4c)**	**4c)**	**4c)**	**2**	
d) **Management of positive mechanical, chemical, and biological indicators of the sterilization process.**	**4d)**	**4d)**	**4d)**	**2**	
e) Sterilized packages are labeled with sterilization date and load identification information.	4e)	4e)	4e)	1	
f) Storage of sterilized packages.	4f)	4f)	4f)	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **TOTALS**					

Primary Care Provider-Medical Record Review Standards

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

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

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

Example for determining the number of medical records to review:

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

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

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

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

The minimum passing score is 80%. A corrective action plan (CAP) is required for a total MRR score below 90%. Also, any section score of less than 80% requires a CAP for the entire MRR, regardless of the total MRR score.

Directions: Score one point if criterion is met. . Score ”R” for documented member refusal, Provider outreach, referral or member non-compliance*. Score zero points if criterion is not met. Not Applicable (N/A) applies to any criterion that does not apply to the medical record being reviewed and must be explained in the comment section. Do not score partial points for any criterion.

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

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

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

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

If 10 shared records are reviewed, score calculation shall be the same as for 10 records reviewed for a single PCP.
If 20 records are reviewed, divide total points given by the “adjusted” total points possible.
If 30 records are reviewed, divide total points given by the “adjusted” total points possible.
Multiply by 100 to calculate percentage rate.

Reviewers have the option to request additional records to review but must calculate scores accordingly.

Scoring Example:

Step 1: Add the points given in each section.
Step 2: Add the points given (Yes + R) for all six sections.
(Format points given)
(Documentation points given)
(Coordination of Care points given)
(Pediatric Preventive points given)
(Adult Preventive points given)
+ (OB/CPSP Preventive points given)
= (Total points given)

Step 3: Subtract the “N/A” points from total points possible.
(Total points possible)
– (N/A points)
= (“Adjusted” total points possible)

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

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

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

I. Format Criteria	
An individual medical record is established for each member.	Practitioners are able to readily identify each individual treated. A medical record is started upon the initial visit.[1] "Family charts" are not acceptable.
A. Member identification is on each Page.	• Member identification includes first and last name, and a unique identifier established for use on clinical site. • Electronically maintained records and printed records from electronic systems must contain member identification.
B. Individual personal biographical information is documented.	Personal biographical information includes: ○ Date of birth ○ Current address ○ Home/work phone numbers ○ Name of parent(s)/legal guardian if member is a minor If member refused to provide information, "refused" is documented in the medical record. Do not deduct points if member has refused to provide all personal information requested by the practitioner.
C. Emergency "contact" is identified.	The name and phone number of an "emergency contact" person is identified for all members. Listed emergency contacts may include: ○ Spouse, relative or friend, and must include at least one of the following: ○ Home, work, pager, cellular, or message phone number. • If the member is a minor, the primary (first) emergency contact person must be a parent or legal guardian and then other persons may be listed as additional emergency contacts. • Adults and emancipated minors may list anyone of their choosing. • If a member refuses to provide an emergency contact, "refused" is noted in the record. Do not deduct points if member has refused to provide personal information requested by the practitioner.

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

I. Format Criteria	
	• Next of kin category is not considered as an emergency contact. The member's emergency contact may be different from the next of kin.
D. Medical records are maintained and organized	• Contents and format of printed and/or electronic records within the practice site are uniformly organized, securely fastened, attached or bound to prevent medical record loss. • Hard copy printed documents shall belong to the medical record established for each member (e.g., reusing the blank side of printed documents from another member is not acceptable and should be scored a "0"). • Medical Record information should be readily available.
E. Member's assigned and/or rendering PCP is identified.	• The assigned and/or rendering PCP is ***always*** identified when there is more than one PCP on site and/or when the member has selected health care from a non-physician medical practitioner. • Various methods can be used to identify the assigned PCP, reviewers must identify specific method(s) used at each individual site such as Health Plan ID Card, practitioner stamp, etc. • If there is only one PCP/Practitioner onsite and is not identified, reviewer may score "N/A".
F. Primary language and linguistic service needs of non-or of limited-English proficiency (LEP) or hearing/speech-impaired persons are prominently noted.	• The primary language is prominently documented at least once in the medical record. • Language documentation is not necessary, score "N/A," if English is the primary language. However, if "English" is documented, the point may be given. **Note:** Title VI of the Civil Rights Act of 1964 prohibits recipients of federal funds from providing services to LEP persons that are limited in scope or lower in quality than those provided to others. Since Medi-Cal is partially funded by federal funds, ***all*** Plans with Medi-Cal LEP members must ensure that these members have equal access to all health care services.[2]

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

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

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

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

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

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II. Documentation Criteria	
A. Allergies are prominently noted.	• Allergies and adverse reactions are listed in a prominent, easily identified, and consistent location in the medical record. • If member has no allergies or adverse reactions, "No Known Allergies" (NKA), "No known Drug Allergies" (NKDA), or ∅ is documented.[4]
B. Chronic problems and/or significant conditions are listed.	• Documentation may be on a separate "problem list," or a clearly identifiable problem list in the progress notes. • All chronic or significant problems are considered current if no "end date" is documented. **Note:** Chronic conditions are current long-term, on-going conditions with slow or little progress.[5]
C. Current continuous medications are listed.	• Documentation may be on a separate "medication list," or a clearly identifiable medication list in the progress notes. • List of current, on-going medications identifies the medication name, strength, dosage, route (if other than oral), and frequency. • Discontinued medications are noted on the medication list or in progress notes.[6]
D. Appropriate Consents are present.	1) Consent must be obtained prior to release of patient information.[7] 2) Adults, parents/legal guardians of a minor or emancipated minor may sign consent forms for operative and invasive procedures.[8] Persons under 18 years

[4] 22 CCR 70527 and 28 CCR 1300.80
[5] 22 CCR 70527 and 28 CCR 1300.80
[6] 22 CCR 70527 and 28 CCR 1300.80
[7] 22 CCR 73524, 22 CCR 51009, and Title 45, Code of Federal Regulations Section 164.524. The CFR is searchable at: https://www.ecfr.gov.
[8] An invasive procedure is a medical procedure that invades (enters) the body, usually by cutting or puncturing the skin or by inserting instruments into the body. Very minor procedures such as drawing blood testing, umbilical cord blood donations and a few other very specific

II. Documentation Criteria	
	of age are emancipated if they have entered into a valid marriage, are on military active duty, or have received a court declaration of emancipation under the CA Family Code, Section 7122.[9] **Note:** Human sterilization requires the Department of Health Care Services (DHCS) Consent Form PM 330 if services are performed at the site.
E. Advance Health Care Directive information is offered. (Adults 18 years of age or older; emancipated minors).	• Adult medical records include documentation of whether the member has been *offered* information or has executed an Advance Health Care Directive.[10] The Physician Orders for Life-Sustaining Treatment (POLST) form and Five Wishes are acceptable if appropriately completed and signed by necessary parties.[11] **Note:** Advance Health Care Directive Information is reviewed with the member at least every 5 years and as appropriate to the member's circumstance.
F. All entries are signed, dated and legible.	**Signature** includes: • First initial, last name, and title of health care personnel providing care, including Medical Assistants. • Initials and titles may be used only if signatures are specifically identified elsewhere in the medical record (e.g. signature page). • Stamped signatures are acceptable, but must be authenticated, meaning the stamped signature can be verified, validated, confirmed, and is countersigned or initialed. **Dated entries** include: • Month/day/year. • Entries are in reasonably consecutive order by date.

tests are not considered invasive and do not require a consent. Consent is implied by entering the provider's office or lab and allowing blood to be drawn. (Ref: National Institutes of Health; American Cancer Society)

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

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

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

II. Documentation Criteria	
	• Handwritten documentation does not contain skipped lines or empty spaces where information can be added. Entries are not backdated or inserted into spaces above previous entries. • Omissions are charted as a new entry. • Late entries are explained in the medical record, signed and dated. **Legibility** means the record entry is readable by a person other than the writer. Handwritten documentation, signatures, and initials are entered in ink that can be readily/clearly copied. Only standard abbreviations are used. All medical record documentation must be in English.[12] **Note:** • In EMR, methods to document signatures (and/or authenticate initials) will vary and must be individually evaluated. • Signature page may be in the member's medical record or available elsewhere onsite and all previous and current employees who document in medical records need to be included on the signature page. • Reviewers should assess the log-in process and may need to request printouts of entries. See the Centers for Medicare and Medicaid Services' (CMS) Guidance on Medicaid Documentation for Medical Office Staff, available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-officestaff-factsheet.pdf.
G. Errors are corrected according to legal medical documentation standards.	• The person that makes the documentation error corrects the error. Example correction methods: • Single line drawn through the error, with the writer's initial and date written above or near the lined-through entry. • Single line and initial.

[12] ACA Section 1557

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

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

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III. Coordination Criteria	
A. History of present illness or reason for visit is documented.	Each focused visit (e.g., primary care, follow-up ER/urgent care, hospital discharge, etc.) includes a documented history of present illness or reason for visit.
B. Working diagnoses are consistent with findings.	Each visit has a documented "working" diagnosis/impression derived from a physical exam, and/or "Subjective" information such as chief complaint or reason for the visit as stated by member/parent. The documented "Objective" information (such as assessment, findings and conclusion) relate to the working diagnoses. **Note:** For scoring purposes, reviewers shall ***not make determinations*** about the "*rightfulness or wrongfulness"* of documented information but shall initiate the peer review process or internal investigation per health plan policy as appropriate.
C. Treatment plans are consistent with diagnoses.	A plan of treatment, care and/or education related to the stated diagnosis is documented for each diagnosis. **Note:** For scoring purposes, reviewers shall ***not make determinations*** about the "*rightfulness or wrongfulness"* of treatment rendered or care plan but shall initiate the peer review process or internal investigation per health plan policy as appropriate.
D. Instruction for follow-up care is documented.	• Specific follow-up instructions and a definite time for return visit or other follow-up care is documented. • Time period for return visits or other follow-up care is definitively stated in number of days, weeks, months, or PRN (as needed). • Every visit with the provider shall have follow-up instructions.
E. Unresolved continuing problems are addressed in subsequent visit(s).	• Previous complaints and unresolved or chronic problems are addressed in subsequent notes until problems are resolved or a diagnosis is made.

III. Coordination Criteria	
	• Each problem need not be addressed at every visit as long as the provider documents a reason for deferring the unresolved problem(s) for subsequent visits. • Documentation demonstrates that the practitioner follows up with members about treatment regimens, recommendations, and counseling.
F. There is evidence of practitioner review of specialty/consult/referral reports and diagnostic test results.	• There is documented evidence of practitioner review of records such as diagnostic studies, lab tests, X-ray reports, consultation summaries, inpatient/discharge records, emergency and urgent care reports, and all abnormal and/or "STAT" reports. • Evidence of review may include the practitioner's initials or signature on the report, notation in the progress notes, or other site-specific method of documenting practitioner review. **Note:** Electronically maintained medical reports must also show evidence of practitioner review and may differ from site to site. Evidence of practitioner review on any page of the report(s) or diagnostic result(s) that have multiple pages is acceptable.
G. There is evidence of follow-up of specialty/consult/referrals made, and results/reports of diagnostic tests, when appropriate.	Documentation includes: • Consultation reports and diagnostic test results for ordered requests. • Abnormal test results/diagnostic reports have explicit notation in the medical record or separate system, including attempts to contact the member/guardian, follow-up treatment, instructions, return office visits, referrals and/or other pertinent information. • Missed/broken appointments for diagnostic procedures, lab tests, specialty appointments and/or other referrals are noted, and include attempts to contact the member/parent and results of follow-up actions. If diagnostic appointments or referrals are documented in a separate system from medical records, they must be readily accessible and meet the medical retention requirements. **Note:**

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

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

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IV. Pediatric Preventive Criteria	
A. Initial Health Appointment (IHA) includes H&P and Risk Assessment	**New Members** IHA must be completed within 120 days of plan enrollment or PCP effective date (whichever is more recent) or documented within the 12 months prior to Plan enrollment/PCP effective date. The IHA include a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases. A complete IHA enables the PCP to assess current acute, chronic, and preventive needs and to identify those Members whose health needs require coordinated services with appropriate community resources/other agencies not covered by the Plan. References: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-030.pdf or current version
1) Comprehensive History and Physical	**New members** The history must be comprehensive to assess and diagnose acute and chronic conditions it includes: ○ History of present illness ○ Past medical history ○ Social history ○ Review of Organ Systems (ROS) If an H&P is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented.

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

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

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

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

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

<table>
<tr><th colspan="2">IV. Pediatric Preventive Criteria</th></tr>
<tr><td></td><td>When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use is present. Validated assessment tools may be used without first using validated screening tools. The AAP recommended assessment tool is available at: http://crafft.org.

Brief Interventions and Referral to Treatment
When brief assessments reveal unhealthy alcohol use, brief misuse counseling with appropriate referral for additional evaluation and treatment options, referrals, or services must be offered.

Brief interventions must include the following:
• Providing feedback to the patient regarding screening and assessment results;
• Discussing negative consequences that have occurred and the overall severity of the problem;
• Supporting the patient in making behavioral changes; and
• Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated.

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

For details on Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment, refer to APL 21-014 or any superseding APL.

Please refer to the link below to The Medi-Cal Provider Manual: https://www.dhcs.ca.gov/formsandpubs/publications/Pages/Manuals.aspx</td></tr>
<tr><td>2) Anemia Screening</td><td>Per AAP, perform risk assessment or screening at 4, 15, 18, 24, and 30 months, 3 years old, and then annually thereafter. Test serum hemoglobin at 12 months old. If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s).

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

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

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

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

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

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<tr><td></td><td>Spanish version:
https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/CDPH%20Document%20Library/CLPPB-antguid(S).pdf.

Order or perform blood lead screening tests on all child members in accordance with the following:
• At 12 months and at 24 months of age.
• When the network provider performing a PHA becomes aware that a child member who is 12 to 24 months of age has no documented evidence of a blood lead screening test taken at 12 months of age or thereafter.
• When the network provider performing a PHA becomes aware that a child member who is 24 to 72 months of age has no documented evidence of a blood lead screening test taken.
• At any time, a change in circumstances has, in the professional judgement of the network provider, put the child member at risk.
• If requested by the parent or guardian.

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

<u>Note</u>: Network providers are not required to perform a blood lead screening test if either of the following applies:
• In the professional judgment of the network provider, the risk of screening poses a greater risk to the child member’s health than the risk of lead poisoning.
• If a parent, guardian, or other person with legal authority to withhold consent for the child refuses to consent to the screening.

Evidence of provider compliance of blood lead screening test if not performed:
• The provider must document the reason(s) for not performing the blood lead screening test in the child member’s medical record.
• In cases where consent has been withheld, the provider must obtain a signed statement of voluntary refusal by parent or guardian.</td></tr>
</table>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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14) Hearing Screening	Per AAP audiometric screenings are performed at: ○ Birth to 2 months old, 4, 5, 8, and 10 years old ○ Once between 11-14 years old ○ Once between 15-17 years old ○ Once between 18-21 years old Per AAP, clinicians must confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs", available at: http://pediatrics.aappublications.org/content/120/4/898.full. A failed audiometric screening is followed-up with a repeat screening at least two weeks and no later than 6 weeks after the initial screening. If the second screening also fails, the primary care provider must make a referral to a specialist. • Non-audiometric assessments shall be performed at each health assessment visit until the child reaches 21 years old and includes an assessment of birth/family history (hearing loss in the family), history of ear infection and the signs and symptoms of hearing loss (i.e. does not startle at loud noises, does not turn to the source of a sound after 6 months of age, speech is delayed and unclear, often says, "Huh?", turns the TV volume up too high, etc.). • Audiometric testing is performed using a newborn hearing screening test (e.g. Automated Auditory Brainstem Response [AABR] or Otoacoustic Emission [OAE] technology) at the birth hospital or specialty facility; or a Behavioral Audiometry Evaluation with an audiometer at the primary care facility starting at 4 years old and includes follow-up care as appropriate. See the AAP periodicity schedule, available at: www.aap.org/periodicityschedule. See the CDC recommendations and guidelines on Hearing Loss in Children, available at: https://www.cdc.gov/ncbddd/hearingloss/recommendations.html. See the CDC guidance on Hearing Screenings for Children, available at: https://www.cdc.gov/ncbddd/hearingloss/screening.html.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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	• Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveals positive risk factors for TB. • Two tests that are used to detect TB bacteria in the body: the TB skin test (TST) (Mantoux) and TB blood tests QuantiFERON-TB Gold Plus. A positive TB skin test or TB blood test only tells that a person has been infected with TB bacteria. TB infection screening test is administered to children *identified at risk,* if there has not been a test in the previous year. The Mantoux is not given if a previously positive Mantoux is documented. Documentation of a positive test includes follow-up care (e.g. further medical evaluation, chest x-ray, diagnostic laboratory studies and/or referral to specialist). • Providers are required to follow current CDC and American Thoracic Society guidelines for TB diagnosis and treatment. The California Pediatric Tuberculosis Risk Assessment tool is available at: https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-Pediatric-TB-Risk-Assessment.pdf. CDC guidance on TB testing and diagnosis is available at: https://www.cdc.gov/tb/topic/testing/default.htm.
23) Vision Screening	• Age-appropriate visual screening occurs at each health assessment visit, with referral to optometrist/ophthalmologist as appropriate. • Per AAP, visual acuity screenings using optotypes (figures or letters of different sizes used for vision screening) are to be performed at ages 3 (if cooperative), 4, 5, 6, 8, 10, 12, and 15 years old. • Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. • Documentation of “PERRLA” is acceptable for children below the age of 3 years. • If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s). • AAP recommended eye charts are: ○ LEA Symbols (3-5 years old)

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	○ HOTV Chart (3-5 years old) ○ Sloan Letters (preferred) or Snellen Letters (over 5 years old) See the AAP publications titled "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" available at: http://pediatrics.aappublications.org/content/137/1/e20153596 and "Procedures for the Evaluation of the Visual System by Pediatricians", available at: http://pediatrics.aappublications.org/content/137/1/e20153597. **Note:** Although specific screening details are not generally documented in the medical record, screening for infants and children (birth to 3 years) may consist of evaluations Such as external eye inspection, ophthalmoscopy red reflex examination, or corneal penlight evaluation. Visual acuity screening usually begins at age 3 years. AAP guidance on Visual System Assessment in Infants, Children, and Young Adults by Pediatricians is available at: https://pediatrics.aappublications.org/content/137/1/e20153596.
D) Childhood Immunizations	Every visit should be an opportunity to update and complete a child's immunizations. Childhood Immunizations Schedules, per the AAP Committee on Infectious Diseases, are available at: https://redbook.solutions.aap.org/SS/immunization_Schedules.aspx. For reference, see the CDC's ACIP webpage, available at: https://www.cdc.gov/vaccines/acip/index.html, also see APL 18-004, Immunization Requirements, or any superseding APL For details on Immunization Requirements.
1) Given according to ACIP guidelines	Immunization status is assessed at each health assessment visit. Practitioners are required to ensure the provision of immunizations according to CDC's most recent ACIP guidelines, unless medically contraindicated, vaccine shortage or refused by the parent. Refer to the following link for more information on ACIP Vaccine Recommendations and Guidelines: https://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

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

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

RN/NP/MD/PA/CNM/LM

V. Adult Preventive Criteria	
A. Initial Health Appointment (IHA): Includes H&P and Risk Assessment	**New Members** IHA must be completed within 120 days of plan enrollment or PCP effective date (whichever is more recent) or documented within the 12 months prior to Plan enrollment/PCP effective date. The IHA include a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases. https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-030.pdf or current version
1) Comprehensive History and Physical	**New members**: The history must be comprehensive to assess and diagnose acute and chronic conditions it includes: o History of present illness o Past medical history o Social history o Review of Organ Systems (ROS) including dental assessment Referrals for any abnormal findings must be documented. If an H&P is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented. A review of the organ systems that include documentation of "inspection of the mouth" or "seeing dentist" meets the criteria for dental assessment during a comprehensive history and physical.
	New members:

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

V. Adult Preventive Criteria	
	https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-025.pdf https://mini-cog.com/wp-content/uploads/2022/03/Standardized-English-Mini-Cog-1-19-16-EN_v1-low-1.pdf https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-009.pdf https://www.cdc.gov/about/sdoh/index.html https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-025.pdf https://www.alz.org/media/documents/gpcog-screening-test-english.pdf
B. Periodic Health Evaluation according to most recent USPSTF guidelines	The type, quantity, and frequency of preventive services is based on the most recent USPSTF recommendations.
1) Comprehensive History and Physical Exam completed at age-appropriate frequency.	• Periodic health evaluations occur in accordance with the frequency that is appropriate for individual risk factors. • In addition to USPSTF recommendations, periodic health evaluations are scheduled as indicated by the member's needs and according to the clinical judgment of the practitioner. Example: A patient with elevated cholesterol levels and other risk factors for coronary heart disease (CHD) may be evaluated more frequently than other persons of the same age without similar risk factors.
2) Subsequent Risk Assessment	• Risk Assessment including social, cultural and health education needs, is completed by the member or parent/guardian must be completed annually or any significant change of health status. An assessment of at least one (1) of the above risk assessment domains (HRA, SDOH, CHA and ACEs) meets the standard. •https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Program-Guide-a11y.pdf •https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf • https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-030.pdf or current version

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

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

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

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

V. Adult Preventive Criteria	
	• The service provided, for example: screen and brief intervention. • The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record). • The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record). • If and where a referral to an alcohol or substance use disorder program was made. A recommended substance abuse assessment tool is available at http://crafft.org. Please refer to the following link to The Medi-Cal Provider Manual: https://www.dhcs.ca.gov/formsandpubs/publications/Pages/Manuals.aspx.
3) Breast Cancer Screening	A routine screening mammography for breast cancer is completed every 1-2 years on all women starting at age 50, concluding at age 75 unless pathology has been demonstrated.[28]
4) Cervical Cancer Screening	• Screen for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years. • Women ages 30 to 65 years who want to lengthen the screening interval, screen with a combination of cytology and human papillomavirus (HPV) co-testing every 5 years OR with high-risk human papillomavirus (hrHPV) testing alone every 5 years. • Follow-up of abnormal test results are documented. Routine Pap testing may not be required for the following: • Women who have undergone hysterectomy in which the cervix is removed (TAH - Total Abdominal Hysterectomy), unless the hysterectomy was performed because of invasive cancer. • Women 66 years and older who have had regular previous screening in which the Pap result have been consistently normal.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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	See the USPSTF Grade A and B Recommendations, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations
13) High Blood Pressure Screening	• All adults including those without known hypertension are screened. • A blood pressure (B/P) measurement for the normotensive adult is documented at least once every 2 years if the last systolic reading was below 120 mmHg and the diastolic reading was below 80 mmHg. • B/P is measured annually if the last systolic reading was 120 to 139 mmHg and the diastolic reading was 80 to 89 mmHg. See the USPSTF Grade A and B Recommendation, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hypertension-in-adults-screening.
14) HIV Screening	USPSTF recommends risk assessment shall be completed at each well visit for patients 65 years old and younger: • Those at high risk (regardless of age) i.e., having intercourse without a condom or with more than one sexual partner whose HIV status is unknown. • IV drug users. • MSM. All shall be tested for HIV and offered pre-exposure prophylaxis (PrEP). [30] Lab results are documented. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening
	• Per the USPSTF, clinicians shall screen for Intimate Partner Violence (IPV) on asymptomatic women of reproductive age, which is defined across studies as

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

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

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

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

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

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

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

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

	• The Mantoux skin test, or other approved TB infection screening test,[34] is administered to all asymptomatic persons at increased risk of developing TB irrespective of age or periodicity if they had not had a test in the previous year. • Adults already known to have HIV or who are significantly immunosuppressed require annual TB testing. The Mantoux is not given if a previously positive Mantoux is documented. Documentation of a positive test includes follow-up care, for example: ○ Further medical evaluation ○ Chest x-ray ○ Diagnostic laboratory studies ○ Referral to specialist Practitioners are required to follow current CDC and American Thoracic Society guidelines for TB diagnosis and treatment. See the CDPH guidance on California Adult TB Risk Assessment, available at: https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-TB-Risk-Assessment-and-Fact-Sheet.pdf. See the USPSTF recommendation on Latent TB Infection Screening, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/latent-tuberculosis-infection-screening. See the CDC publications on TB, available at: www.cdc.gov/tb/publications//.
D) Adult Immunizations	

[34] Per June 25, 2010, CDC MMWR, the FDA approved IGRA serum TB tests, such as QuantiFERON®-TB Gold (QFT-G and QFT-GIT) and T-SPOT®.TB (T-Spot).

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

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

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

RN/NP/MD/PA/CNM/LM

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VI. OB/CPSP Preventive Criteria	
5) Preeclampsia Screening	USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.[56]
a) Low Dose Aspirin	The Provider should advise on the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.[57]
6) Intimate Partner Violence Screening	• USPSTF recommends that clinicians screen for IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services.[58] • Provision of a Domestic Violence Screening is documented. • Assessment checklists, body diagrams and/or documentation in progress notes are acceptable. Domestic violence screening includes: • Medical screening. • Documentation of physical injuries or illnesses attributable to spousal/partner abuse. • Referral to appropriate community service agencies.[59]

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

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

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

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

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

[61] HSC 123640

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

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

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

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

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

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

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

VI. OB/CPSP Preventive Criteria	
	• Tdap is recommended only in the immediate postpartum period before discharge from the hospital or birthing center for new mothers who have never received Tdap before or whose vaccination status is unknown. • Practitioners are required to ensure the provision of immunizations according to CDC's most recent ACIP guidelines, unless medically contraindicated or refused by the member. See the CDC's ACIP recommendations on Routine Vaccination of Infants, Children, Adolescents, Pregnant Women, and Adults, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/preeclampsia-screening1. See the CDC's ACIP guidelines on vaccines, available at: https://www.cdc.gov/vaccines/hcp/acip-recs/index.html. Please note-the administration of pertussis is eligible for the Valued Based Payment (VBP) program. Please consult with the MCP for details.
E. Prenatal care visit periodicity according to most recent ACOG Standards	ACOG's *Guidelines for Perinatal Care* recommend the following prenatal schedule for a 40-week uncomplicated pregnancy: 1) First visit by 6-8th week 2) Approximately every 4 weeks for the first 28 weeks of pregnancy 3) Every 2-3 weeks until 36 weeks gestation 4) Weekly thereafter until delivery If the recommended ACOG schedule is not met, documentation shows missed appointments, attempts to contact member and/or outreach activities. Refer the following link to ACOG for further details: https://www.acog.org/clinical
F. Influenza Vaccine	CDC and ACIP recommend that pregnant women gets vaccinated during any trimester of their pregnancy. Refer to the following link for further information on vaccination schedules:

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

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

VI. OB/CPSP Preventive Criteria	
	Note: Although WIC determines eligibility for program participation, nearly all Medi-Cal beneficiaries are income eligible for WIC. Federal regulations specify that pregnant and breastfeeding women are given the highest priority for WIC Program enrollment.
I. HIV-related services *offered*	Per ACOG, repeat testing in the third trimester is recommended for women known to be at high risk of acquiring HIV infection, and women who declined testing earlier in pregnancy. • The ***offering*** of prenatal HIV information, counseling, and HIV antibody testing is documented.[74] • Practitioners are ***not required*** to document that the HIV test was given or disclose (except to the member) the results (positive or negative) of an HIV test. • Offering a prenatal HIV test is not required if a positive HIV test is already documented in the patient's record or if the patient has AIDS diagnosed by a physician. See the ACOG Guidelines for Perinatal Care, available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx. See the CDC STI Screening Recommendations, available at: https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm. See the ACOG guidance on Prenatal and Perinatal HIV Testing, available at: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Prenatal-and-Perinatal-Human-Immunodeficiency-Virus-Testing?IsMobileSet=false. See the USPSTF recommendation on HIV Screening, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening.

[74] HSC 125107

VI. OB/CPSP Preventive Criteria	
J. AFP/Genetic Screening *offered*	The offering of blood screening tests prior to 20 weeks gestation counting from the first day of the last normal menstrual period is documented.[75] Genetic screening documentation includes: • Family history • Triple marker screening tests: Alpha Fetoprotein (AF), unconjugated estriol (UE), human chorionic gonadotropin (HCG) • Member's consent or refusal to participate For information on the Alpha-Fetoprotein Test, see: https://americanpregnancy.org/prenatal-testing/alpha-fetoprotein-test **Note:** Member's participation is voluntary. Testing occurs through CDPH Expanded AFP Program, and only laboratories designated by CDPH may be used for testing.
K. Family Planning Evaluation	• Women should be counseled about the risks and benefits of repeat pregnancy sooner than 18 months which have been associated with adverse perinatal outcomes, including preterm birth, low birth weight, and small size of gestational age, as well as adverse maternal outcomes. • All postpartum women can be considered at risk for unintended pregnancy for that period of time. Family Planning counseling, including counseling of interpregnancy intervals, contraceptive care, referral or provision of services is documented.[76] Prenatal discussions should include the woman's reproductive life plans, including the desire for and timing of any future pregnancies. See the HHS guidance on Contraceptive Care Measures, available at: https://opa.hhs.gov/research-evaluation/title-x-services-research/contraceptive-care-measures

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Primary Care Provider-Medical Record Review Tool

Health Plan: _____

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

Address: _____

City and Zip Code: _____

Phone: _____ **Fax:** _____

Review Date: _____

Reviewer name/title: _____

Reviewer name/title: _____

Reviewer name/title: _____

Reviewer name/title: _____

Collaborating MCP(s): 1. _____

2. _____

No. of Physicians: _____

Contact person/title: _____

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

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

Medical Record Review: Onsite _____ Remote Access _____

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

Number of Records Reviewed: _____

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

Medical Record Scores

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

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

Scoring Procedure

Scoring is based on <u>10</u> medical records.

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

_____ ÷ _____ = _____ x 100 = _____%

Points Given | Total/ Adjusted Pts. Poss. | Decimal Score | Compliance Rate

Note:
Since Preventive Criteria have different points possible per type (Ped-34, Adult-30, OB/CPSP-59, the <u>total points possible</u> will differ from site to site, depending on the number of *types* of records that are selected. The "No's" column *may* be used to help double-check math. The far-right Section Score % column may be used to determine if section is <80%.

Compliance Rate

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

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

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

____ **Fail: 79% and Below**

____ CAP Required

____ Other follow-up

Next Review Due: _____

Medical Records Reference:

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

* Whichever is more recent

I. Format Criteria

RN/NP/MD/PA/CNM/LM

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

II. Documentation Criteria

RN/NP/MD/PA/CNM/LM

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

III. Coordination of Care Criteria

RN/NP/MD/PA/CNM/LM

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

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

RN/NP/MD/PA/CNM/LM

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

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

RN/NP/MD/PA/CNM/LM

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

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

RN/NP/MD/PA/CNM/LM

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

V. Adult Preventive Criteria

RN/NP/MD/PA/CNM/LM

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

V. Adult Preventive Criteria

RN/NP/MD/PA/CNM/LM

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

V. Adult Preventive Criteria

RN/NP/MD/PA/CNM/LM

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

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

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

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

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

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

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

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

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

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

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

blue california
Promise Health Plan
3840 Kilroy Airport Way
Long Beach, CA 90806

MEDI-CAL COLLABORATIVE HEALTH PLANS
POST SITE REVIEW SATISFACTION SURVEY

To continually enhance the Health Plan Facility, Medical Record, and Physical Accessibility review process(es), we would appreciate your responses on the survey below. Please mark those responses that best indicate your level of satisfaction with today's review. Confidentiality of this survey will be maintained; only the aggregate report will be provided to the health plan and involved associates. Please return this survey by e-mail to:

Blue Shield of California Promise Health Plan
Jesse Brennan-Cooke, Sr. Manager – Clinical Access Programs
Email: Jesse.Brennan-Cooke@blueshieldca.com

Date: _____ DHCS ID: _____

County	Reviewer	Review Type
☐ Los Angeles ☐ San Diego	☐ Angela Pacada Ubiadas, RN, DHCS-CMT ☐ Jane Verde, RN, DHCS-CSR ☐ Lini Teal, RN, DHCS-CSR ☐ Marlyn Enguerra, RN, DHCS-CSR ☐ Erick Enriquez ☐ Moises Ayala ☐ Ruben Diaz	☐ FSR ☐ MRR ☐ PARS ☐ Interim ☐ Focus ☐ Monitoring ☐ PQI ☐ HDO ☐ Other

Please indicate (X) your level of agreement with the following statements	Strongly Agree	Agree	Somewhat Agree	Disagree	Strongly Disagree
The Auditor					
The reviewer arrived on time					
The reviewer was courteous					
The reviewer was able to answer questions					
The reviewer asked for your input to ensure review responses were accurate					
The Audit					
Our office received information explaining what to expect and what the office needed to prepare for the review					
The review was conducted efficiently					
During the review exit conference, the reviewer and I discussed the review results and corrective action requirements with the designated staff and/or Physician					
The Process					
Our office was provided sufficient information to complete the corrective actions					
The review process has been improved by the Health Plan collaboration					

Comments: _____

Provider Name (Optional): _____ Please contact me ☐

PCP SITE IDENTIFICATION FORM

Facility Name: **DHCS Site ID#:**
Address: **Site NPI:**
Site Email Address:
IPA Name(s) for Medi-Cal Managed Care Programs:

Telephone: **Fax:**
Office/Business Hours: Monday Tuesday Wednesday
Thursday Friday Saturday Sunday
Site Contact Person: **Contact Person Email Address:**
Contact Person Phone #: **FSR Review Date:** **Time:**
MRR Review Date: **Time:**

PHYSICIAN PROVIDER INFORMATION (please list additional providers on a separate form)

Name	License #	Provider NPI #	PCP and/or Specialty Type	Specific Days and Hours at this Site	Hospital Privileges			Contracted Plan Partner(s):
					Yes	No	Hospital	
			Board Cert? ☐ Yes ☐ No					☐ ABC ☐ BSP ☐ CM ☐ HNet ☐ LAC ☐ MHC
			Board Cert? ☐ Yes ☐ No					☐ ABC ☐ BSP ☐ CM ☐ HNet ☐ LAC ☐ MHC
			Board Cert? ☐ Yes ☐ No					☐ ABC ☐ BSP ☐ CM ☐ HNet ☐ LAC ☐ MHC
			Board Cert? ☐ Yes ☐ No					☐ ABC ☐ BSP ☐ CM ☐ HNet ☐ LAC ☐ MHC
			Board Cert? ☐ Yes ☐ No					☐ ABC ☐ BSP ☐ CM ☐ HNet ☐ LAC ☐ MHC
			Board Cert? ☐ Yes ☐ No					☐ ABC ☐ BSP ☐ CM ☐ HNet ☐ LAC ☐ MHC

NON-PHYSICIAN (NP, PA, CNM) PROVIDER INFORMATION (please list additional providers on a separate form)

Name	Provider Type	License #	Supervising Physician/License:	Specific Days and Hours at this Site

OTHER BACK OFFICE STAFF:
# of RNs _____ # of LVNs _____ # of MAs _____ # of Other: _____
Title(s) of Other Staff: _____

LANGUAGE CAPABILITIES: List the language skills of on-site staff in addition to English

Physician(s) _____

Other staff _____

AGE OF POPULATION CARED FOR: AGES _____ TO _____

Percentage of population below 21 years of age: _____%

SECURITY OF MEDICAL RECORDS:

Name of the individual responsible for securing and maintaining the security of Medical Records:

_____

If using Electronic Medical Records (EMR), add name of the EMR: _____

PLEASE READ CAREFULLY BEFORE SIGNING

SHARED PRACTICE ATTESTATION

The Department of Health Care Services (DHCS) Policy Letter 14-004 defines the documentation of patient care by all Primary Care Physicians (PCP) on site that occurs in universally shared medical records as a "shared" medical record practice. A shared medical record practice occurs when multiple PCPs see the same patients and use the same medical records for documentation of patient care. Shared medical records are not identified as separate records belonging to any specific PCP. Medical record review scores calculated on shared medical records apply to each PCP listed on the previous page.

Is this site a shared medical record practice? ☐ Yes ☐ No
Are there aspects of the medical record practice that is not shared by all PCPs on site (i.e. provider specialties, member age restrictions with certain PCPs, etc.)? ☐ Yes ☐ No ☐ N/A (please comment below)
Comments: _____
_____
_____

The collaborating Medi-Cal Managed Care and CMC Health Plans define the mutual and routine use of site personnel, office policies & procedures, facilities, equipment and other aspects of the clinic to complete daily activities and patient care in this physical address location as a "shared" site practice. Facility site review scores calculated on a shared site practice apply to each PCP listed on the previous page.

Is this a shared site practice? ☐ Yes ☐ No
Are there aspects of the site that is not shared by all PCPs on site (i.e. equipment, exam rooms, personnel, etc.)? ☐ Yes ☐ No ☐ N/A (please comment below)
Comments: _____
_____

I hereby certify, under the penalty of perjury, that all statements made on this form are true and complete:

Provider/Designee Name (please print): _____ Job Title: _____

Signature: _____ Date: _____

FACILITY SITE REVIEW NOTIFICATION REQUEST: If Facility Site Review scores need to be forwarded to an additional person, please provide the following information:

Name/Title: _____

Name of Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

SITE REVIEWER'S Signature: _____

PCP SITE IDENTIFICATION FORM

Facility Name:		**DHCS Site ID#:**	
Address:		**Site NPI:**	
Site Email Address:			
IPA Name(s) for Medi-Cal Managed Care Programs:			
Telephone:		**Fax:**	
Office/Business Hours:	Monday	Tuesday	Wednesday
Thursday	Friday	Saturday	Sunday
Site Contact Person:		**Contact Person Email Address:**	
Contact Person Phone #:		**FSR Review Date:**	**Time:**
		MRR Review Date:	**Time:**

PHYSICIAN PROVIDER INFORMATION (please list additional providers on a separate form)

Name	License #	Provider NPI #	PCP and/or Specialty Type	Specific Days and Hours at this Site	Hospital Privileges			Contracted Plan Partners
					Yes	No	Hospital	
			Board Cert? ☐ Yes ☐ No					☐ Aetna ☐ BSP ☐ UHC ☐ HN ☐ CHG ☐ MHC
			Board Cert? ☐ Yes ☐ No					☐ Aetna ☐ BSP ☐ UHC ☐ HN ☐ CHG ☐ MHC
			Board Cert? ☐ Yes ☐ No					☐ Aetna ☐ BSP ☐ UHC ☐ HN ☐ CHG ☐ MHC
			Board Cert? ☐ Yes ☐ No					☐ Aetna ☐ BSP ☐ UHC ☐ HN ☐ CHG ☐ MHC
			Board Cert? ☐ Yes ☐ No					☐ Aetna ☐ BSP ☐ UHC ☐ HN ☐ CHG ☐ MHC
			Board Cert? ☐ Yes ☐ No					☐ Aetna ☐ BSP ☐ UHC ☐ HN ☐ CHG ☐ MHC

NON-PHYSICIAN (NP, PA, CNM) PROVIDER INFORMATION (please list additional providers on a separate form)

Name	Provider Type	License #	Provider NPI#	Supervising Physician Name & License #:	Specific Days and Hours at this Site

OTHER BACK OFFICE STAFF:
# of RNs _____ # of LVNs _____ # of MAs _____ # of Other: _____
Title(s) of Other Staff: _____

LANGUAGE CAPABILITIES: List the language skills of on-site staff in addition to English

Physician(s) _____

Other staff _____

AGE OF POPULATION CARED FOR: AGES _____ TO _____

Percentage of population below 21 years of age: _____%

SECURITY OF MEDICAL RECORDS:

Name of the individual responsible for securing and maintaining the security of Medical Records: _____

If using Electronic Medical Records (EMR), add name of the EMR: _____

PLEASE READ CAREFULLY BEFORE SIGNING

SHARED PRACTICE ATTESTATION

The Department of Health Care Services (DHCS) Policy Letter 14-004 defines the documentation of patient care by all Primary Care Physicians (PCP) on site that occurs in universally shared medical records as a "shared" medical record practice. A shared medical record practice occurs when multiple PCPs see the same patients and use the same medical records for documentation of patient care. Shared medical records are not identified as separate records belonging to any specific PCP. Medical record review scores calculated on shared medical records apply to each PCP listed on the previous page.

Is this site a shared medical record practice? ☐ Yes ☐ No
Are there aspects of the medical record practice that is not shared by all PCPs on site (i.e. provider specialties, member age restrictions with certain PCPs, etc.)? ☐ Yes ☐ No ☐ N/A (please comment below)
Comments: _____
_____
_____

The collaborating Medi-Cal Managed Care and CMC Health Plans define the mutual and routine use of site personnel, office policies & procedures, facilities, equipment and other aspects of the clinic to complete daily activities and patient care in this physical address location as a "shared" site practice. Facility site review scores calculated on a shared site practice apply to each PCP listed on the previous page.

Is this a shared site practice? ☐ Yes ☐ No
Are there aspects of the site that is not shared by all PCPs on site (i.e. equipment, exam rooms, personnel, etc.)? ☐ Yes ☐ No ☐ N/A (please comment below)
Comments: _____
_____

I hereby certify, under the penalty of perjury, that all statements made on this form are true and complete:

Provider/Designee Name (please print): _____ Job Title: _____

Signature: _____ Date: _____

FACILITY SITE REVIEW NOTIFICATION REQUEST: If Facility Site Review scores need to be forwarded to an additional person, please provide the following information:

Name/Title: _____

Name of Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

SITE REVIEWER's Signature: _____

PCP	
Section: Access/Safety	
POLICY AND PROCEDURE: Site Accessibility by Individuals with Physical Disabilities	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:
Site shall be accessible and useable by individuals with physical disabilities. The site will meet city, county, and state building structure and access ordinances for persons with physical disabilities.

PROCEDURE:

I. ACCOMMODATIONS

A. The site shall maintain the following safety accommodations for physically disabled persons.

1. Designated parking space for persons with physical disabilities near the primary entrance.
   a. Staff will assist members with physical disabilities who choose to continue to seek care at the site, in spite of inaccessibility.
   b. Staff will discuss the plan with the member prior to a scheduled appointment. A meeting point, as near as possible to an entrance, will be agreed upon.
   c. Staff will meet the member at the scheduled time/place and assist the member as appropriate.
2. Pedestrian ramps will be maintained. (Any path is considered a ramp if the slope is greater than a one-foot rise in 20 feet of horizontal run.)
   a. Level landings at the top and bottom of all ramps will be maintained clear of any obstruction. Every staff member is responsible for clearing the landings at any time an obstruction is noted.
3. Exit doorways width (at least 32 inches) will allow for the passage of a person in a wheelchair.
   a. Landings on each side of exit doors and doorway openings will be maintained clear of any obstruction. Every staff member is responsible for clearing the landings and doorways any time an obstruction is noted.
4. Passenger elevator will be maintained in working condition for multi-level floor accommodation.
5. A clear floor space (at least 30" x 48") will be available at all times in waiting/exam areas for persons in wheelchairs.
   a. A minimum clear space of 60" diameter or square area is needed to turn a wheelchair.
6. The restrooms will be accessible to physically disabled individuals.
   a. Staff may make a reasonable alternative available to the member, as needed. Alternatives may include: direct or accompanying the member to a nearby disabled-accessible restroom, physically

assisting the member into the restroom, providing a urinal, bedpan or commode, and sanitary supplies as acceptable to the member.

b. Ensure sufficient knee clearance space underneath the sink to allow wheelchair users to safely use the sink for hand washing.

7. Hand washing facilities will be available and include running water, soap, and paper towels.
   a. Staff may provide a hand sanitizer to the member if the above items are not available/accessible.

PCP	
Section: Access/Safety	
POLICY AND PROCEDURE: Clean and Sanitary Environment	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:
Site environment will be maintained in a clean and sanitary condition. Environmental safety includes the hygienic condition of the site. The site will utilize products from the current EPA product lists.

PROCEDURE:

I. General Appearance
   A. Patient areas, restrooms, furniture, walls, floors, and carpets will be unsoiled, neat, tidy, uncluttered and in good repair.
      1. Cleaning will be performed regularly, as scheduled, by staff and/or contracted service. Office cleaning schedule is maintained as evidence of completion. (See attachment sample)
      2. Staff are responsible to keep work areas neat and clean.
      3. Staff are responsible for reporting to the office manager/provider if any exam tables, equipment, furniture, carpet, etc. is in need of repair. Office manager/provider will arrange for repair or replacement asneeded.
      4. Staff are responsible to report to the office manager/provider any soiled carpet, walls, etc. that would require professional cleaning, repair, or replacement. Office manager/provider will arrange for services in a timely manner.

II. Sanitary Supplies
   A. Appropriate sanitary supplies will be available for restroom use, including toilet tissue, hand washing soap, paper towels or antiseptic towelettes.
   B. Staff will check restrooms frequently for presence of supplies and replenish supplies as necessary.

ATTACHMENTS: Office Cleaning Schedule
Medical Office Cleaning Log

OFFICE CLEANING SCHEDULE

Date: _____

Clinic Name: _____

Provider Name: _____

Address: _____

Facility, Exam Rooms, Patient Restrooms (if in office) Daily Cleaning:

We contract with _____ for daily routine cleaning of our clinic.
(name of company or "N/A" if staff performs all cleaning)

The following EPA registered disinfectants are used on site: _____

_____

During the day, our staff will clean blood spills, contaminated surfaces, equipment, tables, counters, and floors as needed with the following disinfectant(s):

- ☐ 10% bleach which is reconstituted daily and has a contact/kill-time of 5 minutes.
  - o Bleach is approved by the EPA and hypochlorite content is at least 6.15% or higher.
  - o Date of reconstitution is labeled on bottle.
  - o Original bleach label is present.

- ☐ Other: _____ which has a contact/kill-time of _____ minutes.

Biohazardous Spill during Office Hours:

Assigned Person: _____

- o Uses only the Personal Protective Equipment Kit (Spill Kit or Infection Control Kit)
- o Places materials in red biohazard bag and places in the biohazard storage container.

Medical Office Cleaning Log
Cleaning and Decontamination of Equipment/Work Surfaces

Procedure:

1. All work surfaces and equipment must be cleaned with a 10% bleach solution (1:10 dilution of household bleach and water) or other EPA registered solution.
    - Bleach must be EPA approved and hypochlorite content is at least 6.15% or higher.
    - 10% bleach solution must be changed/reconstituted every 24 hours and the date changed noted on the solution bottle.
2. Other disinfectant solutions used for cleaning must be approved by the EPA (Environmental Protection Agency), effective in killing HIV/HBV/TB, and used according to the product label for the desired effect.
3. Clean work surfaces and/or equipment before and after each patient use and also on a daily basis.

Directions: Staff cleaning work surfaces and equipment must initial the appropriate box (month and day). Staff must initial and sign the bottom of this form to identify the name of the staff member.

LOCATION/AREA CLEANED:_____ **Year**:_____

	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
1												
2												
3												
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31												

Print Staff Name: _____ Staff Signature: _____ Initials: _____

Print Staff Name: _____ Staff Signature: _____ Initials: _____

Print Staff Name: _____ Staff Signature: _____ Initials: _____

Print Staff Name: _____ Staff Signature: _____ Initials: _____

PCP	
Section: Access/Safety	
POLICY AND PROCEDURE: Fire Safety & Prevention and Emergency Non-Medical Procedures	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:
Site shall be maintained in a manner that provides a safe environment for all patients, visitors, and personnel. Site shall meet all city, county, and state fire safety and prevention ordinances. Site staff shall receive training and information on fire safety & prevention and emergency non-medical procedures.

PROCEDURE:

I. Safe Environment
   A. The provider/designee will ensure the following fire and safety precautions:
      1. Lighting is adequate in all areas.
      2. Exit doors and aisles are unobstructed and egress (escape) accessible.
      3. Exit doors are clearly marked with "Exit" signs.
      4. Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location at all elevators, stairs, and exits.

II. Information and Training
   A. Fire Safety & prevention and non-medical emergency information will be available on-site. Staff will be informed of the location of the information and how to use the information. Staff training on fire safety & prevention and emergency non-medical procedures will be verifiable and may be part of staff education documented in:
      - Informal or formal in-services
      - New staff orientation
      - External training courses
   B. Training topics will include:
      1. Fire safety and prevention procedures including:
         a. Evacuation routes and exits for the exam rooms, office suite, and building
         b. Evacuation procedures
         c. Location of fire alarms, extinguishers, sprinklers, and smoke detectors
         d. Emergency phone numbers
         e. Workplace violence procedures including emergency numbers
         f. Personnel know *where to locate* information on-site and *how to use* information

III. Employee Alarm/Alert System
   A. An employee alarm system (e.g., manual pull box alarms, public address systems, radio, telephones) must be installed and maintained. In the event of a fire or other emergency, the employee alarm/alert system must be used to notify all employees as soon as possible.
      1. A back-up alarm/alert shall be provided when systems used are out of service.
         a. For those with 10 or fewer employees in a workplace, direct voice communication is acceptable (provided all employees can hear the alarm or alert) and do not need a back-up system.

Type of Employee Alarm/Alert System used on site: _____
Back-up System: _____

ATTACHMENTS: Workplace Violence Protocol (Resource)
Emergency Earthquake Plan (Resource)
Emergency Fire Plan (Resource)
Site Evacuation Plan (Sample)

Workplace Violence Protocol

I. Any staff member involved in an exchange with a patient or other visitor, which he/she perceives to be escalating will:
   a. Ask the visitor to remain calm. If the discussion continues to escalate he/she will notify the supervisor/practitioner.
   b. Ensure the safety of staff, patients, and visitors.
   c. If alone in the office, ask the visitor to leave.
   d. If the situation continues to escalate, the visitor does not leave, or at any time the staff member feels threatened, **dial 911** to summon police.

II. Any staff member who witnesses violence in the office will:
   a. Immediately dial 911.
   b. Notify the supervisor/practitioner.

Approved by: Dr. _____ **Date:** _____

Emergency Earthquake Plan

STAY CALM AT THE FIRST SIGN OF AN EARTHQUAKE.

Instruct any patients and staff to duck and cover under a sturdy desk, table, or other furniture.

Hold onto it and be prepared to move with it. Stay clear of windows.

Do not try to use stairs or elevators while the building is shaking or while there is danger of being hit by glass or falling debris. Do not rush outside or crowd exits.

After the earthquake, check for any employee or patient injuries.

A. If injured person is not breathing, open the airway. If still not breathing, begin rescue breathing.
B. If person is bleeding put pressure over the wound.
C. Do not attempt to move seriously injured persons unless they are in immediate danger of further injury.

Immediately clean up any spilled medicines, drugs, or other potentially harmful materials.

Office first aid kit is located: _____

Flashlights are located: _____

Examine the area for fire hazards and call 911 if there is a fire hazard.

Outdoors meeting place is: _____

Approved by: Dr. _____ **Date**: _____

Emergency Fire Plan

STAY CALM AT THE FIRST SIGN OF FIRE.

To report a fire, dial 911 and state the following:

Building address: _____ and office number: _____

Spell the last name of the doctor as it is listed on the building: _____

Fire extinguishers are located in the following place(s): _____

Employee _____ is responsible for immediately assisting all patients with leaving the building in a prompt and orderly manner and have all occupants wait outside.

The designated outside meeting place for employees is:

_____

All employees are to familiarize themselves with the emergency exit plan.

Approved by: Dr. _____ **Date**: _____

Sample Site Evacuation Plan

Draw/attach diagram of your office with clearly marked exits and evacuation route.

PCP	
Section: Access/Safety	
POLICY AND PROCEDURE: Emergency Health Care Services	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:
Emergency health care services shall be available and accessible twenty-four hours a day, seven days a week.

PROCEDURE:

I. EMERGENCY MEDICAL EQUIPMENT

A. Minimum emergency medical supplies/equipment, sufficient to establish and maintain a patent/open airway and manage anaphylactic reactions, shall be maintained in the facility. The equipment will include:

1. Portable oxygen tank or wall oxygen delivery system.
   a. Oxygen tank should be at least ¾ full
      - Back-up tank required on-site if less than ¾ full.
   b. Providers may NOT use small oxygen tanks where the liter flow cannot be adjusted. There is no size requirement for the tank, however, it must reflect the content balance in increments of ¼, ½, or ¾ full and full. The oxygen should last long enough to handle an emergency until the arrival of the emergency medical response team.
   c. All oxygen delivery systems must be able to be regulated up to 6 liters of oxygen per minute, maintained for a minimum of 15 minutes.
   d. Office staff will know how to turn on and regulate the oxygen flow.
2. An oxygen delivery system which includes tubing, population-appropriate mask/cannula, and adjustable flow meter.
3. Bulb syringe (peds)
4. Ambu bags – population appropriate (infants, children, adults)
   a. Mask must be checked for solid seals and replaced when needed.

B. Emergency medication for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia shall be maintained in the facility. The medication/supplies will include:

1. Appropriate sizes of safety needles/syringes and alcohol wipes.
2. Dosage chart for all emergency medications in emergency kit.
   - Signed and approved by physician
3. The following medications are required at minimum:
   - Epinephrine 1mg/mL injectable
   - Diphenhydramine (25mg oral or 50mg/ml injectable)
   - Naloxone
   - Chewable Aspirin 81mg (at least 4 tablets)

- Nitroglycerin spray/tablet
- Bronchodilator medication (solution for nebulizer or metered dose inhaler)
- Glucose

C. The supplies/equipment will be located "together" in an accessible location allowing for retrieval by all staff members without the use of assistive devices.

D. The supplies and equipment will be checked for expiration and operating status at least monthly. Staff responsible for checking the equipment/supplies will document:
   1. The date supplies/equipment was checked
   2. His/her initials verifying that equipment is in working order, the oxygen tank is at least ¾ full, the supplies are within expiration dates and the medication dosage chart is present.

E. Replacing/restocking supplies:
   1. An extra oxygen tank will be maintained on-site OR each time the oxygen is used, the remaining supply will be checked. If the tank is ¾ or less full, the supplier will be called to replace the used tank with a full tank.
   2. The month prior to the noted expiration date, the supplies/medication will be ordered to ensure delivery before the supplies actually expire.
   3. The medication and supplies will be ordered/replaced immediately after use.

II. EMERGENCY SERVICES TRAINING

A. All staff members will be trained on the emergency medical protocol. Staff will be able to:
   1. Describe facility-specific actions, and
   2. Locate written emergency procedures and information

B. Training will be completed upon hire and when updates to policy are made.

C. Training will be documented.

III. EMERGENCY INFORMATION

A. Emergency phone number contacts will be posted at the reception desk and at the workstations.
   1. Emergency numbers must be checked annually for current numbers and dated annually.
   2. Posted list includes local emergency response services (e.g., fire, police/sheriff, ambulance), emergency contacts (e.g., responsible managers, supervisors), and appropriate State, County, City, and local agencies (e.g., local poison control number)

ATTACHMENTS: **Emergency Protocol (Sample)**
Emergency Supplies Inventory Log (Sample)
Emergency Medication Dosage Chart (Sample)

Site Specific Emergency Protocol

IN THE EVENT OF A MEDICAL EMERGENCY:

_____ is to call 911.

_____ is to start CPR.

_____ is to bring the Medical Emergency kit.

_____ is to bring the Oxygen tank.

_____ is to attend to other patients.

Emergency Kit location: _____

Oxygen Tank location: _____

- Oxygen is full, secured, has a flow meter and regulator attached, and is with mask/cannula/tubing.

Type of Emergency Employee Alarm/Alert System used on site: _____
_____

Back-up System: _____

Emergency Contact List:

All emergencies:	911
Local Police Department:	_____
Local Fire Department:	_____
Manager/Supervisor Number:	_____
Poison Control:	_____
Child Abuse Hotline:	_____
Elder Abuse Hotline:	_____
Domestic Abuse Hotline:	_____

Approved by Dr.: _____ Date: _____
(Name, Signature)

Date of Annual Review/Update: _____ Provider Initials: _____
Date of Annual Review/Update: _____ Provider Initials: _____
Date of Annual Review/Update: _____ Provider Initials: _____

EMERGENCY KIT INVENTORY

YEAR: _____

Please **indicate the day of the month** when inventory is monitored, **place a check mark** for each available item, and **enter initials** of the staff completing the inventory. All assigned staff shall **print, sign & initial below. Keep all inventory logs for a minimum of 3 years.**

ITEMS **Month:** **Day:**	**JAN** ___	**FEB** ___	**MAR** ___	**APR** ___	**MAY** ___	**JUN** ___	**JUL** ___	**AUG** ___	**SEP** ___	**OCT** ___	**NOV** ___	**DEC** ___
Epinephrine 1mg/mL (SC)												
Diphenhydramine: **25 mg** (PO) or **50 mg/ml**												
Naloxone												
Chewable Aspirin 81mg (at least 4 tabs)												
Nitroglycerin spray/tablet												
Bronchodilator med (Nebulizer solution or metered dose inhaler)												
Glucose (at least 15 grams)												
SubQ Safety Needle/Syringes (1/2" - 5/8"needle)												
IM Safety Needle/Syringes (1" - 1 ½"needle)												
Alcohol Wipes												
Ambu bag w/ mask (Peds & Adults)												
Masks or Nasal Canula & Tubing (Peds & Adults)												
Bulb Syringe (Peds)												
Oxygen Tank (at least ¾ full)												
STAFF INITIALS:												

D Perlas Rev 1-23-20 vers072022;082022

Print Name	Signature	Initials
Print Name	Signature	Initials
Print Name	Signature	Initials

SAMPLE CHART – Ensure dosage chart used in office contains ONLY actual medications in emergency kit
*** Please confirm all dosages with manufacturer of actual medications on site***

Emergency Medications Dosage Chart – SAMPLE ONLY

<table>
<tr><th>Rx Name</th><th>Adults</th><th>Pediatrics</th></tr>
<tr><td>Albuterol sulfate[1] inhalation solution (0.0836% - 2.5 mg/ 3 ml)</td><td>2.5mg to 5mg every 20 minutes for 3 doses, then 2.5 mg to 10 mg every 1 to 4 hours PRN.</td><td>Children: 2.5 mg to 5 mg every 20 minutes for 3 doses, then 2.5 mg to 10 mg every 1 to 4 hours PRN.
Infant: 2.5 mg every 20 minutes for the first hour PRN; if there is rapid response, can change to every 3 to 4 hours PRN.</td></tr>
<tr><td>Albuterol sulfate[1] inhalation aerosol metered dose (90 mcg/actuation)</td><td>4 to 8 inhalations every 20 minutes for up to 4 hours, then 1 to 4 hours PRN.</td><td>Children: 2 to 10 inhalations every 20 minutes for 2 to 3 doses; if rapid response, can change to every 3 to 4 hours PRN.
Infant: 2 to 6 inhalations every 20 minutes for 2 to 3 doses; if there is rapid response, can change to every 3 to 4 hours PRN.</td></tr>
<tr><td>Chewable Aspirin 81 mg (not enteric coated)</td><td>For myocardial infarction (MI):
Chew 2 to 4 tablets upon presentation or within 48 hours of stroke.</td><td>For myocardial infarction (MI):
Chew 2 to 4 tablets upon presentation or within 48 hours of stroke.
*Aspirin is not recommended for patients less than 18 years of age who are recovering from chickenpox or flu symptoms due to association with Reye syndrome.</td></tr>
<tr><td>Benadryl[1] HCL Inj, USP (50mg/ml)</td><td>10 mg to 50 mg IV/IM (not to exceed 400 mg/day)
If IV route, IV push at a rate of ≤25 mg/min.</td><td>Children: 1 to 2 mg/kg/dose IV/IM (not to exceed 50 mg/dose).
If IV route, IV push at a rate of ≤25 mg/min.
Infant: 1 to 2 mg/kg/dose IV/IM (not to exceed 50 mg/dose).</td></tr>
<tr><td>Benadryl[2] Liquid 12.5 mg/5 milliliters (ml)</td><td>25-50 mg every 4-6 hours; max 300 mg/day</td><td>Children weight (pound):
<table>
<tr><th>lbs</th><th>20 to 24</th><th>25 to 37</th><th>38 to 49</th><th>50 to 99</th></tr>
<tr><td>ml</td><td>4</td><td>5</td><td>7.5</td><td>10</td></tr>
</table></td></tr>
<tr><td>Benadryl[1] Chewable 12.5 mg</td><td>2 to 4 chewable tablets every 4 to 6 hours.</td><td>Children weight (pound):
<table>
<tr><th>lbs</th><th>20 to 24</th><th>25 to 37</th><th>38 to 49</th><th>50 to 99</th></tr>
<tr><td>tabs</td><td>N/A</td><td>1</td><td>1 ½</td><td>2</td></tr>
</table></td></tr>
<tr><td>Benadryl[1] Tablet 25mg (oral)</td><td>Take 25 mg to 50mg by mouth.</td><td>Not preferred. Refer to parenteral route or oral solution.</td></tr>
<tr><td>Epinephrine[1] Injection, (1 mg/ml)</td><td>0.3 to 0.5 mg IM, may repeat every 5 to 10 minutes</td><td>0.01 mg/kg IM (up to maximum of 0.3 mg). May repeat every 5 to 10 minutes as needed.</td></tr>
<tr><td>Epinephrine[2] Injection, (0.1 mg/ml)</td><td>0.1 to 0.25 mg IV (1 to 2.5 ml of 0.1mg/ml solution) injected slowly once.</td><td>Infant: 0.05 mg IV slowly once, may repeat at 20 to 30 minute intervals as needed.
Neonates: 0.01 mg/kg of body weight IV slowly once.</td></tr>
</table>

Rx Name	Adults	Pediatrics
Epinephrine[1] Injection, USP auto-injector: **Epipen Jr** (Epinephrine 0.15 mg) **Epipen** (Epinephrine 0.3 mg)	**> 66 lbs**: 0.3 mg/dose IM or subcutaneous into the anterolateral aspect of the thigh.	**33 to 66 lbs**: 0.15 mg/dose IM or subcutaneous into the anterolateral aspect of the thigh. **< 33 lbs**: Not recommended.
Auvi Q (Epinephrine 0.1 mg, 0.15 mg, 0.3 mg)	**> 66 lbs**: 0.3mg IM or subcutaneous into anterolateral aspect of the thigh, through clothing if necessary.	**33 to 66 lbs**: 0.15mg IM or subcutaneous into anterolateral aspect of the thigh, through clothing if necessary. **16.5 - 33 lbs**: 0.1mg IM or subcutaneous into anterolateral aspect of the thigh, through clothing if necessary.
Naloxone (Narcan)[1] injection solution injection (0.4, or 1 mg/mL)	0.4 mg to 2 mg IV, IM, or subcutaneous up to a total dose of 10 mg, may repeat every 2 to 3 minutes as needed.	0.01 mg/kg IV, IM or subcutaneous, may repeat dose every 2 to 3 minutes as needed.
Naloxone auto injector (Evzio) (2 mg in 0.4 ml)	2 mg IM or subcutaneous into the anterolateral aspect of the thigh, may repeat same dose after 2 to 3 minutes.	2 mg IM or subcutaneous into the anterolateral aspect of the thigh, may repeat same dose after 2 to 3 minutes. (Under 1 year old, thigh muscle should be pinched while administering injection).
Naloxone nasal spray (4 mg/actuation)	Spray 4 mg into 1 nostril. If desired response is not achieved after 2 to 3 minutes, give a second dose intranasally into alternate nostril.	Spray 4 mg into 1 nostril. If desired response is not achieved after 2 to 3 minutes, give a second dose intranasally into alternate nostril.
Nitrostat (Nitroglycerin) SL tablets (0.3 mg or 0.4 mg)	0.3 mg to 0.4 mg sublingually or in buccal pouch at onset, may repeat in 5 minutes; max 3 tabs in 15 minutes. Prophylaxis: 5 to 10 minutes before activity.	Not recommended.
Nitroglycerin spray (0.4 mg)	Spray 0.4 mg (1 spray) sublingually every 5 minutes up to 3 doses.	
Glucagon for injection (emergency medication for low blood sugar) 1 mg (1 unit)	**< 20kg**: 0.5 mg or 20 to 30 mcg/kg IM, IV or subcutaneous. **> 20 kg**: 1 mg IM, IV or subcutaneous.	**< 20kg**: 0.5 mg or 20 to 30 mcg/kg IM, IV or subcutaneous. **> 20 kg**: 1 mg IM, IV or subcutaneous. (If the patient does not respond in 15 minutes, may give 1 to 2 more doses).

Rx Name	Adults	Pediatrics
Glucose tablet	15 gm (3 to 4 tablets) by mouth, may repeat in 15 minutes if hypoglycemic symptoms do not resolve. If the patient does not respond in 15 minutes, may give 1 to 2 more doses.	**Children**: 10 gm to 20 gm (0.3gm/kg) by mouth, may repeat in 15 minutes if hypoglycemic symptoms do not resolve. **Infant**: Not preferred. Parenteral route recommended (IV dextrose or IM glucagon).
Ammonia[2] Inhalants	Crack open one (1) capsule	Same as adult.
Lidocaine[2] 1% HCL Inj. USP 10 mg/ml (50ml MDK)	Use only the 10% solution for IM injection. 300 mg in deltoid or thigh muscle.	Individualize
Sodium Chloride[2] **0.9%** Injection USP (1000 ML)	125 drop / minute	**Depends on age:** **1 to 4 years old**: 40 drops/minute **5 to 10 years old**: 60 drops/minute
Solu-Medrol[2] 125 mg/ml Injection, USP 2ml single dose vial	**Initial dosage**: 10-40 mg IV, IM	**Initial dosage**: 0.11 to 1.6 mg/kg/day in 3-4 divided doses IV, IM
Oxygen delivery system – tank at least three-quarters full	Can consider any oxygen delivery systems if appropriate.	**Children**: Nasal prongs or nasal catheters preferred; can consider face mask, bead box, or incubator for older children. **Infant**: Nasal prongs or nasal catheters preferred.
Oxygen delivered 6 to 8 L/minute	6 to 8 L/minute	**Children**: 1 to 4 L/minute **Infant**: 1 to 2 L/minute

[1] Only one emergency medication strength or route required

[2] Not required; optional emergency medications only.

