PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE MEETING NOTICE

FROM: Leslie Erickson, Program Coordinator II, Quality Improvement
DATE: Feb. 13, 2025
SUBJECT: Quality/Utilization Advisory Committee (Q/UAC) Meeting

The California Public Health Emergency has ended and Q/UAC has now returned to in-person meetings per Brown Act guidelines.
Meeting locations (and call-in information for Partnership staff only) are below and also listed on the agenda.
Please use your personal electronic device for reviewing the packet during the meeting. Hard copies will not be provided.

Meeting Time/Date: 7:30 – 8:55 a.m., Wednesday, Feb. 19, 2025
Meeting Locations:

Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534 | Napa/Solano
2525 Airpark Drive, Redding, CA 96002 | Trinity Alps
495 Tesconi Circle, Santa Rosa, CA 95401 | Santa Rosa Huddle
2760 Esplanade Ave., Ste 130, Chico 95973 | Temp Conf Room

Other Locations:
Open Door Community Health Center, 3770 Janes Road, Arcata
HHS, 5730 Packard Ave., Suite 100, Marysville, CA 95901

Staff and members only may join by Telephone: 1-844-621-3956 Access Code 809 114 256
Partnership Offices: Please use the QUAC Partnership HealthPlan's Personal Room in WebEx
https://partnershiphp.webex.com/meet/quac | 809114256 (Need assistance? Contact IT at least one (1) day prior to the meeting.)

Voting Members:
Choudhry, Sara, MD
Gwiazdowski, Steven, MD, FAAP
Hackett, Emma, MD, FACOG
Lane, Brandy, PHC Consumer Member
Luu, Phuong, MD
Montenegro, Brian, MD
Mulligan, Meagan, FNP-BC
Murphy, John, MD
Quon, Robert, MD, FACP
Strain, Michael, PHC Consumer Member
Swales, Chris, MD
Thomas, Randolph, MD
Wilson, Jennifer, MD, MPH

PHC Staff (Ex-Officio) Members:
Barresi, Katherine, RN, BSN, PHN, NE-BC, Chief Health Equity Officer
Bides, Robert, RN, BSN, Mgr, Member Safety-Quality Investigations, QI
Bontrager, Mark, Sr. Director of Behavioral Health, Health Services
Cotter, James, MD, Associate Medical Director
Cox, Bradley, DO, Regional Medical Director, Northeast
Devido, Jeffrey, MD, Behavioral Health Clinical Director
Esget, Heather, BSN, ACM-RN, Director of Utilization Management
Frankovich, Terry, MD, Associate Medical Director
Gast, Brigid, MSN, BS, RN, NEA-BC, Sr. Director of Care Management
Glickstein, Mark, MD, Associate Medical Director
Guevarra, Angela, RN, Associate Director, Care Coordination (SR)
Guillory, Ledra, Senior Manager of Provider Relations Representatives
Hartigan, Nicole, RN, Associate Director, Care Coordination (NR)
Hightower, Tony, CPhT, Associate Director, UM Regulations
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Katz, Dave, MD, Associate Medical Director
Kubota, Marshall, MD, Regional Medical Director, Southwest
Leung, Stan, PharmD., Director of Pharmacy Services
Matthews, R. Douglas, MD, Regional Medical Director, Chico
Moore, Robert, MD, MPH, MBA, Chief Medical Officer (Chair)
Netherda, Mark, MD, Medical Director for Quality (Vice Chair)
Newman, Rachel, RN, BSN, Manager, Clinical Compliance - Inspections
O'Connell, Lisa, MHA, Director, Enhanced Health Services
Randhawa, Manleen, Senior Health Educator, Population Health
Ribordy, Jeff, MD, MPH, FAAP, Regional Medical Director, Northwest
Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Spiller, Bettina, MD, Associate Medical Director
Steffen, Nancy, Senior Dir. of Quality and Performance Improvement
Thornton, Aaron, MD, Associate Medical Director
Townsend, Colleen, MD, Regional Medical Director, Southeast
Watkins, Kory, MBA-HM, Director, Grievance & Appeals

cc:
Andrews, Leigha, Regional Director, Southwest
Bjork, Sonja, JD, Chief Executive Officer
Blake, Jill, Regional Director, Auburn
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brown, Isaac, MHA/MBA, Director of Quality Management, QI
Brunkal, Monika, RPh, Associate Director of Population Health
Campbell, Anna, Policy Analyst, Utilization Management
Davis, Wendi, Chief Operations Officer
Devan, James, Manager of Performance Improvement, QI (NR)
Garcia-Hernandez, Margarita, PhD, Director of Health Analytics
Gual, Kristine, Director of Quality Measurement, QI
Harrell, Bria, Project Manager I, Configuration
Innes, Latrice, Manager of Grievance & Appeals Compliance
Jarrett-Lee, Kevin, RN, Associate Director, UM
Kerlin, Mary, Senior Director of Provider Relations
Klakken, Vicki, Regional Director, Northwest
McCune, Amy, MPH, MS, Manager of Quality Incentive Programs, QI
Morris, Matthew, MD, Regional Medical Director, Auburn
Nakatani, Stephanie, Manager of Provider Relations Representatives
O'Leary, Hannah, MPH, Manager of Population Health
Power, Kathryn, Regional Director, Southeast
Quichocho, Sue, Manager of Quality Improvement, QI
Robinson, Gary, Program Manager II, Regulatory Affairs & Compliance
Sharp, Tim, Regional Director, Northeast
Sivasankar, Shivani, Sr. Data Scientist, Health Analytics, Finance
Stark, Rebecca, Regional Director, Chico
Ward, Lisa, MD, Regional Medical Director, Southwest

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE (Q/UAC)
MEETING AGENDA

Date: Feb. 19, 2025 **Time: 7:30 – 8:55 a.m.**

Locations: Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534 | Napa/Solano Room
2525 Airpark Drive, Redding, CA 96002 | Trinity Alps Conference Room
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Other Locations:
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Health & Human Services Dept., 5730 Packard Ave., Suite 100, Marysville, CA 95901

Partnership Staff only may join by Web-ex:
https://partnershiphp.webex.com/meet/quac Meeting # 809 114 256

Partnership Staff only may join by Telephone:
1-844-621-3956 Access Code: 809 114 256

This Brown Act meeting may be recorded. Any audio or video tape recording of this meeting, made by or at the direction of Partnership, is subject to inspection under the Public Records Act and will be provided without charge, if requested.

Welcome / Introductions / Public welcome at cited locations

	Item	Lead	Time	Page #
I.	**Call to Order – Welcome/Introductions/Announcements/Approval/Acceptance of Minutes**			
1	*Approval of* • Jan. 15 Quality/Utilization Advisory Committee (Q/UAC) Minutes	Robert Moore, MD	7: 30	5 - 17
2	*Acknowledgment and acceptance of draft* • Jan. 7 Internal Quality Improvement (IQI) Committee Meeting Minutes • Jan. 23 Substance Use Internal Quality Improvement (SUIQI) Committee Minutes • Jan. 21 Quality Improvement Health Equity Committee (QIHEC) Minutes • Nov. 19, 2024 QIHEC Approved Minutes			19 - 95
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Isaac Brown, MHA/MBA	7:35	97 - 108
2	HealthPlan Update	Robert Moore, MD	7:40	--
III.	**Old Business**			
	None			
IV.	**New Business – Consent Calendar**			
	Consent Calendar	All	7:45	109
	Care Coordination Policies			
	MCCP2020 – Lactation Policy and Guidelines			111 - 118
	MCCP2021 – Women, Infant and Children (WIC) Supplemental Food Program			119 - 121
	Utilization Management Policies			
	MCUP3064 – Communication Services			123 - 125
	M**P**UG3011 – Criteria for Home Health Services			126 - 130
	M**P**UG3019 – Hearing Aid Guidelines			131 - 138
	MPUP3048 – Dental Services (including Dental Anesthesia)			139 - 144

	Item	Lead	Time	Page #
V.	**New Business – Discussion Policies**			
	Synopsis of Changes			145 - 149
	Quality Improvement			
	MCQP1022 – Site Review Requirements and Guidelines – **NEW Attachment I** *begins on p. 467*	Rachel Newman, RN	7:48	151 - 496
	MPQG1005 – Adult Preventive Health Guidelines	Mark Netherda, MD	7:52	497 - 512
	MPQP1016 – Potential Quality Issue Investigation and Resolution		7:56	513 - 523
	Utilization Management			
	MCUP3103 – Coordination of Care for *Child-Welfare Involved* Members – **NEW TITLE**	Shahrukh Chishty	8:00	525 - 529
VI.	**Presentations**			
1	Care Coordination Grand Analysis • MPCD2013 – Care Coordination Program Description • Complex Case Management (CCM) Program Evaluation for CY 2023 (Report) *begins on p. 553* *Data presentation with Shivani Sivasankar of Health Analytics begins on p. 573*	Shannon Boyle, RN Shivani Sivasankar	8:04	531 - 600
2	PQI/PPC Annual Report	Robert Bides, RN	8:20	601 - 616
3	CY 2024 Site Review Report	Rachel Newman, RN	8:25	617 - 626
4	CY 2024 Physical Accessibility Review Survey (PARS) Report		8:30	627 - 631
5	D-SNP Model of Care	Kermit Jones, MD, JD Kimberly Robertello, PhD	8:35	633 - 650
VII.	**Adjournment scheduled for 8:55 a.m. Q/UAC next meets 7:30 a.m. Wednesday, March 19, 2025**			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES

Quality and Utilization Advisory Committee (Q/UAC) Meeting
Wednesday, Jan. 15, 2025 / 7:30 a.m. – 9:04 a.m. Napa/Solano Room, 1st Floor

All Voting Members Present:	Phuong Luu, MD	Michael Strain, PHC Consumer Member
Sara Choudhry, MD	Brian Montenegro, MD	Chris Swales, MD
Steven Gwiazdowski, MD, FAAP	Meagan Mulligan, FNP-BC	Randolph Thomas, MD
Emma Hackett, MD, FACOG	John Murphy, MD	Jennifer Wilson, MD
Brandy Lane, PHC Consumer Member	Robert Quon, MD, FACP	

Partnership *Ex-Officio* Members Present:	Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI	Netherda, Mark, MD, Medical Director for Quality – Vice Chair
Cox, Bradley, DO, Regional Medical Director (Northeast)	Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
Devido, Jeff, MD, Behavioral Health Clinical Director	O'Connell, Lisa, Director, Enhanced Health Services
Frankovich, Terry, MD, Associate Medical Director	Ribordy, Jeff, MD, Regional Medical Director (Northwest)
Glickstein, Mark, MD, Associate Medical Director	Ruffin, DeLorean, DrPH, Director of Population Health
Hightower, Tony, CPhT, Associate Director, UM Regulations	Spiller, Bettina, MD, Associate Medical Director
Jalloh, Mohamed "Moe", Pharm.D, Dir. of Health Equity (Health Equity Officer)	Steffen, Nancy, Senior Director of Quality and Performance Improvement
Jones, Kermit, MD, JD, Medical Director for Medicare Services	Thornton, Aaron, MD, Associate Medical Director
Katz, Dave, MD, Associate Medical Director	Townsend, Colleen, MD, Regional Medical Director (Southeast)
Kubota, Marshall, MD, Regional Medical Director (Southwest)	Watkins, Kory, MBA-HM, Director, Grievance and Appeals
Leung, Stan, Pharm.D, Director of Pharmacy Services	

Partnership *Ex-Officio* Members Absent:	Guillory, Ledra, Senior Manager of Provider Relations Representatives
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer	Guevarra, Angela, RN, Associate Director, Care Coordination (SR)
Cotter, James, MD, Associate Medical Director	Hartigan, Nicole, RN, Associate Director, Care Coordination (NR)
Esget, Heather, RN, BSN, ACM, Director of Utilization Management	Kerlin, Mary, Senior Director of Provider Relations
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management	Randhawa, Manleen, Senior Health Educator, Population Health

Guests:	
Blake, Jill, Regional Director (Auburn)	Garcia-Hernandez, Margarita, PhD, Director, Health Analytics, Finance
Bontrager, Mark, Sr. Director of Behavioral Health, Administration	Gual, Kristine, PMP, CPHQ, Director of Quality Measurement, QI
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance	Isola, Brandy, Manager of Performance Improvement, QI (Chico)
Brown, Isaac, MBA/MHA, Director of Quality Management, QI	Jarrett-Lee, Kevin, Associate Director of Utilization Management
Brunkal, Monika, RPh, Associate Director, Population Health	Klakken, Vicky, Regional Director (Northwest)
Campbell, Anna, Health Policy Analyst, Utilization Management	Matthews, Richard "Doug," MD, Regional Medical Director (Chico)
Cunningham, Aryana, Policy Analyst, Care Coordination	McCune, Amy, Manager of Quality Incentive Programs, QI
Durst, Jennifer, Sr. Mgr. of Performance Improvement, QI (Santa Rosa)	Nakatani-Phipps, Stephanie, Lead Senior Provider Relations Rep
Erickson, Leslie, Program Coordinator II, QI (scribe)	O'Leary, Hannah, MPH, Manager of Population Health, Pop Health
Foster, Troy, Program Manager II, QI (HQIP)	Wellander, Emily, Improvement Advisor, QI (Santa Rosa)

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *None made* Introductions Approval of Minutes	Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 7:30 a.m. Jennifer Durst, the new Senior Manager of Performance Improvement, introduced herself. Formerly with CommuniCare, Jennifer is based in our Santa Rosa office. She reports to Isaac Brown. The Nov. 20, 2024 Q/UAC Minutes were approved as presented without comment. *Acknowledgment and acceptance of draft meeting minutes of the* • Nov. 12 Internal Quality Improvement (IQI) Committee • Oct. 30 Over/Under Utilization Workgroup • Nov. 7 Substance Use Internal Quality Improvement (SUIQI) Committee • Nov. 21 Member Grievance Review Committee (MGRC) • Dec. 4 Population Needs Assessment (PNA) Committee *Community Health Assessment and Improvement Planning (CHA/CHIP) Update included*	Motion to **approve the Q/UAC minutes:** Steven Gwiazdowski, MD Second: Brian Montenegro, MD *Approved unanimously* Motion to **accept the other minutes:** Steven Gwiazdowski, MD Second: Chris Swales, MD *Approved unanimously*
II. Standing Updates		
1. Quality Improvement (QI) Department Update *Nancy Steffen, Sr. Dir. of Quality and Performance Improvement*	• We are presently in our year-end Primary Care Provider Quality Incentive Program (PCP QIP) grace period, which permits providers to deliver medical record data to demonstrate closure of completed services or gaps in care. • Our Measurement Year 2025 bridge spec doc is posted publicly. The more detailed version will be available when eReports launches in early March. A kick-off webinar will occur today. • December was a very active month relative to Healthcare Effectiveness Data Information Set (HEDIS®). The Department of Health Care Services (DHCS) looking at our overall MY2023 and Managed Care Accountability Set (MCAS) made its sanction notice official Dec. 6: $475,000. We believe we have a compelling case, largely around gaps in data, to challenge about 80% of that amount, and have submitted our formal appeal to an administrative law judge. • Relative to MY2024, we submitted written notifications on sources of incomplete data for which we are primarily reliant on DHCS to provide to fulfill measurement reporting. We have significant gaps continuing in dental data, newborn enrollment data, substance use disorder data, and specialty mental health data. • DHCS notified managed care plans at the very end of November in a webinar and call and then a subsequent draft All Plan Letter (APL) in which they made clear their intention to assess MY2024 MCAS measure performance at the county level. That means we would be assessed at measurement minimum level performance for each of our 24 counties. This presents a great burden to Partnership given our geographical span. We have expressed concerns about the inability to demonstrate a statistically significant sample for each measure, particularly in our smaller, less populated counties, by which we may be assessed to nationally defined benchmarks and percentiles. We will continue to use our own data. We are uniquely positioned to do so given our size to demonstrate this methodology and approach to assuring good quality care to our membership.	For information only: no formal action required. There were no questions for Nancy.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• We are meeting today to talk about what DHCS would like to see from us in terms of performance improvement projects representative of our MY2023 low performing measures. We will leverage our response to MY2022 as we continue working in several areas, including well-care visit performance and expanding our Healthy Babies Growing Together program to help pregnant and recently delivered members. We take the first quarter if every year to share best practices. Our regional Medical Director are key participants in these webinars: o Feb 10: Pediatric Preventive Care for Ages 0-30 Months o Feb. 26: Pediatric Preventive Care for Ages 3-17 Years o March 12: Chronic Disease and Colorectal Cancer Screening o March 26: Perinatal Care and Chlamydia Screening o April 9: Breast and Cervical Cancer Screenings o April 23: Diabetes Control • We have made good progress improving breast cancer screening performance through our mobile mammography clinic events. • We are converting our pediatric lead prevention program from a round-based application process for point of care devices into a continuous application period to help our primary care providers to offer that service at the point in time it is needed.	
2. HealthPlan Update *Robert Moore, MD Chief Medical Officer*	• Much inner organizational energy is going into preparing for our dual special needs plan, Partnership Advantage, launching in eight counties in January 2026. Kermit Jones, MD, JD, is our Medical Director for Medicare Services. We are working hard to get the contracts back or, in some cases, letters of intent, hopefully by the end of the month as this is the first deadline when we submit on our network status to the Centers for Medicare & Medicaid Services (CMS). QUAC members are encouraged to check in with large organizations to see if they have questions and will or will not participate. • Our upcoming Regional Medical Director trainings will increase from the five done last year to six this year, starting in March in Eureka and winding up in Marysville in May. Clinical leaders, CMOs and others are encouraged to attend. • Regional Medical Director Colleen Townsend, MD, is hosting a series of perinatal services webinars. Anyone with concerns or questions about the new perinatal services program is encouraged to enroll. • For those eight counties going live in Medicare, a key to success both for primary care providers and the Health Plan is accurate coding of patients' medical problems. That is how CMS determines how much money to allocate Partnership to take care of the population. Dr. Jones is leading a Feb. 19 webinar intended for a broad clinical audience. It would be appropriate for Billing leadership to attend as well. • The transition from traditional fee-for-service to our Whole Child Model has gone relatively smoothly in our expansion counties, with few administration issues that have now been resolved. • Partnership is making a very large effort trying to ensure that individuals being released from an incarcerated setting have a smooth transition back into the community. We have a pilot in Yuba County, working with the jail there that is going well, but it is very labor intensive. There's a multistakeholder group that meets for an hour a day Monday through Thursday, and they have roughly one discharge a	Q/UAC members are encouraged to read the CG-CAHPS report included as FYI in today's packet. Congratulations to the providers present today on their organizations' results, particularly La Clinica and CommuniCareOLE. *Meeting postscript:* Dr. Moore's December Medical Directors Newsletter was emailed to Q/UAC clinical members. The January newsletter was circulated Jan. 29.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	day. Hopefully that can be made more efficient. The process for assigning Medi-Cal membership begins Feb. 1, and assignment to Enhanced Care Managers will follow. It's a large, large effort. There are two pieces each person needs: a primary care provider and (if they choose) an ECM. The State will try to funnel as many as they can into ECM. They are usually discharged with just 30 days of medication. You will get a call that someone is being discharged from prison and will need an appointment within that first month, especially for those on medication assisted therapy (MAT) for substance use disorders. Per organization, it won't be an overwhelming number per month, but you will have to figure out a way to prioritize these members. In an ideal system, the PCP and ECM are in the same organization. In some cases, there will not be an ECM program in the primary care setting, and communication will be back and forth. • Partnership internally has two enormous core IT system changes occurring this year. There may be unforeseen issues. Randy Thomas, MD, asked about discharge from jails: "Is there any coordination with housing?" Q/UAC member Phuong Luu, MD, health officer for Yuba and Sutter counties, gave her perspective from the jail (not the prison) system. The team to which Dr. Moore referred is hers. "We started the County Justice-involved initiative in October 2024," Dr. Luu said. "We talk about every single inmate who has an active Medi-Cal membership and they have what's called a JIA code activated. Within the multidisciplinary team discussion, we go through a checklist to discuss physical health, behavioral health needs, and their social determinants of health. We talk about their housing needs; we talk about their food insecurity. Sometimes we even talk about if they need (transportation. The ECM provider for Yuba County is Peach Street Health, and they are responsible for contacting Partnership's Ron Klinger, MSN, Senior Manager, Justice Involved Program, in Santa Rosa. We also work with the Yuba Sutter Homeless Consortia. Inmates are inputted into our homeless information management system." Director of Enhanced Health Services Lisa O'Connell addressed Dr. Thomas' question from the state prison perspective. Prior to release, inmates will probably be assigned to an ECM provider who will work with them on housing transition. Some communities do have transitional housing for people that have a justice-involved background, but some do not. The State of California does not have enough housing, so that will be an issue. Some may also qualify for Community Supports. Dr. Moore asked whether these ECM providers are community based in the actual counties they serve or is it statewide? Lisa replied that we will try to connect them to the county where they say they are going to be released; however, they may not go back to that county where for probation they should be.	
III. Old Business – None		
IV. New Business – Consent Calendar (Committee Members as Applicable)		
Consent Calendar	2024 Oversight Audits: CY2023 Carelon – *direct questions to Gary Robinson* 2024 Referral Follow-up – *direct questions to Robert Moore, MD,* or *Tony Hightower, CPhT* ***Health Services Policies*** <u>Quality Improvement</u>	Motion to **approve without the three pulled policies:** Brian Montenegro, MD Second: Steven Gwiazdowski, MD

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	MPQP1018 – Preventive Health Guidelines MPQP1038 – Physician Orders for Life-Sustaining Treatment (POLST) <u>Care Coordination</u> MCCP2018 – Advice Nurse Program MCCP2031 – Private Duty Nursing under EPSDT – **pulled for correction** MPCP2017 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines MPCP2002 – California Children's Services – **ARCHIVE** *effective 01/01/2025* *Because all 24 Partnership counties are under the Whole Child Model, eff. 01/01/2025, the following policies are submitted for language changes. (There are no changes to any policy attachments.)* ***These policies will be brought back as need be on their annual review cycles:*** • MCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services • MCCP2022 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services • MCCP2023 – New Member Needs Assessment • MCCP2025 – Pediatric Quality Committee Policy • MCCP2035 – Local Health Department (LHD) Coordination • MPCP2006 – Coordination of Services for Members with Special Health Care Needs (MSHCN) and Persons with Developmental Disabilities <u>Enhanced Health Services</u> **– pulled to discuss alphanumeric identifiers** MCUP3142 – CalAIM Community Supports (CS) MCUP3143 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) <u>Utilization Management</u> MCUP3034 – PCP-to-PCP Transfers & Assignments of New Members to PCP MPUP3129 – Podiatry Services ***Non-Health Services Policy*** <u>Grievance & Appeals</u> CGA024 – Medi-Cal Member Grievance System Anna Campbell **pulled MCCP2031 and the two EHS policies.** In the first instance, we missed deleting the phrase "in participating counties" from the Whole Child Model definition. Some discussion was had on re-lettering/renumbering the two EHS policies before Dr. Moore asked Q/UAC to approve the policy updates understanding that the identifiers would change after the fact.	*Approved unanimously* Motion to **approve MCCP2031 as amended:** Steven Gwiazdowski, MD Second: Randy Thomas, MD *Approved unanimously* Motion to **approve the two EHS policies as amended:** Steven Gwiazdowski, MD Second: Randy Thomas, MD *Approved unanimously* <u>Next Steps</u>: All policies go to the Physician Advisory Committee (PAC) Feb. 12, 2025 *Meeting Postscript:* Anna Campbell archived UM's MCUP3142 and MCUP3143 and reactivated them with new alphanumerics under EHS. **MCUP3143 is now MCAP7001; MCUP3142 is now MCAP7003. Communications is now setting up a new EHS section under Health Services in the Provider Manual.**
V. New Business – Discussion Policies		
Policy Owner: Quality Improvement – *Presenter: Mark Netherda, MD, Medical Director for Quality*		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
MPQP1053 – Peer Review Committee	**It was decided at Jan. 7 IQI that the policy alpha designation will remain "MP" (multi-program) because this policy may apply in part to "Partnership Advantage," the Medicare product line implementing in eight counties, effective Jan. 1, 2026.** **Section V. Purpose:** Updated to read: The PRC reviews concerns and complaints about the quality of clinical care and services provided to Partnership HealthPlan of California's (Partnership's) members and makes recommendation for actions to prevent reoccurrence of any issues. PRC also reviews sentinel conditions identified as having quality concerns. PRC discussions and documents are protected by federal and state laws governing confidentiality of health care peer review activities conducted in good faith. **VI.A.1. Membership is updated** to allow for certain recently retired physicians to participate as PRC members: "Medi-Cal population experienced physicians who have recently retired from practice within the last two years are also eligible to serve on the PRC." Dr. Netherda thanked Robert Bides, RN, for noticing that the Purpose Statement previously mentioned only oversight of contracted providers when, in fact, Partnership has the obligation to review any provider who cares for our members when the need arises. He then went through the synopsis. Dr. Moore noted that the "half life" of medical knowledge is about five years now, so allowing physicians to serve on Peer Review for no more than two years after retiring from practice is probably a good idea. There were no questions.	Motion to **approve as presented:** Jennifer Wilson, MD Second: Robert Quon, MD *Approved unanimously* Next Steps: Feb. 12 PAC
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations*		
MCUG3022 – Incontinence Guidelines	Per discussion at the December OCMO meeting, this policy was updated (in Attachment A) to remove the prior authorization requirement for non-sterile gloves. Code A4927 will now be covered as per Medi-Cal guidelines for a quantity of 200/month with no prior authorization requirement. This adjustment will need to be configured in our system. Tony noted that our policy had been more restrictive than medical guidelines dictate, and so the policy was adjusted to remove these restrictions. There were no questions.	Motion to **approve as presented:** Steven Gwiazdowski, MD Second: Brian Montenegro, MD *Approved unanimously* Next Steps: Feb. 12 PAC
MCUG3104 – Transplant Authorization Process	**Section VI.A. Footnote 1:** "Magellan" was removed and replaced with " DHCS-contracted pharmacy administrator." **Section VI.B. 6:** During our annual review of this policy, we reviewed the time frames for Direct Member assignment to Health Plan 5 for Continuity of Care for transplant patients. Adjustment was made at VI.B. 6.a. and b. to specify that while Members are generally assigned to Health Plan 5 for 12 months and then re-evaluated for continued need, there are two transplant types where the Direct Member status is longer: a. Heart transplant recipients are granted H5 for plan lifetime. b. Bone Marrow transplant Members (including CAR T-cell therapy and gene therapy) become eligible for assignment to a PCP two years after receiving the transplant, but may qualify for continued H5 based on continuity of care criteria as detailed in policy MCUP3039 Direct Members.	Motion to **approve as presented:** Brian Montenegro, MD Second: Randy Thomas, MD *Approved unanimously* Next Steps: Feb. 12 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VII. References F. – P. Additional DHCS Provider Manual sections were identified for Chemotherapy drugs. Tony went through the synopsis. Dr. Moore noted the HP5 is an internal code that lets us know what kind of a Direct Member any patient is. These members can have a PCP, but they are not assigned, and they may go directly to see their transplant specialist without referral authorization. There were no questions.	
MCUP3113 – Telehealth Services	During this annual review, the Telehealth policy was updated and reorganized for clarity. Additional codes were also added as well as descriptions of modifiers. **Section I:** The following Related Policies were added: MPCR200 - Credentials Committee and CMO Credentialing Program Responsibilities MCND9006 - Doula Services Benefit MCCP2033- Community Health Worker (CHW) Services Benefit MCCP2032- CalAIM Enhanced Care Management (ECM) **Section III:** A definition was added for D: E&M: Evaluation and Management **Section V:** The Purpose section was updated to provide only a brief statement. Information on the history of telehealth was removed. **Section VI:** The body of this policy was reorganized to provide more hierarchy and formatting. The three telehealth services models are defined at **VI.B**. as follows: 1. Synchronous Telehealth Services 2. Synchronous Patient to Provider Telehealth Services 3. Asynchronous Telehealth Services/ and Settings "Store and Forward"/ E-Consults The Reimbursement process for each model is defined in detail at Section **VI.H**. **Sections VI.H.1.b. and VI.H.3.c:** Language has been added to describe the required use of Place of Service codes 02 (indicates that telehealth services were provided to a patient in a location other than their home) and 10 (indicates that the patient was in their home while receiving telehealth services) and to specify that the Place of Service Code requirement is not applicable for FQHCs, RHCs or Tribal Health Centers. **Sections VI.H.1.b. and throughout:** Replaced Indian Health Services (IHS) term with "Tribal Health Centers" except where the IHS Memorandum of Agreement (MOA) rate is specifically mentioned. **Sections VI.H.1.c. and VI.H.2.b.** Language was modified at VI.H.1.c. to say "Each telehealth provider must be licensed in the State of California *(if a licensure pathway is available)."* This change accommodates the additions of non-licensed care personnel such as Doulas and Community Health Workers which was added at VI.H.2.b. **Section VI.H.1.f.2)** Updated Partnership department in charge of specialist contracts to be "Network Services" instead of "Provider Relations." **Section VI.H.1.f. Table Billing guidelines for Distant Site Providers (Traditional Synchronous Telehealth Services):** Added specific codes allowed for Telehealth for ACE Screenings, Mental Health Assessment, Perinatal Educational Counseling and Other Covered Procedures. Clarified codes that are excluded from Telehealth.	There were no questions. Chris Swales, MD, said his provider organization is about to start two pilots for eConsult. Motion to **approve as presented:** John Murphy, MD Second: Steven Gwiazdowski, MD *Approved unanimously* Next Steps: Feb. 12 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.H.2.a. Correction was made to say that a licensed provider who provides E&M services for a patient utilizing telehealth technology to access the provider's office may submit claims for this service using the E&M code ***with*** the .93 or .95 modifier. This section previously said "without" which was incorrect. **Section VI.H.2.d. Table: Billing Guidelines for the Provider Site (Synchronous: Provider to Patient Telehealth Services):** Added code T1015 as an E&M code that may be billed as Licensed Provider Fee. Also deleted codes for Virtual Therapy procedures that were only allowed during COVID-19. **Section VI.H.3.d. Table Billing guidelines for Originating Site Providers (Asynchronous Telehealth Services):** Added code T1015 as an E&M code that may be billed as Licensed Provider Fee. **Section VI.H.3.f.3)** A new table was added for Originating Store and Forward Site (E-Consult) with code 99452 specified. **Section VII. References:** Additional sections of the DHCS Provider Manual were added as References including Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (rural); Tribal Federally Qualified Health Centers (tribal fqhc); Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics (ind health). Welfare and Institutions Codes (WIC) § 14132.725 was also added as Reference C. After Tony went through the synopsis, Dr. Moore added that this policy is not a comprehensive list of codes on what is or is not covered. Things not appropriate for telemedicine should not be billed as telemedicine. Chris Swales, MD, asked if there would be any issues should Medicare not extend telehealth coverage past March 31. Dr. Moore replied that yes, although Medi-Cal has made telemedicine flexible, we would need to bring the policy back if Medicare changes. Dr. Swales asked if, under a Medi-Medi, will Partnership cover telehealth if Medicare decides to no longer do so? Dr. Moore said where Medicare doesn't cover, Medi-Cal will kick in. "That's the good news," he said. "It is becoming a trend. It used to be that Medicare covered things that Medi-Cal did not. Now, it's the other way around: Medi-Cal covers a progressively larger number of things that are not Medicare covered." Associate Medical Director Dave Katz, MD, asked if Partnership has any provider education materials available to our providers as to what is and is not telemedicine-appropriate? Dr. Moore said Partnership has published on our website web-based materials. Still, our medical directors looking at quality issues in peer review are still finding cases of inappropriate use of telemedicine. "The increase helps access, but its overuse can actually harm quality," Dr. Moore said. "There has to be a balance that clinical leaders need to be cognizant about, especially when working with new providers." Dr. Swales noted that some patients, even when told that telemedicine is not appropriate for their complaints, will still ask for that service rather than come in as advised. He asked what Partnership would have providers do in these cases. Dr. Moore responded that if it is documented that the patient was so advised, our quality reviewers would be understanding. Dr. Townsend noted there is a difference between after-hours triage and actual full telehealth, adding she was unsure whether medical schools and other health training programs are now integrating the use of	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	telehealth into their curriculums. Dr. Swales said the medical students he supervises do sit in with him on telehealth visits. Telehealth is becoming part of primary care rotation too. In response to Dr. Moore's inquiry whether Chape-de Indian Health incorporates telehealth training in its new residency program, Q/UAC member Meagan Mulligan, RN, said yes, these students are exposed to "interspersed" telehealth visits. John Murphy, MD, asked if the "inappropriate" for telemedicine codes on speech, occupational, and physical therapy were coming from DHCS? Dr. Moore said these areas are poorly defined by Medi-Cal and extremely well defined by Medicare. "We are going to configure on the back end to follow Medicare for now," he said, despite the uncertainty whether existing telehealth provisions will be renewed past March 31. If a provider uses telehealth, and there is a denial, those reviews may be appealed, Dr. Moore said.	
VI. Presentations		
FY 2023-2024 Hospital Quality Incentive Program (HQIP) Evaluation *Troy Foster, Program Manager II, QI*	The HQIP offers substantial financial incentives to our hospitals for meeting performance targets on selected quality and operational efficiency measures. Our measure year is July 1 to June 30. The invitation-only HQIP consistently has had 26 hospitals participate each of the last several years and a steady program averaging around $7M or so of payment distribution every year. Some of the 33 hospitals include maternity; some do not. (Mad River Community Hospital closed its obstetrics program in October 2024, so they will not be providing that service anymore.) This year, we added six new hospitals (Eastern Plumas District Hospital, Enloe Medical Center, Oroville Hospital, Plumas District Hospital, Seneca District Hospital, and Tahoe Forest Hospital District) from our expansion program, so we have a total of 33 hospitals. Also consistent, about 45% of the hospitals have been top performers. This year, we had 15 top performing hospitals with a score of 90% or more, which is excellent. Eight (including Howard Memorial, Mendocino Coast District Hospital, Redwood Memorial and Petaluma Valley repeating from the previous year) earned a 100% score. Tahoe Forest too earned 100%, an accomplishment for being in the HQIP for the first time. The entire Providence system earned top performer status. A shout out to all and congratulations. Twenty-two of the 33 hospitals are at 75% or greater. Dr. Moore reiterated that participation is by invitation only: the calculus depends on how each hospital negotiation progresses. Some hospitals decline to accept any quality risk to their reimbursement mechanism, and if they decline to do that, they can't be offered the QIP. The Sutter system and Kaiser are not present here. A few other small hospitals in the expansion counties may be added in future. Troy noted that this was the first year that Surprise Valley Community Hospital was able to meet our gateway measure having to do with the electronic health information exchange (HIE) and so participate in the QIP. Jerold Phelps is not noted on the increase and decrease performance breakdowns because they didn't totally participate in 2022-2023 so they didn't have a measure to go against. Banner Lassen Medical Center had one of the largest increases, as well as Sonoma Valley Hospital. Banner did better on some of their maternity measures; Sonoma for the MAT measure, which they didn't meet the year before. Most of the decreased scores didn't fall by much: typically, it was for hospitals who have maternity but didn't quite meet all four maternity measures. The largest such drops were in Northbay and VacaValley. Hospitals are now required to input immunizations into the California Immunization Registry; so, based on this and great performance, the CAIR measure is removed from the MY 2024-2025 measurement set. In the Hospital Compare measure, 27 out of 28 eligible hospitals scored above the state average; so, in MY 2024-2025, we have increased that measure target to challenge the hospitals to do even better.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	For Health Equity, we had 21 hospitals whose reports were approved by us and 12 that did not make the measure. The smaller hospitals really struggled with these plans but are likely to do better in MY 2024-2025. Risk Adjusted Readmissions (RAR) is one of our measures where the hospitals have improved over time: in MY 2023-2024, about 85% of our hospitals earned full points. (This does not consider that hospitals may also have longer lengths of stay.) The six new hospitals did not have this is their measurement set as we did not want them to have to jump right in, and we do need data for the whole year. In 2023-2024 measurement set we have four maternity measures focused on VBAC, Early Elective Delivery before 39 Weeks, Exclusive Breast Milk Feeding, and NTSV rates. Overall, the hospitals have been consistent over the past few years in these areas. … Six out of eight hospitals earned full points for VBAC, a five percent decrease from last year. For Early Elective Delivery, our target is to be less than 1%: 58% of our hospitals earned full points, an 8% increase from last year. Seven of 17 hospitals earned full points for Breast Milk Feeding. For NTSV, the average score is .6% higher than last year. Seven of 14 hospitals captured had positive change; seven had negative change. (This measure captures just 14 hospitals because the three new expansion county hospitals that have maternity were not with us the previous year.) All but one of the 33 hospitals last July attended our annual Hospital Quality Symposium focused on health equity, reducing readmissions, addressing mental health struggles and CalAIM transformation, and providing compassion and effective treatment to the underserved. We will have another symposium coming up at the end of July 2025. This year, we worked communications with providers by offering mid-year check-ins. Twelve accepted this option, giving us a good chance to see how they were doing, to provide them with some data, and to also get ideas from them as well. Then we also worked internally and externally to include three new measures in our 2024-2025 measurement set: targeting expanding delivery privileges, increasing screening mammography capacity, and increasing seven-day clinical follow-up after discharge from the hospital. In summary, hospitals earning full points for RAR this year increased 12% over last year. More members have been seen for MAT; more hospitals earned their points this year than they did in previous years. Our CAIR continues to increase and so we have retired that measure. All hospitals have met their Cal Hospital Compare Patient Experience scores, and we also enhanced some partnerships with outside vendors as well. In 2024-2025, we will • continue to foster participant engagement through mid-year check-ins and other touch points, like advisory groups and our ops meetings • increase support for preliminary raw reports and the seven-day follow-up reports • provide our hospitals with what that is looking like and that will be coming out at the end of January • encourage our hospitals to use Hospital Quality Institute Platform to analyze their data to improve quality • utilize community partnerships, continue a systemic focus on health equity, and encourage our hospital participation in the Vaccinations for Children program. Steven Gwiazdowski, MD, asked if an individual hospital was looking at their numbers and wanted to change, improve, and get better, would Troy be their point of contact? Are there ways through the year they can get incremental data to get a sense of where they might be, where they might be measuring up and what they need to focus on? Troy answered that he is the HQIP point of contact. Providing data to the hospitals is one of the things that we do in our operations meetings, but Troy will also send out emails to hospitals. We have a quarter data lag, so, for example, once our Quarter 1 July – September) data is complete, Troy can send a RAR report to a hospital and they can reply “why was this here? Why did that count against us?” Some hospitals	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	engage here; some just take it as it comes and do not ever ask any questions. Dr. Moore added that because much of our data is annual, we do not have much visibility, unlike the PCP QIP where we can follow individual pap smears, etc. But the data does live within a hospital's system so that quality team could generate reports on all these measures. For example, they can report what the C-section rate is mid-year. Partnership will get accurate year-end numbers from the California Maternal Quality Care Collaborative (CMQCC). We also get yer-end numbers from the California Perinatal Quality Care Collaborative (CPQCC). Dr. Moore encouraged Q/UAC members to have their teams develop their own dashboards as a best practice, and Dr. Gwiazdowski added everyone should check in with Troy's team. Dr. Murphy was curious if hospital declination to accept risk and thus forego participation in the HQIP was because of the way the program is structured? Is it mostly upside? Or is there downside risk as well? Dr. Moore said it is a matter of negotiation. Some hospitals just want the incentive money up front but that is not the way it works. Also, negotiations and negotiators change. Director of Quality Measurement Isaac Brown noted that sometimes we receive a point of contact for a hospital system or clinic. We pass on information to that person and sometimes we don't know where it goes after that. Dr. Moore agreed: If the CEO and the CFO don't know the results of their own QIP, the first step is to make them aware of it.	
QI Initiative: Evaluation of 2024 Cervical Cancer Self-Swab Testing Pilot *Brandy Isola, Manager of Performance Improvement (Chico)* and *Emily Wellander, Improvement Advisor, QI (Santa Rosa)*	Dr. Moore introduced this, saying Partnership does many pilots but for time constraints does not always bring those results to Q/UAC. However, he thinks this one was well done and impactful because the standard is changing now this year to allow self-swab to count for cervical cancer screening in the United States. The results of this pilot will inform all of us on how to proceed. Brandy cautioned that during this presentation one might hear "cervical cancer screening" and "HPV testing" used interchangeably. What we are talking about is a methodology to collect a sample for high-risk HPV testing. Typically. That is done through a physical exam with a provider. In this pilot project, we are evaluating the process of having the patient do the sample collection within the provider environment. When this pilot was planned, it was thought FDA approval was imminent. At-home HPV tests were already available for patients to order direct from the vendor. There was international research that suggested self-swabbing sample collection was an acceptable method for cervical cancer screening and research showing that self-collected samples will increase the uptake of cervical cancer screening. At the time planning occurred, Partnership had only 2022 data. A couple of our regions were doing reasonably well above the minimum performance level; a couple regions needed a little work. That definitely informed our recruitment, but no matter how well we are doing on a measure, we are always trying to improve our performance, trying to find cutting-edge strategies to bring to providers so we can all bring the best services and the easiest preventive care to our members. In this relatively small pilot, we had 200 self-swab kits and, although the expansion counties were coming on board, we focused on our established regions to acquire intelligence on successful implementation of a self-swab option in the primary care office and to develop educational materials for members. We originally recruited five providers in four of the regions. We had a hybrid approach to recruiting, a couple of smaller sized primary care practices who were struggling a little bit with the cervical cancer screening measure in the QIP, and then to ensure representation across our footprint, three larger organizations known to have the capacity to successfully carry out pilot projects.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Current Partnership members were eligible for inclusion if at least 30 years old (the United States Preventive Services Task Force recommendation) and they had declined traditional exams. We purchased 200 kits that the vendor shipped directly to the provider sites. We initially anticipated that this would go quickly, we'd learn something and maybe do a phase two and expand. This is not how that went. The first kits shipped in January 2024 but were not first used until the beginning of February. Right away we started having issues with the vendor. Providers were having to go to a different portal to register the kits and get the results. Something went glitchy, so we never really recovered. More kits were used at the beginning and then midway we had another kick-off call to encourage our providers because it was going more slowly than we anticipated. We encouraged our providers to either go to additional provider patient panels or to different environments. There were only three large practices that survived that initial glitch with the vendor. The two smaller health centers could not get past the work-around and didn't have the capacity to deal with the additional workflow challenge. We ended up using 89 test kits, and called it to a close at the end of September to regroup. By then, the FDA had approved self-sampling methodology. Fifty-five percent of the kits were used in a "normal" visit environment; 42% were used in a street medicine or mobile clinic environment. Two of the three practices started in their field or mobile medicine environment really trying to get to those unhoused individuals or people with other challenges coming into a "normal" environment. One provider expanded into their brick-and-mortar practice after that slow start in the mobile environment. And then one of our providers did a mini test in September trying to incorporate the self-swabbing concept into their mobile mammography that they did with Partnership. In a breakdown of positivity rates by environment, there was a higher positivity rate in the field or street medicine environment, indicating there may be a higher risk in the unhoused or unstably housed patient population. We did several surveys throughout the pilot and had other conversations with our provider practices. We heard that the patients are ready for this option. Some who didn't fit within the pilot heard through the grapevine that this was an option and showed up to ask for it. Providers are ready for this option. Some will not be early adopters, but any option where you can reach the hesitant patient and get that cervical cancer screening finished will be good. There was a provider concern that lingered: if a patient is not willing to do a physical exam for the screening, what will happen if a self-swab indicates positivity and a need for a colposcopy? One of the pilot providers set an additional criterion: if patients would not verbally agree to come back for a colposcopy if indicated, she did not do the screening. So, this is not the be all and end all for some patients, especially in the unhoused population. The question came back to the provider, what if it is positive? This indicated that they really have other bigger challenges within their lives. So, we need to discuss and maybe develop some talking points or some support. Emily talked about the evolving landscape now that the FDA has approved the HPV self swab to screen for cervical cancer in the healthcare setting. Partnership is in communication with our lab vendors, LabCorp and Quest, anxiously awaiting this option. We are advocating for access to new FDA approved self-swab materials and testing to be made available. We are providing support in the network to promote this new option to our members and patients in the clinic, and we are educating our providers on integrating the self-swab option into workflows. Dr. Swales commented that he suspects self-swab HPV testing will be like doing home stool testing kits. "We tell them that if it is positive they will need follow up testing," he said. "That hasn't been too much of an issue. I've had people ask me for self-swab HPVs. And then we've already done self-swabbing for STIs in the clinics, so it is not that much different. This will be great for gender expansive patients who don't want to go through a full pelvic exam to get their HPV screening."	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Dr. Moore said Emily might note the age criterion could one day expand to capture those who should be screened for chlamydia and gonorrhea. Dr. Swales noted that today, however, chlamydia and gonorrhea screening occurs in the 15- to 25-year-old population and HPV not until after the age of 30. Still, people are becoming aware of self-swab testing and have been asking for it. Dr. Thomas wondered at the variability in the unhoused population having a higher rate of cancer. "Was this age matched?" he asked. "Because the closer they are to 30, the less chance they should be having HPV because of when the HPV vaccine was introduced. The older people in the study would be less likely to have had the HPV vaccine." Brandy replied that the average age of positives in field and street medicine was 51, and the average age of positives in the "normal visit environment" was 35. Dr. Moore said this small sample would make a regression analysis nearly improbable. "We can look at that. but we may not hit statistical significance," he said. "My guess is that the numbers are just too small." Dr. Swales noted "it's also exposure risk. There's maybe more exposure through sexual contact in the unhoused than someone who is able to go into an office." Dr. Townsend said as we integrate self-swab testing and are able to accommodate larger populations, at some point we could look at a subset to see who was vaccinated and who was not. "That population of individuals who are unhoused, that is a population really at risk," she said. "Many of those individuals haven't been screened for a really long time, and so that can also speak to their relatively higher rate (of positivity) as well." Dr. Swales asked when the vendors will be ready. Dr. Townsend said the word from both LabCorp and Quest is First Quarter 2025. "We have a webinar all set to go once they have their information available to go out to providers," she said. "We will let you know." Robert Quon, MD, said "the uphill battle is going to be providers starting, because for many this is not how they were trained or what they believe in. I remember when I had to roll this out to my group: it was talking to the specialists that can give you all of the numbers associated with what is the error rate? What is the miss rate? That's going to be important as you roll out to providers who say this is substandard care." Quon urged thinking about how to explain the same info differently to different audiences. "This is a good thing to expand. And I wouldn't just look at the unhoused. Certainly, there are many who are housed who do not come in regularly and who do not want to come in. We're on the precipice of doing something that could be impactful for many of our patients." Dr. Townsend agreed but cautioned that self-swab HPV testing, while available by mail-in and home testing kits elsewhere in the world, has only been approved by the FDA for "clinically observed" use.	
VIII. **Adjournment** – Q/UAC adjourned at 9:04 a.m. Q/UAC next meets at 7:30 a.m. Wednesday, Feb. 20.		

