PCP/Clinic Name: QM Nurse:
Address:

CAP Notification

Date of Review:

PCP ID# _____

Health Plan Performing Evaluation	**IEHP**	**Molina**	**HealthNet**	**LA Care**	**Kaiser**	

Facility Name:	PCP Name(s):	# of PCPs Reviewed: # of Charts Reviewed:
Address:	Contact Person and Title:	
Telephone: / Fax:	☐ Exempted Pass for the Site Review Survey – No CAP Due ☐ Exempted Pass for the Medical Record Review Survey – No CAP Due	
Site Review Score:	**Date Critical Element CAP Due:** Date Site Review CAP Due:	**CAP Follow-up:** ☐ Mail/Fax ☐ Schedule Follow-up visit ☐ Critical Element ☐ Site Review ☐ Medical Records ☐ Follow-up visit scheduled date/time : _____
Medical Record Score:	Date Medical Record CAP Due:	**CAP Closed Date:**
Reviewer's Name/Title (Print):	**Reviewer's signature/Title:**	

Corrective Action Plan (CAP) Completion and Submission Requirements

The Health Plans have collaborated in establishing a process to facilitate compliance while limiting the intrusion into your facility. Participating Health Plans agree to accept evaluation findings of the other Health Plans upon the physician's signature of Disclosure and Release. The collaborative process does not supersede any contractual requirements, and participation is voluntary.

Disclosure and Release

I have received and reviewed copies of the above listed site's evaluations and corrective action plans for the facility and medical record reviews. I agree to correct each identified deficiency by implementing any corrective action that may be required. **I understand that failure to correct any of the noted Critical Element deficiencies within the required 10 business days and any other noted deficiencies within the 30-day time period from the review date,** may result in the exclusion of this facility and the associated provider(s) from the roster. **The completed CAP must include evidence of correction** {e.g. invoices, education sign sheets, forms used} **and dates completed.**

For assistance in completing the CAP, please call_____, QM RN, DHCS-CSR at 909- _____.

I hereby authorize the above mentioned health plans and any government agencies that have authority over the health plans, and authorized county entities in the State of California, to furnish to each other these reviews and corrective action plans of this facility.

_____ _____ _____

Physician/Designee Signature **Printed Name and Title** **Date**

Please Return Completed CAP via U.S. Mail or FAX to: **Attention: QM Coordinator** **FAX 909-890-5746**	**Inland Empire Health Plan** **P.O. Box 1800,** **Rancho Cucamonga, CA 91729-1800**	**PCPs wishing to appeal the results of a Facility Site Review and Medical Record Review Survey must do so in writing, to Chief Medical Officer or Designee, within 14 working days of the date of the notification letter.**	**P.O. Box listed to the left. CMO Fax phone number: (909) 890-2019**

PCP/Clinic Name: QM Nurse:
Address:

INSTRUCTIONS FOR USE

1st Column: (Health Plan Use Only) Health Plan verification and date – The Health Plans Certified Site Reviewer (CSR) will initial and date the deficiency that the site has addressed/corrected. The Provider's Corrective Action Plan will be verified by the CSR through a desk review by the Health Plan and/or a follow-up on site visit.

2nd Column: (Health Plan Use Only) Criteria – The Health Plan's CSR will check the criteria(s) that were found deficient during the site review and/or medical record review processes. The criteria(s) checked should be addressed/corrected by the provider's office. A corrective action plan (CAP) for all critical element deficiencies, which are bolded and underlined, should be submitted to the Health Plan within 10 business days. A corrective action plan for other criteria found deficient is due to the Health Plan within 45 days from the date of audit.

3rd Column: (Health Plan Use Only) Deficiency Cited/Reviewer Comments – This column is for the purpose of notifying the provider and/or designated staff of the deficiency found and/or the CSR findings/comments.

4th Column: (Health Plan and Provider's Office Use) Recommended Corrective Action – The Health Plan's CSR will check and/or write comments for the Provider's office in order to notify the Provider and/or designated staff the documents and/or evidence needed in order to fulfill a deficiency.

5th Column: (Provider's Office Use Only) Correction Date – The provider's office will document the date that a deficiency has been addressed and/or corrected.

6th Column: (Provider's Office Use Only) Practitioners Comments – The provider's office will document corrective actions taken to address/correct a deficiency, as well as provide appropriate documents to support corrective actions taken. If provider's office agrees with items checked in the 4th Column (Recommended Corrective Action) then the provider's office would write "agree with recommended corrective action," as well as submit supporting documents.

7th Column: (Provider's Office Use Only) Signature and Title of Responsible Physician or Designee – The office staff who is responsible for maintaining compliance with a deficiency found during a site audit would put their name, title, and initial in this column.

NOTE: The Health Plan's Certified Site Reviewer (CSR) may conduct a follow-up on site review to verify corrective action within 45 days from the date of audit and/or request the corrective action plan (CAP) to be submitted to the Health Plan via mail and/or fax.

CAP COMPLETION SIGNATURE PAGE

I have completed the corrective action plans for the facility and medical record reviews performed on _____. I affirm each
(Enter Date of Review)

Corrective action has been implemented as indicated on the attached Corrective Action Plan. I hereby authorize the reviewing health plan to furnish to all collaborative health plans, any government agencies that have authority over the health plans, and authorized county entities in the State of California, the corrective action plans and related review tools for this facility.

_____	_____	_____
Physician/Designee Signature	**Printed Name and Title**	**Date**

Please Return Completed Corrective Action Plan and this signature sheet. via U.S. Mail or FAX to:

Inland Empire Health Plan
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800
Attention: QM Coordinator
FAX 909-890-5746

PCP/Clinic Name: QM Nurse:
Address:

Site Review Survey Critical Element CAP DATE DUE:
Signature Responsible Person:

NOTE: ALL CRITICAL ELEMENT CORRECTIVE ACTIONS MUST BE COMPLETED AND SUBMITTED TO THE AUDITING HEALTH PLAN WITHIN 10 BUSINESS DAYS OF THE SITE VISIT. THERE ARE NO EXCEPTIONS. Criteria that are **bolded** and underlined are considered critical elements.

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
I Access/Safety **Site Access/Safety Survey Criteria**						
C. Site is accessible and useable by individuals with physical disabilities ***3CCR 504; 24 CCR (CA Building Standards Code); 28 CFR 35 (American Disabilities Act of 1990, Title II, Title III)***						
	I AS C 4 ☐	**Exit doors and aisles are obstructed and egress (escape) is not accessible.**	☐ Exit doors and aisles have been cleared and egress (escape) is not impeded. ☐ A signed written explanation of corrective actions taken for exit doors and aisles to be unobstructed and egress accessible. ☐ Other:			
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week **22 CCR § 51056, §53216; 28 CCR §1300.67; 42 USC §139.5 (d) RN or MD Review Only**						
	I AS D 4 ☐	**Airway management: oxygen delivery system, bulb syringe nasal cannula or mask, Ambu bag are not available on site.**	☐ A copy of the receipt/invoice for the following: (Circle those that apply) portable oxygen tank, bulb syringe, nasal cannula or mask, ambu bag (adult/child) ☐ A copy of the receipt/work invoice for re-charging oxygen tank to at least ¾ full. ☐ A copy of the office policy and procedure regarding oxygen tank replacement or back up method is attached. ☐Other:			

PCP/Clinic Name: QM Nurse:
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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	IASD 5 ☐	**Emergency medicine such as asthma, chest pain, hypoglycemia and anaphylactic reaction management: Epinephrine 1:1000 (injectable), and Benadryl 25 mg. (oral) or Benadryl 50 mg./ml. (injectable), Naloxone, chewable Aspirin 81 mg, Nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), and glucose. Appropriate sizes of ESIP needles/syringes and alcohol wipes.**	☐ A copy of the receipt/invoice for the following: (Circle those that apply) Naloxone, chewable Aspirin, Nitroglycerine spray/tablet, nebulizer, or metered dose inhaler and glucose. ☐ A copy of the office policy and procedure regarding emergency medications is attached. ☐ Other:			

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE

PCP/Clinic Name: QM Nurse:
Address:

II Personnel **Site Personnel Survey Criteria**						
C. Site personnel are qualified and trained for assigned responsibilities. ***CA Business & Professional (B&P) Code 2069. 16 CCR 1366, 22 CCR 75034, 75035***						
	IIP C 2 ☐	**No evidence that a qualified/trained personnel retrieve, prepare or administer medications**	☐ A copy of the office policy and procedure regarding qualified/trained personnel retrieve, prepare or administer medications is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
III Office Management **Office management survey Criteria**						
E. Procedures for timely referral/consultative services are established on site. **22CCR §53851: 28CCR § 1300.67 RN or MD Review Only**						
	III O M E 2 ☐	**Physician review and follow-up of referral/consultation reports and diagnostic test results is not evident.**	☐ A copy of the office policy and procedure regarding referrals to include the physician review and follow-up of referral/consultation reports and diagnostic test results is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the actual referral log utilized by the office is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
IV Clinical Services **Pharmaceutical Services Survey Criteria**						
C. Drugs are dispensed according to State and federal drug distribution laws and regulations. ***CA B&P Code 4024, 4076, 4170, 4171, 4173, 4174; 22 CCR 75032, 75033, 75036, 75037(a-g), 75038; 75039; 16 CCR 1718.1; 21 CFR 211.137, 42 USC 6A 300AA-26***						
	IV CS C 4 ☐	**Drugs are being dispensed to patients by other than lawfully authorized persons**	☐ A copy of the office policy and procedure regarding dispensing of medications is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A signed written explanation of the corrective action taken in regards to dispensing of medications. ☐ Other:			
	IV CS C5	**Personnel are unable to demonstrate or verbally explain procedures that vaccines are prepared and drawn only prior to administration.**	☐ A copy of the office policy and procedure regarding preparing and drawing up of medications is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A signed written explanation of the corrective action taken in regards to prepping of medications. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