PCP	
Section: Access/Safety	
POLICY AND PROCEDURE: Medical and Lab Equipment Maintenance	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:
Medical and laboratory equipment used for patient care shall be properly maintained.

PROCEDURE:

I. MAINTENANCE OF MEDICAL EQUIPMENT
   A. Operating manuals for medical and lab equipment will be maintained on site.
   B. Operating manuals will be the reference for planning routine maintenance schedules for equipment.
   C. If operating manuals are not available, an annual cycle for safety/calibration service will be adopted.
   D. Documented proof of servicing/calibration/quality control checks will be maintained on site and may be in the following form:
      1. A receipt listing all equipment serviced and date of service.
      2. Stickers applied to equipment noting the date of service.
      3. Work orders/receipts for repair of equipment.
      4. A handwritten log with dates and results of calibration (such as for a glucometer, Hemocue, etc.)

II. MALFUNCTIONING EQUIPMENT
   A. Staff shall inform provider/designee of any equipment found to be malfunctioning or out of service.
      1. Provider/designee will arrange for repair or replacement of malfunctioning equipment.
      2. Documented proof of repair will be maintained on site.

III. QUALIFIED PERSONNEL
   A. Qualified staff assigned to operate equipment will be trained on appropriate use and maintenance.

ATTACHMENTS: **Glucometer Quality Control Log (Sample)**

Glucometer Quality Control Log

1. Keep glucometer(s) operator's manual with this log.
2. Per operator's manual, perform control solution testing when:
   - Using the meter for the first time
   - Opening a new bottle of test strips
   - The test strip bottle cap has been left open for a while
   - The meter has been dropped
   - You suspect the meter or test strips are not working properly
   - Results are repeatedly unexpected/does not match how patient feels
   - Other:_____
   - Other: _____

Date	Time	Staff Initials	Test Strip Lot #	Low Control			High Control			Out of Range (✓)	Action Taken/Comments
				Lot #	Range	Result	Lot #	Range	Result		

Print Name: _____ Signature: _____ Initials: _____
Print Name: _____ Signature: _____ Initials: _____
Print Name: _____ Signature: _____ Initials: _____
Print Name: _____ Signature: _____ Initials: _____

PCP	
Section: Personnel	
POLICY AND PROCEDURE: Staff Qualifications	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:
All professional health care personnel must have current California licenses and/or certifications and must be qualified and trained for assigned responsibilities.

PROCEDURE:

I. HEALTH CARE LICENSE AND CERTIFICATION REQUIREMENTS
   A. All medical professional licenses and certifications must be current and issued from the appropriate agency to practice in California. Copies and/or lists of currently certified or credentialed personnel must be readily available when requested by reviewers.

II. IDENTIFICATION OF HEALTH CARE PERSONNEL
   A. Health care personnel shall disclose, while working, their name and title on a nametag with at least 18-point type.
   B. A health care practitioner in a practice or office, whose license is prominently displayed, may opt not to wear a nametag.

*__NOTE__: It is unlawful for any person to use the title "nurse" in reference to themselves, in any capacity, except for an individual who is a registered nurse (RN) or licensed vocational nurse (LVN).

III. TRAINING OF SITE PERSONNEL
   A. Personnel on site must be qualified for their responsibilities and adequately trained for their scope of work. Site staff should have a general understanding of the systems/processes in place, appropriate supervision, and knowledge of the available sources of information on site.
   B. Provider and staff must be able to demonstrate operation of medical equipment used in their scope of work.

PCP	
Section: Personnel	
POLICY AND PROCEDURE: Unlicensed Personnel	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:'

All professional health care personnel must be qualified and trained for assigned responsibilities.

PROCEDURE:

I. MEDICAL ASSISTANTS

A. Medical Assistants (MA) are unlicensed health personnel who perform basic administrative, clerical, and non-invasive routine technical supportive services under the supervision of a licensed physician. The licensed physician must be physically in the treatment facility during the performance of authorized procedures by the MA.

B. To administer medications by subcutaneous or intramuscular injection, or to perform intradermal skin tests, or venipunctures for withdrawing blood, an MA shall have completed at least the minimum number of training hours established in CCR, Title 16, Section 1366.1.

C. Training may be administered under a licensed physician; or under a RN, LVN, PA or other qualified medical assistant acting under the direction of a licensed physician. The supervising physician is responsible for determining the training content and ascertaining proficiency of the MA. Training documentation must be maintained on-site and include the following:

1. Diploma or certification from an accredited training program/school, or
2. 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

II. MEDICATION ADMINISTRATION

A. Unlicensed staff shall have evidence of appropriate training and supervision in all medication administration methods performed within their scope of work.

1. The supervising physician shall specifically authorize all medications administered by an MA by means of a specific written or standing order prepared by the supervising physician.
2. Medication administration by a MA means the direct application of premeasured medication orally, sublingually, topically, vaginally, or rectally; or by providing a single dose to a patient for immediate self-administration by inhalation or simple injection.
3. The pre-labeled medication container shall be shown to the licensed person prior to withdrawal of the medication from the container and administration.
4. An MA may administer injections of scheduled drugs, including narcotic medications, only if the dosage is verified and the injection is intradermal, subcutaneous, or intramuscular.

5. Medical assistants may not place an intravenous needle, start or disconnect the intravenous infusion tube, administer medications or injections into an intravenous line, or administer anesthesia.

B. All staff who administer medications must confirm correct patient, medication/vaccine, dosage, and route prior to administration.

III. MEDICAL EQUIPMENT

A. Personnel on site shall be qualified for their responsibilities and adequately trained for their scope of work. Site staff shall have a general understanding of the systems/processes in place, appropriate supervisions, and knowledge of the available sources of information on site.

B. Provider and staff shall be able to demonstrate operation of medical equipment used in their scope of work.

I. IDENTIFICATION OF HEALTH CARE PRACTITIONERS

A. A health care practitioner shall disclose his or her name and practitioner's license status, as granted by the State of California, on a nametag with at least 18- point type. A health care practitioner in a practice or office whose license is prominently displayed, may opt not to wear a nametag

Note: It is unlawful for any person to use the title "nurse" in reference to himself or herself, in any capacity, except for an individual who is a registered nurse or licensed vocational nurse.

ATTACHMENTS: **Medical Assistant Letter of Competency (Sample)**
Medical Assistant Supervision Delegation Agreement (Sample)

Medical Assistant Certificate

This is to certify that _____ has demonstrated and completed on-the-job training as a Medical Assistant under the auspices of the undersigned as follows and in compliance with Business and Professions Code section 2069 and 2070 and the California Code of regulations, Title 16, Chapter 14, Sections 1366. 1366.1. 1366.1, 1366.3 and 1366.4.

Please initial the areas of training:

____ Ten (10) clock hours of training in venipuncture and skin puncture for the purpose of drawing blood.

____ Ten (10) clock hours of training in administering injections and performing skin tests.

____ Satisfactory performance by the trainee of at least ten (10) of each of the following procedures: intramuscular injections, subcutaneous injections, skin tests, venipunctures and other skin punctures performed in the office.
(All the training above, shall include knowledge of the following: Pertinent anatomy and physiology appropriate to the procedure; choice of equipment; proper technique including sterile technique; hazards and complications; post treatment and test patient care; emergency procedure; California law and regulations for medical assistants.)

____ Preparing patients for and assisting in exams, procedures, positioning, draping, shaving, and disinfection of treatment sites.

____ Performing, collecting, and recording vital signs including pulse, respiration rate, blood pressure, and basic information about the presenting and previous conditions.

____ Performing simple lab and screening tests, customarily performed in a medical office.

____ Non-Invasive collecting and preserving specimens for testing, including urine, sputum, semen, and stool.

____ Assisting patients in ambulation and transfers.

____ Performing ear lavage to remove impacted cerumen.

____ Removing sutures or staples from superficial incisions or lacerations.

____ Applying and removing bandages, dressings, orthopedic appliances, removing casts, splints, and other internal devices.

____ Administering medications orally, sublingually, topically, vaginally, rectally, or by providing a single dose to a patient for immediate self-administration.

____ Performing an electrocardiogram.

____ Other: _____

Pediatric preventive care screenings for ages 0 to 20 years based on the American Academy of Pediatrics requirements. Training modules are available at the DHCS website: https://www.dhcs.ca.gov/services/chdp/Pages/Training.aspx.

____ Anthropometric Measurements: Collecting and recording patients' data, including head circumference, height, weight, and BMI and plotting values on WHO and CDC growth charts.

____ Hearing Screening: Performing audiometric testing, not requiring interpretation by the medical assistant to obtain test results.

____ Vision Screening: Performing visual field testing, simple or automated ophthalmic testing, not requiring interpretation by the medical assistant to obtain test results.

____ Dental Services: Performing oral and fluoride screenings, establishing a dental home, referral to a dentist at least annually and applying fluoride varnish.

_____ _____ _____

PHYSICIAN'S SIGNATURE PROVIDER NAME DATE

Office Address: _____ Office Telephone Number: _____

Agreement Between Supervising Physician and Non-Physician Medical Provider Regarding Medical Assistant Supervision

This agreement states that medical assistants are allowed to perform certain procedures and technical support services under the supervision of mid-Level providers when the physician is not present.

Per the Medical Board of California, Medical Assistant (MA)description; medical assistants are unlicensed individuals who administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical supportive services under the supervision of a licensed physician and surgeon, podiatrist, physician assistant, nurse practitioner, or nurse midwife in a medical setting. The supervising physician must be on the premises in order for the medical assistant to perform supportive tasks and services. Under the provisions of Business and Professions Code Section 2069 (a)(2), the supervision of a medical assistant may be delegated to a mid-level practitioner when the supervising physician is not on site.

Signatures below authorize the delegation of the supervision of the medical assistant to the non-physician medical provider when the supervising physician is not physically on site.

Supervising physician printed name: _____

Supervising physician signature: _____

Date: _____

Non-physician medical provider printed name: _____

Non-physician medical provider signature: _____

Date: _____

PCP	
Section: PERSONNEL	
POLICY AND PROCEDURE: Non-Physician Medical Practitioners	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:
All primary care provider (PCP) sites that employ non-physician medical providers (NPMP): Nurse Practitioners (NP), Certified Nurse Midwives (CNM), Licensed Midwives (LM), and/or Physician Assistants (PA), shall have standardized procedures (for LMs, NPs and CNM) and/or Practice Agreements/Delegation of Services Agreements (for PAs) that clearly define the scope of services and supervision.

The supervising physician is a physician and/or surgeon licensed by the Medical Board or by the Osteopathic Medical Board of California who supervises one or more physician assistants, possesses a current valid license to practice medicine, and is not currently on disciplinary probation for improper use of a physician assistant. "Supervision" means that a licensed physician and surgeon oversee the activities of, and accept responsibility for, the medical services rendered by a physician assistant. Physicians shall comply with all current and/or revised requirements established by the Medical Board of CA for supervising physician assistants. The supervising physician holds ultimate responsibility for the practice of each supervised non-physician medical practitioner.

PROCEDURE:

I. SCOPE OF PRACTICE OF NON-PHYSICIAN MEDICAL PRACTITIONERS

A. Standardized Nurse Practitioners, Certified Nurse Midwives shall have standardized procedures defining their scope of practice and supervision. Standardized procedures legally define the expanded scope of nursing practice that overlaps the practice of medicine. NPs and CNMs operate under written standardized procedures that are collaboratively developed and approved by the supervising physician, the NP/CNM and administration within the organized health care facility/system in which standardized procedures will be used. Standardized procedures identify the furnishing of drugs or devices, extent of physician supervision, method of periodic review of competence, and review of provisions in the standardized procedures and must be dated and signed by the supervising physician and NP/CNM. All Standardized Procedures shall be readily accessible at all practice sites in which the NP or CNM works.

1. Nurse Practitioner (NP): Nurse practitioners may provide primary care and perform advanced procedures. The extent of required supervision must be specified in the standardized procedures.

2. Certified Nurse Midwife (CNM): The certificate to practice nurse mid-wifery authorizes the holder, under supervision of a licensed physician, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family planning care for the mother and immediate care for the newborn. The supervising and back-up physician for the CNM shall be credentialed to perform obstetrical care in the same delivering facility in which the CNM has delivery privileges

B. Physician Assistants shall have Practice Agreements/Delegation of Service Agreements defining their scope of practice and supervision. Practice Agreements/Delegation of Service Agreements defines specific procedures identified in practice protocols or specifically authorized by the supervising physician, and must be dated and signed by physician and PA. An original or copy must be readily accessible 52 at all practice sites in which the PA works. Failure to maintain a Practice Agreement/Delegation of Services Agreement is a violation of the Physician Assistant Regulations and is grounds for disciplinary action by the Medical Board of California against a physician assistant's licensure.

1. Delegation of Service Agreements (DSA): DSAs established prior to January 1, 2020 defines supervision responsibilities and methods required by Title 16, section 1399.545 of the Physician Assistant Regulations. The following procedures are identified:
   a. Transport and back-up procedures for when the supervising physician is not on the premises
   b. One or more methods for performing medical record review by the supervising physician
   c. Responsibility for physician review and countersigning of medical records; and
   d. Responsibility of the PA to enter the name of approved supervising physician responsible for the patient on the medical record

2. Practice Agreement: According to Senate Bill 697, starting January 1, 2020, newly established Practice Agreements shall define the supervision responsibilities and methods required by the Business and Professions Code, Sections 3502. The Senate Bill 697 removed the required supervisory procedures above under a DSA with the exception of the following: Transport and back-up procedures for when the supervising physician is not on the premises

3. If a PA was hired prior to January 1, 2020, then the Delegation of Services Agreement can be used as the established agreement between the PA and supervising physician. However, if any changes/updates needed to be made to this document after January 1, 2020 would nullify its legitimacy and a Practice Agreement would need to be signed instead.

C. Standardized Procedures and Practice Agreements/Delegation of Service Agreements shall be revised, dated and signed whenever any changes occur.

D. The supervising physician delegates the supervision of Medical Assistants to NPMPs whenever the supervising physician is off premises.

E. Each NP, CNM, and PA that prescribes controlled substances must have a valid DEA Registration Number.

POLICY AND PROCEDURE: Non-Physician Medical Practitioners	

II. SUPERVISION OF NON-PHYSICIAN MEDICAL PRACTITIONERS

A. Standardized The supervising physician holds ultimate responsibility for the practice of each supervised non-physician medical practitioner. The supervising physician is permitted to supervise the following maximum number of NPMPs at any given time/shift in any of their locations:

a. Four (4) Nurse Practitioners with furnishing licenses;
b. Four (4) Certified Nurse Midwives; AND
c. Four (4) Physician Assistants.

This may bring the total number of NPMPs supervised at any given time/shift/location to 12 (the ratio is unlimited for NPs who do not hold furnishing licenses). This ratio is based on each physician, not the number of offices. A primary care physician, an organized outpatient clinic or a hospital outpatient department shall utilize more NPMPs than can be supervised within these stated limits

B. The supervising physician or designated back-up physician shall be available in person or by electronic communication at all times when a NPMP is caring for patients

III. IDENTIFICATION OF HEALTH CARE PRACTITIONERS

A. A health care practitioner shall disclose his or her name and practitioner's license status, as granted by the State of California, on a nametag with at least 18- point type. A health care practitioner in a practice or office, whose license is prominently displayed, may opt not to wear a nametag.

Note: It is unlawful for any person to use the title "nurse" in reference to himself or herself, in any capacity, except for an individual who is a registered nurse or licensed vocational nurse.

ATTACHMENTS: Physician Assistant Notification to Consumers Regulation
PA Agreement – Completion of Controlled Substance Course
PA Agreement – Non-Completion of Controlled Substance Course
Explanation of Standardized Procedure Requirements for NP Practice
Scope of Practice & Standardized Procedure for Nurse Practitioners
Non-Physician Medical Practitioners MA Supervision Agreement

NOTIFICATION TO CONSUMERS REGULATION

Effective August 11, 2011, Section 1399.547, Title 16 of the California Code of Regulations, mandated by Business and Professions Code section 138, requires that physician assistants inform patients that they are licensed and regulated by the Physician Assistant Board. The notification must include the following statement and information:

NOTIFICATION TO CONSUMERS
PHYSICIAN ASSISTANTS ARE LICENSED AND REGULATED BY THE PHYSICIAN ASSISTANT BOARD
(916) 561.8780
WWW.PAC.CA.GOV

Physician assistants may provide this notification by one of the following three methods:

- Prominently posting a sign in an area of their offices conspicuous to patients, in at least 48-point type in Arial font.

- Including the notification in a written statement, signed and dated by the patient or patient's representative, and kept in that patient's file, stating the patient understands the physician is licensed and regulated by the Board.

- Including the notification in a statement on letterhead, discharge instructions, or other document given to a patient or the patient's representative, where the notification is placed immediately above the signature line for the patient in at least 14-point type.

For more information, please contact the Board at (916) 561.8780 or pacommittee@mbc.ca.gov.

1399.547. Notification to Consumers.

(a) A licensee engaged in providing medical services shall provide notification to each patient of the fact that the licensee is licensed and regulated by the board. The notification shall include the following statement and information:

NOTIFICATION TO CONSUMERS

Physician assistants are licensed and regulated

by the Physician Assistant Board

(916) 561-8780

www.pac.ca.gov

(b) The notification required by this section shall be provided by one of the following methods:

(1) Prominently posting the notification in an area visible to patients on the premises where the licensee provides the licensed services, in which case the notice shall be in at least 48-point type in Arial font.

(2) Including the notification in a written statement, signed and dated by the patient or the patient's representative and retained in that patient's medical records, stating the patient understands the physician assistant is licensed and regulated by the board.

(3) Including the notification in a statement on letterhead, discharge instructions, or other document given to a patient or the patient's representative, where the notice is placed immediately above the signature line for the patient in at least 14-point type.

Note: Authority cited: Section 3510, Business and Professions Code. Reference: Section 138, Business and Professions Code.

NOTIFICATION TO CONSUMERS

Physician Assistants are licensed and regulated by the Physician Assistant Board

(916) 561-8780

www.pac.ca.gov

Physician Assistant Practice Agreement

(Controlled Substances Education Course Completed and DEA Registration)

This Practice Agreement has been developed through collaboration among physician(s) and physician assistant(s) in **_____(name of medical practice)_____,** an Organized Health Care System (as defined in Business & Professions Code (BPC) §3501(j) and hereinafter referred to as the "Practice"), for the purpose of defining the medical services which each and every physician assistant ("PA") who executes this Practice Agreement is authorized to perform and to meet the statutory requirement set forth in BPC §3502.3.

1. **Medical Services Authorized**: Pursuant to BPC §3502, the PA is authorized to perform those medical services for which the PA has demonstrated competency through education, training, or experience, under physician supervision as provided in Section 3 of this Practice Agreement. Subject to the foregoing, the PA is further authorized to: (a) perform the medical functions set forth in BPC §3502.3(b); to supervise medical assistants pursuant to BPC §2069; (c) to provide care and sign forms under the workers' compensation program pursuant to Labor Code §3209.10; and (d) any other services or activities authorized under California law.

2. **Ordering and Furnishing of Drugs and Devices**: In compliance with State and Federal prescribing laws, the PA may order and furnish those drugs and devices, including schedule II through V controlled substances, as indicated by the patient's condition, the applicable standard of care, and in accordance with the PA's education, training, experience, and competency, under physician supervision as provided in Section 3 of this Practice Agreement. The furnishing and ordering of schedule II drugs shall be only for those illnesses, injuries, and/or conditions for which the standard of care indicates the use of such schedule II drugs. The PA may dispense drugs and devices as provided for in BPC §4170 and request, sign, and receive drug samples as provided for in BPC §4061.

3. **Physician Supervision**: Any physician and surgeon of the Practice, who meets the definition of a supervising physician in BPC §3501(e), may provide supervision of a PA in the Practice acting under this Practice Agreement. A supervising physician need not be physically present while the PA provides medical services, but be available by telephone or other electronic means at the time the PA is providing medical services in the Practice. Supervision means that a physician and surgeon oversees and accepts responsibility for the activities of the PA.

4. **Patient Care Policies and Procedure**: PA shall consult with, and/or refer the patient to, a supervising physician or other healthcare professional when providing medical services to a patient which exceeds the PA's competency, education, training, or experience.

5. **PA Competency and Qualification Evaluation**: Through a peer review process based on the standard of care, the Practice shall regularly evaluate the competency of a PA. The Practice may credential and privilege the PA to ensure that the PA has the qualifications, training, and experience, to perform the medical services, procedures, and drug and device ordering and furnishing authorized under this Practice Agreement.

6. **Review of Practice Agreement**: This Practice Agreement shall be reviewed on a regular basis and updated by the Practice when warranted by a change in conditions or circumstances.

The physician and PA(s) listed below collaboratively approve this Practice Agreement governing the medical services of PA(s) in the Practice, on behalf of the Practice, and authorize the physicians on the staff of the Practice to supervise the PA(s) named below effective as of the date signed by the PA. The physician named below authorizing this Practice Agreement may or may not also serve as a supervising physician of a PA. Signing this Practice Agreement does not mean the named physician below is accepting responsibility for the medical services provided by the PA(s) named below, rather any physician of the Practice, including a physician named below, would only accept responsibility for a specific PA if, and only during those times, they are serving as a supervising physician as set forth in Section 3 of this Practice Agreement.

Physician: _____ Title: _____

_____

Physician Signature Date

PA: _____ PA: _____

_____ _____

PA Signature Date PA Signature Date

PA: _____ PA: _____

_____ _____

PA Signature Date PA Signature Date

PA: _____ PA: _____

_____ _____

PA Signature Date PA Signature Date

Physician Assistant Practice Agreement

(DEA Registration, but Controlled Substances Education Course Not Completed)

This Practice Agreement has been developed through collaboration among physician(s) and physician assistant(s) in **_____(name of medical practice)_____,** an Organized Health Care System (as defined in Business & Professions Code (BPC) §3501(j) and hereinafter referred to as the "Practice"), for the purpose of defining the medical services which each and every physician assistant ("PA") who executes this Practice Agreement is authorized to perform and to meet the statutory requirement set forth in BPC §3502.3.

1. **Medical Services Authorized**: Pursuant to BPC §3502, the PA is authorized to perform those medical services for which the PA has demonstrated competency through education, training, or experience, under physician supervision as provided in Section 3 of this Practice Agreement. Subject to the foregoing, the PA is further authorized to: (a) perform the medical functions set forth in BPC §3502.3(b); to supervise medical assistants pursuant to BPC §2069; (c) to provide care and sign forms under the workers' compensation program pursuant to Labor Code §3209.10; and (d) any other services or activities authorized under California law.

2. **Ordering and Furnishing of Drugs and Devices**: In compliance with State and Federal prescribing laws, the PA may order and furnish those drugs and devices, including schedule III through V controlled substances, as indicated by the patient's condition, the applicable standard of care, and in accordance with the PA's education, training, experience, and competency, under physician supervision as provided in Section 3 of this Practice Agreement. The furnishing and ordering of Schedule II drugs shall be only based on a patient-specific order approved by the treating or supervising physician. The PA may dispense drugs and devices as provided for in BPC §4170 and request, sign, and receive drug samples as provided for in BPC §4061.

3. **Physician Supervision**: Any physician and surgeon of the Practice, who meets the definition of a supervising physician in BPC §3501(e), may provide supervision of a PA in the Practice acting under this Practice Agreement. A supervising physician need not be physically present while the PA provides medical services, but be available by telephone or other electronic means at the time the PA is providing medical services in the Practice. Supervision means that a physician and surgeon oversees and accepts responsibility for the activities of the PA.

4. **Patient Care Policies and Procedure**: PA shall consult with, and/or refer the patient to, a supervising physician or other healthcare professional when providing medical services to a patient which exceeds the PA's competency, education, training, or experience.

5. **PA Competency and Qualification Evaluation**: Through a peer review process based on the standard of care, the Practice shall regularly evaluate the competency of a PA. The Practice may credential and privilege the PA to ensure that the PA has the qualifications, training, and experience, to perform the medical services, procedures, and drug and device ordering and furnishing authorized under this Practice Agreement.

6. **Review of Practice Agreement**: This Practice Agreement shall be reviewed on a regular basis and updated by the Practice when warranted by a change in conditions or circumstances.

.

The physician and PA(s) listed below collaboratively approve this Practice Agreement governing the medical services of PA(s) in the Practice, on behalf of the Practice, and authorize the physicians on the staff of the Practice to supervise the PA(s) named below effective as of the date signed by the PA. The physician named below authorizing this Practice Agreement may or may not also serve as a supervising physician of a PA. Signing this Practice Agreement does not mean the named physician below is accepting responsibility for the medical services provided by the PA(s) named below, rather any physician of the Practice, including a physician named below, would only accept responsibility for a specific PA if, and only during those times, they are serving as a supervising physician as set forth in Section 3 of this Practice Agreement.

Physician: _____ Title: _____

_____

Physician Signature Date

PA: _____ PA: _____

_____ _____

PA Signature Date PA Signature Date

PA: _____ PA: _____

_____ _____

PA Signature Date PA Signature Date

PA: _____ PA: _____

_____ _____

PA Signature Date PA Signature Date

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
BOARD OF REGISTERED NURSING
PO BOX 944210, Sacramento, CA 94244-2100
P (916) 322-3350 | TTY (800) 326-2297 | www.rn.ca.gov

AN EXPLANATION OF STANDARDIZED PROCEDURE REQUIREMENTS FOR NURSE PRACTITIONER PRACTICE

Standardized Procedures are authorized in the Business and Profession Code, Nursing Practice Act (NPA) Section 2725 and further clarified in California Code of Regulation (CCR 1480). Standardized procedures are the legal mechanism for registered nurses, nurse practitioners to perform functions which would otherwise be considered the practice of medicine. Standardized procedures must be developed collaboratively by nursing, medicine, and administration in the organized health care system where they will be utilized. Because of this interdisciplinary collaboration for the development and approval, there is accountability on several levels for the activities to be performed by the registered nurse, nurse practitioner.

Organized health care systems includes health facilities, acute care clinics, home health agencies, physician's offices and public or community health services. Standardized procedures means policies and protocols formulated by organized health care systems for the performance of standardized procedure functions.

The organized health care system including clinics, physician's offices (inclusive of sites listed above) must develop standardized procedures permitting registered nurse, nurse practitioner to perform standardized procedure functions. A registered nurse, nurse practitioner may perform standardized procedure functions only under the conditions specified in a health care system's standardized procedure; and **must provide the system with satisfactory evidence that the nurse meets its experience, training, and/or education requirements to perform the functions.**

A nurse practitioner is a registered nurse who possesses additional preparation and skill in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program conforming to the Board standards as specified in CCR 1484 (Standards of Education).

The Board of Registered Nursing has set educational standards for nurse practitioner certification which must be met in order to "hold out" as a nurse practitioner. Nurse practitioners who meet the education standards and are certified by the BRN are prepared to provide primary health care, (CCR 1480 b), that which occurs when a consumer makes contact with a health care provider who assumes responsibility and accountability for the continuity of health care regardless of the presence or absence of disease.

Scope of Medical Practice

The Medical Practice Act authorizes physicians **to diagnose** mental and physical conditions, **to use drugs in or** upon human beings, **to sever or penetrate the tissue** of human beings and **to use other methods** in the treatment of diseases, injuries, deformities or other physical or mental conditions. As a general guide, the performance of any of these functions by a registered nurse, nurse practitioner requires a standardized procedure.

Standardized Procedure Guidelines.

The Board of Registered Nursing and the Medical Board of California jointly promulgated the following guidelines. (Board of Registered Nursing, Title 16, California Code of Regulations (CCR) section 1474; Medical Board of California, Title 16, CCR Section 1379.)

(a) Standardized procedures shall include a written description of the method used in developing and approving them and any revision thereof.

(b) Each standardized procedure shall:

(1) **Be in writing, dated and signed by the organized health care system** personnel authorized to approve it.

(2) Specify **which standardized procedure functions** registered nurses may perform and under what circumstances.

(3) State any specific **requirements which are to be followed** by registered nurses in performing particular standardized procedure functions.

(4) Specify any **experience, training, and/or education** requirements for performance of standardized procedure functions.

(5) Establish a method for initial and continuing **evaluation** of the competence of those registered nurses authorized to perform standardized procedure functions.

(6) Provide for a method of maintaining a written record of those **persons authorized to perform** standardized procedure functions.

(7) Specify the scope of **supervision** required for performance of standardized procedure functions, for example, telephone contact with the physician.

(8) Set forth any specialized circumstances under which the registered nurse is to immediately **communicate with a patient's physician** concerning the patient's condition.

(9) State the limitations on **settings**, if any, in which standardized procedure functions may be performed.

(10) Specify patient **record-keeping** requirements.

(11) Provide for a method of **periodic review** of the standardized procedures.

An additional safeguard for the consumer is provided by steps four and five of the guidelines which, together, form a **requirement that the nurse be currently capable** to perform the procedure. If a RN or NP undertakes a procedure without the competence to do so, such an act may constitute gross negligence and be subject to discipline by the Board of Registered Nursing.

Standardized procedures which reference textbooks and other written resources in order to meet the requirements of Title 16, CCR Section 1474 (3), must include book (specify edition) or article title, page numbers and sections. Additionally, the standards of care established by the sources must be reviewed and authorized by the registered nurse, physician and administrator in the practice setting. A formulary may be developed and attached to the standardized procedure. Regardless of format used, whether a process protocol or disease-specific, the standardized procedure must include all eleven required elements as outlined in Title 16, CCR Section 1474.

SUGGESTED FORMAT FOR STANDARDIZED PROCEDURES

I. POLICY

1. Function(s): (2)*
2. Circumstances under which R.N. may perform function: (2)
   a. Setting (9)
   b. Supervision (7)
   c. Patient Conditions
   d. Other

II. PROTOCOL (3)

1. Definitions
2. Data base
   a. Subjective
   b. Objective
3. Diagnosis
4. Plan
   a. Treatment
   b. Patient conditions requiring consultation (8)
   c. Education - patient/family
   d. Follow up
5. Record keeping (10)

III. REQUIREMENTS FOR REGISTERED NURSE: (4)(5)

1. Nurse practitioner education program, specialty
2. Advance level training
3. Experience as a nurse practitioner
4. National Certification in a specialty
5. Method of initial and continuing evaluation of competence

IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

1. Method: (Title 16, CCR Section 1474(a))
2. Review schedule (11)
3. Signatures of authorized personnel approving the standardized procedure, and dates: (1)
   a. Nursing
   b. Medicine
   c. Administration

V. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES (6)

1.
2.

*** Numbers in parentheses correspond to Board of Registered Nursing guideline numbers in Title 16, CCR Section 1474.**

EXAMPLE A (Process Protocol)

The Board of Registered Nursing does not recommend or endorse the medical management of this sample standardized procedure. It is intended as a guide for format purposes only.

Standardized Procedures

General Policy Component

I. Development and Review

A. All standardized procedures are developed collaboratively and approved by the Interdisciplinary Practice Committee (IDPC) whose membership consists of nurse practitioners, nurses, physicians, and administrators and must conform to all 11 steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

B. All standardized procedures are to be kept in a manual which includes dated, signed approval sheets of the persons covered by the standardized procedures.

C. All standardized procedures are to be reviewed every three years and as practice changes by the IDPC.

D. All changes or additions to the standardized procedures are to be approved by the IDPC accompanied by a dated and signed approval sheet.

II. Scope and Setting of Practice

A. Nurses may perform the following functions within their training specialty area and consistent with their experience and credentialing: assessment, management, and treatment of episodic illnesses, chronic illness, contraception, and the common nursing functions of health promotion, and general evaluation of health status (including but not limited to ordering laboratory procedures, x-rays, and physical therapies, recommending diets, and referring to Specialty Clinics when indicated).

B. Standardized procedure functions, such as managing medication regimens, are to be performed in (list area, i.e., short appointment clinic). Consulting physicians are available to the nurses in person or by telephone.

C. Physician consultation is to be obtained as specified in the individual protocols and under the following circumstances:

1. Emergent conditions requiring prompt medical intervention after initial stabilizing care has been started.

2. Acute decompensation of patient situation.

3. Problem which is not resolving as anticipated.

4. History, physical, or lab findings inconsistent with the clinical picture.

5. Upon request of patient, nurse, or supervising physician.

III. Qualifications and Evaluations

A. Each nurse performing standardized procedure functions must have a current California registered nursing license, be a graduate of an approved Nurse Practitioner Program, and be certified as a Nurse Practitioner by the California Board of Registered Nursing.

B. Evaluation of nurses' competence in performance of standardized procedure functions will be done in the following manner:

1. **Initial:** at 3 months, 6 months and 12 months by the nurse manager through feedback from colleagues, physicians, and chart review during performance period being evaluated.

2. **Routine:** annually after the first year by the nurse manager through feedback from colleagues, physicians, and chart review.

3. **Follow-up:** areas requiring increased proficiency as determined by the initial or routine evaluation will be re-evaluated by the nurse manager at appropriate intervals until acceptable skill level is achieved, e.g. direct supervision.

IV. Authorized Nurse Practitioners

List each

V. Protocols

The standardized procedure protocols developed for use by the nurses are designed to describe the steps of medical care for given patient situations. They are to be used in the following circumstances: management of acute/episodic conditions, trauma, chronic conditions, infectious disease contacts, routine gynecological problems, contraception, health promotion exams, and ordering of medications.

STANDARDIZED PROCEDURES FOR NURSE PRACTITIONERS

Revised Spring

Interdisciplinary Practice Committee

(signature) _____		(signature) _____	
full name & title	date	full name & title	date
(signature) _____		(signature) _____	
full name & title	date	full name & title	date
(signature) _____		(signature) _____	
full name & title	date	full name & title	date
(signature) _____		(signature) _____	
full name & title	date	full name & title	date

STANDARDIZED PROCEDURES

Management of Common Primary Care Conditions

I. Policy

A. As described in the General Policy Component.

B. Covers only those registered nurses as identified in General Policy Component.

II. Protocol

A. **Definition:** This protocol covers the management of common primary care conditions seen in the outpatient setting, such as eczema, headaches, acne, fatigue syndromes, allergic rhinitis, and low pain.

B. **Database** - Nursing Practice
(Perform usual total nursing assessment to establish data base).

C. **Treatment Plan** - Medical Regimen

1. **Diagnosis**
   a. Most consistent with subjective and objective findings expected by patient. If diagnosis is not clear, assessment to level of surety plus differential diagnosis.
   b. Assessment of status of disease process when appropriate.

2. **Treatment** - (Common nursing functions)
   a. Further lab or other studies as appropriate.
   b. Physical therapy if appropriate.
   c. Diet and exercise prescription as indicated by disease process and patient condition.
   d. Patient education and counseling appropriate to the disease process.
   e. Follow-up appointments for further evaluation and treatment if indicated.
   f. Consultation and referral as appropriate.

3. **Physician Consultation:** As described in the General Policy Component.

4. **Referral to Physician or Specialty Clinic:** Conditions for which the diagnosis and/or treatment are beyond the scope of the nurse's knowledge and/or skills, or for those conditions that require consultation.

5. **Furnishing Medications** - (Medical Regimen)
Follow furnishing protocol, utilizing formulary.

PROTOCOL: DRUGS AND DEVICES

Definition: This protocol covers the management of drugs and devices for women of all ages presenting to _____ clinic. The nurse practitioner may initiate, alter, discontinue, and renew medication included on, but not limited to the attached formulary. All Schedule I and Schedule II drugs are excluded.

Subjective Data: Subjective information will include but is not limited to:

1. Relevant health history to warrant the use of the drug or device.
2. No allergic history specific to the drug or device.
3. No personal and/or family history which is an absolute contraindication to use the drug or device.

Objective Data: Objective information will include but is not limited to:

1. Physical examination appropriate to warrant the use of the drug or device.
2. Laboratory tests or procedures to indicate/contraindicate use of drug or device if necessary.

Assessment: Subjective and objective information consistent for the use of the drug or device. No absolute contraindications of the use of the drug or device.

Plan: Plan of care to monitor effectiveness of any medication or device.

Patient Education: Provide the client with information and counseling in regard to the drug or device. Caution client on pertinent side effects or complications with chosen drug or device.

Consultation and/or Referral: Non-responsiveness to appropriate therapy and/or unusual or unexpected side effects and as indicated in general policy statement.

REFERENCES: PDR '94 50th Edition (list page)
Primary Care Medicine, 3rd Edition, Chapter (list), pp. (list)
Handbook of Gynecology and Obstetrics, 3rd Edition, Chapter (list), pp. (list)

FORMULARY

To include but not limited to those medications listed below:

Antibiotic: Ampicillin, Penicillin, Amoxicillin, Dicloxacillin, Augmentin, Keflex, Tetracycline, Noroxin, Minocin, Vibramycin, Benemid, Macrodantin, Erythromycin, Rocephin, Gantrisin, Trimethoprim/sulfamethoxazole, Nitrofurantoin, Nalidixic acid.

Antidiarrheal: Imodium, Donnagel

Antiemetic: Trans-derm V, Compazine, Phenergan, Tigan

Antifungal: Mycostatin oral suspension/tablets, Nizoral, Monistat, Femstat, Terazol, Gyne-Lotrimin

Antiviral: Zovirax ointment/capsules, Podophyllin 25-75%, Trichloroacetic acid

Antiparasite: Flagyl/Protostat, Kwell lotion/shampoo, RID lotion, Eurax cream

Biologic: RhoGAM, HypRho-D

Chemotherapeutic: 5FU for vaginal or vulvar use

Devices: Diaphragm, cervical cap, IUD, pessary, Norplant

Diuretic: Spironolactone, Dyazide

Hormone: All oral contraceptives, progesterone preparations, Estrogen (Premarin, Estinyl, Delestrogen, Estrovis, Estrace), Estraderm, Protestins (Aygestin, Provera, Micronor, Nor QD, Ovrette), Estrogen vaginal creams (Premarin, Estrace)

Local anesthetic: Xylocaine Jel 2%, Xylocaine 1% injection

Nonsteroidal Anti-inflammatory: Anaprox, Anaprox DS, Suprol, Motrin, Ponstel, Naprosyn, Rufen

Over the counter: Spermicidal agents, cold & cough preparations (non-narcotic), laxatives, stool softeners, antacids, antiflatulents, analgesics, prostaglandin inhibitors, topicals, vitamin/mineral, antihistamines, decongestants, hemorrhoidal/antidiarrheal.

Rectal:	Anusol HC, Wyanoids
Thyroid:	Synthroid, Armour thyroid tablets
Urinary analgesic:	Pyridium
Vaginal:	All appropriate antifungals, Aminocervical cream, Acijel, Betadine, Triple Sulfa cream, Estrogen cream.
Vitamin/Mineral:	Prenatal vitamins, iron pill

EXAMPLE B (Disease Specific)

The Board of Registered Nursing does not recommend or endorse the medical management of this sample standardized procedure. It is intended as a guide for format purposes only.

Standardized Procedures

DEPARTMENT:_____ FACILITY:_____

POLICY

I. FUNCTIONS NURSE PRACTITIONERS MAY PERFORM:

Provide care for patients with acute conditions as covered in attached protocol (see sample attached) and furnish non-controlled drugs and devices to essentially healthy patients.

II. CIRCUMSTANCES UNDER WHICH NURSE PRACTITIONERS MAY PERFORM THESE FUNCTIONS:

A. May furnish non-controlled drugs and devices under standardized procedures under the supervision of a designated physician (or designee).

B. Applies to nurse practitioners working in (indicate departments involved).

III. EXPERIENCE, TRAINING AND/OR EDUCATION REQUIRED OF THE NURSE PRACTITIONER:

Maintains a current California license to practice as an RN, is certified by the State of California as a Nurse Practitioner, has met all the requirements for and has a current Furnishing Number issued by the Board of Registered Nursing. Is oriented to the facility.

IV. METHOD OF INITIAL AND CONTINUED EVALUATION OF COMPETENCE:

General competency is initially evaluated during the probationary period through a proctoring process by the supervising physician. The registered nurse is assigned to and is supervised by a designated physician who is responsible to annually evaluate appropriateness of practice and clinical decision making. A QA review process is established to assure that compliance to standards relating to important aspects of care are maintained.

V. DOCUMENTATION

Documentation required is outlined in each protocol. Patient specific documentation is entered into the patient's medical record.

DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

I. THIS STANDARDIZED PROCEDURE WAS:

Developed by the supervising physician, or designee, and the Nurse Practitioner. Approved by the department Chief, Director of Nursing Practice, Physician-in-Chief or designees, and Medical Group Administrator.

II. THIS STANDARDIZED PROCEDURE WILL BE REVIEWED AT LEAST ANNUALLY.

REVISION DATED _____ REVIEWED DATED _____
_____ _____
_____ _____

III. THE STANDARDIZED PROCEDURE WAS APPROVED BY:

MEDICINE _____ DATE_____
(Chief of Department)

MEDICINE _____ DATE_____
(PIC/Designee)

NURSING _____ DATE_____
(Director of Nursing Practice)

ADMINISTRATION _____ DATE_____
(Medical Group Administrator)

IV. PRACTITIONERS FUNCTION UNDER THIS STANDARDIZED PROCEDURE:

Current list of authorized personnel are on file in the office of the Medical Group Administrator and department manager.

PROTOCOLS (List those applicable)

I.E., Urinary Tract Infection (see attached).
Respiratory tract infection
Otitis Media
Vaginitis

References: List

URINARY TRACT INFECTION PROTOCOL: INITIAL VISIT

I. RATIONALE

This protocol will assist in the differentiation between pyelonephritis and urinary tract symptoms sufficiently to eradicate the symptoms per se rather than attempt to eradicate any bacteriuria that may or may not be present. The design of the protocol for UTI encompasses these principles.

II. SYMPTOMS

A. CYSTITIS

1. FEMALE PATIENTS

Order a STAT CVMS UA for female patients with any of the following symptoms;

a. Dysuria
b. Frequency
c. Urgency
d. Inability to empty bladder completely

2. Male patients

Male patients with any of the above symptoms should be seen by an M.D., not by a NP, unless they have a urethral discharge (possible VD - follow VD protocol).

B. PYELONEPHRITIS

1. In addition to the above symptoms, patients with pyelonephritis may have:
   a. Fever greater than 100.0 F. or
   b. Flank pains, or
   c. Chills, or
   d. Nausea, vomiting or abdominal pain.
2. Continue with protocol through the physical exam with these patients, but then consult supervising physician before deciding on treatment.

III. HISTORY

A. Consult supervising physician if patient has:
   1. A history of kidney problems, or
   2. Is currently pregnant. To ascertain this, always ask for LMP date and record for all female patients.
   3. Diabetes or insulin.
   4. Three or more UTIs in past 12 months

B. Continue with UTI protocol, but also refer patient to GYN if history of:
   1. Vaginal discharge, or
   2. Perineal inflammation.

IV. PHYSICAL EXAM

A. Perform the following examinations:
   1. Abdominal
   2. CVA
   3. Temperature

B. Consult supervising physician if findings of:
   1. Fever greater than 100.0 F. or
   2. CVA tenderness.

V. LAB TESTS

INITIAL URINALYSIS

A. Consult supervising physician if:
   1. Casts
   2. RBCs or protein are positive (without associated WBC abnormality).

B. If UA shows 10 or more WBCs/hpf and patient is symptomatic, give patient antibiotic prescription as described in the treatment section.

C. If UA revealed 0-10 WBCs, review symptoms. If the symptoms are definite and very severe, treat with antibiotics; if symptoms are vague and poorly defined, then give patient symptomatic treatment as described in the treatment section and consider referral to GYN for pelvic.

D. Should the initial UA be "positive": (defined in guidelines below), then give patient a repeat UA slip for the abnormality found with instructions to have that UA one week following completion of treatment.

Positive UA findings are defined as:

Casts: any except occasional hyaline or rare granular
RBCs > 3 (if not menstruating) and WBC < 5
Protein > trace and WBC < 5

VI. TREATMENT

ANTIBACTERIAL TREATMENT

To be given if initial UA reveals 10 or more WBC/hpf, or in any case where symptoms are severe, even if UA revealed, WBC/hpf.

A. Prescribe appropriate antibiotic drug (see p.6)

B. Instruct patient to call in if symptoms do not subside within 72 hours. If patient does call back, information for treatment failure instructions.

SYMPTOMATIC TREATMENT

To be given only if initial UA reveals, 10WBC/Hpf, and patient has minimal or uncertain symptoms. Consider GYN referral for pelvic.

A. Prescribe either Propantheline 15 mg #20 sig: 1-2 QID prn or Belladonna with Pb tabs #15, sig: 1 tab QID prn.
B. Instruct patient to call in if symptoms persist beyond 72 hours or if symptoms worsen at any time.

VII. REPEAT URINALYSIS (CVMS)

A. Consult supervising physician if UA shows casts.
B. If repeat UA confirms abnormality (protein and/or RBC as listed below) refer to Proteinuria and/or Hematuria protocols.

Positive UA findings are defined as:
Casts: any, except occasional hyaline or rare granular
RBCs >3 (if not menstruating) and WBC <5
Protein > trace and WBC <5

UTC PROTOCOL: ANTIBIOTIC TREATMENT

A. If organism found in patient's urine is not listed in the table below, consult supervising physician for treatment.

B. If this is the first antibiotic course (initial visit), assume E coli and use the first listed drug to which patient is not allergic, as listed for E coli in the drug table below.

C. If this is a second antibiotic course (treatment failure), go to the first drug for the organism listed that is not the same as that previously used and to which the patient is not allergic. If the patient is allergic to all drugs listed, consult supervising physician for treatment.

D. Prescribe according to the prescription table which follows:

1. If symptoms have been present within the past 48 hours, use 1 dose treatment.
2. If symptoms have been present longer than 48 hours, use 5-day treatment.
3. If symptoms persists after treatment with first drug, repeat UA and culture and consult supervising physician.

UTI PROTOCOL: TREATMENT FAILURE

If the patient calls in with persisted or recurrent symptoms after the first course of antibiotic treatment, obtain a CVMS urine specimen for UA and culture and sensitivity.

If the UA is negative, wait for the culture results before treating. If the UA is positive, treat with the next drug listed on the Antibiotic Prescription Table and review treatment choice when the culture and sensitivity results are available.

If culture is positive and patients symptoms are improving, stay with the same antibiotic. If not responding after 3 days, switch to a new antibiotic based on culture sensitivity.

Adapted from protocol developed by: _____, NP

_____, MD

(List names of nurse practitioners and physicians who developed the standardized procedure, including the protocol section).

ANTIBIOTIC PRESCRIPTION TABLE

ORGANISM	DRUG
E. Coli Proteus mirabilis	Septra DS, Amoxicillin Macrodantin, Keflex
Aerobacter Klebsiella	Septra DS, Macrodantin Keflex, Ciprofloxacin
Enterococcus	Ampicillin *Consult MD if allergic
Pseudomonas	Ciprofloxacin (Usually not seen in out-patient setting)

DOSAGES

SEPTRA DS	#3 PO at once or 1 bid x 5 days
AMOXICILLIN	500mg 3gms PO at once or 250mg 1 tid x 5 days
MACRODANTIN	100mg qid x 5 days
KEFLEX	250mg qid x 5 days
CIPROFLOXACIN	250mg qid x 5 days

EXAMPLE C (Procedure Specific)

The Board of Registered Nursing does not recommend or endorse the medical management of this sample standardized procedure. It is intended as a guide for format purposes only.

Standardized Procedure for Dispensing by Registered Nurse

I. Policy

A. Drugs and devices listed in the agency formulary and prescribed by a lawfully authorized prescriber may be dispensed.
B. Setting - Adult Clinic.
C. Supervision - None required at the time of dispensing.

II. Protocol

A. Data Base
1. No patient or family history contraindications.
2. Agency required tests and procedures relative to the drug or device being dispensed demonstrate no contraindications.

B. Action
1. Affix label which contains information that follows.
a. Agency name, address and telephone number.
b. Patient's name.
c. Name of the prescriber and initials of the dispenser.
d. Date dispensed.
e. Trade or generic name of dispensed drug.
f. Quantity and strength of dispensed drug.
g. Directions for use of dispensed drug.
h. Expiration date of the drug's effectiveness.
2. Affix any appropriate auxiliary labels.
3. Use child proof containers.
4. Provide patient with appropriate information including:
- directions for taking the drug;
- what to do and whom to contact if side effects occur;
- common side effects;
- possible serious or harmful effects of the drug; and
- any manufacturer-prepared information required by the FDA.

C. Record Keeping - Document in the patient record:
1. Name, dosage, route and amount of the drug dispensed.
2. Lot number and manufacturer's name.
3. Other information, including patient instructions given.
4. Complete information in the pharmacy dispensing log.

D. Consultation - Contact the prescriber if the item is not listed in the agency formulary for RN dispensing or regarding contraindications.

III. Requirements for Registered Nurses

A. Education, training and experience: successful completion of the agency's in-service program on dispensing.

B. Initial evaluation: Demonstration of competency in skill performance to the satisfaction of the Pharmacy Director.

C. On-going evaluation - Monthly random record review by the pharmacist and an annual performance appraisal including observation of dispensing.

IV. Development and Approval of the Standardized Procedure

This standardized procedure was approved by the following:

NURSING_____ DATE _____

MEDICINE_____ DATE _____

PHARMACY_____ DATE _____

ADMINISTRATION _____ DATE _____

The standardized procedure will be reviewed annually.

V. RNs authorized to perform the procedure.

1. _____ DATE _____

2._____ DATE _____

SCOPE OF PRACTICE AND STANDARDIZED PROCEDURES
FOR NURSE PRACTITIONERS
Version 1

1. PURPOSE: To outline a policy and procedure for requesting approval of Scope of Practice and Standardized Procedures for nurse Practitioners (NPs), as well as define the scope of practice and standardized procedures of the NP's within the [Enter name of facility].

2. POLICY:

   A. This policy gives authorization to NPs and defines the general conditions for implementation of the Scope of Practice and Standardized Procedures as defined in this document and will be referred to generally as the "Standardized Procedures."

   B. By utilizing their assessment and health care management skills in accordance with the Standardized Procedures, NPs can diagnose, treat, and manage all patient situations to meet the health care needs of the patient.

   C. All Standardized Procedures are to be approved by the NP, collaborating physician, Director of the Service Line, Nurse Executive, and the Chief of Staff.

   D. The NP and collaborating physician will review the Scope of Practice and standardized procedures for that NP annually and when modification is deemed necessary. This review will utilize data obtained from the ongoing medical record peer review process. The review will be documented at the time of the annual verification of proficiency and competency. The Peer review process will be utilized for resolution of disagreements between the Nurse Practitioner and physician.

   E. The NP Scope of Practice and standardized procedures will be renewed every two (2) years.

3. DEFINITIONS: None Necessary.

4. RESPONSIBILITIES:

   A. The NP will manage primary, complex, and urgent/emergent medical problems within the primary, secondary, and tertiary care setting, as outlined in this document.

   B. The NP is authorized to implement the Standardized Procedures in this document (Attachment A).

   C. Physician consultation will be available at all times on site or by telephone.

   D. Consultation with a physician will be required:

(1) Whenever situations arise that go beyond the competence, scope of practice, experience of the NP, or the intent of the standardized procedures.

(2) Whenever a patient's condition fails to respond to the management plan in appropriate time or manner.

(3) For any patient conditions that are uncommon or unstable.

(4) For any patient conditions that do not fit the commonly accepted diagnostic patterns for a disease or disorder.

(5) For all emergency situations after initial stabilizing care has been started.

(6) For **significant** unexplained physical, historical, or laboratory findings.

(7) At the request of the patient, nurse practitioner, or physician.

F. Whenever physician consultation is obtained, a notation to that effect, including the physician's name will be made by the NP in the patient's medical record.

F. NPs will perform these standardized procedures at the [Enter name of facility].

G. The NP will be held responsible for the preparation of a complete medical record entry for each patient contact per existing policies.

H. The NP will provide for patient coverage in the case of absence, as needed.

5. PROCEDURES:

A. In addition to basic RN qualifications, each nurse practitioner performing these functions must have the following:

(1) Advanced education in a university-affiliated NP program or in an accredited university-based masters prepared NP program.

(2) Current state certification/licensure as an NP .

(3) Current American Nurses Association or other nationally recognized certification as an NP.

(4) A furnishing license as an NP in the State of California or a corresponding prescriptive authorization from the state of origin.

(a) In the State of California, to be eligible for a furnishing license the NP must have completed a BRN- approved pharmacology course and

have six (6) months of physician-supervised experience in furnishing drugs and devices.

B. The Credentialing and Privileging Office is responsible for:

(1) Verification of NP and collaborating physician credentials.

(2) Verification of competency documentation appropriate to Scope of Practice and Standardized Procedures.

(3) Processing, tracking, and maintaining Scope- of -Practice files on all NPs.

C. Evaluation of the NPs competence in performance of standardized procedure functions will be done in the following manner:

(1) **Initial**: at 3 months, 6 months, and 12 months by [Enter name and title] through feedback from colleagues, physicians, and chart review.

(2) **Routine**: annually after the first year by [Enter name and title] through feedback from colleagues, physicians, and chart review.

(3) **Follow-up**: areas requiring increased proficiency as determined by the initial or routine evaluation will be re-evaluated by [Enter name and title] at appropriate intervals until acceptable skill level is achieved, e.g. direct supervision.

D. The NP's Scope of Practice and Standardized Procedures will be reviewed and approved by the NP, collaborating physician, Director of the Service Line, Nurse Executive, and Chief of Staff.

6. REFERENCES:

7. REVIEW DATE: [Enter Date]

8. ATTACHMENTS:

Attachment A: Scope of Practice and standardized procedures for Nurse Practitioners.

Attachment B: Provider file request.

_____ _____

Name Date
Chief Executive Officer

FOR NURSE PRACTITIONERS

Attachment A

This Scope of Practice and Standardized Procedures are for:

_____, Nurse Practitioner

_____, Care line / Venue

(Check applicable items)

1. Definition: Standardized procedures address delivery of care for primary, complex and urgent/emergent medical problems, prescribing practices, and ordering/interpreting laboratory and diagnostic studies.

☐ A. Primary care is the provision of integrated, accessible health care services by clinicians that are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. The nurse practitioner is authorized to diagnose and treat primary care problems as follows:

(1) A treatment plan is developed, documented and based upon clinical guidelines/pathways and standards of practice.
(2) All other applicable procedures in this document are followed during patient care management.
(3) The polices regarding approval, setting, education, evaluation, patient records, supervision and consultation for the Nurse Practitioner are in force.

☐ B. Complex medical problems are those that fall beyond the scope of management of primary care but do not present as urgent/emergent medical conditions. The nurse practitioner is authorized to diagnose and treat complex medical problems and may practice as follows:

(1) A treatment plan is developed, documented and based upon clinical guidelines/pathways and standards of practice.
(2) Management of the patient may be in conjunction with a physician.
(3) The consultation or referral is documented in the patient's medical record.
(4) All other applicable procedures in this document are followed during patient care management.
(5) The polices regarding approval, setting, education, evaluation, patient records, supervision and consultation for the Nurse Practitioner are in force.

☐ C. The nurse practitioner is authorized to diagnose and treat urgent / emergent conditions as follows:

Initial evaluation and stabilization of the patient may be performed with concomitant notification of and/or immediate management by a physician.

(1) The consultation or referral is documented in the patient's medical record.
(2) All other applicable procedures in this document are followed during patient care management.
(3) The policies regarding approval, setting, education, evaluation, patient records, supervision and consultation for the Nurse Practitioner are in force.

☐ D. The nurse practitioner is authorized to order, collect and interpret laboratory and diagnostic studies as follows:

(1) Laboratory and diagnostic studies may be ordered as appropriate in accordance to clinical guidelines/pathways and standards of practice.
(2) Complex and/or invasive studies are ordered/obtained, utilizing physician consultation as appropriate.
(3) All other applicable procedures in this document are followed during patient care management.
(4) The policies regarding approval, setting, education, evaluation, patient records, supervision and consultation for the Nurse Practitioner are in force.

☐ E. The nurse practitioner may prescribe drugs or devices pursuant to [Enter name of facility], "General Guidelines for Establishing Medication Prescribing Authority". The nurse practitioner is authorized to prescribe medications or devices as follows:

(1) A treatment plan is developed, documented and based upon clinical guidelines/pathways and standards of practice.
(2) All other applicable procedures in this document are followed during patient care management.
(3) The policies regarding approval, setting, education, evaluation, patient records, supervision and consultation for the Nurse Practitioner are in force.

☐ F. Non-restricted legend and non-legend drugs and pharmaceutical devices, including schedule III through schedule V controlled substances, may be **RENEWED** within the [Enter name of facility] Formulary. A Drug Enforcement Agency number (DEA#) is required in order for the APN to prescribe controlled substances. In addition, prescribing of controlled substances schedule III will be in accordance with patient specific protocols in agreement with the collaborating physician (attachment C).

☐ G. Non-restricted legend and non-legend drugs and pharmaceutical devices, including schedule III through schedule V controlled substances, may be **INITIATED and/or MODIFIED** within the [Enter name of facility] Formulary. A Drug Enforcement Agency number (DEA#) is required in order for the APN to prescribe controlled substances. In addition, prescribing of controlled substances schedule III will be in accordance with patient specific protocols in agreement with the collaborating physician (attachment C).

☐ H. Nurse Practitioners assigned to sub-specialty areas are approved to **RENEW** drugs restricted to the specialty area, in accordance with clinical guidelines/pathways (see attached list).

☐ I. Nurse Practitioners assigned to sub-specialty areas are approved to **INITIATE and/or MODIFY** drugs restricted to the specialty area, in accordance with clinical guidelines/pathways (see attached list).

☐ J. Specialized Standardized Procedures (attached if applicable).

Recommended Approval: (signatures)

Nurse Practitioner: _____Date: _____

As collaborating physician for the above named Nurse Practitioner, I agree to supervise and regularly evaluate the performance of the Nurse Practitioner.

Collaborating Physician(s): _____ Date: _____

_____ Date: _____

Director of Service Line: _____Date: _____

Nurse Executive: _____ Date: _____

Chief of Staff: _____Date: _____

PROVIDER FILE REQUEST

Attachment B

Please answer the questions listed below for inclusion in the [Enter name of facility] provider file.

1. Name of Provider:
   _____
   (last, first, middle initial)

2. Sex: _____

3. Date of Birth: _____

4. Social Security Number: _____ _____ _____

5. Mailing Address: _____
   (number and street name)

   _____ _____ _____
   (city) (state) (zip code)

6. Class:
   _____
   (example: Dentist, Physician, Fellow, Intern, Pharmacy Specialist, Nurse Practitioner, Physician Assistant).

7. Type: _____ Enter 1 for full time
   Enter 2 for part-time
   Enter 3 for C & A
   Enter 4 for fee basis
   Enter 5 for house staff

8. DEA #: _____

9. [Enter name of facility] #: _____

10. License expiration date: _____

Agreement Between Supervising Physician and Non-Physician Medical Provider Regarding Medical Assistant Supervision

This agreement states that medical assistants are allowed to perform certain procedures and technical support services under the supervision of mid-Level providers when the physician is not present.

Per the Medical Board of California, Medical Assistant (MA)description; medical assistants are unlicensed individuals who administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical supportive services under the supervision of a licensed physician and surgeon, podiatrist, physician assistant, nurse practitioner, or nurse midwife in a medical setting. The supervising physician must be on the premises in order for the medical assistant to perform supportive tasks and services. Under the provisions of Business and Professions Code Section 2069 (a)(2), the supervision of a medical assistant may be delegated to a mid-level practitioner when the supervising physician is not on site.

Signatures below authorize the delegation of the supervision of the medical assistant to the non-physician medical provider when the supervising physician is not physically on site.

Supervising physician printed name: _____

Supervising physician signature: _____

Date: _____

Non-physician medical provider printed name: _____

Non-physician medical provider signature: _____

Date: _____

PCP	
Section: PERSONNEL	
POLICY AND PROCEDURE: Staff Education Training	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:
All staff at PCP sites receives education/training regarding safety issues, information on members' rights and other issues related to clinical procedures. This education/training should take place initially upon hire, then annually thereafter for those areas identified with an asterisk on the Checklist.

PROCEDURE:

I. NEW HIRE PROCESS

A. Upon hire, all new employees will receive training on safety, Members' rights and clinical procedures as outlined in the attached checklists.

B. Types of training may include, but is not limited to: new employee orientation, in-service training, instructional videos, educational materials, annual training renewal, etc.

C. Upon completion of each criterion within this education/training, the employee's supervisor will initial the Checklist with the corresponding date of completion. The supervisor's initials indicate the employee either stated or demonstrated an understanding of the education/training provided.

1. When all areas on the Checklist have been completed, the employee and the instructor will sign and date the Checklist, signifying the employee was knowledgeable of all criteria presented by the instructor.

2. A copy of the completed Checklist shall be kept in each employee's file. All records of education/training need to be kept for three years.

D. ANNUAL REVIEW

E. All employees must receive an annual renewal of all training/education identified with an asterisk on the Checklist.

F. Follow the same procedure as described above, for the New Employee.

ATTACHMENTS: Sample of Training Checklist Log

blue california | Promise Health Plan

Formerly CareIst Health Plan

PHYSICIAN & OFFICE STAFF TRAINING CHECKLIST

PROVIDER:_____ ADDRESS: _____ DATE OF HIRE: _____

STAFF NAME & TITLE: _____ STAFF SIGNATURE/INITIALS: _____

INSTRUCTOR NAME: _____ INSTRUCTOR SIGNATURE: _____

ANNUAL TRAINING	INITIALS/DATE:	INITIALS/DATE:	INITIALS/DATE:
INFECTION CONTROL/UNIVERSAL PRECAUTIONS	_____/_____	_____/_____	_____/_____
BLOOD BORNE PATHOGENS EXPOSURE PREVENTION	_____/_____	_____/_____	_____/_____
BIOHAZARD WASTE HANDLING	_____/_____	_____/_____	_____/_____

COMPLETED UPON HIRE AND AS NEEDED	
FIRE SAFETY AND PREVENTION	_____/_____
EMERGENCY NON-MEDICAL PROCEDURES	_____/_____
EMERGENCY MEDICAL PROCEDURES	_____/_____
PATIENT CONFIDENTIALITY	
INFORMED CONSENT, INCLUDING HUMAN STERILIZATION	_____/_____
PRIOR AUTHORIZATION REQUESTS	_____/_____
GRIEVANCE/COMPLAINT PROCEDURE	_____/_____
CHILD/ELDER/DOMESTIC VIOLENCE ABUSE REPORTING	_____/_____
SENSITIVE SERVICES/MINORS RIGHTS	
HEALTH PLAN REFERRAL PROCESS/PROCEDURE/RESOURCES	_____/_____
CULTURAL & LINGUISTIC TRAINING	_____/_____
DISABILITY RIGHTS & PROVIDER OBLIGATIONS	_____/_____
OTHER: _____	_____/_____

PCP	
Section: Infection Control	
POLICY AND PROCEDURE: Standard and Universal Precautions	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:
Infection Control standards are practiced on site to minimize risk of disease transmission. Site personnel will apply the principles of "Standard Precautions" (CDC, 1996), used for all patients regardless of infection status. Standard precautions apply to blood, all body fluids, non-intact skin, and mucous membranes, which are treated as potentially infectious for HIV, HBV or HCV, and other blood borne pathogens. "Universal precautions" refer to the OSHA mandated program that requires implementation of work practice controls, engineering controls, blood borne pathogen orientation/education, and record keeping in healthcare facilities.

PROCEDURE:

I. HAND WASHING FACILITIES

A. Hand washing facilities are available in the exam room and/or utility room, and include an adequate supply of running potable water, soap, and single use towels or hot air-drying machines. Sinks with a standard faucet, foot operated pedals, 4-6-inch wing-type handle, automatic shut-off systems or other types of water flow control mechanism are acceptable. Staff is able to demonstrate infection control "barrier" methods used on site to prevent contamination of faucet handle, door handles and other surfaces until hand washing can be performed. On occasions when running water is not readily available, an antiseptic hand cleanser, alcohol-based hand rub, or antiseptic towelettes is acceptable until running water is available (29 CFR 1919.1030).

B. Hand washing prevents infection transmission by removing dirt, organic material and transient microorganisms from hands. Hand washing with plain (nonantimicrobial) soap in any form (e.g., bar, leaflet, liquid, powder, granular) is acceptable for general patient care (Association for Professionals in Infection Control and Epidemiology, Inc., 1995).

II. ANTISEPTIC HAND CLEANER

A. Antimicrobial agents or alcohol-based antiseptic hand rubs are used for hand washing when indicated to remove debris and destroy transient microorganisms (e.g., before performing invasive procedures, after contact with potentially infectious materials). Plain and antiseptic hand wash products are properly maintained and/or dispensed to prevent contamination.

B. Hands shall be washed with soap and water when they are visibly soiled or after healthcare personnel have been in contact with patients with diarrheal illnesses such as Norovirus or C. difficile. As a precaution, wash with soap and water when in contact with any diarrheal illness.

III. WASTE DISPOSAL CONTAINER

A. Contaminated wastes (e.g., dental drapes, band aids, sanitary napkins, soiled disposal diapers) are disposed of in regular solid waste (trash) containers and are maintained to prevent potential contamination of patient/staff areas and/or unsafe access by infants/children.
B. Blood and Other Potentially Infectious Materials (OPIM) are all human body fluids, any unfixed tissue or organ (other than intact skin) from a human (living or dead), and HIV or HBV-containing blood, cells, tissue, organs, cultures, medium or solutions. Containers for blood and OPIM are closable, leak proof, and labeled and/or color-coded. Double bagging is required only if leakage is possible.