Respectfully submitted by: Leslie Erickson, Program Coordinator II, QI

Signature of Approval: _____ Date: _____

Robert Moore, MD, MPH, MBA
Chief Medical Officer and Committee Chair

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, Jan. 7, 2025 / 1:30 – 3:33 PM

Members Present:
Andrews, Leigha, MBA, Regional Director, Southeast
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
Bides, Robert, RN, BSN, Manager of Member Safety – Quality Investigations, QI
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brown, Isaac, MHA, MBA, Director of Quality Management, Quality Improvement
Brundage O'Connell, Lisa, MHA, Director of Enhanced Health Services
Brunkal, Monika, RPh, Assoc. Dir., Population Health
Campbell, Anna, Policy Analyst, Utilization Management
Davis, Wendi, Chief Operating Officer
Esget, Heather, RN, BSN, ACM, Director of Utilization Management
Gast, Brigid, MSN, BS, RN, NEA-BC, Sr. Director, Care Management
Hightower, Tony, CPhT, Associate Director, UM Regulations
Innes, Latrice, Manager of Grievance & Appeals Compliance
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Kerlin, Mary, Senior Director, Provider Relations
Kubota, Marshall, MD, Regional Medical Director – Southwest
Leung, Stan, Pharm.D, Director of Pharmacy Services
Matthews, Richard "Doug," MD, Regional Medical Director – Chico
Moore, Robert, MD, MPH, MBA, Chief Medical Officer, Committee Chair
Netherda, Mark, MD, Medical Director for Quality, Committee Vice-Chair
Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
Randhawa, Manleen, Senior Health Educator, Population Health
Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Steffen, Nancy, Senior Director of Quality and Performance Improvement
Villasenor, Edna, Senior Director, Member Services and G&A

Members Absent:
Ayala, Priscila, Director, Network Services
Bjork, Sonja, JD, Chief Executive Officer
Garcia-Hernandez, Margarita, PhD, Director of Health Analytics
Klakken, Vicki, Regional Director, Northwest
Sharp, Tim, Regional Director, Northeast
Turnipseed, Amy, Senior Director of External and Regulatory Affairs

Guests:
Arrazola, Kelcie, Provider Education Specialist, Provider Relations
Beltran-Nampraseut, Athena, CPhT, Program Manager, PCP/QIP
Bikila, Dejene, Manager of Data Science, Finance
Bontrager, Mark, Senior Director of Behavioral Health, Health Services
Broadhead, Candi, Project Manager II, QI
Bushey, Lindsey, Project Manager I, QI
Clark, Kristen, Manager of Quality & Training, Member Services
Devan, James, Manager of Performance Improvement, QI
Donahue, Celena, Improvement Advisor, QI (Eureka)
Durst, Jennifer, Senior Manager of Performance Improvement, QI
Erickson, Leslie, Program Coordinator II, QI (scribe)
Foster, Troy, Program Manager II, QI (HQIP)
Gual, Kristine, Director of Quality Measurement, QI
Hannah, Bethany, Administrative Assistant I, Health Equity
Hanusiak, Kenzie, Senior Manager of Regulatory Affairs & Compliance
Harris, Vander, Senior Health Data Analyst I, Finance
Isola, Brandy, Improvement Advisor, QI (Redding)
Jamali, Shahrzad, Improvement Advisor, QI (Chico)
Kung, Jen, Senior Health Data Analyst II, Finance
Malvo, Lisa, Senior Director of Claims
Mouille, Matthew, Medicare Program Manager, Administration
Muncy, Kellie, Manager of Change Management and Configuration, Configuration
Nguyen, Tom, Manager of Health Analytics, Finance
Newell, Amber, CPhT, Program Manager I, QI
O'Leary, Hannah, MPH, Manager of Population Health, Pop Health
Power, Kathryn, Regional Director, Southeast
Quichocho, Sue, Manager of Quality Measurement, QI
Rathnayake, Russ, Senior Health Data Analyst I, Finance
Reyes, Gene, Provider Relations Consultant, Provider Relations
Robertello, Kimberly, Senior Medicare QI Program Manager, QI
Roberts, Dorian, Improvement Advisor, QI (Redding)
Romero, Liz, Improvement Advisor, QI (Fairfield)
Smith, Christine, Community Health Needs Liaison, Population Health
Spencer, Ben, Project Coordinator I, Health Equity
Spiller, Bettina, Associate Medical Director
Thomas, Penny, Sr. Health Data Analyst, Finance
Townsend, Colleen, MD, Regional Medical Director, Southeast
Tryan, Tiffany, Improvement Advisor, QI (Redding)
Vaisenberg, Liat, Associate Director of Health Analytics, Finance
Vance, Brooke, Program Manager I, Network Services
Watkins, Kory, Director, Grievance & Appeals

McCune, Amy, Manager of Quality Incentive Programs, QI	Wellander, Emily, Improvement Advisor, QI (Santa Rosa)
Moore, Jordan, Provider Education Specialist, Provider Relations	West, Lise, Administrative Assistant II, Enhanced Health Services
Moraghebi, Roudabeh, Manager of Health Analytics, Finance	Yarcia, Tina, Sr. Provider Education Specialist, Provider Relations

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Introductions Approval of Minutes	Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 1.30 p.m. Jennifer Durst, the new Senior Manager of Performance Improvement working out of Santa Rosa, introduced herself. She reports to Isaac Brown, the Director of Quality Management. Jennifer recently worked at Communicare+OLE. Approval of the Nov. 12, 2024 IQI Minutes *Acknowledgement and Acceptance of draft meeting minutes of the* • Oct. 20, 2024 Over/Under Utilization Workgroup • Nov. 7, 2024 Substance Use Internal Quality Improvement (SUIQI) Committee • Nov. 21, 2024 Member Grievance Review Committee (MGRC) • Dec. 4, 2024 Population Needs Assessment (PNA) Committee *Includes Community Health Assessment and Improvement Planning (CHA/CHIP) Update*	Motion to approve IQI Minutes: Mark Netherda, MD Second: Marshall Kubota, MD Motion to accept other minutes: Lisa O'Connell, MHA Second: Mary Kerlin
Overview of SNP Policy Alignment Process *Kermit Jones, MD, JD, Medical Director for Medicare Services*	Dr. Jones noted that Medicare Dual Special Needs Plan (D-SNP) review will need to occur on all Partnership policies for applicability to Partnership Advantage before the policies go on to IQI review. Most policies will not apply to Medicare or will not need much change if they do apply to Medicare as well as Medi-Cal. Some policies, however, will require a separate Medicare version because of significant regulatory differences. These reviews have already begun and will hopefully wrap before October 2025 when Partnership needs to be able to start receiving prior authorization for SNP, even though the product line itself will not take effect until Jan. 1, 2026. Utilization Management policies are likely to be more impacted than other policies, Dr. Jones said. SNP UM related policies will likely include algorithms to ensure that reviewers understand distinct regulatory differences in the review process and would be able to explain these differences if asked by an auditor. For example, how Medi-Cal defines an appeal and a grievance differs from how Medicare defines each, so different policies are likely to be required: that is, a Partnership Advantage policy will likely be needed apart from the CGA024 on today's agenda. Generally, if a policy is to be reviewed at IQI and/or Q/UAC in February, it should first be submitted in redline no later than mid January to the SNP review team, which will be comprised of Dr. Jones, Matthew Mouille, Anna Campbell, and relevant department subject matter expert (SME), IQI policy lead, and reps from Configuration and Regulatory Affairs & Compliance, as necessary. This committee will prioritize its reviews from most to least relevant to Centers for Medicare and Medicaid Services (CMS) guidance on SNP regulatory changes. Pharmacy policies will have high priority. IQI considers more than 180 policies in any calendar year, so this SNP review committee will need to consider an average of six or more policies each week to meet our October goal. It therefore behooves policy owners to get their redlines to the committee sooner rather than later.	
II. Old Business – None		
III. New Business Consent Calendar (Committee Members as applicable)		
2024 Oversight Audits: CY2023 Carelon – *direct questions to Gary Robinson* ***Health Services Policies*** <u>Quality Improvement</u> MPQP1018 – Preventive Health Guidelines MPQP1038 – Physician Orders for Life-Sustaining Treatment (POLST) <u>Care Coordination</u> MCCP2018 – Advice Nurse Program		The Consent Calendar but for CC and EHS policies was **approved as presented:** Mary Kerlin Second: Mark Netherda, MD

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	MCCP2031 – Private Duty Nursing Under EPSDT MPCP2017 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines **ARCHIVE** effective 1/1/2025: MPCP2002 – California Children's Services *And accept related language changes to* • MCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services • MCCP2022 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services • MCCP2023 – New Member Needs Assessment • MCCP2025 – Pediatric Quality Committee Policy • MCCP2035 – Local Health Department (LHD) Coordination • MPCP2006 – Coordination of Services for Members with Special Health Care Needs (MSHCN) and Persons with Developmental Disabilities <u>Enhanced Health Services</u> MCHP3142 – CalAIM Community Supports (CS) MCHP3143 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) <u>Utilization Management</u> MCUP3034 – PCP-to-PCP Transfers & Assignments of New Members to PCP MPUP3129 – Podiatry Services ***Non-Health Services Policies*** <u>Grievance & Appeals</u> CGA024 – Medi-Cal Member Grievance System <u>Credentialing</u> MPCR11 – Credentialing of Community Health Workers (CHW) Supervising Providers MPCR20 – Medi-Cal Managed Care Plan Provider Screening and Enrollment MPCR300 – Physician Credentialing and Re-credentialing Requirements MPCR700 – Assessment of Organizational Providers Effective Jan. 1, 2025, all 24 Partnership counties are now under the Whole Child Model for California Children's Services (MCCP2024), hence the archiving of MPCP2002. **Anna Campbell pulled all Care Coordination policies** to ensure that in each where WCM is defined, the phrase "in participating counties" be deleted from that definition. **The two EHS policies were pulled** to discuss whether the re-lettering of policies (e.g., MCUP3142 becoming MCHP3142 to reflect policy migration from UM to EHS) should occur now or wait until such time as the external website is updated. Dr. Moore said we will re-letter the policies now, although the policies will remain in the UM bucket on the website until such time as a webmaster is hired and the website is retooled. EHS policies will be signified by the use of the letter H in third place, Dr. Moore said. Lisa O'Connell noted that the "sobering centers" language was added to the benefits in July and that configuration subsequently took place despite this additional benefit not taking effect until Jan. 1, 2025.	Motion to **approve CC policies as amended:** Doug Matthews, MD Second: Marshall Kubota, MD Motion to **approve EHS policies as amended**: Lisa O'Connell, MHA Second: Mohamed Jalloh, Pharm.D <u>Next Steps:</u> All but the Credentialing policies now go to the Jan. 15 Quality/ Utilization Advisory Committee (Q/UAC) and the Feb. 12 Physician Advisory Committee (PAC) *Post-meeting Note: Credentialing policies passed the Credentials Committee on Jan. 8.*
IV. New Business – Discussion Policies		
Policy Owner: Quality Improvement – *Presenter: Mark Netherda, MD, Medical Director for Quality*		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
MPQP1053 – Peer Review Committee	**The policy alpha designation will remain "MP" ("Multi Program") because this policy will apply to both Medi-Cal and Medicare product lines on Jan. 1, 2026.** **Section V. Purpose:** Updated to read: The PRC reviews concerns and complaints about the quality of clinical care and services provided to Partnership HealthPlan of California's (Partnership's) members and makes recommendation for actions to prevent reoccurrence of any issues. PRC also reviews sentinel conditions identified as having quality concerns. PRC discussions and documents are protected by federal and state laws governing confidentiality of health care peer review activities conducted in good faith. **VI.A.1. Membership is updated** to allow for certain recently retired physicians to participate as PRC members: "Medi-Cal population experienced physicians who have recently retired from practice within the last two years are also eligible to serve on the PRC." Dr. Netherda recognized Member Safety Quality Investigations Manager Robert Bides, RN, thanking him for the rewording of the Purpose Statement. The PRC has the obligation to look at any provider who provides care to Partnership members, not just the contracted providers, when a potential issue arises, Dr. Netherda stated. Dr. Moore directed Leslie to check the "Partnership Advantage" box in the policy headers and add the following footnote: "This policy may also apply in part to Partnership Advantage, the HealthPlan's Medicare product effective Jan. 1, 2026 in eight counties: Del Norte, Humboldt, Mendocino, Lake, Marin, Sonoma, Napa, and Solano, and may be subject to change based on Centers for Medicare and Medicaid Services (CMS) rules." The Reference "B" notation is removed because the URL cited refers to reference A and is not a separate reference.	Motion to **approve as amended**: Lisa O'Connell, MHA Second: Doug Matthews, MD Next Steps: Jan. 15 Q/UAC Feb. 12 PAC
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations*		
MCUG3022 – Incontinence Guidelines	Per discussion at the December OCMO meeting, this policy was updated (in Attachment A) to remove the prior authorization requirement for non-sterile gloves. Code A4927 will now be covered as per Medi-Cal guidelines for a quantity of 200/month with no prior authorization requirement. This adjustment will need to be configured in our system. Dr. Moore noted that we had been more strict than the State, so we are amending this policy to be more flexible. There were no questions.	Motion to **approve as presented**: Doug Matthews, MD Second: Anna Campbell Next Steps: Jan. 15 Q/UAC Feb. 12 PAC
MCUP3104 – Transplant Authorization Process	**Section VI.A. Footnote 1:** " Magellan" was removed and replaced with " DHCS-contracted pharmacy administrator." **Section VI.B. 6:** During our annual review of this policy, we reviewed the time frames for Direct Member assignment to Health Plan 5 for Continuity of Care for transplant patients. Adjustment was made at VI.B. 6.a. and b. to specify that while Members are generally assigned to Health Plan 5 for 12 months and then re-evaluated for continued need, there are two transplant types where the Direct Member status is longer: a. Heart transplant recipients are granted H5 for plan lifetime. b. Bone Marrow transplant Members (including CAR T-cell therapy and gene therapy) become eligible for assignment to a PCP two years after receiving the transplant, but may qualify for continued H5 based on continuity of care criteria as detailed in policy MCUP3039 Direct Members.	Motion to **approve as presented**: Mark Netherda, MD Second: Marshall Kubota, MD Next Steps: Jan. 15 Q/UAC Feb. 12 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VII. References F. – P. Additional DHCS Provider Manual sections were identified for Chemotherapy drugs. Anna Campbell noted that nomenclature has changed: the State now prefers "Organs & Bone Marrow Transplants." Dr. Moore noted Partnership's language is more precise regarding bone marrow transplants. Tony agreed Partnership's policy is better defined.	
MCUP3113– Telehealth Services	During this annual review, the Telehealth policy was updated and reorganized for clarity. Additional codes were also added as well as descriptions of modifiers. **Section I:** The following Related Policies were added: F. MPCR200 - Credentials Committee and CMO Credentialing Program Responsibilities G. MCND9006 - Doula Services Benefit H. MCCP2033- Community Health Worker (CHW) Services Benefit I. MCCP2032- CalAIM Enhanced Care Management (ECM) **Section III:** A definition was added for D: E&M: Evaluation and Management **Section V:** The Purpose section was updated to provide only a brief statement. Information on the history of telehealth was removed. **Section VI:** The body of this policy was reorganized to provide more hierarchy and formatting. The three telehealth services models are defined at **VI.B**. as follows: 1. Synchronous Telehealth Services 2. Synchronous Patient to Provider Telehealth Services 3. Asynchronous Telehealth Services/ and Settings "Store and Forward"/ E-Consults The Reimbursement process for each model is defined in detail at Section **VI.H**. **Sections VI.H.1.b. and VI.H.3.c:** Language has been added to describe the required use of Place of Service codes 02 (indicates that telehealth services were provided to a patient in a location other than their home) and 10 (indicates that the patient was in their home while receiving telehealth services) and to specify that the Place of Service Code requirement is not applicable for FQHCs, RHCs or Tribal Health Centers. **Sections VI.H.1.b. and throughout:** Replaced Indian Health Services (IHS) term with "Tribal Health Centers" except where the IHS Memorandum of Agreement (MOA) rate is specifically mentioned. **Sections VI.H.1.c. and VI.H.2.b.** Language was modified at VI.H.1.c. to say "Each telehealth provider must be licensed in the State of California *(if a licensure pathway is available)."* This change accommodates the additions of non-licensed care personnel such as Doulas and Community Health Workers which was added at VI.H.2.b. **Section VI.H.1.f.2)** Updated Partnership department in charge of specialist contracts to be "Network Services" instead of "Provider Relations." **Section VI.H.1.f. Table Billing guidelines for Distant Site Providers (Traditional Synchronous Telehealth Services):** Added specific codes allowed for Telehealth for ACE Screenings, Mental Health Assessment, Perinatal Educational Counseling and Other Covered Procedures. Clarified codes that are excluded from Telehealth. **Section VI.H.2.a.** Correction was made to say that a licensed provider who provides E&M services for a patient utilizing telehealth technology to access the provider's office may submit claims for this service using the E&M code ***with*** the .93 or .95 modifier. This section previously said "without" which was incorrect.	Motion to **approve as presented and accepting changes as noted that will be in the Jan. 15 Q/UAC version**: Anna Campbell Second: Mark Netherda, MD Next Steps: Jan. 15 Q/UAC Feb. 12 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.H.2.d. Table Billing Guidelines for the Provider Site (Synchronous: Provider to Patient Telehealth Services): Added code T1015 as an E&M code that may be billed as Licensed Provider Fee. Also updated codes for Therapy procedures that can be provided by telemedicine. **Section VI.H.3.d. Table Billing guidelines for Originating Site Providers (Asynchronous Telehealth Services):** Added code T1015 as an E&M code that may be billed as Licensed Provider Fee. **Section VI.H.3.f.3)** A new table was added for Originating Store and Forward Site (E-Consult) with code 99452 specified. **Section VII. References:** Additional sections of the DHCS Provider Manual were added as References including Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (rural); Tribal Federally Qualified Health Centers (tribal fqhc); Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics (ind health). Welfare and Institutions Codes (WIC) § 14132.725 was also added as Reference C. Tony said many of these updates are hierarchal in nature. Dr. Moore said the coding is complicated, particularly in speech, occupational, and physical therapies. Our list is now better than it was before, he said. Anna Campbell noted that more code changes may be necessary before Q/UAC as we don't know yet what Configuration has or hasn't done. Dr. Moore asked that IQI approve the policy with that in mind. Dr. Kubota expressed concern that the policy says synchronous telehealth connects the patient with the provider, when it is the patient's information that is connected to the provider. Dr. Moore added that "store and forward" is different from eConsult, and that these terms will be better defined in the policy version going to Q/UAC Jan. 15.	
V. Presentations		
1. Quality and Performance Improvement Update *Nancy Steffen, Senior Director for Quality and Performance Improvement*	• DHCS on Dec. 6 issued $475,000 in monetary sanctions for lower-than MPL (Minimum Performance Level) results within the Measurement Year 2023 MCAS (Managed Care Accountability Set). Our formal appeal, challenging 80% of the sanctions, has been submitted to an administrative law judge. • Partnership on Dec. 20 submitted written notification to DHCS citing several sources of incomplete data for which we are reliant on them for complete and accurate performance reporting on MY2024 MCAS measures. Our internal analysis has identified significant data gaps in MY2024 for dental, newborn enrollment, substance use disorder, and specialty mental health data, which DHCS sends to Partnership via the Plan Data Feed. This analysis gives us an opportunity to defend on the year just closed. • DHCS has also shared a plan to sanction Managed Care Plans at the county level for MCAS measure performance, a methodology we oppose because it will not give us an adequate sample size on certain measures nor meet NCQA's threshold for a statistically significant sample size. Our Healthcare Effectiveness Data Information Set (HEDIS®) team is working on this. • In the Primary Care Provider Quality Incentive Program (PCP QIP), MY2024 closed Dec. 31 and eReports was taken offline to apply Continuous Enrollment criteria and Relative Improvement logic to clinical measure denominators. eReports will come back online Jan. 13, permitting uploads of medical record data to represent completed services through year end. These uploads will be permitted until 5 p.m. Jan. 31. • An ABCs of Quality Improvement in-person training will occur Jan. 30 in Ukiah. • The 2025 Improving Measure Outcomes webinar series will cover Partnership's PCP QIP measures. Content will focus on direct application of best practices, including eliminating health disparities with examples from clinical quality improvement teams who are doing the work.	*For information only.* Southeast Regional Director Kathryn Power asked if there is an opportunity to have talking points ready around the sanctions so we can let everyone know we are working through the data piece. Dr. Moore replied that the summary he recently gave to the Board of Commissioners might be the best start to looking toward the year ahead. Nancy agreed and said she will give Kathryn talking points that can be shared with all the Regional Directors.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	○ Feb. 10: Pediatric Preventive Care for Ages 0-30 Months ○ Feb. 26: Pediatric Preventive Care for Ages 3-17 Years ○ March 12: Chronic Disease and Colorectal Cancer Screening ○ March 26: Perinatal Care and Chlamydia Screening ○ April 9: Breast and Cervical Cancer Screenings ○ April 23: Diabetes Control • The Mobile Mammography Program screened 806 Partnership members across 43 event days at 38 provider sites plan-wide between July 1 and Dec. 31, a feat Nancy called "impressive."	
2. 2024 Referral Follow-up *Robert Moore, MD, Chief Medical Officer*	Dr. Moore presented his referral follow-up monitoring report with data analysis for Jan. 1, 2023 through June 30, 2024. In the main, DHCS wants to see that the loop is closed when a referral to specialty care is made: they assume that every referral results in a visit; however, this isn't always true as a single referral may be made to multiple providers, or the patient improves and the visit does not happen. Dr. Moore went through his slide show showing the number of referrals by specialty and the specialty referrals by county, including the 10 that joined Partnership Jan. 1, 2024. Yolo County always looks worse than it is because one multi-discipline practice doesn't factor into our system, he said. Obstetrics/Gynecology fell to 10th place in the list of the 20 most referred specialties that resulted in a claim in the first half of 2024 because most OB does not now require a referral. The percentage of referrals used ranged from 39% for Gastroenterology (third on the list of 20 specialties) to 64% for Hematology/Oncology (15th on the list). Many large PCPs have converted to EPIC, and this trend is anticipated to continue, making reports more helpful for analysis of disposition of referrals. An analysis of Open Door's referrals January-June 2024 showed that just two percent (166) were denied for capacity – something we watch for Dr. Moore said – ineligibility for services and other reasons. This is a great result, Dr. Moore said. We looked at denials last year in response to audit findings, and found that in all grievance cases the denial came because it was an inappropriate referral. This did reassure DHCS that Partnership is not denying care to our members, Dr. Moore said. Marshall Kubota, MD, asked whether the numbers included telehealth. They do, although the report does not specifically pull-out telehealth numbers. Partnership audits contracted primary care sites for follow-up after referral as part of the site review process, which occurs at least triennially. An analysis by county showed that all but three scored 100% in office management for processing internal and external referrals, consultant reports, and diagnostic tests results. All but five counties scored 100% for office management in physician review and follow-up of referral/consultation reports and diagnostic tests results. Multiple reasons account for members' failure to complete referrals. Providers are reminded in newsletters, in-person meetings and at referral roundtables to reach out to these members and to Partnership when problems are encountered. PCPs are most challenged by general lower level of specialists practicing in our more rural areas. The use of telemedicine and eConsult is being aggressively supported to mitigate these shortages. The Access and Availability Grand Analysis details these and other interventions.	•

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
3. 2024 CG-CAHPS Analysis *Anber Newell, CPhT, Program Manager I, QI*	The Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) provides information on the member's experience with healthcare providers and gives a general indication of how well a practice meets patient expectations. For this report, sufficient patient volume is defined as having a least one visit by 2,400 (up from 1,200 last year) unique Partnership members between April 1, 2023, and March 31, 2024. Adult and child surveys in English and in Spanish were put into the field; results on closely related questions were combined into four composite measures: access, communication, coordination of care, and office staff. In all, 23 parent organizations (POs) are factored into this analysis. Top performers each scoring well above the 50th percentile **for pediatric access** were Redwood Pediatric Medical Group, Mendocino Coast Clinics, Churn Creek Healthcare-Redding Rancheria, United Indian Health Services, NorthBay Healthcare, Community Medical centers, and West County Health Centers. Top performers above the 50th percentile **for adult access** were Sutter Medical Foundation-West, NorthBay, La Clinica, and West County Health Centers. Top performers each scoring well above the 50th percentile **for pediatric communication** were Redwood Pediatric, Churn Creek, United Indian Health, Fairchild Medical Clinic, Shasta Community Health Centers, Alliance Medical Centers, and Sutter. Top performers above the 50th percentile **for adult communication** were Mendocino Coast Clinics, NorthBay, Mountain Valley Health Centers, Sutter, United Indian Health, West County Health Centers, La Clinica, and Church Creek. In all, 19 of the 23 parent organizations scored above the 50th percentile. Amber went through the slides on the Advance Directive questions. Dr. Netherda noted that the numbers add to 100% and do not account for "no response." Amber will look at this. Amy McCune noted this is important feedback as this was our first year with Press Ganey as our vendor, and we are always looking for ways to improve our dashboards. The no response to "have you had either a flu shot or flu spray in the nose" rose significantly in 2024 above 2022 and 2023 rates, perhaps because of the new vendor survey. Amy noted that this is the first time we have offered a QR code method of responding, hoping we would see an increase in yes responses; however, this did not occur. It does appear that our members may be smoking less. Dr. Moore speculated that some may be switching from tobacco to other nicotine products, and he would like to see survey responses broken down by county. As with the flu questions, utilizing the QR code as a response option didn't appear to make a difference. Amy assured Nancy Steffen that we will be considering other outreach options with Press Ganey in the next few weeks. Dr. Moore noted that one PO with whom we did a training showed improvement. La Clinica's improvement is "quite notable," he said. He suggested that both Northeastern Rural Health and Sonoma Valley Community Health Center merit extra attention as they performed less well in 2024 than they did in previous years.	• The team will pull tobacco use results from the Press Ganey dashboard, break them down by county and place those results on Partnership's Y drive. • Press Ganey will remain our vendor for the 2025 CG-CAHPS.