VI Infection Control Infection Control Survey Criteria						
B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. ***8CCR 5193 (Cal OSHA Health Care Worker Needlestick Prevention Act, 1999); H&S Code, 117600-118360 (CA Medical Waste Management Act, 1997); 29 CFR 1910.1030.***						
	VI IC B 1 ☐	**Personal protective equipment is not readily available for staff use.**	☐ A copy of the receipt/invoice for the following is attached: (Circle those that apply) clothing barrier/gown, water repelling gloves, goggles/face shield, mask. ☐ A copy of the office policy and procedure regarding personal protective equipment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	VI IC B 2 ☐	**Blood, other potentially infectious material and regulated wastes are not placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport or shipping.**	☐ A copy of the receipt/invoice for the purchase of an appropriate biohazardous container is attached. ☐ A copy of the office policy and procedure regarding Biohazardous waste handling is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A signed written explanation of the corrective action taken in regards to regulated wastes. ☐ Other:			
	VI IC B 3 ☐	**Needle stick safety precautions are not practiced on site.**	☐ A copy of the receipt/invoice for the purchase of Engineered Sharps Injury Protection (ESIP) is attached. ☐ A copy of the office policy and procedure regarding needle stick safety precautions is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
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D. Re-usable medical instruments are properly sterilized after each use. ***22CCR 53230, 53856; CA H&S Code, Chapter 6.1, 25090***						
	VI IC D 3a ☐	**Staff unable to demonstrate/verbalize necessary steps to ensure sterility and/or high-level disinfection to ensure sterility of equipment.**	☐ A copy of the office policy and procedure addressing steps to ensure sterility or disinfection. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	VI IC D 3c ☐	**Staff unable to demonstrate/verbalize an exposure control plan, Material Safety Data Sheets and procedure for cleaning up cold chemical sterilant spills.** **Site does not maintain appropriate PPE.**	☐ An invoice or receipt for appropriate PPE **plus:** ☐ A copy of the office policy and procedure addressing PPE requirements, exposure plan and clean up instructions. ☐ A copy of the Material Safety Data Sheets (MSDS) ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	VI IC D 4c ☐	**Spore testing of autoclave/steam sterilizer with documented results is not done at least monthly.**	☐ A copy of actual spore test results for the past _____ month(s) is attached. ☐ A copy of the office policy and procedure addressing positive spore test results is attached. ☐ A copy of the office policy and procedure and/or manufacturer's instructions regarding autoclave/steam sterilization is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	VI IC D 4d ☐	**Staff is unable to demonstrate/verbalize site protocols and/or manufacturer/product label for management of a positive spore test.**	☐ A copy of the office policy and procedure addressing positive spore test results is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Site Review Survey

1.

I. Access/Safety

Site Access/Safety Survey Criteria

A. Site is accessible and useable by individuals with physical disabilities
24 CCR (CA Building Standards Code); 28 CFR § 35 (American Disabilities Act of 1990, Title II, Title III)

ADA Regulations: Site must meet city, county and state building structure and access ordinances for persons with physical disabilities. A site/facility includes the building structure, walkways, parking lots, and equipment. All facilities designed, constructed; or altered by, on behalf of, or for the use of public entity must be readily accessible and usable by individuals with disabilities, if the construction or alteration was begun after January 26, 1992 (28 CFR 35. 151). Any alteration to a place of public accommodation or a commercials 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 usable by individuals with disabilities, including individuals who use wheelchairs (28 CFR 36.402).

Sites must have the following safety accommodations for physically disabled persons:
Check only elements that have deficiencies in the criteria column

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	I AS A 1 ☐	There is not a clearly marked (blue) curb or sign designating disabled-parking space near an accessible primary entrance.	☐ A picture of parking space(s) for the disabled have been designated and are designated using reflectorized signs posted conspicuously. ☐ Signed written explanation of corrective action taken in regards to disabled parking space(s). ☐ Facility is located in residential area where designated parking is not permitted. ☐ A copy of the local ordinance is attached. ☐ A copy of the work invoice with completion date or receipts are attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	IASA 2 ☐	Pedestrian ramps do not have a level landing at the top and bottom of the ramp.	☐ A picture of a clear and level landing at the top and bottom of all ramps and on each side of the exit door has been provided**.** ☐ A copy of the work invoice with completion date or receipts are attached. ☐ Other:			
	IASA 3 ☐	Exit doorway openings do not allow for clear passage of a person in a wheelchair.	☐ All appropriate doorways have been remodeled to accommodate patients in wheelchairs. ☐ A 32 inch clearance for exit doorway-openings had been established. ☐ A copy of the completed and dated work invoice or receipts is attached. ☐ A copy of the building wavier is attached. ☐ Other:			
	IASA 4 ☐	There is not an accessible passenger elevator or reasonable alternative for multi-level floor accommodation.	☐ Elevator service has been provided for the facility. ☐ A copy of the completed and dated work invoice or receipts is attached. ☐ A freight elevator has been upgraded for general passenger use. ☐ A building waiver is in effect and is attached. ☐ Other:			
	IASA 5 ☐	Floor space for wheelchair in waiting area and exam room is not clear.	☐Waiting room and exam/treatment room have been rearranged to provide for a stationary adult wheelchair with appropriate room for turning. ☐An appropriate procedure is in place to accommodate a wheelchair. A copy of the procedure is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	I AS A 6 ☐	Restroom facilities are not wheelchair accessible and/or there was no reasonable alternative.	☐ Restroom facilities have been remodeled to accommodate wheelchair accessibility. ☐ A copy of the receipt and/or work invoice is attached. ☐ An alternative procedure is in place and the policy and procedure is attached. ☐ Other:			
	I AS A7 ☐	Hand washing facilities are not wheelchair accessible and/or there was no reasonable alternative.	☐ A sink has been modified to meet wheelchair access and safety requirements. ☐ A copy of the receipt and/or work invoice is attached. ☐ An alternative for hand washing facilities for wheelchair patients is in place and a copy of the policy and procedure is attached. ☐ Other:			
B. Site environment is maintained in a clean and sanitary condition *8 CCR §5193; 28 CCR §1300.80*						
	I AS B 1 ☐	All patient areas including floor/carpet, walls, and furniture are not neat, clean, and well maintained.	☐ The floors, carpets, walls, and furniture have been cleaned and/or repaired. ☐ A copy of the receipt and/or work invoice is attached. ☐ Other:			
	I AS B 2 ☐	Restrooms are not clean and/or do not contain appropriate sanitary supplies.	☐ Appropriate sanitary supplies have been obtained and placed in the restrooms. ☐ Circle which supply is needed: toilet tissue, hand washing soap, cloth/paper towels or antiseptic towelettes. ☐ A copy of the receipt and/or work invoice is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
C. Site environment is safe for all patients, personnel and visitors *8 CCR §3220; 22 CCR §53230; 24 CCR, §2, § 3, §9; 28 CCR §1300.80; 29 CFR §1910.301, §1926.34*						
Evidence that site staff has received training and/or information in the following:						
	I AS C 1 ☐	There is no evidence that site staff has received training and/or information in fire safety and prevention.	☐ Training has been provided to site personnel regarding fire prevention/safety. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office fire safety and prevention policy and procedure is attached. ☐ Other:			
	I AS C 2 ☐	There is no evidence that site staff has received training and/or information in emergency non-medical procedures (e.g. site evacuation, workplace violence, abusive patients)	☐ Training has been provided to site personnel regarding non-medical emergency procedures-site evacuation, workplace violence, and abusive patients. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office non-medical emergency policy and procedure is attached. ☐ Other:			
	I AS C 3 ☐	There is not adequate lighting in all areas to ensure safety.	☐ Lighting in working and walking areas has been installed. ☐ A copy of the receipt and/or work invoice is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	IASC 5 ☐	Exit doors are not clearly marked with "Exit" signs.	☐ "Exit" signs have been posted in the following areas: ☐ A copy of the receipt and/or work invoice is attached. ☐ Other:			
	IASC 6 ☐	There are no clearly diagramed "Evacuation Routes" for emergencies posted in a visible location.	☐ Clearly marked, easy-to-follow escape routes have been posted in visible areas. ☐ A copy of the office evacuation diagram posted is attached. ☐ Other:			
	IASC 7 ☐	Electrical cords and outlets are not in good working condition.	☐ Electrical cords have been replaced/repaired. ☐ Electrical outlets have been replaced/repaired. ☐ A copy of the receipt and/or work invoice is attached. ☐ Other:			
	IASC 8 ☐	There is not at least one type of fire-fighting/protection equipment that is accessible at all times.	☐ Smoke detector with intact, working batteries. ☐ Fire alarm device with code and reporting instructions posted conspicuously at phones and employee entrances. ☐ Automatic sprinkler system with sufficient clearance (10-in.) between sprinkler heads and stored materials. ☐ Fire extinguisher in an accessible location that displays readiness indicators or has an attached current dated inspection tag. A copy of the current dated inspection tag is attached. ☐ Other:			
	IASC9 ☐	There is no employee alarm system in place to warn employees of fire or other emergencies.	☐ Invoice or receipt for employee alarm system. ☐ Policy or procedure addressing employee notification of fire or other emergencies. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week ***22 CCR §51056, §53216; 28 CCR §1300.67*****In order to be fully compliant with this section, please a written policy and procedure and documented evidence of staff training.**						
	I AS D 1 ☐	No evidence of personnel being trained in procedures/action plan to be carried out in case of a medical emergency on site.	☐ A copy of the office medical emergency policy and procedure is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	I AS D 2 ☐	Emergency equipment is not stored together in an easily accessible location.	☐ Emergency equipment is stored in an easily accessible location. ☐ Emergency equipment is appropriately sealed and is within the expiration dates posted on the label/seal. ☐ Other:			
	I AS D 3 ☐	There are no emergency phone number contacts posted.	☐ Emergency phone numbers are posted and are easily accessible to office staff. ☐ A copy of the emergency phone number list is attached. ☐ List should be dated, and updated annually. ☐ Other:			
Emergency medical equipment appropriate to practice/patient population is available on site:						
	I AS D 5 ☐	There is no evidence of anaphylactic reaction management supplies. Minimum supplies include Epinephrine 1:1000 (injectable), and Benadryl 25mg (oral) or Benadryl 50mg/ml (injectable), appropriate sizes of ESIP needles/ syringes and alcohol wipes.	☐ The following anaphylactic reaction management supply has been obtained: ☐ Epinephrine 1:1000 (injectable) ☐ Benadryl 25mg (oral) ☐ Benadryl 50mg/ml (injectable) ☐ Appropriate sizes of ESIP needles/syringes ☐ Alcohol wipes ☐ A copy of the receipt(s) is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	I AS D 6 ☐	Medication dosage chart (or other method for determining dosage) is not kept with emergency medications.	☐ A medication dosage chart has been included for each medication in the emergency kit. ☐ A copy of the following medication dosage chart is attached: ☐ Other:			
	I AS D 7 ☐	There is no documentation on checking of emergency equipment/supplies for expiration and operating status at least monthly.	☐ Emergency equipment/supplies are checked at least monthly for expiration and operating status. ☐ A copy of the office log is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	I AS D 8 ☐	No evidence that emergency equipment is replaced/re-stocked immediately after use.	☐ Emergency equipment is replaced/re-stocked immediately after use. ☐ A copy of the office policy and procedure is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

E. Medical and lab equipment used for patient care is properly maintained
CA Health & Safety Code § 111255; 28 CCR §1300.80, 21 CFR §800-1299
In order to be fully compliant with this section, please submit a written policy and procedure, a receipt for repairs and/or supplies, and documented evidence of staff training.