IV. ISOLATION PROCEDURES

A. If the practitioner indicates that the patient **DOES NOT** have a communicable disease, clean the room as usual between patients and continue to use the room.

B. If you suspect that a patient may have a communicable disease:

a. Take the patient immediately to the closest exam room, place the patient in the exam room and close the door completely.
b. Immediately notify the physician or on-site practitioner of the situation and request that they see the patient as quickly as possible.
c. Wipe the reception counter down with disinfectant cleaning solution and continue seeing patients.

C. If the practitioner indicates that the patient **DOES** have a communicable disease:

a. Airborne precautions:
1. Have patient enter through a separate entrance to the facility (e.g., dedicated isolation entrance), if available, to avoid the reception and registration area.
2. Provide a facemask (e.g., procedure or surgical mask) to the patient and place them immediately in an airborne infection isolation room (AIIR).
3. If an AIIR is not available, place the patient immediately in an exam room with a closed door. If an AIIR is not available, place the patient immediately in an exam room with a closed door. Turn off air condition/heating equipment that may circulate the air from the isolation room into other patient areas within the facility.
4. Instruct the patient to keep the facemask on while in the exam room, if possible, and to change the mask if it becomes wet; and

5. Initiate protocol to transfer patient to a healthcare facility that has the recommended infection-control capacity to properly manage the patient.
6. PPE use:
- Wear a fit-tested N-95 or higher-level disposable respirator, if available, when caring for the patient; the respirator should be donned prior to room entry and removed after exiting room
- If substantial spraying of respiratory fluids is anticipated, gloves and gown as well as goggles or face shield should be worn
7. Perform hand hygiene before and after touching the patient and after contact with respiratory secretions and/or body fluids and contaminated objects/materials.
8. Use soap and water when hands are visibly soiled (e.g., blood, body fluids).
9. Instruct patient to wear a facemask when exiting the exam room, avoid coming into close contact with other patients, and practice respiratory hygiene and cough etiquette.
10. Once the patient leaves, **the exam room should remain vacant for generally one hour before anyone enters**; however, adequate wait time may vary depending on the ventilation rate of the room and should be determined accordingly, and
11. If staff must enter the room during the wait time, they are required to use respiratory protection.

b. Droplet Precautions
1. Provide the patient with a facemask and place the patient in an exam room with a closed door as soon as possible (prioritize patients who have excessive cough and sputum production); if an exam room is not available, the patient is placed in a separate area as far from other patients as possible while awaiting care.
2. PPE use:
   - Wear a facemask, such as a procedure or surgical mask, for close contact with the patient; the facemask should be donned upon entering the exam room.
   - If substantial spraying of respiratory fluids is anticipated, gloves and gown as well as goggles (or face shield in place of goggles) should be worn.
3. Perform hand hygiene before and after touching the patient and after contact with respiratory secretions and contaminated objects/materials; **note**: use soap and water when hands are visibly soiled (e.g., blood, body fluids).
4. Instruct patient to wear a facemask when exiting the exam room, avoid coming into close contact with other patients, and practice respiratory hygiene and cough etiquette; and
5. Clean and disinfect the exam room accordingly.

c. Contact Precautions
1. Apply to patients with any of the following conditions and/or disease:
   - Presence of stool incontinence (may include patients with Norovirus, rotavirus, or Clostridium difficile), draining wounds, uncontrolled secretions, pressure

ulcers, or presence of ostomy tubes and/or bags draining body fluids
- Presence of generalized or diffuse rash.

2. Prioritize placement of patients in an exam room if they have stool incontinence, draining wounds and/or skin lesions that cannot be covered, or have uncontrolled secretions.
3. Perform hand hygiene before touching patient and prior to wearing gloves.
4. PPE use:
    - Wear gloves when touching the patient and the patient's immediate environment or belongings
    - Wear a gown if substantial contact with the patient or their environment is anticipated.
5. Perform hand hygiene after removal of PPE; **note**: use soap and water when hands are visibly soiled (e.g., blood, body fluids), or after caring for patients with known or suspected infectious diarrhea (e.g., Clostridium difficile, Norovirus).
6. Clean/disinfect the exam room accordingly.
7. Instruct patients with known or suspected infectious diarrhea to use a separate bathroom, if available. Clean/disinfect the bathroom before it can be used again.

ATTACHMENTS:
Please refer to link:
https://www.who.int/publications/m/item/hand-hygiene-why-how-when

PCP	
Section: Infection Control	
POLICY AND PROCEDURE: Decontamination of Surfaces	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:
The site will follow decontamination procedures on contaminated surfaces according to Cal-OSHA Standards, 8 CCR §5193; CA H&S Code §118275. The site will utilize products from the Current EPA product lists and information available from the EPA, Antimicrobial Division (703) 308-6411or (703) 308-6437 and Antimicrobial Division's website at https://www.epa.gov/pesticide-registration/selected-epa-registered-disinfectants

PROCEDURE:

I. ROUTINE DECONTAMINATION

A. Contaminated work surfaces are decontaminated with an appropriate disinfectant (29 CFR 1910.1030). Written "housekeeping" schedules have been established and are followed for regular routine daily cleaning. Staff is able to identify frequency for routine cleaning of surfaces and equipment, the disinfectant used and responsible personnel.

II. SPILL PROCEDURE

A. Staff is able to identify procedures for prompt decontamination of blood/body fluid spills, the disinfectant used, and the responsible person(s).

B. PPE for protection against bloodborne pathogen hazards is available on site and shall include water repelling gloves; clothing barrier/gown; face/eye protection (e.g., goggles/face shield); and respiratory infection protection (e.g., mask). It does not include general work clothes (e.g., uniforms, cloth lab coats) that will permit liquid to soak through. General work clothes are appropriate only if blood/OPIM does not penetrate through employee's work clothes, undergarments, skin, eyes, mouth, or other mucous membranes under NORMAL conditions of use. The storage of PPE is adequate to protect the PPE from contamination, loss, damage, water, or sunlight. Proper storage often requires a dry and clean place that is not subject to temperature extremes.

III. WASTE DISPOSAL CONTAINER

A. Contaminated wastes (e.g., dental drapes, band aids, sanitary napkins, soiled disposable diapers) are disposed of in regular solid waste (trash) containers and are maintained to prevent potential contamination of patient/staff areas and/or unsafe access by infants/children. Closed containers are not required

for regular, solid waste trash containers. (California Health and Safety Code Section 118275-118320)
https://www.hercenter.org/rmw/osha-bps.php

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

IV. DISINFECTANT PRODUCTS

A. Products used for decontamination have a current EPA-approved status. Product will effectively kill HIV/HBV/TB. If manufacturer's product label indicates it will kill TB, it is understood that product will effectively kill HIV and HBV. Decontamination products are reconstituted and applied according to manufacturer's guidelines for "decontamination."

V. 10% BLEACH SOLUTION

A. If 10% bleach solution is used (using a minimum of 5.25% sodium hypochlorite concentration), it is changed/reconstituted **every 24 hours** (Due to instability of bleach once mixed with water). Surface is cleaned prior to disinfecting due to presence of organic matter (e.g., dirt, blood, excrement) inactivating active ingredient, sodium hypochlorite. Surface is air dried or allowed appropriate time (stated on label) before drying. Manufacturer's directions, specific to every bleach product, are followed carefully.

ATTACHMENTS: Cleaning Log (sample)
Bleach Comparison Chart with CDC guidelines (resource)
Bleach Labels (sample)
Clorox Broad Spectrum Sell Sheet (resource)

Cleaning log
Cleaning and decontamination of equipment/work surfaces

Procedure:
1. All work surfaces and equipment must be cleaned with an approved disinfectant or a 10% bleach solution (10% bleach solution is changed/reconstituted every 24 hours and has a contact/kill time of least five minutes).
2. Clean work surfaces and/or equipment daily and before and after each patient use.

Directions:
Staff cleaning work surfaces and equipment shall initial the appropriate box (month and day). Staff shall initial and sign the bottom of this form for proper identification.

Location/area cleaned: _____ **Year:** _____

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
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Staff signature/initials:

Print staff name: _____ Staff signature: _____ Initials: _____

Print staff name: _____ Staff signature: _____ Initials: _____

Print staff name: _____ Staff signature: _____ Initials: _____

Print staff name: _____ Staff signature: _____ Initials: _____

Print staff name: _____ Staff signature: _____ Initials: _____

Bleach Comparison Chart

Brand of bleach	CDC* approved tuberculocidal disinfectant At 1:10 (10%) dilution	% of Sodium Hypochlorite concentration	Label instructions for professional (tuberculocidal) disinfection	Contact time	Additional customer service/website information	EPA registered	Warning label
Clorox Germicidal	✓	6.15%	Mix 1 part bleach with 9 parts water = 10% *Tuberculocidal*	5 mins	*Tuberculocidal*	Yes	**Corrosive**
Clorox Regular	✓	6%	(No tuberculocidal claim on label but sodium hypochlorite concentration approved by CDC against TB)	5 mins	Mix 1¾ cup bleach with 1 gallon water = 9.86% *tuberculocidal*	Yes	**Corrosive**
First Street Ultra Germicidal (Smart & Final)	✓	6%	(No tuberculocidal claim on label but sodium hypochlorite concentration approved by CDC against TB)	5 mins		Yes	**Corrosive**
Up & Up (Target)	✓	6%	(No tuberculocidal claim on label but sodium hypochlorite concentration approved by CDC against TB)	5 mins		Yes	**Corrosive**
Clorox Splash-less		6%	For laundry and household cleaning only		*NOT a professional disinfectant due to added thickeners*		Eye irritant
Clorox Scented		2.75%	For laundry and household cleaning only				Eye irritant
Clorox Clean-Up Spray w/ Bleach		1.85%	Spray on affected surface	30 sec	*NOT tuberculocidal*	Yes	Eye irritant
Simply Value (Smart & Final)		2.75%	For laundry and household cleaning only				Eye irritant
LA's Totally Awesome (99 Cents Only Store)		not specified	For laundry and household cleaning only				Eye irritant

* *CDC Guidelines for Disinfection in Healthcare Facilities*, 2008 (Updated February 15, 2017):

1. By law, all applicable label instructions on EPA-registered products must be followed.
2. Disinfect areas contaminated with blood spills using an EPA-registered tuberculocidal agent or freshly diluted hypochlorite solution (bleach).
3. If sodium hypochlorite solutions are selected, use 5.25% to 6.25% sodium hypochlorite (for example, 1:10 dilution) to decontaminate nonporous surfaces after a spill of either blood or other potentially infectious materials (OPIM).
4. Use protective gloves and other personal protective equipment (PPE) appropriate for this task.

MASTER – Use standard **5163 Address Labels** from any local office supplies store

10% Bleach Solution
(Change Daily / 5 min Kill time)

__________Month/Year

Check day of reconstitution
1 ___ 17 ___
2 ___ 18 ___
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Danger
Corrosive

D Perlas 2017

10% Bleach Solution
(Change Daily / 5 min Kill time)
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Danger
Corrosive
D Perlas 2017

Clorox Commercial Solutions®

Broad Spectrum Quaternary Disinfectant Cleaner

Fast and Efficient

Even though there is no time in a busy healthcare environment to waste on slow disinfecting times, some quaternary sprays can take up to 5 minutes or longer to do their job!

- Clorox® Broad Spectrum Disinfectant kills most organisms in 2 minutes, up to 33% faster than a leading quaternary spray.
- No precleaning required.* Less waiting means your staff can move more quickly to the next area.

Powerful, Gentle Cleaning

You no longer have to choose between a quaternary spray that cleans effectively and one that won't leave a room smelling of strong chemicals. Clorox® Broad Spectrum Disinfectant is:

- Fragrance-free to help avoid the harsh chemical fumes associated with other quaternary disinfectant sprays.
- Formulated with powerful grease-cutting agents to clean the toughest messes on almost any surface.
- Tested for surface safety on most hospital-grade materials. See back for details.

90 Healthcare-Relevant Kill Claims

Some quaternary ammonium-based sprays only have 15 EPA-registered kill claims, but with countless types of pathogens in today's healthcare facilities, why risk using a disinfectant that is registered to kill so few microorganisms? Clorox® Broad Spectrum Disinfectant is:

- EPA-registered to kill 90 different pathogens, six times as many as Cavicide®
- EPA-registered to kill all of the ESKAPE pathogens, some of today's most threatening antibiotic-resistant organisms, unlike the leading quaternary sprays.
- EPA-registered to kill other problematic pathogens, including HIV, Hepatitis B and C, MRSA, VRE and TB.

E. faecium
S. aureus
K. pneumoniae
A. baumannii
P. aeruginosa
E. aerogenes

If your current disinfectant isn't registered to kill these organisms and more, your patients may not be protected from these potentially harmful pathogens.†

When it comes to patient protection, don't compromise — switch to Clorox® Broad Spectrum Quaternary Disinfectant Cleaner today!

Product	No. of Claims‡	Bacteria Kill Time	EPA-Registered to Kill all ESKAPE Pathogens	Precleaning Step Required
Clorox® Broad Spectrum	90	2 min	YES	NO
Virex® TB	64	3 min	NO	NO
Cavicide®	15	2–3 min	NO	YES
Ecolab® Asepticare® TB+II	21	3–5 min	NO	YES

* No precleaning step is required for general disinfection with Clorox® Broad Spectrum Quaternary Disinfectant Cleaner. Precleaning is required for disinfection against HIV, HBV, and HCV per OSHA guidelines, regardless of which disinfectant you use.
† Use as directed on hard, nonporous surfaces. Product tested to maintain active stability for 5 years.
‡ Based on Federal Master Label comparisons as of May 1, 2011.

ORGANISMS

BACTERIA: 2-minute contact time

- *Acinetobacter baumannii*
- *Acinetobacter calcoaceticus*
- *Bordetella bronchiseptica*
- *Burkholderia cepacia*
- *Citrobacter freundii*
- *Corynebacterium ammoniagenes*
- *Enterobacter aerogenes*
- *Enterobacter cloacae*
- *Enterococcus faecalis*
- VRE
- *Enterococcus faecium*
- *Enterococcus hirae*
- *Escherichia coli*
- *Escherichia coli* resistant to tetracycline
- *Escherichia coli* with ESBL (Extended Spectrum Beta Lactamase) resistance
- *Escherichia coli* O157:H7
- Flavobacterium
- *Haemophilus influenzae*
- *Hafnia alvei*
- *Klebsiella oxytoca* resistant to ampicillin
- *Klebsiella oxytoca*
- *Klebsiella pneumoniae*
- *Legionella pneumophila*
- *Listeria monocytogenes*
- *Micrococcus luteus*
- *Kytococcus sedentarius*
- *Pasteurella multocida*
- *Proteus mirabilis*
- *Proteus vulgaris*
- *Pseudomonas (Brevundimonas) diminuta*
- *Pseudomonas aeruginosa*
- *Pseudomonas fluorescens*
- *Pseudomonas putida*
- *Pseudomonas stutzeri*
- *Salmonella enterica*
- *Salmonella enteritidis*
- *Salmonella gallinarum*
- *Salmonella paratyphi* B
- *Salmonella pullorum*
- *Salmonella typhi*
- *Salmonella typhimurium*
- *Serratia liquefaciens*
- *Serratia marcescens*
- *Shigella dysenteriae*
- *Shigella flexneri* serotype 1B
- *Shigella sonnei*
- *Staphylococcus aureus*
- MRSA
- CA-MRSA
- *Staphylococcus aureus* resistant to erythromycin, penicillin, tetracycline
- *Staphylococcus aureus* resistant to vancomycin
- *Staphylococcus aureus* toxic shock toxin (TS)
- *Staphylococcus epidermidis* resistant to methicillin
- *Staphylococcus haemolyticus*
- *Streptococcus agalactiae*
- *Streptococcus mutans*
- *Streptococcus pneumoniae* resistant to penicillin
- *Streptococcus pyogenes* (gp. A)
- *Xanthomonas maltophila*
- *Yersinia enterocolitica*

Tuberculocidal Activity: 5-minute contact time: *Mycobacterium bovis* (BCG)

VIRUSES: 30-second contact time

- Rabies virus
- Feline Calicivirus (Norovirus [Norwalk virus] surrogate)

VIRUSES: 1-minute contact time

- Avian Influenza A (H5N1) on precleaned environmental surfaces
- Duck hepatitis B virus (Human hepatitis B surrogate)
- Bovine Viral Diarrhea virus (Hepatitis C surrogate)
- Human Immunodeficiency Virus type 1

VIRUSES: 2-minute contact time

- Avian infectious bronchitis
- Canine distemper virus
- Cytomegalovirus
- Feline viral rhinotracheitis
- Herpes simplex virus type 1
- Herpes simplex virus type 2
- Human Coronavirus
- Infectious bovine rhinotracheitis virus
- Influenza A virus
- Newcastle disease virus
- Parainfluenza virus type 3
- Pseudorabies virus
- Respiratory syncytial virus
- SARS-associated Coronavirus
- Transmissible gastroenteritis virus
- Vaccinia virus

VIRUSES: 3-minute contact time

- Adenovirus type 2
- Poliovirus
- Rhinovirus
- Rotavirus
- Canine parvovirus
- Feline Picornavirus

FUNGI: 2-minute contact time

- *Candida albicans*

Ideal for use in healthcare areas such as:

- Operating rooms
- Emergency rooms
- Intensive care units
- Patient rooms
- Radiology areas
- Pediatric areas
- Nurses' stations
- Public areas
- Long-term-care facilities
- Dialysis facilities
- Laboratories
- Physicians' offices

Cleans and disinfects nonporous medical surfaces, including:

- Counters
- Carts
- Bedside tables
- Bedrails
- Walls
- Mattress covers
- Commodes
- Dialysis machines
- Computer peripherals
- Mobile devices
- Wheelchairs

Compatible with surfaces such as:

- Stainless steel
- Plastic surfaces
- Chrome
- Enamel
- Formica®
- Aluminum
- Glass
- Glazed ceramic
- Glazed porcelain
- Laminated surfaces

PRODUCT INFORMATION

Case UPC 30649 9/32 fl. oz. Spray Bottle
Case UPC 30651 4/128 fl. oz. Refill
EPA Reg. No. 67619-20

For plastic and painted surfaces, spot test on an inconspicuous area before use. Virex Tb is a registered trademark of Diversey, Inc.
Cavicide is a registered trademark of Metrex Research Corporation.
Asepticare is a registered trademark of Ecolab USA Inc.
Formica is a registered trademark of The Diller Corporation.

For more information, contact your Clorox sales representative or call **(800) 234-7700.**
email: healthcare@clorox.com
visit us: cloroxprofessional.com

CLOROX Commercial SOLUTIONS®

NI-16577

PCP	
Section: Infection Control	
POLICY AND PROCEDURE: Blood borne Pathogens and Waste Management	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:

The site will follow the OSHA Blood borne Pathogens Standard and California Waste Management Act according to 8 CCR §5193 (Cal OSHA Health Care Worker Needle stick Prevention Act, 1999); H&S Code, §117600-118360 (CA Medical Waste Management Act, 1997); 29 CFR §1910.1030.

PROCEDURE:

I. BLOOD AND OTHER POTENTIALLY INFECTIOUS MATERIALS (OPIM)

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

II. PERSONAL PROTECTIVE EQUIPMENT (PPE)

A. PPE is specialized clothing and/or equipment for protection against blood borne pathogen hazards, and does not include general work clothes (e.g., uniforms, cloth lab coats) that permit liquid to soak through.

B. PPE is available for staff use on site, and includes:
*Staff must know how to locate this
1. Water repelling gloves
2. Clothing barrier (e.g., gown, sheets)
3. Face/eye protection (e.g., goggles, face shield)
4. Respiratory infection protection (e.g., mask)

C. Other necessary PPE are available specific to the practice and types of procedures performed on site. General work clothes are appropriate only if blood/OPIM does notpenetrate through employee's work clothes, undergarments, skin, eyes, mouth, or other mucous membranes under NORMAL conditions of use.

D. The storage of PPE should be adequate to protect the PPE from contamination, loss, damage, water or sunlight. Proper storage often requires a dry and clean place that is not subject to temperature extremes.

III. LABELS

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

IV. NEEDLESTICK SAFETY

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

V. SHARPS INJURY DOCUMENTATION

A. Site has a method in place to document sharps injuries. Date, time, description of exposure incident, sharp type/brand, follow-up care is documented within 14 days of injury incident (see attached Sharps Injury Report form).
* Staff must know where to locate forms to document sharps injury.

VI. CONTAMINATED LAUNDRY

A. Site has a laundry service contract or a washer and dryer on site to launder contaminated laundry (soiled with blood/OPIM or containing contaminated Sharps). Manufacturer's guidelines are followed to decontaminate and launder reusable protective clothing. Laundry requirements are "not applicable" if only disposable PPE is used on site.

VII. REGULATED WASTE STORAGE

A. Regulated waste is contained separately from other wastes (e.g., contaminated wastes) at the point of origin in the producing facility, placed in red biohazardous bags with Biohazard label, and stored in a closed container that is not accessible to unauthorized persons. If stored outside of the office, a lock secures the entry door, gate, or receptacle lid, and posted warning sign(s) in English and Spanish are visible for a distance of 25-feet. The sign wording states "**CAUTION: BIOHAZARDOUS WASTE STORAGE AREA UNAUTHORIZED PERSONS KEEP OUT**" or "**CUIDADO-ZONA DE RESIDUOS-BIOLOGICOS PELIGROSOS-PROHIBIDA LA ENTRADA A PERSONAS NO AUTHORIZADAS**." Signs prior to the passage of the Medical Waste Act, Infectious Waste are permitted for the "life" of the sign.

B. Regulated wastes include:

1. Biohazardous wastes, e.g., laboratory wastes, human specimens/tissue, blood/contaminated materials "known" to be infected with highly communicable diseases for humans and/or that require Isolation.
2. Medical wastes, e.g., liquid/semi-liquid blood or OPIM, items caked with dry blood or OPIM and capable of releasing materials during handling, and contaminated sharps (Health and Safety Code, Chapter 6.1, CA Medical Waste Management Act).

VIII. MEDICAL WASTE DISPOSAL

A. Medical wastes are hauled to a permitted offsite medical waste treatment facility, to a transfer station, or to another registered generator for consolidation. Hauling is by a registered hazardous waste transporter or by a person with an approved limited quantity hauling exemption granted by the CA DHCS Waste Management Division.

B. The limited quantity hauling exemption is valid for a period of one year and is renewed annually. A limited-quantity exemption is not required for Small Quantity Generator (up to 35.2 pounds). For Large Quantity Generator (more than 35.2 pounds), hauling is done by a registered hazardous waste transporter or by a person with an approved limited quantity hauling exemption granted by the CA DHS Waste Management Division.
When hauling medical wastes, the Large Quantity Generator transporter carries the exemption form in the transporting vehicle. For both Small Quantity Generator and Large Quantity Generator, a medical waste tracking document is maintained that includes name of person transporting, number of waste containers, type of medical wastes, and date of transportation. Tracking document is kept a minimum of 3 years for Large Quantity Generator and 2 years for Small Quantity Generator.

C. The medical building or hospital collects the medical waste from the clinic suite to a central accumulation area in the medical/hospital building where their contracted registered hauler picks up and hauls the waste for disposal.

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

ATTACHMENTS: Blood-Borne Pathogen Exposure Control Plan (sample)
Sharps Injury Log (resource)
Medical Waste Tracking Log (sample)
Medical Waste Log Sheet (sample)

BLOODBORNE PATHOGEN
EXPOSURE CONTROL PLAN

Adapted from the Western Kentucky University Industrial Hygiene Student Association Sample Bloodborne Pathogens Exposure Control Plan.

This sample plan is provided only as a guide to assist in complying with the OSHA Bloodborne Pathogens standard 29 CFR 1910.1030, as adopted by 803 KAR 2:320. It is not intended to supersede the requirements detailed in the standard. Employers should review the standard for particular requirements which are applicable to their situation. It should be noted that this model program does not include provisions for HIV/HBV laboratories and research facilities which are addressed in section (a) of the standard. Employers will need to add information relevant to their particular facility in order to develop an effective, comprehensive exposure control plan. Employers should note that the exposure control plan is expected to be reviewed at least on an annual basis and updated when necessary.

Facility Name: _____

Facility Address: _____

Date of Preparation: _____

Signature of Provider/Designee who prepared the plan: _____

Annual Review Date(s): ___/____ /____, ___/____ /____, ___/____ /____, ___/____ /____

1. EXPOSURE DETERMINATION

OSHA requires employers to perform an exposure determination concerning which employees may incur occupational exposure to blood or other potentially infectious materials. The exposure determination is made without regard to the use of personal protective equipment (i.e. employees are considered to be exposed even if they wear personal protective equipment). This exposure determination is required to list all job classifications – full and part time and per diem - in which all employees may be expected to incur such occupational exposure, regardless of frequency. At this facility the following employees will have occupational exposure:

[ ] Physicians
[ ] Physician Assistants
[ ] Nurses, including Nurse Practitioners
[ ] Laboratory Technicians
[ ] Medical Assistants
[ ] Other: _____

In addition, OSHA requires a listing of job classifications in which some employees may have occupational exposure. Since not all the employees in these categories would be

expected to incur exposure to blood or other potentially infectious materials, tasks or procedures that would cause these employees to have occupational exposure are also required to be listed in order to clearly understand which employees in these categories are considered to have occupational exposure.

The following employees may have occupational exposure:

[ ] Housekeeping Staff
[ ] Administrative/Clerical Staff
[ ] Receptionists
[ ] Other: _____
[ ] Other: _____

The following procedures usually performed in our office involve a potential risk of occupational exposure to blood or other potentially infectious materials:

[ ] Patient examinations
[ ] Burn treatment and dressing
[ ] Wound treatment and dressing
[ ] Cerumen Removal
[ ] Foreign body removal (eg: ear, nose, skin)
[ ] I&D abscess
[ ] Laceration Repair
[ ] Hematoma, subungal
[ ] Spinal lumbar puncture
[ ] Venopuncture
[ ] Injection (eg: antibiotic, adrenalin, etc.)
[ ] Laboratory Procedures (PKU specimen, hematocrit, sed rate, etc)
[ ] Immunizations
[ ] Changing diapers where the presence of blood is visible or suspected)
[ ] Other: _____
[ ] Other: _____
[ ] Other: _____

2. IMPLEMENTATION SCHEDULE AND METHODOLOGY

OSHA also requires that this plan also include a schedule and method of implementation for the various requirements of the standard. The following complies with this requirement:

COMPLIANCE METHODS

Universal precautions will be observed at this facility in order to prevent contact with blood or other potentially infectious material will be considered infectious regardless of the perceived status of the source individual.

Engineering and work practice controls will be utilized to eliminate or minimize exposure to employees at this facility. Where occupational exposure remains after institution of these controls, personal protective equipment shall also be utilized. At this facility the following engineering controls will be utilized:

[ ] Sharps disposal containers
[ ] Engineered sharps (self sheathing needles, sharps safety needles/syringes, etc)
[ ] Other: _____

The above controls will be examined and maintained on a regular schedule. The schedule for reviewing the effectiveness of the controls is as follows:

[ ] The effectiveness of the controls will be examined/monitored daily
[ ] The effectiveness of the controls will be examined/monitored weekly
[ ] The effectiveness of the controls will be monitored _____

The individual who has the responsibility to review the effectiveness of the individual controls is as follows:

[ ] Office Manager
[ ] Medical Assistant
[ ] Nurse Practitioner/Physician Assistant
[ ] Other: _____

Identification of the need for changes in engineering controls and work practices is made by review of OSHA records, employee interviews, and/or staff / committee activities. Both front line workers and management staff are involved in this process. Evaluation of new procedures and/or new products may be completed as necessary or as indicated based on current need.

Handwashing facilities are also available to the employees who incur exposure to blood or other potentially infectious materials. OSHA requires that these facilities be readily accessible after incurring exposure.

Handwashing facilities are located:

[ ] in each exam room
[ ] outside the exam room in hallway/alcove
[ ] in nurses station/lab room in close proximity to patient care area.
[ ] other: _____

If handwashing facilities are not feasible, the employer is required to provide either an antiseptic cleanser in conjunction with a clean cloth/paper towels or antiseptic towelettes. If these alternatives are used then the hands are to be washed with soap and running water as soon as feasibly possible. Employers who must provide alternatives to readily accessible handwashing facilities should list the locations, tasks and responsibilities to ensure maintenance and accessibility of these alternatives. Alternative locations/tasks and responsibilities are as follows:

[ ] N/A
[ ] Other: _____

After removal of personal protective gloves, employees shall wash hands and any other potentially contaminated skin area IMMEDIATELY or soon as feasibly possibly with soap and water.

If employees incur exposure to their skin or mucous membranes then those areas shall be washed or flushed with water as appropriate as soon as feasibly possible following contact.

NEEDLES

Contaminated needles and other contaminated sharps will not be bent, recapped, removed, sheared or purposely broken. Sharps means anything which can penetrate the skin including needles, scalpels, broken glass, broken capillary tubes and exposed ends of dental wires. Shearing or breaking of contaminated sharps is prohibited. Bending, recapping, or removing contaminated sharps, such as contaminated needles, is also prohibited unless there is no feasible alternative or such action is required by the specific medical procedure. If removal or recapping is necessary, removal or recapping must be done either by one-handed scooping (passive recapping) or through a recapping device.

DISPOSAL OF SHARPS AND REUSABLE SHARPS

Since reusable sharps, such as large bore needles, scalpels and saws pose the same percutaneous exposed hazard as disposable sharps, they must be contained in a manner that eliminates or minimizes the hazard until they are reprocessed. The container for disposing of reusables must meet the same standards as for disposable sharps. Sharps must be disposed as follows:

[X] Immediately or as soon as possible after use, all sharps must be placed in appropriate receptacles for reprocessing or disposal.
[X] Sharps must be located as close as possible to where sharps are used or can be reasonably anticipated to be found.
[X] Sharps containers must be maintained in an upright position throughout use, routinely replaced and not allowed to overfill.
[X] Medical assistant/provider will check the containers daily to determine if the container needs to be replaced/emptied.
[ ] For reusable sharps, a container system has been established which does not expose employees to the risk of percutaneous injury. No system involving the manual opening, emptying or cleaning of the container is allowed.
[ ] If the sharps container contains unwinders that separate needles from syringes, the employees will be trained with regard to proper removal of needles.

The sharps containers are puncture resistant, labeled with a biohazardous label and are leak proof. Sharps containers are located in the following places:

[ ] Each exam room
[ ] Nurses station
[ ] Lab and/or blood draw station
[ ] Triage/treatment room
[ ] Other: _____

The following employee(s) have the responsibility for removing sharps from containers/replacing full containers and for checking the containers for need to empty/replace on a daily basis:

[ ] Medical assistant
[ ] Nurse practitioner/physician assistant
[ ] Provider
[ ] Lab technician
[ ] Other: _____

WORK AREA RESTRICTIONS

In work areas where there is a reasonable likelihood of exposure to blood or other potentially infectious materials, employees are not to eat, drink, apply cosmetics or lip balm, smoke or handle contact lenses. Food and beverages are not to be kept in refrigerators, freezers, shelves, cabinets or on counter tops or bench tops where blood or other potentially infectious materials are present.

Mouthing pipetting/suctioning of blood or other potentially infectious materials is prohibited.

All procedures will be conducted in a manner which will minimize splashing, spraying, splattering and generation of droplets of blood or other potentially infectious materials. Methods which will be employed at this facility to accomplish this goal are as follows:

[ ] N/A
[ ] Cover on centrifuge
[ ] use of dental dams
[ ] Other: _____

SPECIMENS

Specimens of blood or other potentially infectious materials will be placed in a container which prevents leakage during the collection, handling, processing, storage, and transport of the specimens.

The container used for this purpose will be labeled or color coded in accordance with the requirements of the OSHA standard.

(Employers should note that the standard provides for an exemption for specimens from the labeling/color coding requirement of the standard provided that the facility utilizes universal precautions in the handling of all specimens and the containers are recognizable as containing specimens. This exemption applies only while the specimens remain in the facility). If the employer chooses to use this exemption then it should be stated below:

[ ] N/A
[ ] _____

Any specimens which could puncture a primary container will be placed within a secondary container which is puncture resistant. (List here how this will be carried out, e.g. which specimens, if any, could puncture a primary container, which containers can be used as a secondary containers and where the secondary containers are located at the facility).

[ ] N/A
[ ] Explanation: _____

_____

If outside contamination of the primary container occurs, the primary container shall be placed within a secondary container which prevents leakage during the handling, processing, storage, transport, or shipping of the specimen.

CONTAMINATED EQUIPMENT

Equipment which has become contaminated with blood or other potentially infectious materials shall be examined prior to servicing or shipping and shall be decontaminated as necessary unless the decontamination of the equipment is not feasible. (List here any equipment which it is felt can not be decontaminated prior to servicing).

[ ] N/A
[ ] list equipment: _____

_____

PERSONAL PROTECTIVE EQUIPMENT

All personal protective equipment used at this facility will be provided without cost to employees. Personal protective equipment will be chosen based on the anticipated exposure to blood or other potentially infectious materials. The protective equipment will be considered appropriate only if it does not permit blood or other potentially infectious materials to pass through or reach the employees' clothing, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.

1. Disposable gloves: Employees must wear appropriate gloves when it can be reasonably anticipated that the employee may have contact with blood (eg: suturing, immunizations, etc.) and other potentially infectious materials and when handling or touching contaminated items or surfaces. Gloves shall be replaced if torn, punctured, contaminated or deteriorated. Disposable gloves are located in:

   [ ] exam rooms/treatment rooms
   [ ] nurses station/ lab area
   [ ] blood draw station/room
   [ ] other: _____

Disposable gloves must be worn when performing the following procedures:

[ ] blood draws/venipuntures
[ ] performing blood testing (eg: hematocrit/hemoglobin etc.)
[ ] cleaning blood /potentially infectious material spills
[ ] cleaning dirty/contaminated instruments
[ ] pap smears/assist with pap smears
[ ] minor surgeries/suturing
[ ] any specimen handling
[ ] caring for isolation patients
[ ] other: _____
[ ] other: _____

2. Utility gloves: Utility Gloves (ie: housekeeping) may be decontaminated for re-use if the integrity of the glove is not compromised. However, they must be discarded if they are cracked, peeling, torn, punctured or exhibit other signs of deterioration. Check utility gloves for cracks or other flaws as noted above and replace as necessary. Utility Gloves are located:

[ ] N/A
[ ] with housekeeping supplies in housekeeping closet/cabinet
[ ] other: _____

Utility gloves will be worn when performing the following procedures:

[ ] Housekeeping duties
[ ] cleaning toilets/sinks/floors etc.
[ ] Other _____

3. Masks, eye protection and face shields: Employees must wear masks, eye protection and/or face shields to protect the mucous membranes of the face and upper respiratory tract from droplet splattering. Minimum protection should consist of a mask in conjunction with eye glasses (goggles) with side shields or a chin length face shield. Masks/eye protection and / or face shield will be worn when performing the following procedures:

[ ] washing contaminated/dirty instruments
[ ] other: _____
[ ] other: _____
[ ] other: _____

4. Protective clothing: Use of protective body clothing such as gowns, aprons, lab coats, clinic jackets, surgical caps, or shoe covers and the degree to which such protective equipment must resist penetration, are performance based. The tasks and the type of exposure anticipated has been evaluated and, based on the determination, the following appropriate personal protective clothing is required:

[ ] Barrier proof gown
[ ] apron
[ ] lab coat
[ ] clinic coat
[ ] shoe cover
[ ] surgical cap
[ ] other: _____
[ ] other: _____

The above noted items will be worn when performing the following procedures:

[ ] N/A
[ ] when washing contaminated/dirty instruments
[ ] other: _____
[ ] other: _____

All personal protective equipment will be cleaned, laundered, and/ or disposed of by the employer at no cost to the employees. All repairs and replacements will be made by the employer at no cost to employees.

All garments which are penetrated by blood shall be removed immediately or as soon as feasibly possible. All personal protective equipment will be removed prior to leaving the work area. The following protocol has been developed to facilitate leaving the equipment at the work area: (list where employees are expected to place the personal protective equipment upon leaving the work area, and other protocols, etc.).

[ ] All personal protective equipment is disposable and will be discarded in biohazardous waste in exam/treatment room.
[ ] other: _____

HOUSEKEEPING

Medical facilities must be maintained in a clean and sanitary condition. The Facility will be cleaned and decontaminated according to the following schedule and/or as follows:

[ ] Please see attached housekeeping schedule

[X] Work surfaces will be decontaminated with an appropriate disinfectant after completion of procedures, immediately when overtly contaminated, after any spill of any blood or other potentially infectious materials and at the end of the work shift when surfaces have become contaminated since the last cleaning.

[ ] Protective coverings, such as plastic wrap, aluminum foil or imperviously-backed absorbent paper, will be used to cover equipment and surfaces when they have become overtly contaminated and at the end of a work shift if they have become contaminated during the shift.

[X] Reusable receptacles, such as bins, pails and cans that have a likelihood for becoming contaminated, will be inspected and decontaminated on a daily basis. When contamination is visible, receptacles will be cleaned and decontaminated immediately or as soon as is feasible.

[X] Broken glassware which may be contaminated will not be picked up directly with the hands. A dust pan and hand broom will be used to sweep up the broken glass. The tools used in the clean up of broken glass will be decontaminated or discarded after use and the broken glass will be placed in a sharps container. Vacuum cleaners are not appropriate for cleanup of contaminated broken glass.

[ ] Sorting or rinsing of contaminated laundry will not be performed in patient care areas. Contaminated laundry will be placed and transported in bags or containers labeled in accordance with labeling requirements set forth in section "labeling". In addition, laundry which is saturated will be placed in leak-proof bags.

[ ] If the facility to which laundry is shipped does not utilize universal precautions, all bags or containers of contaminated laundry will be labeled or color coded. All employees who have contact with contaminated laundry will wear protective gloves and other appropriate personal protective devices.

[ ] Laundry is sent off site for cleaning. The laundry service accepting the laundry is notified in accordance with section (d) of the standard.

The personnel responsible for the above duties indicated by [X] are as follows:

[ ] Medical assistant
[ ] Housekeeping personnel
[ ] Other _____

REGUALTED WASTE DISPOSAL

Regulated waste requires special handling and will be placed in appropriate containers. Regulated waste includes the following: 1.) liquid or semi-liquid blood or other potentially infectious material, 2.) items contaminated with blood or other potentially infectious material that would release these substances in a liquid or semi-liquid state if compressed, 3.) items that are caked with blood or other potentially infectious material and are capable of releasing these materials during handling, 4.) contaminated sharps and 5.) pathologic and microbiological wastes containing blood or other potentially infectious material.

The containers into which regulated wastes is stored, transported or shipped will be closable. The container will also be constructed so as to contain the waste and prevent leakage of its contents. If the waste could puncture the primary container, the primary container must be placed into a puncture resistant secondary container. If outside contamination of the primary container occurs, the primary container will also be placed within a second container which

prevents leakage. For containment requirements of sharps see the section "disposal of sharps and contaminated sharps" above. Regulate waste other than sharps will be placed in appropriate containers lined with red bags.

These biohazardous waste containers are located:

[ ] in each exam room
[ ] treatment room
[ ] lab draw station
[ ] nurses station

HEPATITIS B VACCINE

All employees who have been identified as having exposure to blood or other potentially infectious materials will be offered the Hepatitis B vaccine, at no cost to the employee. The vaccine will be offered within 10 working days of their initial assignment to work involving the potential for occupational exposure to blood or other potentially infectious materials unless the employee has previously had the vaccine or who wishes to submit to antibody testing which shows the employee to have sufficient immunity.

Employees who decline the Hepatitis B vaccine will sign a waiver which uses the wording in Appendix A of the OSHA standard.

Employees who initially decline the vaccine but who later wish to have it may then have the vaccine provided at no cost.

The following individual has responsibility for assuring that the vaccine is offered, the waivers are signed, the vaccine is administered, etc.

[ ] Office manager
[ ] Provider/physician
[ ] Name of person: _____

POST EXPOSURE EVALUATION AND FOLLOW UP

When the employee incurs an exposure incident, it should be reported to:

[ ] Office Manager
[ ] Physician
[ ] Administrator
[ ] Name of person: _____

All employees who incur an exposure incident will be offered post-exposure evaluation and follow-up in accordance with the OSHA standard.

This follow-up will include the following:

- Documentation of the route of exposure and the circumstances related to the incident.
- If possible, the identification of the source individual and if possible, the status of the source individual will be tested (after consent is obtained) for HIV/HBV infectivity.

- Results of testing of the source individual will be made available to the exposed employee with the exposed employee informed about the applicable laws and regulations concerning disclosure of the identity and infectivity of the source individual. (Employers may need to modify this provision in accordance with applicable local laws on this subject. Modifications should be listed here:

  [ ] N/A
  [ ] Explain modifications: _____

  _____

  _____

- The employee will be offered the option of having their blood collected for testing of the employee HIV/HBV serological status. The blood sample will be preserved for up to 90 days to allow the employee to decide if the blood should be tested for HIV serological status. However, if the employee decides prior to that time that testing will or will not be conducted then the appropriate action can be taken and the blood sample discarded. The employee will be offered post exposure prophylaxis in accordance with the current recommendations of the U.S. Public Health Service. These recommendations are currently as follows: (These recommendations may be listed as an appendix to the plan)

  [X] See attached appendix titled “post exposure prophylaxis”.

- The employee will be given appropriate counseling concerning precautions to take during the period after the exposure incident. The employee will also be given information on what potential illnesses to be alert for and to report any related experiences to appropriate personnel. The following person(s) has been designated to assure that the policy outlined here is effectively carried out as well as to maintain records related to this policy:

  [ ] Office manager
  [ ] Physician
  [ ] Administrator
  [ ] Name of person: _____

INTERACTION WITH HEALTH CARE PROFESSIONALS

A written opinion shall be obtained from the health care professional who evaluates employees of this facility. Written opinions will be obtained in the following instances:

1) When the employee is sent to obtain the Hepatitis B vaccine.

2) Whenever the employee is sent to a health care professional following an exposure incident.

Health care professionals shall be instructed to limit their opinions to:

1) Whether the Hepatitis B vaccine is indicated and if the employee has received the vaccine, or for evaluation following an incident.

2) That the employee has been informed of the results of the evaluation, and

3) That the employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials. (Note that the written opinion to the employer is not to reference any personal medical information).

TRAINING

Training for all employees will be conducted prior to initial assignment to tasks where occupational exposure may occur. Training will be conducted in the following manner:

Training for employees will include the following an explanation of:

1) The OSHA standard for Bloodborne Pathogens

2) Epidemiology and symptomatology of bloodborne diseases

3) Modes of transmission of bloodborne pathogens

4) This Exposure Control Plan, i.e. points of the plan, lines of responsibility, how the plan will be implemented, etc.)

5) Procedures which might cause exposure to blood or other potentially infectious materials at this facility

6) Control methods which will be used at the facility to control exposure to blood or other potentially infectious materials.

7) Personal protective equipment available at this facility and who should be contacted concerning

8) Post Exposure evaluation and follow-up

9) Signs and Labels used at the facility

10) Hepatitis B vaccine program at the facility

RECORDKEEPING

All records required by the OSHA standard will be maintained by: The following person/department is responsible for maintaining records:

[ ] Office Manager
[ ] Physician
[ ] Administration department
[ ] Other _____

DATES

All provisions required by the standard will be implemented by:

[ ] (date for implementation of the provisions of the standard) _____

Training will be conducted using:

[ ] videotapes
[ ] written materials
[ ] Inservice class instruction
[ ] Other: _____

The following person will be responsible for ensuring training is completed or for conducting training:

[ ] Nurse/Nurse Practitioner
[ ] Physician Assistant
[ ] Physician
[ ] Office Manager/Administrator
[ ] Other: _____

All employees will receive annual refresher training. Note that this training is to be conducted within one year of the employee's previous training.

The outline for the training material is located (list where the training materials are located):
[ ] Located in the FSR Resource Binder
[ ] Located in the Policy and Procedure Manual
[ ] Located in the Inservice Education Binder/Folder/Manual
[ ] Other: _____

APPENDIX

POST EXPOSURE PROPHYLAXIS (PEP)

These recommendations are taken from
Exposure to Blood What Heatlhcare Personnel Need to Know
Updated July 2003
Department of Health and Human Services
Centers for Disease Control and Prevention

Treatment for exposure to HBV:
All health care personnel who have a reasonable chance of exposure to blood or body fluids should receive a hepatitis B vaccine. Vaccination ideally should occur during the healthcare worker's training period. Workers should be tested 1-2 months after the vaccine series is complete to make sure the vaccination has provided immunity to HBV infection. Hepatitis B immune globulin (HBIG) alone or in combination with vaccine (if not previously vaccinated) is effective in preventing HBV infection after exposure. The decision to begin treatment is based on several factors such as:

1.) Whether the source individual is positive for hepatitis B surface antigen
2.) Whether exposed individual has been vaccinated
3.) Whether the vaccine provided the exposed individual immunity

Treatment for exposure to HCV:
There is no vaccine against hepatitis C and no treatment after an exposure that will prevent infection. Neither immune globulin nor antiviral therapy is recommended after exposure. For these reasons, following recommended infection control practices to prevent percutaneous injuries is imperative.

Treatment for exposure to HIV:
There is no vaccine against HIV. However, results from a small number of studies suggest that the use of some antiretroviral drugs after certain occupational exposures may reduce the chance of HIV transmission. Post exposure prophylaxis (PEP) is recommended for certain occupational exposures that pose a risk of transmission. However, for those exposures without risk of HIV infection, PEP is not recommended because the drugs used to prevent infection may have serious side effects. Exposed individual should discuss the risks and side effects with his/her healthcare provider before starting PEP for HIV.

Exposures to blood from an individual whose infection status is unknown:

HBV-HCV-HIV
If the source individual cannot be identified or tested, decisions regarding follow up should be based on the exposure risk and whether the source is likely to be infected with a bloodborne

pathogen. Follow-up testing should be available to all personnel who are concerned about possible infection through occupational exposure.

Specific drugs recommended for post exposure treatment:

HBV
If the exposed individual has not been vaccinated, then hepatitis B vaccination is recommended for any exposure regardless of the source person's HBV status. HBIG and/or hepatitis B vaccine may be recommended depending on the source person's infection status, the exposed person's vaccination status and, if vaccinated, the exposed person's response to the vaccine.

HCV
There is no post exposure treatment that will prevent HCV infection.

HIV
The Public Health Service recommends a 4 week course of a combination of either two antiretroviral drugs for most HIV exposures, or three antiretroviral drugs for exposures that may pose a greater risk for transmitting HIV (such as those involving a larger volume of blood with a larger amount of HIV or a concern about drug resistant HIV). Differences in side effects associated with the use of these drugs may influence which drugs are selected in a specific situation. These recommendations are intended to provide guidance to clinicians and may be modified on a case by case basis. Determining which drugs and how many drugs to use or when to change a treatment regimen is largely a matter of judgement. Whenever possible, consulting an expert with experience in the use of antiretroviral drugs will be done, especially if a recommended drug is not available, if the source person's virus is likely to be resistant to one or more recommended drugs, or if the drugs are poorly tolerated.

When to start PEP:

HBV
Post exposure treatment should begin as soon as possible after exposure, preferably within 24 hours, and no later than 7 days.

HIV
Treatment should be started as soon as possible, preferably within hours as opposed to days, after the exposure. Although animal studies suggest that treatment is less effective when started more than 24-36 hours after exposure, the time frame after which no benefit is gained in humans is not known. Starting treatment after a longer period (e.g. 1 week) may be considered for exposures that represent in increased risk of transmission.

PEP for pregnant healthcare workers:

HBV
Women who are pregnant or breast-feeding can receive the hepatitis B vaccine and/or HBIG. Pregnant women who are exposed to blood should be vaccinated against HBV infection, because infection during pregnancy can cause severe illness in the mother and a chronic infection in the newborn. The vaccine does not harm the fetus.

HIV
Pregnancy should not rule out the use of post exposure treatment when it is warranted. If the exposed individual is pregnant he/she should understand what is known and not known regarding the potential benefits and risks associated with the use of anti-viral drugs in order to make an informed decision about treatment.

Follow up after exposure:

HBV
Because post exposure treatment is highly effective in preventing HBV infection, CDC does not recommend routine follow up after treatment. However, any symptoms suggesting hepatitis (e.g. yellow eyes or skin, loss of appetite, nausea, vomiting, fever, stomach or joint pain, extreme tiredness) should be reported to the healthcare provider. If hepatitis B vaccine is given, the individual should be tested 1-2 months after completing the vaccine series to determine if the individual has responded to the vaccine and is protected against HBV infection.

HCV
The individual should be tested for HCV antibody and liver enzyme levels (alanine aminotransferase or ALT) as soon as possible after the exposure (baseline) and at 4-6 months after exposure. To check for infection earlier, the individual can be tested for the virus (HCV RNA) 4-6 weeks after exposure. Report any symptoms suggesting hepatitis (mentioned above) to the health care provider.

HIV
The individual should be tested for HIV antibody as soon as possible after exposure (baseline) and periodically for at least 6 months after the exposure (e.g. at 6 weeks, 12 weeks, and 6 months). If the individual is taking antiviral drugs for post exposure treatment, he/she should be checked for drug toxicity by having a complete blood count and kidney and liver function tests just before starting treatment and 2 weeks after starting treatment. An sudden or severe flu like illnesses that occurs during the follow up period, especially if it involves fever, rash, muscle aches, tiredness, malaise, or swollen glands should be reported. Any of these may suggest HIV infection, drug reaction, or other medical conditions. The healthcare provider should be contacted for any questions or problems during the follow up period.

Precautions to take during the follow up period:

HBV
No precautions are necessary.

HCV

No precautions are recommended secondary to a low risk of becoming infected and passing the infection on to others.

HIV

During the follow-up period, especially the first 6-12 weeks when most infected persons are expected to show signs of infection, the following recommendations for preventing transmission of HIV should be followed. These recommendations include not donating blood, semen or organs and not having sexual intercourse. If the individual chooses to have sexual intercourse, using a condom consistently and correctly may reduce the risk of HIV transmission. In addition, women should consider not breast feeding infants during the follow up period to prevent the possibility of exposing the infant to HIV that may be in breast milk.

Sharps Injury Log

The following information, if known or reasonably available, should be documented within 14 working days of the date on which each exposure incident was reported.

1. Date and time of the exposure incident: _____
2. Date of exposure incident report: _____ Report written by: _____
3. Type and brand of sharp involved: _____
4. Description of exposure incident:
   - Job classification of exposed employee: _____
   - Department or work area where the incident occurred: _____
   - Procedure being performed by the exposed employee at the time of the incident: _____
     _____
   - How the incident occurred: _____
   - Body part(s) involved: _____
   - Did the device involved have engineered sharps injury protection? Yes (✓) _____ No (✓) _____
   - Was engineered sharps injury protection on the sharp involved? Yes (✓) _____ No (✓) _____

If Yes	If No
A. Was the protective mechanism activated at the time of the exposure incident? Yes ____ No ____ B. Did the injury occur before, during, or after the mechanism was activated? _____ _____ Comments: _____ _____ _____	A. Does the injured employee believe that a protective mechanism could have prevented the injury? Yes ____ No ____

   - Does the exposed employee believe that any controls (e.g., engineering, administrative, or work practice) could have prevented the injury? Yes (✓) _____ No (✓) _____
   - Employee's opinion: _____
     _____
     _____
     _____
5. Comments on the exposure incident (e.g., additional relevant factors involved): _____
   _____
   _____
   _____
6. Employee interview summary: _____
   _____
   _____
   _____
7. Picture(s) of the sharp(s) involved (please attach if available).

MEDICAL WASTE TRACKING LOG

SITE ADDRESS: _____ (Small quantity generator up to 35.2 lbs)

RECEIVING SITE ADDRESS: _____ (Central location with Biohazardous Waste Hauler Contract)

Name of Person Transporting	Number of Waste Containers*	Type of Medical Wastes*	Date of Transportation

* Please indicate number of wastes. For example: three sharps containers or five biohazard bags

* Please indicate type: Biohazardous waste, Medical waste, Pharmaceutical wastes, Sharps

KEEP LOG FOR 3 YEARS

MEDICAL WASTE LOG SHEET
FOR SMALL QUANTITY GENERATOR FACILITY
Per CA Health & Safety Code (HSC) § 117928 & 117945

California law allows hospitals to pick up bio-hazardous waste from associated medical buildings when they are not required to cross any city streets or public roads. Our medical building located at the following address meets this requirement:

_____

_____

_____

As a service to the physicians of this building, _____ (name of hospital/medical building) will pick up bio-hazardous and sharps waste when properly contained. It will then be transported to the hospital's common storage facility. The hospital is contracted with _____, a registered hazardous waste hauler for the proper transport, treatment and disposal of the bio-hazardous waste. The contract is kept current and on file at: _____

IMPORTANT: Completed log sheets must be kept on-site for at least TWO years.

Container Type (e.g. sharps container, red bag with biohazard waste, etc)	**Quantity**	**Name of Hospital Staff Transporter**	**Date of Removal**	**Comments**

PCP	
Section: Personnel/Office Management	
POLICY AND PROCEDURE: Patient Confidentiality/ Medical Records	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:
Confidentiality of personal medical information is protected according to state and federal guidelines. Patients have the right to privacy for dressing/undressing, physical examination, and medical consultation. Practices are in place to safeguard patient privacy. The patient's private health information shall be maintained secure and confidential in compliance with legal, accrediting, and regulatory agency requirements. All member information is regarded as confidential and obtainable only to authorized persons.

PROCEDURE:

I. The primary care provider (PCP) site shall maintain confidentiality of individual patient information. Individual patient conditions or information not discussed in front of other patients or visitors, displayed, or left unattended in reception and/or patient flow areas. Patient registration sign-in sheets protect patient's privacy from other patients who may also be checking-in for their appointments. Patient sign-in sheets shall collect only minimal information using no more than one (1) patient identifier such as the patient's name.

II. The PCP site shall ensure that exam rooms and dressing areas safeguard patient's right to privacy.

III. The provider/designee shall ensure that there is a system for the following:
1. Medical records are available at each encounter and include outpatient, inpatient, referral services, and significant consultations.
2. Medical records are accessible within the facility, or an approved health record storage facility on the facility premises.

IV. Where applicable, electronic record-keeping system procedures are established to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures, and maintain upkeep of computer systems.
1. Security protection includes:
    a. an off-site backup storage system
    b. an image mechanism with the ability to copy documents
    c. a mechanism to ensure that recorded input is unalterable
    d. file recovery procedures.

2. Confidentiality protection may also include:
    a. Use of encryption - All Protected Health Information (PHI) must be encrypted at rest and in transit.
    b. Detailed user access controls - Each medical professional authorized to access and communicate PHI must have a "**Unique User Identifier**" so that their use of PHI can be monitored.
    c. Transaction logs,
    d. Idle monitor screen protection - The use of any technology to comply with

HIPAA must have an automatic log off to prevent unauthorized access to PHI when a mobile device is left unattended (this also applies to desktop computers).

e. Blinded files.

V. The PCP site shall ensure that 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 will indicate to whom released and for what purpose.

NOTE: The PCP site shall release and furnish necessary health records without the patient's written, signed consent to coordinate the patient's care with physicians, hospitals, or other health care entities, or to coordinate payment. PCPs shall also provide at no charge to health plans and appropriate state and federal regulators without written, signed consent from the patient, prompt access or upon demand, to medical records or information for quality management or other purposes, including utilization review, audits, reviews of complaints or appeals, HEDIS and other studies within 10 days of the request unless otherwise indicated or as agreed upon.

VI. Transmittal of medical records by email shall be always encrypted. Transmission of medical records by fax shall include a fax cover page. The fax cover page includes a confidentiality statement which requires the recipient to maintain the information in a safe, confidential, and secure manner and provide instructions on what steps to take when the transmittal is received by unintended recipients.

VII. The PCP site shall ensure that medical records are retained for a minimum of 10 years following patient encounter.

VIII. The name of the individual delegated the responsible for securing & maintaining the security of medical records at this location is:_____.

ATTACHMENTS:

Signature Page
HIPAA Acknowledgement
Sample of Notice of Privacy / HIPAA
Comprehensive Health Assessment forms
Advance Directive - English
Advance Directive - Spanish
PHQ9 - Adult
PHQ9 - Teen
TB Risk Assessment - Adult
TB Risk Assessment – Peds
Confidentiality, Solicitation & Conflict of Interest Statement

Signature Page

Printed Name	Title	Initials	Signature

HIPAA ACKNOWLEDGMENT/ CONFIDENTIALITY AGREEMENT

Patients expect privacy when they receive healthcare. It is everyone's responsibility to see that these expectations are met by respecting their privacy and securing their information.

As a contract employee working for _____, I understand that it is my job to help maintain privacy for patients as they receive care and to help protect the confidentiality of all verbal, written, and electronic information that they provide to us or that is collected during the visit.

I understand the following to be true: (initial each statement)

_____ There will be times when I see or hear information on a patient.

_____ I know that I may NOT seek out information about patients unless I need to perform my job-related duties.

_____ If I do see or hear patients' information in the course of my job, this information is confidential and I cannot repeat and/or share it with others.

_____ The Organization is committed to protecting patient privacy by keeping patient information confidential and secure.

_____ If I fail to protect patient information by not following the privacy and security policies, I may be subject to civil monetary or criminal penalties and disciplinary action.

While it is expected that all employees will conform to the privacy and security policies, it is recognized that there may be times when the policies are abused. I understand that it is part of my job to report to my manager and/or the office manager of the clinic, who will then report to the HIPAA PRIVACY OFFICER any instance where I suspect that the organization's privacy or security policies are being broken.

By my signature below, I hereby agree to comply with the organization's privacy and security policies pertaining to protected health information.

_____	_____	_____
NAME	SIGNATURE	DATE
_____	_____	_____
NAME (WITNESS)	SIGNATURE	DATE

(SAMPLE) NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, the *AMHCA and ACA Code of Ethics* and Massachusetts statutes and regulations. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

I. USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS, REQUIRING CONSENT

We may use or disclose your PHI for treatment, payment and health care operations purposes with your consent as discussed below:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. An example of treatment would be when we consult with another health care provider, such as a family physician or another mental health provider. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your consent. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

II. USES AND DISCLOSURES REQUIRING AUTHORIZATION

Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization:

- most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record;
- most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications;
- disclosures that constitute a sale of PHI; and
- other uses and disclosures not described in this Notice of Privacy Practices.

III. USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we, in our professional capacity, have reasonable cause to believe that a minor child is suffering physical or emotional injury resulting from abuse inflicted upon him or her which causes harm or substantial risk of harm to the child's health or welfare (including sexual abuse), or from neglect, including malnutrition, we must immediately report such condition to the Massachusetts Department of Children and Families.

- **Elder Abuse:** If we have reasonable cause to believe that an elderly person (age 60 or older) is suffering from or has died as a result of abuse, we must immediately make a report to the Massachusetts Department of Elder Affairs.

- **Abused of a Disabled Person:** If we have reasonable cause to suspect abuse of an adult (ages 18-59) with mental or physical disabilities, we must immediately make a report to the Massachusetts Disabled Persons Protection Commission.

- **Health Oversight:** The Board of Registration of Allied Mental Health and Human Service Professions has the power, when necessary, to subpoena relevant records should we be the focus of an inquiry.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and we will not release information without written authorization from you or your legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** If you communicate to me an explicit threat to kill or inflict serious bodily injury upon an identified person and you have the apparent intent and ability to carry out the threat, I must take reasonable precautions. Reasonable precautions may include warning the potential victim, notifying law enforcement, or arranging for your hospitalization. I must also do so if I know you have a history of physical violence and I believe there is a clear and present danger that you will attempt to kill or inflict bodily injury upon an identified person. Furthermore, if you present

a clear and present danger to yourself and refuse to accept further appropriate treatment, and I have a reasonable basis to believe that you can be committed to a hospital, I must seek said commitment and may contact members of your family or other individuals if it would assist in protecting you.

- **Worker's Compensation:** If you file a workers' compensation claim, your records relevant to that claim will not be confidential to entities such as your employer, the insurer and the Division of Worker's Compensation.

- **Specialized Government Functions.** We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

- **Public Health.** If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

IV. YOUR RIGHTS AND OUR OBLIGATIONS

Patient's Rights:

You have the following rights regarding PHI we maintain about you:

- **Right of Access to Inspect and Copy.** You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your access may be denied in certain circumstances, but in some cases, you may be able to have this decision reviewed. On your request, we will discuss with you the details of the request and denial process. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. On your request, we will provide you with details of the amendment process.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of PHI for which you have neither provided authorization nor consent. On request, we will discuss with you the details of the accounting process. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your

request for a restriction.

- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. (For instance, you may not want a family member to know you are seeing us. Upon your request, we will send your bills to another address.) We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

- **Right to a Paper Copy of this Notice.** You have the right to a paper copy of this notice upon request, even if you have agreed to receive the notice electronically.

Our Obligations:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy practices described in this Notice. Unless we notify you of such changes, however, we are required to comply with the terms currently in effect.
- If we revise our privacy practices, we will _____ [***Notice must describe how mental health counselor will provide individuals with a revised notice, e.g., by mail, etc***.]

V. COMPLAINTS

If you believe we have violated your privacy rights or you disagree with a decision we made about access to your records, you may contact [*add name, or title, and telephone number of a person or office to contact for further information.*] You may also send a written complaint to the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

VI. EFFECTIVE DATE OF PRIVACY PRACTICES

This notice will go into effect on _____ [*add date, which may not be earlier than the date on which the notice is printed or otherwise published*.]