4. 2023-2024 Hospital Quality Incentive Program (HQIP) Evaluation	This year saw 33 hospitals participating: 26 continuing from previous years, Jerold Phelps Community in Garberville deciding to accept the invitation to participate, and an additional six hospitals in our new expansion counties. Eight of the 33 (including new participant Tahoe Forest in Nevada County) scored 100% and 15 scored 90% or better, reflecting an improvement the previous year when six scored 100% and 12 did 90% or better.
	
	The entire Providence system earned top performer status. Four hospitals maintained 100% from MY 2022-2023: Howard Memorial, Mendocino Coast District Hospital, Redwood Memorial, and Petaluma Valley. Both Banner Lassen
		• Three new measures will be part of MY 2024-2025:
		  ○ Expand delivery privileges
		  ○ Increase mammography screening capacity

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Troy Foster, Program Manager II, QI	Medical Center and Sonoma Valley Hospital showed marked improvement above last year. In all, 22 of the 33 hospitals earned more than 75%. The hospitals which raised their scores above last year did so by an average of 12%. In performance relative to targets, 32 hospitals earned full points for quality improvement. Thirty earned full points for use of the California Immunization Registry (CAIR); however, as this use is now mandated by regulations, this measure will not be part of the MY 2024-2025 HQIP. The very small hospitals did not submit health equity plans as they have resource issues. The six new expansion county hospitals were not held accountable to the Risk-Adjusted Readmission measure, in which we have seen steady improvement each year since MY 2020-2021, when only 12 earned full points, to MY 2023-2024 when 23 of the 27 participants earned full points. Six of eight hospitals with maternity earned full points on the Vaginal Birth after C-section (VBAC) measure, averaging a 19.2% rate (target is >/= 5%); however, this represents a 5% decrease from the previous year, and will require some work, Troy said. Two hospitals, one of which is not signed up with the California Maternal Quality Care Collaborative (CMQCC), earned no points here. Early Elective Delivery (EED) before 39 weeks (full points target: </= 1%) improved 8% above last year. Exclusive Breast Milk Feeding (EBMF) and Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean rates each remained relatively stable. Thirty-two of the 33 hospitals attended Partnership's 2024 Hospital Quality Symposium, which focused on health equity, reducing readmissions, addressing mental health struggles, and CalAIM transformation. Mid-year check-ins increased communication with providers. MY 2023-2024 results also show that more members have been seen for Medication Assisted Treatment (MAT), all hospitals improved their Cal Hospital Compare Patient Experience scores, and community partnerships were enhanced. Dr. Moore asked if Surprise Valley and Mayers Memorial are now utilizing PointClickCare. Troy said yes, they are through SacValley MedShare.	○ Increase 7-day clinical follow-up after discharge • The report for both the HQIP and the PQIP may be found on Partnership's Y drive at \\JUPITER.PARTNERSHIPHP.INT\transfer$\QIP\Evaluations
5. 2023-2024 Perinatal Quality Incentive Program (PQIP) Evaluation *Amy McCune, Manager of Quality Incentive Programs*	Time did not permit Amy to give a program overview or go through the year-over-year historical highlight. MY 2023-2024 saw Electronic Clinical Data Systems (ECDS) evolve to lay the groundwork for the new DataLink implementation. This year, timely prenatal care was broken out between < 14 weeks and > 14 weeks gestation so we could capture persons who come in later for that first visit. Overall, we saw a slight decrease in timeliness of prenatal care and a slight increase in postpartum care plan wide. Incentive payouts grew to more than $650,000 paid to 76 provider sites. Sonoma County accounted for $163,387.50; Solano, $98,300, and Shasta, $67,862.50. The report captures a three-year incentive payment comparison of 11 of the 14 legacy counties and highlights this year's improvements over last year's in three of these counties by dollar amount. Dr. Netherda suggested that future reports show percentages rather than dollar amount, so the improvements appear more notable. A year-over-year comparison of the various perinatal measures showed improvement in each but for the second postpartum visit, which declined slightly this year. In summary, increased provider engagement, follow-up and training with providers, Partnership/provider workgroups focusing on improving overall perinatal performance, and a shift in ECDS measure requirements contributed to increased counts of approved timely prenatal attestations, timely postpartum care, timely Tdap and influenza immunizations. The ECDS measure changed significantly as this year the data was submitted to HEDIS® for primary source verification.	• For MY 2024-2025, expansion county providers have been welcomed to the Perinatal QIP, and ECDS shifts to DataLink, which has a much larger scope of measures than what is currently required even for the PCP QIP. This foreshadows preparations for MY 2025-2026, which will include further development of the measure set.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
6. QI Initiative: Evaluation of 2024 Cervical Cancer Self Swab Testing Pilot *Brandy Isola, Manager of Performance Improvement,* and *Emily Wellander, Improvement Advisor, QI*	For context, Brandy began by saying that international research suggests that self-swab sample collection is an acceptable method for cervical cancer screening. Research also shows that self-collected samples increase the uptake of cervical cancer screening. At-home HPV tests were already available for patients to order independently, and so this pilot was timely as federal Food & Drug Administration (FDA) approval was imminent. Prior to this pilot, a three year-over-year comparison showed the Southeast and Southwest regions exceeded the 50th percentile in 2022; the Northwest first meeting the 50th in 2023, while the Northeast has yet to meet the 50th percentile and in fact declined in 2023 from 2022. Southeast and Southwest performance also declined in 2023. Partnership's pilot objectives were to acquire intelligence on successful implementation of a self-swab option in the primary care office, and to develop educational materials for members. Five providers across four regions, including the expansion counties, were recruited; however, resource constraints prohibited the two smallest POs participating. The criteria for patient inclusion was current Partnership membership, age 30 and older, and having declined a cervical cancer screening through traditional methods. The first tests were used Feb. 5, 2024 and the pilot was called to a close in September. In all, the three large practices distributed 89 of the 200 test kits. Two of three practices started in their field or mobile environment, and one expanded to their brick-and-mortar site after a slow start. (Providers struggled at first to find eligible patients willing to participate but word of mouth spread among members.) One practice did a mini-test of integrating this self-swab option at their mobile mammography event. The average patient age was 49 in both the field/street and brick-and-mortar environments. In field/street, 15.2% tested positive for HPV. The average age of these positive patients was 51. In the brick-and-mortar environment, 5.3% tested positive for HPV: patients testing positive averaged 45 years of age. Emily reported on lessons learned. Members and providers alike are ready for this option. Some concerns remain, however. Providers have expressed concern that if patients are not willing to do a pelvic exam for screening, will they be willing to do a colposcopy if the test is positive? Brandy noted that Southeast Regional Medical Director and CCS Pilot Advisor Colleen Townsend, MD, "handled this question brilliantly at the kick-off meeting." (See the Jan. 15 Quality/Utilization Advisory Committee minutes for more.) Some patients still are not interested in even the self-test option, asking "if it's positive, what then"? Emily noted there is an opportunity here to build relationships and educate our members. Emily noted that the landscape is evolving. We are now working with LabCorp and Quest to ensure that they are providing self-swab testing supplies to our providers. We will provide support to the network to promote this new option to patients in clinics. We will educate providers on integrating the self-swab option into their workflows and we will develop patient and provider education.	Dr. Moore said that as the FDA has now approved this collection method, we can now roll out this option with our provider network. Dr. Kubota said this is likely to start this first quarter.

VI. Adjournment
Dr. Moore adjourned the meeting at 3:33 p.m. IQI will next meet Tuesday, Feb. 11, 2025.
Respectfully Submitted by Leslie Erickson, Program Coordinator II, Quality Improvement *Approval Signature:* *Date:* *Robert Moore, MD, MPH, MBA* *Chief Medical Officer and Committee Chair*

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PARTNERSHIP HEALTHPLAN of CALIFORNIA A Public Agency

MEETING AGENDA / MINUTES

Meeting/Project Name:	**SUIQI**		
Date of Meeting:	**01/23/2025**	**Time:**	**10:00 AM**
Meeting Facilitator:	**Stephanie Wilson**	**Location:**	**Webex**

Meeting Objective/s
A committee comprised of appropriate PHC and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for the PHC's Substance Use Services* oversight. Activities and progress are reported to the IQIC.

Meeting Agenda

Topic	Person(s) Responsible	Time Allotted
1. Welcome and Introductions	Stephanie Wilson	5 Minutes
2. Review and Approve Minutes from SUIQI 11/7/2024	Stephanie Wilson	5 Minutes
3. BH Director Update a) BHT – Modernization of the Mental Health Services Act i. County Report	Mark Bontrager	10 Minutes
4. Wellness and Recovery Program Updates, Enhancements, and Highlights a) HSAG/PIPs b) 274 CG c) NACT d) Training Opportunities e) DMC-ODS Annual Compliance Training f) Safeway Long-Acting Injections g) Traditional Healers and Natural Helpers	Nicole Escobar Stephanie Wilson	20 Minutes
5. Monitoring Oversight a) Grievances & Appeals i. FY 24-25 2nd Quarter Report	Latrice Innes	5 Minutes
6. Monitoring and Oversight a) New Providers for Quarter – No New Providers b) Credentialed Network Providers c) Provider Compliance Summary i. Open Admissions CalOMS Reporting ii. Provider CAP Compliance – No	Stephanie Wilson	10 Minutes
7. Monitoring and Oversight d) Utilization Management i. TARs and TAR Denials ii. Member Utilization by Level and County	Stephanie Wilson	10 Minutes

iii. Timely Access iv. Transitions of Care		
8. Monitoring and Oversight e) Claims Processing i. Timeliness of Claims Processing for Quarter ii. Denial Rates iii. DHCS Short Doyle Acceptance Rate iv. Cost Reporting	Stephanie Wilson	5 Minutes
9. Monitoring and Oversight f) Quality Improvement Program Activities i. Q&R Provider Site Reviews	Shawn Porter	5 Minutes
10. Monitoring and Oversight g) Member Services i. Beneficiary Access Line/Call Center Statistics ii. CalOMS Data iii. Member Correspondence	Nicole Escobar	10 Minutes
11. Monitoring and Oversight h) Compliance i. BHINs & Policy Updates ii. BHIN 24-045 DMC-ODS ASAM Assessment Tools iii. BHIN 25-01 Update for Collecting and Reporting CalOMS Discharge	Stephanie Wilson	5 Minutes
12. Walk-On Items	Stephanie Wilson	5 Minutes
13. Wrap-Up and Closing	Stephanie Wilson	5 Minutes

Attendees		
Name	**Department/Division**	**Attended**
Deanna Bay	Humboldt County	X
Michelle Thomas	Humboldt County	X
Nancy Starck	Humboldt County	X
Tiffany Armstrong	Lassen County	X
Jill Ales	Mendocino County	X
Peggy Clevinger	Modoc County	X
Becky Miller	PHC	X
Carina Monroy	PHC	X
Cindy Wilson	PHC	X

Desiree Payumo	PHC	X
Diana Rose	PHC	X
Jennifer Cockerham	PHC	X
Kara Kusalich	PHC	X
Latrice Innes	PHC	X
Mark Bontrager	PHC	X
Mary Kerlin	PHC	X
Matt Ramsey	PHC	X
Mohamed Jalloh	PHC	X
Nicole Escobar	PHC	X
Rebekah Hostettler	PHC	X
Rob George	PHC	X
Ryan Ciulla	PHC	X
Shawn Porter	PHC	X
Stephanie Wilson	PHC	X
Vivian Agudelo	PHC	X
Joanna Chorpenning	Shasta County	X
Loraine Wisler	Siskiyou County	X
Ruth Leonard	Solano County	X

Notes, Decisions, Issues

1. Welcome and Introductions
    a. Stephanie started the meeting by welcoming everyone and reviewed housekeeping items
        i. Stay muted during meeting and raise hand to be called on for questions/comments
        ii. Introduced PHCs W&R new employees: Kara Kusalich and Cindy Wilson
2. Review & Approve Minutes from 11/7/2024
    a. Approved by Nancy and Jill
3. BH Director Update
    a. BHT – Modernization of the Mental Health Services Act
        i. AKA: Prop 1 – tax on millionaires in CA
        ii. Expands the Population that can be serves through MHSA (now BHSA)
        iii. County Report
            1. A lot of requirements and looking for how counties may be trying, or thinking about trying, to approach the new requirements – specifically the new stakeholder process to create a new 3-year budget and integrated plan that includes both MH and SUD
                a. Nancy: Humboldt has an internal planning meeting to identify the priorities for implementation on February 7th.
                b. Jill: Bringing stakeholders from different tables together to have a broader discussion on how counties are actually impacted
4. Wellness and Recovery Program Updates, Enhancements, and Highlights

a. HSAG/PIPs
    i. Shared PowerPoint – will be attached
        1. Non-Clinical PIP: Peer Support Specialist
            a. Unable to use Timely Access because measures exceed 80%
            b. Current baseline is 0 for the requirement to increase percentage of members who receive at least one Peer Support Service – this may be due to lack of billing by our providers or lack of documentation that is going into the charting
            c. If we measure county by county, some of our counties can have very inflated numbers if there is a program that really takes off, but if everyone is okay with keeping that language of running that by person across the Regional Model, a beneficiary will need to be provided anywhere between 275 to 300 single encounters – UNIQUE MEMBERS
            d. Data needs to be submitted through Short Doyle and accepted for them to be able to be reported out
            e. Nicole asked for feedback/thoughts/questions and suggested a roundtable discussion to dive into the measures further
                i. Rob: Is there a timeframe to receive Peer Support Service?
                    1. Nicole: Not completely described in PIP work, but it has a length of time between 2025 and 2027. If we can present a year-over-year and build on initial 5%, that would be great. Reestablish aim for 2026.
                ii. Rob: Any member that received Peer Service in 2025 would count towards this 5%?
                    1. Nicole: Correct
                iii. Deanna: How are we tracking this? Is this Peer Support across all BH entities or specific to SUD programs in the regional model? Due to budget shortfall, Humboldt might not be able to add staff members to our programs. Wondering how we're tracking 5% that has to be SUD or is it okay if we went to other BH services?
                    1. Nicole: I think they're safe, but they would need to be through one of our contracted providers within our SUD network. Shortfalls in one county can be made up in others and we anticipate that with the rate conversation, Waterfront and Crossroads may be very helpful.
                iv. Tiffany: Same question Humboldt had because they do not have allocated funds either. Does it have to be certified peer supports – ANY support specialist or do they have to have an NPI number?
                    1. Nicole: Doesn't state in documentation but we can ask that questions unless we want to have that leniency of utilizing staff that is available. This may be something we can discuss when we roundtable on our PIPs. Ultimately, from a claiming prospect, identify on claim who billed. Box 19 or Box 24 completed with provider's name or NPI for validation to be in compliance.
        2. Clinical PIP: FUA
            a. Follow-up after emergency visit for substance use

b. Current baseline as a model at 30.6% and hoping we can be strategic about our aims.
c. Increasing the number of members who engage in follow-up appointments and not focusing on just folks that schedule. This ensures they're actually attending these appointments after an ED encounter by 2.5% of baseline. Projection would be an additional 310 individuals falling withing in the numerator if the denominator was static – although we know it won't be, for purposes of projecting our efforts.
    i. Nicole: Any thoughts about this? Is 2.5% too aggressive or not aggressive enough?
        1. Deanna: Feels similar to last performance improvement on – the struggle Humboldt had was people were going to residential treatment weren't counted in our numbers of follow-up. Looking for clarity on who is actually going to be counted?
            a. Nicole: With inclusion of 94 codes within our payment reform code set – only a limited amount that count towards the numerator. Significant training opportunity to provide to programs to map out the initial engagement and admission process to bill certain code first. How do you feel about the 2.5%?
            b. Deanna: I am hopeful we can obtain that, but I am not sure that without proper training we will be able to. It also feels like conversations may be a little touchy since we will be telling ED how to bill stuff.
        2. Rob: Is there a minimum improvement percentage that we can utilize?
            a. Nicole: We may be able to argue for it. How do you feel about the 2.5%? Do you think it would be achievable with right intervention and planning behind it?
            b. Rob: I think it is a reasonable benchmark. I do think it will take a lot of infrastructure building on both SUD and MH side. Data sharing between counties and hospitals needs to improve.
        3. Jill: Currently, we have a collaborating team of all the service providers within Mendocino County to create an MOU for a pathway to share data. Once we get it drilled down, we will send a copy to PHC.

b. Network Adequacy
    i. 274 CG
        1. Provider directory
        2. DHCS did a retroactive quality review – one indicator flagged for ADA accommodations

3. Resolved, resubmitted file, and notification received prior to meeting informing it did pass, and code indicators are now clean.

ii. NACT

1. DHCS requesting to measure access by county instead of regional level – as additional feedback is given from them, we will provide. We will be having a quick chat as this will create more obstacles for our rural counties.

c. New Services

i. Safeway Long-Acting Injections

1. If anyone is interested in POD PIP outside of the Regional Model, this would be great
2. Phase I just focusing on two meds: Sublocade and Brixadi
    a. Can be administered in pharmacy or PCP can administer
3. More information will be provided.

ii. Traditional Healers and Natural Helpers

1. Anticipate two of contracted providers will be providing these services
2. Will not be communicating about these draft rates until they are finalized.
3. Once finalized, we will add new code to their contract, and they can begin to provide those services. We will continue to engage with other tribal entities. There are a few that have had a longstanding interest – about three we are actively pursuing.
4. Any additional questions, please reach out to PHC

d. Training Opportunities

i. Email will be sent for these training opportunities

ii. Medi-Cal Peer Support Specialist

1. Free training that is exclusive to counties.
2. Able to train 1,050 Peers statewide
3. Training being held between January and March 2025 in multiple sites across the state. Anyone interested MUST fill out the interest form by January 30.
4. Any questions regarding this may be sent to workforce@calmesa.org
5. Website for general information: www.capeerscertification.org

iii. CAADPE

1. Taking place Jan 30th at 1pm
2. Webinar – link will be provided in email after meeting

e. DMC-ODS Annual Compliance Training

i. PHC has been receiving questions around DMC-ODS Annual Training, which is typically out this time of year, but we are still waiting for DHCS annual guidance to come out.

ii. PHC will send out training within two weeks of receiving guidance

5. Monitoring Oversight

a. Grievances & Appeals

i. FY 24-25 2nd Quarter Report

1. Attached
2. Individual reports sent to each county on January 10th.
3. Nancy: Thank you for providing an example – helps us understand what some of the grievances might look like.
    a. Latrice: I will continue to provide examples.

6. Monitoring Oversight

a. New Providers for Quarter

i. No new providers for the quarter that have completed the contracting and credentialing process yet, but we do have providers that are going through the process now. Hopefully on our next SUIQI meeting, we will have new providers to introduce.

b. Credentialed Network Providers
   i. Last meeting, we were unable to get a report of our newly Credentialed Network Providers. Our credentialing team was going through training, and we did not receive the report prior to this meeting but was received during meeting. Will be sending out to counties – dating back to July (covering both quarters).

c. Provider Compliance Summary
   i. Open Admissions CalOMS Reporting
      1. Unable to report on OA this quarter due to no access to BHIS.
      2. Thank you to all the counties who have worked with Stephanie in getting access. Currently waiting on just Modoc and Siskiyou – both actively working on rectifying that process.
   ii. Provider CAP Compliance
      1. One provider who continues to be out of compliance – MedMark/BayMark. We have plans for a broader CAP for MedMark based on DATAR, CalOMS, Site Review content (which our Site Review team will go over), amongst other issues from a compliance perspective.
   iii. DATAR Reporting
      1. Chart attached with percentage of Providers Updating Datar on Time for FY 24/25 Q1-Q2
      2. Medmark Vallejo was the only provider out of compliance during the reporting period – addressed above.

7. Monitoring Oversight
   a. Utilization Management
      i. TARs and TAR Denials
         1. Residential authorizations charts attached.
         2. 0 denied authorizations
         3. Average turnaround time: 7.8 days
         4. Average length of stay: 43 days with our driver for longer length stays continuing to be co-occurring MH conditions
         5. Larger numbers are coming from bigger counties: Solano, Shasta, Humboldt.
            a. Nancy: How do we know that the driver of the length of stay is co-occurring MH? Is that just by asking our residential providers?
               i. Nicole: We look into the charting. We can see from the problem list what they're still working on.
            b. Rob: Question about overall capacity – with the Kaiser influx in Solano, we want to make sure that overall, from the Regional Model, that capacity is not becoming an issue with influx?
               i. Nicole: Not Kaiser driven. What we've seen is that with new counties coming on and the ODS landscape, we're all abiding by the same contract and when that occurs, the individual looking for bed needs to be engaged quickly as program is about timing. We saw a decrease in auth from July through October (November and December, we typically see a decrease) therefore we are curious to

see how January pans out and if we are back to what we saw in July-October.

ii. Member Utilization by Level and County
    1. Dashboard (attached) that tracks total participating members and total visits
    2. Calendar year – 2024; broken down by counties.
    3. Counties received their individual dashboards via email
        a. Counties are encouraged to reach out to PHC if they have any questions around their individual county reports. Or if any counties want their reports pulled for different time periods, PHC can do that as well.

iii. Timely Access
    1. Dashboard (attached) based on claims and tracks from screening to first treatment episode
    2. Calendar year – 2024
    3. Counties received their individual dashboards via email
        a. Deanna: Who is the one sending these out, I may have missed ours?
            i. Stephanie: Cindy sent them out but can resend, if needed.

iv. Transitions of Care
    1. Dashboard (attached) looks at members transition from one LOC to another
    2. Covers 6/6/2023 to 1/1/2025
    3. Counties received their individual dashboards via email
        a. Same as above, counties are encouraged to reach out to PHC if they have any questions around their individual county reports.
        b. If you did NOT receive data, that is because there wasn't a grievance filed for your county.
        c. Joanna: Can counties that have no grievances get a notice from PHC stating we did not have any?
            i. Stephanie: Yes

8. Monitoring Oversight
    a. Claims Processing
        i. Key Points:
            1. Modoc County: Short Doyle denials indicate a taxonomy code used in county claims is not aligned with outpatient services. This is an issue we are researching further.
            2. Shasta County: Theres the NPPES taxonomy code issue with VOC. We are currently working with the provider to resolve this issue.
            3. Siskiyou County: Denied because NPI for rendering provider is inactive. We are currently researching this issue further.
        ii. Timeliness of Claims Processing for Quarter
        iii. Denial Rates
        iv. DHCS Short Doyle Acceptance Rate
        v. Cost Reporting
            1. Friendly reminder to counties: If you have not completed your cost report, please do so. Majority of the 21-22 are done. Still have a few of the 22-23 that have been kicked back from DHCS that we sent back to your fiscal. Please ask your fiscal partners where they're at with cost reporting to help out DHCS. We figure at some point in the future, they're likely to approach us with a fee-for-service model and having a better understanding whether the PUMP model is working well, or a fee-for-service model may be more beneficial to your fiscal landscape is going to be important to have. Also,

it was added to IGA between counties and DHCS to have these reports done within 18-months of close of a fiscal year.

2. Please reach out if you have any issues or questions. If you need an extra set of hands, we can put you in touch with people who can assist with cost reports.

9. Monitoring Oversight
    a. Quality Improvement Program Activities
        i. W&R Site Reviews
            1. CAPs from October to December
            2. Of 15 sites reviewed, 10 CAPs issued
            3. Most common sightings we saw were: No documentation of physical exam or referral to PHC Care Coordination to get one done, no documentation of outreach for missed appointments, no documentation of MAT services being offered or note that the client is already receiving those services.
            4. Not all sites having problem lists or most recent problem list
            5. Discharge plans were not present for each client, elements of discharge summary were missing – possibly due to new tool established in July.
            6. Medical necessities not being determined appropriately – being signed late, not being done, or not being signed at all.
            7. Three outreach attempts are not documented for clients where provider loses contact
            8. For the facility CAPs where we come and walk around: most common signings names we were seeing are the ASAM training not being done by all the staff who do ASAMs. Most staff are missing fire safety and non-medical emergency training.
            9. Policies: Missing class standards and cultural competency policy, policies are missing for MAT services, and policies related to Native American services.
            10. Bilingual staff interpreting without any kind of proof of training.
            11. Staff missing proof of DMC-ODS trainings.
                a. Jill: Struggled with the word “CAP” when your agency had a 98/99%. I can see below 95% – is there any way to look at all agencies getting a PIP instead of a CAP when the percentage is that high?
                    i. Nicole: We can take a look in our upcoming review. Will follow-up with details.

10. Monitoring Oversight
    a. Member Services
        i. Beneficiary Access Line/Call Center Statistics
            1. Still moving forward with de-delegation of Carelon for member-facing activities.
            2. More information to share between March and April as far as what these timelines look like
            3. Report attached
                a. November and December have lesser value of inbound calls across all LOCs and a spike again in January.
                    i. Deanna: What kind of lag is there going to be when transitioning from Carelon to PHC to get that messaging over to provider and beneficiaries? Is there going to be overlaps when people call Carelon after the transitions happen? What is the mechanism to ensure calls get routed correctly?

1. Nicole: PHC will be purchasing phone number from Carelon and porting it over from an external perspective – it should be seamless.

ii. Jill: One of the things we struggle with Carelon is knowing geographics in the regional model.

1. Nicole: Thank you for bringing your concern to us. PHC is working on identifying which geo mapping tool we intend to use in our access line. We will go live when we are fully ready from a systems perspective, and we will make sure that geography is considered.

ii. CalOMS Data

iii. Member Correspondence

11. Monitoring Oversight
    a. Compliance
        i. BHINs & Policy Updates
            1. BHINs attached to meeting invite and meeting notes packet
            2. No policy updates to report
        ii. BHIN 24-045 DMC-ODS ASAM Assessment Tools
            1. Sent email to network
            2. DHCS put off requirement for providers to using the ASAM criteria assessment guide and ASAM continuum.
        iii. BHIN 25-01 Update for Collecting and Reporting CalOMS Discharge
            1. First notice of 2025
            2. Updates on protocols for discharging clients and to the standard discharge status of one, two, and three. As well as updates the timeframe for an administrative discharge to no sooner than 30-days to no later than 60-days when client has not had one face-t-face telehealth visit with a treatment counselor.
12. Walk-On Items
    a. Deanna: How are we going to shift to meet the incoming need to the complete ASAM criteria?
        i. Stephanie: We're all waiting on DHCS guidance. Relying on Change Companies for ASAM training and as far as systems, we will have to update our systems as far as CalOMS.
        ii. Nicole: Significant lift for all parties involved. Started putting together groups – clinical and non-clinical. Subsequent roundtables will probably happen with our providers as well. Dr. DeVido offered to host.
13. Wrap-Up and Closing
    a. Next meeting: April 24, 2025
    b. Dismissed: 11:50 AM

Action Items

Action	Owner	Due Date
1. Send counties individial dashboards	Cindy Wilson	1/30/2025
2. Send out Meeting Mintutes	Carina Monroy	1/30/2025
3. Send out Trainings via Email	Stephanie Wilson	1/23/2025
4. Send out Calendar Invite and Agenda for Next SUIQI	Stephanie Wilson	3/1/2025

MEETING AGENDA

Meeting / Project Name: Substance Use Internal Quality Improvement Committee Meeting (SUIQI)	
Objective of Meeting: A committee comprised of appropriate PHC and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for the PHC's Substance Use Services* oversight. Activities and progress are reported to the IQIC.	
Date: January 23, 2025	**Time**: 10:00 a.m.
Location: WebEx	**Facilitator**: Stephanie Wilson

PHC Invited Attendees:					
Alicia Kay	Wellness & Recovery Clin. Compl. Inspector II	Garnet Booth	Manager of PT Representatives	Mark Bontrager	Sr. Director of Behavioral Health
Angela Guevarra	Associate Director of CC	Janelle Bickert	Manager of Claims	Matt Ramsey	Behavioral Health Clinical Specialist
Becky Miller	Project Coordinator I	Jeff DeVido	Behavioral Health Clinical Director	Mohamed Jalloh	Director of Health Equity
Carina Monroy	Program Coordinator II	Joanie Williams	Manager of UM	Nicole Escobar	Sr. Manager of Behavioral Health
Cindy Wilson	Program Coordinator II	Kara Kusalich	Program Coordinator II	Shawn Porter	Wellness & Recovery Clin. Compl. Inspector I
Dell Coats	Director of Internal Audit	Katherine Barresi	Acting Chief Executive Officer	Stephanie Wilson	Program Manager II
Diana Rose	Sr. Transportation Services Analyst	Kathryn Power	Regional Director	Tim Sharp	Regional Director
Doreen Crume	Associate Director of CC	Latrice Innes	Manager of Grievance & Appeals Compliance	Vicky Klakken	Regional Director

County Invited Attendees:					
Deanna Bay	Humboldt	Jill Ales	Mendocino	Rose Bullock	Siskiyou
Emi Botzler-Rogers	Humboldt	Kimberly Button	Mendocino	Sarah Collard	Siskiyou
Kaleigh Emry	Humboldt	Navin Bhandari	Mendocino	Toby Reusze	Siskiyou
Michelle Thomas	Humboldt	Dolores Navarro-Turner	Modoc	Emery Cowan	Solano
Nancy Starck	Humboldt	Stacy Sphar	Modoc	Rob George	Solano
Barbara Longo	Lassen	Bailey Cogger	Shasta	Ruth Leonard	Solano
Tiffany Armstrong	Lassen	Rachel Ibarra	Shasta		
Jenine Miller	Mendocino	Joanna Chorpening	Shasta		

Topic	Notes
1) Welcome and Introductions *Time: 5 Minutes* *Lead: Stephanie Wilson*	

2) Review & approve minutes from November 7, 2024 *Time: 5 Minutes* *Lead: Stephanie Wilson*	
3) BH Director Update a. BHT – Modernization of the Mental Health Services Act i. County Report *Time: 10 Minutes* *Speaker: Mark Bontrager* **4) Wellness and Recovery Program Updates, Enhancements and Highlights** a. HSAG/PIPs b. 274 CG c. NACT d. Training Opportunities e. DMC-ODS Annual Compliance Training f. Safeway Long-Acting Injections g. Traditional Healers and Natural Helpers *Time: 20 Minutes* *Speaker: Nicole Escobar & Stephanie Wilson*	
5) Monitoring and Oversight a. Grievances & Appeals i. FY 24-24 2nd Quarter Report *Time: 5 Minutes* *Speaker: Latrice Innes*	
6) Monitoring and Oversight a. New Providers for Quarter – No New Providers b. Credentialed Network Providers c. Provider Compliance Summary i. Open Admissions CalOMS Reporting ii. Provider CAP Compliance – No CAPS iii. DATAR Reporting *Time: 10 Minutes* *Speaker: Stephanie Wilson*	
7) Monitoring and Oversight a. Utilization Management i. TARs and TAR Denials ii. Member Utilization by level and county iii. Timely Access iv. Transitions of Care *Time: 10 Minutes* *Speaker: Stephanie Wilson*	
8) Monitoring and Oversight a. Claims Processing i. Timeliness of Claims Processing for Quarter ii. Denial Rates iii. DHCS Short Doyle Acceptance Rate iv. Cost Reporting	

Time: 5 Minutes *Speaker: Stephanie Wilson*	
9) Monitoring and Oversight a. Quality Improvement Program Activities *i.* W&R Provider Site Reviews *ii. Time: 5 Minutes* *Speaker: Shawn or Jackie*	
10) Monitoring and Oversight a. Member Services i. Beneficiary Access Line/Call Center Statistics ii. CalOMS Data iii. Member Correspondence *Time: 10 Minutes* *Speaker: Nicole Escobar*	
11) Monitoring and Oversight a. **Compliance** i. BHINs & Policy Updates ii. BHIN 24-045 DMC-ODS ASAM Assessment Tools iii. BHIN 25-01 Update for Collecting and Reporting CalOMS Discharge *Time: 5 Minutes* *Speaker: Stephanie Wilson*	
11) Walk on Items *Speaker: Stephanie Wilson*	
12) Wrap up and Closing *Speaker: Stephanie Wilson*	

Program Updates

SUIQI 1/23/2025

HSAG/PIPs

Non-clinical PIP: Peer Support Specialists

- Requirement: Increase the percentage of members who receive at least one Peer Support Service.
  - Current baseline: 0
- Proposed Aim: Increase the number of members who receive at least one peer support specialist encounter by 5% from baseline throughout the Regional Model.
  - Aim projection: 275-300

HSAG/PIPs

Clinical PIP: FUA

- Requirement: Follow-Up After Emergency Department Visit for Substance Use (FUA)
  - Current baseline: 30.6%
  - Denominator: 12204
  - Numerator: 3740
- Proposed Aim: Increase the number of members who engage in a follow-up appointment after an emergency department encounter by 2.5% from baseline.
  - Aim projection: approx. 310

Network adequacy

274 – provider directory

- Quality review: The indicator provided in our 274 file was flagged by DHCS for ADA accommodations. We have since resolved and resubmitted the file on 1/22/2025.
- Modality changes in 274: DHCS has requested Plans separately report on outpatient and IOP services. PHC is working through the changes to the report and will update in the February file.

NACT

- DHCS is requesting to measure access by county versus regionally. We will continue to report as updates come through.