PCP/Clinic Name: QM Nurse:
Address:

	I AS E 1 ☐	There is no evidence that medical equipment is clean.	☐ All specialized medical equipment is cleaned according to manufacturer's guidelines after use. ☐ A signed written explanation of corrective action taken in regards to cleaning of medical equipment. ☐ Other:			

Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	I AS E 2 ☐	There is no evidence of written documentation demonstrating the appropriate maintenance of all specialized medical equipment according to equipment manufacturer's guidelines.	☐ All medical equipment is serviced annually by a qualified technician or according to manufacturer's guidelines. ☐ A copy of the receipt and/or work invoice is attached. ☐ A copy of the calibration log for the following equipment: ☐ Glucometer ☐ Hemocue ☐ Other: ☐ Other:			

II. Personnel
Site Personnel Survey Criteria

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
A. Professional health care personnel have current California Licenses and Certifications. ***CA Business & Professional (B&P) Code §2050,* §2085, §2725, §2746, §2834, §3500, §4110; CCR, Title 16, §1355.4, §1399.547**						
	II P A 1 ☐	No evidence that all required Professional License(s) and Certification(s) issued from appropriate licensing/certification agencies are current.	☐ A copy of the following physician(s)/provider(s) license(s) or DEA certificate(s) is attached: ☐ Other:			
	II P A2 ☐	No evidence of Notification to Consumers for the licensed MD(s) and/or Physician Assistant(s).	☐ A copy of the Notification to Consumers for the licensed MD(s) and/or Physician Assistant(s) is attached: ☐ Other:			
B. Healthcare personnel are properly identified. ***CA B&P Code §680, AB 1439***						
	II P B 1 ☐	Healthcare personnel were not wearing identification badges/tags printed with name and title.	☐ A copy of identification badges/tags printed with name and title. ☐ Licenses and/or certificates are prominently displayed. ☐ A copy of the receipt/invoice is attached. ☐ Other:			
C. Site personnel are qualified and trained for assigned responsibilities. ***CA B&P Code §2069; 16 CCR §1366; 22 CCR §75034, §75035***						
	II P C 1 ☐	There is no documentation maintained on site showing education/training for non-licensed medical personnel.	☐ Diploma or certification from an accredited training program or a letter from current supervising physician certifying demonstrated proficiency of staff member to perform technical supportive services for the following staff is attached: ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	II P C 3 ☐	Site does not have a written policy or procedure documenting the process for confirming correct patient/medication/vaccine dosage prior to administration.	☐ A copy of the office policy and procedure is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II P C4 ☐	There was no evidence that qualified/trained personnel operate medical equipment.	☐ A copy of documentation of training for the following staff and medical equipment operated is attached:☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
D. Scope of practice for Non-Physician Medical Provider (NPMP) is clearly defined. ***16 CCR §1379, §1399.540, §1399.545, §1474, CA B&P Code §2725.1*** **In order to be fully compliant with this section, please submit a copy of the current Procedures, Agreements, or License**						
	II P D 1 ☐	There is no evidence of Standardized Procedures defining the scope of services provided for Nurse Practitioners (NP) and/or Certified Nurse Midwives (CNM).	☐ A copy of the currently signed and dated Standardized Procedures defining the scope of services provided for the Nurse Practitioner(s) (NP) and/or Certified Nurse Midwives (CNM) is attached: ☐ Other:			
	II P D 2 ☐	There is no evidence of a Practice Agreement defining the scope of services provided by Physician Assistants (PA) and Supervisory Guidelines defining the method of supervision by the Supervising Physician.	☐ A copy of the currently signed and dated Practice Agreement(s) is attached for the following physician assistant(s): ☐ A copy of the Practice Agreement(s) defining the method of supervision by the Supervising Physician is attached for the above PAs listed. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	II P D 3 ☐	There is no evidence that the Standardized Procedures, Practice Agreement and Supervisory Guidelines are revised updated and signed by the supervising physician and NPMP when changes in scope of services occur.	☐ Provide evidence of the Practice Agreements and Supervisory Guidelines for PAs as well as Standardized Procedures for NPs and CNMs are revised and signed by physician and mid-level practitioner when the scope of services changes. ☐ Other:			
	II P D 4 ☐	There is no evidence that the NPMP prescribing controlled substances has a valid DEA Registration Number.	☐ A current copy of the DEA Registration certificate for the following NPMP(s) is attached: ☐ Other:			
E. Non-physician medical providers (NPMP) are supervised according to established standards. ***B&P Code 3516(b); W&I Code 14132.966***						
	II P E 1 ☐	The ratio of the designated supervising physician on site and the number of NPMPs exceeds the established ratios in the following combination: a) 1:4 Nurse Practitioners b) 1:4 Certified Nurse Midwives c) 1: 4 Physicians Assistants	☐ A copy of the physicians on duty and the number of NPMP's supervised is attached along with the office policy and procedure on NPMP supervision. ☐ A signed written statement explaining the corrective action taken to establish proper ratios of the designated supervising physician(s) on site. ☐ Other:			
	II P E 2 ☐	There is no evidence the designated supervising or back-up physician is available in person or by electronic communication at all times when a NPMP is caring for patients.	☐ A copy of the policy and procedure for contacting the supervising or back up physician is attached. ☐ A signed written statement explaining the corrective action taken to communicate with the designated supervising or back-up physician. ☐ Other:			
	II P E3 ☐	Sites with Non-physician Medical Practitioners (NPMP) unable to provide evidence of physician supervision reviewing, countersigning, and dating a minimum sample of 5% of records.	☐ A copy of the policy and procedure for reviewing, countersigning, and dating a minimum of five percent sample of records of patients treated by NPMP. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
F. Site personnel receive safety training /information. ***8CCR §5193; CA H&S Code §117600; CA Penal Code §11164, §11168; 29CFR §1910.1030***						
	II P F 1 ☐	There is no evidence the site staff has received annual training and/or information regarding Infection Control / Universal Precautions.	☐ A copy of the office policy and procedure regarding Infection Control/Universal Precaution is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Annual staff training must be conducted regarding Infection Control/ Universal Precautions. ☐ Other:			
	II P F 2 ☐	There is no evidence the site staff has received annual training and /or information regarding Blood Borne Pathogens Exposure Prevention.	☐ A copy of the office policy and procedure regarding Blood Borne Pathogens Exposure Prevention is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Annual staff training must be conducted regarding office Blood Borne Pathogens Exposure Prevention Plan. ☐ Other:			
	II P F 3 ☐	There is no evidence the site staff has received annual training and/or information regarding Biohazardous Waste Handling.	☐ A copy of the office policy and procedure regarding Biohazardous Waste Handling is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Annual staff training must be conducted regarding Biohazardous Waste Handling. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
G. Site personnel receive training and/or information on member rights. ***22 CCR §51009, §51014.1, §51305.1, §53452, §53858; 28 CCR §1300.68***						

PCP/Clinic Name: QM Nurse:
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	II P G 1 ☐	There is no evidence that the staff has received training / information regarding Patient Confidentiality	☐ A copy of the office policy and procedure regarding Patient Confidentiality is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	II P G 2 ☐	There is no evidence that the staff has received training / information regarding Informed Consent, including Human Sterilization	☐ A copy of the office policy and procedure regarding Informed Consent, including Human Sterilization, is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	II P G 3 ☐	There is no evidence that the staff has received training / information regarding Prior Authorization Requests	☐ A copy of the office policy and procedure regarding Prior Authorization Requests is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II P G 4 ☐	There is no evidence that the staff has received training / information regarding Grievance/ Complaint Procedures	☐ A copy of the office policy and procedure regarding Grievances and/or Complaints is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II P G 5 ☐	There is no evidence the staff have specific knowledge of local reporting requirements, agencies, and procedures for Child/Elder/Domestic Violence Abuse reporting.	☐ A copy of the office policy and procedure regarding Child/Elder/Domestic Violence Abuse reporting is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	II P G 6 ☐	There is no evidence that the staff has received training / information regarding Sensitive Services/Minors' Rights	☐ A copy of the office policy and procedure regarding Sensitive Services/Minors' Rights is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II P G 7 ☐	There is no evidence that the staff has received training/information regarding Health Plan referral process/procedures/resources	☐ A copy of the office policy and procedure regarding Health Plan referrals is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form.log utilized is attached. ☐ Other:			
	II P G 8 ☐	There is no evidence that the staff has received training/information regarding Cultural and Linguistic Appropriate Services (CLAS).	☐ A copy of the office policy and procedure regarding Cultural and Linguistic appropriate services is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form.log utilized is attached. ☐ Other:			
	II P G 9 ☐	There is no evidence that the staff has received training/information regarding Disability Rights and Provider Obligations	☐ A copy of the office policy and procedure regarding disability Rights and Provider Obligations ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form.log utilized is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