COMPREHENSIVE HEALTH ASSESSMENT FORMS

INDEX

Hold the 'Ctrl' button and then click on any of the links below to access the forms

COMPREHENSIVE HEALTH ASSESSMENT FORMS

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Comprehensive Health Assessment

Under 1 Month Old	Actual Age:	Date:
Medical Record #		
Gender	☐ Male ☐ Female	
Accompanied by	☐ Mother ☐ Father ☐ Other:	
Parent's Primary Language		
Interpreter Requested	☐ Yes ☐ No ☐ Refused	
Name of Interpreter		

Intake		Vital Signs	
Allergies		Temp	
Height		Pulse	
Weight		Resp	
Head Circumference			
Birth History	Birth Weight:	Gestation:	
Delivery	☐ Vaginal ☐ C-Section	Complications ☐ Yes ☐ No	
OB/GYN Provider			
Post-Partum Appointment Date			
Cord	☐ Absent ☐ Present ☐ Redness/swelling ☐ Yellow drainage		

Chronic Problems/Significant Conditions: ☐ See Problem List

Current Medications/Vitamins: ☐ See Medication List

Interval History		
Nutrition	☐ Breastfed every _____ hours ☐ Formula _____oz every _____ hours Formula Type or Brand:	
Elimination	☐ Normal ☐ Abnormal	
Has WIC	☐ Yes ☐ No	
Sleep	☐ Normal (2-4 hours) ☐ Abnormal	
Sleeping Position	☐ Supine ☐ Prone ☐ Side	
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR	
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease	☐ HTN	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO
☐ Childhood hearing impairment	☐ Other:	
Behavioral / Social / Emotional Risk Assessment	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

Name: DOB:

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Adverse Childhood Experiences	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Behavioral / Social / Emotional	☐ PAPF, ☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Maternal Depression	☐ EPDS, ☐ PHQ-9, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development		
☐ Prone, lifts head briefly	☐ Turns head side to side	☐ Responds to sound
☐ Moro reflex	☐ Blinks at bright light	☐ Keeps hands in a fist

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. open _____cm	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Mouth / Palate	Oral mucosa pink, no cleft lip or palate	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction, leg lengths equal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Name: DOB:

Assessment

Plan

Referrals

☐ WIC	☐ Audiologist	☐ Optometrist / Ophthalmologist
☐ Maternal Behavioral Health	☐ Regional Center	☐ Early Start or Local Education Agency
☐ CA Children's Services (CCS)	☐ Other:	

Orders

☐ Hep B vaccine	☐ Newborn metabolic screen	☐ Obtain newborn hospital records & hearing screen results
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Breastfeeding / formula	☐ No cow's milk	☐ No honey until 1 year old
☐ Feeding position	☐ No bottle in bed	☐ Colic

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Rear-facing Infant car seat	☐ Stimulation from hanging objects & bright colors
☐ Call MD for fever	☐ Choking hazards	☐ Family spacing
☐ Family support, social interaction & communication	☐ Never shake baby	☐ Physical growth
☐ Signs of maternal depression	☐ Matches / burns	☐ Stools
☐ Post-Partum Checkup	☐ Violence prevention, gun safety	☐ Sneezing
☐ Hot liquid away from baby	☐ Poison control phone number	☐ Hiccups
☐ Effects of passive smoking	☐ Smoke detector	☐ Bathing
☐ Skin cancer prevention	☐ Hot water temp < 120° F	☐ Circumcision care
☐ Sleeping position	☐ Drowning / tub safety	☐ Cord care

Next Appointment

☐ At 2 Months Old	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Weight & Head Circumference measurements plotted in WHO growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

Name: DOB:

1 to 2 Months Old	Actual Age:	Date:
Medical Record #		
Gender	☐ Male ☐ Female	
Accompanied by	☐ Mother ☐ Father ☐ Other:	
Parent's Primary Language		
Interpreter Requested	☐ Yes ☐ No ☐ Refused	
Name of Interpreter		

Intake		Vital Signs	
Allergies		Temp	
Height		Pulse	
Weight		Resp	
Head Circumference			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		

Chronic Problems/Significant Conditions: ☐ See Problem List

Current Medications/Vitamins: ☐ See Medication List

Interval History

Feedings	☐ Breastfed every _____ hours ☐ Formula _____oz every _____ hours Formula Type or Brand:	
Elimination	☐ Normal ☐ Abnormal	
Has WIC	☐ Yes ☐ No	
Sleep	☐ Normal ☐ Abnormal	
Sleep Position	☐ Supine ☐ Prone ☐ Side	
Vaccines Up to Date	☐ Yes ☐ No	☐ See CAIR
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease	☐ HTN	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO
☐ Other:		
Behavioral / Social / Emotional Risk Assessment	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Adverse Childhood Experiences	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Behavioral / Social / Emotional	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Maternal Depression	☐ EPDS, ☐ PHQ-9, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development

☐ Prone, lifts head 45°	☐ Vocalizes (cooing)	☐ Grasps rattle
☐ Kicks	☐ Follows past midline	☐ Smiles responsively (social)

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. open _____cm	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction, leg lengths equal	☐
Femoral pulses	Present and equal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Comprehensive Health Assessment

Name: **DOB:**

Assessment

Plan

Referrals

☐ WIC	☐ Dietician / Nutritionist	☐ Audiologist
☐ Maternal Behavioral Health	☐ Optometrist / Ophthalmologist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders

☐ DTaP	☐ IPV	☐ CBC / Basic metabolic panel
☐ Hep B vaccine	☐ PCV	☐ Hct / Hgb
☐ Hib	☐ Rotavirus	☐ ECG ☐ COVID 19 test
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Breastfeeding / formula	☐ No cow's milk	☐ No honey until 1 year old
☐ Feeding position	☐ No bottle in bed	☐ Signs of hunger

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Rear-facing Infant car seat	☐ Childcare plan
☐ Call MD for fever	☐ Choking hazards	☐ Crying
☐ Hot liquid burns	☐ Never shake baby	☐ Family spacing
☐ Signs of maternal depression	☐ Matches / burns	☐ Sibling and family relationships
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Physical growth
☐ Diaper rash	☐ Poison control phone number	☐ Bathing
☐ Skin cancer prevention	☐ Smoke detector	☐ Sleeping position
☐ Crying	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / tub safety	☐ Thumb sucking

Next Appointment

☐ At 4 Months Old	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Weight & Head Circumference measurements plotted in WHO growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

3 to 4 Months Old	Actual Age:	Date:	
Medical Record #			
Gender	☐ Male ☐ Female		
Accompanied by	☐ Mother ☐ Father ☐ Other:		
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter			
Intake		**Vital Signs**	
Allergies		Temp	
Height		Pulse	
Weight		Resp	
Head Circumference			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			
Interval History			
Feedings	☐ Breastfed every _____ hours ☐ Formula _____oz every _____ hours Formula Type or Brand:		
Elimination	☐ Normal ☐ Abnormal		
Has WIC	☐ Yes ☐ No		
Sleep	☐ Normal ☐ Abnormal		
Sleep Position	☐ Supine ☐ Prone ☐ Side		
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR		
Family History	☐ Unremarkable	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Asthma	
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO	
☐ Other:			
Behavioral / Social / Emotional Risk Assessment	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)		
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:		

Name: DOB:

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Adverse Childhood Experiences	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Anemia	☐ H&P, ☐ Other:	☐	☐
Behavioral / Social / Emotional	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Maternal Depression	☐ EPDS, ☐ PHQ-9, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Screener, ☐ H&P, ☐ Other:	☐	☐

Growth and Development		
☐ Head steady when sitting	☐ Squeals or coos	☐ Orients to voices
☐ Eyes follow 180°	☐ Rolls form stomach to back	☐ Brings hands together
☐ Grasps rattle	☐ Gums objects	☐ Laughs aloud

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. open _____cm	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction, leg lengths equal	☐
Femoral pulses	Present and equal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Comprehensive Health Assessment

Name: **DOB:**

Assessment

Plan

Referrals

☐ WIC	☐ Dietician / Nutritionist	☐ Audiologist
☐ Maternal Behavioral Health	☐ Optometrist / Ophthalmologist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders

☐ COVID 19 vaccine	☐ Influenza vaccine	☐ CBC / Basic metabolic panel
☐ DTaP	☐ IPV	☐ Hct / Hgb
☐ Hep B vaccine (if not up to date)	☐ PCV	☐ PPD skin test ☐ QFT
☐ Hib	☐ Rotavirus	☐ ECG ☐ COVID 19 test
☐ DTaP	☐ IPV	☐ Iron-fortified formula ☐ Iron supplements
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Breastfeeding / formula	☐ No cow's milk	☐ No honey until 1 year old
☐ Feeding position	☐ No bottle in bed	☐ Signs of hunger

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Rear facing infant car seat	☐ Childcare plan
☐ Signs of maternal depression	☐ Choking hazards	☐ Rolling
☐ Family support, social interaction & communication	☐ Storage of drugs / toxic chemicals	☐ Family spacing
☐ Effects of passive smoking	☐ Matches / burns	☐ Sibling and family relationships
☐ Skin cancer prevention	☐ Violence prevention, gun safety	☐ Physical growth
☐ Sleeping position	☐ Poison control phone number	☐ Reaching for objects
☐ No bottle in bed	☐ Smoke detector	☐ Bathing
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Minor illness care	☐ Drowning / pool fence	☐ Teething

Next Appointment

☐ At 6 Months Old	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Weight & Head Circumference measurements plotted in WHO growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date

Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

5 to 6 Months Old	Actual Age:	Date:
Medical Record #		
Gender	☐ Male ☐ Female	
Accompanied by	☐ Mother ☐ Father ☐ Other:	
Parent's Primary Language		
Interpreter Requested	☐ Yes ☐ No ☐ Refused	
Name of Interpreter		

Intake		Vital Signs	
Allergies		Temp	
Height		Pulse	
Weight		Resp	
Head Circumference			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		

Chronic Problems/Significant Conditions: ☐ See Problem List

Current Medications/Vitamins: ☐ See Medication List

Interval History		
Feedings	☐ Breastfed every _____ hours ☐ Formula _____oz every _____ hours Formula Type or Brand:	
Elimination	☐ Normal ☐ Abnormal	
Has WIC	☐ Yes ☐ No	
Sleep	☐ Normal ☐ Abnormal	
Sleep Position	☐ Supine ☐ Prone ☐ Side	
Fluoridated Water Supply	☐ Yes ☐ No	
Fluoride Varnish	Date last applied:	
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR	
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease	☐ HTN	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO
☐ Other:		
Behavioral / Social / Emotional Risk Assessment	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

Name: DOB:

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Adverse Childhood Experiences	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Behavioral / Social / Emotional	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Blood Lead	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Maternal Depression	☐ EPDS, ☐ PHQ-9, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development		
☐ No head lag when pulled to sitting	☐ Sits briefly alone	☐ Orients to bell
☐ Bears weight on legs	☐ Rolls both ways	☐ Bangs small objects on surface
☐ Reaches for objects	☐ Gums objects	☐ Babbles

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. open _____cm	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction, leg lengths equal	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Comprehensive Health Assessment

Name: DOB:

Subjective / Objective

Assessment

Plan

Referrals

☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Maternal Behavioral Health	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ Dentist	☐ Regional Center	☐ Early Start or Local Education Agency
☐ CA Children's Services (CCS)	☐ Other:	

Orders

☐ COVID 19 vaccine	☐ IPV	☐ CBC / Basic metabolic panel
☐ DTaP	☐ PCV	☐ Hct / Hgb
☐ Hep A vaccine (if high risk)	☐ Rotavirus	☐ PPD skin test ☐ QFT
☐ Hep B vaccine	☐ Hep B Panel (if high risk)	☐ CXR ☐ Urinalysis
☐ Hib	☐ Rx Fluoride drops / chewable tabs (0.25 mg QD)	☐ ECG ☐ COVID 19 test
☐ Influenza vaccine	☐ Fluoride varnish application	☐ Iron-fortified formula
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Introduction to solids	☐ Fortified Infant Cereals	☐ Start solid foods one at a time
☐ Breastfeeding / formula	☐ No cow's milk	☐ Start feeder cup

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Rear facing infant car seat	☐ Electrical outlet covers
☐ Routine dental care	☐ Choking hazards	☐ Blocks
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Repetitive games
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Play with cloth book
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Physical growth
☐ Caution with strangers	☐ Poison control phone number	☐ Bathing
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Signs of maternal depression	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Teething

Next Appointment

☐ At 9 Months Old	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Weight & Head Circumference measurements plotted in WHO growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date

Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

7 to 9 Months Old	Actual Age:	Date:	
Medical Record #			
Gender	☐ Male ☐ Female		
Accompanied by	☐ Mother ☐ Father ☐ Other:		
Parent's Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter			
Intake		**Vital Signs**	
Allergies		Temp	
Height		Pulse	
Weight		Resp	
Head Circumference			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			
Interval History			
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:		
Feedings	☐ Breastfed every _____ hours ☐ Formula _____oz every _____ hours Formula Type or Brand:		
Elimination	☐ Normal ☐ Abnormal		
Has WIC	☐ Yes ☐ No		
Sleep	☐ Normal ☐ Abnormal		
Sleep Position	☐ Supine ☐ Prone ☐ Side		
Fluoridated Water Supply	☐ Yes ☐ No		
Fluoride Varnish	Date last applied:		
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR		
Family History	☐ Unremarkable	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Asthma	
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO	
☐ Other:			
Behavioral / Social / Emotional Risk Assessment	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)		
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:		

Name: DOB:

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Adverse Childhood Experiences	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Behavioral / Social / Emotional	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Blood Lead	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Developmental Disorder (At 9 Months)	☐ ASQ-3, ☐ SWYC, ☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development		
☐ Sits without support	☐ Transfers object hand to hand	☐ Looks for toy dropped
☐ Begins to crawl	☐ Rolls over	☐ Says "mama" or "dada"
☐ Pulls to stand	☐ Feeds self, cracker	☐ Scribbles

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. open _____cm	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Comprehensive Health Assessment

Name: DOB:

Subjective / Objective

Assessment

Plan

Referrals

☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dentist	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders

☐ COVID 19 vaccine	☐ Meningococcal (if high risk)	☐ CBC / Basic metabolic panel
☐ DTaP (if not up to date)	☐ MMR (if high risk)	☐ Hct / Hgb
☐ Hep A vaccine (if high risk)	☐ PCV (if not up to date)	☐ Lipid panel (if high risk)
☐ Hep B vaccine	☐ Rotavirus	☐ PPD skin test ☐ QFT
☐ Hib (if not up to date)	☐ Hep B Panel (if high risk)	☐ CXR ☐ Urinalysis
☐ Influenza vaccine	☐ Rx Fluoride drops / chewable tabs (0.25 mg QD)	☐ ECG ☐ COVID 19 test
☐ IPV	☐ Fluoride varnish application	☐ Iron-fortified formula
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Introduction to meats & proteins	☐ Fortified Infant Cereals	☐ Mashed table food
☐ Whole grains / iron-rich foods	☐ Finger foods	☐ Start feeder cup
☐ Physical activity / exercise	☐ Healthy food choices	☐ No bottles in bed

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Rear facing infant car seat	☐ Electrical outlet covers
☐ Routine dental care	☐ Choking hazards	☐ Allow to feed self
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Understands "no" but not discipline
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Play with cloth book
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Physical growth
☐ Childcare plan	☐ Poison control phone number	☐ Decreased appetite
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Teething

Next Appointment

☐ At 12 Months Old	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Weight & Head Circumference measurements plotted in WHO growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

12 to 15 Months Old	Actual Age:	Date:	
Medical Record #			
Gender	☐ Male ☐ Female		
Accompanied by	☐ Mother ☐ Father ☐ Other:		
Parent's Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter			
Intake		**Vital Signs**	
Allergies		Temp	
Height		Pulse	
Weight		Resp	
Head Circumference			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			
Interval History			
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:		
Elimination	☐ Normal ☐ Abnormal		
Has WIC	☐ Yes ☐ No		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 30 min/day) ☐ Active (> 30 min/day)		
Sleep	☐ Regular ☐ Sleep regression ☐ Night time fears		
Fluoridated Water Supply	☐ Yes ☐ No		
Fluoride Varnish	Date last applied:		
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR		
Family History	☐ Unremarkable	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Asthma	
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO	
☐ Other:			
Behavioral / Social / Emotional Risk Assessment	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)		
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:		

Name: DOB:

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Adverse Childhood Experiences	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Anemia	☐ H&P, ☐ Other:	☐	☐
Behavioral / Social / Emotional	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Blood Lead	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development		
☐ Walks alone well	☐ Three-word vocabulary	☐ Stacks two-block tower
☐ Stoops and recovers	☐ Plays pat-a-cake	☐ Says "mama" or "dada"
☐ Takes lids off containers	☐ Feeds self	☐ Scribbles

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. open ____cm	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Comprehensive Health Assessment

Name: DOB:

Subjective / Objective

Assessment

Plan

Referrals

☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dentist	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders

☐ COVID 19 vaccine	☐ Meningococcal (if high risk)	☐ CBC / Basic metabolic panel
☐ DTaP	☐ MMR	☐ Hct / Hgb (at 12 months)
☐ Hep A vaccine	☐ PCV	☐ Lipid panel (if high risk)
☐ Hep B vaccine	☐ Varicella	☐ PPD skin test ☐ QFT
☐ Hib	☐ Hep B Panel (if high risk)	☐ CXR ☐ Urinalysis
☐ Influenza vaccine	☐ Blood Lead (at 12 months)	☐ ECG ☐ COVID 19 test
☐ IPV	☐ Rx Fluoride drops / chewable tabs (0.25 mg QD)	☐ Fluoride varnish application
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Relaxed atmosphere / Avoid rushing while eating	☐ Vegetables, fruits	☐ Table food
☐ Whole grains / iron-rich foods	☐ Encourage solids	☐ Using cup
☐ Physical activity / exercise	☐ Healthy food choices	☐ No bottles in bed

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Rear facing toddler car seat	☐ Feeding self
☐ Routine dental care	☐ Choking hazards	☐ Simple games
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Temper tantrum
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Family play
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Mindful of daily movements
☐ Caution with strangers	☐ Poison control phone number	☐ Treatment of minor cuts
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Toileting habits / training

Next Appointment

☐ In 3 Months	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Weight & Head Circumference measurements plotted in WHO growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date

Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

16 to 23 Months Old	Actual Age:	Date:
Medical Record #		
Gender	☐ Male ☐ Female	
Accompanied by	☐ Mother ☐ Father ☐ Other:	
Parent's Primary Language		
Interpreter Requested	☐ Yes ☐ No ☐ Refused	
Name of Interpreter		

Intake		Vital Signs	
Allergies		Temp	
Height		Pulse	
Weight		Resp	
Head Circumference			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		

Chronic Problems/Significant Conditions: ☐ See Problem List

Current Medications/Vitamins: ☐ See Medication List

Interval History		
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:	
Elimination	☐ Normal ☐ Abnormal	
Has WIC	☐ Yes ☐ No	
Physical Activity	☐ Inactive (little or none) ☐ Some (< 30 min/day) ☐ Active (> 30 min/day)	
Sleep	☐ Regular ☐ Sleep regression ☐ Night time fears	
Fluoridated Water Supply	☐ Yes ☐ No	
Fluoride Varnish	Date last applied:	
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR	
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease	☐ HTN	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO
☐ Other:		
Behavioral / Social / Emotional Risk Assessment	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

Name: DOB:

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Adverse Childhood Experiences	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Anemia	☐ H&P, ☐ Other:	☐	☐
Autism Disorder (At 18 Months)	☐ ASQ-3, ☐ SWYC, ☐ M-CHAT, ☐ Other:	☐	☐
Behavioral / Social / Emotional	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Blood Lead	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Developmental Disorder (At 18 Months)	☐ ASQ-3, ☐ SWYC, ☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development		
☐ Walks alone fast	☐ 7 to 20-word vocabulary	☐ Stacks three-block tower
☐ Climbs	☐ Names 5 body parts	☐ Says "mama" or "dada"
☐ Kicks a ball	☐ Indicates wants by pointing and pulling	☐ Sips from cup, a little spillage

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. open _____cm	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities & grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction, leg length equal	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐

Comprehensive Health Assessment

Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dentist	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders

☐ COVID 19 vaccine	☐ Meningococcal (if high risk)	☐ CBC / Basic metabolic panel
☐ DTaP (if not up to date)	☐ MMR (if not up to date)	☐ Hct / Hgb (if high risk)
☐ Hep A vaccine (if not up to date)	☐ PPSV (if high risk)	☐ Lipid panel (if high risk)
☐ Hep B vaccine (if not up to date)	☐ Varicella (2nd Dose)	☐ PPD skin test ☐ QFT
☐ Hib (if not up to date)	☐ Blood Lead	☐ CXR ☐ Urinalysis
☐ Influenza vaccine	☐ Hep B Panel (if high risk)	☐ ECG ☐ COVID 19 test
☐ IPV (if not up to date)	☐ Rx Fluoride drops / chewable tabs (0.25 mg QD)	☐ Fluoride varnish application
☐ Other:		

Name: DOB:

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Relaxed atmosphere / Avoid rushing while eating	☐ Vegetables, fruits	☐ Caloric balance
☐ Whole grains / iron-rich foods	☐ Switch to low-fat milk	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Regular balanced meal with snacks	☐ No bottles

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Rear facing toddler car seat	☐ Independence
☐ Routine dental care	☐ Safety helmet	☐ Make-believe / role play
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Dressing self
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Reading together
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Mindful of daily movements
☐ Caution with strangers	☐ Poison control phone number	☐ Parallel peer play
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Toileting habits / training

Next Appointment

☐ At 2 Years Old	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Weight & Head Circumference measurements plotted in WHO growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

2 Years Old	Actual Age:	Date:	
Medical Record #			
Gender	☐ Male ☐ Female		
Accompanied by	☐ Mother ☐ Father ☐ Other:		
Parent's Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter			
Intake		**Vital Signs**	
Allergies		Temp	
Height		Pulse	
Weight		Resp	
BMI Value		BMI %	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider		Last visit date:	
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			
Interval History			
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Elimination	☐ Normal ☐ Abnormal		
Has WIC	☐ Yes ☐ No		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (> 60 min/day)		
Sleep Pattern	☐ Regular ☐ Sleep regression ☐ Night time fears		
Fluoridated Water Supply	☐ Yes ☐ No		
Fluoride Varnish	Date last applied:		
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR		
Family History	☐ Unremarkable	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Asthma	
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO	
☐ Other:			
Behavioral / Social / Emotional Risk Assessment	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)		
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:		

Name: DOB:

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Adverse Childhood Experiences	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Anemia	☐ H&P, ☐ Other:	☐	☐
Autism Disorder	☐ ASQ-3, ☐ SWYC, ☐ M-CHAT, ☐ Other:	☐	☐
Behavioral / Social / Emotional	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Blood Lead	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Developmental Disorder	☐ ASQ-3, ☐ SWYC, ☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development		
☐ Runs well, walks up and down	☐ Identifies 5 body parts	☐ Helps around the house
☐ Jumps off the ground with both feet	☐ Plays hide and seek	☐ Stacks three-block tower
☐ Puts 2 or more words together	☐ Kicks and throws a ball	☐ Handles spoon well
☐ 7 to 20-word vocabulary	☐ Name at least 1 color	☐ Puts on simple clothes

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. closed	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction	☐

Comprehensive Health Assessment

Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dentist	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders

☐ COVID 19 vaccine	☐ Meningococcal (if high risk)	☐ CBC / Basic metabolic panel
☐ DTaP (if not up to date)	☐ MMR (if not up to date)	☐ Hct / Hgb (if high risk)
☐ Hep A vaccine (if not up to date)	☐ PPSV (if high risk)	☐ Lipid panel (if high risk)
☐ Hep B vaccine (if not up to date)	☐ Varicella (2nd Dose)	☐ PPD skin test ☐ QFT
☐ Hib (if not up to date)	☐ Blood Lead (at 2 Yrs old)	☐ CXR ☐ Urinalysis
☐ Influenza vaccine	☐ Hep B Panel (if high risk)	☐ ECG ☐ COVID 19 test
☐ IPV (if not up to date)	☐ Rx Fluoride drops / chewable tabs (0.25 mg QD)	☐ Fluoride varnish application
☐ Other:		

Name: **DOB:**

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Caloric balance
☐ Whole grains / iron-rich foods	☐ Switch to low-fat milk	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Regular balanced meal with snacks	☐ No bottles

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Seat belt / Toddler car seat	☐ Independence
☐ Routine dental care	☐ Safety helmet	☐ Make-believe / role play
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Dressing self
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Reading together
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Mindful of daily movements
☐ Caution with strangers	☐ Poison control phone number	☐ Parallel peer play
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Toileting habits / training

Next Appointment

☐ At 30 Months Old	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

30 Months Old	Actual Age:	Date:
Medical Record #		
Gender	☐ Male ☐ Female	
Accompanied by	☐ Mother ☐ Father ☐ Other:	
Parent's Primary Language		
Interpreter Requested	☐ Yes ☐ No ☐ Refused	
Name of Interpreter		

Intake		Vital Signs	
Allergies		Temp	
Height		Pulse	
Weight		Resp	
BMI Value		BMI %	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		

Chronic Problems/Significant Conditions: ☐ See Problem List

Current Medications/Vitamins: ☐ See Medication List

Interval History	
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:
Appetite	☐ Good ☐ Fair ☐ Poor
Elimination	☐ Normal ☐ Abnormal
Has WIC	☐ Yes ☐ No
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (> 60 min/day)
Sleep Pattern	☐ Regular ☐ Sleep regression ☐ Night time fears
Fluoridated Water Supply	☐ Yes ☐ No
Fluoride Varnish	Date last applied:
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR

Family History		
	☐ Unremarkable	☐ Diabetes
☐ Heart disease	☐ HTN	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO
☐ Other:		

Behavioral / Social / Emotional Risk Assessment	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:

Name: DOB:

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Adverse Childhood Experiences	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Anemia	☐ H&P, ☐ Other:	☐	☐
Behavioral / Social / Emotional	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Blood Lead	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Developmental Disorder	☐ ASQ-3, ☐ SWYC, ☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development		
☐ Balances on each foot, 1 second	☐ Eats independently	☐ Helps in dressing
☐ Uses 3-word sentences	☐ Goes up stairs alternating feet	☐ Draws a single circle
☐ Plays with other children	☐ Knows age, sex, first, & last name	☐ Cuts with scissors

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. closed	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Courtesy of Anthem Blue Cross. Revised 6/23/22

Comprehensive Health Assessment

Name: DOB:

Subjective / Objective

Assessment

Plan

Referrals

☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dentist	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders

☐ COVID 19 vaccine	☐ MMR	☐ CBC / Basic metabolic panel
☐ DTaP	☐ PPSV	☐ Hct / Hgb (if high risk)
☐ Hep A vaccine (if not up to date)	☐ PPSV (if high risk)	☐ Lipid panel (if high risk)
☐ Hep B vaccine (if not up to date)	☐ Varicella (2nd Dose)	☐ PPD skin test ☐ QFT
☐ IPV	☐ Blood Lead (if not in chart)	☐ CXR ☐ Urinalysis
☐ Influenza vaccine	☐ Hep B Panel (if high risk)	☐ ECG ☐ COVID 19 test
☐ Meningococcal (if high risk)	☐ Rx Fluoride drops / chewable tabs (0.25 mg QD)	☐ Fluoride varnish application
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Meal socialization
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Regular balanced meal with snacks	☐ No bottles

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Seat belt /Toddler car seat	☐ Independence
☐ Routine dental care	☐ Safety helmet	☐ Make-believe / role play
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Dressing self
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Reading together / school readiness
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Knows name, address, & phone number
☐ Caution with strangers	☐ Poison control phone number	☐ Plays with other children
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Toileting habits

Next Appointment

☐ At 3 Years Old	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

3 Years Old	Actual Age:	Date:	
Medical Record #			
Gender	☐ Male ☐ Female		
Accompanied by	☐ Mother ☐ Father ☐ Other:		
Parent's Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter			
Intake		**Vital Signs**	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
BMI %			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Hearing Screening	☐ Responded at ≤ 25 dB at 1000-4000 frequencies in both ears	☐ Non coop	
Vision Screening	OD: OS: OU:	☐ Non coop	
Dental Provider	Last visit date:		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			
Interval History			
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Elimination	☐ Normal ☐ Abnormal		
Has WIC	☐ Yes ☐ No		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (> 60 min/day)		
Sleep Pattern	☐ Regular ☐ Fatigue ☐ Snoring ☐ Enuresis		
Fluoridated Water Supply	☐ Yes ☐ No		
Fluoride Varnish	Date last applied:		
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR		
Family History	☐ Unremarkable	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Asthma	
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO	
☐ Other:			

Name: DOB:

Behavioral / Social / Emotional Risk Assessment	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)		
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:		
AAP Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Adverse Childhood Experiences	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Anemia	☐ H&P, ☐ Other:	☐	☐
Behavioral / Social / Emotional	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Blood Lead	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development		
☐ Balances on each foot, 1 second	☐ Eats independently	☐ Helps in dressing
☐ Uses 3-word sentences	☐ Goes up stairs alternating feet	☐ Draws a single circle
☐ Plays with several children	☐ Knows age, sex, first, & last name	☐ Cuts with scissors

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical, A.F. closed	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction	☐
Femoral pulses	Normal	☐

Comprehensive Health Assessment

Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dentist	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders

☐ COVID 19 vaccine	☐ MMR	☐ CBC / Basic metabolic panel
☐ DTaP	☐ PPSV	☐ Hct / Hgb (if high risk)
☐ Hep A vaccine (if not up to date)	☐ PPSV (if high risk)	☐ Lipid panel (if high risk)
☐ Hep B vaccine (if not up to date)	☐ Varicella (2nd Dose)	☐ PPD skin test ☐ QFT
☐ IPV	☐ Blood Lead (if not in chart)	☐ CXR ☐ Urinalysis
☐ Influenza vaccine	☐ Hep B Panel (if high risk)	☐ ECG ☐ COVID 19 test
☐ Meningococcal (if high risk)	☐ Rx Fluoride drops / chewable tabs (0.25 mg/0.50 mg QD)	☐ Fluoride varnish application
☐ Other:		

Name: DOB:

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Meal socialization
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Regular balanced meal with snacks	☐ School lunch program

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Seat belt /Toddler car seat	☐ Independence
☐ Routine dental care	☐ Safety helmet	☐ Make-believe / role play
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Dressing self
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Reading together / school readiness
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Knows name, address, & phone number
☐ Caution with strangers	☐ Poison control phone number	☐ Plays with other children
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Toileting habits

Next Appointment

☐ At 4 Years Old	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

4 to 5 Years Old	Actual Age:	Date:	
Medical Record #			
Gender	☐ Male ☐ Female		
Accompanied by	☐ Mother ☐ Father ☐ Other:		
Parent's Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter			
Intake		**Vital Signs**	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
BMI %			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Hearing Screening	☐ Responded at ≤ 25 dB at 1000-4000 frequencies in both ears ☐ Non coop		
Vision Screening	OD: OS: OU: ☐ Non coop		
Dental Provider	Last visit date:		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			
Interval History			
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Elimination	☐ Normal ☐ Abnormal		
Has WIC	☐ Yes ☐ No		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (> 60 min/day) ☐ Fainting ☐ Sudden seizures ☐ SOB ☐ Chest pain		
Sleep Pattern	☐ Regular ☐ Fatigue ☐ Snoring ☐ Enuresis		
Fluoridated Water Supply	☐ Yes ☐ No		
Fluoride Varnish	Date last applied:		
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR		
Family History	☐ Unremarkable	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Asthma	
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO	
☐ Other:			

Name: DOB:

Behavioral / Social / Emotional Risk Assessment	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)		
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:		
AAP Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Adverse Childhood Experiences	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Anemia	☐ H&P, ☐ Other:	☐	☐
Behavioral / Social / Emotional	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Blood Lead	☐ Lead Assessment, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development / School Progress		
☐ Hops on one foot	☐ Counts four pennies	☐ Copies a square
☐ Catches, throws a ball	☐ Knows opposites	☐ Recognizes 3-4 colors
☐ Plays with several children	☐ Knows name, address, & phone number	☐ Holds crayon between finger and thumb

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	Symmetrical	☐
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	☐
Ears	Canals clear, TMs normal Appears to hear	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Hips	Good abduction	☐

Comprehensive Health Assessment

Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ WIC	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dentist	☐ Dietician / Nutritionist	☐ Pulmonologist
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ Other:		

Orders

☐ COVID 19 vaccine	☐ MMR	☐ CBC / Basic metabolic panel
☐ DTaP	☐ PCV13 (if not up to date)	☐ Hct / Hgb (if high risk)
☐ Hep A vaccine (if not up to date)	☐ PPSV (if high risk)	☐ Lipid panel (if high risk)
☐ Hep B vaccine (if not up to date)	☐ Varicella (2nd Dose)	☐ PPD skin test ☐ QFT
☐ IPV	☐ Blood Lead (if not in chart)	☐ CXR ☐ Urinalysis at 5 years
☐ Influenza vaccine	☐ Hep B Panel (if high risk)	☐ ECG ☐ COVID 19 test
☐ Meningococcal (if high risk)	☐ Rx Fluoride drops / chewable tabs (0.25 mg/0.50 mg QD)	☐ Fluoride varnish application
☐ Other:		

Name: DOB:

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Meal socialization
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Regular balanced meal with snacks	☐ School lunch program

Accident Prevention & Guidance

☐ Lead poisoning prevention	☐ Seat belt	☐ Independence
☐ Routine dental care	☐ Safety helmet	☐ Make-believe / role play
☐ Brush teeth with fluoride toothpaste	☐ Storage of drugs / toxic chemicals	☐ Dressing self
☐ Fluoride varnish treatment	☐ Matches / burns	☐ Reading together / school readiness
☐ Family support, social interaction & communication	☐ Violence prevention, gun safety	☐ Knows name, address, & phone number
☐ Caution with strangers	☐ Poison control phone number	☐ Plays with other children
☐ Skin cancer prevention	☐ Smoke detector	☐ Limit screen time
☐ Falls	☐ Hot water temp < 120° F	☐ Bedtime
☐ Effects of passive smoking	☐ Drowning / pool fence	☐ Toileting habits

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

6 to 8 Years Old	Actual Age:	Date:	
Medical Record #			
Gender	☐ Male ☐ Female		
Accompanied By	☐ Self ☐ Parent ☐ Other:		
Parent's Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter:			
Intake		**Vital Signs**	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
BMI %			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Hearing Screening	☐ Responded at ≤ 25 dB at 1000-4000 frequencies in both ears	☐ Non coop	
Vision Screening	OD: OS: OU:	☐ Non coop	
Dental Provider	Last visit date:		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			

Interval History		
Diet / Nutrition	☐ Regular ☐ Iron-rich foods ☐ Other:	
Appetite	☐ Good ☐ Fair ☐ Poor	
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 60 min/day) ☐ Fainting ☐ Sudden seizures ☐ SOB ☐ Chest pain	
Sleep Pattern	☐ Regular ☐ Fatigue ☐ Snoring ☐ Enuresis	
Fluoridated Water Supply	☐ Yes ☐ No	
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR	
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease	☐ HTN	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO
☐ Other:		
Behavioral / Social / Emotional Risk Assessment	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

Name: DOB:

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Adverse Childhood Experiences	☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Anemia	☐ H&P, ☐ Other:	☐	☐
Behavioral / Social / Emotional	☐ PSC, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Sudden Cardiac Arrest	☐ H&P, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development / School Progress		
☐ Rides bicycle	☐ Knows right from left	☐ Reads for pleasure
☐ Ties shoelaces	☐ Draws person with 6 parts including clothing	☐ Tells time
☐ Rules and consequences	☐ Independence	☐ Prints first name

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities & grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Comprehensive Health Assessment

Name: DOB:

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Audiologist
☐ Dietician / Nutritionist	☐ Regional Center	☐ Early Start or Local Education Agency
☐ CA Children's Services (CCS)	☐ Other:	

Orders

☐ COVID 19 vaccine	☐ Meningococcal (if high risk)	☐ CBC / Basic metabolic panel
☐ DTaP (if not up to date)	☐ MMR (if not up to date)	☐ Hct / Hgb (if high risk)
☐ Hep A (if not up to date)	☐ Tdap (≥7 YO)	☐ Lipid panel (if high risk)
☐ Hep B (if not up to date)	☐ Varicella (if not up to date)	☐ PPD skin test (if high risk) ☐ QFT (if high risk)
☐ IPV (if not up to date)	☐ Blood Lead (if high risk)	☐ CXR ☐ Urinalysis
☐ Influenza vaccine	☐ Hep B Panel (if high risk)	☐ ECG ☐ COVID 19 test
☐ Rx Fluoride drops / chewable tabs (0.50 mg/1.0 mg QD)	☐ Other:	

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Routine dental care	☐ Use of social media	☐ Peer pressure
☐ Lead Poisoning Prevention	☐ Avoid risk-taking behavior	☐ Independence
☐ Signs of depression (suicidal ideation)	☐ Gun safety	☐ Personal development
☐ Mental health (emotional support)	☐ Non-violent conflict resolution	☐ Physical growth
☐ Form caring & supportive relationships with family & peers	☐ Safety helmet ☐ Seat belt	☐ Daily mindful movements
☐ Early Sex education	☐ Limit screen time	☐ Puberty
☐ Smoking/vaping use/exposure	☐ Skin cancer prevention	☐ Bedtime

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

Name: **DOB:**

9 to 12 Years Old	Actual Age: Date:		
Medical Record #			
Gender	☐ Male ☐ Female		
Accompanied By	☐ Self ☐ Parent ☐ Other:		
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Interpreter Name:		
Intake		**Vital Signs**	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
BMI %			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Hearing Screening	☐ 9-10 Yrs Old: Responded at ≤ 25 dB at 1000-4000 frequencies in both ears ☐ ≥11 Yrs Old: Responded at ≤ 25 dB at 1000-8000 frequencies in both ears	☐ Non coop	
Vision Screening	OD: OS: OU:	☐ Non coop	
Dental Provider	Last visit date:		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			
Interval History			
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 60 min/day) ☐ Fainting ☐ Sudden seizures ☐ SOB ☐ Chest pain		
Sleep Pattern	☐ Regular ☐ Fatigue ☐ Snoring ☐ Enuresis		
Fluoridated Water Supply	☐ Yes ☐ No		
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR		
Sexually active	☐ Yes ☐ No ☐ Multiple Partners ☐ MSM		
Contraceptive Used	☐ None ☐ Condoms ☐ Other:		
LMP (females):		☐ Menorrhagia	
Current Alcohol / Substance use	☐ None	☐ Alcohol	
☐ Drugs (specify):	☐ IV Drugs (or past Hx)	☐ Tobacco / Vape Packs/day:	
Family History	☐ Unremarkable	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Asthma	
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO	
☐ Other:			

Behavioral / Social / Emotional Risk Assessment	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)		
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:		
AAP Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Adverse Childhood Experiences	☐ PEARLS, ☐ PEARLS-12&UP ☐ H&P, ☐ Other:	☐	☐
Alcohol Misuse (Starting at 11 Years Old)	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Anemia	☐ H&P, ☐ Other:	☐	☐
Behavioral / Social / Emotional	☐ PSC, ☐ PSC-Y, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Depression (Starting at 12 Years Old)	☐ PHQ-9A, ☐ H&P, ☐ Other:	☐	☐
Drug Misuse (Starting at 11 Years Old)	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
HIV (Starting at 11 Years Old)	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections (Starting at 11 Years Old)	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Sudden Cardiac Arrest (Starting at 11 Years Old)	☐ H&P, ☐ Other:	☐	☐
Suicide (Starting at 12 Years Old)	☐ ASQ, ☐ PHQ-9A, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development / School Progress		
☐ School achievement	☐ Performs chores	☐ Plays / listens to music
☐ School attendance	☐ Exhibit compassion & empathy	☐ Reads for pleasure
☐ Cause and effect are understood	☐ Participates in organized sports / social activities	☐ Demonstrate social & emotional competence (including self-regulation)
☐ Caring & supportive relationships with family & peers	☐ Adheres to predetermined rules	☐ Knows right from left

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐

Comprehensive Health Assessment

Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ OB/GYN:	☐ Other:	

Orders

☐ COVID 19 vaccine	☐ Tdap	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not given previously)	☐ Varicella (if not up to date)	☐ Hct / Hgb (yearly if menstruating)
☐ HPV vaccine (if not up to date)	☐ Hep B Panel (if not up to date)	☐ Lipid panel (once between 9-11 YO)
☐ Influenza vaccine	☐ Chlamydia ☐ Gonorrhea	☐ PPD skin test ☐ QFT
☐ Meningococcal vaccine (11 to 12 YO)	☐ HIV ☐ Herpes	☐ CXR ☐ Urinalysis
☐ MMR (if not up to date)	☐ Syphilis ☐ Trichomonas	☐ ECG ☐ COVID 19 test
☐ Rx Fluoride drops / chewable tabs (0.50 mg/1.0 mg QD)	☐ Other:	

Name: DOB:

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Social media use	☐ Peer pressure
☐ Signs of depression (suicidal ideation)	☐ Avoid risk-taking behavior	☐ Independence
☐ Mental health (emotional support)	☐ Gun safety	☐ Personal development
☐ Form caring & supportive relationships with family & peers	☐ Non-violent conflict resolution	☐ Physical growth
☐ Early Sex education / Safe sex practices	☐ Safety helmet	☐ Mindful of daily movements
☐ Skin cancer prevention	☐ Seat belt	☐ Puberty
☐ Smoking/vaping use/exposure	☐ Routine dental care	☐ Bedtime

Tobacco Cessation Quit Date:

☐ Advised to quit smoking	☐ Discuss smoking cessation medication	☐ Discuss smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

13 to 16 Years Old	Actual Age:	Date:	
Medical Record #			
Gender	☐ Male ☐ Female		
Accompanied By	☐ Self ☐ Parent ☐ Other:		
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Interpreter Name:		
Intake		**Vital Signs**	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
BMI %			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Hearing Screening	☐ Responded at ≤ 25 dB at 1000-8000 frequencies in both ears	☐ Non coop	
Vision Screening	OD: OS: OU:	☐ Non coop	
Dental Provider	Last visit date:		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			

Interval History		
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:	
Appetite	☐ Good ☐ Fair ☐ Poor	
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 60 min/day) ☐ Fainting ☐ Sudden seizures ☐ SOB ☐ Chest pain	
Fluoridated Water Supply	☐ Yes ☐ No	
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR	
Sexually Active	☐ Yes ☐ No ☐ Multiple Partners ☐ MSM	
Contraceptive Used	☐ None ☐ Condoms ☐ Other:	
LMP (females):		☐ Menorrhagia
Current Alcohol / Substance use	☐ None	☐ Alcohol
☐ Drugs (specify):	☐ IV Drugs (or past Hx)	☐ Tobacco / Vape Packs/day:
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease	☐ HTN	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO
☐ Other:		

Name: DOB:

Behavioral / Social / Emotional Risk Assessment	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:

AAP Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Adverse Childhood Experiences	☐ PEARLS, ☐ PEARLS-12&UP, ☐ H&P, ☐ Other:	☐	☐
Alcohol Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Anemia	☐ H&P, ☐ Other:	☐	☐
Behavioral / Social / Emotional	☐ PSC, ☐ PSC-Y, ☐ HEADSSS, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Depression	☐ PHQ-9A, ☐ H&P, ☐ Other:	☐	☐
Drug Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
HIV	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Sudden Cardiac Arrest	☐ H&P, ☐ Other:	☐	☐
Suicide	☐ ASQ, ☐ PHQ-9A, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development / School Progress		
☐ School achievement	☐ Performs chores	☐ Plays / listens to music
☐ School attendance	☐ Learns new skills	☐ Reads
☐ Understands parental limits & consequences for unacceptable behavior	☐ Participates in organized sports / social activities	☐ Uses both hands independently
☐ Ability to get along with peers	☐ Learns from mistakes & failures, tries again	☐ Preoccupation with rapid body changes

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐

Comprehensive Health Assessment

Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest/Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ OB/GYN:	☐ Other:	

Orders

☐ COVID 19 vaccine	☐ Tdap	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Varicella (if not up to date)	☐ Hct / Hgb (yearly if menstruating)
☐ HPV vaccine (if not up to date)	☐ Hep B Panel (if high risk)	☐ Lipid panel (if high risk)
☐ Influenza vaccine	☐ Chlamydia ☐ Gonorrhea	☐ PPD skin test ☐ QFT
☐ Meningococcal vaccine (if not up to date)	☐ HIV ☐ Herpes	☐ CXR ☐ Urinalysis
☐ MMR (if not up to date)	☐ Syphilis ☐ Trichomonas	☐ ECG ☐ COVID 19 test
☐ Rx Fluoride drops / chewable tabs (0.50 mg/1.0 mg QD)	☐ Other:	

Name: DOB:

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Social Media Use	☐ Goals in life
☐ Signs of depression (suicidal ideation)	☐ Avoid risk-taking behavior	☐ Independence
☐ Mental health (emotional support)	☐ Gun safety	☐ Personal development
☐ Intimate partner violence	☐ Violent behavior	☐ Academic or work plans
☐ Sex education (partner selection)	☐ Safety helmet	☐ Family support, social interaction & communication
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Seat belt	☐ Mindful of daily movements
☐ Skin cancer prevention	☐ Motor vehicle safety (no texting & driving)	☐ Physical growth
☐ Smoking/vaping use/exposure	☐ Routine dental care	☐ Sexuality

Tobacco Cessation Quit Date:

☐ Advised to quit smoking	☐ Discuss smoking cessation medication	☐ Discuss smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

Name: **DOB:**

17 to 20 Years Old	Actual Age: Date:		
Medical Record #			
Gender	☐ Male ☐ Female		
Accompanied By	☐ Self ☐ Parent ☐ Other:		
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Interpreter Name:		
Intake		**Vital Signs**	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
BMI %			
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Hearing Screening	☐ Responded at ≤ 25 dB at 1000-8000 frequencies in both ears	☐ Non coop	
Vision Screening	OD: OS: OU:	☐ Non coop	
Dental Provider	Last visit date:		
Advance Directive Info given/discussed	☐ Yes ☐ Refused Starting at 18 Years Old		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			
☐ Taking 0.4 to 0.8 mg of folic acid daily (females of reproductive age)			
Interval History			
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 60 min/day) ☐ Fainting ☐ Sudden seizures ☐ SOB ☐ Chest pain		
Weight ☐ Loss ☐ Gain	_____ lbs ☐ Intentional ☐ Unintentional		
Vaccines Up to Date	☐ Yes ☐ No ☐ See CAIR		
Sexually Active	☐ Yes ☐ No ☐ Multiple Partners ☐ MSM		
Contraceptive Used	☐ None ☐ Condoms ☐ Other:		
LMP (females):	G P A	☐ Menorrhagia	
Current Alcohol / Substance use	☐ None	☐ Alcohol	
☐ Drugs (specify):	☐ IV Drugs (or past Hx)	☐ Tobacco / Vape Packs/day:	

Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease	☐ HTN	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Family Hx of unexpected or sudden death < 50 YO
☐ Other:		
Behavioral / Social / Emotional Risk Assessment	☐ WNL - Stable relationships w/ social/emotional support ☐ Changes in family since last visit (move, job, death) ☐ Problems with housing, food, employment ☐ Family stressors (mental illness, drugs, violence/abuse)	
Lives with	☐ 1 Parent ☐ 2 Parents ☐ Other:	

AAP Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Adverse Childhood Experiences	☐ ACEs, ☐ PEARLS, ☐ H&P, ☐ Other:	☐	☐
Alcohol Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Anemia	☐ H&P, ☐ Other:	☐	☐
Behavioral / Social / Emotional	☐ PSC-Y, ☐ H&P, ☐ Other:	☐	☐
Dental (cavities, no dental home)	☐ H&P, ☐ Other:	☐	☐
Depression	☐ PHQ-9A, ☐ H&P, ☐ Other:	☐	☐
Drug Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Hepatitis C (Starting at 18 Years Old)	☐ H&P, ☐ Other:	☐	☐
HIV	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Sudden Cardiac Arrest	☐ H&P, ☐ Other:	☐	☐
Suicide	☐ ASQ, ☐ PHQ-9A, ☐ Other:	☐	☐
Tobacco Use / Exposure	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Growth and Development / School Progress		
☐ Hobbies / work	☐ Plays sports	☐ Plays / listens to music
☐ School achievement / attendance	☐ Acts responsibly for self	☐ Takes on new responsibility
☐ Improved social skills; maintains family relationships	☐ Sets goals & works towards achieving them	☐ Preparation for further education, career, marriage & parenting

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐

Comprehensive Health Assessment

Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal Tanner stage: I II III IV V	☐
Male	Circ / uncircumcised, testes in scrotum	☐
Female	No lesions, normal external appearance	☐
Vaginal exam	Done or completed elsewhere OB/GYN name:	☐
Femoral pulses	Normal	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist/ Ophthalmologist	☐ Dietician/ Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ CA Children's Services (CCS)	☐ Regional Center	☐ Early Start or Local Education Agency
☐ OB/GYN	☐ Other:	

Orders

☐ COVID 19 vaccine	☐ Hep B Panel (if high risk)	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Hep C Antibody test (at least once ≥ 18 YO)	☐ Hct / Hgb (yearly if menstruating)
☐ HPV vaccine (if not up to date)	☐ Rx for folic acid 0.4-0.8mg daily (females)	☐ Lipid panel (once between 17-21 YO)
☐ Influenza vaccine	☐ Chlamydia ☐ Gonorrhea	☐ PPD skin test ☐ QFT
☐ Meningococcal vaccine (if not up to date)	☐ HIV ☐ Herpes	☐ CXR ☐ Urinalysis
☐ MMR (if not up to date)	☐ Syphilis ☐ Trichomonas	☐ ECG ☐ COVID 19 test
☐ Tdap	☐ Other:	

Name: DOB:

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Social media use	☐ Transitioning to adult provider
☐ Routine dental care	☐ Avoid risk-taking behavior	☐ Independence
☐ Signs of depression (suicidal ideation)	☐ Gun safety	☐ Personal development & goals in life
☐ Intimate partner violence	☐ Violent behavior	☐ Academic or work plans
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Seat belt / Safety Helmet	☐ Testicular self-exam
☐ Skin cancer prevention	☐ Motor vehicle safety (no texting & driving)	☐ Self-breast exam
☐ Smoking/vaping use/exposure	☐ Mental health (emotional support)	☐ Prenatal care / encourage breastfeeding

Tobacco Cessation Quit Date:

☐ Advised to quit smoking	☐ Discuss smoking cessation medication	☐ Discuss smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated & signed by provider	☐ Height / Weight / BMI measurements plotted in CDC growth chart	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

Name: **DOB:**

21 to 39 Years: Female	Actual Age:	Date:	
Medical Record #			
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter			
Intake		**Vital Signs**	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		
Advance Directive Info Given/Discussed	☐ Yes ☐ Refused		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List ☐ taking 0.4 to 0.8 mg of folic acid daily (for reproductive females)			
Limitations (physical or mental):			
Interval History			
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 2 ½ hrs per week w/ 2 days strength training)		
Weight ☐ Loss ☐ Gain	_____ lbs ☐ Intentional ☐ Unintentional		
LMP:	G P A	☐ Menorrhagia	
Sexually active	☐ Yes ☐ No ☐ Multiple Partners		
Contraceptive Used	☐ None ☐ Condoms ☐ Other:		
Last PAP	Date:	☐ WNL	
Current Alcohol / Substance Use	☐ None	☐ Alcohol	
☐ Drugs (specify):	☐ IV Drugs (or past Hx)	☐ Tobacco / Vape Packs/day:	
Family History	☐ None	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Hip fracture	
☐ High cholesterol	☐ Cancer	☐ Other:	

Immunization History / Date	☐ None ☐ See CAIR	☐ Tdap:
☐ COVID #1: ☐ COVID #2:	☐ Influenza:	☐ Varicella:
☐ COVID Booster(s):	☐ MMR:	☐ Zoster:
☐ Hepatitis B:	☐ Pneumococcal:	☐ Other:

USPSTF Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Alcohol Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Cervical Cancer	☐ H&P, ☐ Other:	☐	☐
Depression	☐ PHQ2, ☐ PHQ9, ☐ Other:	☐	☐
Diabetes	☐ H&P, ☐ Other:	☐	☐
Drug Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Hepatitis C	☐ H&P, ☐ Other:	☐	☐
HIV	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Intimate Partner Violence	☐ HARK, ☐ HITS, ☐ H&P, ☐ Other:	☐	☐
Obesity	☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment ☐ H&P, ☐ Other:	☐	☐

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear, Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐

Comprehensive Health Assessment

Female	No lesions, normal external appearance	☐
Vaginal exam	Done or completed elsewhere OB/GYN name:	☐
Femoral pulses	Present & equal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ OB/GYN:	☐ Other:	

Orders

☐ COVID 19 vaccine / booster	☐ Varicella (if not up to date)	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Hep B Panel (if high risk)	☐ Hct / Hgb ☐ Lipid panel
☐ HPV vaccine (if not up to date)	☐ Hep C Antibody test	☐ Low to moderate dose statin
☐ Influenza vaccine	☐ Chlamydia ☐ Gonorrhea	☐ PPD skin test ☐ QFT
☐ Meningococcal vaccine (if not up to date)	☐ HIV ☐ Herpes	☐ CXR ☐ Urinalysis
☐ MMR (if not up to date)	☐ Syphilis ☐ Trichomonas	☐ ECG ☐ COVID 19 test
☐ Pneumococcal (if high risk)	☐ Rx for folic acid 0.4-0.8mg daily	☐ Fasting plasma glucose / HbA1C
☐ Tdap	☐ PAP	☐ Bone Density Test
☐ Other:		

Name: DOB:

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Avoid risk-taking behavior	☐ Independence
☐ Routine dental care	☐ Gun safety	☐ Personal development
☐ Signs of depression (suicidal ideation)	☐ Violent behavior	☐ Goals in life
☐ Intimate partner violence	☐ Mindful of daily movements	☐ Family support, social interaction & communication
☐ Diabetes management	☐ Motor vehicle safety (DUI / no texting & driving)	☐ Academic or work plans
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Seat belt	☐ Self-breast exam
☐ Skin cancer prevention	☐ Safety helmet	☐ Breastfeeding
☐ Smoking/vaping use/exposure	☐ ASA use	☐ Sex education (partner selection)

Tobacco Cessation Quit Date:

☐ Advised to quit smoking	☐ Discuss smoking cessation medication	☐ Discuss smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	☐ Problem / Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

21 to 39 Years: Male	Actual Age:	Date:	
Medical Record #			
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter			
Intake		**Vital Signs**	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider		Last visit date:	
Advance Directive Info given/discussed	☐ Yes ☐ Refused		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			
Limitations (physical or mental):			
Interval History			
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (> 2 ½ hrs per week w/ 2 days strength training)		
Weight ☐ Loss ☐ Gain	_____ lbs ☐ Intentional ☐ Unintentional		
Sexually Active	☐ Yes ☐ No ☐ Multiple Partners ☐ MSM		
Contraceptive Used	☐ None ☐ Condoms ☐ Other:		
Current Alcohol / Substance use	☐ None	☐ Alcohol	
☐ Drugs (specify):	☐ IV Drugs (or past Hx)	☐ Tobacco / Vape Packs/day:	
Family History	☐ None	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Asthma	
☐ High cholesterol	☐ Cancer	☐ Other:	

Name: DOB:

Immunization History / Date	☐ None ☐ See CAIR	☐ Tdap:
☐ COVID #1: ☐ COVID #2:	☐ Influenza:	☐ Varicella:
☐ COVID Booster(s):	☐ MMR:	☐ Zoster:
☐ Hepatitis B:	☐ Pneumococcal:	☐ Other:

USPSTF Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Alcohol Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Depression	☐ PHQ2, ☐ PHQ9, ☐ Other:	☐	☐
Diabetes	☐ H&P, ☐ Other:	☐	☐
Drug Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Hepatitis C	☐ H&P, ☐ Other:	☐	☐
HIV	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Obesity	☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ / uncircumcised, testes in scrotum Prostate Exam / Rectal	☐
Femoral pulses	Normal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐

Comprehensive Health Assessment

Name: **DOB:**

Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ Other:		

Orders

☐ COVID 19 vaccine / booster	☐ Tdap	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Varicella (if not up to date)	☐ Hct / Hgb ☐ Lipid panel
☐ HPV vaccine (if not up to date)	☐ Hep B Panel (if at risk)	☐ Low to moderate dose statin
☐ Influenza vaccine	☐ Hep C Antibody test	☐ PPD skin test ☐ QFT
☐ Meningococcal vaccine (if not up to date)	☐ Chlamydia ☐ Gonorrhea	☐ CXR ☐ Urinalysis
☐ MMR (if not up to date)	☐ HIV ☐ Herpes	☐ ECG ☐ COVID 19 test
☐ Pneumococcal (if high risk)	☐ Syphilis ☐ Trichomonas	☐ Fasting plasma glucose ☐ HbA1C
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Avoid risk-taking behavior	☐ Independence
☐ Signs of depression (suicidal ideation)	☐ Gun safety	☐ Personal development
☐ Mental health (emotional support)	☐ Violent behavior	☐ Goals in life
☐ Diabetes Management	☐ Motor vehicle safety (DUI / no texting & driving)	☐ Academic or work plans
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Seat belt	☐ Family support, social interaction & communication
☐ Skin cancer prevention	☐ Safety helmet	☐ Testicular self-exam
☐ Smoking/vaping use/exposure	☐ Routine dental care	☐ Sex education (partner selection

Tobacco Cessation Quit Date:

☐ Advised to quit smoking	☐ Discuss smoking cessation medication	☐ Discuss smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	☐ Problem/Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

40 to 49 Years: Female	Actual Age:	Date:	
Medical Record #			
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused Interpreter Name:		
Intake		**Vital Signs**	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		
Advance Directive Info Given/Discussed	☐ Yes ☐ Refused		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List ☐ taking 0.4 to 0.8 mg of folic acid daily (for reproductive females)			
Limitations (physical or mental):			
Interval History			
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 2 ½ hrs per week w/ 2 days strength training)		
Weight ☐ Loss ☐ Gain	_____ lbs ☐ Intentional ☐ Unintentional		
LMP:	G P A	☐ Menorrhagia ☐ Menopause	
Hysterectomy	☐ Partial ☐ Total		
Sexually active	☐ Yes ☐ No ☐ Multiple Partners		
Contraceptive Used	☐ None ☐ Condoms ☐ Other:		
Last PAP	Date: ☐ WNL		
Last Mammogram	Date: ☐ WNL		
Last Colonoscopy	Date: ☐ WNL		
Current Alcohol / Substance Use	☐ None	☐ Alcohol	
☐ Drugs (specify):	☐ IV Drugs (or past Hx)	☐ Tobacco / Vape Packs/day:	
Family History	☐ None	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Hip fracture	
☐ High cholesterol	☐ Cancer	☐ Other:	

Name: **DOB:**

Immunization History / Date	☐ None ☐ See CAIR	☐ Tdap:
☐ COVID #1: ☐ COVID #2:	☐ Influenza:	☐ Varicella:
☐ COVID Booster(s):	☐ MMR:	☐ Zoster:
☐ Hepatitis B:	☐ Pneumococcal:	☐ Other:

USPSTF Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Alcohol Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Breast Cancer	☐ H&P, ☐ Other:	☐	☐
Cervical Cancer	☐ H&P, ☐ Other:	☐	☐
Colorectal Cancer	☐ H&P, ☐ Other:	☐	☐
Depression	☐ PHQ2, ☐ PHQ9, ☐ Other:	☐	☐
Diabetes	☐ H&P, ☐ Other:	☐	☐
Drug Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Hepatitis C	☐ H&P, ☐ Other:	☐	☐
HIV	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Intimate Partner Violence	☐ HARK, ☐ HITS, ☐ H&P, ☐ Other:	☐	☐
Obesity	☐ H&P, ☐ Other:	☐	☐
Osteoporosis	☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Screener, ☐ H&P, ☐ Other:	☐	☐

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐

Comprehensive Health Assessment

Genitalia	Grossly normal	☐
Female	No lesions, normal external appearance	☐
Vaginal exam	Done or completed elsewhere OB/GYN name:	☐
Femoral pulses	Present & equal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ OB/GYN	☐ Other:	

Orders

☐ COVID 19 vaccine / booster	☐ Hep B Panel (if high risk)	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Hep C Antibody test (if high risk)	☐ Hct / Hgb ☐ Lipid panel
☐ Influenza vaccine	☐ Chlamydia ☐ Gonorrhea	☐ PPD skin test ☐ QFT
☐ MMR (if not up to date)	☐ HIV ☐ Herpes	☐ CXR ☐ Urinalysis
☐ Pneumococcal (if high risk)	☐ Syphilis ☐ Trichomonas	☐ ECG ☐ COVID 19 test
☐ Tdap	☐ Rx for folic acid 0.4-0.8mg daily	☐ Fasting plasma glucose ☐ Oral glucose tolerance test
☐ Varicella (if not up to date)	☐ gFOBT or Fit ☐ Colonoscopy	☐ HbA1C ☐ Low to moderate dose statin
☐ Zoster (if high risk)	☐ PAP ☐ Mammogram	☐ Bone Density Test ☐ TSH
☐ Other:		

Name: DOB:

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Avoid risk-taking behavior	☐ Independence
☐ Signs of depression (suicidal ideation)	☐ Gun safety	☐ Personal development
☐ Mental health (emotional support)	☐ Violent behavior	☐ Goals in life
☐ Diabetes management	☐ Mindful of daily movements	☐ Work activities
☐ Intimate partner violence	☐ Motor vehicle safety (DUI / no texting & driving)	☐ Family support, social interaction & communication
☐ Sex education (partner selection)	☐ Seat belt	☐ Self-breast exam
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Safety helmet	☐ Aging process
☐ Smoking/vaping use/exposure	☐ Routine dental care	☐ Perimenopause education

Tobacco Cessation Quit Date:

☐ Advised to quit smoking	☐ Discuss smoking cessation medication	☐ Discuss smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	☐ Problem / Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

Name: DOB:

40 to 49 Years: Male	Actual Age:	Date:
Medical Record #		
Primary Language		
Interpreter Requested	☐ Yes ☐ No ☐ Refused	
Name of Interpreter		

Intake		Vital Signs	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		
Advance Directive Info Given/Discussed	☐ Yes ☐ Refused		

Chronic Problems/Significant Conditions: ☐ See Problem List

Current Medications/Vitamins: ☐ See Medication List

Limitations (physical or mental):

Interval History		
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:	
Appetite	☐ Good ☐ Fair ☐ Poor	
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (> 2 ½ hrs per week w/ 2 days strength training)	
Weight ☐ Loss ☐ Gain	_____ lbs ☐ Intentional ☐ Unintentional	
Sexually active	☐ Yes ☐ No ☐ Multiple Partners ☐ MSM	
Contraceptive Used	☐ None ☐ Condoms ☐ Other:	
Last Colonoscopy	Date:	☐ WNL
Current Alcohol / Substance Use	☐ None	☐ Alcohol
☐ Drugs (specify):	☐ IV Drugs (or past Hx)	☐ Tobacco / Vape Packs/day:
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease	☐ HTN	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Other:
Immunization History / Date	☐ None ☐ See CAIR	☐ Tdap:
☐ COVID #1: ☐ COVID #2:	☐ Influenza:	☐ Varicella:
☐ COVID Booster(s):	☐ MMR:	☐ Zoster:
☐ Hepatitis B:	☐ Pneumococcal:	☐ Other:

USPSTF Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Alcohol Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Colorectal Cancer	☐ H&P, ☐ Other:	☐	☐
Depression	☐ PHQ2, ☐ PHQ9, ☐ Other:	☐	☐
Diabetes	☐ H&P, ☐ Other:	☐	☐
Drug Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Hepatitis C	☐ H&P, ☐ Other:	☐	☐
HIV	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Obesity	☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ/uncircumcised, testes in scrotum Prostate Exam / Rectal	☐
Femoral pulses	Present & equal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Comprehensive Health Assessment

Name: DOB:

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ Other:		

Orders

☐ COVID 19 vaccine / booster	☐ Hep B Panel (if high risk)	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Hep C Antibody test (if high risk)	☐ Hct / Hgb ☐ Lipid panel
☐ Influenza vaccine	☐ Chlamydia ☐ Gonorrhea	☐ Low to moderate dose statin
☐ MMR (if not up to date)	☐ HIV ☐ Herpes	☐ PPD skin test ☐ QFT
☐ Pneumococcal vaccine	☐ Syphilis ☐ Trichomonas	☐ CXR ☐ Urinalysis
☐ Tdap	☐ gFOBT or Fit ☐ Colonoscopy	☐ ECG ☐ COVID 19 test
☐ Varicella (if not up to date)	☐ HbA1C	☐ Fasting plasma glucose
☐ Zoster	☐ PSA	☐ Oral glucose tolerance test
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Avoid risk-taking behavior	☐ Independence
☐ Signs of depression (suicidal ideation)	☐ Gun safety	☐ Personal development
☐ Mental health (emotional support)	☐ Violent behavior	☐ Goals in life
☐ Diabetes management	☐ Mindful of daily movements	☐ Work activities
☐ Sex education (partner selection)	☐ Motor vehicle safety (DUI / no texting & driving)	☐ Family support, social interaction & communication
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Seat belt	☐ Testicular self-exam
☐ Smoking/vaping use/exposure	☐ Safety helmet	☐ Routine dental care

Tobacco Cessation

Quit Date:

☐ Advised to quit smoking	☐ Discuss smoking cessation medication	☐ Discuss smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	☐ Problem / Medication Lists updated

MA / Nurse Signature	Title	Date

Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

Name: **DOB:**

50+ Years: Female	Actual Age:	Date:	
Medical Record #			
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter			
Intake		**Vital Signs**	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider		Last visit date:	
Advance Directive Info Given/Discussed	☐ Yes ☐ Refused		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List ☐ taking 0.4 to 0.8 mg of folic acid daily (for reproductive females)			
Limitations (physical or mental):			
Interval History			
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:		
Appetite	☐ Good ☐ Fair ☐ Poor		
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (> 2 ½ hrs per week w/ 2 days strength training)		
Weight ☐ Loss ☐ Gain	_____ lbs ☐ Intentional ☐ Unintentional		
LMP:	G P A	☐ Menorrhagia ☐ Menopause	
Hysterectomy	☐ Partial ☐ Total		
Sexually active	☐ Yes ☐ No ☐ Multiple Partners		
Contraceptive Used	☐ None ☐ Condoms ☐ Other:		
Last PAP	Date:	☐ WNL	
Last Mammogram	Date:	☐ WNL	
Last Colonoscopy	Date:	☐ WNL	
Current Alcohol / Substance Use	☐ None	☐ Alcohol	
☐ Drugs (specify):	☐ IV Drugs (or past Hx)	☐ Tobacco / Vape Packs/day:	
Family History	☐ None	☐ Diabetes	
☐ Heart disease	☐ HTN	☐ Hip fracture	
☐ High cholesterol	☐ Cancer	☐ Other:	

Immunization History / Date	☐ None ☐ See CAIR	☐ Tdap:
☐ COVID #1: ☐ COVID #2:	☐ Influenza:	☐ Varicella:
☐ COVID Booster(s):	☐ MMR:	☐ Zoster:
☐ Hepatitis B:	☐ Pneumococcal:	☐ Other:

USPSTF Risk Screener	**Screening Tools Used**	**Low Risk**	**High Risk** (see Plan/ Orders/AG)
Alcohol Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Breast Cancer	☐ H&P, ☐ Other:	☐	☐
Cervical Cancer	☐ H&P, ☐ Other:	☐	☐
Colorectal Cancer	☐ H&P, ☐ Other:	☐	☐
Depression	☐ PHQ2, ☐ PHQ9, ☐ Other:	☐	☐
Diabetes	☐ H&P, ☐ Other:	☐	☐
Drug Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Hepatitis C	☐ H&P, ☐ Other:	☐	☐
HIV	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Lung Cancer	☐ H&P, ☐ Other:	☐	☐
Obesity	☐ H&P, ☐ Other:	☐	☐
Osteoporosis	☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Screener, ☐ H&P, ☐ Other:	☐	☐

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest / Breast	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐

Comprehensive Health Assessment

Genitalia	Grossly normal	☐
Female	No lesions, normal external appearance	☐
Vaginal exam	Done or completed elsewhere OB/GYN name:	☐
Femoral pulses	Present & equal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐
Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ OB/GYN	☐ Other:	

Orders

☐ COVID 19 vaccine / booster	☐ Hep B Panel (if high risk)	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Hep C Antibody test (if high risk)	☐ Hct / Hgb ☐ Lipid panel
☐ Influenza vaccine	☐ Chlamydia ☐ Gonorrhea	☐ PPD skin test ☐ QFT
☐ MMR (if not up to date)	☐ HIV ☐ Herpes	☐ CXR ☐ Urinalysis
☐ Pneumococcal	☐ Syphilis ☐ Trichomonas	☐ ECG ☐ COVID 19 test
☐ Tdap	☐ Rx for folic acid 0.4-0.8mg daily	☐ Fasting plasma glucose ☐ Oral glucose tolerance test
☐ Varicella (if not up to date)	☐ gFOBT or Fit ☐ Colonoscopy	☐ HbA1C ☐ Low to moderate dose statin
☐ Zoster	☐ PAP ☐ Mammogram ☐ Bone Density Test	☐ Low Dose CT (20-pack year smoking history & currently smoke or have quit within past 15 years)
☐ Other:		

Name: **DOB:**

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Avoid risk-taking behavior	☐ Independence
☐ Signs of depression (suicidal ideation)	☐ Gun safety	☐ Personal development
☐ Mental health (emotional support)	☐ Violent behavior	☐ Goals in life
☐ Diabetes management	☐ Mindful of daily movements	☐ Work or retirement activities
☐ Sex education (partner selection)	☐ Motor vehicle safety (DUI / no texting & driving)	☐ Family support, social interaction & communication
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Seat belt	☐ Self-breast exam
☐ Smoking/vaping use/exposure	☐ Safety helmet	☐ Aging process
☐ Routine dental care	☐ ASA use	☐ Perimenopause education

Tobacco Cessation Quit Date:

☐ Advised to quit smoking	☐ Discuss smoking cessation medication	☐ Discuss smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	☐ Problem / Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

Comprehensive Health Assessment

50+ Years: Male	Actual Age:	Date:	
Medical Record #			
Primary Language			
Interpreter Requested	☐ Yes ☐ No ☐ Refused		
Name of Interpreter			
Intake		**Vital Signs**	
Allergies		Temp	
Height		BP	
Weight		Pulse	
BMI Value		Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10		
Dental Provider	Last visit date:		
Advance Directive Info Given/Discussed	☐ Yes ☐ Refused		
Chronic Problems/Significant Conditions: ☐ See Problem List			
Current Medications/Vitamins: ☐ See Medication List			
Limitations (physical or mental):			

Interval History		
Diet / Nutrition	☐ Regular ☐ Low calorie ☐ ADA ☐ Iron-rich foods ☐ Other:	
Appetite	☐ Good ☐ Fair ☐ Poor	
Physical Activity	☐ Inactive (little or none) ☐ Some (< 2 ½ hrs/week) ☐ Active (≥ 2 ½ hrs per week w/ 2 days strength training)	
Weight ☐ Loss ☐ Gain	_____ lbs ☐ Intentional ☐ Unintentional	
Sexually active	☐ Yes ☐ No ☐ Multiple Partners ☐ MSM	
Contraceptive Used	☐ None ☐ Condoms ☐ Other:	
Last Colonoscopy	Date: ☐ WNL	
Current Alcohol / Substance Use	☐ None	☐ Alcohol
☐ Drugs (specify):	☐ IV Drugs (or past Hx)	☐ Tobacco / Vape Packs/day:
Family History	☐ Unremarkable	☐ Diabetes
☐ Heart disease	☐ HTN	☐ Asthma
☐ High cholesterol	☐ Cancer	☐ Other:
Immunization History / Date	☐ None ☐ See CAIR	☐ Tdap:
☐ COVID #1: ☐ COVID #2:	☐ Influenza:	☐ Varicella:
☐ COVID Booster(s):	☐ MMR:	☐ Zoster:
☐ Hepatitis B:	☐ Pneumococcal:	☐ Other:

Name: DOB:

USPSTF Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Abdominal Aortic Aneurism	☐ H&P, ☐ Other:	☐	☐
Alcohol Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Colorectal Cancer	☐ H&P, ☐ Other:	☐	☐
Depression	☐ PHQ2, ☐ PHQ9, ☐ Other:	☐	☐
Diabetes	☐ H&P, ☐ Other:	☐	☐
Drug Misuse	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Dyslipidemia	☐ H&P, ☐ Other:	☐	☐
Hepatitis B	☐ H&P, ☐ Other:	☐	☐
Hepatitis C	☐ H&P, ☐ Other:	☐	☐
HIV	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Lung Cancer	☐ H&P, ☐ Other:	☐	☐
Obesity	☐ H&P, ☐ Other:	☐	☐
Sexually Transmitted Infections	☐ SHA, ☐ H&P, ☐ Other:	☐	☐
Tobacco Use	☐ SHA, ☐ CRAFFT, ☐ H&P, ☐ Other:	☐	☐
Tuberculosis Exposure	☐ TB Risk Assessment, ☐ H&P, ☐ Other:	☐	☐

Physical Examination		**WNL**
General appearance	Well-nourished & developed No abuse/neglect evident	☐
Head	No lesions	☐
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	☐
Ears	Canals clear, TMs normal Hearing grossly normal	☐
Nose	Passages clear, MM pink, no lesions	☐
Teeth	No visible cavities, grossly normal	☐
Mouth / Pharynx	Oral mucosa pink, no lesions	☐
Neck	Supple, no masses, thyroid not enlarged	☐
Chest	Symmetrical, no masses	☐
Heart	No organic murmurs, regular rhythm	☐
Lungs	Clear to auscultation bilaterally	☐
Abdomen	Soft, no masses, liver & spleen normal	☐
Genitalia	Grossly normal	☐
Male	Circ /uncircumcised, testes in scrotum Prostate Exam / Rectal	☐
Femoral pulses	Present & equal	☐
Extremities	No deformities, full ROM	☐
Lymph nodes	Not enlarged	☐
Back	No scoliosis	☐

Comprehensive Health Assessment

Name: **DOB:**

Skin	Clear, no significant lesions	☐
Neurologic	Alert, no gross sensory or motor deficit	☐

Subjective / Objective

Assessment

Plan

Referrals

☐ Dentist	☐ Optometrist / Ophthalmologist	☐ Dietician / Nutritionist
☐ Drug / ETOH Tx rehab	☐ Behavioral health	☐ Tobacco cessation class
☐ Other:		

Orders

☐ COVID 19 vaccine / booster	☐ Hep B Panel (if high risk)	☐ CBC / Basic metabolic panel
☐ Hep B vaccine (if not up to date)	☐ Hep C Antibody test (if high risk)	☐ Hct / Hgb ☐ Lipid panel
☐ Influenza	☐ Chlamydia ☐ Gonorrhea	☐ Low to moderate dose statin
☐ MMR (if not up to date)	☐ HIV ☐ Herpes	☐ PPD skin test ☐ QFT
☐ Pneumococcal	☐ Syphilis ☐ Trichomonas	☐ CXR ☐ Urinalysis
☐ Tdap	☐ gFOBT or Fit ☐ Colonoscopy	☐ ECG ☐ COVID 19 test
☐ Varicella (if not up to date)	☐ Low Dose CT (20-pack year smoking history & currently smoke or have quit within past 15 years)	☐ Fasting plasma glucose ☐ Oral glucose tolerance test
☐ Zoster	☐ AAA Ultrasound (65 to 75 who have ever smoked >100 cigarettes in lifetime)	☐ HbA1C ☐ PSA
☐ Other:		

Anticipatory Guidance (AG) / Education (√ if discussed)

Diet, Nutrition & Exercise

☐ Weight control / obesity	☐ Vegetables, fruits	☐ Lean protein
☐ Whole grains / iron-rich foods	☐ Limit fatty, sugary & salty foods	☐ Limit candy, chips & ice cream
☐ Physical activity / exercise	☐ Healthy food choices	☐ Eating disorder

Accident Prevention & Guidance

☐ Alcohol/drug/substance misuse counseling	☐ Avoid risk-taking behavior	☐ Independence
☐ Signs of depression (suicidal ideation)	☐ Gun safety	☐ Personal development
☐ Diabetes management	☐ Violent behavior	☐ Goals in life
☐ Sex education (partner selection)	☐ Mindful of daily movements	☐ Work or retirement activities
☐ Safe sex practices (condoms, contraception, HIV/AIDS)	☐ Motor vehicle safety (DUI / no texting & driving)	☐ Family support, social interaction & communication
☐ Smoking/vaping use/exposure	☐ Seat belt	☐ Testicular self-exam
☐ Routine dental care	☐ Safety helmet	☐ Aging process

Tobacco Cessation Quit Date:

☐ Advised to quit smoking	☐ Discuss smoking cessation medication	☐ Discuss smoking cessation strategies

Next Appointment

☐ 1 year	☐ RTC PRN	☐ Other:

Documentation Reminders

☐ Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	☐ Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	☐ Problem / Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	**Title**	**Date**

Notes (include date, time, signature, and title on all entries)

California Advance Health Care Directive

This form lets you have a say about how you want to be treated if you get very sick.