New services

Long Acting Injectables

- Partnering with Safeway/ Albertsons to offer Sublocade and Brixadi to Medi-Cal beneficiaries
- Medication administration will be provided as a medical benefit
- Prescribing requirements remain, however Safeway will provide follow-up and engagement for the member to ensure medication compliance

Traditional Healers and Natural Helpers

- Draft rates have been provided by DHCS
- Expecting New Life and UIHS to provide services
- Services will be paid by DHCS through the tribal payment arrangement

Training opportunities

Medi-Cal Peer Support Specialist certification – exclusive to counties

CAADPE - The ASAM Criteria 4th Edition: Implications for California's Substance Use Treatment Provider Agencies with Dr. Brian Hurley: https://caadpe.org/spark-t/

DMC-ODS Annual Compliance Training

- PHC will provide a slide deck and recorded training within 2 weeks of the release of the annual compliance BHIN
- Programs will have 30 days to complete the training, provide an employee roster and attestation of completion by all staff listed within the roster

IHS Traditional Healers & Natural Helpers

DHCS has released the draft BHIN for Traditional Healers and Natural Helpers as well as draft rates. Only IHS providers are eligible to provide the services, and currently 2 providers are contracted within the Regional Model.

Implementation strategy: PHC's tribal liaison will be including an overview of the benefit during IHS provider joint-ops sessions. Rates will not be discussed with providers until they are finalized by DHCS. As with other tribal services, claims will be processed outside of the PUPM.

Provider Descriptions:

Traditional Healer

A Traditional Healer is a person with knowledge, skills and practices based on the theories, beliefs, and experiences which are accepted by that Indian community as handed down through the generations and which can be established through the collective knowledge of the elders of that Indian community.

Natural Healer:

A Natural Helper is a health advisor contracted or employed by the IHCP who seeks to deliver health, recovery, and social supports in the context of Tribal cultures. A Natural Helper could be a spiritual leader, elected official, paraprofessional or other individual who is a trusted member of a Native American Tribe, Nation, Band or Rancheria.

Appeal and Grievance Data
FY 24/25 Quarter 2

October 1, 2024 to December 31, 2024

Reports and evidence of submission were emailed to each county on 1/10/25.

Four grievances and zero appeals were reported for the region.

Two grievances were resolved within the quarter and met the DHCS-regulated timeframe of 30 calendar days. The other two grievances are still pending resolution.

One (1) case was regarding Interpersonal Relationships. The member alleged discrimination based on disability at Archway Recovery Services in October 2024. The member had trouble using the stairs. They received different answers from different staff when they asked to use the elevator. The case was reviewed by different departments, including the Population Health Department for discrimination concerns and a Medical Director for potential quality issues. After investigation, it was found that the member was able to use the elevator after contacting their case manager. Discrimination was deemed unlikely.

Continued Trend:
Most of the cases this quarter were related to Interpersonal Relationship issues.

PARTNERSHIP HEALTHPLAN PROGRAM SUMMARY – Fiscal Year 2024/2025

Open Admissions

Open Admissions in CalOMS data is monitored to ensure that CalOMS data is kept up to date. Open admissions should have either an annual update at 12 months or a discharge. Admissions not updated/discharged for longer than 14 months are considered out of compliance. A point in time Open Admissions Report is pulled prior to the 20th of each month from DHCS data and shared with providers. The table below shows overall count of records appearing in each Open Admissions Report pulled during the fiscal year.

The table shows the count of open admissions, the number of those admissions that were over 14 months, and the percent of those open admissions that were in compliance at the time of reporting. Those months with less than 95% of records in compliance are highlighted in red. The chart gives a picture view of the same data.

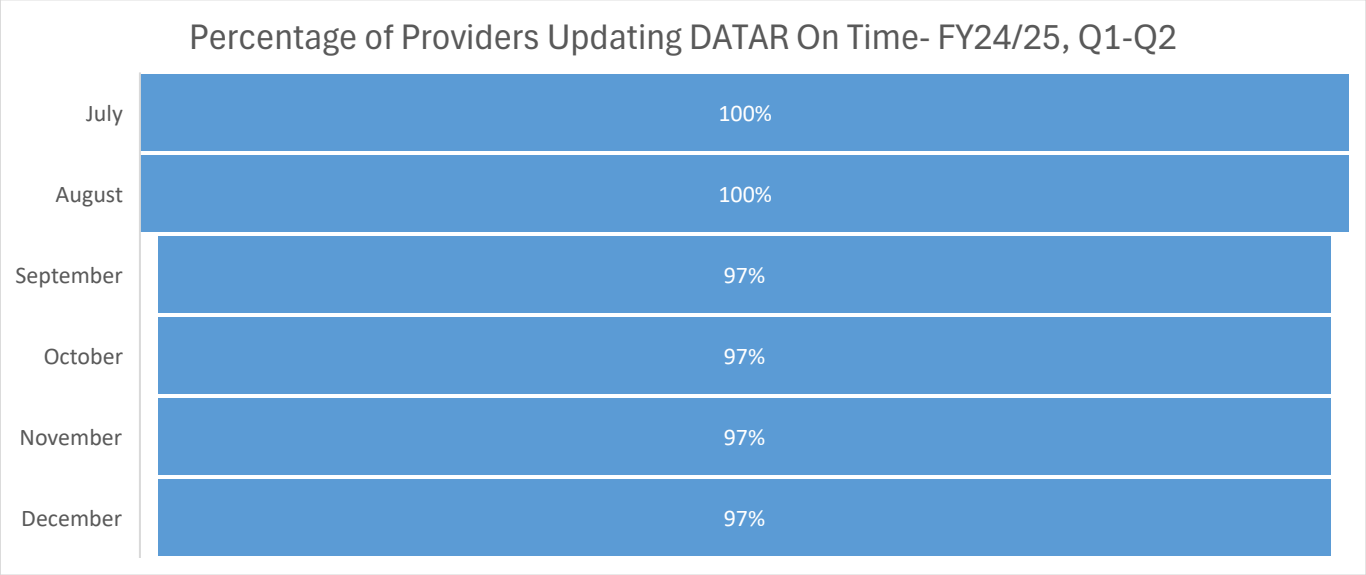
DHCS has removed PHC's access to BHIS. Stephanie Wilson has been working with each county to address, please ensure documents and BHIS task is completed so DHCS can restore access.

CAPS: Working with MedMark/ Baymark on a CAP that will address all out of compliance issues.

DATAR

DATAR is a State run site to monitor treatment capacity of addiction treatment facilities in California. PHC works with providers, counties, and the State to ensure all providers have access and training to use the site. The chart below shows the percent of providers who have updated their information on time each month. Reporting has now stabilized as all providers have gained access to the site.

Chart 2 - The chart shows the fluctuation of providers updating the website on time, by the 10th of the month.

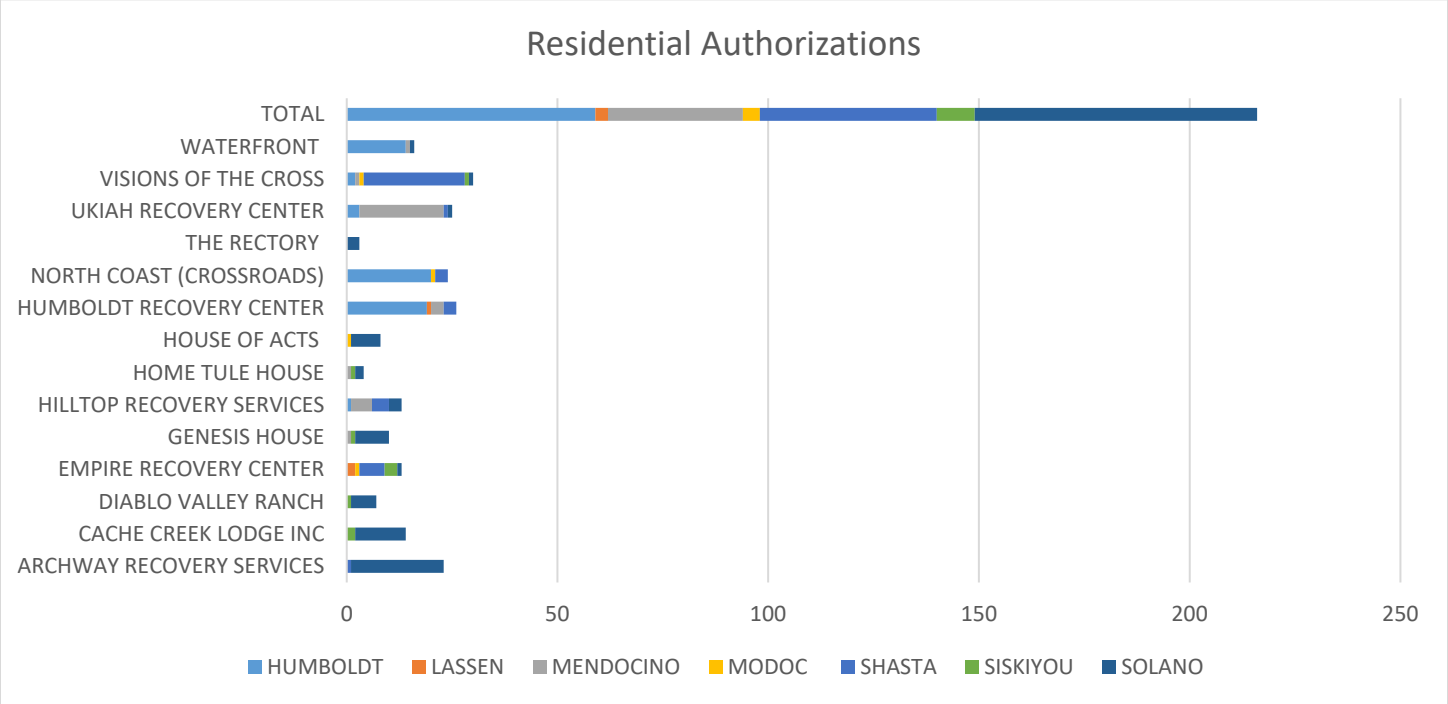


Partnership has developed a communication process to assist providers with timely update of DATAR system. Partnership has modified the deliverable date to the 5th of the month, with the intent of allowing time to work with the provider before they fall out of compliance.

CAP(s) Issued: Medmark Vallejo was the only provider out of compliance during the reporting period. Addressed in larger compliance discussion.

Residential Authorizations – Q2 FY24/25

Key Notes:
Denied authorizations: 0
Average turnaround time: 7.8 days
Average length of stay: 43
Driver for longer length of stay continues to be co-occurring mental health conditions.



	HUMBOLDT	LASSEN	MENDOCINO	MODOC	SHASTA	SISKIYOU	SOLANO
ARCHWAY RECOVERY SERVICES					1		22
CACHE CREEK LODGE INC						2	12
DIABLO VALLEY RANCH						1	6
EMPIRE RECOVERY CENTER		2		1	6	3	1
GENESIS HOUSE			1			1	8
HILLTOP RECOVERY SERVICES	1		5		4		3
HOME TULE HOUSE			1			1	2
HOUSE OF ACTS				1			7
HUMBOLDT RECOVERY CENTER	19	1	3		3		
NORTH COAST (CROSSROADS)	20			1	3		
THE RECTORY							3
UKIAH RECOVERY CENTER	3		20		1		1
VISIONS OF THE CROSS	2		1	1	24	1	1
WATERFRONT	14		1				1
TOTAL	59	3	32	4	42	9	67

Wellness and Recovery Service Type

This dashboard tracks Members and Visits related to Wellness and Recovery program across the participating counties (more details in Info icon). This view displays data from paid claims by Service Type and Member County using W&R billing codes valid **after** July 2023. Note: NPT/OTP means Narcotic Treatment Program / Opioid Treatment Program.

Data Refresh Schedule: Monthly on 5th and 20th
Last Refreshed: **1/5/2025 11:26:49 PM**
Prepared by Tiphanie Salehi (tsalehi@partnershiphp.org)

5,354
Total participating Members

482,011
Total Visits

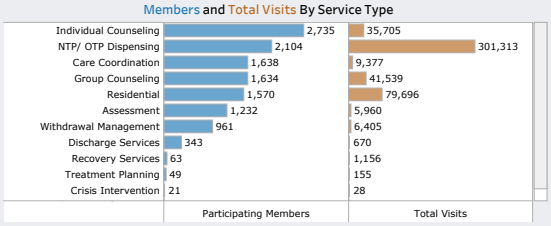
Service Date
1/1/2024 to 1/1/2025 and Null values

Mbr County
Multiple values

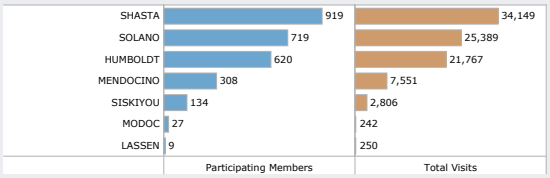
Serv Prov Full Name
All

Service Type
All

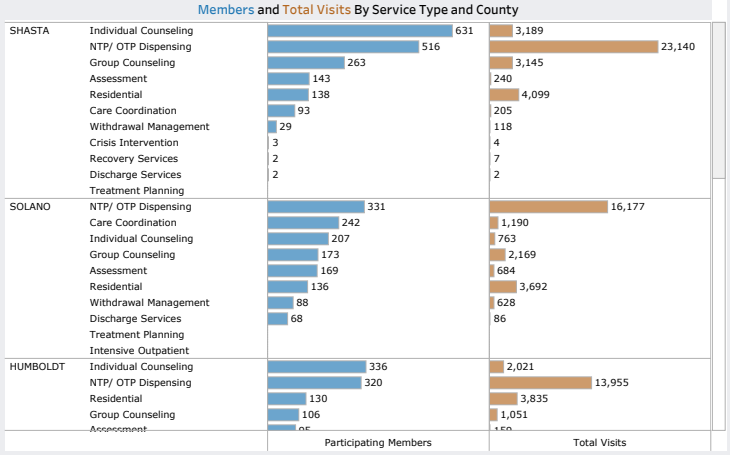
Members and Total Visits By Service Type



Members and Total Visits By County



Members and Total Visits By Service Type and County



Timely Access of Substance Use Disorder Treatment

The dashboard shows metrics on how timely substance use disorder (SUD) treatment is received after Level of Care (LOC) Screenings by Beacon and participating Providers. Urgent Episodes have a U9 or UA modifier code. Non-Urgent Episodes are other not Urgent SUD episodes. Regulations are Met if days from screening to treatment is within 3 days for Urgent Episodes and 10 days for Non-Urgent Episodes. View the information (i) icon for more details.

Health Analytics

Last Updated 12/16/2024 11:01:11 PM
Data Refreshed Monthly
Episodes up to 12/6/2024
Screenings up to 9/30/2024
Prepared by Jen Kung

# SUD Treatment Episodes	Episodes that Met Regulations	Walk-In Episodes
5,573	5,189 (93% of Episodes)	3,933 (71% of Episodes)

Service Date
1/1/2024 to 1/1/2025 and Null values

Provider
All

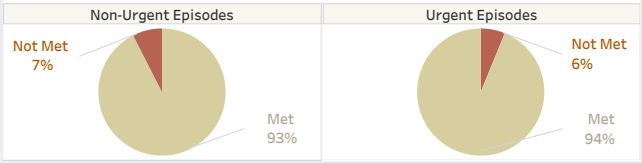
Member County
All

Is Walk-In Episode
- [x] No
- [x] Yes

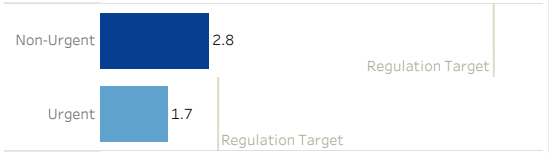
Is Pending Episode
- [x] No
- [ ] Yes

Level of Care
- [x] Non-Urgent
- [x] Urgent

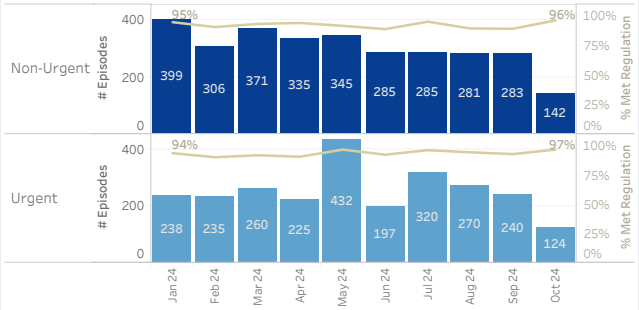
Share of Episodes that Met Regulation by Level of Care



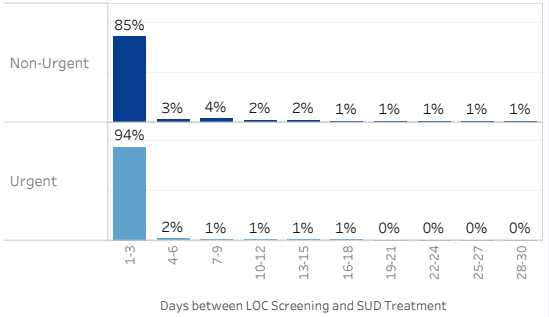
Average Number of Days from LOC Screening to SUD Treatment



Episode Volume and Percent that Met Regulation Criteria by Month



Distribution of Days between LOC Screening and SUD Treatment



Transitions of Care

This dashboard summarizes the number of days between each level of care for Wellness and Recovery Members over time, by county and service provider (counted after the occurance of the transition). Be cautious when interpreting aggregate transition days of counties and providers with low number of members which are highlighted in yellow.

Health Analytics

Service Date from **7/1/2020** to **12/30/2024**
Refreshed on **1/5/2025 11:00:39 PM** Next Refresh on **02/5/2025**
Contact: Shivani Sivasankar (ssivasankar@partenrshiphp.org)

By Transition Type?
- ○ Yes
- ◉ No

Transition Days Measure
- ◉ Average
- ○ Median

Members without transition
4,042

Members with transition
2,191

Step Down	Step Up	No Change
1,809	1,114	436

Average Transition Days
1.89

Step Down	Step Up	No Change
2.27	7.08	0.97

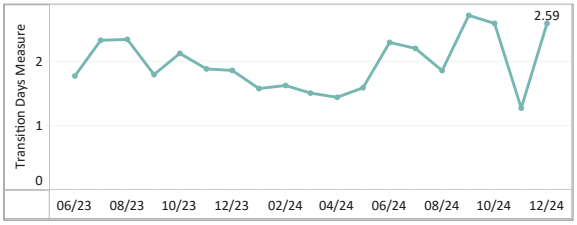
Service date
6/6/2023 to 1/1/2025 and Null values

Transition days > 90 days
No

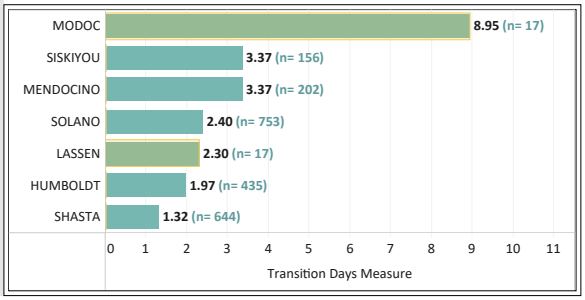
Transition Type
Multiple values

Povider Name
All

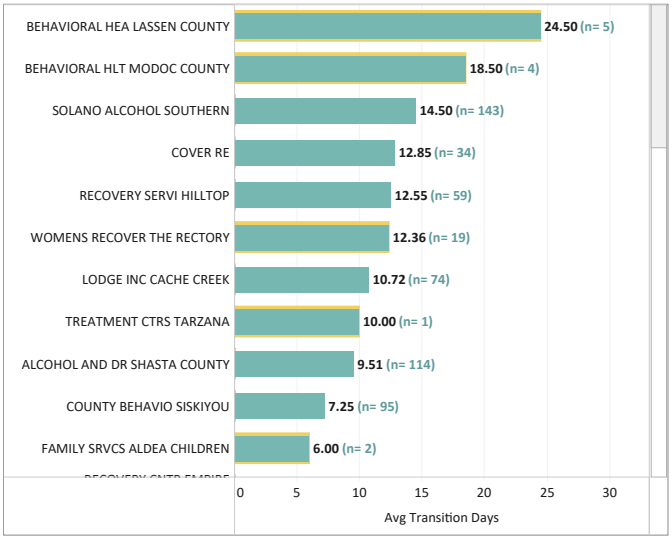
Average Days of Transition over Time



Average Days of Transition by County



Average Days of Transition by Service Provider



Short Doyle Claims

- Modoc County: Short Doyle denials indicate taxonomy used in county claims is not aligned with outpatient services. Researching the issue further.
- Shasta County: NPPES taxonomy issue with VOTC. Working with provider to resolve.
- Siskiyou County: Short-Doyle denied this service because the NPI of the rendering provider is inactive in NPPES. Researching the issue further.

		Jul '24	Aug '24	Sep '24	Oct '24	Nov '24
12	Humboldt	99.59%	99.44%	99.54%	97.45%	95.71%
18	Lassen	98.43%	100.00%	91.45%	100.00%	100.00%
23	Mendocino			81.37%	100.00%	
25	Modoc	79.66%		70.83%	89.13%	54.17%
45	Shasta	97.23%	97.10%	96.56%	96.66%	76.40%
47	Siskiyou	86.38%	100.00%	83.77%	97.16%	20.45%
48	Solano		82.48%	93.56%	88.81%	

Beneficiary Access Line

As in previous years, referrals decreased through November and December, likely a result of the holiday season. This resulted in 20% decrease in call volume into the beneficiary access line in Q2.

	# of inbound calls
July	339
August	330
September	303
October	314
November	238
December	217

Quarter	Call Type	# of Inbound Calls	# of Abandoned Calls	% of Abandoned Calls	Delay to Answer Time	% Answered Within 30 Seconds
FY 24/25-Q1	SUD	962	8	1.56%	32 seconds	83.56%
FY 24/25-Q2	SUD	769	4	0.52%	3 seconds	98.05%

In Q1 of FY 24/25 40% of screenings resulted in providers being unresponsive (not answering the phone). While we recognize this remains an issue, the number of screenings resulting in poor provider outcomes improved this quarter.

Referral Outcome	# of referrals	% of referrals
Already linked to provider	2	2%
Appointment scheduled	32	33%
Call dropped	7	7%
Emergency department referral	4	4%
County walk in	1	1%
Waitlist	12	12%
Member refused linkage	14	14%
Providers unresponsive	26	27%
Total	98	

DATE: January 10, 2025

Behavioral Health Information Notice No: 25-001
Supersedes ADP Bulletins: 10-08 and 11-10

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies California
Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: Update to Protocols for Collecting and Reporting Discharge Data in California Outcomes Measurement System Treatment (CalOMS Tx)

PURPOSE: To notify counties and network providers of updated business rules and guidelines for collecting and reporting data for discharging Substance Use Disorder (SUD) treatment clients.

REFERENCE: CalOMS Tx Data Collection Guide, Code of Federal Regulations chapter 45 section 96.136(d)(6), Welfare and Institutions Code 14184.102 Subdivision d; Behavioral Health Information Notice (BHIN) 23-068; California Code of Regulations, Title 22, § 51341.1(h)(6)

BACKGROUND:
Counties and direct providers are required to collect SUD treatment outcomes data and submit this information electronically to the Department of Health Care Services (DHCS) via CalOMS Tx. It is critical that counties and treatment providers collect accurate and complete client outcome data at discharge so client outcomes can be measured and reported to public funding agencies to demonstrate the benefits and efficacy of treatment services. Data must be collected on all individuals served, by all SUD providers that receive funding from DHCS, regardless of the source of funds used for the service provided.

This BHIN updates protocols and definitions for discharging clients for the following standard discharge values:

- Completed Treatment Plan & Goals – Referred/Standard (status 1)
- Completed Treatment Plan & Goals – Not Referred/Standard (status 2)
- Left Before Completion with Satisfactory Progress – Referred/Standard (status 3)

In addition, DHCS is updating the timeframe when an administrative discharge can occur for non-residential outpatient programs. These updates to discharge protocols align with current trends in SUD treatment, improve the collection of Treatment Episode Data Sets[1], and are in line with the American Society of Addiction Medicine (ASAM) 4th Edition, Dimension 6[2] for person centered considerations.

This BHIN does not update existing treatment planning[3] or discharge planning[4] protocols.

POLICY:
For a complete list of discharge protocols, including the updates described in this BHIN, authorized users can refer to the CalOMS Tx Data Collection Guide "Section 8 – Discharge Data Collection" by logging in to the Behavioral Health Information Systems.

Updates to Protocols for Discharging Clients:
Discharge protocols have been updated to include the following language:

"When a discharge interview is scheduled, but the client experiences a life circumstance that prevents them from completing the discharge interview and/or last treatment service, SUD treatment providers may complete the standard discharge questions when all of the following conditions are met:

- *The client made satisfactory progress in their treatment service;*
- *discharge planning has commenced;*
- *the client left the program due to a life circumstance and notified the program; and*
- *the treatment program has sufficient client file documentation needed to accurately complete the discharge questions without guessing the responses.*

Treatment providers will use their understanding of the client's life circumstance and make client-centered decisions to determine when a standard discharge without a face-

[1] Treatment Episode Data Set (samhsa.gov)
[2] About the ASAM Criteria
[3] BHIN 23-068
[4] California Code of Regulations, Title 22, § 51341.1(h)(6)

to-face or telehealth[5] *discharge interview is appropriate. Examples of life circumstances include, but are not limited to relocation, family illness/emergency, or securing employment. Programs do not need to obtain DHCS approval of a client's life circumstance to proceed with a standard discharge. It is the responsibility of the treatment programs to maintain sufficient client file documentation, including the method used to obtain the responses to the standard discharge questions.*

Efforts to conduct the interview and an explanation of the client's absence from the discharge interview and/or the final treatment service must be documented in the client's file. Programs should never guess client responses when completing discharge questions."

Updates to Standard Discharge Status 1, 2 and 3 Definitions:

To reflect the updated discharge protocol outlined above, discharge status definitions have been revised as follows:

- **Standard Discharge status 1, 2, and 3** definitions have been updated to allow for a standard discharge when the client "*has made satisfactory progress in treatment, discharge planning has commenced ,but experiences a life circumstance that prevents them from completing the discharge interview and/or last treatment service and notifies the program; and the treatment program has the information and client file documentation necessary to accurately complete the discharge questions without having to guess the responses.*"[6]

Program Participants Administratively Discharged by Modality:
The time frame for administratively discharging clients in **non-residential outpatient treatment programs** when the client has not had at least one face-to-face or telehealth visit with a treatment counselor has been updated from "30 consecutive days" to " no sooner than *30 but no later than 60 consecutive days*. *Treatment programs will use their knowledge of the client, program capacity, and other clinical, treatment, or financial factors to determine when the non-residential outpatient client is discharged for lack of participation*."

REQUIREMENTS:
Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) programs shall implement the guidance in this BHIN no later than 90 calendar days from

[5] The term "telehealth" is used to describe both synchronous audio-only (telephone) and synchronous video interactions.
[6] CalOMS Tx Data Collection Guide, Section 8.4

the date of publication. Implementation shall include but is not limited to updating policies and procedures as well as supporting materials for DMC and DMC-ODS providers needed to ensure compliance. Additionally, Medi-Cal behavioral health delivery systems shall communicate these updates to their staff, subcontractors if applicable, and network providers that provide or administer DMC and DMC-ODS services, and ensure the appropriate staff, subcontractors, and network providers are trained on requirements set forth in this BHIN.

Please contact DATAR-CalOMSProgramSupport@dhcs.ca.gov for questions.

Sincerely,

Original signed by

Marlies Perez, Chief
Community Services Division

Attachment A – CalOMS Tx Data Collection Guide Section 8 Discharge Data Collection Excerpt

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: December 23, 2024

Behavioral Health Information Notice No: 24-045

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) American Society of Addiction Medicine (ASAM) Assessment Tools

PURPOSE: To postpone implementation of specified DMC and DMC-ODS Assessment requirements included in BHIN 23-068.

REFERENCE: Welfare & Institutions Code (W&I), § 14184.402, subd. (h)(3)

BACKGROUND:
As part of the California Advancing and Innovating Medi-Cal initiative, the Department of Health Care Services (DHCS) released BHIN 23-068, which updated documentation requirements for Specialty Mental Health, DMC, and DMC-ODS delivery systems.[1] BHIN 23-068 requires providers to use an ASAM Criteria assessment for DMC and DMC-ODS members. BHIN 23-068 further requires DMC and DMC-ODS providers to begin using either the free ASAM Criteria® Assessment Interview Guide or ASAM CONTINUUM software, or a validated tool subsequently approved by DHCS and added to the list of approved DMC and DMC-ODS ASAM assessment tools, effective January 1, 2025.

[1] W&I § 14184.402(a), (e), and (i)

Both the ASAM Criteria® Assessment Interview Guide and ASAM CONTINUUM software were created utilizing the ASAM Criteria 3rd Edition. After the release of BHIN 23-068, ASAM published an updated volume of their criteria, ASAM Criteria 4th Edition.

Currently, the ASAM Criteria® Assessment Interview Guide and ASAM CONTINUUM software are being updated to reflect the ASAM Criteria 4th Edition.

In order to reduce administrative burden on DMC counties and DMC-ODS plans and allow sufficient time for implementation of new assessment tools based on ASAM's 4th Edition criteria, DHCS is superseding, in part, the DMC and DMC-ODS ASAM Criteria assessment policy provided at (a)(3)(v) on page 5 within BHIN 23-068.

POLICY:
Applicability
The policy outlined in this BHIN applies to DMC counties, DMC-ODS plans, and providers of DMC and DMC-ODS services.

Overarching Policy
DMC and DMC-ODS Assessments
This BHIN postpones the requirement for DMC counties, DMC-ODS plans, and providers to implement the free ASAM Criteria® Assessment Interview Guide or ASAM CONTINUUM software (or a validated tool subsequently approved by DHCS and added to the list of approved DMC and DMC-ODS ASAM assessment tools) effective January 1, 2025.

DMC counties, DMC-ODS plans, and providers may continue to utilize ASAM assessment tools that are currently in use, including but not limited to the free ASAM Criteria® Assessment Interview Guide or ASAM CONTINUUM software, until forthcoming DHCS guidance is released and updated tools utilizing the ASAM Criteria 4th Edition are available and can be implemented statewide. An implementation date will be specified in future DHCS guidance.

All other policy and guidance provided in BHIN 23-068 remains in effect and unaffected by the policy and guidance in this BHIN. Questions regarding this BHIN may be directed to BHCalAIM@dhcs.ca.gov.

Sincerely,

Original signed by

Ivan Bhardwaj, Chief

Medi-Cal Behavioral Health Policy Division

Michele Wong, Chief
Behavioral Health Oversight & Monitoring Division

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4665 Business Center Drive
Fairfield, California 94534

MEETING Minutes

Meeting & Project Name: Quality Improvement & Health Equity Committee (QIHEC)

Date: 1/21/2025 **Time**: 7:30 a.m.- 9:30 a.m.

Facilitator: Mohamed Jalloh, HEO

Coordinator: Bethany Hannah

Meeting Locations:

- WebEx

Attendees:

Shannon Boyle, Monika Brunkal, Anna Campbell, Dawn Cook, Nicole Curreri, , Heather Esget, Ledra Guillory, Bethany Hannah, Mohamed Jalloh Amanda Kim, Vicky Klakken, Marshall Kubota, Yolanda Latham, Sue Lee, Stan Leung, Robert Moore, ,Lilian Morino, Rachel Newman, Hannah O'Leary, Katheryn Power, Sue Quichocho, Manleen Randhawa, Denise Rivera, Dorian Roberts, Leila Romero, Delorian Ruffin, Anthony Sacket, Rebecca Stark, Wendy Starr, Nancy Steffen, Amanda Smith, Christine Smith, Ben Spencer, Liat Vaisenberg, Vicquita Velazquez, Kory Watkins

Absent: Priscilla Ayala, Katherine Barresi, Robert Bides, Sonja Bjork, Mark Bontrager, Isaac Brown, Cathryn Couch, Wendi Davis, Noemi Doohan, Greg Allen Friedman, Shandi Fuller Margarita Garcia-Hernandez, Brigid Gast, Nisha Gupta, Tony Hightower, Latrice Innes, Mary Kerlin, Rachel Newman, Mark Netherda, Lynn Scuri, Tim Sharp, Stephen Stake, Amy Turnipseed, Edna Villasenor

4665 Business Center Drive
Fairfield, California 94534

External Advisory Members

Name	Affiliation	Org Type	1/21/25	3/18/25	5/20/25	7/15/25	9/16/25	11/18/25
Jason Cunningham, MD Chief Executive Officer	West County Health Centers	FQHC						
Eugene Durrah	Solano County	County						
Suzanne Edison-Ton, MD Chief Medical Officer	Communicare+ Ole	FQHC						
Hendry Ton, MD Associate Vice Chancellor	UC Davis	Health System						
Shandi Fuller, MD Maternal Child and Adolescent Health	Solano County	Public Health Department						
TBD	Providence	Health System	X					
Valerie Padilla Director of Quality and Patient Safety	Open Door Community Health	Health System						
Arlene Pena Senior Program of Quality Improvement	Aliados Health	Community Based Org	X					
Jeremy Plumb Systems Director, Quality Division	Northbay Medical Center	Hospital	X					
Lelia Romero Health Program Specialist - Health Equity	Lake County	Public Health Department						
Robin Schurig, MPH, CPH Executive Director	Health Alliance of Northern California	Community Based Org	X					
Candi Stockton, MD Health Officer of Humboldt County	Humboldt County	Public Health Department	X					
Tiffani Thomas	Solano County	Local	X					

4665 Business Center Drive
Fairfield, California 94534

Case Manager	Superior Court	Government						
Brandon Thornock	Shasta Community Health Center	Health System	X					
Denise Whitsett Quality Improvement Coordinator	Community Medical Centers	Health System	X					

***FQHC= Federally Qualified Health Center

*****Members who do not attend at least half of meetings will be considered for removal per vote of committee.

Agenda Topic	Notes	Action Item
Agenda Item 1 **Introductions**	A. Dr. Jalloh introduced Bethany Hannah as the new coordinator for the QIHEC meeting. He then conducted a roll call for external advisory members to mark their attendance. B. Quorum was met by having 9 members present.	
Agenda Item 2 **Renaming QIHEC**	A. Dr. Jalloh introduces two options for renaming QIHEC; Option 1: HEART (Health Equity Advisory Committee for Reform and Transformation) or Option 2 IDEA (Inclusion Diversity, Equity, and Access) or Option 3: No change.	1. No motion was made to change the name at this time.
Agenda Item 3 **CMO Partnership Health Plan Updates.** Speaker: Dr. Moore	A. Medicare Advantage product using the name Partnership Advantage. • The plan will be 8 counties: Dell North, Humbolt, Mendocino, Lake, Sonoma, Marin, Napa and Solano in the initial phase. • Low enrollment expected initially, somewhere between 3000 and 8000 members. • Scheduled to submit our bid in the next month or so to CMS. • Working on developing a network between these 8 counties. B. 10 counties have successfully transitioned to the whole child model. • There is a large amount of care management and care coordination is now the responsibility of our partnership team. C. Announced that they would be sanctioning several health plans across the state for below average quality performance in a series of metrics.	