III. Office Management
Office Management Survey Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
A. Physician coverage is available 24 hours a day, 7 days a week 22 CCR §56500, §53855 **The following are maintained current on site:**						
	III OMA 1 ☐	Clinic Office Hours are not posted or readily available upon request.	☐ The clinic office hours are now posted. ☐ The clinic office hours are readily available at the reception desk. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	III OMA 2 ☐	Provider office hour schedules are not available to staff.	☐ Provider office hours are available to staff. ☐ A copy of the provider office hours is attached. ☐ Other:			
	III OMA 3 ☐	Arrangement/schedule for after-hours, on-call, supervisory back-up physician coverage is not available to site staff.	☐ Arrangement/schedule for after-hours, on-call, supervisory back-up physician coverage is available to site staff. ☐ A copy of the arrangement/schedule for after-hours coverage is attached. ☐ Other:			
	III OMA 4 ☐	Contact information for off-site physician(s) is not available at all times during office hours	☐ Contact information for off-site physician(s) is available to staff. ☐ A copy of the contact information is attached. ☐ Other:			
	III OMA 5 ☐	Routine, urgent, and after-hours emergency care instructions/telephone information is not made available to patients..	☐ Routine, urgent, and after-hours emergency information is supplied to patients by the voice mail system and/or answering service. ☐ A copy of the policy and procedure and the script for provision of the information is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
B. **There are sufficient health care personnel to provide timely, appropriate health care services.** 22 CCR §53855; 28 CCR §1300.67.1, §1300.80						
	III OM B 1 ☐	Appropriate personnel do not handle emergent, urgent, and medical advice telephone calls.	☐ A copy of the office policy and procedure regarding Handling emergent, urgent, and medical advice telephone calls is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	III OM B 2 ☐	Telephone answering machine, voice mail system or answering service is not used whenever office staff does not directly answer phone calls.	☐ A telephone answering machine, voice mail system, and/or answering service has been put in place and a copy of the contract and/or invoice is attached. ☐ A signed written statement explaining the corrective action taken. ☐ Other:			
	III OM B 3 ☐	Telephone system, answering service, recorded telephone information, and recording device are not periodically checked and updated.	☐ A policy and procedure regarding periodically checking and updating the telephone system, answering service or recorded telephone information and related equipment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
C. **Health care services are readily available.** 22 CCR §56000 (2) **RN or MD review only.**						
	III O M C 1 ☐	Appointments are not scheduled according to patients stated clinical needs within the timeliness standards established for Plan members.	☐ A copy of the office policy and procedure regarding appointment scheduling is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	III O M C 2 ☐	Patients are not notified or reminded of scheduled routine and/or preventive screening appointments	☐ A copy of the office policy and procedure regarding notification of routine and/or preventive screening appointments is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	III O M C 3 ☐	There is no process in place to verify follow up on missed and canceled appointments	☐ A copy of the office policy and procedure and/or process regarding missed and/or cancelled appointments is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
D. **There is 24-hour access to interpreter services for limited-English proficient members.** 22 CCR §53851; 28 CCR 1300.67.04						
	III O M D 1 ☐	Interpreter services are not made available in identified threshold languages specified for location of the site.	☐ A copy of the office policy and procedure regarding interpretive services is attached. ☐ A signed written statement explaining the corrective action taken to provide interpretive services is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	III O M D 2 ☐	There is no evidence that persons providing language interpreter services on site are trained in medical interpretation.	☐ Documentation of training/assessment for the following personnel used for medical interpretation on site is attached: ☐ Other:			
E. **Procedures for timely referral/consultative services are established on site.** 22 CCR §53851; 28 CCR §1300.67 and §1300.80 **RN or MD Review Only** **Office practice procedures allow timely provision and tracking of:**						
	III O M E 1 ☐	There is no established system evident for processing internal and external referrals, consultant reports and diagnostic test results	☐ A copy of the office policy and procedure regarding processing internal and/or external referrals is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the referral log is attached. ☐ Other:			
F. **Member Grievance/Complaint processes are established on site** 22 CCR §53858, §56260						
	III O M F 1 ☐	Phone number(s) for filing grievances/complaints are not located on site	☐ The phone number(s) for filing grievances/complaints are located on site. ☐ A copy of the phone number(s) for filing grievances/complaints is attached. ☐ Other:			
	III O M F 2 ☐	Complaint forms and a copy of the grievance procedure(s) are not available on site.	☐ A copy of the office policy and procedure regarding grievances/complaints is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the complaint/grievance form utilized by the office is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
G. **Medical records are available for the practitioner at each scheduled patient encounter.** 22 CCR §75055; 28 CCR §1300.80						
	III O M G 1 ☐	Medical records are not readily retrievable for scheduled patient encounters.	☐ A copy of the office policy and procedure regarding medical record availability is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	III O M G2 ☐	Medical documents are not filed in a timely manner to ensure availability for patient encounters.	☐ A copy of the office policy and procedure regarding medical record accessibility and storage is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
H. Confidentiality of personal medical information is protected according to State and Federal guidelines. 22 CCR §51009, §53861, §75055; **§**28 CCR §1300.80; CA Civil Code §56.10 (Confidentiality of Medical Information Act) **RN or MD Review Only**						
	III O M H 1 ☐	Exam rooms and dressing areas do not safeguard patients' right to privacy.	☐ A signed written statement explaining the corrective action taken to provide patients' right to privacy is attached. ☐Other:			
	III O M H 2 ☐	Procedures are not followed to maintain the confidentiality of personal patient information.	☐ A copy of the office policy and procedure regarding confidentiality of medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Medical Record storage should be secured and/or inaccessible to unauthorized persons. ☐ A copy of the receipt and/or work order is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	III O M H 3 ☐	Medical record release procedures are not compliant with State and Federal guidelines.	☐ A copy of the office policy and procedure regarding medical record release is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the medical record release form utilized by the office is attached. ☐ Other:			
	III O M H 4 ☐	Storage and transmittal of medical records does not preserve confidentiality and security.	☐ A copy of the office policy and procedure regarding medical record storage and transmittal is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the receipt/invoice and/or contract with a medical record storage company is attached. ☐ Other:			
	III O M H 5 ☐	Medical records are not retained according to current State and DHS Standards.	☐ A copy of the office policy and procedure regarding retaining medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
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IV. Clinical Services
Pharmaceutical Services Survey Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
A. Drugs and medication supplies are maintained secure to prevent unauthorized access. ***CA B&P Code* §4172; *22 CCR* §75037(a-g), §75039; *21 CFR* §1301.75, §1301.76, §1302.22; *16 CCR* §1356.3**						
	IV CS A 1 ☐	Drugs are not stored in specifically designated cupboards, cabinets, closets or drawers.	☐ Drugs have been placed in a designated space. ☐ The drug storage space is lockable and is not accessible by unauthorized person(s). ☐ A copy of the receipt is attached. ☐ The drug area is kept locked when authorized personnel are not in the immediate area. ☐ Other:			
	IV CS A 2 ☐	Prescription, sample and over-the-counter drugs, hypodermic needles/syringes, prescription pads are not securely stored in a lockable space (cabinet or room) within the office/clinic.	☐ Prescription, sample and over-the-counter drugs, hypodermic needles/syringes, prescription pads are stored in a lockable space. ☐The space is lockable and is not accessible by unauthorized person(s) for the following items: ☐ A copy of the receipt and/or work invoice is attached. ☐ Other:			
	IV CS A 3 ☐	Controlled drugs are not stored in a locked space accessible only to authorized personnel.	☐ Controlled drugs have been stored in a locked space accessible only to authorized personnel. ☐Controlled drug keys are with the authorized personnel only. (Physician must specify authorized personnel) ☐ A copy of the receipt and/or work invoice is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	IV CS A 4 ☐	A dose-by-dose controlled substance distribution log is not maintained.	☐ A copy of the controlled substance distribution log is attached and includes the following information: the Providers DEA Number, Name of medication, original quantity of drug, dose, date, name of patient receiving drug, name of authorized person dispensing drug, and number of remaining doses. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	IV CS A5 ☐	Sites does not have a written site-specific policy or procedure for the safe and effective distribution, control, storage, and use and disposition of drugs including samples.	☐ A copy of the office policy and procedure regarding the dispensing of sample drugs is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
B. Drugs are handled safely and stored appropriately. ***22 CCR §75037(a-g), §75039; 21 CFR §211.137; 21 USC §351***						
	IV CS B 1 ☐	Drugs are not prepared in a clean area, or "designated clean" area if prepared in a multipurpose room.	☐ There is a "designated clean" area established in the facility. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	IV CS B 2 ☐	Drugs for external use are not stored separately from drugs for internal use.	☐ Drugs have been separated for external and internal use. ☐ A signed written statement explaining the corrective action taken to separate external and internal drugs is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	IV CS B 3 ☐	Items other than medications are in refrigerator/freezer with drugs and are not in a separate compartment from the drugs.	☐ Medications are kept separate from food, lab specimens, cleaning supplies, and/or other items that may potentially cause contamination. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	IV CS B 4 ☐	Refrigerator thermometer temperature is not at 35° - 46° Fahrenheit or 2° - 8° Centigrade (at time of site visit) or there is no thermometer present.	☐ A thermometer with appropriate gradations has been purchased and is in the refrigerator. ☐ A copy of the receipt and/or invoice is attached. ☐ Other:			
	IV CS B 5 ☐	Freezer Thermometer temperature is not 5° Fahrenheit or -15° Centigrade, or lower at time of site visit or there is no thermometer present	☐ A thermometer with appropriate gradations has been purchased and is in the freezer. ☐ A copy of the receipt and/or invoice is attached. ☐ Other:			
	IV CS B6 ☐	Drug/vaccine storage units onsite do not maintain the required temperature. Dormitory-style or bar-style combined refrigerator/freezer units are not to be used for vaccine storage under any circumstances.	☐ An appropriate storage unit able to maintain required temperatures has been purchased. ☐ A copy of the receipt and/or invoice is attached. ☐ Other:			
	IV CS B 7 ☐	Daily temperature readings of medication refrigerator and freezer are not documented.	☐ A copy of the daily temperature log with separate daily readings of the refrigerator and/or freezer temperatures is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	IV CS B8 ☐	Sites does not have a written plan for vaccine protection in case of a power outage or refrigerator or freezer unit malfunction.	☐ A copy of the site's plan for protecting vaccines in the case of a power outage or refrigeration malfunction. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
Health Plan verification and date	CRITERI	**Deficiency Cited / Reviewer Comments**	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE

PCP/Clinic Name: QM Nurse:
Address:

						PHYSICIAN OR DESIGNEE
	IV CS B 9 ☐	Drugs are not stored separately from test reagents, germicides, disinfectants, and other household substances.	☐ Drugs have been moved to a storage area away from test reagents, germicides, disinfectants and other household substances. ☐ A signed written statement explaining the corrective action taken regarding drug storage. ☐ Other:			
	IV CS B 10 ☐	Hazardous substances are not appropriately labeled.	☐ All hazardous substances now have labels indicating the substance in the container and the date prepared and/or appropriate symbol if needed. ☐ Other:			

Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	IV CS B 11 ☐	Site does not have method(s) in place for drug and hazardous substance disposal.	☐ A disposal method is in place for drug and hazardous substance disposal that is within county and city ordinances. ☐ A copy of the office procedure regarding drug and hazardous substance disposal is attached. ☐ A copy of an appropriate medical waste disposal contract. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
C. Drugs are dispensed according to State and federal drug distribution laws and regulations. ***CA B&P Code §4024, §4076, §4170, §4171, §4173, §4174; 22 CCR §75032, §75033, §75036, §75037(a-g), §75038, §75039; 16 CCR §1718.1; 21 CFR §211.137; 42 USC 6A §300AA-26***						
	IV CS C 1 ☐	Expired drugs were found on site.	☐ All expired drugs were removed and disposed of properly on site. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
Health Plan verification and date	**CRITERI**	**Deficiency Cited / Reviewer Comments**	Recommended Corrective Action	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE**

PCP/Clinic Name: QM Nurse:
Address:

						PHYSICIAN OR DESIGNEE
	IV CS C 2 ☐	The site has no procedure to check expiration date of all drugs (including vaccines and samples), and infant and therapeutic formulas.	☐ A copy of the office procedure regarding checking expiration dates of all drugs on site is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of a log utilized to document checking of expired drugs and supplies. ☐ Other:			
	IV CS C3 ☐	All stored and dispensed prescriptions drugs are not appropriately labeled.	☐ A copy of the office procedure regarding labeling of stored and dispensed prescription drugs is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of a sample label for dispensing medications is attached. ☐ Other:			

Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	IV CS C 6	Vaccine Information sheets (VIS) are not present on site, for distribution to patients.	☐ A copy of the in-service outline (agenda) and sign-in sheet are attached.			

PCP/Clinic Name: QM Nurse:
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	☐		☐ Attached are copies of VIS information is available according to patient population. ☐ Other:			
	IV CS C 7 ☐	Pharmacy on site, is not licensed by the CA state Board of Pharmacy.	☐ A copy of the current pharmacy license is attached. ☐ A copy of the office procedure regarding medication dispensing/storage is attached. ☐ A licensed pharmacist monitoring drug distribution and current CA license is attached. ☐ Other:			
	IV CS C8 ☐	Site does not utilize California Immunization Registry (CAIR) or most current version.	☐ A copy of the office procedure regarding entering dates of all immunizations given into CAIR is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
Laboratory Services Survey Criteria						
D. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations ***17 CCR §1050; 22 CCR §51211.2, §51137.2; B&P Code §1220; 42 USC 263a; Public Law 100-578***						
	IV CS D 1 ☐	Laboratory test procedures are not performed according to current site-specific CLIA Certificate.	☐ A copy of the current CLIA certificate is attached. ☐ A copy of the application/renewal for a CLIA certificate is attached. ☐ Other:			
	IV CS D 2 ☐	Testing personnel performing clinical lab procedures have not been trained.	☐ Documentation of training and/or certificate of training for the following procedure(s) is attached: ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**

PCP/Clinic Name: QM Nurse:
Address:

	IV CS D 3 ☐	Lab supplies (e.g. vacutainers, vacutainer tubes, culture swabs, test solutions) are accessible to unauthorized persons. .	☐ A written explanation of the corrective action(s) taken for lab supplies to not be accessible to unauthorized persons. ☐ A copy of the receipt and/or invoice is attached. ☐ Other:			
	IV CS D 4 ☐	Lab test supplies are expired.	☐ Expired laboratory supplies were removed from the storage area. ☐ A copy of a log utilized to document checking of expired drugs and supplies. ☐ Other:			
	IV CS D 5 ☐	Site does not have a procedure to check expiration date and a method to dispose of expired lab test supplies.	☐ A copy of a log utilized to document checking of expired drugs and supplies. ☐ A copy of the office procedure regarding medication dispensing/storage is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
Radiology Services Survey Criteria						
E. Site meets CDPH Radiological inspection and safety regulations. ***17 CCR* §*30255,* §*30305,* §*30404,* §*30405***						
	IV CS E 1 ☐	The site does not have a current California Radiologic Health Branch Inspection Report and/or Proof of Registration, if there is radiological equipment on site.	☐ A copy of the current California Radiologic Health Branch Inspection Report is attached. ☐ A copy of the Inspection Report and short form sign-off sheet is attached. ☐ A copy of the Inspection Report and notice of violation form and approval letter for corrective action plan is attached. ☐ A copy of Proof of Registration is attached. ☐ Other:			

Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**

PCP/Clinic Name: QM Nurse:
Address:

	IV CS E 2 ☐	The site does not have a current copy of Title 17 and/or a posted notice about availability of Title 17 and its location posted.	☐ A current copy of Title 17 is available in the office. ☐ A copy of the posted notice about available of Title 17 and its location is attached. ☐ A copy of the receipt and/or invoice is attached. ☐ Other:			
	IV CS E 3 ☐	The "Radiation Safety Operating Procedures" are not posted in a highly visible location.	☐ A copy of the office policy and procedure regarding "Radiation Safety Operating Procedures" is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the receipt and/or invoice is attached. ☐ Other:			
	IV CS E 4 ☐	A "Notice to Employees poster" is not posted in a highly visible location.	☐ A "Notice to Employees Poster" has been obtained and is posted in a highly visible location. ☐ A copy of the receipt and/or invoice is attached. ☐ Other:			
	IV CS E 5 ☐	A "Caution, X-Ray" sign is not posted on or next to door of each room that has X-Ray Equipment.	☐ A "Caution, X-Ray" sign is posted on or next to the door of each room that has X-Ray equipment. ☐ A copy of the receipt and/or invoice is attached. ☐ Other:			
	IV CS E 6 ☐	There is no Physician Supervisor/Operator Certificate posted and/or is not within current expiration date.	☐ A copy of the Physician Supervisor/ Operator Certificate has been posted. ☐ A copy of the current Supervisor/ Operator certificate is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	IV CS E 7 ☐	There is no Technologist certificate posted and/or is not within current expiration date .	☐ A copy of all technologist certificates are posted in the X-Ray Room and is attached. ☐ A current copy of the following technologist certificate is attached: ☐ Other:			
	IV CS E 8 ☐	There is no lead apron or lead shield to protect the equipment operator.	☐ A lead apron or shield for operator protection during operation of the X-Ray equipment has been obtained. ☐ A copy of the receipt and/or invoice is attached. ☐ Other:			
	IV CS E 9 ☐	There is no gonad shield for patient protection during procedures in which gonads are in direct beam.	☐ A gonad shield for patient protection during procedures has been obtained. ☐ A copy of the receipt and/or invoice is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

V. Preventive Services
Preventive Services Survey Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
A. Preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases. ***22CCR §53851, §56210; 28 CCR §1300.67***						
	V PS A 1 ☐	The exam tables are not in good repair. The exam lights are not in good repair.	☐ Each exam table has a protective barrier that is changed between patients. ☐ The exam table(s) has been repaired and is in good working order. ☐ The light(s) have been repaired and is in good working order. ☐ A copy of the receipt and/or product label is attached. ☐ Other:			
	V PS A 2 ☐	There is no stethoscope on site. There is no sphygmomanometer with various size cuffs on site.	☐A stethoscope(s) has been purchased and is kept on site. ☐ The purchase of a sphygmomanometer with the following size cuffs was purchased: child / adult / obese/thigh ☐ A copy of the receipt and/or product label is attached. ☐ Other:			
	V PS A 3 ☐	There is no thermometer with a numeric reading on site.	☐ A thermometer with a numeric reading has been purchased and is available on site. ☐ A copy of the receipt and/or product label is attached. ☐ Other:			
	V PS A 4 ☐	There is no percussion hammer on site, or the number is inadequate for the site. There are no tongue blades on site. There are no patient gowns on site, or inappropriate types for the site population.	☐ The following has been purchased and is available on site (circle those that apply): percussion hammer, tongue blades, patient gowns. ☐ A copy of the receipt and/or product label is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	V PS A 5 ☐	There is no balance scale or acceptable alternative scale on site. There is no infant scale on site.	☐ A balance scale or acceptable alternative scale has been purchased ☐ An infant scale has been purchased and is kept on site. ☐ A copy of the receipt and/or product label is attached. ☐ Other:			
	V PS A 6 ☐	There is no wall mounted right angle height measuring device. There is no right-angle infant length measuring unit on site. There is no acceptable tape measure on site for head circumference measurement.	☐A wall mounted right angle height-measuring device has been purchased and is available on site. ☐A right-angle infant length measuring unit has been purchased and is available on site. ☐An acceptable tape measure has been purchased and is available on site. ☐ A copy of the receipt and/or product label is attached. ☐ Other:			
	V PS A 7 ☐	There is no literate eye chart on site. There is no illiterate eye chart on site. There is no vision occluder for vision testing on site.	☐A literate and/or illiterate eye chart has been purchased and is kept on site. ☐A vision occluder or acceptable alternative has been purchased and is available on site. ☐ A copy of the receipt and/or product label is attached. ☐ Other:			
	V PS A 8 ☐	There is no ophthalmoscope on site or an inadequate number for the site.	☐ An ophthalmoscope(s) has been purchased and is available on site. ☐ A copy of the receipt and/or product label is attached. ☐ Other:			
	V PS A 9 ☐	There is no otoscope on site. There are no appropriate ear speculums on site.	☐ An otoscope(s) has been purchased and is available on site. ☐ Appropriate ear speculums have been purchased and are available on site. ☐ A copy of the receipt and/or product label is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	V PS A 10 ☐	There is no pure tone, air conduction audiometer on site, or acceptable alternative system. There is no quiet location for audiometer testing.	☐ A pure tone, air conduction audiometer has been purchased and is available on site. ☐ A quiet location for audiometer testing has been arranged and is in use. ☐ A copy of the receipt and/or product label is attached. ☐ Written explanation of process for acceptable alternative. ☐ Other:			
Health Education Survey Criteria						
B. Health Education services are available to Plan members. ***22CCR §53851; 28 CCR 1300.67***						
	V PS B 1 ☐	Health education materials are not readily accessible on site or are not made available in a timely manner upon request. Plan specific resource information is not readily accessible on site or is not made available in a timely manner upon request.	☐ Health education materials or a method of timely provision is in place. ☐ Health plan specific resource information or a method of timely provision is in place. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A signed written explanation of the corrective action taken. ☐ Other:			
	V PS B 2 ☐	Health education materials and plan-specific resource information is not applicable to the practice and population served by the site.	☐ Health education materials and plan specific resource information has been updated to the practice and population served by this site. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A signed written explanation of the corrective action taken. ☐ Other:			