- **This form has 3 parts. It lets you:**

Part 1: Choose a health care agent.

A health care agent is a person who can make medical decisions for you if you are too sick to make them yourself.

Part 2: Make your own health care choices.

This form lets you choose the kind of health care you want.

This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.

Part 3: Sign the form.

It must be signed before it can be used.

You can fill out Part 1, Part 2, or both.
Fill out only the parts you want.
Always sign the form in Part 3.

Go to the next page

If you only want a health care agent go to **Part 1** on page 3.

If you only want to make your own health care choices go to **Part 2** on page 6.

If you want both then fill out **Part 1 and Part 2.**

Always sign the form in Part 3 on page 9.

What do I do with the form after I fill it out?

Share the form with those who care for you:

- doctors
- nurses
- social workers
- family
- friends

What if I change my mind?

- Change the form.
- Tell those that care for you about your changes

What if I have questions about the form?

- Bring it to your doctors, nurses, social workers, family or friends to answer your questions

What if I want to make health care choices that are not on this form?

- Write your choices on a piece of paper
- Keep the paper with this form
- Share your choices with those who care for you

PART 1 Choose your health care agent

The person who can make medical decisions for you if you are too sick to make them yourself.

Whom should I choose to be my health care agent?

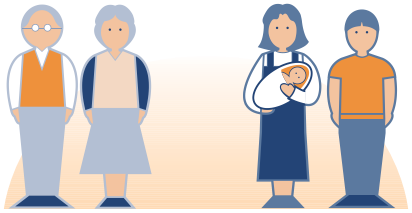
A family member or friend who:

- is at least 18 years old
- knows you well
- can be there for you when you need them
- you trust to do what is best for you
- can tell your doctors about the decisions you made on this form

Your agent cannot be your doctor or someone who works at your hospital or clinic, unless they are a family member.

What will happen if I do not choose a health care agent?

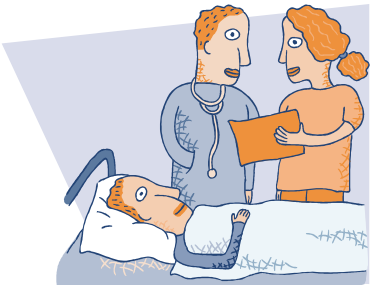
If you are too sick to make your own decisions, your doctors will ask your closest family members to make decisions for you.



If you want your agent to be someone other than family, you must write his or her name on this form.

What kind of decisions can my health care agent make?

Agree to, say no to, change, stop or choose:



- doctors, nurses, social workers
- hospitals or clinics
- medications or tests
- what happens to your body and organs after you die

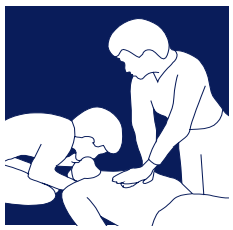
Go to the next page

Other decisions your agent can make:

Life support treatments – medical care to try to help you live longer

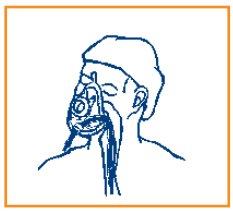
- **CPR or cardiopulmonary resuscitation**

cardio = heart pulmonary = lungs resuscitation = to bring back



This may involve:

- pressing hard on your chest to keep your blood pumping
- electrical shocks to jump start your heart
- medicines in your veins



- **Breathing machine or ventilator**

The machine pumps air into your lungs and breathes for you.

You are not able to talk when you are on the machine.

- **Dialysis**

A machine that cleans your blood if your kidneys stop working.

- **Feeding Tube**

A tube used to feed you if you cannot swallow. The tube is placed down your throat into your stomach. It can also be placed by surgery.

- **Blood transfusions**

To put blood in your veins.

- **Surgery**
- **Medicines**

End of life care – if you might die soon your health care agent can:

- call in a spiritual leader
- decide if you die at home or in the hospital

Show your health care agent this form.

Tell your agent what kind of medical care you want.

Go to the next page

Your Health Care Agent

I want this person to help make my medical decisions

first name | last name

street address | city | state | zip code

( ) – ( ) –

home phone number | work phone number

If the first person cannot do it, then I want this person to help make my medical decisions.

first name | last name

street address | city | state | zip code

( ) – ( ) –

home phone number | work phone number

Put an X next to the sentence you agree with.

- ☐ My health care agent can make decisions for me **now**.
- ☐ My health care agent will make decisions for me **only** after I cannot make my own decisions.

To make your own health care choices go to part 2 on the

To sign this form go to part 3 on

PART 2 Make your own health care choices

Write down your choices so those who care for you will not have to guess.

- **Think about what makes your life worth living.**
  Put an X next to all the sentences you most agree with.

❑ **My life is only worth living if I can:**

- ❍ talk to family or friends
- ❍ wake up from a coma
- ❍ feed, bathe, or take care of myself
- ❍ be free from pain
- ❍ live without being hooked up to machines
- ❍ I am not sure

❑ **My life is always worth living no matter how sick I am**

- **If I am dying, it is important for me to be:**

❑ at home ❑ in the hospital ❑ I am not sure

- **Is religion or spirituality important to you?**

❑ yes ❑ no

- **What should your doctors know about your religion or spirituality?**

_____

_____

If you are sick, your doctors and nurses will always try to keep you comfortable and free from pain.

Go to the next page

Life support treatments are used to try to keep you alive. These can be CPR, a breathing machine, feeding tubes, dialysis, blood transfusions, or medicine.

Put an X next to the sentences you most agree with.
Please read this whole page before you make your choices.

If I am so sick that I may die soon:

❑ Try all life support treatments that my doctors think might help.

If the treatments **do not work** and there is little hope of getting better, **I want to stay** on life support machines.

❑ Try all life support treatments that my doctors think might help.

If the treatments **do not work** and there is little hope of getting better, **I do not want to stay** on life support machines.

❑ Try all life support treatments that my doctors think might help **but not** these treatments. Mark what you do not want.

- ❍ CPR
- ❍ dialysis
- ❍ breathing machine
- ❍ feeding tube
- ❍ blood transfusion
- ❍ medicine
- ❍ other treatments _____

❑ I **do not want any** life support treatments.

❑ I want my **health care agent** to decide for me.

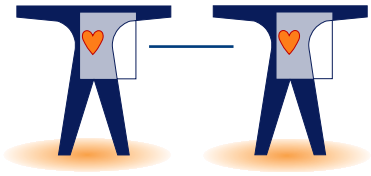
❑ I am not sure.

Go to the next page

Part 2: Make your own health care choices

Put an X next to the sentences you most agree with

Donating (giving) your organs can help save lives.



- ❑ I **want** to donate my organs

  Which organs do you want to donate?

  - ❍ any organs
  - ❍ only _____

- ❑ I **do not** want to donate my organs.
- ❑ I want my **health care agent** to decide.
- ❑ I am not sure.

An autopsy can be done after death to find out why someone died. It is done by surgery. It can take a few days.

- ❑ I **want** an autopsy.
- ❑ I **do not** want an autopsy.
- ❑ I may want an autopsy if there are questions about my death.
- ❑ I want my **health care agent** to decide.
- ❑ I am not sure.

What should your doctors know about how you want your body to be treated after you die?

_____

_____

Go to Part 3 on the next page to sign this form

PART 3 Sign the form

Before this form can be used, you must:

- sign this form.
- have two witnesses sign the form.

If you do not have witnesses, you need a notary public.
A notary public's job is to make sure it is you signing the form.

Sign your name and write the date.

_____ / / _____

sign your name date

_____

print your first name print your last name

_____

address city state zip code

Your witnesses must:

- be over 18 years of age.
- know you.
- see you sign this form.

Your witnesses cannot:

- be your health care agent, doctor, nurse, or social worker.
- benefit financially (get any money) after you die.
- work at the place that you live.
  (if you live in a nursing home, go to page 12)

Only one witness can be a family member.

The second witness must be someone other than family.

Witnesses need to sign their names on the next page.

If you do not have witnesses, take this form to a notary public and have them sign on page 11.

Have your witnesses sign their names and write the date

- **Witness #1**

sign your name _____ / / date

print your first name _____ print your last name _____

address _____ city _____ state _____ zip code _____

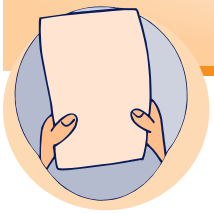
- **Witness #2**

sign your name _____ / / date

print your first name _____ print your last name _____

address _____ city _____ state _____ zip code _____

You are now done with this form.



Share this form with your doctors, nurses, social workers, friends, and your family.

Talk with them about your choices.

NOTARY PUBLIC

- Take this form to a notary public **ONLY** if two witnesses have not signed this form.
- Bring photo I.D. (driver's license, passport, etc.)

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

STATE OF CALIFORNIA

County of _____

On this _____ day of _____ in the year _____ before me

_____

(print name of notary public)

personally appeared _____

(print name of person completing this form)

and has proved to me on the basis of satisfactory evidence, to be the person whose name is indicated on this advance health care directive, and has stated that he or she did complete this form. I declare under penalty of perjury, that the person, whose name is indicated in the advance health care directive, appears to be of sound mind and is under no duress, fraud, or undue influence.

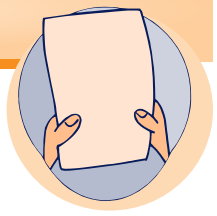
NOTARY SEAL

_____

(Signature) (Date)

You are now done with this form.

Share this form with your doctors, nurses, social workers, friends, and your family.



Talk with them about your choices.

For California Nursing Home Residents ONLY

- **Give this form to your nursing home director only if you live in a nursing home.**
- **California law requires nursing home residents to have the nursing home ombudsman as a witness of advance directives.**

STATEMENT OF THE PATIENT ADVOCATE OR OMBUDSMAN

"I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code."

sign your name _____ date / /

print your first name _____ print your last name _____

address _____ city _____ state _____ zip code _____

Designed by Rebecca Sudore, MD & PM Creative for the San Francisco Department of Public

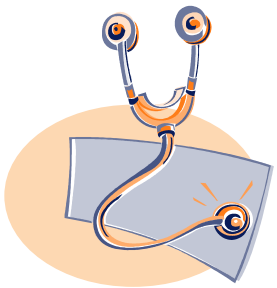
Instrucción anticipada de atención de salud de California

Este formulario le permite indicar la manera en que desea que lo traten si está muy enfermo.

- **Este formulario consta de 3 partes. Le permite:**

Parte 1: Escoger a un apoderado de atención de salud.

Un apoderado de atención de salud es una persona que puede tomar decisiones médicas por usted si está muy enfermo para tomarlas por usted mismo.



Parte 2: Tomar sus propias decisiones en cuanto a su atención de salud.

Este formulario le permite escoger el tipo de atención de salud que desea. De esta manera, las personas encargadas de su cuidado no tendrán que adivinar lo que desea si está muy enfermo para decirlo por usted mismo.

Parte 3: Firmar el formulario.

Se debe firmar antes de que se pueda usar.

Usted puede llenar la Parte 1, la Parte 2 ó ambas.
Llene sólo las partes que desee.
Siempre firme el formulario en la Parte 3.

Vaya a la página siguiente.

Si sólo desea un apoderado de atención de salud, vaya a la **Parte 1** en la página 3.

Si sólo desea tomar sus propias decisiones de atención de salud, vaya a la **Parte 2** en la página 6.

Si desea hacer ambas cosas, llene la Parte 1 y la Parte 2.

Siempre firme el formulario en la Parte 3 que está en la página 9.

¿Qué hago con el formulario después de llenarlo?

Compártalo con aquellos encargados de su cuidado:

- médicos
- enfermeras
- trabajadores sociales
- familiares
- amigos

¿Qué sucede si cambio de opinión?

- Cambie el formulario.
- Informe sobre los cambios a aquellos encargados de su cuidado.

¿Qué sucede si tengo preguntas sobre el formulario?

- Hágaselas a los médicos, enfermeras, trabajadores sociales, familiares o amigos para que se las respondan.

¿Qué sucede si tengo decisiones de atención de salud que no aparecen en este formulario?

- Escriba sus decisiones en una hoja.
- Mantenga la hoja junto a este formulario.
- Comparta sus decisiones con aquellos encargados de su cuidado.

Escoja su apoderado de atención de salud

La persona que puede tomar decisiones médicas por usted si está muy enfermo para tomarlas por usted mismo.

¿A quién debo escoger como mi apoderado de atención de salud?

Un familiar o amigo que:

- tenga 18 años o más de edad
- lo conozca bien

pueda estar con usted cuando lo necesite

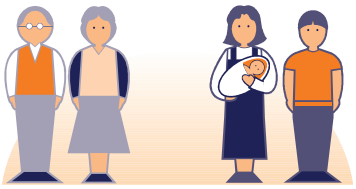
usted confíe que hará lo mejor para usted

pueda informarle a los médicos sobre las decisiones que tomó en este formulario

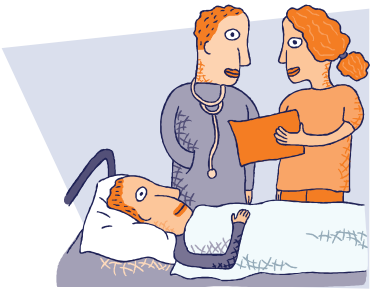
Su apoderado no puede ser su médico o alguien que trabaje en el hospital o clínica, a menos que sea un familiar.

¿Qué sucede si no escojo a un apoderado de atención de salud?

Si está muy enfermo como para tomar sus propias decisiones, los médicos les pedirán a sus familiares más íntimos que tomen las decisiones por usted.
Si desea que su apoderado no sea un familiar, debe escribir su nombre en este formulario.



¿Qué tipo de decisiones puede tomar mi apoderado de atención de salud?



Aceptar, rechazar, cambiar, suspender o escoger:

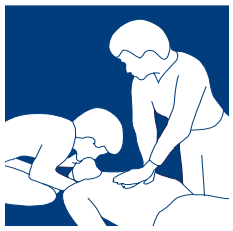
- a médicos, enfermeras y trabajadores sociales.
- hospitales o clínicas
- medicamentos o exámenes
- lo que sucederá con su cuerpo y órganos después de su muerte

Vaya a la página siguiente.

Otras decisiones que su apoderado puede tomar:

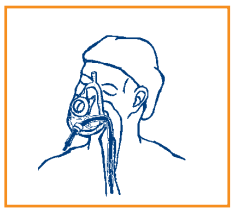
- **Tratamientos de mantenimiento de vida:** tratamiento médico para ayudarle a vivir más tiempo.
  - **CPR o reanimación cardiopulmonar**

    cardio = corazón pulmonar = pulmones resucitación = reanimación



Esto puede incluir:

- presionar con fuerza su pecho para mantener la circulación de la sangre
- choque eléctrico para hacer que su corazón vuelva a funcionar
- medicamentos a través de sus venas



- **Respirador artificial**

  El respirador bombea aire a sus pulmones y respira por usted. Usted no puede hablar cuando se encuentra conectado al respirador.

- **Diálisis**

  Una máquina que limpia su sangre si sus riñones dejan de funcionar.

- **Sonda de alimentación**

  Una sonda que se usa para alimentarle si no puede tragar. Esta sonda se inserta por la garganta hasta su estómago. También se puede colocar con una cirugía.

- **Transfusiones de sangre**

  Poner sangre en sus venas.

- **Cirugía**

- **Medicamentos**

- **Cuidados paliativos:** Si existe la posibilidad de que muera pronto su apoderado de atención de salud puede:

- llamar a un consejero espiritual
- decidir si muere en su casa o en el hospital

Comparta este formulario con su apoderado de atención de salud.

Dígale a su apoderado el tipo de tratamiento médico que desea.

Vaya a la página siguiente.

Su apoderado de atención de salud

- **Yo deseo que esta persona ayude a tomar mis decisiones médicas.**

nombre apellido

dirección ciudad estado código postal

( ) – ( ) –

número de teléfono particular número de teléfono del trabajo

- **Si la primera persona no lo puede hacer, entonces deseo que esta persona ayude a tomar mis decisiones médicas.**

nombre apellido

dirección ciudad estado código postal

( ) – ( ) –

número de teléfono particular número de teléfono del trabajo

- **Marque con una X la frase con la cual esté de acuerdo.**

1 ☐ Mi apoderado de atención de salud puede tomar decisiones por mí **ahora**.

2 ☐ Mi apoderado de atención de salud tomará decisiones por mí **sólo** cuando yo no pueda tomar las decisiones por mí mismo.

Para tomar sus propias decisiones de atención de salud, vaya a la Parte 2 de la página siguiente.

Para firmar este formulario vaya a la Parte 3 en la página 9.

PARTE 2 Tome sus propias decisiones de atención de salud

Escriba sus decisiones de manera que aquellos encargados de su cuidado no tengan que adivinar.

- **Piense en las cosas que hacen que su vida valga la pena. Marque con una X todas las frases con las cuales esté más de acuerdo.**

1 ❑ **Mi vida sólo vale la pena si puedo:**

- a ○ conversar con mi familia o amigos
- b ○ despertar de un estado de coma
- c ○ alimentarme, bañarme y cuidar de mí mismo
- d ○ no sentir dolor
- e ○ vivir sin estar conectado a máquinas
- f ○ no estoy seguro

2 ❑ **Mi vida siempre vale la pena sin importar lo enfermo que esté.**

- **Si estoy muriendo, es importante para mí estar:**

1 ❑ en casa 2 ❑ en el hospital 3 ❑ no estoy seguro

- **¿Es importante para usted la religión o la espiritualidad?**

1 ❑ Sí 2 ❑ No

- **¿Qué deben saber los médicos sobre su religión o espiritualidad?**

_____

_____

Si está enfermo, sus médicos y enfermeras siempre intentarán mantenerlo lo más cómodo posible y sin dolor.

Vaya a la página siguiente.

Los tratamientos de mantenimiento de vida se usan para mantenerlo vivo. Éstos pueden ser CPR, un respirador artificial, sondas de alimentación, diálisis, transfusiones de sangre o medicamentos.

Marque con una X las frases con las cuales esté más de acuerdo.
Lea toda esta página antes de tomar sus decisiones.

Si estoy muy enfermo y puedo morir pronto:

1 ☐ Deseo que se intenten todos los tratamientos de mantenimiento de vida que mis médicos crean que pueden ayudar. Si los tratamientos **no funcionan** y existe una mínima esperanza de mejorarme, **deseo que me conecten** a máquinas de mantenimiento de vida.

2 ☐ Deseo que se intenten todos los tratamientos de mantenimiento de vida que mis médicos crean que pueden ayudar. Si los tratamientos **no funcionan**, y existe una mínima esperanza de mejorarme, **no deseo que me conecten** a máquinas de mantenimiento de vida.

3 ☐ Deseo que se intenten todos los tratamientos de mantenimiento de vida que mis médicos crean que pueden ayudar, **pero** no los siguientes. Marque los tratamientos que no desee.

- a ○ CPR
- b ○ diálisis
- c ○ respirador artificial
- d ○ otros tratamientos _____
- e ○ sonda de alimentación
- f ○ transfusión de sangre
- g ○ medicamentos

4 ☐ **No deseo ningún** tratamiento de mantenimiento de vida.

5 ☐ Deseo que mi **apoderado de atención de salud** decida por mí.

6 ☐ No estoy seguro.

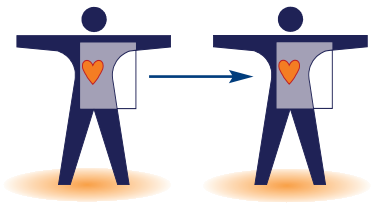
Vaya a la página siguiente.

Parte 2: Tome sus propias decisiones de atención de salud

Sus médicos pueden preguntar sobre la donación de órganos y autopsia después de morir. Infórmenos sus deseos.

Marque con una X las frases con las cuales esté más de acuerdo.

- **Donar (dar) sus órganos puede ayudar a salvar vidas.**



1 ❑ **Deseo** donar mis órganos.

¿Qué órganos desea donar?

a ❍ cualquier órgano

b ❍ sólo _____

2 ❑ **No deseo** donar mis órganos.

3 ❑ Deseo que mi **apoderado de atención de salud** decida.

4 ❑ No estoy seguro.

- **Se puede realizar una autopsia después de la muerte para saber por qué murió una persona. Se realiza mediante una cirugía. Puede tardar algunos días.**

1 ❑ **Deseo** una autopsia.

2 ❑ **No deseo** una autopsia.

3 ❑ Es posible que desee una autopsia si existe alguna duda sobre mi muerte.

4 ❑ Deseo que mi **apoderado de atención de salud** decida.

5 ❑ No estoy seguro.

- **¿Qué deben saber sus médicos sobre la forma en que desea se trate su cuerpo después de que muera?**

_____

_____

Vaya a la Parte 3 en la página siguiente para firmar este formulario.

PARTE 3 Firme el formulario

Antes de que se pueda usar este formulario, usted debe:

- firmarlo
- decirle a dos testigos que lo firmen

Si no tiene testigos, tendrá que ser ante un notario público. El trabajo del notario público es asegurarse de que sea usted quien firma el formulario.

Firme e indique la fecha.

_____ / / _____

firma fecha

_____

nombre en letra de molde apellido en letra de molde

_____

dirección ciudad estado código postal

Sus testigos deben:

- ser mayor de 18 años
- conocerlo
- verlo firmar este formulario

Sus testigos no pueden:

- ser su agente de cuidado médico
- ser su proveedor médico
- trabajar para su proveedor médico
- trabajar en el lujar donde vive (si vive en un hospital de enfermería y rehabilitación a largo plazo, vaya a la página 12)

También, uno de los testigos no puede:

- ser su familiar, de ningún modo
- obtener beneficios tal como dinero o propiedad después de que usted muera

Los testigos tienen que firmar la página siguiente.

Si no tiene testigos, lleve este formulario a un notario público y pídale que firme la página 11.

Pídales a sus testigos que firmen y escriban la fecha

Por medio de mi firma, yo prometo que _____, firmó este formulario mientras yo lo mire. Estaba pensando con claridad y no fue forzado a firmar.

También prometo que:

- lo conozco o puede mostrarme quien es
- tengo 18 años o más
- no soy su agente de cuidado médico
- no soy su proveedor médico
- no trabajo por su proveedor médico
- no trabajo en el lugar donde vive

Un testigo también tiene que prometer que:

- no soy su familiar por medio de sangre, matrimonio o adopción
- no tendré beneficio de su dinero o propiedad después de que muera

Testigo 1

_____ / ____ / _____

firma fecha

nombre en letra de molde apellido en letra de molde

dirección ciudad estado código postal

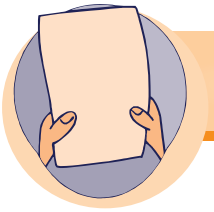
Testigo 2

_____ / ____ / _____

firma fecha

nombre en letra de molde apellido en letra de molde

dirección ciudad estado código postal



Ha terminado de llenar este formulario.

Comparta este formulario con sus médicos, enfermeras, trabajadores sociales, amigos y familiares.

Converse con ellos sobre sus decisiones.

NOTARIO PÚBLICO

- Lleve este formulario a un notario público **SÓLO** si no lo han firmado dos testigos.
- Traiga una identificación con fotografía (licencia de conducir, pasaporte, etc.)

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

State of California

County of _____

On _____ before me, _____, personally
Date — Here insert name and title of the officer

appeared _____
Name(s) of Signer(s)

_____,

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

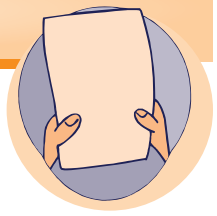
Signature _____
Signature of Notary Public

Description of Attached Document
Title or Type of document: _____
Date: _____ Number of pages: _____
Capacity(ies) Claimed by Signer(s)
Signer's Name: _____
☐ Individual
☐ Guardian or conservator
☐ Other _____

RIGHT THUMBPRINT OF SIGNER
Top of thumb here

(Notary Seal)

Ha terminado de llenar este formulario.



Comparta este formulario con sus médicos, enfermeras, trabajadores sociales, amigos y familiares.

Converse con ellos sobre sus decisiones.

SÓLO para residentes de California que viven en un hospital de enfermería y rehabilitación a largo plazo

- **Entréguele este formulario al director de su hospital de enfermería y rehabilitación a largo plazo, sólo si vive en uno.**
- **La ley de California exige que los residentes de un hospital de enfermería y rehabilitación a largo plazo tengan como testigo de las instrucciones anticipadas de atención de salud de California al defensor legal (ombudsman) de su hospital.**

DECLARACIÓN DEL DEFENSOR LEGAL (OMBUDSMAN) DEL PACIENTE

"Declaro bajo pena de perjurio en conformidad con las leyes del estado de California que soy el defensor legal (ombudsman) del paciente designado por el Departamento Estatal de Edad Avanzada y que estoy sirviendo como testigo según lo estipulado en la Sección 4675 del Código de Sucesiones."

/ /

firma fecha

nombre en letra de molde apellido en letra de molde

dirección ciudad estado código postal

Esta instrucción anticipada de atención de salud de California está conforme con el Código Testamentario de California, Sección 4671-4675. http://www.leginfo.ca.gov/calaw.html

Diseñado por Rebecca Sudore, MD & PM Creativa para el Departamento de Salud Pública del San Francisco

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

PHQ-9: Modified for Teens

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) **Not At All**	*(1)* **Several Days**	*(2)* **More Than Half the Days**	*(3)* **Nearly Every Day**
1. Feeling down, depressed, irritable, or hopeless?	☐	☐	☐	☐
2. Little interest or pleasure in doing things?	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep, or sleeping too much?	☐	☐	☐	☐
4. Poor appetite, weight loss, or overeating?	☐	☐	☐	☐
5. Feeling tired, or having little energy?	☐	☐	☐	☐
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	☐	☐	☐	☐
7. Trouble concentrating on things like school work, reading, or watching TV?	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐ Yes ☐ No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐ Yes ☐ No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐ Yes ☐ No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: Severity score: _____

Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)

Scoring the PHQ-9 modified for Teens

Scoring the PHQ-9 modified for teens is easy but involves thinking about several different aspects of depression.

To use the PHQ-9 as a diagnostic aid for Major Depressive Disorder:

- Questions 1 and/or 2 need to be endorsed as a "2" or "3"
- Need five or more positive symptoms (positive is defined by a "2" or "3" in questions 1-8 and by a "1", "2", or "3" in question 9).
- The functional impairment question (How difficult….) needs to be rated at least as "somewhat difficult."

To use the PHQ-9 to screen for all types of depression or other mental illness:

- All positive answers (positive is defined by a "2" or "3" in questions 1-8 and by a "1", "2", or "3" in question 9) should be followed up by interview.
- A total PHQ-9 score $\geq$ 10 (see below for instructions on how to obtain a total score) has a good sensitivity and specificity for MDD.

To use the PHQ-9 to aid in the diagnosis of dysthymia:

- The dysthymia question (In the past year…) should be endorsed as "yes."

To use the PHQ-9 to screen for suicide risk:

- All positive answers to question 9 as well as the two additional suicide items MUST be followed up by a clinical interview.

To use the PHQ-9 to obtain a total score and assess depressive severity:

- Add up the numbers endorsed for questions 1-9 and obtain a total score.
- See Table below:

Total Score	**Depression Severity**
0-4	No or Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

California Adult Tuberculosis Risk Assessment

- Use this tool to identify asymptomatic **adults** for latent TB infection (LTBI) testing.
- **Do not repeat testing** unless there are **new risk factors** since the last test.
- Do not treat for LTBI until active TB disease has been excluded:
  For patients with TB symptoms or an abnormal chest x-ray consistent with active TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.

LTBI testing is recommended if any of the boxes below are checked.

☐ **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month

- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
- If resources require prioritization within this group, prioritize patients with at least one medical risk for progression (see the California Adult Tuberculosis Risk Assessment User Guide for this list).
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for non-U.S.-born persons ≥2 years old

☐ **Immunosuppression,** current or planned

HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication

☐ **Close contact** to someone with infectious TB disease during lifetime

Treat for LTBI if LTBI test result is positive and active TB disease is ruled out.

☐ **None**; no TB testing is indicated at this time.

Provider Name: _____

Assessment Date: _____

Patient Name: _____

Date of Birth: _____

See the California Adult Tuberculosis Risk Assessment User Guide for more information about using this tool. To ensure you have the most current version, go to the TB RISK ASSESSMENT page (https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/TB-Risk-Assessment.aspx)

California Adult TB Risk Assessment User Guide

Avoid testing persons at low risk

Routine testing of persons without risk factors is not recommended and may result in unnecessary evaluations and treatment because of falsely positive test results.

Prioritize persons with risks for progression

If health system resources do not allow for testing of all non-U.S. born persons from a country with an elevated TB rate, prioritize patients with at least one of the following medical risks for progression:

- diabetes mellitus
- smoker within past 1 year
- end stage renal disease
- leukemia or lymphoma
- silicosis
- cancer of head or neck
- intestinal bypass/gastrectomy
- chronic malabsorption
- body mass index ≤20
- History of chest x-ray findings suggestive of previous or inactive TB (no prior treatment). Includes fibrosis or non-calcified nodules, but does not include solitary calcified nodule or isolated pleural thickening. In addition to LTBI testing, evaluate for active TB disease.

United States Preventive Services Task Force

The USPSTF has recommended testing persons born in or former residents of, a country with an elevated tuberculosis rate and persons who live in or have lived in high-risk congregate settings such as homeless shelters and correctional facilities. Because the increased risk of exposure to TB in congregate settings varies substantially by facility and local health jurisdiction, clinicians are encouraged to follow local recommendations when considering testing among persons from these congregate settings. The USPSTF did not review data supporting testing among close contacts to persons with infectious TB or among persons who are immunosuppressed because these persons are recommended to be screened by public health programs or by clinical standard of care.

Children

This risk assessment tool is intended for adults. A risk assessment tool created for use in California for children is available on the TBCB Risk Assessment page. (https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-Pediatric-TB-Risk-Assessment.pdf)

Local recommendations

Local recommendations and mandates should also be considered in testing decisions. Local TB control programs can customize this risk assessment according to local recommendations. **Providers should check with local TB control programs for local recommendations.** A directory of TB Control Programs is available on the CTCA website. (https://www.ctca.org/locations.html)

Mandated testing and other risk factors

Several risk factors for TB that have been used to select patients for TB screening historically or in mandated programs are not included among the components of this risk assessment. This is purposeful in order to focus testing on patients at highest risk. However, certain populations may be mandated for testing by statute, regulation, or policy. This risk assessment does not supersede any mandated testing. Examples of these populations include: healthcare workers, residents or employees of correctional institutions, substance abuse treatment facilities, homeless shelters, and others.

Age as a factor

Age (among adults) is not considered in this risk assessment. However, younger adults have more years of expected life during which progression from latent infection to active TB disease could develop. Some programs or clinicians may additionally prioritize testing of younger non-U.S.-born persons when all non-U.S.-born are not tested. An upper age limit for testing has not been established but could be appropriate depending on individual patient TB risks, comorbidities, and life expectancy.

Foreign travel

Travel to countries with an elevated TB rate may be a risk for TB exposure in certain circumstances (e.g., extended duration, likely contact with persons with infectious TB, high prevalence of TB in travel location, non-tourist travel). The duration of at least 1 consecutive month to trigger testing is intended to identify travel most likely to involve TB exposure. TB screening tests can be falsely negative within the 8 weeks after exposure, so are best obtained 8 weeks after return from travel.

When to repeat a test

Re-testing should only be done in persons who previously tested negative, and have new risk factors since the last assessment. In general, this would include new close contact with an infectious TB case or new immunosuppression, but could also include foreign travel in certain circumstances.

When to repeat a risk assessment

The risk assessment should be administered at least once. Persons can be screened for new risk factors at subsequent preventive health visits.

IGRA preference in BCG vaccinated

Because IGRA has increased specificity for TB infection in persons vaccinated with BCG, IGRA is preferred over the TST in these persons. Most persons born outside the United States have been vaccinated with BCG.

Previous or inactive tuberculosis

Chest radiograph findings consistent with previous or inactive TB include fibrosis or non-calcified nodules, but do not include a solitary calcified nodule or isolated pleural thickening. Persons with a previous chest radiograph showing findings consistent with previous or inactive TB should be tested for LTBI. In addition to LTBI testing, evaluate for active TB disease.

Negative test for LTBI does not rule out active TB disease

It is important to remember that a negative TST or IGRA result does not rule out active TB disease. In fact, a negative TST or IGRA in a patient with active TB disease can be a sign of extensive disease and poor outcome.

Symptoms that should trigger evaluation for active TB disease

Patients with any of the following symptoms that are otherwise unexplained should be evaluated for active TB disease: cough for more than 2-3 weeks, fevers, night sweats, weight loss, and hemoptysis.

How to evaluate for active TB disease

Evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease

Most patients with LTBI should be treated

Persons with risk factors who test positive for LTBI should generally be treated once active TB disease has been ruled out. However, clinicians should not feel compelled to treat persons who have no risk factors but have a positive test for LTBI.

Emphasis on short course for treatment of LTBI

Shorter regimens for treating latent TB infection have been shown to be as effective as 9 months of isoniazid, and are more likely to be completed. Use of these shorter regimens is preferred in most patients. Drug-drug interactions and contact to drug resistant TB are typical reasons these regimens cannot be used.

Shorter duration LTBI treatment regimens

Medication	Frequency	Duration
Rifampin	Daily	4 months
Isoniazid + rifapentine	Weekly	12 weeks*

* 11-12 doses in 16 weeks required for completion.

Patient refusal of recommended LTBI treatment

Refusal should be documented. Recommendations for treatment should be made at future encounters with medical services. If treatment is later accepted, TB disease should be excluded and CXR repeated if it has been more than 6 months from the initial evaluation; or more than 3 months if there is immunosuppression, or the prior CXR was abnormal and consistent with potentially active TB disease.

Resources

Fact Sheets for LTBI Regimens, Isoniazid+Rifapentine, Rifampin, and Isoniazid are available on the TBCB LTBI Treatment page. (www.cdph.ca.gov/LTBITreatment)

U.S. Preventive Services Task Force Latent TB Infection Screening Recommendations are available on the U.S. Preventive Services Task Force website. (https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/latent-tuberculosis-infection-screening)

Abbreviations

AFB= acid-fast bacilli BCG= Bacillus Calmette-Guérin
CXR= chest x-ray DOT= directly observed therapy
IGRA=interferon gamma release assay LTBI= latent TB infection
MDR =multiple drug resistant NAAT= nucleic acid amplification testing
SAT= self-administered therapy TST= tuberculin skin test

California Pediatric Tuberculosis Risk Assessment

- Use this tool to identify asymptomatic **children** for latent TB infection (LTBI) testing.
- **Do not repeat testing** unless there are **new risk factors** since the last test.
  If initial negative screening test occurred prior to 6 months of age, repeat testing should occur at age 6 months or older
- Do not treat for LTBI until active TB disease has been excluded:
  For children with TB symptoms or abnormal chest x-ray consistent with active TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.

LTBI testing is recommended if any of the boxes below are checked.

☐ **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month

- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
- If resources require prioritization within this group, prioritize patients with at least one medical risk for progression (see the California Adult Tuberculosis Risk Assessment User Guide for this list).
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for non-U.S.-born persons ≥2 years old

☐ **Immunosuppression,** current or planned

HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥2 mg/kg/day, or ≥15 mg/day for ≥2 weeks) or other immunosuppressive medication

☐ **Close contact** to someone with infectious TB disease during lifetime

Treat for LTBI if LTBI test result is positive and active TB disease is ruled out.

☐ **None**; no TB testing is indicated at this time.

Provider Name: _____

Assessment Date: _____

Patient Name: _____

Date of Birth: _____

See the California Pediatric TB Risk Assessment User Guide for more information about using this tool. To ensure you have the most current version, go to the TB RISK ASSESSMENT page (https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/TB-Risk-Assessment.aspx)

California TB Pediatric Risk Assessment User Guide

Avoid testing persons at low risk

Routine testing of persons without risk factors is not recommended and may result in unnecessary evaluations and treatment because of falsely positive test results.

Local recommendations, mandated testing and other risk factors

Several risk factors for TB that have been used to select children for TB screening historically or in mandated programs are not included among the 3 components of this risk assessment. This is purposeful in order to focus testing on children at highest risk. However, certain populations may be mandated for testing by statute, regulation, or policy. This risk assessment does not supersede any mandated testing. Testing can also be considered in children with frequent exposure to adults at high risk of TB infection, such as those with extensive foreign travel in areas with high TB rates. Local recommendations should also be considered in testing decisions. Local TB control programs and clinics can customize this risk assessment according to local recommendations. **Providers should check with local TB control programs for local recommendations.** A directory of TB Control Programs is available on the CTCA website. (https://www.ctca.org/locations.html)

Most patients with LTBI should be treated

Persons with risk factors who test positive for LTBI should generally be treated once active TB disease has been ruled out with a physical exam, chest radiograph and, if indicated, sputum smears, cultures, and nucleic acid amplification testing (NAAT). However, clinicians should not feel compelled to treat persons who have no risk factors but have a positive test for LTBI.

When to repeat a risk assessment and testing

Risk assessments should be completed for new patients, patients thought to have new potential exposures to TB since last assessment, and during routine pediatric well-child visits. Repeat risk assessments should be based on the activities and risk factors specific to the child. Children who volunteer or work in health care settings might require annual testing and should be considered separately. Re-testing should only be done in persons who previously tested negative and have new risk factors since the last assessment (unless they were <6 months of age at the time of testing). In general, new risk factors would include new close contact with an infectious TB case or new immunosuppression, but could also include foreign travel.

Immunosuppression

The exact level of immunosuppression that predisposes to increased risk for TB progression is unknown. The threshold of steroid dose and duration used in the Pediatric TB Risk Assessment are based on data in adults and in accordance with ACIP recommendations for live vaccines in children receiving immunosuppression.

Foreign travel or residence

Travel or residence in countries with an elevated TB rate may be a risk for TB exposure in certain circumstances (e.g., extended duration, likely contact with persons with infectious TB, high prevalence of TB in travel location, non-tourist travel). The duration of at least 1 consecutive month to trigger testing is intended to identify travel most likely to involve TB exposure. TB screening tests can be falsely negative within the 8 weeks after exposure, so are best obtained 8 weeks after a child's return.

IGRA preference in non-U.S.-born children ≥2 years old

Because IGRA has increased specificity for TB infection in children vaccinated with BCG, IGRA is preferred over the tuberculin skin test for non-U.S.-born children ≥2 years of age. IGRAs can be used in children <2 years of age, however, there is an overall lack of data in this age group, which complicates interpretation of test results. In BCG vaccinated immunocompetent children with a positive TST, it may be appropriate to confirm a positive TST with an IGRA. If IGRA is not done the TST result should be considered the definitive result.

Negative test for LTBI does not rule out active TB

It is important to remember that a negative TST or IGRA result does not rule out active TB disease. A negative TST or IGRA in a patient with active TB disease can be a sign of extensive disease. Any suspicion for active TB disease or extensive exposure to TB should prompt an evaluation for active TB disease, including physical exam, symptom review, and 2-view chest x-ray.

Emphasis on short course for treatment of LTBI

Shorter regimens for treating latent TB infection have been shown to be as effective as 9 months of isoniazid, and are more likely to be completed. Use of these shorter regimens is preferred in most patients, although the 12 week regimen is not recommended for children <2 years of age or children on antiretroviral medications. It is under study in pregnancy. Drug- drug interactions and contact to drug resistant TB are other contra-indications for shorter regimens.

Shorter duration LTBI treatment regimens

Medication	Frequency	Duration
Rifampin	Daily	4 months
Isoniazid + rifapentine	Weekly	12 weeks*

* 11-12 doses in 16 weeks required for completion.

Refusal of recommended LTBI treatment

Refusal should be documented. Recommendations for treatment should be made at future encounters with medical services. If treatment is later accepted, TB disease should be excluded and chest x-ray repeated if it has been more than 6 months from the initial evaluation for children 5 years or older and 3 months for children less than 5 years of age.

Symptoms that should trigger evaluation for active TB

Patients with any of the following symptoms that are otherwise unexplained should be evaluated for active TB disease: cough for more than 2-3 weeks, fevers, night sweats, weight loss, lymphadenopathy, hemoptysis or excessive fatigue.

Resources

Fact Sheets for LTBI Regimens, Isoniazid+Rifapentine, Rifampin, and Isoniazid are available on the TBCB LTBI Treatment page. (www.cdph.ca.gov/LTBITreatment)

American Academy of Pediatrics, Red Book Online, Tuberculosis is available on the Red Book Online website. (https://redbook.solutions.aap.org/chapter.aspx?sectionid=189640207&bookid=2205)

Abbreviations

AFB= acid-fast bacilli BCG= Bacillus Calmette-Guérin
CXR= chest x-ray DOT= directly observed therapy
IGRA=interferon gamma release assay LTBI= latent TB infection
MDR =multiple drug resistant NAAT= nucleic acid amplification testing
SAT= self-administered therapy TST= tuberculin skin test

Confidentiality, Solicitation & Conflict of Interest Statement

I understand and am in compliance with the policy regarding the following:

Confidentiality:

Employees agree to maintain the confidentiality of its records, including billings, in accordance with all applicable State, Federal and Local laws relating to confidentiality of patient records and information.

- No duplication of patient records without written permission from patient.
- No portion of patients' records or disclosure of information can be removed from clinic premises unless proper release of records has been established.
- No discussion of patient records with anyone other than for medical consultation.
- No discussions of patient care with patient in exposed areas where others are present.

Solicitation:

Solicitations refer to all types, whether to obtain memberships for subscriptions, collection of contributions or sale of any items on behalf of any company, club, society, labor union, religious organization, political party or similar organizations.

- Outsiders are not permitted to engage in solicitations for any purpose in the clinic's
- premises at any time.
- Employees are not permitted to engage in solicitations for any purpose in the clinic's
- working areas during work hours.
- Clinic employees are permitted to engage in solicitations during non-working hours
- and in non-working areas only.

Conflict of Interest:

Employees are expected to be free of any interest or acts that may be considered in conflict with the goals and business of _____. Such "conflict situations" could include:

- Working or owning any interest or influence in a clinic supplier or patient company (except shares of stock in publicly held companies).
- Employees are cautioned against accepting compensation, gifts, loans, expensive entertainment, any material service, gift or promise or personal gain, directly or indirectly, from suppliers or patients. No such gifts, compensation, or favors should be accepted that could be construed as influencing the employee in future decisions affecting the clinic, supplier, or client. All such offers should be reported to the physician and/or the supervisor.

All employees are responsible for notifying their supervisor in the event that they are aware of any violation of conflict-of-interest regulations.

Employee Signature: _____ Print Name: _____ Date:_____

PCP	
Section: Personnel	
POLICY AND PROCEDURE: Informed Consent and Human Sterilization	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:
Site personnel receive training and/or information on member rights that include informed consent and human sterilization consent.

PROCEDURE:

I. Written Member Rights should be available at the office site. Staff should be able to locate the written Member Rights list and explain how to use the information.

II. Staff trainings regarding member rights may be part of office staff education documented in:
   A. Informal or formal in-services
   B. New staff orientation
   C. External training courses

III. Topics included in the trainings must include:
   A. Informed Consent for Human Sterilization

      1. Patients shall be informed about any proposed treatment or procedure that includes medically significant risks, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment. Documentation of this discussion and the signed consent shall be written and included in the member's medical record.

      Note: Patient Rights incorporate the requirements of the Joint Commission on Accreditation of Healthcare Organizations, Title 22, California Code of Regulations, Section 70707 and Medicare Conditions of Participation.

      Requirements include and are not limited to:
      a) Conducted by physician or physician designee
      b) Offered booklet published by the DHCS and copy of consent form must be given to the member
      c) Provided answers to any question the member may have
      d) Inform the member they may withdraw or withhold consent to procedure at any time before the sterilization
      e) Describe fully the available alternatives of family planning and birth control
      f) Advise that the sterilization procedure is considered irreversible

g) Explain full the description of discomforts and risks and benefits of the procedure
h) Utilize the PM330 sterilization consent form

Forms may be ordered directly from DHCS by placing a request to:

Department of Health Care Services Warehouse
1037 North Market Blvd., Suite 9
Sacramento, CA 95834
Fax: 916-928-1326

ATTACHMENTS: PM-330 English/Spanish Consent Form
PM330 example
Sterilization Consent Form Tips

State of California -- Health and Human Services Agency

CONSENT FORM
PM 330

Department of Health Services

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from

_____ . When I first asked for
(doctor or clinic)

the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a

_____ .
(Name of procedure)

The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on ____/____/____ .
Mo Day Yr

I, _____
Last

_____ _____
First *M. I.*

hereby consent of my own free will to be sterilized by

_____ by a
(Doctor's name)

method called _____ .
(Name of procedure)

My consent expires **180 days** from the date of my **signature below**.

I also consent to the release of this form and other medical records about the operation to:

- **Representatives of the Department of Health and Human Services.**
- **Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.**

I have received a copy of this form.

_____ *Date:* ____/____/____
Signature of individual to be sterilized *Mo Day Yr*

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent

form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ *Date:* ____/____/____
Signature of Interpreter *Mo Day Yr*

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the
(Name of Individual to be sterilized)

consent form, I explained to him/her the nature of the sterilization

operation _____, the fact that it
(Name of procedure)

is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at anytime and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____ *Date:* ____/____/____
Signature of person obtaining consent *Mo Day Yr*

_____
Name of Facility where patient was counseled

_____
Address of Facility where patient was counseled *City* *State* *Zip Code*

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon

_____ on
(Name of individual to be sterilized)

____/____/____ *(Date of Sterilization),* I explained to him/her the nature of the
Mo Day Yr

sterilization operation _____ ,
(Name of procedure)

the fact that it is intended to be final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of Alternative Final Paragraphs**: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery when the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. **Cross out the paragraph below which is not used.**

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (**check applicable box below and fill in information requested**.)

A ☐ Premature delivery date: ____/____/____ Individual's **expected date**
Mo Day Yr

of delivery: ____/____/____ (Must be 30 days from date of patient's signature).
Mo Day Yr

B ☐ Emergency abdominal surgery; describe circumstances: _____

_____

_____ *Date:* ____/____/____
Signature of Physician performing surgery *Mo Day Yr*

State of California -- Health and Human Services Agency

CONSENT FORM - PM 330

Department of Health Services

NOTA: NINGUNO DE LOS BENEFICIOS QUE RECIBO DE LOS PROGRAMAS O PROYECTOS SUBSIDIADOS CON FONDOS FEDERALES SE ME CANCELARÁ O SUSPENDERÁ EN CASO DE QUE YO DECIDA NO ESTERILIZARME.

■ CONSENTIMIENTO PARA ESTERILIZACIÓN ■

Declaro que he solicitado y obtenido información sobre esterilización de _____ (*doctor o clinica*). Al solicitar información se me dijo que yo soy la única persona que puede decidir esterilizarme o no y que estoy en mi derecho a negarme a ser esterilizado. Mi decisión de no esterilizarme no afectará mi derecho a recibir atención o tratamiento médico en el futuro, y tampoco dejaré de recibir ningún tipo de asistencia o beneficios que recibo actualmente de los programas subsidiados con fondos federales, tales como A.F.D.C. o Medicaid o de aquellos a los que pudiera tener derecho en el futuro.

ENTIENDO QUE LA ESTERILIZACIÓN DEBE SER CONSIDERADA **PERMANENTE** E **IRREVERSIBLE**. DECLARO QUE ES MI DECISIÓN EL NO QUERER VOLVER A EMBARAZARME, DAR A LUZ O SER PADRE NUEVAMENTE.

Declaro que se me ha informado acerca de la existencia de otros métodos anticonceptivos temporales que están a mi disposición y que me permitirían en un futuro tener hijos o ser padre nuevamente. Sin embargo, he rehusado estos metodos alternativos y he decidido esterilizarme.

Entiendo que se me va a esterilizar mediante un método conocido como:

_____ (*Nombre del procedimiento*)

Declaro que se me explicaron los malestares, riesgos y beneficios asociados con la operación, y que se respondió a todas mis preguntas satisfactoriamente.

Entiendo que la operación no se llevará a cabo hasta por lo menos treinta (30) días después de que firme este formulario, y que puedo cambiar de parecer en cualquier momento y decidir no esterilizarme. Si decido no esterilizarme, no dejaré de recibir ninguno de los beneficios o servicios médicios ofrecidos por los programas subsidiados con fondos federales.

Declaro tener al menos 21 años de edad y que nací en ____/____/____. *Mes Día Año*

Apellido

Nombre *I.*

por medio de la presente doy mi consentimiento libre y voluntario para ser esterilizado/a por _____ (*Nombre del Doctor*)

utilizando un método conocido como _____ (*Nombre del procedimiento*)

Mi consentimiento es válido sólo por un plazo de **180 días** a partir de la fecha en que firme este formulario como se muestra **abajo**.

Asimismo, doy mi consentimiento para que este formulario y otros expedientes médicos sobre la operación se den a conocer a:

- **Representantes del Departamento de Salud y Servicios Humanos.**
- **Empleados de los programas o proyectos que reciben fondos de dicho Departamento, pero únicamente para determinar si se cumplieron las leyes federales.**

He recibido copia de este formulario.

_____ *Fecha:* ____/____/____

Firma de la persona a se esterilizada *Mes Día Año*

■ DECLARACIÓN DEL INTÉRPRETE ■

Si se requiere de un intérprete para asistir a la persona que va a ser esterilizada: Declaro que he traducido la información y los consejos verbales que la persona que recibe este consentimiento le ha dado a la persona que va a ser esterilizada. También le he leído a la persona el contenido de este formulario de consentimiento en idioma _____ y le he explicado su contenido. A mi mejor saber y entender dicha persona ha comprendido las explicaciones que se le dieron.

_____ *Fecha:* ____/____/____

Firma del intérprete *Mes Día Año*

PM 330 (1/99) (Sp)

■ DECLARACION DE LA PERSONA QUE RECIBE EL CONSENTIMIENTO ■

Declaro que antes de que _____ (*Nombre de la persona a ser esterilizada*) firmara el formulario de consentimiento, le expliqué la naturaleza del método de esterilización conocido como _____ (*Nombre del procedimiento*). También le expliqué que dicha operación es final e irreversible, y le informe sobre los malestares, riesgos y beneficios asociados con dicho procedimiento.

Declaro que le he explicado a la persona a ser esterilizada acerca de la existencia de otros métodos anticonceptivos temporales y que a diferencia de estos, el método de esterilización es irreversible.

Declaro que le he informado a la persona a ser esterilizada que puede desistir en cualquier momento a este consentimiento y que esto no traerá como consecuencia la péridida de ningún servicio médico o beneficio subsidiado con fondos federales

Declaro que, a mi mejor saber y entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y parece estar en su sano juicio. Dicha persona, de forma voluntaria y con conocimiento de causa, ha solicitado ser esterilizada y parece entender la naturaleza y las consecuencias del procedimiento.

_____ *Fecha:* ____/____/____

Firma de quien recibe el consentimiento *Mes Día Año*

_____

Nombre del lugar donde el paciente recibió la información

_____

Dirección del lugar donde el paciente recibió la información Ciudad Estado Código Postal

■ DECLARACIÓN DEL MÉDICO ■

Declaro que poco aqntes de operar a _____ (*Nombre de la persona a ser esterilizada*) en ____/____/____ (*Fecha de esterilización*), le explique la naturaleza del metodo de esterilizacion conocido como _____ (*Nombre del procedimiento*), también le expliqué que este método es final e irreversible y le informé de los malestares, riegos y beneficios asociados con este procedimiento.

Mes Día Año

Declaro que le he explicado a la persona a ser esterilizada acerca de la existencia de otros métodos anticonceptivos temporales y que ha diferencia de estos, el método de esterilización es irreversible.

Declaro que le he informado a la persona a ser esterilizada que puede desistir en cualquier momento a este consentimiento y que esto no traerá como consecuencia la pérdida de ningún servicio médico o beneficios subsidado con fondos federales.

Declaro que, a mi mejor saber y entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y parece estar en su sano juicio. Dicha persona, de forma voluntaria y con conocimiento de causa, ha solicitado ser esterilizada y parece entender la naturaleza y las consecuencias del procedimiento.

(**Instrucciones para el Uso Alternativo de los Párrafos Finales:** Use el primer párrafo de abajo excepto en caso de parto prematuro o cirugía del abdomen de emergencia cuando la esterilización se lleve a cabo antes de que se cumplan treinta (30) días desde que la persona firmó este consentimiento. En dichos casos se debe usar el segundo párrafo. **Tachar el párrafo de abajo que no es usado.**

(1) Han pasado por lo menos trienta (30) días desde que la persona firmó este consentimiento y la fecha en que se realizó la esterilización.

(2) La esterilización se realizó en menos de 30 días, pero después de 72 horas desde que la persona firmó este consentimiento debido a lo siguiente: (**Marque la casilla correspondiente de abajo y escriba la información que se solicita.**)

A ☐ Fecha de parto prematuro: ____/____/____ **Fecha anticipada** del parto: ____/____/____ (Debe ser 30 dias a partir de la firma de la persona).

Mes Día Año

B ☐ Cirugía del abdomen de emergencia; describa las circunstancias: ____

_____

_____ *Fecha:* ____/____/____

Firma del Doctor a cargo de la cirugía *Mes Día Año*

Example of PM-330 Sterilization Consent Form

State of California -- Health and Human Services Agency

CONSENT FORM
PM 330

Department of Health Services

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from (1) _____ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from A.F.D.C. or Medicaid that I am now g

I UNDER BE CONSIDERED **PERMANENT** D THAT I DO NOT WANT TO BEC THER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a (2) _____ (Name of procedu

Fields 2, 6, 13, & 20
Bilateral Tubal Ligation

Bilateral Tubal Ligation

The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my satisfaction.

Fields 4, 7, 12, & 18
Penny L. Sillen

not be done until at least thirty days after I change my mind at any time and that my I will not result in the withholding of any b federally funded programs.

I, (4) _____ (Last) _____ (First) _____ M. I., was born on (3) ___/___/___ (Mo Day Yr).

hereby consent of my own free will to be sterilized by (5) _____ (Doctor's na by a method called (6) _____ (Name of procedure).

Bilateral Tubal Ligation

My consent expires **180 days** from the date of my **signature below.**

I also consent to the release of this form and other medical records about the operation to:

- **Representatives of the Department of Health and Human Services.**
- **Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.**

I have received a copy of this form.

(7) *Penny L. Sillen,* _____ Date: (8) ___/___/___
Signature of individual to be sterilized (Mo Day Yr)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in (9) _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ Date: (11) ___/___/___
Signature of Interpreter (Mo Day Yr)

PM 330 (1/99)

■ STATEMENT OF PERS NSENT ■

Before (12) *Penny L. Sillen,* _____ (Name of individual to be sterilized) signed the consent form, I explained to zation operation (13) **Bilateral Tubal Ligation** (Name of procedure) that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at anytime and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ Date: (15) ___/___/___
Signature of person obtaining consent (Mo Day Yr)

(16) _____
Name of Facility where patient was counseled

(17) _____
Address of Facility where patient was counseled City State Zip Code

■ PHYSICIAN'S STATEMENT ■

Shortly b n operation upon (18) *Penny L. Sillen,* _____ (Name of individual to be sterilized) on (19) ___/___/___ (Mo Day Yr) (Date of Sterilization), I explained to him/her the nature of the sterilization operation (20) **Bilateral Tubal Ligation** (Name of procedure), the fact that it is intended to be final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/sh y Federal funds.

To the best of my t least 21 years old and d voluntarily requested to b d consequences of the proc

Fields 21 & 22
Cross off the Paragraph which DOES NOT APPLY

(Instructions for use of Alternative Final Paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery when the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. **Cross out the paragraph below which is not used.**

(21) (1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(22) (2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (**check applicable box below and fill in information requested.**)

Fields 27 & 28
Physician Signature & Date must be ON or AFTER Sterilization DATE

idual's **expected date** of patient's signature).

nstances: _____

(27) *Marcus J. Welby M.D.* _____ Date: (28) ___/___/___
Signature of Physician performing surgery (Mo Day Yr)

PM-330 *Sterilization Consent Form*
Tips & Reminders for Successful Billing

☑ **Name of procedure.** **Fields 2, 6, 13 and 20** require the name of the procedure. The name of the procedure must be present and must be **consistent** throughout the form and **must** match name of procedure on the claim.

☑ **Patient's name.** **Fields 4, 7, 12 and 18** require the name of the patient to be consistent throughout the form.

Tip: Use the name as reflected on the BIC or the name used when determining Family PACT eligibility.

☑ **Field 21 and 22 (Alternative Final Paragraphs).** The paragraph that does not apply **must be crossed out** (an **'X'** through the paragraph that does not apply is required).

(21) Paragraph one. **Do not** cross off paragraph one if the minimum waiting period of 30 days has been met.

(22) Paragraph two. **Do not** cross off paragraph two if the minimum waiting period of 30 days **has not** been met.

☑ **Physician's signature.** **Field 27** requires full signature of the Physician who has verified consent and who actually performed the operation.

☑ **Date.** **Field 28** must be present (month/day/year). Date must be on or after the sterilization date.

Note: These instructions must be followed **exactly** or the *Consent Form* will be returned and reimbursement delayed.

A completed PM 330 *Sterilization Consent Form* must accompany all claims directly related to the sterilization surgery. This requirement extends to all providers, attending physicians, surgeons, assistant surgeons, anesthesiologists and facilities.

The above tips are being provided to assist in the prevention of common RAD code denials:

105 – This service requires a valid sterilization consent form.

115 – Sterilization Consent Form is incomplete. A letter has been sent that indicates needed correction.

Provider Manual Reference – Part 2: *Sterilization* section

PCP	
Section: Personnel/Office Management	
POLICY AND PROCEDURE: Prior Authorizations/Referrals	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:
To ensure that referrals for specialty care and medical procedures are processed in a timely manner, the site will have a process for the timely processing of internal and external referrals, consultant reports, and diagnostic test results.

PROCEDURE:

I. REFERRAL FORMS

A. The staff has an organized, timely referral system clearly evident for making and tracking referrals, physician review of reports, and providing and/or scheduling follow-up care.

a. Appropriate referral forms shall be available at the Primary Care Physician site. The practitioner shall complete the referral form and attach all relevant medical information. Refer to the attached Health Plan specific referral forms.

B. Primary Care Physician offices are required to maintain a "Referral Tracking Log" or an appropriate tickler system. Refer to the referral tracking log attached.

a. The PCP must ensure timely receipt of the specialist's report or medical procedure report. Reports must be in the patient's medical record within thirty (30) days from the date of the procedure or appointment. If the PCP site has not received the report within 30 days, the PCP/staff will contact the specialist or procedure site to request a copy of the report.