Agenda Topic	Notes	Action Item
	• The methodology for this is problematic if a measure is sanctionable if it's below average, therefore more than half of all health plans are subject to these sanctions. • Over half of the sanctions for dental Fluoride measure are reliant upon data from DHS, we are lacking the data, as a result Partnership has appealed that sanction. D. A big issue for the Partnership is to undergo a couple of major system updates. • The first major system update is the claims processing system, which is scheduled for within the next 6 months (HRP). • The second major system update is a change to the utilization management care coordination population health care system (JIVA)	
Agenda Item 5 **Community Updates from ALIADOS and HANC.** Speaker: Arlene Pena	A. ALIADOS: Health Equity Dashboard • Arlene Pena shares that starting this year they are working on the development of a health equity dashboard as well as provide training to health centers on how to utilize the dashboards. • The dashboard is built into the population health management system, and they have started breast cancer screening and controlling high blood pressure. • Arlene stated that their next step is to build in some statistical analysis onto the dashboard. • Next steps are to develop cervical cancer screening and colorectal cancer screening and then roll out well child visits and immunizations next. She stated there is some grant funding to build in some geo mapping into the dashboard to look visually briefly at what regions have a lower rate of compliance for those measures. B. HANC: No Updates.	

Agenda Topic	Notes	Action Item
Agenda Item 6 **Meeting minutes** Speaker: Dr. Jalloh	A. Meeting minutes were distributed the morning of the QIHEC Meeting, therefore committee members were unable to review them. B. Dr. Jalloh called for a motion for approval, but no one had time to review, therefore they will be reviewed and approved at the next QIHEC meeting in March.	1. Review and approve Nov and January QIHEC Meeting minutes
Agenda Item 7 **Grand Analysis: Disparity Analysis (Language Stratification)** Speaker: Dr. Jalloh	A. This analysis was completed for data measurement year 2023. ○ This data included 14 counties; data may be changing this upcoming year when we are able to do the analysis based on the year 2024. ○ All studied linguistic groups (English Spanish, Russian, Tagalog) met minimum performance level (MPL) for prenatal and postnatal care. ○ Spanish, Russian, Tagalog groups did not meet minimum performance level for Controlling Blood Pressure but there waws no statistically significant difference when compared to English group. ○ The Tagalog group was the group that had numerically higher rates of poor hemoglobin control when compared to the English group. B. Vietnamese group had significantly lower rates of WCV when compared to English speaking community ○ Preliminary goal is to increase the well care visit rate of Vietnamese speaking population by 12% in SE region and to have all underperforming regions achieve 50th percentile (MPL) in 12 to 24 months. C. Observations of Language Disparities in Communities: ○ Jeremy Plumb (North Bay) shared that the Spanish-speaking population is facing significant disparities in diabetes management and Medicare. He emphasized the need for outreach and education as key interventions. ○ Dr. Jalloh asked if Partnership can support this community, and Jeremy confirmed that outreach and education would be critical. ○ Wendy Starr suggested exploring the Promotores Program (community health workers from within the Hispanic community) for outreach, especially with Spanish-speaking individuals. She shared her experience	

Agenda Topic	Notes	Action Item
	with the program in Humboldt and Del Norte counties, noting that it's informed and effective because it comes from within the community. D. Arlene Pena supported this, suggesting combining community health workers with mobile health units to reach vulnerable communities, especially in the current political climate. Language and Acculturation Considerations: ○ Dr. Moore raised concerns about ensuring cultural sensitivity when addressing language disparities. He noted that acculturation impacts outcomes differently—sometimes improving, sometimes worsening them. He cautioned against assuming language disparities are solely based on language, suggesting acculturation should be respected without interference. Dr. Jalloh agreed. E. Dr. Candy Stockton stressed the importance of considering the political climate when designing outreach efforts to avoid exposing vulnerable populations, particularly undocumented individuals, to risk D. Concerns About Outreach Events: ○ Dr. Candy Stockton warned that targeted outreach events for specific populations could inadvertently put participants at risk due to the political climate, potentially making them targets. ○ Dr. Kubota highlighted that language disparities often overlap with concerns related to fear among non-primary English speakers due to the political climate. He suggested that this issue should be treated separately, emphasizing that some Hispanic communities have a lower rate of grievances and appeals, which is problematic and hasn't changed over time. ○ Dr. Kubota also noted that the Partnership's member handbook is being revised and stressed the importance of ensuring it is accessible and understandable for non-English speakers, particularly regarding cultural and language nuances. F. Communication and Feedback:	

Agenda Topic	Notes	Action Item
	○ Dr. Jalloh emphasized the need to gather direct feedback from non-English-speaking members and to involve communities in the design of communication materials. He suggested hosting indirect focus groups for this purpose. ○ Denise Whitsett from TNT shared that they have recently started a patient advisory committee and are actively recruiting members from their community for input. They are committed to ensuring the community's voice is heard. ○ Arlene Pena mentioned that several health centers in the Aliados network have patient advisory councils and emphasized the importance of balancing engagement without tokenizing individuals. She also mentioned some community-based organization (CBO) projects that might offer opportunities for Partnership. ○ Dr. Candy Stockton shared an example of a translation issue she encountered when trying to translate documents into Moong for an older Moong-speaking family. She explained that the family was unable to read or write in Moong, highlighting the issue of non-written literacy in some non-English-speaking immigrant populations	
Agenda Item 8 **Health Equity Integration Policy** Speaker: Dr. Jalloh	A. A preliminary draft is being refined with internal staff over the next 6-9 months, aiming to guide health centers and systems in integrating health equity. ○ IHI Health Equity Organization Readiness Assessment and Diversity Assessment ▪ The tool encourages organizations to assess how well equipped they are for addressing health disparities. ○ Organizations should look to have staff, leadership, and governing bodies resemble the community they are serving. ○ REAL/SOGI Data Collection and Non-Stigmatizing Practices: ▪ Organizations should follow guidelines for collecting Race, Ethnicity, and Language (REAL) and Sexual Orientation and Gender Identity (SOGI) data in a sensitive, non-stigmatizing manner.	A. Further discussion on ensuring accessible communication materials and involving community members in feedback and design will be prioritized.

Agenda Topic	Notes	Action Item
	○ Medical Documentation, Clinical Score Tool, and Medical Device Update ▪ Organizations should evaluate clinical score tools to ensure they don't reinforce health disparities, with recommendations for alternative tools. ○ Arlene Pena proposed considering AI's impact on patient care.	
Agenda Item 9 **Disparity Discussions: Prenatal and Postpartum Care in AI/AN** Speaker: All	A. Partnership Goals: • The partnership's goal is to send DHCS an annual report outlining key efforts to address disparities. B. Categories of Activities to Address Disparities: Dr. Jalloh explained that these three categories will be the focus of a recurring cycle of discussions: Policy Changes, Key Activities, and Community Engagement. **Prenatal/Postpartum Disparities in AI/AN:** **A. Policy Discussion (PPC – PRE-Post AI/AN):** *Policies to be Evaluated with their corresponding IQI/QUAC dates:* • April 2025: MCP2026 Diabetes Prevention Program • June 2025: MPXG5008 Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing; MPXG5009 Lactation Clinical Practice Guidelines • August 2025: MCUG3118 Prenatal and Perinatal Care; MCUP3119 Sterilization Consent Protocol • September 2025: MCUP3050 Medication Abortion in First Trimester • November 2025: MCNP9006 Doula Service Benefit *A motion was made to approve the review and feedback process for these policies to address disparities.* 1st Motion: Denise Whitset 2nd Motion: Candy Stockton, MD	A. Share Updated Draft with interested QIHEC members and Partnership Staff Members B. Motion to approve the policies chosen to review and provide timely feedback to policies to help address corresponding disparities. 1st Motion: Denise Whitset 2nd Motion: Candy Stockton, MD • Motion from the committee to add pediatric guidelines to list of policies to review. 1st Motion to approve: Arlene Pena • 2nd Motion: Tifanni Thomas • Anna Cambell will send the details for the pediatric guidelines policy. Policy #: MCQG1015

Agenda Topic	Notes	Action Item
	F. All feedback is due by March. Addition of Pediatric Guidelines: - *A Motion to Add Pediatric Guidelines:* 1st Motion: Arlene Pena 2nd Motion: Tifanni Thomas	

Disparity Discussions: Well-Care Visits in Rural Community	**Well-Child Visit Disparities in Rural Community**
	QI/PHM Intervention Review:
	• Community Engagement: Amanda Smith shared that Partnership's Growing Together Program incentivizes well-child visits by offering gift cards to parents.
	  ○ Program Details: The program incentivizes parents to access care for their children or perinatal care. Gift cards are given when parents bring their child for well-child visits.
	  ○ No recommendations or motions were made	

Disparity Discussions: Controlling Blood Pressure in AA Community	Blood Pressure Control for Tribal and African American Communities: - Community Health Workers (CHWs): Partnership will explore integrating CHWs into community settings such as churches, barbershops, beauty salons, etc. A. IPP Grant: A grant was approved to pilot this initiative. B. Community Suggestions: • Churches, libraries, Parent Teacher Associations • Recreation centers • LGBTQ community centers, day labor centers	• The group will continue to work on integrating community health workers into various organizations throughout the year to improve health outcomes in targeted communities.

Agenda Topic	Notes	Action Item
Agenda Item 10 **Next Meeting** Speaker: Dr. Jalloh	Next Meeting: March 18th, 2025, 7:30 a.m. – 9:00 a.m.	

4665 Business Center Drive
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MEETING Minutes

Meeting & Project Name: Quality Improvement Health Equity Committee (QIHEC)

Date: November 19, 2024 **Time**: 7:30 AM – 9:00 AM

Facilitator: Mohamed Jalloh, Pharm.D., Health Equity Officer (HEO)

Coordinator: Vicquita Velazquez

Meeting Locations:

- WebEx

Internal Attendees:

Leigha Andrews; Priscila Ayala; Mark Bontrager; Isaac Brown; Monika Brunkal, RPh; Anna Campbell; Shahrukh Chishty; Dawn R. Cook; Nicole Curreri; Greg Allen Friedman; Latrice Innes; Brandy Isola; Amanda Kim; Vicki Klakken; Marshall Kubota, MD; Yolanda Latham; Sue Lee; John Lemoine; Lilian Merino; Robert Moore, MD; Mark Netherda, MD; Rachel Newman, RN; Hannah O'Leary; Sue Quichocho; Manleen Randhawa; Kimberly Robertello; Dorian Roberts; DeLorean Ruffin, DrPH; Amanda Smith; Christine Smith; Rebecca Stark; Nancy Steffen; Kory Watkins

External Attendees:

Suzanne Edison-Ton, MD; Eva Julian; Valerie Padilla; Arlene Pena; Leila Romero; Candy Stockton, MD; Denise Whitsett; Jeremy Plumb; Tiffany Thomas EdD, Hendry Ton, MD; Lisa Wada

Absent:

Katherine Barresi, RN, BSN, PHN; Robert Bides, RN; Sonja Bjork; Mark Bontrager; Shannon Boyle, RN; Cathryn Couch; Jason Cunningham; Jeffrey DeVido, MD; Nicole Escobar; Heather Esget, RN; Margarita Garcia-Hernandez, Ph.D.; Nisha Gupta; Mary Kerlin; Jaymee James; Tony Hightower; Eva Julian; Kermit Jones, MD; Rachel Joseph; Matthew Konar; Stan Leung, Pharm.D; Liat Vaisenberg; Eugene Durrah; Rocio Rodriguez; Saveena Sandhu; Lisa Wada; Harold Wallace; Amy Turnipseed; Edna Villasenor

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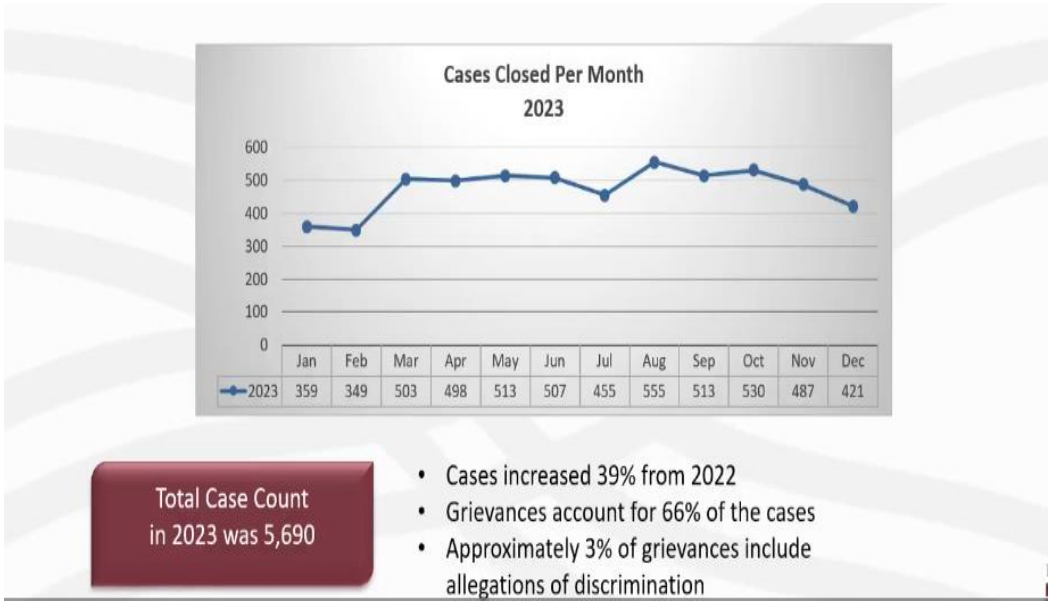
Agenda Topic	Notes	Action Item
1. Welcome/ Introductions/ Roll Call *Time: 5 minutes* *Speaker: Mohamed Jalloh, Pharm.D*	• Introduction of the committee members. • The quorum was met by having 10 members present.	
	Dr. Jalloh welcomed the committee members and said that the Health Equity team will hire a new person to take over Vicquita's duties as lead of this meeting. Thank you, Vicquita, for all your good work. The new person will engage with the committee members and hopes to meet with you all in person over the next year.	
2. Tribal Health Liaison Introduction *Time: 15 minutes* *Speaker: Yolanda Latham, MBA*	Yolanda Latham gave us her background, including her joining the Health Equity team and her tribal background as an enrolled member of the Hoopa Valley tribe. Her role in health equity is to integrate tribal health perspectives in the work we do for all communities, collaborate on ensuring health initiatives are relevant to tribal communities, and address any unique challenges faced by tribal communities. We have 21 tribal health programs and 50 physical sites, and the California tribes that we serve are 51 federally recognized tribes in eight non-federally recognized tribes. We have a large rural geographic region. To the top right of California, we have Modoc County, to the top left Del Norte County, to the southwest area down by Marin, and to the east near Placer. Our tribal communities are in areas with snow, road issues, and other things. And this is where our transportation must pick up our members to take them to their appointments.	

Agenda Topic	Notes	Action Item
	Some of her responsibilities and functions as a tribal liaison include reducing tribal community fatigue by aligning with similar initiatives. For instance, if the county or state is working on something, how are we aligning with the tribes and their programs? Also, to deepen the relationship between PHC, tribal public health, and other partners, many tribes have tribal public health authority, but we don't talk about it that often. Those are some things that we should be talking about. It promotes a deeper understanding of tribal needs and Indigenous social determinants of health. And, to support tribal health's response to emerging trends, the example she gives is that we have the times of the year in which we go out and talk about breast cancer screening and mammography, but if there's an emerging trend in a tribal community, are we talking about it? How do we make it relevant? She asked, regarding quality improvement in the health equity committee, how you can help me do my work or help our team. She is looking for feedback and collaboration. Data analysis, analysis, recommendations, and training and education recommendations matter. Your voices matter. Over the past year, she has helped people navigate benefits because they are unfamiliar with them. She also helped develop relationships with other organizations by bringing them together. She plans to do some workshops in the future and then host listening sessions. We ask questions and interact in ways that listen and consider their needs and the services they request.	

Agenda Topic	Notes	Action Item
	Question from Dr. Stockton: I know at PHC that you're able to give us in public health certain specific data for our county, statistical data, and diagnostic data for patients who reside within our county. Are you able to do the same thing for tribal public health departments? I'm asking because I've been working on a request from the Yurok tribe, and I only have partial data. Specifically, they've asked us for information about when an individual who's a tribal member dies from an overdose so that they can do outreach and prevention. Do you have information on when they are treated for an overdose and survive, and do you have tribal enrollment data? *Response from Dr. Moore:* California collects data on race, Hispanic ethnicity, present or absent, and tribal enrollment at the time of Medi-Cal enrollment. They do not pass any of that on to us. They have an algorithm where they process it and give us a single race category and which systematically undercounts the American Indian population by somewhere between, you know, sixfold and twelvefold. They don't give us tribal enrollment data. We have asked them to start providing that, and they seem inclined to begin in 2025 to include it with this new population health management product called Medi-Cal Connect. *Comment from Dr. Stockton:* If anybody's interested, we've elected to hand-comb our desk certificates every month and provide the names and dates of birth for all individuals who work corner referral cases, which reduces our list to about 30. *Comment from Dr. Kubota:* We do not get much information when a member dies.	

Agenda Topic	Notes	Action Item
	Comment from Yolanda Latham: Dr. Stockton, it would be good to meet again to discuss data and data sovereignty. It is usually led by tribes that want data, but that does not mean you can't reach a method of understanding to get the necessary information. It's a matter of navigating what that looks like, the laws around it, and whether the tribe is willing to work with you.	
2. Meeting Minutes *Time: 5 minutes* *Speaker: Mohamed Jalloh, Pharm.D*	Dr. Jalloh brought the committee's attention to last month's meeting minutes and asked if anyone in attendance had any questions. There were no questions, and a motion was made to approve the minutes. • **First motion:** Dr. Stockton • **Second motion:** Denise Whitsett There were no opposed motions.	
3. ALIADOS/HANC Community Update *Time: 10 minutes*	Arlene Pena from Aliados mentioned that some health centers in their network are experiencing limited capacity to expand social determinants of health (SDOH) screenings to all adult populations. Many of their health centers focus on a limited population to screen for SDOH; they have been doing this to support their health centers by developing a health equity dashboard. We have two dashboards, one for blood pressure and the other for breast cancer screenings. They track the demographic data of patient populations for trends related to blood pressure control and breast cancer screening compliance based on the definitions of quality improvement plans. A disparity index graph shows potential disparities among the patient populations. Therefore, we are currently working to train our health centers to roll them out. They plan to launch a regional collaborative in 2025 to use mobile health to address breast and cervical cancer disparities.	

Agenda Topic	Notes	Action Item
	Another highlight is that they launched the Behavioral Health Leads peer group in October, which will meet quarterly. The group will offer a space to share challenges, successes, and best practices for providing BH at community help centers and developing areas for regional collaboration. Guest speakers will be invited to share relevant topics and training. Carla Denner leads the group.	
4. Disparity Data Update: Grievance and Appeals Grand Analysis *Time: 20 minutes* *Speaker: Kory Watkins*	 Kory is the director of Grievance and Appeals, and we are reviewing the process of grievance and appeal cases. In 2023, we processed 5690 cases, including grievances, appeals, and second-level appeals. Our cases have increased since the pandemic. We saw a 39% increase and anticipate an even bigger increase for 2024 due to expansion. Members can file	

Agenda Topic	Notes	Action Item
	grievances for any issue. About 3% of the cases we receive include some allegation of discrimination. The member does not have to use the word discrimination. They can allude to discrimination; we will flag it for a higher level and dive deeper into the case.  She has compiled last year's data on the right side: the 2023 cases by ethnicity. The left chart is a compilation of 2021 and 2022. The cases did not change much by ethnicity from year to year. However, for 2024, we anticipate a change due to the expansion. Our white members make up 38% of our demographics, but they are filing over half of the grievances.	

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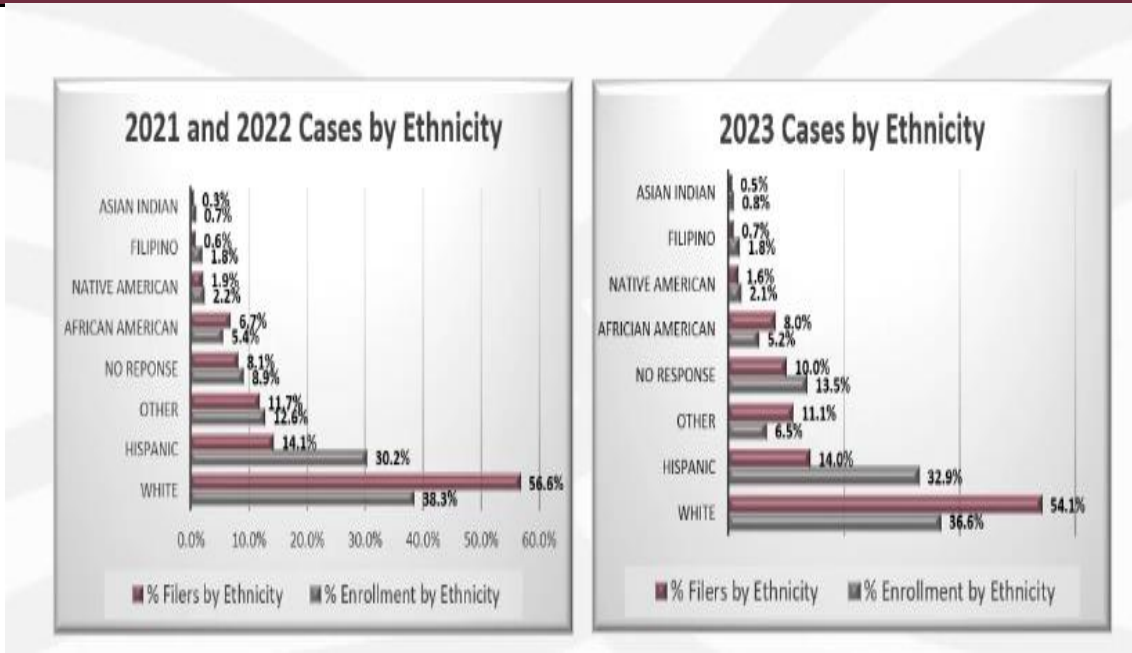
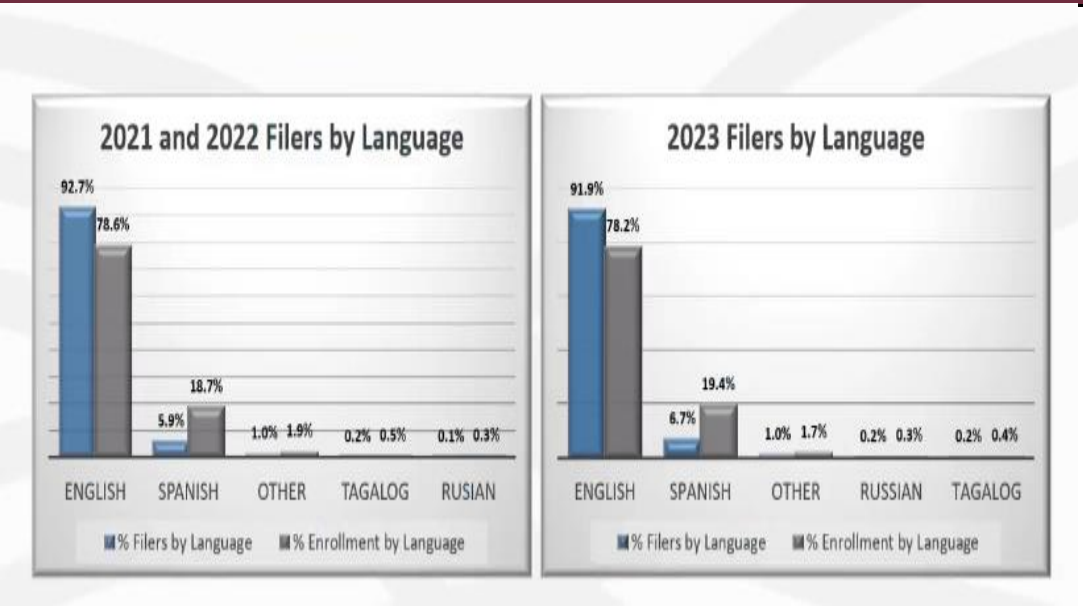
Agenda Topic	Notes	Action Item



The cases that we receive are broken down by the members' language. So again, here, English is the most common language spoken by our members, the members who file grievances and appeals, and Spanish is the second most common language. Spanish members are underrepresented. They account for a much higher percentage of enrollment than the grievances they file. Only our threshold languages, including Tagalog and Russian, were included, but we do get many other languages, but the number is very low.

Agenda Topic	Notes	Action Item
	 Once the case comes in, if the member mentions anything that seems like discrimination, the case will be flagged. The grievance and appeals department will work directly with the provider against whom the allegations are made. G&A works closely with provider relations for grievances, but because of its sensitive nature, they work directly with the provider. We ask for their perspective and questions about what kind of training they provide and how often it is provided. We then send the case to Population Health currently, and in the future, it will be Health Equity for an assessment on their behalf to see if they feel like discrimination likely occurred or likely did not occur. Once they give their assessment, one of our internally certified civil rights coordinators will conduct a holistic review and ask if they think discrimination is likely or unlikely. There are times when there is a difference of opinions, and if that happens, it is reviewed by one of our medical directors, Dr. Jalloh, and Kory.	

Agenda Topic	Notes	Action Item
	 Once the decision is made, we send a resolution letter to the members, letting them know our findings. We also send a letter to the provider if we find that discrimination likely occurred. We provide the provider with training resources. If discrimination is not likely, we do not send a letter, but we will be updating that process starting in 2025 at the request of one of our providers. When all parties are notified, we report the case to DHCS with all the details.	

Agenda Topic	Notes	Action Item

Discrimination Categories	# Reported Concerns
Race or Ethnicity	50
Disability	44
Limited English Skills	13
Age	11
Auxiliary Aids and Services	8
Language	3
Language Assistance Services	2
Gender	2
Nationality	2
Sexual Orientation	1
Religion	1

Question from Dr. Jalloh:
What data points would you like to see in the upcoming year?

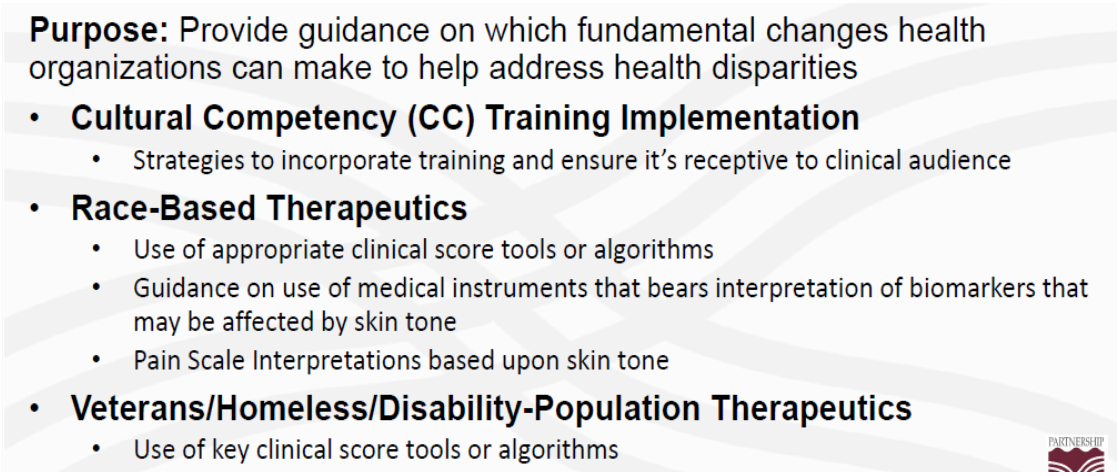
Response from Dr. Kubota:
It will be interesting to see if the election results decrease the number of grievances filed by the Hispanic population in the coming year.

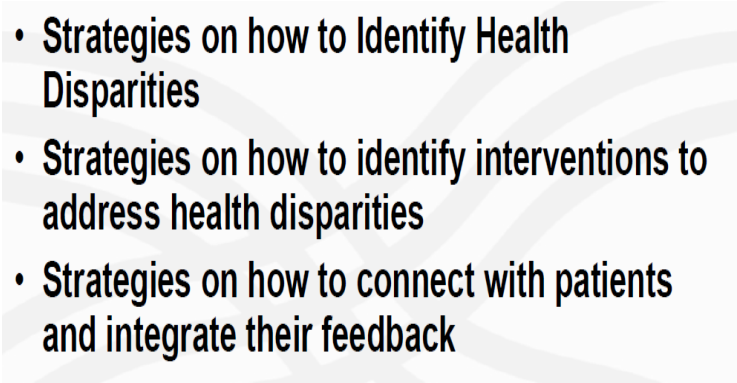
Response from Dr. Ton:
You might be interested in measuring provider ethnicity. We found that certain ethnicities are discriminated against, and we believe that there's discrimination against providers as well. We've been looking into UC data because we've noticed that providers of certain ethnicities are discriminated against. Some providers feel discriminated against by their patients. We are in the beginning stages of that.

Agenda Topic	Notes	Action Item
	Question from Isaac Brown: It would be good to know what the members felt about our process. *Response from Kory:* As I explained earlier, the Department of Healthcare Services does not mandate some of those in the current process. For example, the letter to the provider that we send DHCS does not mandate that, and the letter to the provider that we will begin implementing lets them know that we found discrimination was not likely. So, there are some steps that we can take that are not mandated. *Comment from Denise Whitsett:* In-person meetings and training on microaggressions and cultural humility are impactful. They encourage us to give grace.	
5. Policy Discussion for Health Equity Disparities **DEI Training Policy Feedback** **HE Foundations Policy Feedback** *Time: 20 minutes* *Speaker: Mohamed Jalloh, Pharm.D*	The goal is to align the diversity, equity, and inclusion (DEI) policy with what DHCS wants us to do. As an overview, DHCS has a new all-plan letter saying that as a health plan, we must develop and distribute DEI training to all our contractors and providers, etc. We have a vendor with whom we've signed a contract to create this LMS type of training. And the goal is that we'll be giving this training to all of our new contracted providers starting in June 2025. We will probably deliver this training to over ten to maybe 15000 people over the next two to three years. What can we do to encourage practitioners to take this training? *Response from Dr. Thomas:* Do we have to keep the DEI label, or can you rebrand it to something like implicit-biased training?	

Agenda Topic	Notes	Action Item
	Comment from Dr. Jalloh: That is a good idea. I am open to calling it something else, such as “Community Connection Training.” *Comment from Dr. Ton:* I think the acronym DEI is being misused. It would be good to spell it out as Diversity, Equity, and Inclusion and frame it as health equity. A study showed if mandatory training improved the organization’s inclusion mission. It would have been more effective if the training had focused on developing skill sets. We should ask the providers whether the module helped them at all. *Comment from Dr. Jalloh:* We are not going to require every health system to do our training. We will give an opportunity if a health system already has a DEI program, and we know some health systems with such a comprehensive one. They can send it to us with attestation. *Comment from Sue Lee:* I think the DEI training also requires approval in terms of the content. I'm sure we have some great feedback over here. How can we reconcile what we want versus what DHCS will finally stamp the training content? *Comment from Dr. Jalloh:* That is a good question. DHCS does not have a clear plan for its goals; it just wants to ensure that people complete the DEI training. *Comment from Dr. Kubota:*	

Agenda Topic	Notes	Action Item
	Our training should meet the requirements for their training and ours so that the providers do not have to do it twice. Comment from Dr. Jalloh; That is a good point. We can get feedback when we do the pilot. Comment from Dr. Ton: It would also be good to focus on the evaluation. The training should address attitude and how it can help provide services. It should be skills-orientated and attitude-orientated. After the training, it would be good to ask ourselves how this training helped me. Then, we have the data to show why the training was beneficial. Frequently, we see a vocal minority trying to undermine the training. *Comment from Dr. Jalloh:* It would be helpful to see the data so people can see the return on investment in taking the training. The goal is to help save time writing (completing) grievances that the practitioners may receive. Is March a good time for providers to submit their training? *Response from Valerie Padilla:* Yes, that should be enough time. Will you be working with the contracted vendors just as mobile mammography? There was an incident with one of our providers (Alinea). We had a language incident, and they do not do training as an organization. *Comment from Dr. Jalloh:* The APL says we must do training with subcontractors. I must confirm if it is in our contract with them, and I will follow up personally by email.	

Agenda Topic	Notes	Action Item
	Dr. Jalloh continued the conversation by mentioning that we are developing a foundation policy for integrating Health Equity throughout our network.  Are there any topics you would like to add or remove from the list? • Layla mentioned in the chat adding the LGBTQ community. • Denise suggested the deaf and hard-of-hearing community. • Leigha says the disabled community. • Dr. Jalloh mentioned aging	

Agenda Topic	Notes	Action Item
	We are creating a quick, almost like a PDF playbook, specifically on what health systems should do to be able to identify health disparities. Is there anything the committee would like to add?  Response from Dr. Ton: One additional suggestion is to prioritize the disparities and resources needed for each group after identifying the health disparities. Comment from Nancy Stephens: The last bullet point concerns strategies for connecting with patients and integrating their feedback. We could consider including a reference to providers interacting with patients because often, they're key in member engagement and identifying the member perspective and how to address it.	

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Agenda Topic	Notes	Action Item
6. QMSI Presentation of Interventions for Disparities *Time: 15 minutes* *Speaker: Brandi Isola*	I'm here speaking on behalf of our quality measure score improvement workgroups within PHC. We have four of them categorized by health topic, and today, the disparities we'll discuss are specific to our pediatric QMSI work group. **Disparity** / **Proposed Intervention** Fewer **Native Hawaiian and Other Pacific Islander** members are receiving annual well care visits than our white members. — WCV Enhanced Incentive Pilot (details on next slide) Fewer **Black/African American members** are receiving annual well care visits than our white members. — WCV Enhanced Incentive Pilot (details on next slide) Not enough of our members aged 3-21 are receiving annual well care visits. — WCV Enhanced Incentive Pilot (details on next slide); Plan, Do, Study, Act (PDSA) improvement project with a northwest primary care practice focusing on Spanish speaking and native American members to educate and encourage members to come in for the well child visits.; Locum initiative to increase appointment availability for Annual Well Child Visits (2024). The lack of access to our network is a real driver of our low performance. We have an enhanced incentive pilot for the groups.	

Agenda Topic	Notes	Action Item

Work with 9 Large Provider Organizations throughout the network* to intensively outreach and incentivize an annual well child visit for 1,031 children and adolescents in a group shown to be experiencing a disparity in this measure.

- Direct text outreach from PHC to members with care gap.
- Includes "direct" members who are not assigned to a PCP and therefore are not directly impacted by the PCP QIP.
- $200 per member who receives a WCV before 12/31/2024
- Evaluate impact and modify, expand or abandon and redirect

We're working on it in our various regions but targeting specific subpopulations in these regions.