PCP/Clinic Name: QM Nurse:
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Health Plan verification and date	CRITERIA	**Deficiency Cited / Reviewer Comments**	Recommended Corrective Action	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	V PS B 3 ☐	Health Education materials and plan-specific resource information is not available in threshold languages identified for county and/or area of site location.	☐ Health Education materials and plan-specific resource information in appropriate threshold languages is available from the health plan. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A signed written explanation of the corrective action taken. ☐ Other:			

VI. Infection Control
Infection Control Survey Criteria

Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
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***						
	VI IC A 1 ☐	Antiseptic hand cleaner is not available in, or in reasonable proximity, to treatment areas for hand washing. Running water is not available in, or in reasonable proximity, to treatment areas for hand washing.	☐ Antiseptic hand cleaner is available on site in reasonable proximity to treatment areas. ☐ Running water is available on site in reasonable proximity to treatment areas. ☐ A copy of the receipt and/or work invoice is attached. ☐ A signed written statement of corrective action taken in regards to antiseptic hand cleaner and/or running water. ☐ Other:			
	VI IC A 2 ☐	A waste disposal container is not available in the exam, treatment and rest rooms.	☐ Waste disposal containers have been purchased and placed in the following area(s) ☐ A copy of the receipts/invoice is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	VI IC A 3 ☐	There is no site procedure for effectively isolating infectious patients with potential communicable conditions.	☐ A copy of the office policy and procedure regarding isolating infectious patients with potential communicable conditions is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. ***8 CCR §5193 (Cal OSHA Health Care Worker Needlestick Prevention Act, 1999); H&S Code, §117600-118360 (CA Medical Waste Management Act, 1997); 29 CFR §1910.1030.***						
	VI IC B 4 ☐	No Sharps Injury Log available on site. Sharp injury incidents are not documented.	☐ A copy of the sharps injury incidents form and log which describe the date, time, description of exposure incident, sharp type/brand, and follow-up care received within 14 days. ☐ A copy of the office policy and procedure regarding documentation of sharp injury incidents is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	VI IC B 5 ☐	Biohazardous (non-sharp) wastes are not contained separately from other trash/waste.	☐ Biohazardous wastes are contained separately from other trash/waste. ☐ A copy of the office policy and procedure regarding biohazardous wastes is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the receipt is attached. ☐ Other:			

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Health Plan verification and date	CRITERIA	**Deficiency Cited / Reviewer Comments**	Recommended Corrective Action	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VI IC B 6 ☐	Storage areas for regulated medical wastes are not maintained secure and inaccessible to unauthorized persons.	☐ Storage area for regulated medical waste has been created and is kept locked. ☐ A copy of the office policy and procedure regarding storage of regulated medical waste is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the receipt and/or work invoice is attached. ☐ Other:			
	VI IC B 7 ☐	Contaminated laundry is not laundered at the workplace or through a commercial laundry service. (This is not required if only disposable gowns/sheets, etc are used)	☐ A commercial laundry service is used for contaminated laundry and a copy of the contract is attached. ☐ ☐ A washer and dryer have been purchased and installed on site for use with contaminated laundry. A copy of the purchase and installation invoice or receipt is attached. ☐ Other:			
	VI IC B 8 ☐	Transportation of regulated medical wastes is not done by a registered hazardous waste hauler or by a person with an approved limited-quantity exemption.	☐ A copy of the contract and/or proof of service with a registered hazardous waste hauler is attached. ☐ A copy of a current approved limited-quantity exemption and medical waste tracking document is attached. ☐ Other:			
C. Contaminated surfaces are decontaminated according to Cal-OSHA Standards. ***8 CCR §5193; CA H&S Code §118275***						

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	VI IC C 1 ☐	Equipment and work surfaces are not appropriately cleaned and decontaminated after contact with blood or other potentially infectious material.	☐ A copy of the office policy and procedure regarding decontamination of work surfaces and/or equipment after contact with blood or other potentially infectious material is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	☐ **VI IC C 2**	Routine cleaning and decontamination of equipment/work surfaces is not completed according to site-specific written schedule.	☐ A copy of the written routine cleaning schedule for all equipment and work surfaces is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VI IC C 3 ☐	Disinfectant solutions used on site are not approved by the Environmental Protection Agency (EPA).	☐ All non-approved disinfectant solutions have been removed and replaced with EPA approved solutions. ☐ A copy of the receipt and/or work invoice is attached. ☐ A copy of the product label. ☐ Other:			
	VI IC C 4 ☐	Disinfectant solutions used on site are not effective in killing TB/HIV/HB	☐ A copy of the office policy and procedure regarding disinfectant solutions is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the product label. ☐ A copy of the receipt and/or invoice is attached. ☐ Other:			
	VI IC C 5 ☐	Disinfectant solutions used on site are not used according to manufacturer instructions.	☐ A copy of the manufacturer instructions of the disinfectant solution used on site. ☐ If 10% Bleach solution is used it is changed/reconstituted every 24 hours and			

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			the label must contain the reconstituted date and time. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
D. Re-usable medical instruments are properly sterilized after each use. ***22 CCR §53230, §53856***						
	VI IC D 1 ☐	Written site-specific policy/procedures or Manufacturer's Instructions for instrument/equipment sterilization are not available to staff.	☐ A copy of the site-specific policy and procedure or Manufacturer's instructions regarding autoclave/sterilization is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

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	VI IC D 2 ☐	Cleaning reusable instruments/equipment is not done prior to sterilization.	☐ A copy of the site-specific policy and procedure or Manufacturer's instructions regarding cleaning reusable instruments and/or equipment prior to sterilization is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	VI IC D 3b ☐	There is no confirmation from manufacturer item(s) is/are heat-sensitive.	☐ A copy of the site-specific policy and procedure or Manufacturer's instructions regarding cold chemical sterilization is attached. ☐ A copy of the product label. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	VI IC D 4a ☐	Autoclave/steam sterilization. Staff cannot demonstrate or verbalize necessary steps/process to ensure sterility.	☐ A copy of the manufacturer's instructions and/or site-specific policy and procedure regarding autoclave/steam sterilization is attached. ☐ Written operating procedures for autoclave are available on site to staff.			

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			☐ If instruments/equipment are transported off-site for sterilization, equipment handling and transport procedures are available on site to staff. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	VI IC D4 b ☐	Autoclave is not maintained and serviced according to manufacturer's guidelines.	☐ A copy of the manufacturer's guidelines for maintenance of the autoclave is attached. ☐ A copy of the service receipt/invoice from a qualified technician within the past 12 months is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

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	VI IC D 4e ☐	Sterilized packages are not labeled with sterilization date and load identification information.	☐ Storage area(s) for sterilized packages are clean, dry and separated from non-sterile items by a functional barrier.			

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			☐ Sterilized package labels include date of sterilization, load run identification information, and general contents. ☐ A copy of the office policy and procedure regarding routine evaluation of sterilized packages is attached. ☐ A copy of the sterilization log used in the office is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the log to check sterilized packages is attached. ☐ Other:			
	VI IC D 4f	Site does not maintain a storage area for keeping sterilized packages clean, dry, and separated from non-sterile items by a functional barrier. Staff unable to demonstrate or verbalize process for routine evaluation of sterilized packages	☐ A copy of the office policy and procedure addressing storage of sterilized packages. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

Medical Record Review Survey

NOTE: All criteria in this section were not documented in the medical record review.