C. The PCP shall ensure that referral informational resources, i.e. Health Plan Specialty and Network Directory are readily available for use by site personnel.

a. The following elements should be included within the referral system:
- Patient Name
- Date of Referral
- Referral Type
- Appointment Date
- Appointment Kept or Failed
- Date report received
- Appointment Kept or Failed

D. Site staff shall be able to demonstrate the office referral process from beginning to end.

ATTACHMENTS: Referral Tracking Log

Referral Log

Referral Date	Patient Name and/or Medical Record Number	Referred to: Specialist/ Facility	Auth. Status & Date Approved/ Denied/ Deferred	Date Patient Notified	Date of Appt/ Services	Kept or Failed Appt	Date Report Received or Physician Followed up Documentation	Complete

Instructions: When the physician orders a procedure, test, or consultation, enter the information in the specified columns. When the report of the ordered services is received, enter the date received. If the report is not received within the timeframe per policy, of the scheduled date of the ordered service, call the provider of the service to inquire about the results report and document the call(s). Call the patient if needed. Record results of actions taken to obtain report and/or documentation of the follow-up attempts with the patient. Check off completed referrals in last column.

PCP	
Section: Personnel/Office Management	
POLICY AND PROCEDURE: Member Grievances/Complaints	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:

The site has an established process for member grievances and complaints.

- A "grievance" is defined as any written or oral expression of dissatisfaction that involves coverage dispute, healthcare medical necessity, experimental or investigational treatment. The health plan does not delegate the resolution of grievances to contracted medical groups.

- A "complaint" is any expression of dissatisfaction regarding the quality of service (excluding quality of care) which can be resolved in the initial contact. A "complaint" is self-limiting (e.g. service complaints, appointment wait times) that can be resolved to the member's satisfaction, such as they do not ask for additional assistance

PROCEDURE:

A. The staff will ensure that any member who expresses a grievance or complaint is informed of the right for a State Fair Hearing and offered the following numbers:

    1. The California Department of Managed Health Care 1-888-HM0-2219

    2. For Hearing and Speech impaired call 1-800-735-2929

    3. State Fair Hearing 1-800-952-5253

    4. Ombudsman 1-888-452-8609

B. Staff will ensure that grievance forms (in threshold languages) for each participating health plan will be provided to members promptly upon request.

    - The grievance form must be submitted to the health plan within 1 business day.

C. The Staff will ensure that all complaints (self-limiting complaints: e.g. service complaints, appointments wait times) are logged and submitted to the health Plan monthly (if were complaints during the time period).

    1. These complaints may be resolved at the point of service

    2. Log the complaint and include:

        a. Date of complaint

b. Name of complainant and ID#

c. Nature of the complaint

d. Resolution/action taken (include information that health plan was notified as appropriate)

e. Date of resolution/action

f. Date log submitted to health plan

D. Blue Shield Promise has link to download forms of different languages and may fill out and submit online. The link below is for appeals and Grievance:

1. Appeals and grievance process | Blue Shield of CA (blueshieldca.com)

ATTACHMENTS:

Grievance log
Grievance forms (ENGLISH & SPANISH)
How to file a Grievance

POLICY AND PROCEDURE: Member Grievances/Complaints	

Member Grievance Procedure

Definitions: Grievances are any written or oral expressions of dissatisfaction made by a member/patient regarding quality of service, access to care, interpersonal communication, or any other aspect of the physician/provider.

Purpose: To assure the quality and continuity of care given to Medi-Cal Managed Care patients/members. To monitor and resolve all quality of care issues and administrative issues through an internal grievance process.

Procedure to file a Grievance:

1. Patients/members may file a grievance with the Physician or Office Manager of the doctor's office.
2. They may file a grievance by telephone, correspondence, or a grievance report form.
3. If the grievance is filed by telephone: The office personnel must document the grievance on a grievance report form and submit a copy to the physician.
4. If the grievance is filed by correspondence: The office personnel must document the grievance on a grievance report form, attach the correspondence, and submit a copy to the physician.
5. If the grievance is filed by a grievance report: The office personnel must submit a copy to the physician.
6. The grievance form must be completed in its entirety with as much detail as possible.
7. If the grievance is solvable by the physician and office personnel, then documentation of the grievance must be kept on file and recorded on the grievance log.
8. If the grievance is not solvable by the physician and/or office personnel, then a copy of the grievance form and any supporting documents must be sent to the members/patients corresponding Health Plan within one (1) working day.
9. **All** grievances must be documented on a grievance form.
10. **All** grievances must be recorded and tracked on the grievance log.
11. **All** grievances must be resolved within twenty (20) days of the initial grievance. If the grievance is not resolved at the provider level within twenty (20) working days, the member must be offered the opportunity to file a written grievance with their corresponding Health Plan. This must be documented on the grievance form if the member/patient is offered to file a written grievance to their Health Plan, regardless of whether they agree or refuse the offer.

NOTE: All grievance forms, grievance logs, and supporting documents must be kept in a separate folder, not in the patient's medical records.

Blue Cross	Blue Shield Promise	CHP	Kaiser	L.A. Care
888-285-7801	1-800-544-0088 TTY 800 735-2929	800-475-5550	800-464-4000	888-452-2273

DMHC	DMHC – TDD Line	Ombudsman	
888-HMO-2219	**877-688-9891**	**1 -888-452- 8609**	**http://www.hmohelp.ca.gov**

GRIEVANCE LOG

Date of complaint	Name of complainant & ID#	Nature of the complaint	Resolution/action taken (include information that health plan was notified as appropriate) Yes/No	Gave appropriate numbers to patient YES/NO	Date of resolution/ action	Date log (submitted to health plan)

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HOW TO FILE A GRIEVANCE
INSTRUCTIONS

What is a Grievance?

A grievance is an expression of dissatisfaction, or a complaint. A grievance is different from a request for an organization determination, a coverage determination, or a request for an appeal because grievances do not involve problems related to coverage or payment for care or Part D benefits, problems about being discharged from the hospital too soon, and problems about coverage for Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation (CORF) services ending too soon. These issues are addressed by following a different procedure. Please call Blue Shield of California Promise Health Plan Member Services at 1-800-544-0088 (TTY 1-800-735-2929),from 8:00 a.m. to 8:00 p.m., seven days a week for more information. You may also refer to the Blue Shield of California Promise Health Plan Evidence of Coverage.

What types of problems might lead to you filing a grievance?

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you feel that you are being encouraged to leave (dis-enroll from) Blue Shield Promise Medicare Advantage Plan.
- Problems with the Member Service you receive.
- Problems with how long you have to spend waiting on the phone, in the waiting room, in a network pharmacy, or in the exam room.
- Problems with getting appointments when you need them, or having to wait a long time for an appointment.
- Disrespectful or rude behavior by doctors, nurses, receptionists, network pharmacists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, network pharmacies, or hospitals.
- If you disagree with our decision not to expedite your request for an expedited coverage determination, organization determination, redetermination, or reconsideration.
- You believe our notices and other written materials are difficult to understand.
- Failure to give you a decision within the required timeframe.
- Failure to forward your case to the independent review entity if we do not give you a decision within the required timeframe.
- Failure by the Plan to provide required notices, or required notices that comply with CMS standards.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance." In certain cases, you can ask for a "fast grievance," meaning your grievance will be decided within 24 hours.

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Filing a grievance with Blue Shield of California Promise Health Plan:

If you have a grievance, you can call Blue Shield of California Promise Health Plan Member Services at 1-800-544-0088 (TTY 1-800- 735-2929). A Blue Shield of California Promise Health Plan Representative will be available to assist you seven days a week, 8:00 a.m. to 8:00 p.m. We will try to resolve any grievance that you might have over the phone. If you request a written response to your phone grievance, we will respond in writing to you. If we cannot resolve your grievance over the phone, we have a formal procedure called the Standard Grievance Procedure.

Whether you call or write, you should contact Member Services right away. The complaint must be made within 60 calendar days after you had the problem you want to complain about.

You may file a standard grievance by:

- Calling Member Services at 1-800-544-0088 (TTY 1-800-735-2929)
- Submitting a written grievance by mail to:
  Blue Shield of California Promise Health Plan
  Appeals and Grievances Unit
  601 Potrero Grande Drive
  Monterey Park, CA 91755
- Submitting a written grievance by fax to 323-837-0853
- Filing electronically via the internet at www.blueshieldca.com/promise

Forms for filing grievances are also available in your doctor's office. Blue Shield of California Promise Health Plan will acknowledge receipt of your grievance within five days of receiving it. We will conduct a review of your issues. We may request your medical records as part of our review. We will mail you a response to your grievance within thirty days of receiving your grievance.

We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your grievance. We may extend the timeframe by up to 14 days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

At Blue Shield of California Promise Health Plan, we strive to earn the trust of those we serve and improve the health of our community. Should you have additional questions, please call Blue Shield of California Promise Health Plan Member Services at the telephone number listed above.

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Medicare Advantage Prescription Drug (MAPD) Plan
Member Grievance Form

This form is for filing a formal grievance regarding any aspect of the care or service provided to you. Blue Shield of California Promise Health Plan is required by law to respond to your grievances. A detailed procedure exists for resolving these situations. If you have any questions, please feel free to call the Blue Shield of California Promise Health Plan Member Services Department at 1-800-544-0088 (TTY 800-735-2929).

Please print or type the following information:

Member Name (last, first, middle initial): _____

_____ Address

_____ Home Phone Number

_____ City, State, Zip

_____ Alternate Phone Number

_____ Member ID #

_____ Date of Birth

Please state the nature of the grievance, giving dates, times, persons, places, etc. involved. Please attach copies of any additional information that may be relevant to your grievance or appeal. Use another sheet of paper if necessary.

_____

_____

_____

_____

_____

_____

_____

Please sign below and forward by mail to: Blue Shield of California Promise Health Plan
Appeals & Grievances Unit
601 Potrero Grande Drive
Monterey Park, CA 91755

OR by fax: 1-323-837-0853

Signature: _____ Date: _____

Signature of Representative: _____ Date: _____

If the grievance is filed by someone other than the member, please fill out and sign the Appointment of Representative Form (AOR) available on the Blue Shield of California Promise Health Plan website and submit it with this Grievance Form or you can also obtain a copy of the AOR Form by contacting the Blue Shield of California Promise Health Plan Member Services Department at 1-800-544-0088 (TYY 1-800-735-2929) from 8:00 a.m. to 8:00 p.m., seven days a week.

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GRIEVANCE FORM

MEMBER INFORMATION

Member Name (Last) (First)	Birth Date: Mo. Day Yr.	Effective Date of Enrollment: Mo. Day Yr.
Address (Street) (City) (State)		(ZIP Code)
Telephone (Home)	(Work)	Number of Plan Members in Family, Including Member Grievance:
Name of person completing form, if different from member name		(Daytime Telephone)

Where did the problem occur? (Name of Pharmacy, Hospital or Clinic)	Date of Incident: Mo. Day Yr.
Who was involved beside yourself? (Give names of involved staff, if possible.)	
Please describe what happened as specifically as possible: (Include the sequence of events and how the problem affected you.) **See Attachment**	

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against Blue Shield Promise, you should first telephone Blue Shield Promise at **1-800-605-2556** (TDD/TTY for the hearing impaired at **1-877-735-2929**) and use Blue Shield Promise's grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Blue Shield Promise, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for an Independent Medical Review
(IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department of Managed Health Care also has a toll-free telephone number (**1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet web site, **http://www.dmhc.ca.gov,** has complaint forms, IMR application forms, and instructions on-line.
You may also ask for a State Fair Hearing within 90 days of the incident. Write to:

Department of Social Services
State Hearings Division
P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430

You may call the Department of Social Services directly at 1-800-952-5253. You may call the Office of the OMBUDSMAN to assist you at 1**-888-452-8609**.

ACTION REQUESTED

What would you like to see done about this problem?
See Attachment

Grievance Received By:	In Person ☐	
	By Telephone ☐	Date
Date Received: Time Received	By Mail ☐	Member's Signature (optional)
	Online ☐	I UNDERSTAND THAT THE PLAN WILL CONTACT ME WITHIN THIRTY (30) DAYS TO GIVE ME A REPORT ON ITS INVESTIGATION AND/OR ACTION REGARDING MY COMPLAINT.

Rev. 0509

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DESCRIBE WHAT HAPPENED:

ACTION REQUESTED:

(OFFICIAL USE ONLY) **OUTCOME/RESOLUTION:**
(*Complete only if an Expedited Appeal*) **Member was acknowledged verbally and notified of the 72 hours appeal process: Yes ☐ No ☐**
Grievance Received by: **Date Received:**

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FORMULARIO PARA QUEJAS

INFORMACIÓN DEL MIEMBRO

Apellido	Nombre	Fecha de nacimiento: Mes	Día	Año	Día efectivo de inscripción: Mes	Día	Año

Domicilio	Ciudad	Estado	Zona postal

Teléfono de la casa	Teléfono del trabajo	Número de miembros inscritos incluyendo al demandante:

Nombre de la persona completando el formulario (representante), si es diferente del miembro	Télefono del representante

¿Dónde ocurrió el problema? (Nombre de la farmacia, hospital o clínica)	Fecha del incidente: Mes	Día	Año

Además de usted, mencione al personal que está implicado en su queja.

Favor de describir lo ocurrido tan especificamente sea posible (Incluya la secuencia de eventos y de que manera le afectó este problema. Use otra página si es necesario para describirlo con más detalle.)

Vea el documento adjunto

El Departamento de Atención Médica Administrada de California (DMHC, por sus siglas en inglés) se encarga de regular los planes de salud. Si usted tiene alguna queja sobre Blue Shield Promise, debe llamar primero a Blue Shield Promise, al **1-800-605-2556,** (para las personas con problemas auditivos, el teléfono TDD/TTY es **1-877-688-9891**) y seguir el trámite de quejas del plan, antes de comunicarse con el DMHC. El trámite de quejas no anula ningún derecho o recurso legal que usted pueda tener a su disposición. Si necesita ayuda con una queja relacionada con una emergencia, o con una queja que Blue Shield Promise no haya resuelto satisfactoriamente, o si su queja lleva más de treinta (30) días sin ser resuelta, puede llamar a DMHC para pedir asistencia. Es posible que también pueda solicitar una Revisión Médica Independiente (IMR, por sus siglas en inglés). Si reúne los requisitos necesarios para la IMR, este proceso hará una revisión imparcial de las decisiones médicas tomadas por su plan de salud. El objetivo de la IMR es determinar la necesidad médica de un servicio o tratamiento propuesto y tomar decisiones sobre la cobertura de tratamientos de tipo experimental o de investigación y sobre disputas por el pago de servicios médicos urgentes o de emergencia. El DMHC cuenta también con un número de teléfono sin cargo **(1-888-466-2219)** y una línea TDD **(1-877-688-9891)** para las personas con problemas auditivos o del habla. La página web del DMHC, **http://www.dmhc.ca.gov**, incluye formularios de queja, de solicitud de IMR e instrucciones en Internet. Usted puede solicitar también una audiencia estatal durante los 90 días después del incidente. Escriba a:

Department of Social Services
State Hearings Division
P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430

Puede llamar directamente al Department of Social Service (Departamento de Servicios Sociales) al **1-800-952-5253.** Asimismo, usted puede llamar para solicitar ayuda a la oficina del Mediador (OMBUDSMAN) al **1-888-452-8609**.

ACCIÓN REQUERIDA

¿Qué medida(s) quisiera que se aplicaran a este problema?

Vea el documento adjunto

Queja recibida por:		En persona Por teléfono Por correo En línea	
Fecha que se recibió:	Hora que se recibió:		Firma (Opcional) Fecha TENGO ENTENDIDO QUE EL PLAN SE COMUNICARÁ CONMIGO DENTRO DE 30 DÍAS PARA DARME UN INFORME SOBRE SU INVESTIGACIÓN Y/O SU ACCIÓN CON RESPECTO A ESTE PROBLEMA.

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DESCRIBA LO QUE OCURRIO:

ACCIÓN REQUERIDA:

(OFFICIAL USE ONLY) **OUTCOME/RESOLUTION:**
(*Complete only if an Expedited Appeal*) **Member was acknowledged verbally and notified of the 72 hours appeal process: Yes ☐ No ☐**
Grievance Received by: **Date Received:**

PCP	
Section: Personnel	
POLICY AND PROCEDURE: Child Abuse Reporting	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:

Any health care practitioner who has knowledge of or observes a child who, in a professional capacity or within the scope of his or her employment, is a suspected victim of child abuse or neglect, shall report the suspected incident of abuse or neglect to a "child protective services" agency.

PROCEDURE:

I. REPORTING

A. A report shall be made to child protective services (hereafter "CPS") agency. A child protective services agency is any county or probation department or a police or Sheriff's department (P.C. 11165.9, 11166[a]).

B. The initial report shall be made immediately (or as soon as possible, without delay) to the CPS agency by phone

C. A written report shall be forwarded to the CPS agency within 36 hours of receiving the information regarding the incident.

D. Written reports must be submitted on a Department of Justice form – Form SS 8572 (DOJ SS 8572) which can be requested from your local CPS agency.

E. A single report may be made if two or more persons have knowledge of suspected child abuse or neglect

F. The following information should be included in the report:

1. Name of reporter
2. Name and present location of the child
3. Nature and extent of the injury, and any evidence of prior abuse
4. Any other information, including what led you to suspect child abuse, if requested by the child protective agency (P.C. § 11167 [a]).

G. Failure to make a required report is a misdemeanor punishable by up to six months in jail and/or up to a $1,000 fine (P.C. 1172[e]). Persons who fail to report can also be subject to a civil lawsuit, and found liable for damages, especially if the child-victim or another child is further victimized because of the failure to report.

II. INDICATORS OF ABUSE

A. Physical Abuse

1. Physical Indicators of Physical Abuse
   a. Fractures lacerations, bruises, that cannot be explained, or explanations which are improbably given the extent of the injury
   b. Burns (cigarette, rope, scalding water, iron, radiator)
   c. Infected burns, indicating delay in seeking treatment
   d. Facial injuries (black eyes, broken jaw, broken nose, bloody nose, bloody or swollen lips) with implausible or nonexistent explanations
   e. Subdural hematomas, long-bone fractures, fracture in different states of healing

f. Pattern of bruising (e.g., parallel or circular bruises) or bruises in different stages of discoloration, indicating repeated trauma over time

2. Behavioral Indicators of Physical Abuse
   a. Hostile, aggressive, verbally abusive towards others
   b. Fearful or withdrawn behavior
   c. Self-destructive (self-mutilates, bangs head, etc.)
   d. Destructive (breaks windows, sets fires, etc.)
   e. Out-of-control behavior (seems angry, panics, easily agitated)
   f. Frightened of going home, frightened of parents/caretakers or, at the other extreme, is overprotective of parent(s) or caretaker(s)
   g. Attempts to hide injuries; wears excessive layers of clothing, especially in hot weather
   h. Difficulty sitting or walking
   i. Clingy, forms indiscriminate attachments
   j. Apprehensive when other children cry
   k. Wary of physical contact with adults
   l. Exhibits drastic behavioral changes in and out of parental/caretaker presence
   m. Suffers from seizures or vomiting
   n. Exhibits depression, suicide attempts, substance abuse, or sleeping and eating disorders

B. Sexual Abuse

1. Physical indicators of Sexual Abuse: the following may be indicative of sexual abuse:
   a. Wears torn, stained, or bloody underclothing
   b. Physical trauma or irritation to the anal/genital area (pain, itching, swelling, bruising, bleeding, laceration, abrasions), especially if injuries are unexplained or there is an inconsistent explanation
   c. Knowledge of a child's history of previous or recurrent injuries/diseases
   d. Swelling or discharge from vagina/penis
   e. Visible lesions around mouth or genitals
   f. Complaint of lower abdominal pain
   g. Painful urination, defecation
   h. Sexually transmitted diseases
   i. Difficulty in walking or sitting due to genital or anal pain
   j. Psychosomatic symptoms (stomachaches, headaches)

2. Behavioral Indicators of Sexual Abuse
   a. Sexualized behavior (has precocious knowledge of explicit sexual behavior and engages self or others in overt or repetitive sexual behavior)
   b. Compulsive indiscreet masturbation
   c. Excessive curiosity about sexual matters or genitalia (self or others)
   d. Unusually seductive with classmates, teachers and other adults
   e. Excessive concern about homosexuality, especially by boys

3. Behavioral Indicators of Sexual Abuse in Younger Children; the following may be exhibited by younger children who are experiencing sexual abuse:
   a. Wetting pant, bed wetting or fecal soiling
   b. Eating disturbances such as overeating, under eating
   c. Fears or phobias
   d. Compulsive behavior
   e. School problems or significant change in school performance (attitude and grades)
   f. Age-inappropriate behavior, including pseudomaturity or regressive behavior such as bed wetting or thumb sucking
   g. Inability to concentrate
   h. Drastic behavior changes
   i. Speech disorders
   j. Frightened of parent/caretaker or of going home

C. Neglect

1. Physical Indicators of Neglect
   a. Failure to thrive-the child fails to gain weight at the expected rate for a normal child
   b. Malnutrition or poorly balanced diet (bloated stomach, extremely thin, dry, flaking skin, pale, fainting)
   c. Inappropriate dress for weather
   d. Dirty unkempt, extremely offensive body odor
   e. Unattended medical or dental conditions (e.g., infections, impetigo)
   f. Evidence of poor or inadequate supervision for the child's age

2. Behavioral Indicators of Neglect
   a. Inappropriate dress for weather
   b. Clingy or indiscriminate attachment
   c. Depressed, withdrawn, or apathetic
   d. Antisocial or destructive behavior
   e. Fearfulness
   f. Substance abuse
   g. Speech, eating, or habit disorders (biting, rocking, whining)
   h. Often sleepy or hungry
   i. Brings only candy, chips, and soda for lunch or consistently "forget" to bring food

III. DEFINITIONS

A. Physical abuse: characterized by physical injury (for example, bruises and fractures) resulting from punching, beating, kicking, biting, burning, or otherwise harming a child. Any injury resulting from physical punishment that requires medical treatment is considered outside the realm of normal disciplinary measures.

B. Neglect: the negligent treatment or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the part of the responsible person.

C. Severe neglect: the negligent failure of a person having the care or custody of a child to protect the child from severe malnutrition or medically diagnosed nonorganic failure to thrive. "Severe neglect" also means those situations of neglect where any person having the care or custody of a child willfully causes or permits the person or health of the child to be placed in a situation such that his or her person or heath is endangered, including the intentional failure to provide adequate food, clothing, shelter, or medical care.

D. Sexual abuse: refers to sexual assault or sexual exploitation

1. Sexual assault includes rape, statutory rape, rape in concert, incest, sodomy, and lewd or lascivious acts upon a child, oral copulation, sexual penetration, or child molestation. It includes, but is not limited to, all the following:
   a. Any penetration, however slight, of the vagina or anal opening of one person by the penis of another person, whether or not there is the emission of semen
   b. Any sexual contact between the genitals or anal opening of one person and the mouth or tongue of another person
   c. Any intrusion by one person into the genital or anal opening of another person, including the use of any object for this purpose, excepting acts performed for a valid medical reason
   d. The intentional touching of the genitals or intimate parts (including the breasts, genital area, groin, inner thighs, and buttocks) or the clothing covering them, of a child, or of the perpetrator by a child, for purposes of sexual arousal or gratification, excepting acts that may reasonably be construed to be normal caretaker responsibilities; interaction with, or demonstrations of affection for, the child; or acts performed for a valid medical purpose
   e. The intentional masturbation of the perpetrator's genitals in the presence of a child (P.C. 11165.1[b])

2. Sexual exploitation refers to any of the following:
   a. Depicting a minor engaged in obscene acts in violation of law; preparing, selling, or distributing obscene matter that depicts minors; employment of minor to perform obscene acts
   b. Any person who knowingly promotes, aids, or assists, employs, uses, persuades, induces, or coerces a child, or any person responsible for a child's welfare, who knowingly permits or encourages a child to engage in, or assists other to engage in, prostitution or a live performance involving obscene sexual conduct, or to either pose or model alone or with others for purposes of preparing a film, photograph, negative, slide, drawing, painting, or other pictorial depiction, involving obscene sexual conduct. "Person responsible for a child's welfare" means a parent, guardian, foster parent, or a licensed administrator or employee of a public or private residential home, residential school, or other residential institution

c. Any person who depicts a child in, or who knowingly develops, duplicates, prints or exchanges, any film, photograph, video tape, negative, or slide in which a child is engaged in an act of obscene sexual conduct, except for those activities by law enforcement and prosecution agencies and other persons described in subdivisions {c) and (e) of Section 311.3 (P.C. 11165.1[c])

ATTACHMENTS: Child Abuse Reporting Instructions and Form

SUSPECTED CHILD ABUSE REPORT
(Pursuant to Penal Code section 11166)

To Be Completed by Mandated Child Abuse Reporters
PLEASE PRINT OR TYPE

CASE NAME: _____

CASE NUMBER: _____

A. REPORTING PARTY

NAME OF MANDATED REPORTER	TITLE	MANDATED REPORTER CATEGORY
REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS Street City Zip		DID MANDATED REPORTER WITNESS THE INCIDENT? ☐ YES ☐ NO
REPORTER'S TELEPHONE (DAYTIME)	SIGNATURE	TODAY'S DATE

B. REPORT NOTIFICATION

☐ LAW ENFORCEMENT ☐ COUNTY PROBATION ☐ COUNTY WELFARE / CPS (Child Protective Services)

AGENCY

ADDRESS Street City Zip

DATE/TIME OF PHONE CALL

OFFICIAL CONTACTED - NAME AND TITLE

TELEPHONE

C. VICTIM
One report per victim

NAME (LAST, FIRST, MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip			TELEPHONE
PRESENT LOCATION OF VICTIM	SCHOOL	CLASS	GRADE

PHYSICALLY DISABLED? ☐ YES ☐ NO	DEVELOPMENTALLY DISABLED? ☐ YES ☐ NO	OTHER DISABILITY (SPECIFY)	PRIMARY LANGUAGE SPOKEN IN HOME

IN FOSTER CARE? ☐ YES ☐ NO

IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE:
☐ DAY CARE ☐ CHILD CARE CENTER ☐ FOSTER FAMILY HOME
☐ FAMILY FRIEND ☐ GROUP HOME OR INSTITUTION ☐ RELATIVE'S HOME

TYPE OF ABUSE *(CHECK ONE OR MORE)*:
☐ PHYSICAL ☐ MENTAL
☐ SEXUAL ☐ NEGLECT
☐ OTHER (SPECIFY) _____

RELATIONSHIP TO SUSPECT	PHOTOS TAKEN? ☐ YES ☐ NO	DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? ☐ YES ☐ NO ☐ UNK

D. INVOLVED PARTIES

VICTIM'S SIBLINGS

NAME	BIRTHDATE	SEX	ETHNICITY	NAME	BIRTHDATE	SEX	ETHNICITY
1.				3.			
2.				4.			

VICTIM'S PARENTS/GUARDIANS

NAME (LAST, FIRST. MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE		BUSINESS PHONE
NAME (LAST, FIRST. MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE		BUSINESS PHONE

SUSPECT

SUSPECT'S NAME (LAST, FIRST. MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip			TELEPHONE

OTHER RELEVANT INFORMATION

E. INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ☐ IF MULTIPLE VICTIMS, INDICATE NUMBER: _____

DATE/TIME OF INCIDENT	PLACE OF INCIDENT

NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incident's involving the victim(s) or suspect)

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code section 11169 to submit to DOJ a Child Abuse or Severe Neglect Indexing Form BCIA 8583 if (1) an active investigation was conducted and (2) the incident was determined to be substantiated.

SUSPECTED CHILD ABUSE REPORT
(Pursuant to Penal Code section 11166)

DEFINITIONS AND GENERAL INSTRUCTIONS FOR COMPLETION OF FORM BCIA 8572

All Penal Code (PC) references are located in Article 2.5 of the California PC. This article is known as the Child Abuse and Neglect Reporting Act (CANRA). The provisions of CANRA may be viewed at: http://leginfo.legislature.ca.gov/faces/codes.xhtml (specify "Penal Code" and search for sections 11164-11174.3). A mandated reporter must complete and submit form BCIA 8572 even if some of the requested information is not known. (PC section 11167(a).)

I. MANDATED CHILD ABUSE REPORTERS

Mandated child abuse reporters include all those individuals and entities listed in PC section 11165.7.

II. TO WHOM REPORTS ARE TO BE MADE ("DESIGNATED AGENCIES")

Reports of suspected child abuse or neglect shall be made by mandated reporters to any police department or sheriff's department (not including a school district police or security department), the county probation department (if designated by the county to receive mandated reports), or the county welfare department. (PC section 11165.9.)

III. REPORTING RESPONSIBILITIES

Any mandated reporter who has knowledge of or observes a child, in his or her professional capacity or within the scope of his or her employment, whom he or she knows or reasonably suspects has been the victim of child abuse or neglect shall report such suspected incident of abuse or neglect to a designated agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof ***within 36 hours*** of receiving the information concerning the incident. (PC section 11166(a).)

No mandated reporter who reports a suspected incident of child abuse or neglect shall be held civilly or criminally liable for any report required or authorized by CANRA. Any other person reporting a known or suspected incident of child abuse or neglect shall not incur civil or criminal liability as a result of any report authorized by CANRA unless it can be proven the report was false and the person knew it was false or made the report with reckless disregard of its truth or falsity. (PC section 11172(a).)

IV. INSTRUCTIONS

SECTION A – REPORTING PARTY: Enter the mandated reporter's name, title, category (from PC section 11165.7), business/agency name and address, daytime telephone number, and today's date. Check yes/no whether the mandated reporter witnessed the incident. The signature area is for either the mandated reporter or, if the report is telephoned in by the mandated reporter, the person taking the telephoned report.

IV. INSTRUCTIONS (*continued*)

SECTION B – REPORT NOTIFICATION: Complete the name and address of the designated agency notified, the date/time of the phone call, and the name, title, and telephone number of the official contacted.

SECTION C – VICTIM (One Report per Victim): Enter the victim's name, birthdate or approximate age, sex, ethnicity, address, telephone number, present location, and, where applicable, enter the school, class (indicate the teacher's name or room number), and grade. List the primary language spoken in the victim's home. Check the appropriate yes/no box to indicate whether the victim may have a developmental disability or physical disability and specify any other apparent disability. Check the appropriate yes/no box to indicate whether the victim is in foster care, and check the appropriate box to indicate the type of care if the victim was in out-of-home care. Check the appropriate box to indicate the type of abuse. List the victim's relationship to the suspect. Check the appropriate yes/no box to indicate whether photos of the injuries were taken. Check the appropriate box to indicate whether the incident resulted in the victim's death.

SECTION D – INVOLVED PARTIES: Enter the requested information for Victim's Siblings, Victim's Parents/Guardians, and Suspect. Attach extra sheet(s) if needed (provide the requested information for each individual on the attached sheet(s)).

SECTION E – INCIDENT INFORMATION: If multiple victims, indicate the number and submit a form for each victim. Enter date/time and place of the incident. Provide a narrative of the incident. Attach extra sheet(s) if needed.

V. DISTRIBUTION

Reporting Party: After completing form BCIA 8572, retain a copy for your records and submit copies to the designated agency.

Designated Agency: ***Within 36 hours*** of receipt of form BCIA 8572, the initial designated agency will send a copy of the completed form to the district attorney and any additional designated agencies in compliance with PC sections 11166(j) and 11166(k).

ETHNICITY CODES

1 Alaskan Native	6 Caribbean	11 Guamanian	16 Korean	22 Polynesian	27 White-Armenian
2 American Indian	7 Central American	12 Hawaiian	17 Laotian	23 Samoan	28 White-Central American
3 Asian Indian	8 Chinese	13 Hispanic	18 Mexican	24 South American	29 White-European
4 Black	9 Ethiopian	14 Hmong	19 Other Asian	25 Vietnamese	30 White-Middle Eastern
5 Cambodian	10 Filipino	15 Japanese	21 Other Pacific Islander	26 White	31 White-Romanian

PCP	
Section: Personnel	
POLICY AND PROCEDURE: Elder and Adult Dependent Abuse Reporting	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:

Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment, has observed, suspects, or has knowledge of an incident that reasonably appears to be physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect), or is told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, isolation, financial abuse, abduction, or neglect, shall report the known or suspected instance of abuse to the appropriate agency. (Welfare and Institutions Code§ 15630 [b]).

PROCEDURE:

I. REPORTING

A. Reports must be made both by telephone and in writing.

1. A telephone report must be made immediately or as soon as practically possible, without delay.
2. A written report is to be made within two working days using the SOC 341, "Report of Suspected Elder/Dependent Adult Abuse" form (see attachment)

• To request a supply of SOC 341s, send a letter or fax to:

Department of Social Services Warehouse
P.0. Box 980788
West Sacramento, Ca 95798-078
Fax: 916-371-3518

3. All the following types of abuse must be reported:
   a. Physical abuse (including sexual abuse)
   b. Abandonment
   c. Isolation
   d. Abduction
   e. Financial abuse
   f. Neglect (including self-neglect)

4. Report to the local law enforcement agency or to Adult Protective Services when abuse, neglect or self-neglect is suspected to have occurred in the community
5. Report to the local law enforcement agency or to Long Term Care Ombudsman when the abuse or neglect is suspected to have occurred in a long-term care facility

6. Failure to make a mandated report is a misdemeanor, punishable imprisonment in the county jail for up to six months, or a fine of up to $1,000 or both
7. Any mandated reporter who willfully fails to report abuse of an elder or a dependent adult, where the abuse results in death or great bodily injury, may be punished by up to one year in the county jail, or by a fine of up to $5,000, or y both imprisonment and fine
8. A single report may be made when two or more persons have knowledge of a suspected instance of abuse

II. EXCEPTIONS TO REPORTING REQUIREMENT

A. There are exceptions to the requirement to report:
   1. Reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred
   2. The elder or the dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of mental illness or dementia
   3. The reporter reasonably believes that the abuse did not occur

III. POSSIBLE INDICATORS OF ABUSE OR NEGLECT

A. Physical Signs
   1. Injury that has not been cared for properly
   2. Injury that is inconsistent with explanation for cause
   3. Pain from touching
   4. Cuts puncture wounds, burn, bruises, and welts
   5. Dehydration or malnutrition without illness-related cause
   6. Poor coloration
   7. Sunken eyes or cheeks
   8. Inappropriate administration of medication
   9. Soiled clothing or bed
   10. Frequent use of hospital or health care/doctor shopping
   11. Lack of necessities such as food, water, or utilities
   12. Lack of personal effects, pleasant living environment, and personal items
   13. Forced isolation

B. Behavioral Signs

1. Fear
2. Anxiety, agitation
3. Anger
4. Isolation, withdrawal
5. Depression
6. Non-responsiveness, resignation, ambivalence
7. Contradictory statements, implausible stories
8. Hesitation to talk openly
9. Confusion or disorientation

C. Signs by Caregiver

1. Prevents elder from speaking to or seeing visitors
2. Anger, indifference, aggressive behavior toward elder
3. History of substance abuse, mental illness, criminal behavior, or family violence
4. Lack of affection toward elder
5. Flirtation or coyness as possible indicator of inappropriate sexual relationships
6. Conflicting accounts of incidents
7. Withholds affection

IV. DEFINITIONS

A. Abandonment: The desertion or willful forsaking of an elder or dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide are or custody

B. Abduction: The removal from California, and/or the restraint from returning to California, of an elder/dependent adult who does not have the capacity to consent to such removal or restraint, as well as the removal or restraint of any conservative without the consent of the conservator or court

C. Abuse of an elder or a dependent adult: Physical abuse (including sexual abuse), neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or mental suffering, or the deprivation by a care custodian of goods or services that is necessary to avoid harm or mental suffering

D. Dependent adult: Any person between the ages of 18 and 64 years, who has Physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights. This includes, but is not limited to, persons who have physical or developmental disabilities. It also includes those whose physical or mental abilities have diminished because of age as well as any 10 to 64 year old who is admitted as an inpatient to a 24-hour health facility

E. Elder: Any person who is 65 years of age or older

F. Financial Abuse: A situation in which a person or entity takes, secretes, appropriates or retains the real or personal property of an elder or dependent adult to a wrongful use, or with intent to defraud, or both, OR assists another in this process. The person or entity is deemed to have committed financial abuse if such actions were taken, in bad faith. A person or entity is considered to have acted in bad faith if he/they knew or should have known that the elder or dependent adult had the right to have the property transferred or made readily available to him/her or to his/her representative

G. Goods and services: includes but is not limited to all of the following:
   1. The provision of medical care for physical and mental health needs
   2. Assistance in personal hygiene
   3. Adequate clothing
   4. Adequately heated and ventilated shelter
   5. Protection from health and safety hazards
   6. Protection from malnutrition, under circumstances where the results include, but are not limited to, malnutrition and deprivation of necessities or physical punishment
   7. Transportation and assistance necessary to secure the above goods and services

H. Isolation: any of the following unless performed pursuant to a medical care plan, or unless performed in response to a reasonably perceived threat of danger to property or physical safety:
   1. Preventing the elder or dependent adult from receiving his/her mail or telephone calls
   2. Telling a caller or visitor that the elder or dependent adult does not wish to see/speak to the person, when this is contrary to the elder or dependent adult's wishes, regardless of whether he/she is mentally competent
   3. False imprisonment, as defined in California Penal Code, Section 236
   4. Physical restraint of the elder or dependent adult to prevent contact with family, friends, or concerned persons

I. Mental suffering: fear, agitation, confusion severe depression, or other forms of serious emotional distress that is brought about by threats, harassment, or other forms of intimidating behavior

J. Neglect: the negligent failure of any person having care or custody of an elder or dependent adult to exercise that degree of care that a reasonable person in a like position would exercise, including, but not limited to:
   1. Failure to assist in personal hygiene or in the provision of food, clothing, or shelter
   2. Failure to provide medical care for physical and mental health needs

K. Physical abuse: assault, battery, assault with a deadly weapon or with force likely To produce great bodily injury, unreasonable physical constraint, prolonged or continual deprivation of food or water, sexual assault or battery or rape including spousal rape, incest, sodomy, oral copulation, or penetration by a foreign object). Physical abuse also includes the use of physical or chemical restraint or psychotropic medication either for punishment or for a period or purpose beyond which the restraint or medication was ordered by the attending, licensed physician

L. Reasonable suspicion: an objectively reasonable suspicion of abuse that a Person should entertain, based upon the facts, and drawing upon the person's training and experience

M. Self-neglect: failure of the elder or dependent adult to exercise a reasonable Degree of care in providing for his/her own needs in such areas as personal hygiene, food, clothing, shelter, medical and mental health care, or avoiding health and safety hazards, malnutrition or dehydration, when that failure is due to ignorance, illiteracy, incompetence, mental limitation, substance abuse or poor health

ATTACHMENTS: Abuse Report form

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

Date Completed

CONFIDENTIAL REPORT - NOT SUBJECT TO PUBLIC DISCLOSURE

TO BE COMPLETED BY REPORTING PARTY. PLEASE PRINT OR TYPE.
SEE GENERAL INSTRUCTIONS.

A. VICTIM ☐ Check box if victim consents to disclosure of information (Ombudsman use only - WIC 15636(a))

Name (Last Name, First Name)	Age	Date of Birth	SSN

Gender Identity	Sexual Orientation	Ethnicity	Race
☐ Male ☐ Female ☐ Transgender ☐ Other/Nonbinary ☐ Unknown/Not Provided	☐ Straight ☐ Gay/Lesbian ☐ Bisexual ☐ Questioning ☐ Unknown/Not Provided		Language (Check one) ☐ Non-Verbal ☐ English ☐ Other (Specify) _____

Address (If facility, include name and notify ombudsman)	City	Zip Code	Telephone
Present Location (If different from above)	City	Zip Code	Telephone

☐ Elderly (65+) ☐ Developmentally Disabled ☐ Mentally Ill/Disabled ☐ Physically Disabled ☐ Unknown/Other

☐ Lives Alone ☐ Lives with Others

B. SUSPECTED ABUSER Check if ☐ Self-Neglect

Name of Suspected Abuser

Address	City	Zip Code	Telephone

☐ Care Custodian (Type)_____ ☐ Parent ☐ Son/Daughter ☐ Other _____
☐ Health Practitioner (Type)_____ ☐ Spouse ☐ Other Relation _____

Gender	Ethnicity	Age	D.O.B
☐ Male ☐ Female			

Height	Weight	Eyes	Hair

C. REPORTER'S OBSERVATIONS, BELIEFS, AND STATEMENTS BY VICTIM IF AVAILABLE. DOES ALLEGED PERPETRATOR STILL HAVE ACCESS TO THE VICTIM? DOES THE ALLEGATION INVOLVE A SERIOUS BODILY INJURY (see definition in section "Reporting Responsibilities and Time Frames" within the General Instructions)? PROVIDE ANY KNOWN TIME FRAME (2 days, 1 week, ongoing, etc.). LIST ANY POTENTIAL DANGER FOR INVESTIGATOR (animals, weapons, communicable diseases, etc.) or concerns about the client's mental health.

☐ CHECK IF MEDICAL, FINANCIAL (ACCOUNT INFORMATION, ETC.), PHOTOGRAPHS, OR OTHER SUPPLEMENTAL INFORMATION IS ATTACHED.

D. REPORTING PARTY Check appropriate box if reporting party waives confidentiality to
☐ All ☐ All but victim ☐ All but perpetrator

Name	Signature	Occupation	Agency/Name of Business

Relation to Victim/How Abuse is Known	Street	City	Zip Code

Telephone	E-mail Address

E. INCIDENT INFORMATION - Address where incident occurred

Date/Time of Incident(s)

Place of Incident (Check One)
☐ Own Home ☐ Community Care Facility ☐ Hospital/Acute Care Hospital
☐ Home of Another ☐ Nursing Facility/Swing Bed ☐ Other (Specify)_____

F. REPORTED TYPES OF ABUSE (Check All that Apply)

1. Perpetrated by Others (WIC 15610.07 & 15610.63)
a. ☐ Physical (e.g. assault/battery, constraint or deprivation, chemical restraint, over/under medication)
b. ☐ Sexual
c. ☐ Financial
d. ☐ Neglect (including Deprivation of Goods and Services by a Care Custodian)
e. ☐ Abandonment
f. ☐ Isolation
g. ☐ Abduction
h. ☐ Psychological/Mental
i. ☐ Other _____

2. Self-Neglect (WIC 15610.57 (b)(5))
a. ☐ Neglect of Physical Care (e.g. personal hygiene, food, clothing, malnutrition/dehydration)
b. ☐ Self-Neglect of Residence (unsafe environment)
c. ☐ Financial Self-Neglect (e.g. inability to manage one's own personal finances)

Abuse Resulted In (Check All that Apply)
☐ No Physical Injury ☐ Minor Medical Care ☐ Hospitalization ☐ Care Provider Required
☐ Death ☐ Mental Suffering ☐ Serious Bodily Injury* ☐ Other (Specify)_____
☐ Unknown ☐ Health & Safety Endangered

G. OTHER PERSON BELIEVED TO HAVE KNOWLEDGE OF ABUSE
(Family, significant others, neighbors, medical providers, agencies involved, etc.)

Name	Relationship
Address	Telephone
Name	Relationship
Address	Telephone

H. FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM'S CARE

(If known, list contact person) If Contact person check ☐

Name			Relationship
Address	City	Zip Code	Telephone

I. TELEPHONE REPORT MADE TO ☐ APS ☐ Law Enforcement ☐ Local Ombudsman ☐ Calif. Dept. of State Hospitals ☐ Calif. Dept. of Developmental Services

Name of Official Contacted by Phone	Telephone	Date/Time

J. WRITTEN REPORT

Enter information about the agencies receiving this report. If the abuse occurred in a LTC facility and resulted in Serious Bodily Injury*, please refer to "Reporting Responsibilities and Time Frames" in the General Instructions. Do not submit report to California Department of Social Services Adult Programs Division.

Agency Name	Address or Fax	☐ Date Mailed	☐ Date Faxed
Agency Name	Address or Fax	☐ Date Mailed	☐ Date Faxed
Agency Name	Address or Fax	☐ Date Mailed	☐ Date Faxed

K. RECEIVING AGENCY USE ONLY ☐ Telephone Report ☐ Written Report

1. Report Received By	Date/Time

2. Assigned ☐ Immediate Response ☐ Ten-Day Response ☐ No Initial Response (NIR) ☐ Not APS ☐ Not Ombudsman ☐ No Ten-Day (NTD)

Approved By	Assigned To (optional)

3. Cross-Reported to ☐ CDPH-Licensing & Cert.; ☐ CDSS-CCL; ☐ Local Ombudsman; ☐ Bureau of Medi-Cal Fraud & Elder Abuse; ☐ Calif. Dept. of State Hospitals; ☐ Law Enforcement; ☐ Professional Licensing Board; ☐ Calif. Dept. of Developmental Services; ☐ APS; ☐ Other (Specify) _____
Date of Cross-Report _____

4. APS/Ombudsman/Law Enforcement Case File Number

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE
GENERAL INSTRUCTIONS

PURPOSE OF FORM

This form, as adopted by the California Department of Social Services (CDSS), is required under Welfare and Institutions Code (WIC) Sections 15630 and 15658(a)(1). This form documents the information given by the reporting party on the suspected incident of abuse or neglect of an elder or dependent adult. **Abuse** means any treatment with resulting physical harm, pain, or mental suffering or the deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering. **Neglect** means the negligent failure of an elder or dependent adult or of any person having the care or custody of an elder or a dependent adult to exercise that degree of self-care or care that a reasonable person in a like position would exercise. **Elder** means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). **Dependent Adult** means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age (WIC Section 15610.23). Dependent adult includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility (defined in the Health and Safety Code Sections 1250, 1250.2, and 1250.3).

COMPLETION OF THE FORM

1. This form may be used by the receiving agency to record information through a telephone report of suspected dependent adult/elder abuse.
2. If any item of information is unknown, enter “unknown.”
3. Item A: Check box to indicate if the victim waives confidentiality.
4. Item C: Check box if the reporting party waives confidentiality. Please note that mandated reporters are required to disclose their names, however, non-mandated reporters may report anonymously.

REPORTING RESPONSIBILITIES AND TIME FRAMES:

Any mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse or neglect, or reasonably suspects that abuse or neglect has occurred, shall complete this form for each report of known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect (self-neglect), isolation, and abandonment) involving an elder or dependent adult.

***Serious bodily injury** means an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ or of mental faculty, or requiring medical intervention, including, but not limited to, hospitalization, surgery, or physical rehabilitation (WIC Section 15610.67).

Reporting shall be completed as follows:

- If the abuse occurred in a Long-Term Care (LTC) facility (as defined in WIC Section 15610.47) and resulted in serious bodily injury, report by telephone to the local law enforcement agency immediately and no later than two (2) hours after observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local Long-Term Care Ombudsman Program (LTCOP), and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within two (2) hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in a LTC facility, was physical abuse, but did not result in serious bodily injury, report by telephone to the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local LTCOP, and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in a LTC facility, was physical abuse, did not result in serious bodily injury, and was perpetrated by a resident with a physician's diagnosis of dementia, report by telephone to the local law enforcement agency or the local LTCOP, immediately or as soon as practicably possible. Follow by sending the written report to the LTCOP or the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in a LTC facility, was abuse other than physical abuse, report by telephone to the LTCOP or the law enforcement agency immediately or as soon as practicably possible. Follow by sending the written report to the local law enforcement agency or the LTCOP within two working days.

- If the abuse occurred in a state mental hospital or a state developmental center, mandated reporters shall report by telephone or through a confidential Internet reporting tool (established in WIC Section 15658) immediately or as soon as practicably possible and submit the report within two (2) working days of making the telephone report to the responsible agency as identified below:

    - If the abuse occurred in a State Mental Hospital, report to the local law enforcement agency or the California Department of State Hospitals.

    - If the abuse occurred in a State Developmental Center, report to the local law enforcement agency or to the California Department of Developmental Services.

- For all other abuse, mandated reporters shall report by telephone or through a confidential Internet reporting tool to the adult protective services agency or the local law enforcement agency immediately or as soon as practicably possible. If reported by telephone, a written or an Internet report shall be sent to adult protective services or law enforcement within two working days.

REPORTING PARTY DEFINITIONS

Mandated Reporter (WIC Section 15630 (a)) Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter.

Care Custodian (WIC Section 15610.17) means an administrator or an employee of any of the following public or private facilities or agencies, or persons providing are or services for elders or dependent adults, including members of the support staff and maintenance staff: (a) Twenty-four hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code; (b) Clinics; (c) Home health agencies; (d) Agencies providing publicly funded in-home supportive services, nutrition services, or other home and community-based support services; (e) Adult day health care centers and adult day care; (f) Secondary schools that serve 18- to 22-year-old dependent adults and postsecondary educational institutions that serve dependent adults or elders; (g) Independent living centers; (h) Camps; (i) Alzheimer's Disease Day Care Resource Centers; (j) Community care facilities, as defined in Section 1502 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code; (k) Respite care facilities; (l) Foster homes; (m) Vocational rehabilitation facilities and work activity centers; (n) Designated area agencies on aging; (o) Regional centers for persons with developmental disabilities; (p) State Department of Social Services and State Department of Health Services licensing divisions; (q) County welfare departments; (r) Offices of patients' rights advocates and clients' rights advocates, including attorneys; (s) The Office of the State Long-Term Care Ombudsman; (t) Offices of public conservators, public guardians, and court investigators; (u) Any protection or advocacy agency or entity that is designated by the Governor to fulfill the requirements and assurances of the following: (1) The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, contained in Chapter 144 (commencing with Section 15001) of Title 42 of the United States Code, for protection and advocacy of the rights of persons with developmental disabilities; or (2) The Protection and Advocacy for the Mentally Ill Individuals Act of 1986, as amended, contained in Chapter 114 (commencing with Section 10801) of Title 42 of the United States Code, for the protection and advocacy of the rights of persons with mental illness; (v) Humane societies and animal control agencies; (w) Fire departments; (x) Offices of environmental health and building code enforcement; or (y) Any other protective, public, sectarian, mental health, or private assistance or advocacy agency or person providing health services or social services to elders or dependent adults.

Health Practitioner (WIC Section 15610.37) means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage, family, and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage, family, and child counselor trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, or an unlicensed marriage, family, and child counselor intern registered under Section 4980.44 of the Business and Professions Code, state or county public health or social service employee who treats an elder or a dependent adult for any condition, or a coroner.

Any officer and/or employee of a financial institution is a mandated reporter of suspected financial abuse and shall report suspected financial abuse of an elder or dependent adult on form SOC 342, "Report of Suspected Dependent Adult/Elder Financial Abuse".

MULTIPLE REPORTERS

When two or more mandated reporters are jointly knowledgeable of a suspected instance of abuse of a dependent adult or elder, and when there is agreement among them, the telephone report may be made by one member of the group. Also, a single written report may be completed by that member of the group. Any person of that group, who believes the report was not submitted, shall submit the report.

IDENTITY OF THE REPORTER

The identity of all persons who report under WIC Chapter 11 shall be confidential and disclosed only among APS agencies, local law enforcement agencies, LTCOPs, California State Attorney General Bureau of Medi-Cal Fraud and Elder Abuse, licensing agencies or their counsel, Department of Consumer Affairs Investigators (who investigate elder and dependent adult abuse), the county District Attorney, the Probate Court, and the Public Guardian. Confidentiality may be waived by the reporter or by court order.

FAILURE TO REPORT

Failure to report by mandated reporters (as defined under "Reporting Party Definitions") any suspected incidents of physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect) of an elder or a dependent adult is a misdemeanor, punishable by not more than six months in the county jail, or by a fine of not more than $1,000, or by both imprisonment and fine. Any mandated reporter who willfully fails to report abuse of an elder or a dependent adult, where the abuse results in death or great bodily injury, may be punished by up to one year in the county jail, or by a fine of up to $5,000, or by both imprisonment and fine (WIC Section 15630(h)).

No one, including a supervisor, employer, or lawyer, can excuse a mandated reporter from his or her personal legal duty to report known or suspected abuse. Anyone who attempts to impede or inhibit a mandated reporter from reporting may be prosecuted for a misdemeanor punishable by a fine, imprisonment, or both. Mandated reporters are therefore expected to report any such efforts to law enforcement, as well as any other responsible agency (see Welfare and Institutions Code Section 15630(f) and (h).

Officers or employees of financial institutions are mandated reporters of financial abuse (effective January 1, 2007). These mandated reporters who fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $1,000. Individuals who willfully fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $5,000. These civil penalties shall be paid by the financial institution, which is the employer of the mandated reporter, to the party bringing the action.

DISTRIBUTION OF SOC 341 COPIES

Mandated reporter: After making the telephone report to the appropriate agency or agencies, the reporter shall send the written report to the designated agencies (as defined under “Reporting Responsibilities and Time Frames”); and keep one copy for the reporter’s file.

Receiving agency: Place the original copy in the case file. Send a copy to a cross-reporting agency, if applicable.

DO NOT SEND A COPY TO THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES ADULT PROGRAMS DIVISION.

PCP	
Section: Personnel	
POLICY AND PROCEDURE: Domestic Violence Reporting	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:_____

POLICY:
Health care providers who provide medical services for a physical condition to a patient whom he or she knows or reasonably suspects of suffering from injuries resulting from a firearm or assaultive or abusive conduct, are required to make a report (Penal Code Section 11160 et. seq.).

PROCEDURE:

I. Reporting
   A. Reports must be made both by telephone and in writing to a local law enforcement agency
      1. A telephone report must be made immediately or as soon as practically possible
      2. A written report is to be made within two working days of receiving the Information using OCJP 920: Suspicious Injury Report Form (see attachment)
      3. The report must include the following:
         • Name of the injured person, if known
         • The injured person's whereabouts
         • Character and extent of the person's injuries
         • The identity of the person who allegedly inflicted the injury
      4. Failure to make a mandated report is a misdemeanor, punishable by imprisonment in the county jail for up to six months, or a fine of up to $1,000 or both
      5. Check with the local law enforcement agency of where to report if the patient was injured in another county
      6. If the battered patient is a minor then the Child Abuse and Neglect Reporting Act applies. (see Child Abuse Reporting policy and procedure)

II. Medical Record
   A. The law (P.C. § 11161 [b]) recommends that the medical record include the following:
      • Any comments by the injured person regarding past domestic violence or regarding the name of any person suspected of inflicting the injury
      • A map of the injured person's body showing and identifying injuries and Bruises
      • A copy of the reporting form

III. Important Considerations
   A. Sensitivity and awareness
      • Reassure patient he/she is not alone and does not deserve to be treated this way
      • Be careful not to imply patient is to blame

- Patients may be scared of seeking care because they do not want police involvement
- Some patients may fear reporting for other reasons (i.e. immigration status)
- There are many barriers to leaving an abusive situation (i.e. threats from the batterer, fear of financial instability, failure of police and others to effectively intervene, hope the relationship can work, feel responsible for the battering, may be embarrassed, humiliated, and degraded about the abuse)

B. Patient Safety
- Address directly the risk of retaliation by the batterer and discuss how the patient might protect her/himself from further abuse
- Discuss the patient's short-term option and plan, including whether the patient can safely return home
- Indicate on the reporting form any special concerns regarding how the report should be handled to maximize patient safety

C. Referral
- Provide patient with referrals to domestic violence services
- Assist the patient in calling a domestic crisis line if willing

D. Special Considerations
- Patients who plan to leave with their children (applies to children for whom the abusive partner is the biological or adoptive parent) should call one of the shelter lines to learn how to file a "Good Cause Report" which can protect them from kidnapping charges

IV. Definitions

A. Assaultive or abusive conduct is defined to include a list of 24 criminal offenses, among which are murder, manslaughter, torture, battery, sexual battery, incest, assault with a deadly weapon, rape, spousal rape, abuse of spouse or cohabitant, sodomy, oral copulation and an attempt to commit any of these crimes

ATTACHMENTS: SUSPICIOUS INJURY REPORT

State of California
Office of Emergency Services
(www.oes.ca.gov)

MANDATED SUSPICIOUS INJURY REPORT

CAL OES 2-920

For copies of this form or assistance in completing the Cal OES 2-920, please contact the
California Clinical Forensic Medical Training Center:
(916) 930-3080 or
Contact Us @ www.ccfmtc.org

SUSPICIOUS INJURY REPORT

STATE OF CALIFORNIA
California Office of Emergency Services

Cal OES 2-920

Confidential Document

Penal Code Section 11160 requires that if any health practitioner, within their scope of their employment, provides medical services for a wound or physical injury inflicted as a result of assaultive or abusive conduct, or by means of a firearm, shall make a telephone report immediately or as soon as possible. They shall also prepare and submit a written report within 2 working days of receiving the information to a local law enforcement agency. This is the official form (Cal OES 2-920) for submitting the written report.

This form is used by law enforcement only and is confidential in accordance with Section 11163.2 of the Penal Code. In no case shall the person identified as a suspect be allowed access to the injured person's whereabouts.

Part A: PATIENT WITH SUSPICIOUS INJURY

1. Name of Patient (Last, First, Middle)	2. Birth Date	3. Gender ☐ M ☐ F	4. SAFE Telephone Number

5. Patient Address (Number and Street / Apt – **No P.O. Box**) City State Zip

6. Patient Speaks English ☐ Yes ☐ No If No, identify language spoken:_____	7. Date and Time of Injury Date: Time: ☐ am ☐ pm ☐ unknown

8. Location / Address Where Injury Occurred, if Available. Check here if unknown: ☐

9. Patient description of the incident. Include any identifying information about the person the patient alleges caused the injury and the names of any persons who may know about the incident. ☐ Additional Pages Attached

10.Name of Suspect, if Identified by the Patient	11. Relationship to Patient. ☐ No Relationship

12. Suspicious Injury Description. Include a brief description of physical findings, lab tests completed or pending, and other pertinent information. ☐ Additional Pages

Part B: REQUIRED – AGENCIES RECEIVING PHONE AND WRITTEN REPORTS

13. Law Enforcement Agency Notified By Phone (Mandated by PC 11160)	14. Date and Time Reported Date: Time: am pm

15. Name of Person Receiving Phone Report (First and Last)	16. Title	17. Phone Number

18. Law Enforcement Agency Receiving Written Report (Mandated by PC 11160)	19. Agency Incident Number

Part C: PERSON FILING REPORT

20. Name of Health Practitioner (First and Last)	Title	Telephone

21. Employer's Name	Phone Number

22. Employer's Address (Number and Street) City State Zip

23. HEALTH PRACTITIONER'S SIGNATURE:	26. Date Signed:

Reset Form

PCP	
Section: Personnel	
POLICY AND PROCEDURE: Sensitive Services/Minors Rights	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:
Site personnel receive training and/or information on member rights that include minors' rights to sensitive services. Provide medical services per California Law Family Code to protect minors' rights to sensitive services.

PROCEDURE:

I. Written Member Rights shall be available at the office site. Staff shall be able to locate the written Member Rights list and explain how to use the information.

II. Staff trainings regarding member rights shall be part of office staff education documented in:
- Informal or formal in-services
- New staff orientation
- External training courses

III. Sensitive Services/Minors' Rights

A. Parental consent is not required for members under the age of 18 to access pregnancy-related services, including family planning. **California Law Family Code Section 6925.

B. A minor who is 12 years of age or older and who may have come into contact with an infectious, contagious, or communicable disease may consent to medical care related to the diagnosis or treatment of the disease, if the disease or condition is one that is required by law or regulation adopted pursuant to law to be reported to the local health officer, or is a related sexually transmitted disease, as may be determined by the State Director of Health Services.

The minor's parents or guardian are not liable for payment for medical care provide pursuant to this section. ** California Law Family Code Section 6926 (6920-6929).

C. A minor who is 12 years of age or older and who is alleged to have been raped may consent to medical care related to the diagnosis or treatment of the condition and the collection of medical evidence with regard to the alleged rape.

D. A minor who is 12 years of age or older may consent to medical care and counseling relating to the diagnosis and treatment of a drug- or alcohol-related problem.

E. A minor who is 12 years of age or older and who states that the minor is injured as a result of intimate partner violence may consent to medical care related to the diagnosis or treatment of the injury and the collection of medical evidence with regard to the alleged intimate partner violence.

F. A minor who is alleged to have been sexually assaulted may consent to

medical care related to the diagnosis and treatment of the condition, and the collection of medical evidence with regard to the alleged sexual assault. The professional person providing medical treatment shall attempt to contact the minor's parent or guardian and shall note in the minor's treatment record the date and time the professional person attempted to contact the parent or guardian and whether the attempt was successful or unsuccessful. This does not apply if the professional person reasonably believes that the minor's parent or guardian committed the sexual assault on the minor.

G. A minor may consent to the minor's medical care or dental care if all of the following conditions are satisfied:
   1. The minor is 15 years of age or older.
   2. The minor is living separate and apart from the minor's parents or guardian, whether with or without the consent of a parent or guardian and regardless of the duration of the separate residence.
   3. The minor managing the minor's own financial affairs, regardless of the source of the minor's income.
      a. The parents or guardians are not liable for medical care or dental care provided pursuant to this section.
      b. A physician and surgeon or dentist may, with or without the consent of the minor patient, advise the minor's parent or guardian of the treatment given or needed if the physician and surgeon or dentist has reason to know, on the basis of the information given by minor, the whereabouts of the parent or guardian. ** California Law Family Code Section 6922 (6920-6929).

H. Special Precautions must be taken to ensure that communication regarding the medical information of a minor related to sensitive services is protected (i.e. letters and phone calls should NOT be directed to the home without the minor's authorization).
   1. Communications are directly to minor's designated alternative mailing address, email address, or telephone number; OR,
   2. In the absence of a designated alternative mailing address, email address, or telephone number: to the address or telephone number on file in the name of the minor.
   3. Communications regarding a protected minor's receipt of sensitive services shall include:
      • Bills and attempts to collect payment.
      • A notice of adverse benefits determinations.
      • An explanation of benefits notice.
      • A plan's request for additional information regarding a claim.
      • A notice of a contested claim.
      • The name and address of a provider, description of services provided, and other information related to a visit.
      • Any written, oral, or electronic communication from a plan that contains protected health information

RESOURCES: California Law Family Code Section 6920-6930 Codes Display Text (ca.gov)
Civil Code Section 56 et seq. Codes Display Text (ca.gov)

ATTACHMENT: California Minor Consent and Confidentiality Laws

CALIFORNIA MINOR CONSENT AND CONFIDENTIALITY LAWS*

MINORS OF ANY AGE MAY CONSENT	LAW/DETAILS	MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?
PREGNANCY	"A minor may consent to medical care related to the prevention or treatment of pregnancy," except sterilization. (Cal. Family Code § 6925**).**	The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. The provider can only share the minor's medical information with them with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).
CONTRACEPTION	A minor may receive birth control without parental consent. (Cal. Family Code § 6925).	
ABORTION	A minor may consent to an abortion without parental consent. (Cal. Family Code § 6925; *American Academy of Pediatrics v. Lungren,* 16 Cal.4th 307 (1997)).	The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. The provider can only share the minor's medical information with them with a signed authorization from the minor. (*American Academy of Pediatrics v. Lungren,* 16 Cal.4th 307 (1997); Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).
SEXUAL ASSAULT[1] SERVICES [1]For the purposes of minor consent alone, sexual assault includes acts of oral copulation, sodomy, and other crimes of a sexual nature.	"A minor who [may] have been sexually assaulted may consent to medical care related to the diagnosis,…treatment and the collection of medical evidence with regard to the …assault." (Cal. Family Code § 6928).	The health care provider must attempt to contact the minor's parent/guardian and note in the minor's record the day and time of the attempted contact and whether it was successful. This provision does not apply if the treating professional reasonably believes that the parent/guardian committed the assault. (Cal. Family Code § 6928). Both rape and sexual assault of a minor are considered child abuse under California law and must be reported as such to the appropriate authorities by mandated reporters. The child abuse authorities investigating a child abuse report legally may disclose to parents that a report was made. (See Cal. Penal § 11167 and 11167.5.)
RAPE[2] SERVICES FOR MINORS UNDER 12 YRS[3] [2]Rape is defined in Cal. Penal Code **§ 261**. [3]See also "Rape Services for Minors 12 and Over" on page 3 of this chart	A minor under 12 years of age who may have been raped "may consent to medical care related to the diagnosis,…treatment and the collection of medical evidence with regard" to the rape. (Cal. Family Code § 6928).	

MINORS OF ANY AGE MAY CONSENT	LAW/DETAILS	MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?
EMERGENCY MEDICAL SERVICES* *An emergency is "*a situation . . . requiring immediate services for alleviation of severe pain or immediate diagnosis of unforeseeable medical conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death*" (Cal. Code Bus. & Prof. § 2397(c)(2)).	A provider shall not be liable for performing a procedure on a minor if the provider "reasonably believed that [the] procedure should be undertaken immediately and that there was insufficient time to obtain [parental] informed consent." (Cal. Bus. & Prof. Code § 2397).	The parent or guardian usually has a right to inspect the minor's records. (Cal. Health & Safety Code §§ 123110(a); Cal. Civ. Code § 56.10. *But see exception at endnote ([EXC.])).*
SKELETAL X-RAY TO DIAGNOSE CHILD ABUSE OR NEGLECT* * The provider does not need the minor's or her parent's consent to perform a procedure under this section.	"A physician and surgeon or dentist or their agents . . . may take skeletal X-rays of the child without the consent of the child's parent or guardian, but only for purposes of diagnosing the case as one of possible child abuse or neglect and determining the extent of." (Cal. Penal Code § 11171.2).	Neither the physician-patient privilege nor the psychotherapist-patient privilege applies to information reported pursuant to this law in any court proceeding.
MINORS 12 YEARS OF AGE OR OLDER MAY CONSENT	**LAW/DETAILS**	**MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?**
INFECTIOUS, CONTAGIOUS COMMUNICABLE DISEASES (DIAGNOSIS, TREATMENT)	"A minor who is 12 years of age or older and who may have come into contact with an infectious, contagious, or communicable disease may consent to medical care related to the diagnosis or treatment of the disease, if the disease… is one that is required by law…to be reported…." (Cal. Family Code § 6926).	The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. The provider can only share the minor's medical information with them with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).
SEXUALLY TRANSMITTED DISEASES (PREVENTIVE CARE, DIAGNOSIS, TREATMENT)	A minor 12 years of age or older who may have come into contact with a sexually transmitted disease may consent to medical care related to the prevention, diagnosis or treatment of the disease. (Cal. Family Code § 6926).	