Disparity	Proposed Intervention
Fewer **Black/African American members** are receiving *timely prenatal care (visit during first trimester)* than white members.	Solano Perinatal Clinical Collaborative. Explore expanding to other geographies. Leveraging Enhanced Care Management (ECM) Birth Equity Population of focus to collaborate with and support providers serving this population.
Fewer **American Indian/Alaskan Native members** are receiving *timely prenatal care* (visit during first trimester) than white members.	Tribal Perinatal Initiative (ECM Birth Equity Population of Focus)
Fewer **American Indian/Alaskan Native members** are receiving *postpartum care* than white members.	Tribal Perinatal Initiative (ECM Birth Equity Population of Focus)

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Agenda Topic	Notes	Action Item
7. Intervention Discussion for Black Prenatal Care Disparity *Time: 10 minutes* *Speaker: DeLorean Ruffin, DrPH*	Dr. Ruffin says to review the packet. You'll see the flyer for the December 13th event that we're having at Partnership on-site for our pregnant mothers to celebrate their journey. We want to promote further improved quality of care among our providers until we display our members through a mini photo shoot, so you'll see all those details on the flyer in the packet.	
8. Adjournment *Time: 1 minute* *Speaker: Mohamed Jalloh, Pharm.D*	***Next Meeting:*** *January 21st, 2025, via WebEx*	

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PARTNERSHIP HEALTHPLAN of CALIFORNIA

QI DEPARTMENT UPDATE
FEBRUARY 2025
PREPARED BY NANCY STEFFEN
SENIOR DIRECTOR, QUALITY AND PERFORMANCE IMPROVEMENT

QUALITY IMPROVEMENT PROGRAMS (QIPS)

PROGRAM	UPDATE
PRIMARY CARE PROVIDER QUALITY IMPROVEMENT PROGRAM (PCP QIP)	• Measurement Year (MY) 2024 ended at 5 pm on 01/31/2025. The first week of February is the Validation Period where providers will be able to review data in eReports for accuracy. Providers are strongly encouraged to review their year-end data closely during this period as this data is used to finalize point earnings. If a provider notifies Partnership of a calculation or point attribution error before this period concludes, and it can be substantiated, the final data will be corrected in time to coincide with the upcoming MY2024 payment. • Final stages for MY2025 eReports User Acceptance Testing are in progress. The official launch of eReports to all users is targeted for Monday, 03/03/2025. • The 2025 Preventive Care Dashboard launched 01/01/2025 and is refreshed daily.

QUALITY DATA TOOLS

TOOL	UPDATE
PARTNERSHIP QUALITY DASHBOARD (PQD)	• The 2025 PQD QIP Business Requirements Document is being finalized in preparation for development to begin in March. The go-live timing of 2025 PQD is pending finalization of HRP's (i.e. Partnership's new core claims system) launch this year. Go-live of PQD MY2025 QIP specific dashboards will be delayed beyond the typical May timeframe; as more specific timeline details are available; they will be shared with the provider network.
EREPORTS	• MY2025 HRP UAT is in progress, in preparation for a cut-over from Amisys to HRP later this year.

PERFORMANCE IMPROVEMENT (PI)

ACTIVITY	UPDATE
STATE MANDATED WORK: *PERFORMANCE IMPROVEMENT PROJECT (PIP) & PLAN-TO-DO-STUDY-ACT (PDSA) CYCLE*	*DHCS Comprehensive Quality Improvement (QI) & Health Equity (HE) Process* • Partnership met with DHCS on 01/15/2025 to review MY2023 HEDIS rates for Partnership's legacy 14 counties. DHCS indicated that several reporting regions showed performance below the Minimum Performance Level (MPL) of the Medicaid 50th national percentile. As a result, Partnership is required to develop strategies and actions to address the performance issues noted below and submit to DHCS by 02/14/2025: ○ Both Northern and Southern regions showed underperformance in several pediatric measures like newborn well visits, developmental screening, and lead screening. ○ The Northern region underperformed in asthma medication ratio and A1c control. This is the first time the chronic disease domain has triggered mandated activities which means Partnership must conduct a root-cause analysis before identifying strategies and actions.

	○ The Northern region underperformed in the Reproductive Health & Cancer Prevention domains for chlamydia screening, breast and cervical cancer screening, and pre-natal care. • In the prior year, Partnership was required to develop strategies and actions for Behavioral Health measures due to underperformance in Follow-up for ED Visits for Mental Illness. However, MY2023 performance exceeded both state and regional averages which means Partnership is not obligated to conduct improvement projects, however the rates are below the Medicaid 50th percentile and still warrant on-going focus and activities to drive improvement.
QUALITY MEASURE SCORE IMPROVEMENT	• A Developmental Screening Webinar aimed at educating providers regarding developmental screening tools and CPT codes will be hosted by Dr. Frankovich on Thursday, April 3rd at 12pm. Dr. Frankovich is a pediatrician and one of the Partnership Medical Directors, based in the Eureka Region. • The *Health Babies Growing Together Program (*GTP*)* flyer was approved by DHCS and translated into Spanish, Russian, Tagalog, Hmong, Punjabi. Copies of the flyer will be distributed to providers and cited as a best practice during the upcoming *Improving Measure Outcomes: Pediatric Preventive Care* webinar on 02/10/2025. • Partnership is preparing to publish co-branded colorectal cancer screening guidelines flyers in collaboration with the American Cancer Society. Flyers will be available to distribute within practices.
IMPROVEMENT ACADEMY	• On 01/30/2025, an *ABCs of Quality Improvement* in-person training was held in Ukiah. There were 21 external attendees, representing 8 unique organizations. The next in-person training will be held on 03/25/2025 in Redding. • Two *Improving Measure Outcomes* webinars focused on Pediatric Preventative Care for Ages 0 – 30 months and Ages 3 – 17 years are being offered throughout February.
JOINT LEADERSHIP INITIATIVE (JLI)	• Spring sessions are in the process of being scheduled.
REGIONAL IMPROVEMENT MEETINGS	• Quarterly regional quality meetings in the Redding and Eureka regions are in the process of being scheduled for February. • The next Southeast Regional Quality meeting is scheduled for 03/13/2025 in Fairfield.

Note: Detailed information and recordings of Performance Improvement related webinars are posted to the PHC Website: http://www.partnershiphp.org/Providers/Quality/Pages/PIATopicWebinarsToolkits.aspx

QI PROGRAM & PROJECT MANAGEMENT

ACTIVITY	UPDATE
CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS® (CAHPS) PROGRAM -MEDI-CAL PRODUCT LINE	• The MY 2024 CAHPS® regulated survey formally launched in February. The survey will remain open through mid-May. MY 2024 marks the first CAHPS® Regulated survey to include both legacy and expansion counties. • Member Experience / CAHPS® related articles will appear in both the Spring 2025 Provider Newsletter and the Summer 2025 Member Newsletter. • The 24/25 Organizational Goal dedicated to improving member experience and access has eight (8) goal milestones, with a mid-year status completion rate of 42.8%.

& ORG GOALS – FY 24/25 MEMBER EXPERIENCE AND ACCESS	• The QI CAHPS team is leading milestones 3 & 8, while also overseeing progress in all goal deliverables. Notable Milestone Status Updates: ○ Milestone #3 Focus - Activity in-process: The pilot strike-team concept utilizes real-time data sources to conduct proactive research, assessments, and enhancements aimed at reducing member dissatisfaction. The team is focused on closing benefit literacy gaps. Internal workgroup(s) are actively planning and executing activities the health plan can use to close these gaps. These activities are being informed by a survey recently completed across Population Health Management and Member Services leadership and staff. These staff are central to assisting our members daily. From this input, a quick-hit triage list of the most common member-asked questions was created. Notable survey results include the following top four topical areas: Providers (PCP, internist, pediatrician, etc.), Transportation, Coordination of Benefits – access to care issues, and Dental Service. ○ Milestone #8 Focus - Completed: Patient Experience- Unit of Service Measure Development (CG-CAHPS® Performance/Survey Option) in PCP QIP that includes adoption of at least one change to better align with Partnership's member experience and access improvement goals.
CAPACITY ENHANCEMENT GRANTS	• Background: For the first time in Partnership's 30-year history, contract negotiations were not fulfilled prior to the expiration of a provider contract. Dignity Health's contract termination affected over 64,000 members in Nevada, Shasta, Siskiyou, Tehama, and Yolo counties for several weeks in April through June. In response to this disruption, the Capacity Enhancement Grant (CEG) was created and offered to providers who agreed to take member assignments previously with Dignity Health. • Grant Implementation Process: Upon acceptance into the program, provider organizations submitted progress reports approximately three (3) months after the initial payment was awarded, detailing outcomes of their proposed activities, spending breakdowns, number of Dignity patients seen since the reassignment, and feedback on the CEG program. Although most providers adhered to their originally proposed plans, deviations from proposed activities were allowed if providers summarized alternative fund use. Examples of activities funded include: ○ Staff-related interventions such as sign-on bonuses, additional hiring and retention activities, incentives to clinicians for increasing number of visits and locum employment. ○ Extended clinic hours, including weekends. ○ Clinic space expansions and associated equipment purchases. • Summary of Results: The CEG Program closed upon the distribution of the second and final installment of funding, totaling $1,441,857.50. The evaluation of the program is now complete. This grant offering was a commendable initiative aimed at addressing the disruption caused by Dignity Health's contract termination, while at the same time developing capacity within the Partnership Primary Care network to serve all our

members. The program management team successfully launched the grant under tight deadlines, processing applications and issuing payments promptly. However, discrepancies in provider reporting and limited member impact underscore the need for improved accountability and strategic alignment in future iterations. By strengthening evidence requirements, enhancing cross-departmental coordination, and leveraging established frameworks, future programs can achieve a greater and more sustainable impact for members and providers alike.

- At the Chief Medical Officer's (CMO) recommendation, the CEG PM team conducted a discrepancy analysis with one of the participants, Elica Health Centers.
    - The total number of Dignity member visits identified by Partnership matches the report provided by Elica Health Centers. However, their reported total is higher because Elica counted multiple visits by the same member, whereas Partnership counts only one visit per member.
- The table below shows the discrepancy between the data Partnership collected compared to the data the CEG providers reported. The green triangles represent the sum of multiple sites within an organization.
    - Of the 27,357 reassigned members, only 1,419 were seen during the program's duration (May - September 2024)
    - 47% of members stayed with newly assigned PCPs, while 35% returned to Dignity.
    - The remaining 18% are a combination of members who lost eligibility and were not assigned to a PCP, who had a PCP that was neither Dignity nor a CEG participant, or who temporarily became Direct members.

Parent Org	Number of Dignity Members Assigned May 2024	Total Dignity Members with Visits	Reported Number of Dignity Members Seen
Adventist Health	950	30	50
Ampla Health	957	19	50
Anderson Walk In Medical	1416	78	90
Colusa Medical Center	2406	0	700
Elica Health Centers	934	7	42
Greenville Rancheria	808	168	661
Mccloud Healthcare (formerly known as Shasta Cascade)	585	24	85
Mountain Valley Health Centers	1004	43	175
Northern Valley Indian Health	2072	97	1200
Ole Health DBA CommuniCare Ole	8920	560	4422
Pediatric Medical Associates	453	40	30
Prime Heathcare (Shasta Regional)	772	0	327
River Bend (aka Francisco L. Garcia, M.D.)	819	37	1033
Shasta Community Health Centers	1976	122	Unable to calculate approx. number of reported Dignity members seen
Tarichi Primary Care	1071	41	396
Western Sierra Medical Clinic	811	81	272
Winters Healthcare Foundation	1403	72	296
Total:	**27357**	**1419**	**9829**

EXACT SCIENCES: PROMOTING COLORECTAL CANCER SCREENINGS

- To centralize efforts within Partnership and Exact Sciences, and to align with Colorectal Cancer Awareness Month in March, Partnership is offering a Cologuard ® multi-patient order program. This program eliminates the minimum patient count needed for each provider as Partnership will place one order on behalf of any provider that wishes to participate. Kits are being shipped mid-March. An open office hour was held on

	02/05/2025 to address any questions or concerns providers may have regarding the process.

EQUITY AND PRACTICE TRANSFORMATION (EPT) PROGRAM	• The DHCS Equity and Practice Transformation (EPT) Program is a statewide initiative with the goal of advancing health equity while reducing COVID-19 driven care disparities. The funding is divided between three (3) programs; the Initial Planning Incentives Payments (IPIP), the Provider Directed Payment Program (PDPP), and the Statewide Learning Collaborative (SLC).
	• Partnership received $1,526,085.49 in Initial Planning Incentives Payments (IPIP) funding.
	  ○ $10,000 was awarded to twenty-three (23) qualifying provider organizations through the IPIP program. The IPIP is geared toward small and medium-sized independent practices to support their planning and application process for the Provider Directed Payment Program (PDPP).
	  ○ The EPT PM team is drafting a proposal for Executive review to use the remaining $1.2 Million for two areas of unmet need for low-performing Primary Care Physicians (PCPs); Leadership training and Support for replacing outdated Electronic Health Records (EHRs).
	• All twenty-seven (27) provider organizations, who were invited by DHCS to participate in the PDPP, sent acceptance responses to DHCS by the 01/26/2024 deadline. Partnership had the third most accepted applications of all managed care plans with a 49% acceptance rate vs 29% state-wide. The accepted provider organizations are spread across each of Partnership's sub-regions, including five (5) provider organizations contracted with Partnership from the 2024 - 10 county expansion, eight (8) tribal health centers, and seven (7) provider organizations already engaged under Partnership's EPE program. DHCS has recalculated the final award amounts, due to budget revisions.
	  ○ Following the budget revisions, the dropout rate for the EPT cohort across the state is 5% and all twenty-seven (27) provider organizations sponsored by Partnership are currently enrolled and engaged in the program.
	  ○ EPT practices that did not complete the below 2024 deliverables on 11/01/2024 have until 11/01/2025 to submit as a requirement to remain enrolled in the program:
	  ▪ Empanelment and Access Milestone 1: Empanelment Assessment
	  ▪ Empanelment and Access Milestone 2: Empanelment Policy and Procedure
	  ▪ Data to Enable Population Health Management (PHM) Milestone 1: Data Governance and HEDIS Reporting Assessment and Data Governance Policy and Procedure.
	  ○ PHLC sent EPT milestone deliverable reports to all MCPs and the following summarizes the progress of Partnership's sponsored provider organizations.
	  ▪ 80% of submitted Empanelment and Access Milestone 1 deliverables were accepted; seventeen (17) practices submitted, and no submissions were rejected.

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28 % of submitted Empanelment and Access Milestone 2 deliverables were accepted; ten (10) practices submitted, and (4) submissions were rejected.
74% of submitted Data Governance & HEDIS Assessment deliverables were accepted; twenty (20) practices submitted, and no submissions were rejected.
52% of submitted Data Governance Policy & Procedure deliverables were accepted; thirteen (13) practices submitted, and one (1) submission was rejected.
85% of submitted Key Performance Indicator (KPI) deliverables were accepted; twenty-three (23) practices submitted, and no submissions were rejected.

The next EPT submission period will open on 05/01/2025 and the following deliverables will be due:

Year 2 PhmCAT
Data to Enable PHM Milestone 2: Implementation Plan
Stratified HEDIS-like measures
Key Performance Indicators (KPI) reports
All Rejected or unsubmitted 2024 EPT deliverables

By March 2025 DHCS will funnel EPT payment(s) through MCPs and EPT POs will receive their funding no later than 04/30/2025.

The Statewide Learning Collaborative (SLC) is meant to support practices awarded the PDPP funding in the implementation of practice transformation activities, sharing and spread of best practices, practice coaching activities, and achievement of quality and equity goals stated in their PDPP applications. Participation in the SLC is a requirement for all participants in the PDPP.

To remain in the EPT program, practices will need to demonstrate 80% attendance in the Practice Track and Learning Community sessions of the EPT Technical Assistance.
The EPT Practice Level Reporting was submitted to PHLC on 01/31/2025.
The upcoming HEDIS-like data submissions are as follows:

<table>
<tr><th>Report Number</th><th>Due Date</th><th>Reporting Period</th><th>Submission Cycle</th></tr>
<tr><td>Report 1</td><td>01/31/25</td><td>01/01/23 - 12/31/23</td><td>May 2025</td></tr>
<tr><td>Report 2</td><td>07/31/25</td><td>01/01/24 - 12/31/24</td><td>November 2025</td></tr>
<tr><td>Report 3</td><td>01/31/26</td><td>07/01/24 - 06/30/25</td><td>May 2026</td></tr>
<tr><td>Report 4</td><td>07/31/26</td><td>01/01/25 - 12/31/25</td><td>November 2026</td></tr>
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<tr>
<td>LOCUM PILOT INITIATIVE</td>
<td>The QI Locum Pilot Initiative was developed as a short-term solution to provide access to clinicians with the goal of improving HEDIS performance in preventative care, specifically well-child visits and cervical cancer screenings. This offering is designed as a limited grant program, whereby select provider organizations are granted funds to select and hire a Locum Tenens Provider for a 4-week period.

A total budget of $250,000 was approved; participants receive up to:

$45,000 when hiring a Physician.

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	○ $31,600 when hiring an Advanced Practicing Clinician. • The Grant is paid for in two installments: ○ 50% upon signing the agreement. ○ 50% upon completion of the four-week assignment and submission of a post-program survey. • Program Implementation and Participation ○ The initial cohort of providers was selected from those participating in the PCP Modified QIP. Out of six extended invitations, four applications were received and approved. The Locum assignment periods are being carried out asynchronously through the end of 2024. Weekly Provider check-ins and data collection are conducted by a Partnership Improvement Advisor throughout the Locum Provider's employment. ○ Locum Providers are alleviating a backlog of well-child and adolescent visits (WCV) while enabling urgent care coverage, allowing patients to schedule visits with their preferred physician. • Provider Specific Updates ○ Hill Country Community Clinic: A Nurse Practitioner began their three-month in early December, with the expectation the schedule and pace will ramp up slowly. Weekly check-ins are being conducted and will continue until they have met the grant requirements; anticipated by end of January 2025. ○ Round Valley Indian Health: The Executive Director indicated they would utilize their current locum to complete the grant activities. A request to extend the grant agreement through May 2025 has been made with Non-Provider Contracting. A weekly email check-in is initiated with their HR and/or QI teams to monitor and encourage progress; the Executive Director communicated they will let Partnership know when the grant activities begin. ○ Community Medical Center: Completed the initial grant activities and was awarded an extension to fund their locum through December 2024 to continue focusing on well-child visits, including disparity groups. Initial efforts resulted in the completion of 272 visits. During the extension, an additional 345 patient visits have been completed, primarily well-child visits and acute care. ○ Pit River Health Service: The grant activities and final evaluation have been completed, and payment of the 2nd installment was made. Successfully completed 218 patient visits, primarily well-child visits.
MOBILE MAMMOGRAPHY PROGRAM	• Between 07/01/2024 to 12/31/2024, Partnership sponsored 43 Mobile Mammography events days with 24 provider organizations at 38 provider sites. (Note: This represents a small update (i.e. increase) versus what was reported in January's QI Update.)

Completed Event Days 07/01/2024 – 12/31/2024				
Legacy Region	**# of Provider Organizations**	**# of Provider Sites**	**# of Event Days**	**# of Completed Partnership Screenings**
ER	6	13	15	309
NE	7	8	10	235
NW	2	7	8	170
SE	2	3	3	75
SW	7	7	7	145
Plan Wide	**24**	**38**	**43**	**934**

- Two (2) event days in the Northwest Region were held at a Tribal Health Center in Humboldt County.
- One (1) event day in the Northeast Region was held at a Tribal Health Center in Trinity County.
- One (1) event day in the Southwest Region was held at a Tribal Health Center in Mendocino County.
- Three (3) event days in the Eastern Region were held at a Tribal Health Center in Tehama County.
- Scheduling for Mobile Mammography events for Q3 (January – March 2025) continues. Upcoming confirmed events in February and March include:

Upcoming Event Days January through March 2025			
Legacy Region	**# of Provider Organizations**	**# of Provider Sites**	**# of Event Days**
ER	1	1	1
NE	2	2	3
SE	2	2	2
SW	1	1	1
Plan Wide	**6**	**6**	**7**

Partnering For Pediatric Lead Prevention Program (PPLP)

- Applications to request a LeadCare II Point of Care device continue to be open year-round and are readily available on our Lead Poisoning and Prevention provider facing webpage, along with related resources.
- Providers approved in Fall 2023, who received their devices in January – February 2024, are currently being evaluated to determine if they met the 2024 QIP 50th percentile goal of 62.79.

	• The program has developed a promotional strategy to communicate the importance of lead testing, highlight available resources, and emphasize year-round enrollment. Promotional materials, including links and QR codes to the provider-facing page, have been distributed to provider facing teams.
	• Outreach efforts are underway for providers with a denominator of 100+, who did not meet the 2024 QIP 50th percentile. Meetings are being scheduled to review the workflows, provide feedback based on 2024 best practices and address challenges.
	• PPLP continues to collaborate with:
	  ○ QI - Performance Improvement Team: Developing 2025 Best Practices using 2024 program feedback.
	  ○ Population Health Team & Butte County Public Health: Supporting CALAIM Bold Goal efforts to exceed the 50th percentile for children's preventative care measures; Butte County Public Health submitted their application for a LeadCare II device in December 2024, and an MOU is in progress.
	  ○ Communications Team: Updating the Lead Poisoning and Prevention member-facing page with current resources.

QI TRILOGY PROGRAM	• Mid-year status updates for the 2024-25 QI Work Plan were received from Business Owners in January. A mid-year report will be shared with Quality Committees in March. • Initial notices for the 2025-26 QI Program Description were emailed to Business Owners on 02/10/2025. Submissions are due 03/03/2025.

D-SNP

ACTIVITY	UPDATE
Model of Care (MOC)	• The Quality Project Management team completed the formatting of the Dual Eligible Special Needs (D-SNP) Model of Care (MOC) and the corresponding MOC Matrices. The MOC, Department of Healthcare Services (DHCS) Matrix and the National Committee for Quality Assurance (NCQA) Matrix were submitted to the Regulatory and Compliance (RAC) team on 01/22/2025. RAC is expected to submit all MOC related documents by the 02/12/2025 deadline. • A summary presentation of the MOC is occurring at Quality Committees this month.
D-SNP Education	• A special webinar titled: "Capturing Patient Acuity through Coding" will be presented on 02/19/2025. The target audience for this webinar is network providers and coding support personnel within organizations in the eight D-SNP counties. CME/CE was offered and will continue as an opportunity for Enduring Learning Credit through the end of the calendar year.
CAHPS Survey Project – Medicare Product Line	• The Medicare CAHPS program is in development. Interviews with sister plans have been conducted and relationships established for ongoing exchanges to help inform the buildout. • CMS approved survey vendors have been identified and RFIs were sent; three responses were received. The CAHPS team has scheduled follow-up calls to continue discussions with the three vendors and consider whether a formal RFP will be necessary

	to identify and move forward with the preferred vendor. We will be prepared to contract with a vendor mid-2025.

QUALITY ASSURANCE AND PATIENT SAFETY

ACTIVITY	UPDATE
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: **12/30/2024 TO 01/28/2025**	• PQI referrals received during this period: 22 with 16 of these cases referred from Grievance and Appeals, four from Utilization Management, and two from Medical Directors • 26 cases were processed and closed to completion. • PQI cases that are currently open: 88 cases • One new PQI case was reviewed at the Peer Review Committee (PRC) in January. There are currently seven cases awaiting PRC review.
FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR) FOR THE PERIOD: **12/30/2024-1/24/2025**	• As of 1/29/2025, we have a total of 457 PCP and OB sites with an additional 31 reviews due to multiple check-6ins (totaling 488 reviews). **Primary Care and OB Reviews Completed in this reporting period:** **Region** / **# of FSR conducted** / **# of MRR conducted** / **# of FSR CAP issued** / **# of MRR CAP issued** Auburn / 3 / 1 / 0 / 1 Chico / 2 / 0 / 0 / 0 Eureka / 5 / 4 / 0 / 1 Fairfield / 0 / 0 / 0 / 0 Redding / 3 / 4 / 2 / 4 Santa Rosa / 3 / 1 / 0 / 1 New sites opened this period à • Chico – Sycamore Pediatrics • Eureka – New Life • Santa Rosa – MarinHealth Medical Network

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

ACTIVITY	UPDATE
Annual HEDIS® Projects	• The HEDIS MY2024 Annual Audits are scheduled: o DHCS Managed Care Accountability Set (MCAS) – 02/13/2025 o NCQA Health Plan Accreditation (HPA) – 02/26/2025 • Preparation is underway to receive and integrate all data to support the HEDIS MY2024 regulatory required reporting; this includes all non-standard supplemental data sources that will require Primary Source Verification (PSV), which must be approved by both auditors. • A special W30+6 medical record review (MRR) project launched in mid-January 2025 and will conclude by 02/28/2025. This special project is focused on retrieving,

	abstracting, and overreading compliant medical records to supplement the W30+6 administrative rate for MY2024. • Continued preparation is underway to begin plan-wide reporting as required by both DHCS MCAS and NCQA HPA HEDIS auditors in MY2024 reporting. • Additionally, beginning in MY2024, County-Level Reporting directly to DHCS will be completed for all 24 counties using the over-sampling methodology recently communicated by DHCS in late 2024.
HEDIS® Program Overall	• Partnership held a series of meetings with DHCS's Data Team on 01/10/2025 and 01/24/2025, with the goal of improving data capture for the Dental Fluoride Varnish for Children (TFL-CH) MCAS measure. DHCS and Partnership are moving forward with a strategy to validate the completeness of the Denti-Cal data that DHCS has provided Partnership for MY2024, and to improve data capture and completeness of Denti-Cal data for the MY2025 MCAS cycle. • DHCS continues to share aspects of their plan to sanction MCPs at the county level for MY2024 MCAS performance below the MPL. DHCS has shared plans to allow MCPs to substitute all plan rates for MCAS hybrid measures within counties having an eligible member population below DHCS's threshold of 100 members; Partnership is awaiting guidance on whether this instruction also applies to administrative measures.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE
NCQA Health Plan Accreditation (HPA)	• Applicable teams will participate in a full scope Mock File Review with our consultant, Managed Healthcare Resources (MHR), in either April or May 2025. The purpose of the Mock File Review is to sustain file review performance and to ensure full compliance with the Must-Pass elements throughout the HPA Renewal Survey look-back period. This review will include files from Partnership and non-NCQA Accredited delegates. The Mock File Review will be based on the 2025 HPA Standards and Guidelines and will follow NCQA's 8/30 methodology. Upon completion of the Mock File Review, the NCQA Program Management Team will coordinate Corrective Action Plan (CAP) submissions and provide assistance to ensure the actions are addressed promptly and the file review elements are compliant before the start of the look-back period in September 2025 (except for Credentialing files, as that look-back period started September 2023).
NCQA Health Equity Accreditation (HEA)	• In preparation for Partnership's HEA Initial Survey scheduled on 06/17/2025, Business Owners are required to submit their annotated and bookmarked evidence by 03/28/2025. The NCQA Program Management Team hosted an evidence preparation training session on 01/23/2025 which provided guidance and tips on how to prepare and present evidence in a standardized manner. Business Owners are asked to follow the plan-wide preparation instructions to ensure consistency in Partnership's evidence to streamline the review by the NCQA surveyors. The NCQA Program Management Team shared evidence submission instructions to all Business Owners via email on 01/28/2025. This communication also included an Evidence Submission Tracker specific to their assigned standards.

	• As of January 2025, Partnership's HEA compliance rate is at 85.19%, receiving 23 points out of the 27 total applicable points available. The NCQA Program Management Team is working closely with the Business Owners to ensure all applicable evidence is revised to sustain compliance in accordance with NCQA's look-back periods, timelines, and expectations.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE (Q/UAC)

Consent Calendar

Feb. 19, 2025

Items on the Consent Calendar have minor or no changes and are recommended by staff for approval.

	Page #
Care Coordination Policies	
MCCP2020 – Lactation Policy and Guidelines	111 - 118
MCCP2021 – Women, Infant and Children (WIC) Supplemental Food Program	119 - 121
Utilization Management Policies	
MCUP3064 – Communication Services	123 - 125
MPUG3011 – Criteria for Home Health Services	126 - 130
MPUG3019 – Hearing Aid Guidelines	131 - 138
MPUP3048 – Dental Services (including Dental Anesthesia)	139 - 144

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCCP2020 (previously MCUP3009; MPUG3009; UG100309)</td><td colspan="3">Lead Department: Health Services
Business Unit: Care Coordination</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Lactation Policy and Guidelines (formerly Breastfeeding Guidelines)</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/19/2000</td><td colspan="4">Next Review Date: ~~03/13/2025~~03/12/2026
Last Review Date: ~~03/13/2024~~03/12/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td colspan="2">☒ Medi-Cal</td><td>☐ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td>☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td>☐ COMPLIANCE ☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE ☒ PAC</td></tr>
<tr><td>☐ CEO ☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td>☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~03/13/2024~~03/12/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MPXG5009 - Lactation Clinical Practice Guideline
B. MPCR16 - Lactation Consultant Credentialing Policy
C. MCUG3118 - Prenatal and Perinatal Care
D. MCUP3041 - Treatment Authorization Request (TAR) Review Process
E. MCCP2021 - Women, Infants and Children (WIC) Supplemental Food Program
F. MCUP3013 – Durable Medical Equipment (DME) Authorization
G. MCUG3011 – Criteria for Home Health Services
H. MCNP9006 - Doula Services Benefit
I. MPCR15 – Doula Credentialing and Re-Credentialing Criteria

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Electronic Visit Verification (EVV): A federally mandated telephone and computer-based application program that electronically verifies in-home service visits for Medicaid-funded personal care services and home health care services for in-home visits by a provider. In California, this is known as CalEVV.
B. Essential Health Benefits - A set of health care service categories that must be covered by certain plans - Categories include, among others, ambulatory patient services, emergency services, hospitalization, maternity and newborn care, and mental health and substance use disorder services.
C. WIC - Women, Infants and Children Supplemental Nutrition Program - The Special Supplemental Nutrition Program for Women, Infants, and Children - A 100% federally funded program providing nutritious food (via prescriptive checks), individual counseling and nutrition education, breastfeeding promotion and support, and referrals to other needed services to at-risk, low- to moderate-income (up to 185% of the federal poverty level) pregnant, postpartum, and breastfeeding members, -children up to the age of five; and parents/guardians and other family members in households with a child under age five.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

A. To support optimal nutrition in the healthy infant by appropriately supporting the parent's efforts to

initiate and sustain breastfeeding exclusively for about 6 months and with complementary foods (not formula) for at least 12 months per American Academy of Pediatrics (AAP) recommendations.

B. To give the policy framework around provisions of the Affordable Care Act (ACA), Section 4106a, Women's Health Preventive Services. It is the goal of Partnership HealthPlan of California (Partnership~~HC~~) to be fully compliant with this portion of the ACA. This section states that pregnant and postpartum members are eligible to receive the following as preventive services:
   1. Comprehensive lactation services including counseling by a trained health care provider or allied health professional during pregnancy and/or the postpartum period.
   2. To have access to breast pumps and breastfeeding equipment and supplies, as indicated to support lactation.

VI. POLICY / PROCEDURE:

A. General Breastfeeding Guidelines
   1. Introduction: Human breast milk is uniquely specific to the needs of the human infant. Breastfeeding is acknowledged as the preferred method of infant feeding by Partnership~~HC~~ and the AAP. Research has demonstrated numerous health benefits of breastfeeding. Additional to health benefits breastfeeding also provides social, economic and environmental benefits for both parent and infant.

B. Promotion and Support of Breastfeeding
   1. Lactation Education and Support Services: Each county served by Partnership~~HC~~ has a local Women Infants and Children (WIC) Nutrition Program that includes lactation education, support and provision of breast pumps, for low-income individuals, including Partnership~~HC~~ members. All pregnant members should be referred to WIC. Lactation support for Partnership~~HC~~ members is a shared goal and responsibility of WIC and the health delivery system provided through Partnership~~HC~~, by the following providers and support services:
      a. Primary care providers (PCPs) are encouraged to provide opportunities for members to learn about the advantages of breastfeeding through educational materials. Referrals for all pregnant members to prenatal breastfeeding classes will ensure they have current evidence-based information about breastfeeding.
      ~~b.~~ Prenatal care providers should specifically assess a pregnant member's knowledge and interest in breastfeeding at the first prenatal visit. Obstetrical care includes documentation of a complete breast exam and anticipatory guidance for any condition that could affect breastfeeding. Education regarding the advantages of breastfeeding should be ongoing. Pregnant members and their families should be referred to a breastfeeding class and have access to one-on-one breastfeeding education prenatally and postnatally. This is especially important for members who are first-time parents or have not breastfed in the past.
      b.
      c. The Comprehensive Perinatal Services Program (CPSP) has divided authority between the California Department of Health Services (DHCS) and the California Department of Public Health (CDPH). It is an enhanced program of perinatal services to be offered through the Medi-Cal program and reimbursed (by DHCS) at higher rates than traditional obstetrical services. The CPSP provider certification process is administered and approved by the CDPH. *Note:* Partnership HealthPlan of California (Partnership) encourages, but does not require, providers to be CPSP certified in order to provide obstetrical and perinatal services, however, obstetrics providers need to provide CPSP-like services or refer to another CPSP provider for non-obstetric CPSP or CPSP-like services. (*see also the Partnership HealthPlan Perinatal Services (PHPS) definition below*)
      ~~c. Comprehensive Perinatal Service Programs (CPSP): PartnershipHC strongly supports having all pregnant members receive support services provided through CPSP providers, which provide~~

~~comprehensive assessments as part of their total perinatal care. CPSP providers may provide their own lactation support services or refer to other community resources to provide breastfeeding promotion, education and counseling.~~

~~d.~~ Partnership~~HC~~ Population Health: Through specific programs and general case management support, Partnership~~HC~~ Population Health supports breastfeeding in accordance with current guidelines and evidence-based practices. Members who are planning to breastfeed and need specific resources are encouraged to call for assistance with breastfeeding when wanted.

d.

e. Partnership HealthPlan Perinatal Services (PHPS): CPSP-like services that are equivalent to, or substantially similar to, the services defined by the CDPH-defined CPSP program. *(see also the Comprehensive Perinatal Services Program (CPSP) definition above)*

~~e.~~f. Postpartum follow-up: Calls are made to Partnership~~HC~~ members within the first month after delivery, when possible, to encourage a timely postpartum visit. If needed, referrals are made for lactation assistance, support, education and information.

~~f.~~g. Hospitals providing obstetrical care play a key role in supporting successful initiation of breastfeeding. Standards of care for hospitals in this area are fully outlined in the UNICEF/WHO Baby Friendly Hospital Initiative) (https://www.unicef.org/documents/baby-friendly-hospital-initiative) and will also include:

1) The hospital should receive information on the member's prenatal record stating the infant feeding plan. That plan should be confirmed when a member is admitted for delivery.
2) Family centered childbirth practices allowing for early parent-infant contact and breastfeeding within one half-hour of birth as well as rooming in. Hospitals are encouraged to view initiation of breastfeeding as a process accomplished over several days and offer support, assistance, and education accordingly.
3) Newborns should be nursed whenever they show signs of hunger/interest approximately 8-12 times every 24 hours after the first 24 hours. Parents can be encouraged to hold their infants even when not feeding to better assist them as they begin the process of learning and understanding their infant's feeding cues.
4) Members need access to qualified nursing staff and/or International Board Certified Lactation Consultant (IBCLC) to assist with initiation of breastfeeding, evaluate breastfeeding progress and to give ongoing information during the hospital stay.
5) Supplements such as formula should not be given to breastfeeding newborns unless there is an order from the Health Care Provider.
6) Discharge planning includes the assessment of the need for follow-up with WIC, a peer counselor, the infant care office, an IBCLC, home health, or public health nurse visit specifically to assist the parent with breastfeeding. Whenever possible this should occur within 1-2 days of discharge.
7) The lactating parent leaves the hospital with a list of resources for support and assistance with breastfeeding, information on how to tell if the baby is getting enough milk, and referral to a breastfeeding support group.

~~g.~~h. Infant Care providers should encourage exclusive breastfeeding for about six months and breastfeeding with complementary foods (not formula) for at least 12 months per AAP recommendations. Infant Care providers should consider a referral to a qualified lactation consultant, Home Health Nurse or Public Health Nurse for evaluation before suggesting supplementation with formula or cessation of lactation. Providers need to consider the parent's health and well-being when giving recommendations. If a baby needs to stop feeding at the breast, the parent is to be provided with a breast pump and instructions on how to use it to maintain the milk supply.