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
I. Format Criteria						
	I A ☐	Member identification was not on each page.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	I B ☐	Individual personal biographical information was not documented.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	I C ☐	Emergency "contact" was not identified.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the form utilized is attached. ☐ Other:			
	I D ☐	Medical records on site were not consistently organized.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the form utilized is attached. ☐ Other:			
	I E ☐	Member's assigned primary care physician (PCP) was not identified.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	I F ☐	Primary language and linguistic service needs of non -or limited-English proficient (LEP) or hearing-impaired persons were not prominently noted.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	I G ☐	Person or entity providing medical interpretation is not identified in the record.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the form utilized is attached. ☐ Other:			
	I H ☐	Signed copy of the Notice of Privacy was not found in the record.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
II. Documentation Criteria						
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	II A ☐	Allergies were not prominently noted.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II B ☐	Chronic problems and/or significant conditions were not listed.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the chronic problem(s) and/or significant conditions form is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	II C ☐	Current *continuous* medications were not listed.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the current continuous medications form is attached. ☐ Other:			
	II D1	Signed release of medical records was not present in the chart	☐ A copy of the policy and procedure regarding release of medical records. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the informed consent form(s) are attached as follows: ☐ Other:			
	II D2	Appropriate consent was not present for invasive procedures.	☐ A copy of the policy and procedure regarding informed consent is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the informed consent form(s) are attached as follows: ☐ Other:			
	II E ☐	Advance Health Care Directive information was not offered. (Only for: Adults, 18 years/older; emancipated minors)	☐ A copy of the information is available regarding Advance Health Care Directive is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

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	II F ☐	All entries were not signed, dated and legible	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II G ☐	Errors were not corrected according to legal medical documentation standards.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

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Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
III. Coordination/Continuity of Care Criteria						
	III A ☐	History of present illness was not documented.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	III B ☐	Working diagnoses were not consistent with findings.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	III C ☐	Treatment plans were not consistent with diagnoses.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	III D ☐	Instruction for follow-up care was not documented.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	III E ☐	Unresolved/continuing problems were not addressed in subsequent visit(s).	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	III F ☐	No evidence of practitioner review of consult/referral reports and diagnostic test results.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form and/or stamp utilized is attached. ☐ Other:			
	III G ☐	No evidence of follow up of specialty referrals made and results/reports of diagnostic tests.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form and/or stamp utilized is attached. ☐ Other:			
	III H ☐	Missed primary care appointments and outreach efforts/follow-up contacts are not documented.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form and/or stamp utilized is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
Address:

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
IV. Pediatric Preventive Criteria						
	IV A1 ☐	Initial Health Assessment (IHA): No evidence of History and Physical (H&P) performed within the first 120-days of enrollment in the health plan.	☐ A copy of the policy and procedure regarding IHA is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV A2 ☐	No evidence that an initial Individual Health Education Behavioral Assessment (IHEBA) was performed within the first 120-days of enrollment in the health plan.	☐ A copy of the policy and procedure regarding IHEBA/SHA is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV B1 ☐	Subsequent Comprehensive Health Assessment: Comprehensive History and Physical exam completed at age-appropriate frequency.	☐ A copy of the policy and procedure regarding Physical exam completed at age-appropriate frequency is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV B2 ☐	Individual Health Education Behavioral Assessment (IHEBA). Subsequent Periodic IHEBA.	☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C1 ☐	Well-Child Visit: Alcohol/Drug misuse: Screening and behavioral counseling.	☐ A copy of the policy and procedure regarding Alcohol/Drug misuse screening/counseling is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached.			

PCP/Clinic Name: QM Nurse:
Address:

			☐ Other:			

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	IV C2 ☐	Well-Child Visit: Anemia Screening	☐ A copy of the policy and procedure regarding Anemia Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C3 ☐	Well-Child Visit: Anthropometric Measurements	☐ A copy of the policy and procedure regarding Anthropometric measurements is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C4 ☐	Well-Child Visit: Anticipatory Guidance	☐ A copy of the policy and procedure regarding Anticipatory Guidance is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C5 ☐	Well-Child Visit: Autism Spectrum Disorder Screening	☐ A copy of the policy and procedure regarding Autism Spectrum Disorder screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

	IV C6 ☐	Well-Child visit: Blood Lead Screening Test	☐ A copy of the policy and procedure regarding Blood Lead Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	IV C7 ☐	Well-Child Visit: Blood Pressure Screening	☐ A copy of the policy and procedure regarding Blood Pressure Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C8 ☐	Well-Child Visit: Dental/Oral Health Assessment	☐ A copy of the policy and procedure regarding Dental/Oral Health Assessment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 8a ☐	Well-Child Visit: Dental Assessment: Fluoride Supplements	☐ A copy of the policy and procedure regarding Fluoride supplementation is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 8b ☐	Well-Child Visit: Dental Assessment: Fluoride Varnish	☐ A copy of the policy and procedure regarding Fluoride Varnish is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached.			

			☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C9 ☐	Well Child Visit: Depression Screening	☐ A copy of the policy and procedure regarding Depression screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 9a ☐	Well Child Visit: Suicide-Risk Screening	☐ A copy of the policy and procedure regarding Suicide-Risk screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	IV C 9b ☐	Well-Child Visit: Maternal Depression Screening	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 10 ☐	Well-Child Visit: Developmental Disorder Screening	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

	IV C 11 ☐	Well-Child Visit: Developmental Surveillance	☐ A copy of the policy and procedure regarding Developmental Surveillance is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 12 ☐	Well-Check Visit: Drug Use Disorder Screening and Behavioral Counseling	☐ A copy of the policy and procedure regarding Drug Use Disorder Screening and Behavioral Counseling attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 13 ☐	Well-Child Visit: Dyslipidemia Screening	☐ A copy of the policy and procedure regarding Dyslipidemia Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	IV C 14 ☐	Well-Child Visit: Hearing Screening	☐ A copy of the policy and procedure regarding Hearing Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 15 ☐	Well-Child visit: Hepatitis B Screening	☐ A copy of the policy and procedure regarding Hepatitis B Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached.			

			☐ Other:			
	IV C 16 ☐	Well-Child visit: Hepatitis C Screening	☐ A copy of the policy and procedure regarding Hepatitis C Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 17 ☐	Well-Child visit: HIV Screening	☐ A copy of the policy and procedure regarding HIV is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 18 ☐	Well-Child Visit: Psychosocial/Behavioral Assessment	☐ A copy of the policy and procedure regarding Psychosocial/Behavioral Assessment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 19 ☐	Well-Child Visit: STI Screening and counseling	☐ A copy of the policy and procedure regarding STI Screening and counseling is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 20 ☐	Well-Child Visit: Sudden Cardiac Arrest and Sudden Cardiac Death Screening	☐ A copy of the policy and procedure regarding Sudden Cardiac Arrest and Sudden Cardiac Death Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached.			

			☐ Other:			
	IV C 21 ☐	Well-Child Visit: Tobacco products use, Screening and Prevention and Cessation Services	☐ A copy of the policy and procedure regarding Tobacco products use, Screening and Prevention and Cessation Services is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	IV C 22 ☐	Well-Child Visit: Tuberculosis screening	☐ A copy of the policy and procedure regarding TB risk Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV C 23 ☐	Well-Child Visit: Vision Screening	☐ A copy of the policy and procedure regarding Vision Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV D1 ☐	Childhood Immunizations: Given according to ACIP guidelines	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

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	IV D2 ☐	No evidence that documentation of immunization administration included manufacturer's name, lot number, site and initials.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	IV D3 ☐	No evidence that publication date of Vaccine Information Statement (VIS) was documented for each immunization administered.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

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V. Adult Preventive Criteria						
	V A1 ☐	Initial Health Assessment (IHA): No evidence that History and Physical (H&P) was performed within the first 120-days of enrollment in the health plan.	☐ A copy of the policy and procedure regarding IHA is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	V A2 ☐	No evidence that an initial Individual Health Education Behavioral Assessment (IHEBA) was performed within the first 120-days of enrollment in the health plan.	☐ A copy of the policy and procedure regarding IHEBA/SHA is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	V B1 ☐	Periodic Health Evaluation according to most recent USPSTF Guidelines.	☐ A copy of the policy and procedure regarding adult periodic health evaluations is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	V B2 ☐	Subsequent Periodic IHEBA	☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	V C1 ☐	Adult Preventive Care Screenings: Abdominal Aneurysm Screening	☐ A copy of the policy and procedure regarding Abdominal Aneurysm screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached.			

			☐ Other:			
	V C2 ☐	Adult Preventive Care Screenings: Alcohol Misuse: Screening and Behavioral Counseling	☐ A copy of the policy and procedure regarding Alcohol Use Disorder Screening and Behavioral Counseling is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

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	V C3 ☐	Adult Preventive Care Screenings: Breast Cancer Screening	☐ A copy of the policy and procedure regarding Breast Cancer Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	V C4 ☐	Adult Preventive Care Screenings: Cervical Cancer Screening	☐ A copy of the policy and procedure regarding Cervical Cancer Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	V C5 ☐	Adult Preventive Care Screenings: Colorectal Cancer Screening	☐ A copy of the policy and procedure regarding Colorectal Cancer Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	V C6 ☐	Adult Preventive Care Screenings: Depression Screening	☐ A copy of the policy and procedure regarding Depression Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	V C7 ☐	Adult Preventive Care Screenings: Diabetic Screening	☐ A copy of the policy and procedure regarding Diabetic Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached.			

			☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VC 7a ☐	Adult Preventive Care Screenings: Diabetic Comprehensive Care	☐ A copy of the policy and procedure regarding Diabetic Comprehensive Care is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VC8 ☐	Adult Preventive Care Screenings: Drug Disorder Screening and Behavioral Counseling	☐ A copy of the policy and procedure regarding Drug Disorder Screening and Behavioral Counseling is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VC9 ☐	Adult Preventive Care Screenings: Dyslipidemia Screening	☐ A copy of the policy and procedure regarding Dyslipidemia Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VC 10 ☐	Adult Preventive Care Screenings: Folic Acid Supplementation	☐ A copy of the policy and procedure regarding Folic Acid Supplementation is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

	VC 11 ☐	Adult Preventive Care Screenings: Hepatitis B Screening	☐ A copy of the policy and procedure regarding Hepatitis B Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VC 12 ☐	Adult Preventive Care Screenings: Hepatitis C Screening	☐ A copy of the policy and procedure regarding Hepatitis C Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VC 13 ☐	Adult Preventive Care Screenings: High Blood Pressure Screening	☐ A copy of the policy and procedure regarding High Blood Pressure Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VC 14 ☐	Adult Preventive Care Screenings: HIV Screening	☐ A copy of the policy and procedure regarding HIV screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VC 15 ☐	Adult Preventive Care Screenings: Intimate Partner Violence Screening	☐ A copy of the policy and procedure regarding Intimate Partner Violence Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached.			