MINORS 12 YEARS OF AGE OR OLDER MAY CONSENT	LAW/DETAILS	MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?
AIDS/HIV TESTING AND TREATMENT	A minor 12 and older is competent to give written consent for an HIV test. (Cal. Health and Safety Code § 121020). A minor 12 and older may consent to medical car related to the prevention, diagnosis and treatment of HIV/AIDS. (Cal. Family Code § 6926).	The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. The provider can only share the minor's medical information with them with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).
RAPE SERVICES FOR MINORS 12 and OVER	"A minor who is 12 years of age or older and who is alleged to have been raped may consent to medical care related to the diagnosis or treatment of the condition and the collection of medical evidence with regard to the alleged rape." (Cal. Family Code **§** 6927).	The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. The provider can only share the minor's medical information with them with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11). <u>RAPE</u> Rape of a minor is considered child abuse under California law and mandated reporters, including health care providers, must report it as such. Providers cannot disclose to parents that they have made this report without the adolescent's authorization. However, adolescent patients should be advised that the child abuse authorities investigating the report may disclose to parents that a report was made.

MINORS 12 YEARS OF AGE OR OLDER MAY CONSENT	LAW/DETAILS	MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?
OUTPATIENT MENTAL HEALTH SERVICES[4]/ SHELTER SERVICES [4]This section does not authorize a minor to receive convulsive therapy, psychosurgery or psychotropic drugs without the consent of a parent or guardian.	Two statutes give minors the right to consent to mental health treatment. If a minor meets the criteria under either statute, the minor may consent to his or her own treatment. If the minor meets the criteria under both, the provider may decide which statute to apply. There are differences between them. See endnote ** for more on these differences: <u>Family Code § 6924</u> "A minor who is 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis or to residential shelter services, if both of the following requirements are satisfied: (1) The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services. AND (2) The minor (A) would present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling or residential shelter services, or (B) is the alleged victim of incest or child abuse." (Cal. Family Code § 6924.) <u>Health & Safety Code § 124260</u> "[A] minor who is 12 years of age or older may consent to [outpatient] mental health treatment or counseling services if, in the opinion of the attending professional person, the minor is mature enough to participate intelligently in the mental health treatment or counseling services." (Cal. Health & Saf. Code § 124260.)	<u>MENTAL HEALTH TREATMENT:</u> The health care provider is required to involve a parent or guardian in the minor's treatment unless the health care provider decides that such involvement is inappropriate. This decision and any attempts to contact parents must be documented in the minor's record. (Cal. Fam. Code § 6924; 45 C.F.R. 164.502(g)(3)(ii).) For services provided under Health and Safety Code § 124260, providers must consult with the minor before deciding whether to involve parents. (Cal. Health & Saf. Code § 124260(a).) While this exception allows providers to inform and involve parents in treatment when appropriate, it does not give providers a right to disclose medical records to parents without the minor's authorization. The provider can only share the minor's medical records with parents with a signed authorization from the minor. (Cal. Health & Saf. Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11, 56.30; Cal. Welf. & Inst. Code § 5328. *See also endnote(*[EXC]).) <u>SHELTER:</u> Although minor may consent to service, the shelter must use its best efforts based on information provided by the minor to notify parent/guardian of shelter services.

MINORS 12 YEARS OF AGE OR OLDER MAY CONSENT	LAW/DETAILS	MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?
DRUG AND ALCOHOL ABUSE TREATMENT • This section does not authorize a minor to receive replacement narcotic abuse treatment without the consent of the minor's parent or guardian. • This section does not grant a minor the right to refuse medical care and counseling for a drug or alcohol related problem when the minor's parent or guardian consents for that treatment. (Cal. Family Code § 6929(f)).	"A minor who is 12 years of age or older may consent to medical care and counseling relating to the diagnosis and treatment of a drug or alcohol related problem." (Cal. Family Code §6929(b)).	There are different confidentiality rules under federal and state law. Providers meeting the criteria listed under 'federal' below must follow the federal rule. Providers that don't meet these criteria follow state law. **FEDERAL**: Federal confidentiality law applies to any individual, program, or facility that meets the following two criteria: 1. The individual, program, or facility is federally assisted. (Federally assisted means authorized, certified, licensed or funded in whole or in part by any department of the federal government. Examples include programs that are: tax exempt; receiving tax-deductible donations; receiving any federal operating funds; or registered with Medicare.)(42 C.F.R. §2.12); **AND** 2. The individual or program: 1) Is an individual or program that holds itself out as providing alcohol or drug abuse diagnosis, treatment, or referral; **OR** 2) Is a staff member at a general medical facility whose primary function is, and who is identified as, a provider of alcohol or drug abuse diagnosis, treatment or referral; **OR** 3) Is a unit at a general medical facility that holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral. (42 C.F.R. §2.11; 42 C.F.R. §2.12). For individuals or programs meeting these criteria, federal law prohibits disclosing any information to parents without a minor's written consent. One exception, however, is that an individual or program may share with parents if the individual or program director determines the following three conditions are met: (1) that the minor's situation poses a substantial threat to the life or physical well-being of the minor or another; (2) that this threat may be reduced by communicating relevant facts to the minor's parents; and (3) that the minor lacks the capacity because of extreme youth or a mental or physical condition to make a rational decision on whether to disclose to her parents. (42 C.F.R. §2.14). **STATE RULE**: Cal. Family Code §6929(c). Parallels *c*onfidentiality rule described under "Mental Health Treatment" at page 4 above. *See also exception at endnote ([EXC]).*

MINOR 15 YEARS OF AGE OR OLDER	LAW/DETAILS	MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?
GENERAL MEDICAL CARE	"A minor may consent to the minor's medical re or dental care if all of the following conditions are satisfied: (1) The minor is 15 years of age or older. (2) The minor is living separate and apart om the minor's parents or guardian, whether with r without the consent of a parent or guardian and gardless of the duration of the separate residence.) The minor is managing the minor's own financial affairs, regardless of the source of the minor's income." (Cal. Family Code § 6922(a).)	"A physician and surgeon or dentist may, with or without the consent of the minor patient, advise the minor's parent or guardian of the treatment given or needed if the physician and surgeon or dentist has reason to know, on the basis of the information given by the minor, the whereabouts of the parent or guardian." (Cal. Family Code § 6922(c). *See also exception at endnote (EXC)).*
MINOR MUST BE EMANCIPATED (GENERALLY 14 YEARS OF AGE OR OLDER)	**LAW/DETAILS**	**MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?**
GENERAL MEDICAL CARE for EMANCIPATED YOUTH	An emancipated minor may consent to medical, dental and psychiatric care. (Cal. Family Code § 7050(e)). *See* Cal. Family Code § 7002 for emancipation criteria.	The health care provider is not permitted to inform a parent or legal guardian without minor's consent. The provider can only share the minor's medical information with them with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).

Endnotes:

* There are many confidentiality and consent rules. Different rules apply in different contexts. This chart addresses the rules that apply when minors live with their parents or guardians. It does not address the rules that apply when minors are under court jurisdiction or in other special living situations. Further, the confidentiality section focuses on parent and provider access. It does not address when other people or agencies may have a right to access otherwise confidential information.

** In addition to having slightly different eligibility criteria, there are other small differences between Health and Safety Code §124260 and Family Code § 6924. For example, the two laws both allow "professional persons" to deliver minor consent services but the two laws define "professional person" differently. Also, there is a funding restriction that applies to Health and Safety Code §124260 but not to Family Code § 6924. (See Cal. Family Code 6924, Cal. Health & Saf. Code § 124260 and Cal. Welf. & Inst. Code § 14029.8 and look for more information on www.teenhealthlaw.org.).

EXC: Providers may refuse to provide parents access to a minor's medical records, where a parent normally has a right to them, if "the health care provider determines that access to the patient records requested by the [parent or guardian] would have a detrimental effect on the provider's professional relationship with the minor patient or the minor's physical safety or psychological well-being." Cal. Health & Safety Code § 123115(a)(2). A provider shall not be liable for any good faith decisions concerning access to a minor's records. Id.

PCP	
Section: Personnel/Office Management	
POLICY AND PROCEDURE: Cultural and Linguistics / Interpreter Services	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:

All patients shall be assessed for cultural and ethnic characteristics that may affect behaviors and treatment. All clinical staff shall demonstrate understanding of cultural and ethnic variances related to illness and care of patients. Every effort will be made to adapt services to meet specific needs within cultural and ethnic differences. These differences may affect communication, activities of daily living, food practices, beliefs about medicines and healing, responses to pain and touch, birth and death rituals, family relationships and spiritual health practices.

PROCEDURE:

I. All staff shall demonstrate sensitivity to different culture and ethnic backgrounds especially when caring for patients with different cultural and ethnic needs.

II. Providing services to persons with different cultural and ethnic backgrounds:

1. The most effective tool in working with patients from other cultural and ethnic background is respect. Patients may pick up quickly when there is a tone of condescension of judgement that comes from a staff person. Negative non-verbal communication is powerful in rendering ineffective care. Look for aspects of the patient's culture that are admirable.

2. Accept responsibility for any misunderstanding that may occur rather than expecting the patient to bridge the cultural and ethnic gap.

3. Do not assume anything about anyone, even though you are "well-read" about the practices of a particular group. Be willing to admit that you do not know. Remember, you are in an insider to your own cultural and an outsider to another ethnicity and culture.

4. If a staff or provider has difficulty working with patients from another culture, that staff or provider must assess and address those barriers when working with patients from that culture.

5. The more conscious you are of your own biases, the more open minded and understanding you can be.

6. Assume there are good reasons for why patients do what they do. Depending on the culture and other reasons, patients make decisions that you may not be privy to.

7. Listen actively and carefully. Listen not only for factual information but closely watch the patient's reaction. Notice what the patient asks about. Stop talking as soon as the patient seems they have something to say. Accept silence as a natural part of conversation.

8. Give non-judgmental feedback to be sure you heard what you thought you heard. Be careful about how literal you take things and how literal your statements might be taken.

9. Expect to enjoy meeting patients with experiences different from your own. There may be times when we seek out the familiar people and things, but cultural venturing can be stimulating and gratifying.

10. Notice and remember what patients call themselves. Be a bit on the formal side at first in language and behavior until you are more acquainted. Be sure to remain professional whether more formal or more casual.

11. If it appears to be appreciated, act as a cultural guide-coach to the patient. Look for ethnic and cultural guides or coaches, to help you put things in perspective. Ask questions. Some people appreciate interest in their experiences. Be careful, though, because asking questions may have a judgement tone, implying that the thing you ask is not acceptable.

12. If someone speaks more loudly than you, or stand more still, adjust your behavior. Watch cultural groups interacting among themselves and learn what their norms are.

III. What Successful Communicators Never Do

1. Never make assumptions based on a person's appearance, name, and membership in a group. Do not expect people of a group to look, act and think alike.

2. Never show amusement or shock at something that is strange to you.

3. Never imply that the established way of doing things is the only way or the best way. This refers to lifestyles, not laws, rules or regulations.

LINGUISTIC SERVICES

POLICY:

According to the Department of Justice, "People who are completely bilingual are fluent in two languages. They can conduct the business of the workplace in either of those languages. Bilingual staff can assist in meeting the Title VI and Executive Order 13166 requirement for federally conducted and federally assisted programs and activities to ensure meaningful access to LEP (limited English proficient) persons."

One of the primary ways that bilingual staff can be used as part of a broader effort to ensure meaningful access is to have them conduct business with the agencies' LEP clients directly in the clients' primary language." "This is sometimes called "monolingual communication in a language other than English."

POLICY AND PROCEDURE: Cultural and Linguistics / Interpreter Services	

An interpreter is defined as a person who provides immediate communication of meaning from one language (the source language) into another (the target language). An interpreter is usually a third party who interprets between speakers who speak different languages.
The site has 24-hour access to interpreter services for non-/LEP members and the hearing impaired.

PROCEDURE:

I. Staff shall ensure that interpreter services are made available in identified threshold languages specified for location of site.

II. All personnel providing language interpreter services on site are trained/competent in medical interpretation.

III. The provider/designee shall assess interpreter skills and capabilities of their staff providing interpreter services using at least one or more of the following (please check all that apply):

1. Assessment of interpreter skills may include written or oral assessment of bilingual skills.
2. Documentation of the number of years of employment as an interpreter or translator.
3. Documentation of successful completion of a specified type of interpreter training programs, i.e., medical, legal, court, or semi-technical; OR
4. Other reasonable alternative documentation of interpreter capability as specified below:

_____
_____
_____

IV. Staff shall document in the medical record any request for, or refusal of, language interpreter services and the name of the interpreter.

V. The PCP shall ensure that 24-hour language and hearing-impaired interpreter services are available for all members either through telephone/video language services or interpreters on site.

You may download any of the forms that we reference on our website:
Cultural awareness and linguistics program | Blue Shield of CA (blueshieldca.com)

For printed copies, you may call the Cultural & Linguistic Department at (800) 468-9935.
Email BlueShieldofCAHealthEducation@blueshieldca.com

Blue Shield of California
Promise Health Plan
601 Potrero Grande Drive
Monterey Park, CA 91755
Cultural & Linguistics Department
1-323-889-6638 ext. 3397

Monday - Friday
8:30 AM to 5:00 PM
Except Holidays

Hard of Hearing Assistance TTY
(through California Relay Service)
1-800-735-2929
24-hours, 7 days a week

RESOURCES:

Provider Cultural & Linguistics Responsibilities 2019 (blueshieldca.com)
Protocol for How to Access Interpreting Services (blueshieldca.com)
Protocol for TTY-TDD Assistance (blueshieldca.com)
Los Angeles and Orange County Community Resource Directory (blueshieldca.com)
San Diego County Community Resource Directory and Referral Request form (blueshieldca.com)

ATTACHMENTS: Request/Refusal Form for Interpretive Services (English)
Request/Refusal Form for Interpretive Services (Spanish)
Free American Sign Language Interpreter Services - poster
Language Assistance Notice

blue california | Promise Health Plan

Request/Refusal Form for Interpretive Services

Patient name: _____

Primary language: _____

☐ **Yes, I am requesting interpretive services.**
Language(s): _____

☐ **No, I prefer to use my family or friend as an interpreter.**

☐ **No, I do not require interpretive services.**

☐ **Not Applicable.**

Please explain:

_____

_____

_____ _____

Patient Signature **Date**

Please place this form in the patient's medical record.
Request/Refusal - English

blue california | Promise Health Plan

Formulario Para Solicitar/Rechazar Servicios de Intérprete

Nombre del paciente: _____

Idioma preferido: _____

☐ **Si, necesito servicios de intérprete.**
Idioma(s):
_____

☐ **No, Prefiero utilizar un familiar o amistad como intérprete.**

☐ **No, requiero servicios de intérprete.**

☐ **No, me corresponde.**

Por favor explique:

_____

_____

_____
Firma del paciente

_____
Fecha

Please place this form in the patient's medical record. Request/Refusal - Spanish

Blue Shield of California Promise Health Plan members can get free interpretation services including **American Sign Language**.

Ask your doctor's office or pharmacist.

SPANISH	Los miembros de Blue Shield of California Promise Health Plan pueden obtener servicios de interpretación gratis, incluyendo el lenguaje de señas americano. Consulte en la oficina de su doctor o farmacéutico.
ARMENIAN	Blue Shield of California Promise Health Plan - ի անդամները կարող են ստանալ անվճար թարգմանչական ծառայություններ, այդ թվում՝ Ամերիկյան նշանալեզվի ծառայություններ: Հարցրեք ձեր առողջական խնամքի մատակարարողին կամ դեղագործին:
CHINESE	Blue Shield of California Promise Health Plan 計劃會員可以獲得免費口譯服務，其中包 括美國手語。請向您的醫生診所或藥劑師詢問。
FARSI	اعضای Blue Shield of California Promise Health Plan می توانند خدمات ترجمه رایگان را که شامل زبان اشاره آمریکایی می شود دریافت کنند. از ارائه دهنده مراقبت های درمانی و یا داروساز خود سؤال کنید.
KHMER	សមាជិក Blue Shield of California Promise Health Plan អាចទទួលសេវាបកប្រែភាសាដោយឥតគិតថ្លៃ រួមទាំងភាសាសញ្ញាអាមេរិកាំង ផងដែរ។ សូមសាកសួរការិយាល័យនៃវេជ្ជបណ្ឌិត ឬឱសថការរបស់អ្នក។
KOREAN	Blue Shield of California Promise Health Plan 가입자에게는 미국수화를 포함한 무료 언어통역서비스가 제공됩니다. 의료제공자나 약사에게 문의하십시오.
RUSSIAN	Все участники программы Blue Shield of California Promise Health Plan могут бесплатно воспользоваться услугами переводчика, в том числе переводчика американского языка жестов. Обращайтесь к своему поставщику медицинских услуг или фармацевту.
TAGALOG	Ang mga miyembro ng Blue Shield of California Promise Health Plan ay maaaring mabigyan ng libreng serbisyo ng pagsasalin-wika kasama na ang American Sign Language. Magtanong sa iyong tagabigay ng pangangalaga ng kalusugan o parmasyotiko.
VIETNAMESE	Hội viên Blue Shield of California Promise Health Plan có thể sử dụng dịch vụ thông dịch miễn phí kể cả dịch vụ thông dịch ngôn ngữ bằng dấu hiệu Hoa Kỳ. Xin hỏi chuyên viên y tế hoặc dược sĩ.
ARABIC	يستطيع أعضاء Blue Shield of California Promise Health Plan الحصول على خدمات الترجمة الفورية مجاناً. بما فيها لغة الإشارة الأمريكية. أطلب ذلك من مكتب طبيبك أو صيدلي/ صيدلانية.

To request telephonic or face-to-face interpreting services, please call Customer Care at:

1-800-605-2556 for LA Medi-Cal members
1-855-699-5557 for SD Medi-Cal members
1-855-905-3825 for CalMediConnect members

blue california

Promise Health Plan

www.blueshieldca.com/promise

0022-0312-CL

blue california
Promise Health Plan

Language Assistance Notice

English
ATTENTION: If you need help in your language call 1-800-605-2556 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-605-2556 (TTY: 711). These services are free of charge.

الشعار بالعربية (Arabic)
يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ 1-800-605-2556 (TTY: 711). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ 1-800-605-2556 (TTY: 711). هذه الخدمات مجانية.

Հայերեն պիտակ (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք 1-800-605-2556 (TTY՝ 711) հեռախոսահամարով: Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք 1-800-605-2556 (TTY՝ 711) հեռախոսահամարով: Այդ ծառայություններն անվճար են:

ឃ្លាសំគាល់ភាសាខ្មែរ (Cambodian)
ចំណាំ៖ បើសិនអ្នកត្រូវការជំនួយ ជាភាសារបស់អ្នក សូមទូរស័ព្ទទៅលេខ 1-800-605-2556 (TTY: 711) ។ ជំនួយ និងសេវា សំរាប់ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរប្រៃ្រល សំរាប់ជនពិការភ្នែក ឬឯកសារជាអក្សរពុម្ពធំៗ ក៏មានដែរ។ ទូរស័ព្ទមកលេខ 1-800-605-2556 (TTY: 711)។ សេវាទាំងនេះមិនគិតថ្លៃឡើយ។

简体中文标语 (Chinese)
请注意：如果您需要以您的母语提供帮助，请致电 1-800-605-2556（TTY: 711）。另外还提供针对残疾人士的帮助和服务，例如文盲和需要较大字体阅读，也是方便取用的。请致电 1-800-605-2556（TTY: 711）。这些服务都是免费的。

مطلب به زبان فارسی (Farsi)
توجه: اگر میخواهید به زبان خود کمک دریافت کنید، با 1-800-605-2556 (TTY: 711) تماس بگیرید.
کمکها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با 1-800-605-2556 (TTY: 711) تماس بگیرید. این خدمات رایگان ارائه میشوند.

Medi_21_58_LA_09142021
MU 0004142 ENG1 0321

Blue Shield of California Promise Health Plan
601 Potrero Grande Drive | Monterey Park, CA 91755

हिन्दी टैगलाइन (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-800-605-2556 (TTY: 711) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 1-800-605-2556 (TTY: 711) पर कॉल करें। ये सेवाएं निःशुल्क हैं।

Nqe Lus Hmoob Cob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1-800-605-2556 (TTY: 711). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 1-800-605-2556 (TTY: 711). Cov kev pab cuam no yog pab dawb xwb.

日本語表記 (Japanese)

注意日本語での対応が必要な場合は1-800-605-2556 (TTY: 711) へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。1-800-605-2556 (TTY: 711) へお電話ください。これらのサービスは無料で提供していますへお電話ください。これらのサービスは無料で提供しています。

한국어 태그라인 **(Korean)**

유의사항: 귀하의 언어로 도움을 받고 싶으시면 1-800-605-2556 (TTY: 711)번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1-800-605-2556 (TTY: 711)번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແທກໄລພາສາລາວ (Laotian)

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ 1-800-605-2556 (TTY: 711). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະ ມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ 1-800-605-2556 (TTY: 711). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien Tagline (Mien)

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-800-605-2556 (TTY: 711). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-800-605-2556 (TTY: 711). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1-800-605-2556 (TTY: 711)। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਕਾਲ ਕਰੋ 1-800-605-2556 (TTY: 711)। ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

Русский слоган (Russian)

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1-800-605-2556 (линия TTY: 711). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 1-800-605-2556 (линия TTY: 711). Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)
ATENCIÓN: Si necesita ayuda en su idioma, llame al 1-800-605-2556 (TTY: 711). Para las personas con discapacidades, también hay asistencia y servicios gratuitos disponibles, como documentos en braille y letra grande. Llame al 1-800-605-2556 (TTY: 711). Estos servicios son gratuitos.

Tagalog Tagline (Tagalog)
PAUNAWA: Kung kailangan ninyo ng tulong sa inyong wika, tumawag sa 1-800-605-2556 (TTY: 711). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malalaking titik. Tumawag sa 1-800-605-2556 (TTY: 711). Libre ang mga serbisyong ito.

แท็กไลน์ภาษาไทย (Thai)
โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-605-2556 (TTY: 711) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-605-2556 (TTY: 711) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Примітка українською (Ukrainian)
УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1-800-605-2556 (TTY: 711). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер 1-800-605-2556 (TTY: 711). Ці послуги безкоштовні.

Khẩu hiệu tiếng Việt (Vietnamese)
CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-800-605-2556 (TTY: 711). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số 1-800-605-2556 (TTY: 711). Các dịch vụ này đều miễn phí.

PCP	
Section: Personnel	
POLICY AND PROCEDURE: Disability Rights and Provider Obligations	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:
Site shall be accessible and useable by individuals with physical disabilities. The site will meet city, county and state building structure and access ordinances for persons with physical disabilities.

PROCEDURE:

I. A notice of consumer civil rights shall be posted in a prominent location in the clinic.

II. The site shall maintain the following safety accommodations available for physically disabled persons or has an alternative plan in place for making program services available to persons with physical disabilities (see checked items that apply):

1. Designated disabled parking spaces are located near the primary entrance.

A. Parking spaces for persons with physical disabilities are located in close proximity to accessible building entrances.

B. Each parking space reserved for persons with disabilities is identified by a permanently affixed reflectorized sign posted in a conspicuous place; or reasonable alternative if the provider has no control over availability of accessible parking within the lot or nearby street spaces for persons with disabilities:_____
_____

C. Staff will assist disabled members who choose to continue to seek care at the site, in spite of inaccessibility.

D. Staff will discuss the plan with the member prior to a scheduled appointment. A meeting point, as near as possible to an entrance, will be agreed upon.

E. Staff will meet the member at the scheduled time/place, and assist the member as appropriate.

2. Pedestrian ramps with a clear and level landing at the top and bottom of all ramps and on each side of an exit door – if the clinic has multiple levels.

3. Exit and exam room doorway openings have minimum opening of 32 inches with the door open at 90 degrees to allow for clear passage of a person in a wheelchair; or reasonable alternative:
_____

A. Door hardwares are operable with a single effort without requiring ability to grasp hardware (latch or push-bars instead of door knobs)

B. Effort to operate interior doors do not exceed 5 pounds of pressure

C. Furniture and other items do not obstruct exit doorways or interfere with door swing pathway

4. Accessible passenger elevator for multi-level floor accommodation; or reasonable alternative:

   _____

5. Clear floor space (at least 30-in. x 48-in.) for wheelchair in waiting area and exam room to accommodate a single, stationary adult wheelchair and occupant; and a minimum clear space of 60-inch diameter or square area to turn a wheelchair; or reasonable alternative:

   _____

6. Wheelchair accessible restroom facilities are available; or reasonable alternative:

   _____

7. Wheelchair accessible handwashing facilities are available; or reasonable alternative:

   _____

8. A 24-hour language and hearing-impaired interpreter services are available for all members either through telephone/video language services or interpreters on site
9. Other accommodations or specialized equipment (i.e., heigh adjustable exam tables, wheelchair accessible weight scales, signage in raised letters and Braille, etc.):

   _____

   _____

10. Health education materials are made available to the members in alternative formats; providers can obtain these materials from there contracted health plans Health Education Departments.

II. CHANGES IN ACCESS/AVAILABILITY

A. Notification

1. If at any time the site becomes inaccessible to physically disabled individuals, all contracted health plans will be notified in writing.

RESOURCES:

DHCS PL 12-006 Physical Accessibility Review Survey Information and Tool
https://www.hhs.gov/sites/default/files/ocr/civilrights/resources/factsheets/504.pdf
https://www.hhs.gov/sites/default/files/section-1557-final-rule-faqs.pdf
https://www.hhs.gov/sites/default/files/1557-fs-lep-508.pdf
https://www.ecfr.gov/search

ATTACHMENT: Notice of Nondiscrimination (sample)

Appendix A to Part 92—Sample Notice Informing Individuals About Nondiscrimination and Accessibility Requirements and Sample Nondiscrimination Statement:

Discrimination is Against the Law

[Name of covered entity] complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. [Name of covered entity] does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

[Name of covered entity]:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:

○ Qualified sign language interpreters

○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:

○ Qualified interpreters

○ Information written in other languages

If you need these services, contact [Name of Civil Rights Coordinator]

If you believe that [Name of covered entity] has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: [Name and Title of Civil Rights Coordinator], [Mailing Address], [Telephone number], [TTY number—if covered entity has one], [Fax], [Email]. You can file a

grievance in person or by mail, fax, or email. If you need help filing a grievance, [Name and Title of Civil Rights Coordinator] is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

PCP	
Section: Personnel	
POLICY AND PROCEDURE: Disability Rights and Provider Obligations	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:
Site shall be accessible and useable by individuals with physical disabilities. The site will meet city, county and state building structure and access ordinances for persons with physical disabilities.

PROCEDURE:

I. A notice of consumer civil rights shall be posted in a prominent location in the clinic.

II. The site shall maintain the following safety accommodations available for physically disabled persons or has an alternative plan in place for making program services available to persons with physical disabilities (see checked items that apply):

1. Designated disabled parking spaces are located near the primary entrance.

A. Parking spaces for persons with physical disabilities are located in close proximity to accessible building entrances.

B. Each parking space reserved for persons with disabilities is identified by a permanently affixed reflectorized sign posted in a conspicuous place; or reasonable alternative if the provider has no control over availability of accessible parking within the lot or nearby street spaces for persons with disabilities:_____
_____

C. Staff will assist disabled members who choose to continue to seek care at the site, in spite of inaccessibility.

D. Staff will discuss the plan with the member prior to a scheduled appointment. A meeting point, as near as possible to an entrance, will be agreed upon.

E. Staff will meet the member at the scheduled time/place, and assist the member as appropriate.

2. Pedestrian ramps with a clear and level landing at the top and bottom of all ramps and on each side of an exit door – if the clinic has multiple levels.

3. Exit and exam room doorway openings have minimum opening of 32 inches with the door open at 90 degrees to allow for clear passage of a person in a wheelchair; or reasonable alternative:
_____

A. Door hardwares are operable with a single effort without requiring ability to grasp hardware (latch or push-bars instead of door knobs)

B. Effort to operate interior doors do not exceed 5 pounds of pressure

C. Furniture and other items do not obstruct exit doorways or interfere with door swing pathway

4. Accessible passenger elevator for multi-level floor accommodation; or reasonable alternative:

   _____

5. Clear floor space (at least 30-in. x 48-in.) for wheelchair in waiting area and exam room to accommodate a single, stationary adult wheelchair and occupant; and a minimum clear space of 60-inch diameter or square area to turn a wheelchair; or reasonable alternative:

   _____

6. Wheelchair accessible restroom facilities are available; or reasonable alternative:

   _____

7. Wheelchair accessible handwashing facilities are available; or reasonable alternative:

   _____

8. A 24-hour language and hearing-impaired interpreter services are available for all members either through telephone/video language services or interpreters on site
9. Other accommodations or specialized equipment (i.e., heigh adjustable exam tables, wheelchair accessible weight scales, signage in raised letters and Braille, etc.):

   _____

   _____

10. Health education materials are made available to the members in alternative formats; providers can obtain these materials from there contracted health plans Health Education Departments.

II. CHANGES IN ACCESS/AVAILABILITY

A. Notification

1. If at any time the site becomes inaccessible to physically disabled individuals, all contracted health plans will be notified in writing.

RESOURCES:

DHCS PL 12-006 Physical Accessibility Review Survey Information and Tool
https://www.hhs.gov/sites/default/files/ocr/civilrights/resources/factsheets/504.pdf
https://www.hhs.gov/sites/default/files/section-1557-final-rule-faqs.pdf
https://www.hhs.gov/sites/default/files/1557-fs-lep-508.pdf
https://www.ecfr.gov/search

ATTACHMENT: Notice of Nondiscrimination (sample)

Appendix A to Part 92—Sample Notice Informing Individuals About Nondiscrimination and Accessibility Requirements and Sample Nondiscrimination Statement:

Discrimination is Against the Law

[Name of covered entity] complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. [Name of covered entity] does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

[Name of covered entity]:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:

○ Qualified sign language interpreters

○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:

○ Qualified interpreters

○ Information written in other languages

If you need these services, contact [Name of Civil Rights Coordinator]

If you believe that [Name of covered entity] has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: [Name and Title of Civil Rights Coordinator], [Mailing Address], [Telephone number], [TTY number—if covered entity has one], [Fax], [Email]. You can file a

grievance in person or by mail, fax, or email. If you need help filing a grievance, [Name and Title of Civil Rights Coordinator] is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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PCP	
Section: Office Management	
POLICY AND PROCEDURE: Provision of services 24 hours/day	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:

The site/clinic shall have a provision for appropriate, coordinated access to health care services 24 hours a day, seven (7) days a week.

PROCEDURE:

A. The Clinic staff shall ensure that office hours are posted or readily available upon request.

B. The Provider office hour schedules are always available to all staff during office hours.

C. The PCP shall ensure that the following current site-specific resource information are available to site personnel and members related to the following:
   1. Physician office after-hours schedule(s),
   2. Group and/or Plan-specific systems for after-hours urgent care,
   3. Emergent provider/on-call coverage available 24 hours a day, 7 days per week, and
   4. A system for providing follow-up care.

D. When the PCP is not on site during regular office hours, personnel are able to contact the provider (or covering provider) by telephone, cell phone, pager, etc.

E. During after-hours or when the PCP is not on site during regular office hours, the PCP (or covering provider) shall respond to urgent/emergent member matters within 30 minutes.

F. Telephone answering machine, voice mail system or answering service are used whenever office staff does not directly answer phone calls.

G. Telephone system, answering service, recorded telephone information, and recording device are periodically checked and updated to ensure functionality and validity of information:
   - ☐ Monthly
   - ☐ Quarterly
   - ☐ Other: _____

H. After-hours emergent, urgent, and routine care instructions/clinic information are made available to patients. The site has the following answering service/machine greeting and instructions (if different from below, see attached script):

"You have reached the office of _____ (Clinic/PCP name). Our office is currently closed. If this is a life-threatening emergency, hang up and call 911 or go to the nearest emergency room. If this is urgent matter and you need to speak to the doctor, please call _____ (provider's after-hours phone or pager number). Your call will be returned within 30 minutes. For routine matters such as appointments or prescription refills, please leave a message after the tone. Please be sure to include your name and your telephone number with the area code. We will return your call during our normal office hours. Our normal office hours are _____ (day) through _____ (day), _____ (opening time) until _____ (closing time. "

OTHER AFTER-HOURS SAMPLE SCRIPT:

One of the following scripts may be used by your medical group as a template for ensuring members have access to timely medical care after normal business hours.
IMPORTANT: Effective telephone service after normal business hours providers for callers to reach a live voice or answering machine within 45 seconds.

I. CALLS ANSWERED BY A LIVE VOICE (E.G. ANSWERING SERVICE OR CENTRALIZED TRIAGE):

If the caller believes the situation is an emergency, advise the caller to call 911 immediately.

If the caller believes the situation is an emergency, advise the caller to call 911 immediately or proceed to the nearest Emergency Room or Urgent Care Center. Give the address of the Emergency Room or Urgent Care.

If the member indicates a need to speak with a physician, facilitate the contact with the physician by:

a) Putting the caller on hold momentarily and then connecting the caller to the on-call physician, or
b) Get the members number and advise a physician will call them back within 30 minutes, or,
c) Provide the caller with the doctor's number or pager number and advise the caller to call back if they have not heard from the Provider within 30 minutes, and
d) If a member indicates a need for interpreter services, facilitate the contact by accessing interpreter services.

II. CALLS ANSWERED BY AN ANSWERING MACHINE

POLICY AND PROCEDURE: Provision of Services 24hrs/day	

If this is an emergency, please hang up and call 911immedicatly.
Hello, you have reached _____ (Name of the Doctor/Medical Group). If you wish to speak with the physician on-call,

a) Please hold and you will be connected to _____ (Provider's name).
b) You may reach the on-call doctor directly by calling_____ (Provider's after-hours telephone number).
c) Please call _____ (Provider's after-hours telephone number). The doctor will be paged, and you may expect a return call within 30 minutes.
If you do not hear from the doctor within 30 minutes, please go to the Urgent Care Center or the nearest Emergency Room (if an Urgent Care Center is not available).
d) Our urgent Care Center is located at _____ (Address and telephone number).
[Appropriate language options should be provided for the location.]

EJEMPLO DE GUION PARA DESPUES DEL HORARIO DE ATTENCION MEDICA

Cualquiera de los siguientes guiones puede ser utilizado como guia por su grupo medico, para asegurarse de que los miembros reciban atencion medica oportuna despues del horario normal de atencion.

IMPORTANTE: El servicio telefonico efectivo despues del horario normal de atencion hace posible que las personas que llaman, se comuniquen con una persona o con un contestador automatico dentro en un lapso de 45 segundos.

I. LLAMADAS RESPONDIDAS POR EL PERSONAL (POR EJEMPLO, POR UN SERVICIO DE ATENCION DE LLAMADAS O DE GUARDIAS CENTRALIZADAS):

Si la persona que llama cree que la situacion constituye una emergencia, aconsejele que llame al 911 immediatamente.

Si la persona que llama cree que la situacion puede ser de emergencia o es urgent, aconsejele que llame al 911 immediatamente o que acuda a la sala de emergencias o al centro de atencion de urgencias mas cercanos. Proporcionele la direccion de la sala de emergencia o del centro de atencion de urgencias.

Si el miembro le idica la necesidad de hablar con un medico, facilitele el contacto con el medico, de la siguiente manera:

a) Coloque a la persona que llama momentaneamente en espera y luego comuniquela con el medico de guardia o,
b) Obtenga el numero telefonico del miembro e indiquele que un medico le llamara en el lapso de 30 minutos o,
c) Proporcionele a la persona que llama el numero del localizador del medico de guardia y aconsejele qye vuelva a llamar si no ha tenido noticias del medico en el lapso de 30 minutos.
d) Si el miembro le indica que necesita los servicios de un interprete, facilitele la comunicacion, accediendo a los servicios de interpretacion.

POLICY AND PROCEDURE: Provision of Services 24hrs/day	

II. LLAMADAS RESPONDIDAS POR UN CONTESTADOR AUTOMATICO:

Si es una emergencia, por favor cuelgue y llame immediatamente al 911.

Hola, usted se a comunicado con (nombre del medico/ Grupo medico). Si desea hablar con el medico de guardia:

a. Por Favor, espere y sera comunicado con el Dr. _____ (nombre).\
b. Usted Puede comunicarse directamente con el medico de guardia llamando al _____/.
c. Por favor, llame al _____ /. El medico recibira el mensaje en su localizador y usted Debera esperar la llamada del medico, que se producria en el lapso de una hora. Si no recibe noticias del medico dentro de dicho plazo por favor acuda a la sala de emergencias o al centro de atencion de urgencias disponible,
d. Nuestra sala de emergencias o el centro se atencion de urgencias se encuentraubicado en _____/*.

[Para la ubicacion deben porporcionarse las opciones adecuadas de idiomas)

PCP	
Section: Office Management	
POLICY AND PROCEDURE: Triage	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:

The site shall have sufficient health care personnel to provide timely, appropriate health care services. Triage is the sorting and classification of information to determine priority of need and proper place of treatment. Telephone triage is the system for managing telephone callers during and after office hours. "Triage" or "screening" means the assessment of an enrollee's health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage an enrollee who may need care for the purpose of determining the urgency of the enrollee's need for care (Section 1300.67 of Title 28 of the California Code of Regulations).

PROCEDURE:

A. The PCP will ensure that appropriate personnel handle emergent, urgent, and medical advice telephone calls. This includes licensed medical personnel such as a CNM, NP, RN or PA. LVN's cannot perform triage independently (MCPB letter 92-15). LVNs and unlicensed personnel such as medical assistants may provide patient information or instructions only as authorized by the physician (Title 16, 1366b)

B. Staff will ensure that a telephone answering machine, voice mail system or answering service is utilized whenever office staff does not directly answer phone calls.

- The medical practitioner is responsible for the answering service it uses. If a member calls after hours or on a weekend for a possible medical emergency, the practitioner is held liable for authorization of, or referral to emergency care given by the answering service. There must be a message immediately stating, "If this is an emergency, hang up and call 911 or go to the nearest emergency room."

- Answering service staff handling member calls cannot provide telephone medical advice if they are not a licensed, certified, or registered health care professional.

Staff members may ask questions on behalf of a licensed professional to help ascertain the condition of the member so that the member can be referred to licensed staff; however, they are not permitted, under any circumstance, to use the answers to questions, to assess, evaluate, advise, or make any decision regarding the condition of the member, or to determine when a member needs to be seen by a licensed medical professional.

Unlicensed telephone staff should have clear instructions on the parameters relating to the use of answers in assisting a licensed provider

C. Staff will ensure that the telephone system, answering service, recorded telephone information, and recording devices are periodically checked and updated (Refer to suggested scripts in Provisions of Care 24 hours/day Policy).

D. Health Plans encourage that Answering Services follow these steps when receiving a call:

- Inform the member that if they are experiencing a medical emergency, they should hang up and call 911 or proceed to the nearest emergency medical facility.

- Question the member according to the PCP's or PPG's established instructions, (who, what, when, and where) to assess the nature and extent of the problem.

- Contact the on-call physician with the facts as stated by the member.

- After office hours, physicians are required to return telephone calls and pages within 30 minutes. If an on-call physician cannot be reached, direct the member to a medical facility where emergency or urgent care treatment can be given. This is considered authorization, which is binding and cannot be retracted.

PCP	
Section: Office Management	
POLICY AND PROCEDURE: Appointments and Patient Recall	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:

Systems, practices, and procedures are established on site that provides timely access to appointments for routine care, urgent care, prenatal care, pediatric periodic health assessments/immunizations, adult initial health assessments, specialty care and emergency care.

PROCEDURE:

A. Patients will be notified of scheduled routine and/or preventive screening appointments and remind members of scheduled appointments and/or preventive screening appointments.

B. The PCP shall provide an initial health assessment (IHA) for each adult member within 120 days of the date of enrollment, unless the member's PCP determine that the member's medical record contains complete and current information consistent with the assessment requirements within periodicity time requirements.

C. The Health Plan shall follow its procedure to advise the plan members of the availability and value of scheduling an IHA appointment. The Health Plan will provide monthly eligibility reports to PCPs, listing the members' names, addresses, and telephone numbers. If a member or guardian refuses to have an IHA performed, this information shall be documented in the member's medical record.

D. Missed and/or canceled appointments and contact attempts via mail or phone must be documented in the member's medical record. At least three attempts shall be made and documented in the patient's medical record.

E. The PCP shall ensure that appointments are scheduled according to the patient's clinical needs and within the following timeliness standards:

- Primary care appointment (adult and pediatric):
  - Urgent Care that does not require prior authorization: **within 48hours**
  - Urgent Care that requires prior authorization: **within 96 hours**
  - Non-Urgent Care: **within 10 business days**
  - Preventive care appointment: **within 30 business days**
  - Access to the first Prenatal Visit: **within 10 business days**
  - Well child Visit: **within 14 days**
  - Routine Specialty Care visit: **within 15 business days**

PCP	
Section: Clinical Services	
POLICY AND PROCEDURES: Pharmaceutical Services	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:

The site will maintain competent, efficient, and ethical Pharmaceutical Services According to state and federal statues for the health and safety of its patients

PROCEDURE:

I. Drugs and medication supplies are maintained secure to prevent unauthorized access:

A. All drugs (including sample and over-the-counter medications), medication supplies, prescription pads, and hazardous substances are securely stored in a lockable space (e.g., a room, closet, cabinet, drawer, etc.) within the office/clinic (CA B&P Code, §4051.3). Keys to the locked storage area are available only to staff authorized by the physician to have access (16 CCR, Chapter, Division 3, §1356.32).

- During business hours, the lockable space may remain unlocked ONLY if there is no access to this area by unauthorized persons and authorized clinic personnel always remain in the immediate area. At all other times, all prescription pads and hazardous substances must be securely locked.

1. Controlled drugs are stored separately from other drugs, in a secured, lockable space accessible ONLY to authorized personnel (including physicians, dentists, podiatrists, physician assistants, licensed nurses and pharmacists) (Control Substance Act, CFR §1301.75). There is no need for the controlled substances to be double locked.
- Controlled Substances include all Schedule I, II, III, IV, and V substances listed in the CA Health and Safety Code, §§11053-11058.

2. A dose-by-dose controlled substance distribution log maintained and includes the following:
   a) Date
   b) Provider's DEA number
   c) Name of controlled substance
   d) Original quantity of controlled substance
   e) Dose administered, Number of doses remaining
   f) Name of patient receiving controlled substance
   g) Name of authorized person dispensing controlled substance

II. Drugs are managed safely and stored appropriately.

Preparation:

- Drugs are prepared in a clean area, or a "designated clean" area if prepared in a multipurpose room.

- Drugs or medication supplies are considered "adulterated" if it contains any filthy, putrid, or decomposed substance, or if it has been prepared, packed, or held under unsanitary conditions (21 USC §351).

1. Storage:

- Items other than medications in refrigerator/freezer are kept in a secured, separate, compartment from drugs, as these items may potentially cause contamination.
- Drugs are stored separately from test reagents, germicides, disinfectants, and other household substances.
- Drugs are stored under appropriate conditions of temperature, humidity, and light, so that the identity, strength, quality, and purity of the drug product are not affected (21 CFR, §211.142). Room temperature where drugs are stored does not exceed 30ºC (86ºF) (Title 22, §75037(d)).

2. Immunobiologics:

- Vaccines are placed in a refrigerator or freezer (not on the door) immediately upon receipt on site and are stored according to specific instructions in the package insert for each vaccine.
- Vaccines, such as DTP, DtaP, DT, Td, Hep A, Hep B, Enhanced Inactive Polio (E-IPV), and Pneumococcal, are kept in a refrigerator maintained at 2°- 8°C, or 35°- 46°F (at time of visit). [MMR and varicella are always protected from light and kept cold]. Oral polio vaccine (OPV), MMR, MMRV and varicella vaccines are stored in a freezer maintained at -15°C, or 5°F, or lower (at time of visit). Failure to adhere to recommended specifications for storage and handling immunobiologics could make these products impotent.
- A written plan for vaccine protection in case of power outage or malfunction of the refrigerator or freezer is required for VFC providers (see Attachments).
- Site personnel can verbalize the procedures in the plan used to promptly respond to out of range temperatures.
- Refrigerator and freezer temperatures must be checked at least once a day (required twice daily for VFC providers) and documented (U.S. Pharmacopeial Convention Regulations and Recommendations)). CDC recommends use of a continuous temperature monitoring device (data loggers), calibrated at least every 2 years, to monitor vaccine storage unit temperatures. Data loggers should have a minimum accuracy of +/- 1°F (0.5°C), be equipped with buffered probe, an active temperature display outside of the unit, and the capacity for continuous monitoring and recording where the data can be routinely downloaded. A back-up device should be readily available for emergency vaccine transport or when

primary data logger is sent in for calibration.

- The CA DHS Immunization Branch recommends checking temperatures twice a day, first thing in the morning and last thing at night (see Attachments).
- The most current Vaccine Information Statements (VIS) are available from state and local health departments or can be downloaded from the CDC website at **http://www.cdc.gov/vaccines/pubs/vis/default.htm** or by calling the CDC Immunization Hotline at **800-CDC-INFO (800-232-4636).**

3. Hazardous substances (Substances that are physical or health hazards):

- Safety practices on site are followed in accordance with current/updated CAL-OSHA standards.
- The manufacturer's label is not removed from a container if the hazardous material (or residue from the material) remains in the container.
- All portable containers of hazardous chemicals and secondary containers (into which hazardous substances are transferred or prepared) require labeling. Hazardous substances are appropriately labeled with the following information:
    a. Identity of hazardous substance
    b. Description of hazard warning: can be word, pictures, symbols
    c. 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. **
- Site has method(s) in place for drug and hazardous substance disposal. Proper disposal is via the site's contracted/licensed medical waste hauler.

III. Drugs are administered or dispensed according to State and Federal drug distribution laws and regulations.

A. Drug Dispensing and Administration

- Drug dispensing follows all applicable State and Federal laws and regulations. Drugs are not offered for sale, charged, or billed to Medi-Cal members (Business and Professions Code, Article 13, §4193).

- Criteria for selecting pharmaceutical manufacturers and suppliers shall be established to ensure that patients receive pharmaceuticals and related supplies of the highest quality.

- The clinic shall govern the activities of manufacturers' representatives or vendors of drug products (including related supplies and devices) within the ambulatory care setting. Representatives

should not be permitted access to patient care areas and should be provided with guidance on permissible activities. All promotional materials and activities
shall be reviewed and approved by the provider.

- Adequate inventory controls must be maintained to allow proper inventory levels of medications based on utilization.

- A list of drugs available for dispensing or administration in the clinic shall be maintained (see Attachments).

- Each prescription medication is dispensed in a container that is not cracked, soiled, or without secure closures (Title 22, CCR, §75037 (a)).

- **Drugs are dispensed ONLY** by a physician, pharmacist, or other persons (i.e., NP, CNM, RN, PA) lawfully authorized to dispense medication upon the order of a licensed physician or surgeon. **Personnel, such as medical assistants, office managers, and receptionists DO NOT DISPENSE DRUGS**.

- A record of all drugs dispensed is entered in the patient's medical record.

- California Pharmacy Law does not prohibit furnishing a limited quantity of sample drugs if dispensed to the patient in the package provided by the manufacturer, no charge is made to the patient, and appropriate documentation is made in the patient's medical record (CA Business and Professions Code, §§ 4170-4171).

- Administration of medications ordered by the licensed practitioner may be completed by the MA using the following procedures:

a. Prepare medication in a **clean area.**
b. Have the ordering practitioner or another licensed practitioner (i.e., MD, NP, PA, CNM, RN, LVN) verify the medication and dosage prior to administration of the drug by:
  - o Showing the bottle or vial and medicine cup or syringe to the verifying practitioner
  - o Show the patient's chart and original medication order to another verifying practitioner when the ordering practitioner is not available
  - o Administer to the patient only after a licensed practitioner has checked the prepared medication for the correct medication, correct dose, correct route, and the appropriate time; and the patient's identity is verified.

c. To help reduce the risk of medication errors, staff shall confirm the patient's identity prior to administration by asking the patient/parent, to confirm the patient's name and date of birth.

d. Drugs and vaccines are prepared and drawn only prior to administration.

e. Unused prefilled syringes shall be discarded if not used within the same day that they are filled. Unused syringes that are prefilled by the manufacturer and

activated (i.e., syringe cap removed, or needle attached) shall be discarded at the end of the clinic day.

NOTE: No MA may administer any anesthetic agent, or any medication mixed with an anesthetic agent (e.g., Rocephin diluted with Xylocaine).

- All vaccines administered in the clinic shall be reported by the clinic to an immunization registry (i.e., California Immunization Registry or "CAIR").

B. Vaccine Information Statements (VIS):

- Since 1994, the National Childhood Vaccine Injury Act (§2126 of the Public Health Services Act) mandates that parents/guardians or adult patients be informed before vaccines are administered. Health care providers must give a copy of the most recent VIS to patients prior to each vaccination dose of ALL vaccines (i.e., DTaP, Td/Tdap, MMR, Influenza, Hepatitis A/B, Pneumococcal, etc.). VIS sheets for all vaccines are available through the CDC website: **http://www.cdc.gov/vaccines/pubs/vis/default.htm**

- VIS sheets for distribution to patients are present on site. Site personnel should be able to verbalize standard practices regarding VIS distribution.

- The date the VIS was given, and the publication date of the VIS MUST be documented in the patient's medical record. (See Attachments)

- The most current Vaccine Information Statements (VIS) are available from state and local health departments or can be downloaded from the CDC website at **http://www.cdc.gov/vaccines/pubs/vis/default.htm** or by calling CDC Immunization Hotline at **800-CDC-INFO (800-232-4636).**

C. Prescription Labeling:

All stored and dispensed prescription drugs are appropriately labeled with the following:

a. Provider's name
b. Patient's name
c. Drug name
d. Dose
e. Frequency
f. Route
g. Quantity dispensed
h. Manufacturer's name and lot number

D. Pharmacy:

- If there is a pharmacy on site, it is licensed by the CA State Board of Pharmacy, with a licensed pharmacist monitoring drug distribution and

current policies/procedures for drug storage and dispensing.

E. Drug Expiration:

- There are no expired drugs on site, as they may not be distributed or dispensed.
- The manufacturer's expiration date must appear on the label of all drugs. All prescription or over the counter (OTC) drugs not bearing the expiration date are deemed to have expired.
- Multi-dose vials (MDV): Per CDC, MDV injectable expire 28 days once opened unless manufacturer recommends a longer or shorter expiration date. Vials must be labeled with date opened. Unlabeled open vials are deemed to have expired.
- Site follows the procedures below to monitor for expiration date and a method of dispose of expired medications/hazardous substances (i.e., sample medications), vaccines, and infant formula. A tracking log is the preferred method of tracking expiration dates (see Attachments).

Frequency of Monitoring:	Method of Disposal:
□ Monthly, □ Weekly, or □ Other:	Prescription & OTC drugs / hazardous substances / infant formula: Vaccines:

NOTE: All site review survey deficiencies related to Pharmaceutical Services REQUIRE a corrective action plan.

ATTACHMENTS:
Vaccine Disaster Recovery Plan
Monthly Potency Verification Log
Temperature Log for Freezer (Celsius & Fahrenheit)
Temperature Log for Refrigerator (Celsius & Fahrenheit)
Emergency Response Worksheet – for Vaccines
Controlled Substance Log

Vaccine Disaster Recovery Plan

Practice Name:	**County:**
Person Completing Form:	**Date:**

If **you have any questions about vaccine transportation or stability call: 1-877-243-8832 (CA Vaccines for Children Program**

In advance of emergency, all providers should:

1. Identify an alternative storage facility (e.g., hospital, health department, fire department, etc.) with backup power (generator) where the vaccine can be properly stored and monitored for the interim.
2. Ensure the availability of staff to pack and move the vaccine.
3. Maintain the appropriate packing materials (coolers, gel packs, dry ice for Varicella, etc.)
4. Ensure a means of transport for the vaccine to the secure storage facility.

NOTE: Whenever possible, facilities should suspend vaccine activities BEFORE the onset of emergency conditions to allow sufficient time for packing and transporting vaccine.

Emergency Procedures

A. List emergency phone numbers, companies, and points of contact for:

Designated person(s) responsible for:

- **0** Monitoring the operation of the vaccine storage equipment and systems daily.
- **0** Track inclement weather conditions. Set up and maintain a monitoring/notification system during times of inclement weather or other conditions that would create a shutdown in power. An alarm/notification system is recommended for practices with an inventory of $5000 or more.
- **0** Assure the appropriate handling of the vaccine during the disaster or power outage.

Name of Employee	Title of Employee	Work Phone	Home Phone
Primary			
Backup			

Determine if your refrigerator is having a mechanical failure (no lights in the refrigerator, no fan noise, etc.) or if the building has lost electrical power. Check with the building maintenance to ensure that the generator is operational and has been activated. If a timeframe for the restoration

cannot be determined, implement the following procedures.

Designated Company responsible for restoring electrical power to location in the event of a power failure.

Electrical Power Company	Point Of Contact	Work Phone	Emergency Phone

Building Maintenance	Point Of Contact	Work Phone	Emergency Phone

Designated Company responsible for Repair where the compressor or other refrigerator equipment has been destroyed or you need emergency maintenance.

Name of repair company	Point Of Contact	Work Phone	Emergency Phone

Designated Company responsible for: Supplying Dry Ice for Varicella/MMR packing, when a location with a backup generator cannot be identified within a reasonable distance. Preparations should be made to have coolers, frozen ice packs and/ or dry ice to temporarily and safely store your Varicella/MMR vaccine.

Name of Dry Ice Company	Point Of Contact	Telephone Number

B. List Back-up locations, phone numbers and points of contacts for:

- A location with a backup generator. This may be the local hospital, retirement home, fire station, another practice or an employees' home. Make arrangements with the site to store your vaccine there when inclement weather predictions call for such inclement weather and when your vaccine storage equipment cannot be fixed, or the power cannot be

restored within 6 hours. Before moving your Vaccine, call the location to ensure their back-up generator is working.

Alternate Facility	Point Of Contact	Work Phone	Emergency Phone

C. Entering Vaccine Storage Facility:

Describe how to enter the building and vaccine storage spaces in an emergency if closed or after hours. Include a floor diagram and the locations of:

Item	Location
Doors	
Flashlights	
Spare Batteries	
Light Switches	
Keys	
Locks	
Alarms	
Circuit Breakers	
Packing Materials	

D. Conduct an inventory before you transport the vaccine.

E. Package the vaccine in a well-insulated container with ice packs.
Unpackaged vials of DtaP, eiPV, Hib, Hep A,Hep *AlB,* Influenza, PCV7, PPV23, etc., must not directly touch cold packs as the vaccine may be inactivated. It is best to keep vaccines in their original package during transport. MMR is the exception and may be Transported directly on cold packs. Remember that Varicella must be kept frozen therefore package Varicella separately from the other vaccines. Do not expose the other vaccines (except MMR) to freezing temperatures.

F. Move vaccines to back up storage according to pre-arranged plans.
• How to load transportation vehicle

- Routes to take (alternative routes if necessary)
- Time in route

G. Ensure vaccine containers are properly in the emergency storage facility.
(Varicella and MMR in the freezer; refrigerated vaccines in refrigerator, adequate circulation, functioning temperature monitoring devices, etc.)

H. Preparation:
Fill the empty space in your refrigerator with jugs of water and line the sides and bottom of your freezer with ice packs. In the event that your refrigerator/freezer is out of order, this practice will help maintain the temperature for a longer period of time.

I. Other useful information:

Immunization Branch California Department of Health Services
www.dhs.ca.gov
2151 Berkeley Way Room 712 Berkeley, CA 94704
1-877-243-8832

National Weather Service
www.nws.noaa.gov/

Vaccine Manufacturers:

Merck Sharpe & Dhome	1-800-672-6372
Aventis Pasteur	1-800-822-2463
GlaxoSmith Kline	1-888-825-5249
Wyeth Lederle Labs	1-800-666-7248

MONTHLY POTENCY VERIFICATION LOG

Month Year_____.	MEDICATION ROOM In refrigerator and freezer, in cabinets	EXAM ROOMS Medications, fixative, culture medium	SAMPLE MEDICATIONS	LABORATORY Vacutainer tubes, culture medium, collection systems, disinfectants	UTILITY ROOM Cidex, disinfectants
January					
February					
March					
April					
May					
June					
July					
August					
September					
October					
November					
December					

Notes:

1. Please initial & date each category as you check the items
2. An initial indicates that the items were checked, expired items were properly disposed, and replaced as appropriate.
3. Dated items expire on the last date of the month, unless the manufacturer stamped a specific expiration date on the package
4. No item will be kept beyond the manufacturer's expiration date.

PP-4-905-A

Temperature Log for Freezer – Celsius

DAYS 1–15

Month/Year _____ **VFC PIN or other ID #** _____

Facility Name _____

Monitor temperatures closely!

1. Write your initials below in "Staff Initials," and note the time in "Exact Time."
2. Record temps twice each workday.
3. Record the min/max temps once each workday—preferably in the morning.
4. Put an "X" in the row that corresponds to the freezer's temperature.
5. If any out-of-range temp, see instructions to the right.
6. After each month has ended, save each month's log for 3 years, unless state/local jurisdictions require a longer period.

Take action if temp is out of range—too warm (above -15°C) or too cold (below -50°C).

1. Label exposed vaccine "do not use," and store it under proper conditions as quickly as possible. Do not discard vaccines unless directed to by your state/local health department and/or the manufacturer(s).
2. Record the out-of-range temps and the room temp in the "Action" area on the bottom of the log.
3. Notify your vaccine coordinator, or call the immunization program at your state or local health department for guidance.
4. Document the action taken on the "Vaccine Storage Troubleshooting Record" on page 3.

Day of Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Staff Initials															
Exact Time	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Min/Max Temp (since previous reading)															
Danger! Temperatures above -15°C are too warm! Write any out-of-range temps and room temp on the lines below and call your state or local health department immediately!															
ACCEPTABLE TEMPERATURES -15°C															
-16°C															
-17°C															
-18°C															
-19°C															
-20°C															
-21°C															
-22°C															
-50°C to -23°C															
ACTION Write any out-of-range temps (above -15°C or below -50°C) here.															
Room Temperature															

If you have a vaccine storage issue, also complete "Vaccine Storage Troubleshooting Record" found on page 3.

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Technical content reviewed by the Centers for Disease Control and Prevention
www.immunize.org/catg.d/p3037C.pdf ▪ Item #P3038C (8/13)

Temperature Log for Freezer – Celsius

DAYS 16–31

Month/Year _____ VFC PIN or other ID # _____

Facility Name _____

Monitor temperatures closely!

1. Write your initials below in "Staff Initials," and note the time in "Exact Time."
2. Record temps twice each workday.
3. Record the min/max temps once each workday—preferably in the morning.
4. Put an "X" in the row that corresponds to the freezer's temperature.
5. If any out-of-range temp, see instructions to the right.
6. After each month has ended, save each month's log for 3 years, unless state/local jurisdictions require a longer period.

Take action if temp is out of range—too warm (above -15°C) or too cold (below -50°C).

1. Label exposed vaccine "do not use," and store it under proper conditions as quickly as possible. Do not discard vaccines unless directed to by your state/local health department and/or the manufacturer(s).
2. Record the out-of-range temps and the room temp in the "Action" area on the bottom of the log.
3. Notify your vaccine coordinator, or call the immunization program at your state or local health department for guidance.
4. Document the action taken on the "Vaccine Storage Troubleshooting Record" on page 3.

Day of Month	16		17		18		19		20		21		22		23		24		25		26		27		28		29		30		31	
Staff Initials																																
Exact Time	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Min/Max Temp (since previous reading)																																
Danger! Temperatures above -15°C are too warm! Write any out-of-range temps and room temp on the lines below and call your state or local health department immediately!																																
ACCEPTABLE TEMPERATURES **-15°C**																																
ACCEPTABLE TEMPERATURES **-16°C**																																
ACCEPTABLE TEMPERATURES **-17°C**																																
ACCEPTABLE TEMPERATURES **-18°C**																																
ACCEPTABLE TEMPERATURES **-19°C**																																
ACCEPTABLE TEMPERATURES **-20°C**																																
ACCEPTABLE TEMPERATURES **-21°C**																																
ACCEPTABLE TEMPERATURES **-22°C**																																
ACCEPTABLE TEMPERATURES **-50°C to -23°C**																																
ACTION Write any out-of-range temps (above -15°C or below -50°C) here.																																
ACTION Room Temperature																																

If you have a vaccine storage issue, also complete "Vaccine Storage Troubleshooting Record" found on page 3.

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Vaccine Storage Troubleshooting Record (check one) ☐ Refrigerator ☐ Freezer

Use this form to document any unacceptable vaccine storage event, such as exposure of refrigerated or frozen vaccines to temperatures that are outside the manufacturers' recommended storage ranges.
A fillable troubleshooting record (i.e., editable PDF or WORD document) can also be found at www.immunize.org/clinic/storage-handling.asp.

Date & Time of Event If multiple, related events occurred, see Description of Event below.	**Storage Unit Temperature** at the time the problem was discovered		**Room Temperature** at the time the problem was discovered	**Person Completing Report**	
Date:	Temp when discovered:		Temp when discovered:	Name:	
Time:	Minimum temp:	Maximum temp:	Comment (optional):	Title:	Date:

Description of Event *(If multiple, related events occurred, list each date, time, and length of time out of storage.)*

- General description (i.e., what happened?)
- Estimated length of time between event and last documented reading of storage temperature in acceptable range (35° to 46°F [2° to 8°C] for refrigerator; -58° to 5°F [-50° to -15°C] for freezer)
- Inventory of affected vaccines, including (1) lot #s and (2) whether purchased with public (for example, VFC) or private funds (Use separate sheet if needed, but maintain the inventory with this troubleshooting record.)
- At the time of the event, what else was in the storage unit? For example, were there water bottles in the refrigerator and/or frozen coolant packs in the freezer?
- Prior to this event, have there been any storage problems with this unit and/or with the affected vaccine?
- Include any other information you feel might be relevant to understanding the event.

Action Taken *(Document thoroughly. This information is critical to determining whether the vaccine might still be viable!)*

- When were the affected vaccines placed in proper storage conditions? (Note: Do not discard the vaccine. Store exposed vaccine in proper conditions and label it "do not use" until after you can discuss with your state/local health department and/or the manufacturer[s].)
- Who was contacted regarding the incident? (For example, supervisor, state/local health department, manufacturer—list all.)
- IMPORTANT: What did you do to prevent a similar problem from occurring in the future?

Results

- What happened to the vaccine? Was it able to be used? If not, was it returned to the distributor? (Note: For public-purchase vaccine, follow your state/local health department instructions for vaccine disposition.)

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www.immunize.org/catg.d/p3041.pdf ▪ Item #P3041 (8/13)

Vaccine Storage Troubleshooting Record (check one) ☐ Refrigerator ☑ Freezer

Use this form to document any unacceptable vaccine storage event, such as exposure of refrigerated or frozen vaccines to temperatures that are outside the manufacturers' recommended storage ranges.
A fillable troubleshooting record (i.e., editable pdf or WORD document) can also be found at www.immunize.org/clinic/storage-handling.asp

Date & Time of Event If multiple, related events occurred, see Description of Event below.	**Storage Unit Temperature** at the time the problem was discovered		**Room Temperature** at the time the problem was discovered	**Person Completing Report**	
Date: 7/16/2013	Temp when discovered: 13°C		Temp when discovered: 25°C	Name: Nancy Nurse	
Time: 8:00 am	Minimum temp: -17°C	Maximum temp: 14°C	Comment (optional): temp is approx	Title: VFC Coordinator	Date: 7/15/13

Description of Event *(If multiple, related events occurred, list each date, time, and length of time out of storage.)*

- General description (i.e., what happened?)
- Estimated length of time between event & last documented reading of storage temperature in acceptable range (35° to 46°F [2° to 8°C] for refrigerator; -58° to 5°F [-50° to -15°C] for freezer)
- Inventory of affected vaccines, including (1) lot #s and (2) whether purchased with public (for example, VFC) or private funds (Use separate sheet if needed, but maintain the inventory with this troubleshooting record)
- At the time of the event, what else was in the storage unit? For example, were there water bottles in the refrigerator and/or frozen coolant packs in the freezer?
- Prior to this event, have there been any storage problems with this unit and/or with the affected vaccine?
- Include any other information you feel might be relevant to understanding the event.

When checked vaccine freezer (in lab) at 8:00 am on Tuesday, 7/16/2013, discovered freezer door slightly ajar. Digital readout on data logger read 13°C. Data logger located in center of freezer with probe in glycol. Review of computer readings (taken every 15 minutes) showed steady rise in temps from -17°C at 5:30 pm (7/15/2013) to 13°C reading discovered when arrived at clinic on Tuesday morning (7/16/2013). Readings hit -14°C at 11 pm (7/15) and 7°C at 2 am (7/16). Total time out of recommended storage temp of -15°C or below = 9 hours. (See attached document of continuous temp readings.) Freezer contained Varivax, ProQuad, and Zostavax (inventory attached).