~~h.~~i. Home Health Nurse or Public Health Nurse Visit: All members are eligible to receive Home

Health Nurse visits or Public Health Nurse visits after discharge from the hospital for assistance with breastfeeding. It is strongly recommended that home visiting nurses have specific training in lactation/breastfeeding support. The first parent-baby home health visit by a Home Health Nurse does not require prior authorization and subsequent visits are easily available through the authorization process. Public Health Nurse visits do not require authorization and can be ordered in a variety of ways including by notation on the postpartum discharge orders at time of discharge or by contacting the local county Public Health Department.

1) Electronic Visit Verification (EVV) Requirements:
   a) Effective January 1, 2023, as per APL 22-014, EVV requirements must be implemented for all Medi-Cal personal care services and home health care services that are delivered during in-home visits by a provider, which includes visits that begin in the community and end in the home, or vice versa.
   b) Please refer to policy MCUG3011 Home Health Services for further information on EVV requirements.

i. Doulas offer various types of support, including lactation support. For more details, refer to Partnership~~HC~~ policy MCNP9006 Doula Services Benefit and MPCR15 Doula Credentialing and Re-credentialing Criteria.

C. Partnership HealthPlan of California Breastfeeding Services

1. Timing of Lactation Support Services: Lactation Education and Support is different in the prenatal, immediate postpartum (in the hospital), early postpartum (from hospital discharge to 84 days after delivery), and late post-partum periods (from 84 days to 365 days post-delivery). From a Partnership~~HC~~ standpoint, care during the postpartum period includes two specifically defined postpartum visits, one occurring prior to 21 days after delivery and the second between 21 to 84 days after delivery. This postpartum review and examination includes obtaining a history, performing a physical exam and evaluation of infant feeding. Additionally, earlier post discharge follow-up lactation visits should be encouraged, preferably in the first few days after discharge home. Some parents also need lactation education and support after 84 days post-delivery. Lactation visits independent of the standard postpartum visits are covered by Partnership~~HC~~. See billing and codes section for specific requirements.
2. Providers of Lactation support services:
   a. Basic lactation support services may be provided in a provider office by a medical professional as follows: Physician, Nurse Practitioner (NP), Physician Assistant (PA), Certified Nurse Midwife (CNM), or Licensed Midwife (LM).
      1) Providers offering lactation support services will ensure that the services are provided by an individual who has the appropriate education and knowledge.
      2) Registered Nurse (RN), Registered Dietician (RD), International Board Certified Lactation Consultants (IBCLC), Lactation Educators and other lactation support staff without additional health professional licensure may provide basic lactation support services under the supervision of a Partnership~~HC~~ contracted Physician.
   b. IBCLCs with an underlying health professional licensure (RN, RD, Doctor of Medicine [MD], Doctor of Osteopathic Medicine [DO], CNM, NP, PA) may become contracted/credentialed to provide lactation support services through Partnership~~HC~~.
      1) Contracted/credentialed IBCLC will ensure that any services provided by an individual within their employment has appropriate education and knowledge.
      2) Lactation Educators and other lactation support staff without additional health professional licensure may provide basic lactation support services under the supervision of a Partnership~~HC~~ contracted /credentialed IBCLC.
      3) IBCLCs must be credentialed by the credentials committee, as described under policy MPCR #16 Lactation Consultant Credentialing Policy.

3. Other Health Professionals who are Certified Lactation Consultants or trained Lactation Educators, under the supervision of a Partnership~~HC~~ contracted/credential IBCLC or provider office, may perform lactation consultation services outside of the hospital setting.
4. Lactation Educators: A Lactation Educator may provide basic lactation education services. The Lactation Educator must always work under the supervision of a Partnership~~HC~~ contracted/credentialed IBCLC or provider office, who is ultimately responsible for the patients seen by lactation educators.
    a. If an IBCLC is supervising lactation educators, the following documentation must be maintained in the lactation educator's personnel file:
        1) Documentation of successful completion of a basic lactation education program.
        2) A letter from their supervising IBCLC describing the training and experience of the Lactation Educator, and the manner in which they are supervised.
    b. The IBCLC must maintain written protocols for the Lactation Educator, listing:
        1) Documentation standards
        2) Topics that the Lactation Educator may address
        3) Indications for referral to the IBCLC, with standards for timeliness of referrals.
5. Lactation Support Services:
    a. No Referral Authorization is required for up to 60 calendar days of services; however, a Treatment Authorization Request (TAR) is required for visits after 60 calendar days, with a written treatment plan and specific request for additional visits. These TARs will be reviewed for medical necessity, according to the usual TAR process.
    b. Services provided in a contracted hospital outpatient services, physician office, IBCLC private office or member's home may be billed to Partnership~~HC~~ using the S9445 HCPCS code, billed in 15 minute increments, up to a maximum of 4 units per day. In addition, lactation services provided by a Comprehensive Perinatal Service Program (CPSP) after the post-partum member's eligibility for CPSP has expired, may also use the S9445 HCPCS Code.
6. Breast Pumps: When breastfeeding is interrupted or discontinued the use of Breast Pumps and alternative feeding fluids may be necessary. If lactating parent is unable to feed the baby at the breast due to a medically based separation or a physical problem of varying duration, and until resolution of any of these problems are achieved, providing a breast pump in a timely fashion is appropriate and a covered benefit.
    a. Electric breast pumps may be recommended for infants with feeding problems where a lactating parent must be separated from or is unable to nurse the baby. Partnership~~HC~~ strongly recommends the use of an electric breast pump for adequate maintenance of milk supply when a baby is not able to breastfeed.
    b. In partnership with local WIC agencies, multi-user electric breast pumps and the breast pump equipment (Kits) are provided through each county's WIC program, when available. They provide the pump, equipment and education to support appropriate use.
    c. Single-user personal double electric breast pumps are also available for Partnership~~HC~~ members, or for lactating parents whose infant is a Partnership~~HC~~ member (who is 12 months old or younger). These pumps are available by prescription from a number of Partnership~~HC~~ contracted durable medical equipment (DME) providers. No TAR is required. Partnership~~HC~~ breast pump benefit is limited to one pump every three years.
        1) Providers will utilize DME order form with prescription to submit request for pump no sooner than 30 calendar days prior to the Estimated Due Date (EDD), up to 12 months after delivery.
        2) Providers will provide supportive pump education on how to successfully use the selected pump at a health education visit prior to the EDD.
        3) Providers will be reimbursed up to 1 hour for breast pump education utilizing CPSP health

education codes, or billing code S9445. Office visit codes may also be used, for appropriate providers.

d. When infants are born at less than 36 weeks gestation and remain hospitalized, arrangements will be made on an individual case by case basis to use a multi-phase hospital grade electric pump for the initiation and maintenance of the lactating parent's milk supply while the infant is hospitalized. Specific instruction and support for the use of this pump will be provided by the hospital staff.

7. Alternate Feeding Fluids:
   a. Banked Human Milk is available in limited supplies for infants with specific conditions and for whom their lactating parent's milk is temporarily not available.
      1) Banked Human Milk for newborns whose lactating parents are unable to breastfeed due to medical reasons is a covered benefit under Partnership~~HC~~. Prior Authorization is required.
      2) Donor/processed banked breast milk requires a prescription from a physician. The prescription must specify *Processed human milk __# of ounces per day for __# of weeks* as well as the infant's name and Client Identification Number (CIN) along with the parent/guardian's name and phone number and a diagnosis. The prescription can be faxed or scanned and emailed to the milk bank.
      3) If the infant requires an increase in supply, a new prescription is needed.
      4) For outpatient infants, the first shipment is usually for one week of milk. The parent/guardian can request up to a 2 week supply on subsequent orders.
      5) When a hospital orders the milk, a purchase order number is required, along with the parent's address, attending physician, and whether the order is for premature milk or mature milk. The hospital can provide a verbal order and then fax a written doctor's order to the milk bank. Partnership~~HC~~ does not pay for Banked Human Milk in hospitalized recipients as the bank will bill the hospital directly in those instances.
      6) For some newborn intensive care units (NICUs) in California, the physician may want to have a supply of processed donor milk stored in the freezer at all times. Other hospitals order donor milk when a patient needs it. The processed milk has a six-month expiration period.
   b. Special infant formulas for specific medical conditions must be prescribed by an approved Medi-Cal prescriber and dispensed to the member by a Medi-Cal Rx pharmacy provider (when approved through the State Medi-Cal Pharmacy TAR process).
      1) The pharmacy (prescription) benefit is carved-out to State Medi-Cal as of January 1, 2022. For State Medi-Cal authorization requirements, please refer to the State Medi-Cal Enteral Nutrition policy https://medi-calrx.dhcs.ca.gov/home/enteral-nutrition-products/
      2) WIC may be able to provide specialty infant formulas when authorization for a pharmacy TAR is pending with State Medi-Cal. Providers should check with the local WIC office for availability of interim product in urgent cases.

VII. REFERENCES:

A. American Academy of Pediatrics, Clinical Practice Guidelines: https://publications.aap.org/pediatrics/collection/523/Clinical-Practice-Guidelines
B. Affordable Care Act, Section 4106a, Women's Health Preventive Services
C. Hale, Thomas Wright, Krutsch, Kaytlin. *Hale's Medications & Mothers' Milk 2023: A Manual of Lactational Pharmacology*. 20th ed., New York, NY: Springer Publishing Company, 2022.
D. Kimberlin, David W., editor. *Red Book: 2021-2024 Report of the Committee on Infectious Diseases*. 32nd ed., Itasca, IL: American Academy of Pediatrics, 2021.
E. Infant Risk Center: https://infantrisk.com/breastfeeding -Call 806-352-2519

F. CA WIC Association: Ramping up for Reform-Quality Breastfeeding Support in Preventive Care. https://thewichub.org/ramping-up-for-reform-quality-breastfeeding-support-in-preventive-care/
G. Department of Health and Human Services/Center for Medicaid and CHIP Services
H. Medicaid Coverage of Lactation Services. CMS Bulletin
I. DHCS All Plan Letter (APL) 22-012 *Revised* – Governor's Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits From Managed Care to Medi-Cal Rx (12/30/2022)
J. DHCS APL 22-014 Electronic Visit Verification Implementation Requirements (07/21/2022)
K. Partnership~~HC~~ Website: Pregnancy & Breastfeeding - Breastfeeding Booklet https://www.partnershiphp.org/Members/Medi-Cal/Pages/Health%20Education/Pregnancy--Breastfeeding.aspx

VIII. DISTRIBUTION:
A. Partnership~~HC~~ Department Directors
B. Partnership~~HC~~ Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:
MCCP2020 (02/15/17)
*03/14/18; 06/12/19; 06/10/20; 08/11/21; 03/09/22; 03/08/23; 03/13/24; 03/12/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:
Medi-Cal (UG100309; MPUG3009; MCUP3009: 04/19/2000 to 02/15/2017)
05/16/01; 05/15/02; 10/20/04; 10/19/05; 08/20/08; 04/21/10; 09/15/10; 10/01/10; 06/20/12; 11/20/13; 08/20/14; 04/15/15; 01/20/16; 10/19/16 to 02/15/17

Healthy Families:
MPUG3009 - 10/01/2010 to 03/01/2013

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership~~HC~~ to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership~~HC~~.

Partnership~~HC~~'s authorization requirements comply with the requirements for parity in mental health and

substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCCP2021 (previously MCUP3100)</td><td colspan="3">Lead Department: Health Services
Business Unit: Care Coordination</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Women, Infants and Children (WIC) Supplemental Food Program</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/21/2010</td><td colspan="4">Next Review Date: ~~03/13/2025~~03/12/2026
Last Review Date: ~~03/13/2024~~03/12/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td colspan="2">☒ Medi-Cal</td><td>☐ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~03/13/2024~~03/12/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCUG3118 – Prenatal & Perinatal Care
B. MCQG1015 - Pediatric Preventive Health Guidelines
C. MCNP9006 – Doula Services Benefit
~~C.~~D. MCCP2036 - Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Members Services

III. DEFINITIONS:

A. WIC - Women, Infants and Children Supplemental Nutrition Program - The Special Supplemental Nutrition Program for Women, Infants, and Children - A 100% federally funded program providing nutritious food (via prescriptive checks), individual counseling and nutrition education, breastfeeding promotion and support, and referrals to other needed services to at-risk, low- to moderate-income (up to 185% of the federal poverty level) pregnant, postpartum, and breastfeeding members, children up to the age of five; and parents/guardians and other family members in households with a child under age five.

IV. ATTACHMENTS:

N/A

V. PURPOSE:

~~To define the responsibilities of Partnership HealthPlan of California (PHC) and the respective Women, Infants and Children (WIC) Providers in the counties PHC serves.~~ To define the responsibilities of Partnership HealthPlan of California (Partnership) and the respective Women, Infants and Children (WIC) Providers in the counties Partnership serves.

VI. POLICY / PROCEDURE:

A. Coverage Guidelines:
   1. WIC services are not covered by Partnership~~HC~~. However, Partnership~~HC~~ members who are eligible for WIC supplemental food services will be referred to their respective County WIC Providers.

2. WIC serves pregnant, postpartum, and breastfeeding members, as well as children up to age five and parents/guardians and/or other family members in households with a child under age five.

B. Identification and Referral
1. The primary care provider (PCP) or obstetrician (OB) is responsible for identifying and referring members who are pregnant, breastfeeding or postpartum and children under the age of five who are eligible for WIC supplemental food.
2. During a well-child visit, PCPs will perform a nutritional assessment, as well as hemoglobin or hematocrit laboratory tests following the AAP Bright Futures Periodicity schedule (refer to link: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf for further details), and refer each WIC-eligible member to a county WIC program per Federal WIC requirements for program eligibility.
3. Partnership~~HC~~ will be responsible for the cost of hemoglobin or hematocrit laboratory value and lead test. Lab results will be documented in the member's medical record with the PCP.
4. PCP/OB will refer all eligible Partnership~~HC~~ members to WIC and include the member's hemoglobin or hematocrit lab results.
5. Partnership~~HC~~ refers the members who are pregnant, breastfeeding, or postpartum, or a legal guardian for a member under the age of five, to the WIC program either as part of the initial evaluation of newly pregnant members pursuant to 42 CFR section 431.635(c) and PL 98-010. Referrals occur during various outreach activities. All referrals are documented in member's medical record.

C. Follow-up, Education and Training
1. As part of ongoing provider training, Partnership~~HC~~ will work to ensure that providers understand the WIC program, eligibility requirements, and the referral process.
2. Partnership~~HC~~, through its member handbook, newsletters, and brochures, seeks to promote member understanding of the WIC program, the need for and how to obtain services, and the benefits to be realized by following instructions received.

D. Memorandum of Understanding (MOU) Requirements
1. Per APL 23-029 Attachment G WIC MOU, Partnership~~HC~~ and the respective WIC Providers in the counties Partnership~~HC~~ serves shall execute a MOU outlining respective responsibilities and obligations.
~~1.~~2. Refer to Partnership policy MCCP2036 - Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities for more details.

VII. REFERENCES:

A. Title 42 Code of Federal Regulations (CFR) Section 431.635(c)
B. Title 22 California Code of Regulations (CCR) Sections 50157 and 50184
C. Contract between Department of Health Care Services (DHCS) and Partnership~~HC~~: Contract Exhibit A, Attachment III Section 4.3.19
D. California Department of Public Health WIC Program Overview: https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/AboutWIC.aspx
E. DHCS APL 23-029 - Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (01/08/2025~~10/11/2023~~)
- Attachment G: Women, Infant, & Children Memorandum of Understanding Template

F. DHCS Policy Letter (PL) 98-010: Breastfeeding Promotion (12/10/1998)

VIII. DISTRIBUTION:

Policy/Procedure Number: MCCP2021 (previously MCUP3100)			**Lead Department:** Business Unit: Care Coordination
Policy/Procedure Title: Women, Infants and Children (WIC) Supplemental Food Program			☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/21/2010			**Next Review Date: 03/12/2026~~03/13/2025~~** **Last Review Date: 03/12/2025~~03/13/2024~~**
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

A. Partnership~~HC~~ Department Directors
B. Partnership~~HC~~ Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:
MCCP2021 (02/15/17)
*03/14/18; 03/13/19; 03/11/20; 03/10/21; 03/09/22; 03/08/23; 03/13/24; 03/12/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:
MCUP3100 (04/21/2010 to 02/15/2017)
05/15/13; 05/20/15; 05/18/16 to 02/15/2017

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- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

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<tr><td colspan="3">Policy/Procedure Number: MCUP3064 (previously UP100364)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Communications Services</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 02/16/2005</td><td colspan="4">Next Review Date: ~~04/10/2025~~03/12/2026
Last Review Date: ~~04/10/2024~~03/12/2025</td></tr>
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</table>

I. RELATED POLICIES:

A. MPUD3001 - Utilization Management Program Description
B. MCCP2018 – Advice Nurse Program
C. MCNP9004 – Regulatory Required Notices and Taglines
D. ~~MCND9002~~ MCND9001 – ~~Cultural and Linguistic Program Description~~Population Health Management Strategy & Program Description

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

N/A

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the availability for providers and ~~member~~Members to access information from the Utilization Management (UM) department staff about the UM process and authorization of care.

VI. POLICY / PROCEDURE:

A. Partnership HealthPlan of California ~~(PHC)~~ provides access to UM staff for ~~member~~Members and practitioners seeking information about the UM process and the authorization of care in the following ways:
   1. Calls from ~~member~~Members are triaged through Member Services staff who are accessible to providers and ~~member~~Members to discuss UM issues during normal working hours when the HealthPlan is in operation (Monday – Friday 8 a.m. – 5 p.m.).
   2. After normal business hours, ~~member~~Members and providers may contact the ~~PHC~~Partnership voicemail service to leave a message which is communicated to the appropriate person on the next business day. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
   3. After normal business hours, ~~member~~Members may contact the advice nurse line at (866) 778-8873 for clinical concerns.

4. Practitioners both in-network and out-of-network may contact UM staff directly either through secure email or voicemail. Each voice mailbox is confidential and will accept messages after normal business hours. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
    a. ~~PHC~~Partnership has a dedicated after-hours phone number local (707) 430-4808 or toll free (855) 798-8759 to receive calls from physicians and hospital staff for addressing post-stabilization care and inter-facility transfer needs 24 hours per day, 7 days per week. Calls are returned within 30 minutes of the time the call was received. ~~PHC~~Partnership's Chief Medical Director or physician designee is on call 24 hours per day 7 days per week to authorize medically necessary post-stabilization care services and to respond to hospital inquiries within 30 minutes. ~~PHC~~Partnership clinical staff are available 24 hours per day 7 days per week to coordinate the transfer of a ~~member~~Member whose emergency medical condition is stabilized.
5. ~~PHC~~Partnership UM staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues. For a list of UM Program Staff and Assigned Responsibilities, please refer to policy MPUD3001 Utilization Management Program Description.
6. ~~PHC~~Partnership maintains a toll free number that is available to both ~~member~~Members and providers. The number is (800) 863-4155.

B. Linguistic services to discuss UM issues are provided by ~~PHC~~Partnership to monolingual, non-English speaking or Limited English Proficiency (LEP) Medi-Cal beneficiaries as well as eligible ~~member~~Members with sensory impairment for population groups as determined by contract. These services include the following:
1. No cost linguistic services
2. Qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries
3. Written information and materials (to include notice of action, grievance acknowledgement and resolution letters) are fully translated by qualified translators into threshold languages for ~~PHC~~Partnership ~~member~~Members according to regulatory timeframes, and into other languages or alternative formats as indicated in the ~~member~~Member's record or upon request. Alternative m~~M~~aterial formats include audio, large print and electronically for ~~member~~Members with hearing and/or visual disabilities. Braille versions are available for ~~member~~Members with visual disabilities. Auxiliary aids are also available upon request. Please refer to MCND9002 Cultural and Linguistic Program Description for more information. The organization may continue to provide translated materials in other languages represented by the population at the discretion of ~~PHC~~Partnership, such as when the materials were previously translated or when translation may address Health Equity concerns.
4. Use of California Relay Services for hearing impaired [TTY/TDD: (800) 735- 2929 or 711]

C. Members can view information about ~~PHC~~Partnership's language assistance services and disability services in the Member Handbook which is made available to ~~member~~Members upon enrollment and is always available online at http://www.partnershiphp.org/Members/Medi-Cal/Documents/MCMemberHandbook.pdf
Additionally, ~~PHC~~Partnership provides annual written notice to Members about our language assistance services and disability services (e.g. TTY for hearing impaired) in our Member Newsletter.

D. ~~PHC~~Partnership regularly assesses and documents ~~member~~Member cultural and linguistic needs to determine and evaluate the cultural and linguistic appropriateness of its services. Assessments cover language preferences, reported ethnicity, use of interpreters, traditional health beliefs and beliefs about health and health care utilization (see policy MCND9001 ~~2~~ Population Health Management Strategy & ~~Cultural and Linguistic~~ Program Description).

Policy/Procedure Number: MCUP3064 (previously UP100364)			**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Communications Services			☒ **External Policy** ☐ **Internal Policy**
Original Date: 02/16/2005		**Next Review Date: 04/10/202503/12/2026** **Last Review Date: 04/10/202403/12/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

VII. REFERENCES:

A. Department of Health Care Services (DHCS) Contract
B. DHCS All Plan Letter (APL) 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services (*Revised* ~~04/08/2021~~05/24/2023)
C. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 2024) UM 3 Communication Services Element A Factors 1 - 5

VIII. DISTRIBUTION:

A. ~~PHC~~Partnership Provider Manual
B. ~~PHC~~Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director, Health Services

X. REVISION DATES: 10/17/07; 10/15/08; 11/18/09; 01/18/12; 08/20/14; 01/20/16; 10/19/16; 10/18/17; *11/14/18; 11/13/19; 10/14/20; 10/13/21; 10/12/22; 03/08/23; 04/10/24; 03/12/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by ~~PHC~~Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under ~~PHC~~Partnership.

~~PHC~~Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

Guideline/Procedure Number: MP~~C~~UG3011 (previously MCUG3011, UG100311)			**Lead Department: Health Services** Business Unit: Utilization Management	
Guideline/Procedure Title: Criteria for Home Health Services			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 08/1998		**Next Review Date:** ~~04/10/2025~~03/12/2025 **Last Review Date:** ~~04/10/2024~~03/12/2025		
Applies to:	☒ **Medi-Cal**	☐ **Employees**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~04/10/2024~~03/12/2025	

I. RELATED POLICIES:

A. MCCP2022 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services
B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
C. MCCP2031 – Private Duty Nursing Under EPSDT
D. MPCR700 – Assessment of Organizational Providers
E. MPPRO1102 – Contracted Provider Education
F. MCUP3115 – Community Based Adult Services
G. MCCP2024 – Whole Child Model for California Children's Services (CCS)
H. MCUP3143 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Provider Relations

III. DEFINITIONS:

A. Electronic Visit Verification (EVV): A federally mandated telephone and computer-based application program that electronically verifies in-home service visits for Medicaid-funded personal care services and home health care services for in-home visits by a provider. In California, this is known as CalEVV.

B. Partnership Advantage: Effective January 1, 2026, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

~~B.~~C. Personal Care Services (PCS): Services supporting individuals with their activities of daily living, such as movement, bathing, dressing, toileting, and personal hygiene. PCS can also offer homemaker services support for instrumental activities of daily living, such as meal preparation, money management, shopping, and telephone use.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To provide guidelines for Treatment Authorization Request (TAR) submission for Home Health Services.

VI. GUIDELINE / PROCEDURE:

A. Member Selection Criteria
   1. Members receiving home health services must meet all of the following criteria.
      a. Member must be Partnership HealthPlan of California (PHC) eligible at the time services are rendered.
      b. Member must be homebound.
         1) A memberMember is a homebound recipient if he or she is essentially confined to his or her home due to illness or injury, and if ambulatory or otherwise mobile, is unable to be absent from his or her home except on an infrequent basis or for periods of relatively short duration; for example, for a short walk prescribed as therapeutic exercise.
      c. Member must need skilled nursing services on an intermittent or part-time basis, or physical therapy or speech therapy, or have a continuing need for occupational therapy.
         1) Partnership Medi-Cal Members: To meet the requirement for "intermittent" skilled nursing care, an individual must have a medically predictable recurring need for skilled nursing services. This may be met if the memberMember requires a skilled nursing service at least once every sixty (60) days and when the skilled service is determined to be medically necessary.
         1)2) Partnership Advantage Members: To meet the requirement for "intermittent" skilled nursing care means it is either provided or needed on fewer than 7 days each week or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).
      d. Member must be under the care of a physician or specialist.
         1) This physician may be the memberMember's primary care provider (PCP). The attending physician must order the services, establish the plan of treatment, and certify the necessity for home health care. Home health services may also be ordered by a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA) operating under the supervision of a licensed physician.

B. Home Health Services
   1. The following services may be rendered by the home care agency if medical necessity criteria are met.
      a. Physical, speech, or occupational therapies are subject to benefit limitations and exclusions.
         1) Physical Therapy – Authorized services must relate directly and specifically to an active written treatment regimen established by the physician or non-physician practitioner (PA, CNS, or NP) after any needed consultation with the qualified physical therapist and must be reasonable and necessary to the treatment of the memberMember's illness or injury.
         1)2) Occupational Therapy – Authorized services must be prescribed by a physician or non-physician practitioner (PA, CNS, or NP) and it must be performed by a qualified occupational therapist. Services must be reasonable and necessary for the treatment of the individual's illness or injury and the therapy must be expected to result in a significant practical improvement in the individual's level of functioning within a reasonable period of time.
         2)3) Speech Therapy – Authorized services include assistance to the physician or non-physician practitioner (PA, CNS, or NP) in evaluating memberMembers to determine the type of speech or language disorder and the appropriate corrective therapy.

b. Medical Social Services
   1) Services dealing with social, economic, and emotional factors related to the illness.

~~c.~~a. ~~The services must be performed by or under the direct supervision of a licensed nurse (Registered Nurse [RN], Licensed Practical Nurse [LPN], Licensed Vocational Nurse [LVN]). In some cases, the services of a home health aide may be a covered benefit. In determining which services require the skill of a nurse, the following are considered:~~
   ~~1) The inherent complexity of the services~~
   ~~2)~~1)~~The condition is such that a service which would normally be classified as skilled can be provided safely and effectively only by a nurse~~

~~d.~~c. Home infusion therapy services (codes G0088 and G0089) are reimbursable subject to authorization. Services are for treatment of a disease or condition which is unresponsive to oral medications. The TAR must document the following:
   1) The service is medically necessary
   2) The diagnosis and prescription are written by a physician or licensed professional practitioner
   3) The name of medication/solution, route, frequency, duration, strength, and total units
   4) A trained registered nurse or licensed health professional following the physician's orders provides the service, including documentation of patient status for the duration of treatment

d. Daily skilled services: These should generally should not extend beyond three (3) weeks. The physician should re-evaluate and provide medical documentation for additional services including an estimate on the length of time daily services will be required.
   1) The services must be performed by or under the direct supervision of a licensed nurse (Registered Nurse [RN], Licensed Practical Nurse [LPN], Licensed Vocational Nurse [LVN]).

e. In some cases, the services of a home health aide may be a covered benefit. In determining which services require the skill of a nurse, the following are considered:
   ~~1)~~ The inherent complexity of the services
   1)
   ~~—~~The condition is such that a service which would normally be classified as skilled can be provided safely and effectively only by a nurse
   2)

~~e.~~f. Home nursing services are provided only through certified home health agencies. ~~PHC~~Partnership may authorize home nursing services through credentialed RN/LVN/LPNs who are EPSDT supplemental service providers if, and only if, there is documented non-availability of a home health agency to provide the needed services. See policies MCCP2022 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services and MCCP2031 Private Duty Nursing Under EPSDT.

~~f.~~g. Lab draws via implanted device port in the home setting: ~~—H~~home health agencies may bill for this service under code 36591.

C. Initial TAR Process

1. Home health services are reimbursable as an outpatient benefit when prescribed by a physician, nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA) and provided at the recipient's home in accordance with a written treatment plan reviewed by a physician, NP, CNS, or PA every 60 days.

~~1.~~2. The home health agency must submit a TAR, along with a documented evaluation and written treatment plan to ~~PHC~~Partnership. ~~Items and services must be furnished under a plan of care established and periodically reviewed by a physician which relate specifically to the patient's present condition.~~ The treatment plan must include the following:
   a. Date of onset of the illness

b. Medical diagnosis necessitating the service, with a summary of the clinical history
c. Related medical conditions
d. Functional limitations
e. Prognosis
f. Description of home situation, including assistance available from household members or other care givers, including language or communication problems
g. Therapeutic goals to be achieved by each discipline and anticipated time to achieve goals
h. Types of services to be rendered by each discipline related to the problem with Current Procedural Terminology (CPT) codes
i. Description of plan to instruct household members or other caregivers to provide needed care including plans to overcome barriers

2.3. If the request meets medical criteria, the TAR will be approved. If not, the case will be further reviewed by the Chief Medical Officer or physician designee who will make the determination.

D. If services beyond the initially approved TAR are requiredexceeded, a new TAR must be submitted with home health progress notes.
1. If another evaluation is needed within 6 months, it will be granted only if there is a significant change in the memberMember's condition or family situation which requires a new individual treatment plan.
2. A monthly evaluation is covered only if there is a significant change in the memberMember's medical condition or if the treatment plan is complex and involves a variety of services during the month.

E. In the event of a hospital admission during the time home health services are authorized and being rendered, notification to PHCPartnership must be made. Upon discharge from the acute setting and a return to home health services, a new TAR with current clinical notes must be submitted. A new treatment plan/-form 485 is not necessary.

F. Electronic Visit Verification Requirements (EVV)
1. Effective January 1, 2023, as per APL 22-014, EVV requirements must be implemented for all Medi-Cal Personal Care Services (PCS) and Home Health Care Services (HHCS) that are delivered during in-home visits by a provider, which includes visits that begin in the community and end in the home, or vice versa.
2. All Medi-Cal PCS and HHCS providers must capture and transmit the following six mandatory data components:
   a. The type of service performed
   b. The individual receiving the service
   c. The date of the service
   d. The location of service delivery
   e. The individual providing the service
   f. The time the service begins and ends
3. PCS and HHCS providers should utilize the Department of Health Services (DHCS) EVV System, or CalEVV, which is a telephone and computer-based application program that electronically verifies in-home service visits.
   a. While not recommended, if a provider uses any alternate EVV system, it must comply with all business requirements and technical specifications, including the ability to capture and transmit the required data elements to the state-sponsored EVV Aggregator.
4. All claims for PCS and HHCS services must be submitted with allowable Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes as outlined in the Medi-Cal Provider Manual. https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual
   a. The proper Place of Service Code or Revenue Code must also be indicated on claims and/or

encounters to indicate the rendering of PCS or HHCS in a ~~member~~Member's home. Please refer to the DHCS EVV webpage https://www.dhcs.ca.gov/provgovpart/Pages/EVV.aspx for current EVV Provider Type, Procedure, and Place of Services Codes.

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines: Home Health Agencies *(home hlth)*
~~A.~~B. Welfare and Institutions Code Section 14132(t)
C. Department of Health Services (DHCS) All Plan Letter (APL) 22-014 Electronic Visit Verification Implementation Requirements (07/21/2022)
~~B.~~D. Medicare Benefit Policy Manual 100-02, Chapter 7 Home Health Services

VIII. DISTRIBUTION:

A. ~~PHC~~Partnership Department Directors
B. ~~PHC~~Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 06/21/00; 04/18/01; 01/16/02; 08/20/03; 02/16/05; 10/17/07; 10/15/08; 07/21/10; 02/15/12; 02/20/13; 08/20/14; 01/20/16; 08/17/16; 06/21/17; *08/08/18; 04/10/19; 03/11/20; 03/10/21; 08/11/21; 08/10/22; 01/11/23; 04/12/23; 04/10/24; **MPUG** 03/12/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by ~~PHC~~Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under ~~PHC~~Partnership.

~~PHC~~Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

Guideline/Procedure Number: ~~MCUG3019~~MPUG3019 (previously MCUG3019, UG100319)				**Lead Department: Health Services** Business Unit: Utilization Management	
Guideline/Procedure Title: Hearing Aid Guidelines				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 01/19/1995		**Next Review Date:** ~~03/13/2025~~03/12/2026 **Last Review Date:** ~~03/13/2024~~03/12/2025			
Applies to:	☒ **Medi-Cal**	☐ **Employees**		☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**		☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**		☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**		☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**		☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date:** 03/12/2025~~03/13/2024~~	

I. RELATED POLICIES:

MCUP3041 – Treatment Authorization Request (TAR) Review Process

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. ASHA: American Speech-Language-Hearing Association
B. Medically necessary: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
~~B.~~C. Partnership Advantage: Effective January 1, 2026, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

IV. ATTACHMENTS:

A. Documentation for Authorization of Hearing Aids

V. PURPOSE:

To describe the process by which Partnership HealthPlan of California ~~(PHC)~~ authorizes medically necessary hearing aids for ~~PHC~~Partnership ~~-~~eligible ~~member~~Members.

VI. GUIDELINE / PROCEDURE:

A. General Hearing Aid Guidelines
   1. A Treatment Authorization Request (TAR) is required (see policy MCUP3041 TAR Review Process.)
      a. Routine authorization will be for one hearing aid only.
   2. Hearing aids are a covered benefit of ~~PHC~~Partnership when supplied by a hearing aid dispenser with

a prescription from an otolaryngologist or, for ~~member~~Members age 17 and older, t he ~~member~~Member's primary care provider (PCP) (in consultation with the evaluating otolaryngologist if possible), when no otolaryngologist is available in the community.

a. An audiological evaluation, including a hearing aid evaluation, must be performed by, or under the supervision of, the above provider or by a licensed audiologist.
b. If pure conductive hearing loss or any concerning symptoms or "red flags" (e.g., visible deformity; evidence of fluid, pus, or blood; sudden or fluctuating hearing loss; feeling of canal blockage; pain) are observed during the audiological evaluation, a complete ear, nose, and throat examination by an otolaryngologist or the ~~member~~Member's PCP is required. The patient should be evaluated by a licensed healthcare provider that specializes in ear disease (i.e., otologist, otolaryngologist) prior to proceeding with the hearing aid evaluation.
c. Hearing loss criteria considered during the authorization review process is specified in VI.A.4 and 5. below.