			☐ A copy of the office form utilized is attached. ☐ Other:			
	VC 16 ☐	Adult Preventive Care Screenings: Lung Cancer Screening	☐ A copy of the policy and procedure regarding Lung Cancer Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VC 17 ☐	Adult Preventive Care Screenings: Obesity Screening & Counseling	☐ A copy of the policy and procedure regarding Obesity Screening & Counseling is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VC 18 ☐	Adult Preventive Care Screenings: Osteoporosis Screening	☐ A copy of the policy and procedure regarding Osteoporosis Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VC 19 ☐	Adult Preventive Care Screenings: Sexually Transmitted Infection (STI) Screening & Counseling	☐ A copy of the policy and procedure regarding Sexually Transmitted Infection (STI) Screening & Counseling is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

	V C 20 ☐	Adult Preventive Care Screenings: Skin cancer Behavioral Counseling	☐ A copy of the policy and procedure regarding Skin cancer Behavioral Counseling is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	V C 21 ☐	Adult Preventive Care Screenings: Tobacco Use Counseling and Interventions	☐ A copy of the policy and procedure regarding Tobacco Use Counseling and Interventions is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	V C 22 ☐	Adult Preventive Care Screenings: Tuberculosis Screening	☐ A copy of the policy and procedure regarding Tuberculosis Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	V D1 ☐	Adult Immunizations: Given according to ACIP guidelines	☐ A copy of the policy and procedure regarding Adult Immunizations is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	V D2 ☐	Adult Immunizations: Vaccine administration documentation	☐ A copy of the policy and procedure regarding Vaccine administration documentation is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached.			

			☐ A copy of the office form utilized is attached. ☐ Other:			
	V D3 ☐	Adult Immunizations: Vaccine Information Statement (VIS) documentation	☐ A copy of the policy and procedure regarding Vaccine Information Statement (VIS) documentation is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

PCP/Clinic Name: QM Nurse:
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VI. Perinatal Preventive Criteria						
	VI A1 ☐	No evidence of an Initial Comprehensive Prenatal Assessment (ICA) completed within 4 weeks of entry to prenatal care	☐ A copy of the policy and procedure regarding Initial prenatal visit is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI A2 ☐	Initial Comprehensive Prenatal Assessment (ICA): Obstetrical and Medical History	☐ A copy of the policy and procedure regarding Obstetrical and Medical History is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI A3 ☐	Initial Comprehensive Prenatal Assessment (ICA): Physical Exam	☐ A copy of the policy and procedure regarding Physical Exam is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI A4 ☐	Initial Comprehensive Prenatal Assessment (ICA): Dental Assessment	☐ A copy of the policy and procedure regarding Dental Assessment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI A5 ☐	Initial Comprehensive Prenatal Assessment (ICA): Healthy Weight Gain and Behavior Counseling	☐ A copy of the policy and procedure regarding Healthy Weight Gain and Behavior Counseling is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached.			

			☐ A copy of the office form utilized is attached. ☐ Other:			

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	VI A 6a ☐	Initial Comprehensive Prenatal Assessment (ICA), Lab Tests: Bacteriuria Screening	☐ A copy of the policy and procedure regarding Bacteriuria Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI A 6b ☐	Initial Comprehensive Prenatal Assessment (ICA), Lab Tests: Rh Incompatibility Screening	☐ A copy of the policy and procedure regarding Rh Incompatibility Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI A 6c ☐	Initial Comprehensive Prenatal Assessment (ICA), Lab Tests: Diabetes Screening	☐ A copy of the policy and procedure regarding Diabetes Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI A 6d ☐	Initial Comprehensive Prenatal Assessment (ICA), Lab Tests: Hepatitis B Virus Screening	☐ A copy of the policy and procedure regarding Hepatitis B Virus Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI A 6e ☐	Initial Comprehensive Prenatal Assessment (ICA), Lab Tests: Hepatitis C Virus Screening	☐ A copy of the policy and procedure regarding Hepatitis C Virus Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached.			

			☐ A copy of the office form utilized is attached. ☐ Other:			
	VI A 6f ☐	Initial Comprehensive Prenatal Assessment (ICA), Lab Tests: Chlamydia Infection Screening	☐ A copy of the policy and procedure regarding Chlamydia Infection Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VI A 6g ☐	Initial Comprehensive Prenatal Assessment (ICA), Lab Tests: Syphilis Infection Screening	☐ A copy of the policy and procedure regarding Syphilis Infection Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI A 6h ☐	Initial Comprehensive Prenatal Assessment (ICA), Lab Tests: Gonorrhea Infection Screening	☐ A copy of the policy and procedure regarding Gonorrhea Infection Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI A 6i ☐	Initial Comprehensive Prenatal Assessment (ICA), Lab Tests: HIV Screening	☐ A copy of the policy and procedure regarding HIV Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

	VI B1 ☐	First Trimester Comprehensive Assessment: Individualized Care Plan (ICP)	☐ A copy of the policy and procedure regarding ICP is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI B2 ☐	First Trimester Comprehensive Assessment: Nutrition Assessment	☐ A copy of the policy and procedure regarding Nutrition Assessment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI B 3a ☐	Psychosocial Assessment: Maternal Mental Health Screening	☐ A copy of the policy and procedure regarding Maternal Mental Health Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VI B 3b ☐	Psychosocial Assessment: Social Needs Assessment	☐ A copy of the policy and procedure regarding Social Needs Assessment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI B 3c ☐	Psychosocial Assessment: Substance Use/Abuse Assessment	☐ A copy of the policy and procedure regarding Substance Use/Abuse Assessment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached.			

			☐ A copy of the office form utilized is attached. ☐ Other:			
	VI B4 ☐	First Trimester Comprehensive Assessment: Breast Feeding & Health Education Assessment	☐ A copy of the policy and procedure regarding Breast Feeding & Health Education Assessment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI B5 ☐	First Trimester Comprehensive Assessment: Preeclampsia Screening	☐ A copy of the policy and procedure regarding Preeclampsia Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI B6 ☐	First Trimester Comprehensive Assessment: Intimate Partner Violence Screening	☐ A copy of the policy and procedure regarding Intimate Partner Violence Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VI C1 ☐	Second Trimester Comprehensive Re-assessment: Individualized Care Plan Updated and follow up	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

	VI C2 ☐	Second Trimester Comprehensive Re-assessment: Nutrition Assessment	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI C 3a ☐	Second Trimester Comprehensive Psychosocial Assessment: Maternal Mental Health Screening	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI C 3b	Second Trimester Comprehensive Psychosocial Assessment: Social Needs Assessment	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI C 3c ☐	Second Trimester Comprehensive Psychosocial Assessment: Substance Use/Abuse Assessment	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VI C4	Second Trimester Comprehensive Assessment: Breast Feeding & other Health Education	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

	VI C5 ☐	Second Trimester Comprehensive Assessment: Preeclampsia Screening	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI C 5a ☐	Second Trimester Comprehensive Assessment: Preeclampsia Screening – Low does Aspirin	☐ A copy of the policy and procedure regarding Low does Aspirin is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI C6 ☐	Second Trimester Comprehensive Assessment: Intimate Partner Violence Screening	☐A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI C7 ☐	Second Trimester Comprehensive Assessment: Diabetes Screening	☐A copy of the policy and procedure regarding Diabetes Screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI D1 ☐	Third Trimester Comprehensive Assessment: Individualized Care Plan	☐A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI D2 ☐	Third Trimester Comprehensive Assessment: Nutrition	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached.			

			☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VI D 3a ☐	Third Trimester Psychosocial Assessment: Maternal Mental Health Screening	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI D 3b ☐	Third Trimester Psychosocial Assessment: Social Needs Assessment	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI D 3c ☐	Third Trimester Psychosocial Assessment: Substance Use/Abuse Assessment	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI D4 ☐	Third Trimester Comprehensive Assessment: Breast Feeding & other Health Education	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

	VI D5 ☐	Third Trimester Comprehensive Assessment: Preeclampsia Screening	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI D 5a ☐	Third Trimester Comprehensive Assessment: Preeclampsia Screening – Low dose Aspirin	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI D6 ☐	Third Trimester Comprehensive Assessment: Intimate Partner Violence Screening	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI D7 ☐	Third Trimester Comprehensive Assessment: Diabetic Screening	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI D8 ☐	Third Trimester Comprehensive Assessment: Screening for Strep B	☐ A copy of the policy and procedure regarding Screening for Strep B is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI D8 ☐	Third Trimester Comprehensive Assessment: TDAP Immunization	☐ A copy of the policy and procedure regarding TDAP Immunization is attached.			

			☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI E ☐	Prenatal care visit periodicity according to most recent ACOG standards	☐ A copy of the policy and procedure regarding Prenatal care visit periodicity according to most recent ACOG standards is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI F ☐	Influenza Vaccine	☐ A copy of the policy and procedure regarding Influenza Vaccine is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI G ☐	COVID Vaccine	☐ A copy of the policy and procedure regarding Covid Vaccine is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	VI H ☐	No evidence of a Referral to WIC and assessment of Infant Feeding status.	☐ A copy of the policy and procedure regarding Referral to WIC and assessment of Infant Feeding status.is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			

	VI I ☐	No evidence that HIV-related services were *offered.*	☐ A copy of the policy and procedure regarding HIV-related services is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI J ☐	No evidence that AFP/Genetic screening was *offered.*	☐ A copy of the policy and procedure regarding AFP/Genetic screening is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI K ☐	No evidence of a Family Planning Evaluation.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI L1 ☐	Postpartum Comprehensive Assessment: Individualized Care Plan	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**

	VI L2 ☐	Postpartum Comprehensive Assessment: Nutrition Assessment	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI L 3a ☐	Postpartum Comprehensive Psychosocial Assessment: Maternal Mental Health /Postpartum depression screening	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI L 3b ☐	Postpartum Comprehensive Psychosocial Assessment: Social Needs Assessment	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI L 3c ☐	Postpartum Comprehensive Psychosocial Assessment: Substance Use/Abuse Assessment	☐ A copy of the policy and procedure regarding Substance Use/Abuse Assessment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**

	VI L4 ☐	Postpartum Comprehensive Health Education Assessment	☐ A copy of the policy and procedure regarding Postpartum Comprehensive Health Education Assessment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			
	VI L5 ☐	Postpartum Comprehensive Physical Exam	☐ A copy of the policy and procedure regarding Postpartum Comprehensive Physical Exam is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the office form utilized is attached. ☐ Other:			