Frozen packs stored on freezer floor and shelves in door. No recent adjustments to temp controls and no previous temp excursions noted with this freezer before 7/15.

Action Taken *(Document thoroughly. This information is critical to determining whether the vaccine might still be viable!)*

- When were the affected vaccines placed in proper storage conditions? (Note: Do not discard the vaccine. Store exposed vaccine in proper conditions and label it "do not use" until after you can discuss with your state/local health department and/or the manufacturer[s].)
- Who was contacted regarding the incident? (For example, supervisor, state/local health department, manufacturer—list all.)
- IMPORTANT: What did you do to prevent a similar problem from occurring in the future?

Upon discovery, vaccines marked "Do Not Use" and stored in 2nd clinic freezer (in exam room #3) at -17°C. Also placed "Do Not Use" note on main freezer in lab. Notified Susie Supervisor about the issue. Contacted Victor Vaccine at My State Immunization Program at 8:30 am. Provided Victor with details of event and list of vaccines in freezer. Victor said to maintain vaccines in 2nd freezer and that he would check with Merck (manufacturer of all the affected vaccines) to determine next steps. Called Jim's Appliance Repair to examine freezer. Repairman replaced freezer door gasket and recommended removal of ~½ of freezer packs in door because size and weight of packs potentially interfered with door closing completely. No problems identified with thermostat or other mechanical components.

Removed half of freezer packs located in shelf in door, per recommendation. Reset data logger on center shelf of freezer with probe in glycol. All staff received refresher training on ensuring freezer door is closed after each use, and a reminder sign was placed prominently on freezer door.

Results

- What happened to the vaccine? Was it able to be used? If not, was it returned to the distributor? (Note: For public-purchase vaccine, follow your state/local health department instructions for vaccine disposition.)

After repair, monitored temps in empty freezer for 1 week, per state requirements. Freezer maintained -18° to -17°C temps for entire week. Submitted repair documentation and data logger readings to Victor Vaccine for approval and ordered replacement vaccines. Victor had checked with manufacturer. After reviewing history and stability data, manufacturer stated vaccine was acceptable for continued use. Discussed entire situation with Susie Supervisor and clinic director, Dr. Immunize, who agreed on continued use of vaccine. Vaccine to be labeled as "use first."

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www.immunize.org/catg.d/p3041.pdf ▪ Item #P3041 (8/13)

Temperature Log for Freezer – Fahrenheit

DAYS 1–15

Month/Year _____ VFC PIN or other ID # _____

Facility Name _____

Monitor temperatures closely!

1. Write your initials below in "Staff Initials," and note the time in "Exact Time."
2. Record temps twice each workday.
3. Record the min/max temps once each workday—preferably in the morning.
4. Put an "X" in the row that corresponds to the freezer's temperature.
5. If any out-of-range temp, see instructions to the right.
6. After each month has ended, save each month's log for 3 years, unless state/local jurisdictions require a longer period.

Take action if temp is out of range—too warm (above 5°F) or too cold (below -58°F).

1. Label exposed vaccine "do not use," and store it under proper conditions as quickly as possible. Do not discard vaccines unless directed to by your state/local health department and/or the manufacturer(s).
2. Record the out-of-range temps and the room temp in the "Action" area on the bottom of the log.
3. Notify your vaccine coordinator, or call the immunization program at your state or local health department for guidance.
4. Document the action taken on the "Vaccine Storage Troubleshooting Record" on page 3.

Day of Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Staff Initials															
Exact Time	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Min/Max Temp (since previous reading)															
Danger! Temperatures above 5°F are too warm! Write any out-of-range temps and room temp on the lines below and call your state or local health department immediately!															
ACCEPTABLE TEMPERATURES 5°F															
4°F															
3°F															
2°F															
1°F															
0°F															
-1°F															
-2°F															
-3°F															
-4°F															
-58°F to -5°F															
ACTION Write any out-of-range temps (above 5°F or below -58°F) here.															
Room Temperature															

If you have a vaccine storage issue, also complete "Vaccine Storage Troubleshooting Record" found on page 3.

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www.immunize.org/catg.d/p3038F.pdf ▪ Item #P3038F (8/13)

Temperature Log for Freezer – Fahrenheit

DAYS 16–31

Month/Year _____ VFC PIN or other ID # _____

Facility Name _____

Monitor temperatures closely!

1. Write your initials below in "Staff Initials," and note the time in "Exact Time."
2. Record temps twice each workday.
3. Record the min/max temps once each workday—preferably in the morning.
4. Put an "X" in the row that corresponds to the freezer's temperature.
5. If any out-of-range temp, see instructions to the right.
6. After each month has ended, save each month's log for 3 years, unless state/local jurisdictions require a longer period.

Take action if temp is out of range—too warm (above 5°F) or too cold (below -58°F).

1. Label exposed vaccine "do not use," and store it under proper conditions as quickly as possible. Do not discard vaccines unless directed to by your state/local health department and/or the manufacturer(s).
2. Record the out-of-range temps and the room temp in the "Action" area on the bottom of the log.
3. Notify your vaccine coordinator, or call the immunization program at your state or local health department for guidance.
4. Document the action taken on the "Vaccine Storage Troubleshooting Record" on page 3.

Day of Month	16		17		18		19		20		21		22		23		24		25		26		27		28		29		30		31	
Staff Initials																																
Exact Time	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Min/Max Temp (since previous reading)																																
Danger! Temperatures above 5°F are too warm! Write any out-of-range temps and room temp on the lines below and call your state or local health department immediately!																																
ACCEPTABLE TEMPERATURES **5°F**																																
4°F																																
3°F																																
2°F																																
1°F																																
0°F																																
-1°F																																
-2°F																																
-3°F																																
-4°F																																
-58°F to -5°F																																
ACTION Write any out-of-range temps (above 5°F or below -58°F) here.																																
Room Temperature																																

If you have a vaccine storage issue, also complete "Vaccine Storage Troubleshooting Record" found on page 3.

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Vaccine Storage Troubleshooting Record (check one) ☐ Refrigerator ☐ Freezer

Use this form to document any unacceptable vaccine storage event, such as exposure of refrigerated or frozen vaccines to temperatures that are outside the manufacturers' recommended storage ranges.
A fillable troubleshooting record (i.e., editable PDF or WORD document) can also be found at www.immunize.org/clinic/storage-handling.asp.

Date & Time of Event If multiple, related events occurred, see Description of Event below.	**Storage Unit Temperature** at the time the problem was discovered		**Room Temperature** at the time the problem was discovered	**Person Completing Report**	
Date:	Temp when discovered:		Temp when discovered:	Name:	
Time:	Minimum temp:	Maximum temp:	Comment (optional):	Title:	Date:

Description of Event *(If multiple, related events occurred, list each date, time, and length of time out of storage.)*

- General description (i.e., what happened?)
- Estimated length of time between event and last documented reading of storage temperature in acceptable range (35° to 46°F [2° to 8°C] for refrigerator; -58° to 5°F [-50° to -15°C] for freezer)
- Inventory of affected vaccines, including (1) lot #s and (2) whether purchased with public (for example, VFC) or private funds (Use separate sheet if needed, but maintain the inventory with this troubleshooting record.)
- At the time of the event, what else was in the storage unit? For example, were there water bottles in the refrigerator and/or frozen coolant packs in the freezer?
- Prior to this event, have there been any storage problems with this unit and/or with the affected vaccine?
- Include any other information you feel might be relevant to understanding the event.

Action Taken *(Document thoroughly. This information is critical to determining whether the vaccine might still be viable!)*

- When were the affected vaccines placed in proper storage conditions? (Note: Do not discard the vaccine. Store exposed vaccine in proper conditions and label it "do not use" until after you can discuss with your state/local health department and/or the manufacturer[s].)
- Who was contacted regarding the incident? (For example, supervisor, state/local health department, manufacturer—list all.)
- IMPORTANT: What did you do to prevent a similar problem from occurring in the future?

Results

- What happened to the vaccine? Was it able to be used? If not, was it returned to the distributor? (Note: For public-purchase vaccine, follow your state/local health department instructions for vaccine disposition.)

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Vaccine Storage Troubleshooting Record (check one) ☐ Refrigerator ☑ Freezer

Use this form to document any unacceptable vaccine storage event, such as exposure of refrigerated or frozen vaccines to temperatures that are outside the manufacturers' recommended storage ranges.
A fillable troubleshooting record (i.e., editable pdf or WORD document) can also be found at www.immunize.org/clinic/storage-handling.asp

Date & Time of Event If multiple, related events occurred, see Description of Event below.	**Storage Unit Temperature** at the time the problem was discovered		**Room Temperature** at the time the problem was discovered	**Person Completing Report**	
Date: 7/16/2013	Temp when discovered: 55°F		Temp when discovered: 77°F	Name: Nancy Nurse	
Time: 8:00 am	Minimum temp: 2°F	Maximum temp: 57°F	Comment (optional): temp is approx	Title: VFC Coordinator	Date: 7/15/13

Description of Event *(If multiple, related events occurred, list each date, time, and length of time out of storage.)*

- General description (i.e., what happened?)
- Estimated length of time between event & last documented reading of storage temperature in acceptable range (35° to 46°F [2° to 8°C] for refrigerator; -58° to 5°F [-50° to -15°C] for freezer)
- Inventory of affected vaccines, including (1) lot #s and (2) whether purchased with public (for example, VFC) or private funds (Use separate sheet if needed, but maintain the inventory with this troubleshooting record)
- At the time of the event, what else was in the storage unit? For example, were there water bottles in the refrigerator and/or frozen coolant packs in the freezer?
- Prior to this event, have there been any storage problems with this unit and/or with the affected vaccine?
- Include any other information you feel might be relevant to understanding the event.

When checked vaccine freezer (in lab) at 8:00 am on Tuesday, 7/16/2013, discovered freezer door slightly ajar. Digital readout on data logger read 55°F. Data logger located in center of freezer with probe in glycol. Review of computer readings (taken every 15 minutes) showed steady rise in temps from 2°F at 5:30 pm (7/15/2013) to 55°F reading discovered when arrived at clinic on Tuesday morning (7/16/2013). Readings hit 6°F at 11 pm (7/15) and 45°F at 2 am (7/16). Total time out of recommended storage temp of 5°F or below = 9 hours. (See attached document of continuous temp readings.) Freezer contained Varivax, ProQuad, and Zostavax (inventory attached).

Frozen packs stored on freezer floor and shelves in door. No recent adjustments to temp controls and no previous temp excursions noted with this freezer before 7/15.

Action Taken *(Document thoroughly. This information is critical to determining whether the vaccine might still be viable!)*

- When were the affected vaccines placed in proper storage conditions? (Note: Do not discard the vaccine. Store exposed vaccine in proper conditions and label it "do not use" until after you can discuss with your state/local health department and/or the manufacturer[s].)
- Who was contacted regarding the incident? (For example, supervisor, state/local health department, manufacturer—list all.)
- IMPORTANT: What did you do to prevent a similar problem from occurring in the future?

Upon discovery, vaccines marked "Do Not Use" and stored in 2nd clinic freezer (in exam room #3) at 1°F. Also placed "Do Not Use" note on main freezer in lab. Notified Susie Supervisor about the issue. Contacted Victor Vaccine at My State Immunization Program at 8:30 am. Provided Victor with details of event and list of vaccines in freezer. Victor said to maintain vaccines in 2nd freezer and that he would check with Merck (manufacturer of all the affected vaccines) to determine next steps. Called Jim's Appliance Repair to examine freezer. Repairman replaced freezer door gasket and recommended removal of ~½ of freezer packs in door because size and weight of packs potentially interfered with door closing completely. No problems identified with thermostat or other mechanical components.

Removed half of freezer packs located in shelf in door, per recommendation. Reset data logger on center shelf of freezer with probe in glycol. All staff received refresher training on ensuring freezer door is closed after each use, and a reminder sign was placed prominently on freezer door.

Results

- What happened to the vaccine? Was it able to be used? If not, was it returned to the distributor? (Note: For public-purchase vaccine, follow your state/local health department instructions for vaccine disposition.)

After repair, monitored temps in empty freezer for 1 week, per state requirements. Freezer maintained 0–2°F temps for entire week. Submitted repair documentation and data logger readings to Victor Vaccine for approval and ordered replacement vaccines. Victor had checked with manufacturer. After reviewing history and stability data, manufacturer stated vaccine was acceptable for continued use. Discussed entire situation with Susie Supervisor and clinic director, Dr. Immunize, who agreed on continued use of vaccine. Vaccine to be labeled as "use first."

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www.immunize.org/catg.d/p3041.pdf ▪ Item #P3041 (8/13)

Temperature Log for Refrigerator – Celsius

DAYS 1–15

Month/Year _____ VFC PIN or other ID # _____

Facility Name _____

Monitor temperatures closely!

1. Write your initials below in "Staff Initials," and note the time in "Exact Time."
2. Record temps twice each workday.
3. Record the min/max temps once each workday—preferably in the morning.
4. Put an "X" in the row that corresponds to the refrigerator's temperature.
5. If any out-of-range temp, see instructions to the right.
6. After each month has ended, save each month's log for 3 years, unless state/local jurisdictions require a longer period.

Take action if temp is out of range—too warm (above 8°C) or too cold (below 2°C).

1. Label exposed vaccine "do not use," and store it under proper conditions as quickly as possible. Do not discard vaccines unless directed to by your state/local health department and/or the manufacturer(s).
2. Record the out-of-range temps and the room temp in the "Action" area on the bottom of the log.
3. Notify your vaccine coordinator, or call the immunization program at your state or local health department for guidance.
4. Document the action taken on the "Vaccine Storage Troubleshooting Record" on page 3.

Day of Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Staff Initials															
Exact Time	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Min/Max Temp (since previous reading)															
Danger! Temperatures above 8°C are too warm! Write any out-of-range temps and room temp on the lines below and call your state or local health department immediately!															
TEMPERATURES 8°C															
7°C															
6°C															
Aim for 5° 5°C															
ACCEPTABLE 4°C															
3°C															
2°C															
Danger! Temperatures below 2°C are too cold! Write any out-of-range temps and room temp on the lines below and call your state or local health department immediately!															
ACTION Write any out-of-range temps (above 8°C or below 2°C) here:															
Room Temperature															

If you have a vaccine storage issue, also complete "Vaccine Storage Troubleshooting Record" found on page 3.

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www.immunize.org/catg.d/p3037C.pdf ▪ Item #P3037F (8/13)

Temperature Log for Refrigerator – Celsius

DAYS 16–31

Month/Year _____ **VFC PIN or other ID #** _____

Facility Name _____

Monitor temperatures closely!

1. Write your initials below in "Staff Initials," and note the time in "Exact Time."
2. Record temps twice each workday.
3. Record the min/max temps once each workday—preferably in the morning.
4. Put an "X" in the row that corresponds to the refrigerator's temperature.
5. If any out-of-range temp, see instructions to the right.
6. After each month has ended, save each month's log for 3 years, unless state/local jurisdictions require a longer period.

Take action if temp is out of range—too warm (above 8°C) or too cold (below 2°C).

1. Label exposed vaccine "do not use," and store it under proper conditions as quickly as possible. Do not discard vaccines unless directed to by your state/local health department and/or the manufacturer(s).
2. Record the out-of-range temps and the room temp in the "Action" area on the bottom of the log.
3. Notify your vaccine coordinator, or call the immunization program at your state or local health department for guidance.
4. Document the action taken on the "Vaccine Storage Troubleshooting Record" on page 3.

Day of Month	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Staff Initials																
Exact Time	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Min/Max Temp (since previous reading)																
Danger! Temperatures above 8°C are too warm! Write any out-of-range temps and room temp on the lines below and call your state or local health department immediately!																
TEMPERATURES 8°C																
7°C																
6°C																
Aim for 5° 5°C																
ACCEPTABLE 4°C																
3°C																
2°C																
Danger! Temperatures below 2°C are too cold! Write any out-of-range temps and room temp on the lines below and call your state or local health department immediately!																
ACTION Write any out-of-range temps (above 8°C or below 2°C) here:																
Room Temperature																

If you have a vaccine storage issue, also complete "Vaccine Storage Troubleshooting Record" found on page 3.

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Vaccine Storage Troubleshooting Record (check one) ☐ Refrigerator ☐ Freezer

Use this form to document any unacceptable vaccine storage event, such as exposure of refrigerated vaccines to temperatures that are outside the manufacturers' recommended storage ranges.
A fillable troubleshooting record (i.e., editable PDF or WORD document) can also be found at www.immunize.org/clinic/storage-handling.asp.

Date & Time of Event If multiple, related events occurred, see Description of Event below.	**Storage Unit Temperature** at the time the problem was discovered		**Room Temperature** at the time the problem was discovered	**Person Completing Report**	
Date:	Temp when discovered:		Temp when discovered:	Name:	
Time:	Minimum temp:	Maximum temp:	Comment (optional):	Title:	Date:

Description of Event *(If multiple, related events occurred, list each date, time, and length of time out of storage.)*

- General description (i.e., what happened?)
- Estimated length of time between event and last documented reading of storage temperature in acceptable range (35º to 46ºF [2º to 8ºC] for refrigerator; -58º to 5ºF [-50º to -15ºC] for freezer)
- Inventory of affected vaccines, including (1) lot #s and (2) whether purchased with public (for example, VFC) or private funds (Use separate sheet if needed, but maintain the inventory with this troubleshooting record.)
- At the time of the event, what else was in the storage unit? For example, were there water bottles in the refrigerator and/or frozen coolant packs in the freezer?
- Prior to this event, have there been any storage problems with this unit and/or with the affected vaccine?
- Include any other information you feel might be relevant to understanding the event.

Action Taken *(Document thoroughly. This information is critical to determining whether the vaccine might still be viable!)*

- When were the affected vaccines placed in proper storage conditions? (Note: Do not discard the vaccine. Store exposed vaccine in proper conditions and label it "do not use" until after you can discuss with your state/local health department and/or the manufacturer[s].)
- Who was contacted regarding the incident? (For example, supervisor, state/local health department, manufacturer—list all.)
- **IMPORTANT:** What did you do to prevent a similar problem from occurring in the future?

Results

- What happened to the vaccine? Was it able to be used? If not, was it returned to the distributor? (Note: For public-purchase vaccine, follow your state/local health department instructions for vaccine disposition.)

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Vaccine Storage Troubleshooting Record (check one) ☑ Refrigerator ☐ Freezer

Use this form to document any unacceptable vaccine storage event, such as exposure of refrigerated vaccines to temperatures that are outside the manufacturers' recommended storage ranges.
A fillable troubleshooting record (i.e., editable pdf or WORD document) can also be found at www.immunize.org/clinic/storage-handling.asp

Date & Time of Event If multiple, related events occurred, see Description of Event below.	**Storage Unit Temperature** at the time the problem was discovered		**Room Temperature** at the time the problem was discovered	**Person Completing Report**	
Date: (see below)	Temp when discovered: 7°C		Temp when discovered: 25°C	Name: Nancy Nurse	
Time: (see below)	Minimum temp: 3°C	Maximum temp: 12°F	Comment (optional): temp is approx	Title: VFC Coordinator	Date: 6/24/13

Description of Event *(If multiple, related events occurred, list each date, time, and length of time out of storage.)*

- General description (i.e., what happened?)
- Estimated length of time between event & last documented reading of storage temperature in acceptable range (35° to 46°F [2° to 8°C] for refrigerator; -58° to 5°F [-50° to -15°C] for freezer)
- Inventory of affected vaccines, including (1) lot #s and (2) whether purchased with public (for example, VFC) or private funds (Use separate sheet if needed, but maintain the inventory with this troubleshooting record)
- At the time of the event, what else was in the storage unit? For example, were there water bottles in the refrigerator and/or frozen coolant packs in the freezer?
- Prior to this event, have there been any storage problems with this unit and/or with the affected vaccine?
- Include any other information you feel might be relevant to understanding the event.

At 8 am on Monday (6/24/13) morning when clinic opened, identified 3 temperature excursions over the weekend in refrigerator with readings as high as 12°, 10° & 9°C in primary vaccine storage unit #1. Recordings taken every 15 min on calibrated digital data logger overnight. Data logger probe in glycol located in middle of refrigerator with vaccines.

Total time out of range: approximately 3 hrs — maximum temp 12°F (see attached document of continuous temp readings)

Inventory of vaccines: see attached

Water bottles in refrigerator door. No vaccine stored in freezer. No problems with storage unit prior to Saturday night. Thunderstorms in area over weekend may have affected power.

Action Taken *(Document thoroughly. This information is critical to determining whether the vaccine might still be viable!)*

- When were the affected vaccines placed in proper storage conditions? (Note: Do not discard the vaccine. Store exposed vaccine in proper conditions and label it "do not use" until after you can discuss with your state/local health department and/or the manufacturer[s].)
- Who was contacted regarding the incident? (For example, supervisor, state/local health department, manufacturer—list all.)
- IMPORTANT: What did you do to prevent a similar problem from occurring in the future?

Vaccines currently stored appropriately at 7°C. Refrigerator and vaccines labeled "Do Not Use."

My State Immunization Program contacted at 8:30 am. Spoke with Victor Vaccine. Provided Victor with details of event and list of vaccines. Vaccine to remain quarantined until we hear back from Victor.

Called electric company and confirmed 2 short power outages during weekend.

Checked refrigerator seals — called refrigerator maintenance company to replace seals.

Checked plug on unit — placed tape over plug to prevent inadvertent dislodging. Plan to purchase plug guard.

Plan to follow up with Immunization Program on data loggers with alarms that could be sent to coordinator and back-up phones.

Results

- What happened to the vaccine? Was it able to be used? If not, was it returned to the distributor? (Note: For public-purchase vaccine, follow your state/local health department instructions for vaccine disposition.)

Late on Monday, I talked with Victor regarding continued use of vaccine. Victor had checked with manufacturers which confirmed that vaccine is acceptable for use. He told me that vaccine could therefore be removed from quarantine. I discussed the entire situation with Susie Supervisor and Dr. Director (clinic medical director) who agreed that we could put vaccine back in use.

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Vaccine Storage Troubleshooting Record (check one) ☑ Refrigerator ☐ Freezer

Use this form to document any unacceptable vaccine storage event, such as exposure of refrigerated vaccines to temperatures that are outside the manufacturers' recommended storage ranges.
A fillable troubleshooting record (i.e., editable pdf or WORD document) can also be found at www.immunize.org/clinic/storage-handling.asp

Date & Time of Event If multiple, related events occurred, see Description of Event below.	**Storage Unit Temperature** at the time the problem was discovered		**Room Temperature** at the time the problem was discovered	**Person Completing Report**	
Date: 7/16/2013	Temp when discovered: -2°C		Temp when discovered: 25°C	Name: Nancy Nurse	
Time: 8:00 am	Minimum temp: -2°C	Maximum temp: 6°C	Comment (optional): temp is approx	Title: VFC Coordinator	Date: 7/15/13

Description of Event *(If multiple, related events occurred, list each date, time, and length of time out of storage.)*

- General description (i.e., what happened?)
- Estimated length of time between event & last documented reading of storage temperature in acceptable range (35° to 46°F [2° to 8°C] for refrigerator; -58° to 5°F [-50° to -15°C] for freezer)
- Inventory of affected vaccines, including (1) lot #s and (2) whether purchased with public (for example, VFC) or private funds (Use separate sheet if needed, but maintain the inventory with this troubleshooting record)
- At the time of the event, what else was in the storage unit? For example, were there water bottles in the refrigerator and/or frozen coolant packs in the freezer?
- Prior to this event, have there been any storage problems with this unit and/or with the affected vaccine?
- Include any other information you feel might be relevant to understanding the event.

When checked main clinic fridge (in lab) at 8:00 am on Tuesday, 7/16/2013, digital readout on data logger read -2°C. Data logger located in center of fridge with probe in glycol. Review of computer readings (taken every 15 minutes) showed steady drop in temps from 6°C at 8:15 pm (7/15/2013) to -2°C reading discovered when arrived at clinic on Tuesday morning (7/16/2013). Readings hit 1°C at 11 pm (7/15) and 0°C at 2 am (7/16). Total time out of recommended storage temps = 9 hours, with 6 hours at freezing or below (see attached document of continuous temp readings). Inventory of vaccines attached.

Water bottles in refrigerator door and crisper area. No vaccines stored in freezer. No recent adjustments to temp controls and no previous temp excursions noted with this refrigerator before 7/15.

Action Taken *(Document thoroughly. This information is critical to determining whether the vaccine might still be viable!)*

- When were the affected vaccines placed in proper storage conditions? (Note: Do not discard the vaccine. Store exposed vaccine in proper conditions and label it "do not use" until after you can discuss with your state/local health department and/or the manufacturer[s].)
- Who was contacted regarding the incident? (For example, supervisor, state/local health department, manufacturer—list all.)
- **IMPORTANT:** What did you do to prevent a similar problem from occurring in the future?

Upon discovery, vaccines marked "Do Not Use" and stored in 2nd clinic fridge (in exam room #3 at 5°C). Also placed "Do Not Use" note on main fridge in lab. Notified Susie Supervisor about the issue. Contacted Victor Vaccine at My State Immunization Program at 8:30 am. Provided Victor with details of event and list of vaccines in fridge. Victor said to maintain vaccines in 2nd fridge and that he would check with manufacturers to determine next steps.

Called Jim's Appliance Repair to examine fridge. Repairman found and replaced faulty thermostat in unit.

Reset data logger on center shelf in fridge with probe in glycol.

Results

- What happened to the vaccine? Was it able to be used? If not, was it returned to the distributor? (Note: For public-purchase vaccine, follow your state/local health department instructions for vaccine disposition.)

After fridge thermostat repaired, monitored temps in empty fridge for 1 week, per state requirements. Fridge maintained 3° to 4°C temps for entire week. Submitted repair documentation and data logger readings to Victor Vaccine for approval and ordered replacement vaccines. Victor had checked with manufacturers who confirmed that all vaccines in fridge EXCEPT MMR were no longer viable and should be returned per state policy guidelines. MMR may be used because pkg insert allows storage down to -50°C. Discussed entire situation with Susie Supervisor and clinic director, Dr. Director, who agreed on continued use of MMR. Will continue to monitor fridge closely to watch for pattern of temp fluctuations indicating potential problem with thermostat. If problems, contact Victor Vaccine for advice on purchasing new fridge meeting criteria for appropriate vaccine storage.

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Temperature Log for Refrigerator – Fahrenheit

DAYS 1–15

Month/Year _____ VFC PIN or other ID # _____

Facility Name _____

Monitor temperatures closely!

1. Write your initials below in "Staff Initials," and note the time in "Exact Time."
2. Record temps twice each workday.
3. Record the min/max temps once each workday—preferably in the morning.
4. Put an "X" in the row that corresponds to the refrigerator's temperature.
5. If any out-of-range temp, see instructions to the right.
6. After each month has ended, save each month's log for 3 years, unless state/local jurisdictions require a longer period.

Take action if temp is out of range—too warm (above 46°F) or too cold (below 35°F).

1. Label exposed vaccine "do not use," and store it under proper conditions as quickly as possible. Do not discard vaccines unless directed to by your state/local health department and/or the manufacturer(s).
2. Record the out-of-range temps and the room temp in the "Action" area on the bottom of the log.
3. Notify your vaccine coordinator, or call the immunization program at your state or local health department for guidance.
4. Document the action taken on the "Vaccine Storage Troubleshooting Record" on page 3.

Day of Month	1		2		3		4		5		6		7		8		9		10		11		12		13		14		15	
Staff Initials																														
Exact Time	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Min/Max Temp (since previous reading)																														
Danger! Temperatures above 46°F are too warm! Write any out-of-range temps and room temp on the lines below and call your state or local health department immediately!																														
TEMPERATURES **46° F**																														
45° F																														
44° F																														
43° F																														
42° F																														
41° F																														
Aim for 40° **40° F**																														
ACCEPTABLE **39° F**																														
38° F																														
37° F																														
36° F																														
35° F																														
Danger! Temperatures below 35°F are too cold! Write any out-of-range temps and room temp on the lines below and call your state or local health department immediately!																														
ACTION Write any out-of-range temps (above 46°F or below 35°F) here:																														
Room Temperature																														

If you have a vaccine storage issue, also complete "Vaccine Storage Troubleshooting Record" found on page 3.

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Temperature Log for Refrigerator – Fahrenheit

DAYS 16–31

Month/Year _____ VFC PIN or other ID # _____

Facility Name _____

Monitor temperatures closely!

1. Write your initials below in "Staff Initials," and note the time in "Exact Time."
2. Record temps twice each workday.
3. Record the min/max temps once each workday—preferably in the morning.
4. Put an "X" in the row that corresponds to the refrigerator's temperature.
5. If any out-of-range temp, see instructions to the right.
6. After each month has ended, save each month's log for 3 years, unless state/local jurisdictions require a longer period.

Take action if temp is out of range—too warm (above 46°F) or too cold (below 35°F).

1. Label exposed vaccine "do not use," and store it under proper conditions as quickly as possible. Do not discard vaccines unless directed to by your state/local health department and/or the manufacturer(s).
2. Record the out-of-range temps and the room temp in the "Action" area on the bottom of the log.
3. Notify your vaccine coordinator, or call the immunization program at your state or local health department for guidance.
4. Document the action taken on the "Vaccine Storage Troubleshooting Record" on page 3.

Day of Month	16		17		18		19		20		21		22		23		24		25		26		27		28		29		30		31	
Staff Initials																																
Exact Time	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Min/Max Temp (since previous reading)																																
Danger! Temperatures above 46°F are too warm! Write any out-of-range temps and room temp on the lines below and call your state or local health department immediately!																																
TEMPERATURES **46°F**																																
45°F																																
44°F																																
43°F																																
42°F																																
41°F																																
Aim for 40° **40°F**																																
ACCEPTABLE **39°F**																																
38°F																																
37°F																																
36°F																																
35°F																																
Danger! Temperatures below 35°F are too cold! Write any out-of-range temps and room temp on the lines below and call your state or local health department immediately!																																
ACTION Write any out-of-range temps (above 46°F or below 35°F) here:																																
Room Temperature																																

If you have a vaccine storage issue, also complete "Vaccine Storage Troubleshooting Record" found on page 3.

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Vaccine Storage Troubleshooting Record (check one) ☐ Refrigerator ☐ Freezer

Use this form to document any unacceptable vaccine storage event, such as exposure of refrigerated vaccines to temperatures that are outside the manufacturers' recommended storage ranges.
A fillable troubleshooting record (i.e., editable PDF or WORD document) can also be found at www.immunize.org/clinic/storage-handling.asp.

Date & Time of Event If multiple, related events occurred, see Description of Event below.	**Storage Unit Temperature** at the time the problem was discovered		**Room Temperature** at the time the problem was discovered	**Person Completing Report**	
Date:	Temp when discovered:		Temp when discovered:	Name:	
Time:	Minimum temp:	Maximum temp:	Comment (optional):	Title:	Date:

Description of Event *(If multiple, related events occurred, list each date, time, and length of time out of storage.)*

- General description (i.e., what happened?)
- Estimated length of time between event and last documented reading of storage temperature in acceptable range (35° to 46°F [2° to 8°C] for refrigerator; -58° to 5°F [-50° to -15°C] for freezer)
- Inventory of affected vaccines, including (1) lot #s and (2) whether purchased with public (for example, VFC) or private funds (Use separate sheet if needed, but maintain the inventory with this troubleshooting record.)
- At the time of the event, what else was in the storage unit? For example, were there water bottles in the refrigerator and/or frozen coolant packs in the freezer?
- Prior to this event, have there been any storage problems with this unit and/or with the affected vaccine?
- Include any other information you feel might be relevant to understanding the event.

Action Taken *(Document thoroughly. This information is critical to determining whether the vaccine might still be viable!)*

- When were the affected vaccines placed in proper storage conditions? (Note: Do not discard the vaccine. Store exposed vaccine in proper conditions and label it "do not use" until after you can discuss with your state/local health department and/or the manufacturer[s].)
- Who was contacted regarding the incident? (For example, supervisor, state/local health department, manufacturer—list all.)
- IMPORTANT: What did you do to prevent a similar problem from occurring in the future?

Results

- What happened to the vaccine? Was it able to be used? If not, was it returned to the distributor? (Note: For public-purchase vaccine, follow your state/local health department instructions for vaccine disposition.)

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Vaccine Storage Troubleshooting Record (check one) ☑ Refrigerator ☐ Freezer

Use this form to document any unacceptable vaccine storage event, such as exposure of refrigerated vaccines to temperatures that are outside the manufacturers' recommended storage ranges.
A fillable troubleshooting record (i.e., editable pdf or WORD document) can also be found at www.immunize.org/clinic/storage-handling.asp

Date & Time of Event If multiple, related events occurred, see Description of Event below.	**Storage Unit Temperature** at the time the problem was discovered		**Room Temperature** at the time the problem was discovered	**Person Completing Report**	
Date: (see below)	Temp when discovered: 45°F		Temp when discovered: 77°F	Name: Nancy Nurse	
Time: (see below)	Minimum temp: 38°F	Maximum temp: 53°F	Comment (optional): temp is approx	Title: VFC Coordinator	Date: 6/24/13

Description of Event *(If multiple, related events occurred, list each date, time, and length of time out of storage.)*

- General description (i.e., what happened?)
- Estimated length of time between event & last documented reading of storage temperature in acceptable range (35° to 46°F [2° to 8°C] for refrigerator; -58° to 5°F [-50° to -15°C] for freezer)
- Inventory of affected vaccines, including (1) lot #s and (2) whether purchased with public (for example, VFC) or private funds (Use separate sheet if needed, but maintain the inventory with this troubleshooting record)
- At the time of the event, what else was in the storage unit? For example, were there water bottles in the refrigerator and/or frozen coolant packs in the freezer?
- Prior to this event, have there been any storage problems with this unit and/or with the affected vaccine?
- Include any other information you feel might be relevant to understanding the event.

At 8 am on Monday (6/24/13) morning when clinic opened, identified 4 temperature excursions over the weekend in refrigerator with readings as high as 54°, 50°, 49° & 53°F in primary vaccine storage unit #1. Recordings taken every 15 min on calibrated digital data logger overnight. Data logger probe in glycol located in middle of refrigerator with vaccines.

Total time out of range: approximately 3 hrs — maximum temp 53°F (see attached document of continuous temp readings)

Inventory of vaccines: see attached

Water bottles in refrigerator door. No vaccine stored in freezer. No problems with storage unit prior to Saturday night. Thunderstorms in area over weekend may have affected power.

Action Taken *(Document thoroughly. This information is critical to determining whether the vaccine might still be viable!)*

- When were the affected vaccines placed in proper storage conditions? (Note: Do not discard the vaccine. Store exposed vaccine in proper conditions and label it "do not use" until after you can discuss with your state/local health department and/or the manufacturer[s].)
- Who was contacted regarding the incident? (For example, supervisor, state/local health department, manufacturer—list all.)
- IMPORTANT: What did you do to prevent a similar problem from occurring in the future?

Vaccines currently stored appropriately at 45°F. Refrigerator and vaccines labeled "Do Not Use."

My State Immunization Program contacted at 8:30 am. Spoke with Victor Vaccine. Provided Victor with details of event and list of vaccines. Vaccine to remain quarantined until we hear back from Victor.

Called electric company and confirmed 2 short power outages during weekend.

Checked refrigerator seals — called refrigerator maintenance company to replace seals.

Checked plug on unit — placed tape over plug to prevent inadvertent dislodging. Plan to purchase plug guard.

Plan to follow up with Immunization Program on data loggers with alarms that could be sent to coordinator and back-up phones.

Results

- What happened to the vaccine? Was it able to be used? If not, was it returned to the distributor? (Note: For public-purchase vaccine, follow your state/local health department instructions for vaccine disposition.)

Late on Monday, I talked with Victor regarding continued use of vaccine. Victor had checked with manufacturers which confirmed that vaccine is acceptable for use. He told me that vaccine could therefore be removed from quarantine. I discussed the entire situation with Susie Supervisor and Dr. Director (clinic medical director) who agreed that we could put vaccine back in use.

DISTRIBUTED BY THE
IMMUNIZATION ACTION COALITION 1573 Selby Avenue ▪ St. Paul, MN 55104 ▪ 651-647-9009 ▪ www.immunize.org ▪ www.vaccineinformation.org
Technical content reviewed by the Centers for Disease Control and Prevention
www.immunize.org/catg.d/p3041.pdf ▪ Item #P3041 (8/13)

Vaccine Storage Troubleshooting Record (check one) ☑ Refrigerator ☐ Freezer

Use this form to document any unacceptable vaccine storage event, such as exposure of refrigerated vaccines to temperatures that are outside the manufacturers' recommended storage ranges.
A fillable troubleshooting record (i.e., editable pdf or WORD document) can also be found at www.immunize.org/clinic/storage-handling.asp

Date & Time of Event If multiple, related events occurred, see Description of Event below.	**Storage Unit Temperature** at the time the problem was discovered		**Room Temperature** at the time the problem was discovered	**Person Completing Report**	
Date: 7/16/2013	Temp when discovered: 28°F		Temp when discovered: 77°F	Name: Nancy Nurse	
Time: 8:00 am	Minimum temp: 28°F	Maximum temp: 42°F	Comment (optional): temp is approx	Title: VFC Coordinator	Date: 7/15/13

Description of Event *(If multiple, related events occurred, list each date, time, and length of time out of storage.)*

- General description (i.e., what happened?)
- Estimated length of time between event & last documented reading of storage temperature in acceptable range (35° to 46°F [2° to 8°C] for refrigerator; -58° to 5°F [-50° to -15°C] for freezer)
- Inventory of affected vaccines, including (1) lot #s and (2) whether purchased with public (for example, VFC) or private funds (Use separate sheet if needed, but maintain the inventory with this troubleshooting record)
- At the time of the event, what else was in the storage unit? For example, were there water bottles in the refrigerator and/or frozen coolant packs in the freezer?
- Prior to this event, have there been any storage problems with this unit and/or with the affected vaccine?
- Include any other information you feel might be relevant to understanding the event.

When checked main clinic fridge (in lab) at 8:00 am on Tuesday, 7/16/2013, digital readout on data logger read 28°F. Data logger located in center of fridge with probe in glycol. Review of computer readings (taken every 15 minutes) showed steady drop in temps from 42°F at 8:15 pm (7/15/2013) to 28°F reading discovered when arrived at clinic on Tuesday morning (7/16/2013). Readings hit 34°F at 11 pm (7/15) and 32°F at 2 am (7/16). Total time out of recommended storage temps = 9 hours, with 6 hours at freezing or below (see attached document of continuous temp readings). Inventory of vaccines attached.

Water bottles in refrigerator door and crisper area. No vaccines stored in freezer. No recent adjustments to temp controls and no previous temp excursions noted with this refrigerator before 7/15.

Action Taken *(Document thoroughly. This information is critical to determining whether the vaccine might still be viable!)*

- When were the affected vaccines placed in proper storage conditions? (Note: Do not discard the vaccine. Store exposed vaccine in proper conditions and label it "do not use" until after you can discuss with your state/local health department and/or the manufacturer[s].)
- Who was contacted regarding the incident? (For example, supervisor, state/local health department, manufacturer—list all.)
- IMPORTANT: What did you do to prevent a similar problem from occurring in the future?

Upon discovery, vaccines marked "Do Not Use" and stored in 2nd clinic fridge (in exam room #3 at 41°F). Also placed "Do Not Use" note on main fridge in lab. Notified Susie Supervisor about the issue. Contacted Victor Vaccine at My State Immunization Program at 8:30 am. Provided Victor with details of event and list of vaccines in fridge. Victor said to maintain vaccines in 2nd fridge and that he would check with manufacturers to determine next steps.

Called Jim's Appliance Repair to examine fridge. Repairman found and replaced faulty thermostat in unit.

Reset data logger on center shelf in fridge with probe in glycol.

Results

- What happened to the vaccine? Was it able to be used? If not, was it returned to the distributor? (Note: For public-purchase vaccine, follow your state/local health department instructions for vaccine disposition.)

After fridge thermostat repaired, monitored temps in empty fridge for 1 week, per state requirements. Fridge maintained 38°-40°F temps for entire week. Submitted repair documentation and data logger readings to Victor Vaccine for approval and ordered replacement vaccines. Victor had checked with manufacturers who confirmed that all vaccines in fridge EXCEPT MMR were no longer viable and should be returned per state policy guidelines. MMR may be used because pkg insert allows storage down to -58°F. Discussed entire situation with Susie Supervisor and clinic director, Dr. Director, who agreed on continued use of MMR. Will continue to monitor fridge closely to watch for pattern of temp fluctuations indicating potential problem with thermostat. If problems, contact Victor Vaccine for advice on purchasing new fridge meeting criteria for appropriate vaccine storage.

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Emergency Response Worksheet

What to do in case of a power failure or other event that results in vaccine storage outside of the recommended temperature range

For information on COVID-19 vaccine storage, see the COVID-19 Vaccine Addendum in CDC's *Vaccine Storage and Handling Toolkit* at www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf.

Follow these procedures:

1. Close the door tightly.
2. Ensure the vaccine is kept at appropriate temperatures. Make sure the refrigerator or freezer is plugged in and working properly, or move the vaccines into proper storage conditions as quickly as possible.
3. Do NOT discard the affected vaccines unless directed to by your state/local health department and/or the manufacturer(s). Label the vaccines "Do Not Use" so that the potentially compromised vaccines can be easily identified.
4. Notify the state/local health department or call the manufacturer (see manufacturers' phone numbers below).
5. Document the inventory of affected vaccines below and document the circumstances of the event and the actions taken on the *Vaccine Storage Troubleshooting Record* (see www.immunize.org/catg.d/p3041.pdf).

Vaccines Stored in Refrigerator

Vaccine	Manufacturer	Lot #	Expiration Date	# of Doses (i.e., *not* # of vials)

Vaccines Stored in Freezer

Vaccine	Manufacturer	Lot #	Expiration Date	# of Doses (i.e., *not* # of vials)

Important Contact Information:

Vaccine Manufacturers

AstraZeneca	(877) 633-4411	GlaxoSmithKline	(877) 356-8368	Sanofi Pasteur	(800) 822-2463
Bavarian Nordic[1]	(844) 422-8274	MassBiologics	(617) 474-3220	Seqirus	(855) 358-8966
Dynavax Technologies	(844) 375-4728	Merck & Co., Inc.	(800) 672-6372	Valneva[4]	(301) 556-4500
Emergent BioSolutions[2]	(866) 300-7602	Pfizer Inc.[3]	(800) 438-1985		

Manufacturer for less commonly used vaccine:
1. Bavarian Nordic: Rabavert (rabies), Jynneos (smallpox and monkeypox)
2. Emergent Biosolutions: Biothrax (anthax), Vaxchora (cholera), Vivotif (typhoid)
3. Pfizer: Ticovac (tick-borne encephalitis)
4. Valneva: Ixiaro (Japanese encephalitis)

Health Departments

Local Health Department phone _____ State Health Department phone _____

Adapted by the Immunize.org, courtesy of the Michigan Department of Community Health

Controlled Substance Log

Medication Name: _____ Dosage: _____

Original Quantity of Drug: _____ Lot Number: _____

Manufacturer Name: _____

Physician's DEA Number: _____ DEA Expires: _____

Date Administered	Name of Patient Receiving Drug	Quantity Dispensed/ Additions	Remaining Doses on Hand	Print Name of Authorized Person dispensing drug	Initials

PCP	
Section: Clinical Services	
POLICY AND PROCEDURE: Laboratory Services	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:
The site will operate in compliance with Clinical Laboratory Improvement Amendment (CLIA) regulations. Therefore, the site shall meet all quality standards to ensure accuracy, reliability and timeliness of patient test results. All lab results are to be communicated to the provider and member in a timely manner.

PROCEDURE:

I. CLIA

A. Laboratory test procedures are performed according to the current site specific CLIA certificate.

1. All sites that perform laboratory testing for human health assessment, diagnosis, prevention, or treatment of disease, have a current, unrevoked, unsuspended site-specific CLIA certificate, or evidence of renewal.

a. The CLIA Certificate on site includes one of the following:

- Certificate of Waiver: Site is able to perform only exempt waived tests, so therefore, has a current CLIA Certificate of Waiver. The current listing of waived tests may be obtained at: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm
    - There are no specific CLIA regulations regarding the performance of waived tests. Therefore, site personnel are expected to follow the manufacturer's instructions.
    - Laboratories with Certificates of Waiver may not be routinely inspected by DHCS Laboratory Field Services Division, but may be inspected as part of complaint investigations and/or on a random basis to determine whether only waived tests are being performed.

b. Certificate for Provider-Performed Microscopy (PPM): Physicians, dentists, or mid-level practitioners are able to perform PPM procedures and waived tests.

c. Certificate of Registration: Allows moderate and/or high complexity lab testing to be conducted until compliance with CLIA regulations is determined by survey.

- For moderate and/or high complexity lab testing, the CLIA regulations list specific requirements for laboratory proficiency testing, patient test management, quality control, quality

- assurance, personnel and inspections.

d. Certificate of Compliance: Lab has been surveyed and found to be in compliance with all applicable CLIA requirements.

e. Certificate of Accreditation: Lab is accredited by an Accreditation organization approved by the Centers for Medicare & Medicaid Services (CMS).

2. CLIA certification/re-certification includes an evaluation every two years (or sooner, if compliant driven) by DHCS of personnel licenses/training, laboratory site inspection and demonstration of testing proficiency for moderate and high-complexity test sites.

B. Testing personnel performing clinical lab procedures have been trained.
   1. Prior to testing biological specimens, personnel are appropriately trained for the type and complexity of the laboratory services performed. Personnel have demonstrated the ability to perform all testing operations reliably and to report results accurately.
   2. Site personnel that perform CLIA waived tests have access to and are able to follow test manufacturer's instructions.
   3. When requested, site personnel are able to provider a step-by-step verbal explanation or demonstration of test procedure and how to determine test results.
   4. The required training and certification is established by legislation (CA B&P Codes , §1200-1213) for personnel performing moderate and high complexity tests. Reviewers are not expected to complete an in-depth evaluation of personnel performing moderate and high complexity tests.

C. Lab supplies are inaccessible to unauthorized persons, (e.g., vacutainers, culture swabs, test solutions), not left in unlocked drawers/cabinets in exam rooms.

D. Lab test supplies are not expired. Site has procedure to check expiration date and a method to dispose of expired lab test supplies.
   1. Date lab supplies which expire 90 days from open date.

E. The provider will review, initial, and date the original/electronic copy of each laboratory report, which is then filed in the member's medical record.

****For questions regarding CLIA certification, laboratory licensing, and personnel, call CA Department of Public Health Laboratory Field Services at (510) 620-3800.**

ATTACHMENTS: **Glucometer Calibration Log** (see Access/Safety – Lab equipment/maintenance)
Lab supplies expiration Log (see Clinical Services – Pharmaceutical Services)

PCP	
Section: Clinical Services	
POLICY AND PROCEDURE: Radiology Services	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:

The site will meet California DHCS Radiological inspection and safety regulations by ensuring that radiation is used safely and effectively, individuals are protected from unnecessary radiation exposure and that environmental quality is preserved and maintained (17 CCR §30255, §30305, §30404, §30405).

The Radiologic Health Branch of the Food, Drug, and Radiation Safety Division of the CDPH enforces the Radiation Control Laws and regulations designed to protect both the public and employees against radiation hazards. Enforcement is conducted through licensing, registration, and periodic inspection of sources of radiation, such as radiation machines.

PROCEDURE:

1. Site has current CA Radiologic Health Branch Inspection Report if there is radiological equipment on site. If no current inspection report on site, there is either a:

    A. Short Form Sign-off Sheet (issued for minimal problems that are easily corrected) or,
    B. Notice of Violation Form (issued if there are more serious violations) with an approval letter for a corrective action plan forms the CA Radiologic Health Branch.

2. Equipment inspection, based on a "priority" rating system, is established by legislation (CA H&S Code, Section 115115).

    A. Mammography equipment is inspected annually (Mammography Quality Standards Act, 21 CFR, Section 900), and must have federal FDA Certification on site and CA Mammography X-ray Equipment and Facility Accreditation Certification posted on the machine.
    B. High Priority equipment (e.g., fluoroscopy, portable X-ray) is inspected every three years.
    C. Medium Priority equipment is inspected every 4-5 years depending on the volume of patients, frequency of x-ray equipment uses, and likelihood of radiation exposure.
    D. DEXA scanner equipment: According to the CA Radiological Branch, a lead apron/shield and gonad shields are usually not required. The CA Radiologic Health Branch (RHB) has additional requirements. Such as, the registration of the Dexa Scanner and use of dosimeter badges. Ref: CCR Title 17 Sections 3011,30305,3040
    E. If reviewer is uncertain about the "current" status of equipment inspection, call the Radiological Health Branch.

3. The following documents are posted on site:

A. Current copy of Title 17 with a posted notice about availability of Title 17 and its location.
B. Radiation Safety Operating Procedures" posted in a highly visible location.
C. "Notice to Employees Poster" posted in highly visible location.
D. "Caution, X-Ray" sign posted on or next to door of each room that has X-Ray equipment.
E. Physician Supervisor/Operator certificate posted and within current expiration date.
F. Technologist certificate posted and within current expiration date.
   a. If there are a large number of technicians, a list of names, license numbers and expiration dates may be substituted.
   b. The Certified Radiological Technologist (CRT) certificate permits the technologist to perform all radiology films except mammography and fluoroscopy, which require separate certificates.
   c. The "Limited Permit" limits the technician to one of the 10 X-ray categories specified on the limited certificate: Chest, Dental Laboratory, Dermatology, Extremities, Gastrointestinal, Genitourinary, Leg-podiatric, Skull, Torso-skeletal, and X-Ray bone densitometry.

4. The following radiological protective equipment is present on site:
   A. Operator protection devices: radiologic equipment operator must use lead apron or lead shield.
   B. Gonadal shield (0.5 mm or greater lead equivalent): for patient procedures in which gonads are in direct beam

***NOTE:**

For questions regarding radiologic safety (e.g., expired, or missing inspection documentation on site), call CDPH Radiological Health Branch (Compliance Unit) at (916) 327-5106. For Radiation Emergency Assistance, call 1-800-852-7550

ATTACHMENTS: Posting Required by Title 17 §30255(b)(2): RADIATION SAFETY INSTRUCTIONS

POLICY AND PROCEDURE: Radiology Services	

Posting Required by Title 17 §30255(b) (2)

RADIATION SAFETY INSTRUCTIONS

In accordance with the "California Code of Regulations'', Title 17, the registrant supervisor is responsible for radiation safety. Responsibilities include: 1) assuring that only component persons operate x-ray equipment under his/her jurisdiction; 2) the supervisor must provide safety rules to each individual operating x-ray equipment and installation meet the applicable requirements of the regulations.

A. Items pertinent to radiation safety include:
1. Careful collimation is used to restrict the X-ray beam to the area of clinical interest only. (The X-ray field may never be larger than the size of the film used.)
2. Gonadal shielding is used where and when appropriate. Policies regarding the use of gonadal shielding must be made available to X-ray technical personnel.
3. The X-ray room is cleared of all nonessential persons before X-ray technical personnel take X-rays.
4. X-ray technical personnel stand behind a leaded shield or in a protective booth for every X-ray exposure.
5. Personnel monitoring devices must be worn when they are provided or required. The monitoring device must be worn on the collar of the apron when a lead apron is worn.
6. X-ray technical personnel do not hold patients and no person is regularly or repeatedly used to hold patients. (Exception: in real emergencies when there is no other method of obtaining diagnostic radiographs, X-ray technical personnel may hold a patient.)
7. Individuals who hold patients use appropriate protective apparel such as a leaded apron (at least 0.25 millimeters of lead equivalence) and lead gloves or lead shields.

B. Items pertinent to technical aspects of X-ray examinations:
1. Use the best film-screen combination for the lowest dose practicable and commensurate with objectives of the X-ray examination.
2. Know exactly what examination and which view, or views are to be taken.
3. Position the patient correctly for the required examination and view before making the actual exposure.
4. Use high (optimum) kilovolt peak (kVp) and low milliampere-second (mAs) techniques for low dose radiography consistent with obtaining a diagnostic quality image.
5. Take steps to avoid patient motion by clearly instructing patients not to move, by using appropriate immobilization or positioning aids, and by keeping the patient comfortable and under constant observation.
6. Use unexposed film that has not passed its expiration date.
7. Handle films carefully to prevent artifacts due to static electricity, fingerprints, crinkle marks, and other causes.
8. Ensure that the cassette closure provides good film screen contact.
9. Keep the dark room "light-tight" by sealing off light leaks.
10. Use only fresh (not exhausted) chemicals for film processing.
11. Make sure the processing temperature is correct for the chemicals and film used.
12. Keep cassettes and screens clean.
13. Assure the film processor is cleaned regularly.
14. Place positioning markers correctly on the film and identify each film with the patient's name.
15. Ensure no sight development is done if films are hand developed.

NOTE: FAILURE TO OBTAIN DIAGNOSTIC QUALITY RADIOGRAPHS WITH THE LEAST EXPOSURE TO THE PATIENT, FOR THE X-RAY EXAMINATION REQUIRED, MEANS FAILURE TO MEET THE ACCEPTED STANDARD OF CARE.

Notices Provided by: Quality Assurance Services, Inc. Medical Physicists (888) 727-2550

PCP	
Section: Preventive Services	
POLICY AND PROCEDURE: Screening and Equipment	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:

Preventive health care services and health appraisal examinations are provided on a periodic basis for detection of asymptomatic diseases. Examination equipment, appropriate for primary care services is required to be available at the Primary Care Physician office site.

PROCEDURE:

I. The following equipment shall be maintained onsite and will be appropriate to the population served.

A. Examination table: the examination table has a protective barrier to cover the exam table surface that is changed between patient contact. The exam table is in "good repair". "Good repair" means clean and well maintained in proper working order.

B. Scales: Precise, reproducible measurements required correct equipment, which is maintained and regularly checked (per manufacturer recommendations or at least annually), for proper functioning and accuracy.

1. Infant scales are marked and accurate to increments of one (1) ounce or less and have a capacity of at least 35 pounds. Infants and children are weighed undressed or wearing indoor minimal clothing. If the child resists to the extent that s/he cannot be weighed accurately, document in the medical record that the child resisted, and the weight measurement is imprecise.
2. Standing floor scales are marked and are accurate to increments of one-fourth (¼)pound or less with a capacity of at least 300.
3. Balance beam or electronic scales are appropriate for clinic use.
4. Electronic or digital scales have automatic zeroing and lock-in weight features.
5. Spring balance scales (e.g., bathroom scales) are UNSATISFACTORY for clinical use.

C. Measuring stature devices includes length, height, and head circumference.

1. Rigid 90° right angle headboard block that is perpendicular to the recumbent measurement surface or vertical to the wall mounted standing measurement surface.
2. Flat, paper, or plastic non-stretchable tape or yardstick marked to one-eighth inch

(1/8 in or 1 mm) or less. The "0" of the tape is exactly at the base of the headboard for recumbent measurement, or exactly at foot level for standing measurement.

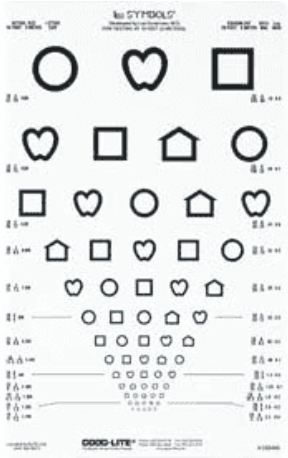
3. Non-flexible footboard at 90° right angle perpendicular to the recumbent measurement surface or a flat floor surface for standing. Adult scale height measuring devices are unacceptable.
4. Head circumference measurement uses a non-stretchable tape measuring device marked to (1/8 in. or 1 mm) or less (up to 24 months of age).

D. Basic exam equipment available for use in exam rooms:

1. Thermometers: oral and/or tympanic
2. Stethoscope and sphygmomanometer with various sized cuffs (e.g., child, adult, extra-large / obese/thigh)
3. Percussion hammer
4. Tongue blades
5. Patient gowns are appropriate to the population served on site.
6. Ophthalmoscope
7. Otoscope with adult and pediatric ear speculums

E. Vision testing:

1. Members who are 3 to 20 years old and are seen for pediatric preventive services shall have a visual acuity screening using eye charts recommended by the American Academy of Pediatrics (AAP). Both literate (e.g., Sloan or Snellen) and illiterate (e.g., HOTV or LEA) eye charts are available.



2. Wall mounted eye charts are height adjustable and positioned at the eye-level of the patient.
3. Heel lines are clearly established and aligned with the center of the eye chart at a distance of 10 or 20 feet depending on the 10-foot or 20-foot vision chart used. Examiners shall stand their patients with their heels to the line unless the eye chart that is being used to screen specifically instructs the patient to be positioned elsewhere.
4. Eye charts are located in an area with adequate lighting and at height appropriate to patient (adjustable).

5. Effective occlusion, such as with tape or an occlusive patch of the eye not being tested, is important to eliminate the possibility of peeking. If patch is not available or tolerated, acceptable occluders include specially designed occlusion glasses and for children 10 years and older, an occlusive paddle with a hole for the child to look through.
6. For infection control purposes, disposable occlusive devices are preferred because they minimize the risk of transmitting infection between patients.

F. Audiometric testing

1. Tester will assess the testing room for noise level prior to the start of testing. To ensure the testing room is quiet enough to perform the hearing screening.
2. Members who are 4 to 20 years old and are seen for pediatric preventive services shall have an audiometric screening with a pure tone, air conduction audiometer available. Members that are referred to another provider for audiometric testing shall have a copy of their test results/ report available in the member's medical record for review.
3. The pure tone audiometer shall have the minimum ability to:
   a. Produce intensities between 0 to 80 db.
   b. Have a headset with right and left earphones.
   c. Be operated manually; and
   d. Produce frequencies at 1000, 2000, 3000, 4000, 6000, and 8000 Hz.

RESOURCES:

Please visit the AAP link for more detailed requirements:
https://pediatrics.aappublications.org/content/137/1/e20153597

Please visit the following links for more detailed requirements:
https://pediatriccare.solutions.aap.org/DocumentLibrary/periodicity_schedule.pdf
https://www.sciencedirect.com/science/article/abs/pii/S1054139X16000483

PCP	
Section: Preventive Services	
POLICY AND PROCEDURE: Health Education	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:

Health education services and Plan-specific resource information are available to Plan members.

PROCEDURE:

A. Health education materials will be maintained on site or made available upon request.

1. Providers and/or staff will provide health education materials and/or resources to members as appropriate.

2. Providers and/or staff providing verbal health education, educational materials, Plan-specific resources and/or referrals to classes will document titles / content in the patient's medical record.

B. Educational materials maintained on site will be applicable to the practice and the population served.

C. Educational materials will be available in threshold languages identified for county and/or area of site location.

RESOURCES:

Materials to Keep You Informed
Health education brochures provide you with information on how to stay healthy and/or manage a disease. You can call our Health Education department at 1-323-827-6036 or email: BlueShieldofCAHealthEducation@blueshieldca.com.
We also have materials available in other topics, languages and in alternative formats. Please call the Health Education Department for more information or go to our web site https://www.blueshieldca.com/promise/providers/index.asp?secProviders=health-education-materials

PCP	
Section: Infection Control	
POLICY AND PROCEDURE: Instrument Sterilization	Approved Date:_____ Approved By:_____ Effective Date:_____ Revised Date:_____ Revised Date:

POLICY:
This site will ensure that all reusable medical instruments are properly sterilized after each use.

PROCEDURE:

I. CLEANING PRIOR TO STERILIZATION

A. Prior to undergoing the sterilization process, soiled instruments/equipment are thoroughly cleaned, rinsed, dried and inspected for the presence of dried blood or other debris. Trained personnel will be able to demonstrate or verbally explain procedure(s) used for cleaning prior to sterilization, according to site-specific policy and/or manufacturer/product label directions.

II. COLD/CHEMICAL STERILIZATION

A. The use of liquid cold chemical sterilant shall be restricted to reprocessing devices that are heat sensitive and incompatible with other sterilization methods. All other items should be heat sterilized (using an autoclave) or are disposable. Product manufacturer's directions are strictly followed for instrument pre- soaking treatment, solution preparation, solution exposure procedures, safety precautions (e.g., room temperature, area ventilation), and post-sterilization processes. Sterilization exposure times and solution expiration date/time is communicated to staff. Written site-specific policy/procedures or Manufacturer's Instructions for cold sterilization are available on site for staff reference.

B. The OSHA Hazard Communication Standard requires manufacturers and importers of hazardous chemicals to develop **Material Safety Data Sheets (MSDS**) for each chemical or mixture of chemicals. MSDS for cold chemical sterilant shall be readily available on site to staff who work with the products to which they could be exposed. Staff shall attend training classes in safety awareness about the use and exposure to cold chemical sterilant used on site. Personnel are familiar with and is able to recognize signs and symptoms of exposure to cold chemical sterilant used on site. Staff shall be aware of the procedures and are able to perform the appropriate clean up in the event of spillage. The appropriate PPE for cold chemical sterilant clean-up shall be readily available.

III. AUTOCLAVE/STEAM STERILIZATION

A. The autoclave manufacturer's directions are strictly followed for instrument pre cleaning, machine loading, operation safety precautions, minimum time temperature criteria, and post sterilization processes. Written operating procedures for autoclave are available on site to staff.

B. If instruments/equipment are transported off-site for sterilization, equipment-handling and transport procedures are available on site to staff.

IV. AUTOCLAVE MAINTENANCE

A. The autoclave is maintained and serviced according to manufacturer's guidelines. The autoclave is serviced annually by a qualified technician if the manufacturer's guidelines are not available. A dated sticker indicating the maintenance date will be placed on the autoclave or a service receipt will be kept on file to indicate documentation of mechanical problems, results/outcome of routine servicing, calibration, and repairs.

B. An autoclave log will be kept on file and will include the following:

- Date
- Time
- Duration of run cycle
- Temperature
- Steam pressure
- Load identification information
- Operator of each run

Cleaning per manufactures recommendations. This includes the recommended cleaning solutions for the Autoclave.

V. SPORE TESTING

A. Autoclave spore testing is performed at least monthly, unless otherwise stated in the manufacturer's guidelines. Spore testing reports will be maintained on file and will include the following:

- Date
- Results
- Types of spore test used
- Person performing/documenting test results

B. For positive spore tests, the autoclave is removed from service immediately until inspection is completed and a negative retest occurs. The following procedures will be followed with a positive spore test:
(**REPORT/REPAIR/RETRIEVE/RETEST/RE-STERILIZE**)

- **Report** problem to Office Manager or Doctor
- **Repair** autoclave
- **Retrieve** all instruments sterilized since last negative spore test

- **Re-test** autoclave
- **Re-sterilize** retrieved instruments

VI. STERILE PACKAGES

A. Storage areas for sterilized packages are maintained clean, dry and separated from non-sterile items by a functional barrier (e.g., shelf, cabinet door, drawer)

B. Sterilized package labels include:
- Date of sterilization
- Load run identification information
- General contents (e.g., suture set)

C. Each item in a sterile package will not be listed on the label if a master list of package contents is available elsewhere on site. It is understood that maintenance of sterility is event related, not time related. Sterilized items are considered sterile until use, unless an event causes contamination. Sterilized items are not considered sterile if package is opened, wet/moist, discolored or damaged. Compromised packages shall be removed from sterile package storage area and immediately, repackaged, relabeled, and re-sterilized.

D. This site's process for routine evaluation of the integrity and condition of sterilized packages is as follows:

☐ Monthly inspection of sterile packages by assigned personnel

☐ Other:

_____

_____

ATTACHMENTS: Instrument Sterilization Log (sample)
Autoclave Maintenance and Run Log (sample)
Cold Sterilization Log (sample)
Cold Chemical Sterilization Solution Log Sheet (sample)

Sterility is EVENT related, not time related; Pack is considers sterile unless an event causes contamination (example: punctured, torn, cracked packs= unsterile; evidence of water damage or yellowed packs= unsterile) Have Process to routine evaluation of sterile packs.

Log Process: Write date and Load # on Pack (if more than 1 load is run in the same day, write date and load #1 and then date and load #2 etc)

Date	Time	Load#	Item(s)	Temperature(250-254 Degrees)	Steam Pressure (15-17 psi)	Duration of Run (30 Minutes)	Person Responsible

Autoclave Maintenance and Run Log Year _____

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Monthly Spore Testing Results												
Monthly Cleaning												
Annual Calibration												

Sterility is EVENT related, not time related; Pack is considers sterile unless an event causes contamination (example: punctured, torn, cracked packs= unsterile; evidence of water damage or yellowed packs= unsterile) Have Process to routine evaluation of sterile packs.

Log Process: Write date and Load # on Pack (if more than 1 load is run in the same day, write date and load #1 and then date and load #2 etc)

Date	Time	Load#	Item(s)	Temperature(250-254 Degrees)	Steam Pressure (15-17 psi)	Duration of Run (30 Minutes)	Person Responsible

Cold Sterilization Log

<u>Follow Manufacture's</u> recommend solution soaking time for sterilization; use of the test strips to ensure solution efficiently destroys 100% of Mycobacterium Tuberculosis and Solution change.

Name of Solution _____

Date	Solution Tested Pass / Fail	Fail/Exp Date	Comment or Action Taken	Type of instruments in Solution	Length of time Items in solution	Initials
	+ / -					
	+ / -					
	+ / -					
	+ / -					
	+ / -					
	+ / -					
	+ / -					
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	+ / -					
	+ / -					

Cold Chemical Sterilization Solution Log Sheet

Name of Solution ______________________________

Date Solution was changed	Date Solution Test Strip(according to manufacturer's directions)	Test results (+) Pass/ (-) Fail Circle one	Test By: Initials
		+ / -	
		+ / -	
		+ / -	
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		+ / -	
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