3. Medi-Cal recipients younger than 21 years of age must be referred to California Children's Services (CCS) for determination of eligibility for CCS hearing services. (Reference CCS Numbered Letters noted in sections VII.I. – M. of this policy.) For children younger than 17 years of age, the prescribing physician must be an otolaryngologist.
4. Generally, authorization for hearing aids may be granted only when:
   a. Tests of the better ear, after treatment of any condition contributing to the hearing loss, reveal an average hearing loss level of 25 dB or greater, American National Standards Institute (ANSI), 1969, for 500, 1000, 2000, and 4000 Hertz (Hz) by pure tone air conduction, or
   b. Speech communication is effectively improved or auditory contact is necessary for sound awareness (personal safety) in the environment in which the recipient exists.
   c. Specialized hearing aids for ~~member~~Members with an unusual pattern of hearing loss must be authorized for medical necessity as a CCS-eligible condition for children under age 21 or by the Chief Medical Officer or physician designee for adults. Digital hearing aids may be authorized if the Treatment Authorization Request (TAR) is submitted with a standard code (V5050 or V5060). Aids requested with an unlisted code require approval by the Chief Medical Officer or physician designee.
5. Binaural hearing aids may be authorized under the following conditions:
   a. For Medi-Cal recipients 20 years of age or under, under either of the following conditions:
      1) Tests of each ear reveal a hearing loss level of 25 dB or greater, ANSI, 1969, for 500, 1000, 2000, and 4000 Hz by pure tone air conduction.
      2) The hearing loss is associated with legal blindness
   b. For Medi-Cal recipients 21 years of age or over:
      1) Tests of each ear reveal a hearing loss level of 25 dB or greater, ANSI, 1969, for 500, 1000, 2000, and 4000 Hz by pure tone air conduction and
         a) The hearing loss is associated with legal blindness
         b) There is documentation that binaural aids are medically necessary for the safety of the ~~member~~Member, or
         c) Using standard audiometric procedures and recorded work lists, if word discrimination scores are significantly improved in the binaural condition over the monaural condition in either quiet or noise, then a binaural fitting may be authorized, or
         d) Where the provision of a binaural hearing aid is the basis for employment, recipients with the above hearing loss shall be referred to the California Department of Rehabilitation for evaluation, consultation, and case management (Title 22 Section 51014.)
6. Documentation for hearing aid requests shall be presented to ~~PHC~~Partnership in a format acceptable

per Title 22 CCR Section 51319(e). Providers must submit documentation containing the following information:

a. For the purchase of new hearing aids: Attachment A, a signed prescription from an otolaryngologist or from the ~~member~~Member's PCP submitted with the following:
   1) Appropriately signed and completed ear, nose, and throat examination
   2) Appropriately signed and completed audiological evaluation including a hearing aid evaluation performed by or under the supervision of the above physician or by a licensed audiologist. This examination report must include the results of the following tests:
      a) Pure tone air conduction threshold and bone conduction tests of each ear at 500, 1,000, 2,000, 3,000 and 4,000 Hz with effective masking as indicated.
      b) Speech tests, aided and unaided, shall include the following:
         i. Speech Reception Threshold (SRT) using Spondee words.
         ii. A Word Discrimination Score (WDS) derived from testing at 40 dB above the SRT or at the Most Comfortable Loudness (MCL) using standard discrimination word lists (such as PB or W22) utilizing either recorded or live voice.
         iii. Sound Field Aided and Unaided Speech Scores (SRT or WDS) shall be established.
         iv. For the non-English speaking client, the provider must submit a description of alternative testing and the results of such testing.
         v. The ear to be fitted must be specified.

b. For the replacement of lost, stolen, or irreparably damaged hearing aids, the following is required:
   1) A statement describing the circumstances of the loss, theft, or destruction of the hearing aid, signed by the recipient and the otolaryngologist or the PCP.
   2) A completed audiometric report dated within the last 12 months is required unless the request is for the replacement of a recently purchased hearing aid within the last three months. [

c. For the replacement of a hearing aid that no longer meets the needs of the recipient whose hearing impairment requires amplification or correction not within the capabilities of the recipient's present hearing aid, the provider must submit documentation consistent with that required for the purchase of new hearing aids as detailed above.

d. For hearing aid repairs that exceed the cost of $50.00 per repair service, the provider shall submit all of the following:
   1) Description of the problem requiring repair.
   2) Hearing aid manufacturer's name, unit, model designation, date of purchase, and serial number.
   3) Ear to which the aid is fitted.

8. An authorization for a hearing aid takes into account the needs of individual ~~member~~Member and the characteristics of the local delivery system.
9. ~~PHC~~Partnership may consult an independent otolaryngologist on an as-needed basis to assist with the review of a hearing aid request for a ~~member~~Member.

B. External Hearing Aids
1. Total hearing aid cost is limited to $1510.00 per fiscal year (July 1 through June 30 of the following year) per Member, including sales tax as per Welfare and Institutions Code Section 14131.05. The following are excluded from the $1510 maximum benefit cap:
   a. Pregnancy-related benefits and benefits for the treatment of other conditions that might complicate the pregnancy.
   b. Recipients under the Early and Periodic Screening Diagnosis and Treatment Program.
   c. Recipients who are receiving long-term care in a licensed skilled nursing facility or intermediate

care facility (NF-A and NF-B). Recipients who are receiving long-term care in a licensed intermediate care facility for the developmentally disabled (ICF/DD), including ICF/DD Habilitative and ICF/DD Nursing.

d. Recipients in the Program for All-Inclusive Care for the Elderly (PACE).

e. Replacement of hearing aids that are lost, stolen or irreparably damaged due to circumstance beyond the recipient's control.

2. Prior authorization is required for the trial period of a hearing aid and for hearing aid repairs which exceed a cost of $50.00 per item (an item is defined as all related components of a given device) or service repair. Hearing aid cords, receivers, ear molds, and hearing aid garments do not require prior authorization.
3. Binaural external hearing aids must be authorized and billed using the appropriate Healthcare Common Procedure Coding System (HCPCS) codes (V5120 – V5150) and a quantity of "1" not "2". V5298 quantity 1 = 1 set hearing aids
4. All external hearing aids shall be guaranteed for at least one year exclusive of ear piece, cord and batteries. The guarantee is to cover the repair or replacement of any or all defective parts and labor on a new hearing aid (out-of-guarantee repairs are to have a minimum guarantee of at least six months). A separate charge is payable for postage and handling during the guarantee period.
5. Hearing aid maximum allowances are for new instruments and include up to six post-sale visits for training, adjustments and fitting, a cord, receiver, and other components normally required to use the instrument. An additional allowance is included for one standard package of batteries.
6. Hearing aid replacement may be authorized only if:
   a. The prior hearing aid has been lost, stolen, or irreparably damaged due to circumstances beyond the recipient's control.
   b. The hearing impairment of the recipient requires amplification or correction not within the capabilities of the recipient's present hearing aid. The new aid shall be prescribed and authorized in accordance with the above guidelines described for the purchase of a new hearing aid.
7. Initial hearing aid batteries supplied with the hearing aid are covered by ~~PHC~~Partnership when supplied with a hearing aid that has been prior authorized. Replacement batteries are not covered under ~~PHC~~Partnership except for children under age 21 as noted below.
   a. Under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, per Title 22 CCR Section 51340.1(c)(2), children under the age of 21 years may receive one package of batteries, size 675, 13, 312, or 10A, on a quarterly basis without prior authorization. Batteries in sizes other than those listed, and hearing aid batteries provided at more frequent intervals, may be obtained with prior authorization.

C. Cochlear Implants
1. Cochlear implant candidates must meet all of the following criteria:
   a. Diagnosis of bilateral sensorineural deafness, established by audiologic and medical evaluation
   b. If recipient is a child, age appropriateness, as per current Food and Drug Administration (FDA) recommendations, up to age 20
   c. Post-lingual deafness (if recipient is 21 years or older)
   d. For post-lingual candidates, a score of less than 30 percent on an open-set sentence recognition test (tape-recorded speech comprehension) as well as indications of cognitive ability to use auditory cues.
   e. An accessible cochlear lumen structurally suited to implantation, with no lesions in the auditory nerve and acoustic areas of the central nervous system, as demonstrated by a computerized tomography (CT) scan or other appropriate radiologic evaluation
   f. No infection or other active disease of the middle ear

g. No contraindications to anesthesia/surgery
h. Cognitive ability to use auditory clues
i. Motivation of candidate, and/or commitment of family/care-giver(s), to undergo a program of prosthetic fitting, training and long-term rehabilitation
j. Realistic expectations of candidate, and/or family/caregiver(s), for post-implant educational/vocational rehabilitation, as appropriate
k. Reasonable anticipation by treating providers that cochlear implant will confer awareness of speech at conversational levels

2. Cochlear implant in the contralateral ear (that is, a second implant) is not a Medi-Cal benefit.
3. Batteries and accessories for cochlear implants require a TAR and may be supplied as noted below:
   a. L8615 Headset/headpiece for use with cochlear implant device, replacement. (Frequency Limit: May be supplied up to two times in a rolling 12-month period)
   b. L8616 Microphone for use with cochlear implant device, replacement. (Frequency Limit: May be supplied up to two times in a rolling 12-month period)
   c. L8617 Transmitting coil for use with cochlear implant device, replacement (Frequency Limit: May be supplied up to two times in a rolling 12-month period)
   d. L8618 Transmitter cable for use with cochlear implant or auditory osseointegrated device, replacement. (Frequency Limit: May be supplied up to eight times in a rolling 12-month period)
   e. L8619 Cochlear implant external speech processor and controller, integrated system, replacement. (Frequency Limit: 1 replacement every 5 years is covered)
   f. L8621 Zinc air replacement battery, disposable/single use battery~~, lasts up to 48 hours only.~~ f~~F~~or use with cochlear implant device and auditory osseointegrated sound processors, replacement. (Frequency Limit: Up to 900 batteries may be supplied in a rolling 12-month period)
   g. L8622 Alkaline battery for use with cochlear implant device, any size, replacement, each. (Frequency: Up to 900 batteries may be supplied in a rolling 12-month period)
   h. L8623~~, L8624~~ Lithium ion battery - rechargeable. ~~Lasts approximately 60-90 hours. Not recommended for children under the age of 10.~~ For use with cochlear implant device speech processor, other than ear level, replacement, each. (Frequency: May be supplied up to four times in a rolling 12-month period)
   ~~h.~~i. L8624 Lithium ion battery - rechargeable. For use with cochlear implant or auditory osseointegrated device speech processor, ear level, replacement, each. (Frequency: May be supplied up to four times for each device/side in a rolling 12-month period)
   ~~i.~~j. L8625 External recharging system for battery for use with cochlear implant or auditory osseointegrated device, replacement only, each. Modifiers LT or RT are required when billing this code. (Frequency: May be supplied one time in a rolling 12-month period)
   ~~j.~~k. L8627 Cochlear implant; external speech processor, component, replacement
   ~~k.~~l. L8628 Cochlear implant; external controller component, replacement
   ~~l.~~m. L8629 Transmitting coil and cable, integrated, for use with cochlear implant device, replacement
   ~~m.~~n. L9900 Orthotic and prosthetic supply, accessory, and/or service component of another L Code. Specifically, cochlear implant accessories such as ear hooks, ear bands, harnesses and magnets. (Frequency: May be supplied up to three times in a rolling 12-month period)

D. Bone Anchored Hearing Aids
   1. Bone Anchored Hearing Aids (BAHA) may be covered for individuals with moderate to severe conductive or mixed hearing loss if there is a medical reason involving the external or middle ear

such that air conducted hearing aids and/or contralateral routing of signal (CROS) devices cannot be used.

2. Binaural BAHA may be considered for individuals who have moderate to severe conductive or mixed hearing loss in both ears if bone conduction thresholds are symmetrical and do not exceed 10 dB average difference at 0.5, 1, 2, and 3 kHz. Binaural hearing aid criteria as stated earlier in section VI.A.5 of this policy also applies.

3. BAHA Covered Conditions:
   a. Congenital or surgically induced middle ear malformation of the external or middle ear
   b. Otosclerosis in patients who cannot undergo stapedectomy
   c. Severe chronic otitis externa precluding use of air conducted hearing aids
   d. Chronic otitis media with drainage that precluding use of air conducted hearing aids
   e. Tumors of the external ear canal or tympanic cavity
   f. Other anatomic or medical condition that contraindicates use of an air conduction hearing aid
   g. Unilateral sensorineural hearing loss (single sided deafness) is a covered condition for CCS ~~member~~Members.
4. BAHA Coverage Exclusions:
   a. Children younger than 5 years of age
   b. Bilateral sensorineural hearing loss
   c. Pure tone average bone conduction threshold exceeds 65 dB at 0.5, 1, 2, and 3 kHz.
5. BAHA Replacement:
   a. Component is no longer functional and cannot be repaired.
   b. The replacement is not solely for better technology or improved aesthetics.
   c. It has been at least five years since implantation and the processor is not functional.
   d. The original processor was being used daily until it became non-functional.

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines: Audiological Services (*audio*); Hearing Aids (*hear aid*)
B. Title 22 California Code of Regulations (CCR) Section 51014
C. Title 22 California Code of Regulations (CCR) Section 51319(e)
D. Title 22 California Code of Regulations (CCR) Section 51340.1(b)(2)
E. Welfare and Institutions Code (W&I Code), Section 14131.05
F. Clark, J. G. (1981). Uses and abuses of hearing loss classification. ASHA, 23, 493–500.
G. InterQual® criteria
H. Chandrasekhar, Sujana,S. MD and Kohan, Darius, MD. *Implantable Auditory Devices.* Otolaryngologic Clinics of North America Volume 52, Number 2 April 2019.
I. California Children's Services (CCS) Numbered Letter (NL) 11-0807 Hearing Aid Supplies and Maintenance 08/30/2007
J. CCS NL 07-1011 Hearing Aids 10/17/2011
K. CCS NL 12-0818 Cochlear Implant Updated Candidacy Criteria and Authorization Procedure 08/24/2018
L. CCS NL 01-0616 Cochlear Implant Batteries and Parts 06/28/2016
M. CCS NL 12-1120 Bone Conduction Hearing Devices 11/19/2020
N. U.S. Food and Drug Administration (FDA) recommendations for Cochlear Implants
~~N.~~O. Medicare National Coverage Determinations (NCD) Manual 100-03: Chapter 1, Part 1, Section 50.3 Cochlear Implantation

Guideline/Procedure Number: ~~MCUG3019~~ MPUG3019 (previously MCUG3019, UG100319)			**Lead Department: Health Services** **Business Unit: Utilization Management**
Guideline/Procedure Title: Hearing Aid Guidelines			☒**External Policy** ☐**Internal Policy**
Original Date: 01/19/1995		**Next Review Date:** ~~03/13/2025~~03/12/2026 **Last Review Date:** ~~03/13/2024~~03/12/2025	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

VIII. DISTRIBUTION:

A. ~~PHC~~Partnership Department Directors
B. ~~PHC~~Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 09/07/95; 03/08/00; 11/28/01 vs. 11/21; 10/16/02; 04/21/04; 02/16/05; 08/16/06; 08/20/08; 01/18/12; 08/20/14; 01/20/16; 04/20/16; 08/17/16; 08/16/17; *09/12/18; 03/13/19; 02/12/20; 02/10/21; 03/09/22; 03/08/23; 03/13/24; **MPUG** 03/12/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by ~~PHC~~Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under ~~PHC~~Partnership.

~~PHC~~Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

DOCUMENTATION FOR AUTHORIZATION OF HEARING AIDS

To be filled out by a licensed clinician and submitted with the TAR

1. Name of Patient: _____ Medi-Cal ID#: _____
2. Age_____ Sex: _____ DOB: _____ Examination Date: _____
3. Diagnosis (Otological):_____ Place of Exam: _____
4. Hearing loss: AS _____ AD _____ Onset _____
5. Has the patient ever worn a hearing aid? YES ____ NO _____
   If Yes, Patient has worn a hearing aid for _____ years on the _____ ear.
6. If the request is to replace a current hearing aid, please clarify why a new hearing aid is needed at this time:

   _____

   _____

   _____

   _____
7. The patient has had a complete examination of the ear, nose and throat by me and the patient has the requisite psychological and physical well-being to successfully wear and care for a hearing aid. YES ____ NO ____
8. The audiological evaluation was performed by me _____, or by a licensed audiologist _____under my personal supervision.
9. SIGNATURE: _____ MD/ DO/ NP/ PA

   Name: _____

   Address: _____

   City/State/Zip: _____

PARTNERSHIP HEALTH PLAN OF CALIFORNIA

POLICY/PROCEDURE

Policy/Procedure Number: MPUP3048 (previously MCUP3048)				**Lead Department: Health Services** **Business Unit:** Utilization Management	
Policy/Procedure Title: Dental Services (including Dental Anesthesia)				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 9/20/2000		**Next Review Date:** ~~03/13/2025~~03/12/2026 **Last Review Date:** ~~03/13/2024~~03/12/2025			
Applies to:	☐ **Employees**	☒ **Medi-Cal**		☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**		☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**		☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**		☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**		☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date:** ~~03/13/2024~~03/12/2025	

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCCP2022 – Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Closed loop referral: A closed loop referral means bidirectional information sharing between two or more parties to communicate requests for services and the associated outcomes of the requests. The frequency and format of this information sharing varies by service provider and by the degree of formality that may be required according to local community norms. Depending on the type of service needed, this process may include referral to medical, dental, behavioral, and /or social services or community agencies. While a warm hand off may occasionally be appropriate, a closed loop referral does not imply that a warm hand off is required.

~~A.~~B. Partnership Advantage: Effective January 1, 2026, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

~~B.~~C. Physician-Administered Drug (PAD) or Medical Benefit Medications: A physician-administered drug is an outpatient drug other than a vaccine that is typically administered by a health care provider in a physician's office or other outpatient clinical setting. For example, drugs that are infused or injected are typically physician-administered drugs. The provider bills the appropriate CMS ~~state~~ Medicaid or Medicare program (e.g. fee-for-service, managed care plan, or county operated health system) for the drug using the appropriate national drug code (NDC) and Healthcare Common Procedure Coding System (HCPCS) code.

IV. ATTACHMENTS:

A. N/A

Policy/Procedure Number: MPUP3048 (previously MCUP3048)			**Lead Department: Health Services** **Business Unit:** Utilization Management
Policy/Procedure Title: Dental Services (including Dental Anesthesia)			☒**External Policy** ☐**Internal Policy**
Original Date: 9/20/2000		**Next Review Date: ~~03/13/2025~~03/12/2026** **Last Review Date: ~~03/13/2024~~03/12/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

V. PURPOSE:

To define the coverage under which Partnership HealthPlan of California (~~PHC~~Partnership) authorizes and reimburses for dental anesthesia and dental services for ~~Medi-Cal~~ M~~m~~embers.

VI. POLICY / PROCEDURE:

A. ~~PHC~~Partnership provides benefit coverage for medical services related to dental services including physician-administered medications (defined at Section III. above), laboratory services, pre-admission physical examinations required for dental offices, admission to an ambulatory surgical setting or an inpatient hospital stay for a dental procedure, and facility fees as applicable. (Note: Effective January 1, 2022 with the implementation of Medi-Cal Rx, the Medi-Cal pharmacy benefit is carved-out to Medi-Cal Fee-For-Service as described in All Plan Letter (APL) 22-012 *Revised* and all medications (Rx and OTC) which are provided by a pharmacy must be billed to the State Medi-Cal/~~Magellan~~ DHCS-contracted pharmacy administrator instead of ~~PHC~~Partnership).

B. ~~PHC~~Partnership covers and ensures that dental screenings and oral health assessments are included for all ~~member~~Members.

1. Members are given "closed loop referrals" to appropriate Medi-Cal dental providers as follows:
   a. ~~PHC~~Partnership's Population Health Team includes the encouragement and referral to dental services in their outreach campaigns.
   b. ~~PHC~~Partnership's Population Health Team follows up with the ~~member~~Member to ensure the ~~member~~Member received the dental services as appropriate.

C. Medi-Cal dental providers may contact ~~PHC~~Partnership's Care Coordination department at (800) 809-1350 or by emailing the Care Coordination Help Desk at CCHelpDeskSR@partnershiphp.org (Southern Region), CCHelpDeskNR@partnershiphp.org (Northern Region) or CCHelpDeskEA@partnershiphp.org (Eastern Region) for assistance with referring a ~~member~~Member to other covered services.

D. ~~PHC~~Partnership provides Medically Necessary Federally Required Adult Dental Services (FRADS), fluoride varnish, and dental services that may be performed by a medical professional.

E. ~~PHC~~Partnership provides benefit coverage for the topical application of fluoride for children younger than age six (6), up to three (3) times in a 12-month period. Refer to policy MCCP2022 Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services for more information regarding dental services for ~~member~~Members less than 21 years of age.

F. ~~PHC~~Partnership is responsible for services related to dental procedures that require IV moderate sedation or deep sedation/ general anesthesia and are provided by individuals other than dental personnel, including laboratory services, physical examinations required for admission to a medical facility, outpatient surgical center services and inpatient hospital services required for a dental procedure.

G. Dental anesthesia services require prior authorization from ~~PHC~~Partnership (except as noted in VI.G.2 below). Treatment Authorization Requests (TARs) must be submitted to ~~PHC~~Partnership electronically through ~~PHC~~Partnership's online services system or in writing via facsimile at (707) 863-4118.

1. TARs will be reviewed according to the criteria provided in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 23-028 Attachment A "Policy for Intravenous Moderate Sedation and Deep Sedation/ General Anesthesia).
   a. Actual decisions for determining medical necessity for dental anesthesia in individual cases take into account the needs for individual patients and the characteristics of the local delivery system.

2. A TAR is not required prior to delivering intravenous (IV) moderate sedation or deep sedation/ general anesthesia as part of an outpatient dental procedure in a state certified skilled nursing facility (SNF) or any category of intermediate care facility (ICF) for the developmentally disabled per APL 23-028 Attachment A "Policy for Intravenous Moderate Sedation and Deep Sedation/ General Anesthesia.
3. During an inpatient stay, authorization for general anesthesia provided by a physician anesthesiologist or a certified registered nurse anesthetist (CRNA) to a ~~PHC~~Partnership Member must be part of the authorization for the inpatient admission. This does not preclude any subsequent inpatient stay necessary due to an outpatient procedure. In addition, an inpatient stay is not required for the provision of services in an accredited ambulatory surgical center (stand-alone facility).
4. For assistance with the TAR process, providers may contact ~~PHC~~Partnership Utilization Management at (800) 863-4144. For TAR inquiries, ~~member~~Members may contact ~~PHC~~Partnership Member Services at (800) 863-4155.

H. Providers are required to adhere to all regulatory requirements (Federal, State, Licensing Board, etc) for:
1. Preoperative and perioperative care
2. Monitoring and equipment requirements
3. Emergencies and transfers
4. Monitoring guidelines

I. Criteria:
1. As per state law and Medi-Cal program policy (Partnership Medi-Cal Members) as well as~~,~~ Federal regulations and Medicare program policy (Partnership Advantage Members), ~~PHC~~Partnership covers medically necessary IV moderate sedation and deep sedation/general anesthesia for dental procedures for Members who meet specific criteria.
2. Members may receive treatment for a dental procedure provided under IV moderate sedation or deep sedation/ general anesthesia by a physician anesthesiologist or CRNA in the settings listed below only if ~~PHC~~Partnership determines the setting is appropriate and meets criteria:
   a. Hospital
   b. Accredited ambulatory surgical center (stand-alone facility)
   c. Dental Office; and
   d. A Community Clinic that:
      1) Accepts Medi-Cal dental program
      2) Is a non-profit organization; and
      3) Is recognized by DHCS as a licensed community clinic or a Federally Qualified Health Center (FQHC) or FQHC look-alike.
3. If sedation is indicated, then the least profound procedure should be attempted first. The procedures are ranked from low to high profundity in the following order:
   a. Conscious Sedation via inhalation or oral anesthetics
   b. Intravenous (IV) moderate sedation
   c. Deep sedation/ General Anesthesia
4. If the provider documents both a. and b. below, then the ~~member~~Member shall be considered for IV moderate sedation or deep sedation/ general anesthesia:
   a. Failure of Behavioral Modification AND
   b. Failure of conscious sedation, either inhalation or oral
5. If the provider documents any one of the following, then the ~~member~~Member shall be considered for IV moderate sedation or deep sedation/ general anesthesia:
   a. Failure of effective communication techniques and the inability for immobilization (~~member~~Member may be dangerous to self or staff)
   b. Patient requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or conscious sedation.

c. Patient has acute situational anxiety due to immature cognitive functioning
d. Patient is uncooperative due to certain physical or mental compromising outcomes.

6. Appropriate review of treatment authorization requests for conducting dental procedures under IV moderate sedation or deep sedation/ general anesthesia requires the ~~member~~Member's medical history, physical status, and indications for anesthetic management. Documentation of a recent (preferably no more than six [6] months prior to procedure) pre-operative exam completed by the ~~member~~Member's primary care physician should be submitted with the TAR. The PCP's pre-operative exam should evaluate for medical conditions, medical history, family history or medications that increase anesthesia risk. The assessment should include a statement that the patient is "cleared for general anesthesia," or an equivalent statement.
7. Members with certain medical conditions, such as but not limited to: moderate to severe asthma, reactive airway disease, congestive heart failure, cardiac arrhythmias, and significant bleeding disorders should be treated in a hospital setting or licensed facility capable of responding to a serious medical crisis.
8. The anesthesiologist performing anesthesia or sedation will be responsible for conducting a pre-operative history and focused physical to assess any interaction risk and plan accordingly per the American Society of Anesthesiologists' "Basic Standards for Preanesthesia Care." December 13, 2020 available on this website: https://www.asahq.org/standards-and-practice-parameters/basic-standards-for-preanesthesia-care
9. ~~PHC~~Partnership recommends medical and dental procedures follow the recommendations of the American Academy of Pediatrics – Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures (see VII. A. References).

VII. REFERENCES:

A. Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures: Update 2016. American Academy of Pediatrics, American Academy of Pediatric Dentistry, Charles J. Coté, MD, FAAP, Stephen Wilson, DMD, MA, PhD. *Pediatrics*. 2016; 138(1):e20161212. http://pediatrics.aappublications.org/content/138/1/e20161212
B. Title 10 California Code of Regulations (CCR) Chapter 5.8 Article 3 Sections 2699.6700-6707, 6709-6711
C. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-028 Dental Services-Intravenous Moderate Sedation and Deep Sedation/ General Anesthesia Coverage (10/03/2023) and
   1. Attachment A "Policy for Intravenous Moderate Sedation and Deep Sedation/ General Anesthesia
   2. Attachment B "Intravenous Moderate Sedation and Deep Sedation/General Anesthesia: Prior Authorization/Treatment Authorization Request and Reimbursement Scenarios
D. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006 Delegation and Subcontractor Network Certification (03/28/2023)
E. American Society of Anesthesiologists (ASA) "Basic Standards for Preanesthesia Care." December 13, 2020. https://www.asahq.org/standards-and-practice-parameters/basic-standards-for-preanesthesia-care
F. 42 Code of Federal Regulations (CFR) §411.15(a)

VIII. DISTRIBUTION:

A. ~~PHC~~Partnership Provider Manual
B. ~~PHC~~Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

Policy/Procedure Number: MPUP3048 (previously MCUP3048)			**Lead Department: Health Services** **Business Unit:** Utilization Management
Policy/Procedure Title: Dental Services (including Dental Anesthesia)			☒**External Policy** ☐**Internal Policy**
Original Date: 9/20/2000		**Next Review Date: ~~03/13/2025~~03/12/2026** **Last Review Date: ~~03/13/2024~~03/12/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

X. REVISION DATES:

Medi-Cal and Partnership Advantage (effective January 1, 2026)
03/12/2025

Medi-Cal
10/17/01; 08/20/03; 10/20/04; 10/19/05; 10/18/06; 02/20/08; 04/21/10; 08/18/10; 10/20/10; 03/21/12; 06/19/13; 08/19/15; 04/20/16; 04/19/17; *06/13/18; 05/08/19; 06/10/20; 01/13/21; 11/10/21; 11/09/22; 11/08/23; 03/13/24

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:
Healthy Kids – KKUM103, MPUP3048 (Healthy Kids program ended 12/01/2016)
02/20/08, 04/21/10; 08/18/10; 10/20/10; 03/21/12; 06/19/13; 08/19/15; 04/20/16 to 12/01/2016

Partnership*Advantage*:
MPUP3048 - 02/20/2008 to 01/01/2015

Healthy Families:
MPUP3048 - 10/20/2010 to 03/01/2013

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by ~~PHC~~Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under ~~PHC~~Partnership.

~~PHC~~Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

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Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the Feb. 19, 2025 Quality/Utilization Advisory Committee (Q/UAC) meeting. Please look over the changes to each and note any questions or comments you may have to help keep a progressive meeting agenda.

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
Policy Owner: Quality Improvement – *Rachel Newman, RN, Manager, Clinical Compliance Inspection Team*			
MCQP1022 – Site Review Requirements and Guidelines	151 - 496 ***NEW*** *Attachment I begins on p. 467*	**Formerly MPQP1022, the alphanumeric is changing to "MC" as this policy only applies to Medi-Cal. Other agencies are responsible for Medicare site review.** Likewise, the alphanumeric also changes for Attachments A-L. A Supplemental Facility/Mobile Unit/Street Medicine Facility Site Review Tool is added as a NEW Attachment I. (Former attachments I, J, and K now become J, K, and L, respectively.) The Department of Health Care Services (DHCS) delegated the making of this new tool to all the Managed Care Plans (MCPs). This is what the MCPs submitted to DHCS, and we await their response. Some of the provisions herein may not apply to the street medicine component. "PHC" changed to "Partnership" throughout the document.	Provider Relations Health Services Compliance Grievance & Appeals
Policy Owner: Quality Improvement – *Mark Netherda, MD, Medical Director for Quality*			
MPQG1005 – Adult Preventive Health Guidelines	497 - 512	**Formerly MCQG1005, the alphanumeric is changing to "MP" as this policy will apply in part to Partnership Advantage, effective Jan. 1, 2026 in eight Partnership counties. Accordingly, both the footnote disclaimer and the Medicare link https://www.medicare.gov/coverage/preventive-screening-services are added to this policy.** This policy has a few minor changes pursuant to All Plan Letter (APL) 24-008, Immunization Requirements, which DHCS adopted last fall, subsequently causing updates to the Pediatric Preventive Guidelines and Initial Health Assessment policies that this committee saw in November 2024. **Related Policies additions:** MCUP3052 – Medical Nutrition Services and MCCP2026 – Diabetes Prevention Services **Purpose Statement:** Reference to Preventive Care for Medicare recipients is added. **VI.C. Medicare Preventive Care is added**: **1.** All recommendations described in Attachment A apply to Medicare recipients, provided age and other individual specific criteria are met. **2.** All adult vaccinations recommended by the current CDC's Advisory Committee on Immunization Practices apply. **3.** The following services are available to both Medicare and Medi-Cal recipients: a. Medical Nutrition Services (MNT) as outlined in Partnership policy MCUP3052 –	Health Services Claims Provider Relations

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
		Medical Nutrition Services. b. Diabetes Prevention Services (DPP) as outlined in Partnership policy MCCP2026 – Diabetes Prevention Services. 4. Medicare-specific preventive care visits as outlined on the Medicare website at http://www.medicare.gov/coverage/preventive-screening-services including, but not limited to **a.** A "Welcome to Medicare" visit **b.** An annual "adult wellness visit" (AWV) **c.** A cardiovascular behavioral therapy visit (performed by the PCP) **d.** An obesity behavioral therapy visit (performed by the PCP). **References are added:** K. Medicare Preventive & Screening Services – https://www.medicare.gov/coverage/preventive-screening-services L. California Assembly Bill 2132 Health Care Services: Tuberculosis (Sept. 29, 2024) https://leginfo.legislature.ca.gov/ **Attachment A is updated** in some sections, including: • Assessment for Hearing Impairment • *Screening for* Depression and Suicide *Risks in Adults and Perinatal Depression* • Tobacco Use and Tobacco Caused Disease Counseling, *including for Pregnant Persons* • Breast Cancer Screening by Mammography The USPSTF (April 2024) recommends biennial mammography for persons with breasts and assigned female at birth ages 40 to 74 years (Grade B). For Transgender and Gender Diverse persons, consider "… the length of time of hormone use, dosing, current age, and the age at which hormones were initiated." Shared decision making is recommended. • *Vitamin D, Calcium or Combined Supplementation for the Primary Prevention of Fractures in* Postmenopausal Persons Assigned as Female at Birth	
MPQP1016 – Potential Quality Issue Investigation and Resolution	513 - 523	**This policy is being brought early to coincide with the annual PQI report and to make some language changes. References to "severity level" have been changed to "severity rating." Some timeframes have been clarified. The Partnership Advantage footnote disclaimer has been added.** Timeframes amended throughout document to clarify "days" as "calendar days." **III.D. Corrective Action Plan is now redefined:** A directive from the Peer Review Committee specifying required actions/ activities to be undertaken by a provider of concern. CAPs are given to educate the provider/facility on the identified issue/concern, with the goals of helping to prevent identified issues from recurring and improving member safety. CAPs contain clearly stated goals and timeframes for completion.	Health Services Provider Relations Grievance & Appeals

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
		VI.C.1.a. addition: The Investigator will begin an investigation within 30 days of receiving the PQI case referral. **VI.C.3.d.ii:** The timeframe for clinicians to acknowledge receipt and initiation of a CAP is 30 calendar days. If the CAP is not acknowledged and initiated by day 31, the Investigator will contact the POC. A 15-day extension may be granted for reasonable concerns. If the POC has not acknowledged and initiated the CAP by day 46, the Investigator will forward the case to the CMO/physician designee for further determination, including possible review by the Credentials Committee. **VI.C.3.d.iv.f):** "Coaching/counseling from the POC's Medical Director" is added to the list of what a CAP may stipulate. **VI.E.1. Track and Trend Report is modified to note:** In addition, providers and/or facilities who were given a severity rating of P2 or S2 and above at PRC will be monitored for at least the following year via the track and trend reports to determine if the identified concern is ongoing. If through this process, any additional concerns are identified, further investigation or actions may be implemented. **VI.E.4. is added:** A monthly report of the number of PQI referrals, open cases, and cases pending PRC presentation will be sent to the CMO and to the Medical Director of Quality.	
Policy Owner: Utilization Management – *Presenter: Shahrukh Chishty, Senior Manager of Foster Care Programs*			
MCUP3103 Coordination of Care for *Child Welfare-Involved* Members ~~in Foster Care~~	525 - 529	This policy was updated and approved by DHCS for APL 24-013 "Managed Care Plan Child Welfare Liaison." • The name of the policy was updated to reflect the new "Child Welfare-Involved" language. • Policy template changes were also made to specify Behavioral Health as the Business Unit responsible for this policy. **Section I:** Two Related Policies were added as follows: • MCCP2032 - CalAIM Enhanced Care Management (ECM) • MPQD1001- Quality and Performance Improvement Program Description **Section III.** New Definitions were added for • Assembly Bill 2083 • Child Welfare-Involved Youth • Enhanced Care Management (ECM) Provider:' • ECM Lead Care Manager • Resource Family **Section VI.** Language updates were made throughout the main policy section to use the phrase "child welfare-involved youth" in lieu of previous language, "children in foster care."	Health Services Claims Member Services

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
		Section VI.C. A new policy section was added to define the roles and responsibilities of Child Welfare Liaisons at Partnership. **Section VII. References:** Two new References were added for F. DHCS APL 24-013 G. California Foster Youth Bill of Rights	
Policy Owner: Care Coordination – *Presenter: Shannon Boyle, RN, Manager of Care Coordination Regulatory Performance*			
MPCD2013 Care Coordination Program Description	519 - 540	**Policy is due for Annual Review** **Department Objectives & Goals (Page 3):** **Updated** foster care to Members involved in child welfare and foster care per APL 24-013 **Updated** referral source to include internal departments such as PHM, EHS, and Behavioral Health **Updated footnote (Page 6):** MCUP3143 updated to reflect new policy number MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) MCUP3142 updated to reflect new policy number MCAP7003 CalAIM Community Supports (CS) **Enhanced Care Management (ECM) Benefit (Page 12):** MCUP3143 updated to reflect new policy number MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) **Team Roles and Responsibilities (Page 12) Added:** Senior Director of Care Management- RN Associate Director of Clinical Integration Manager of Clinical Integration Supervisor of Case Management-LVN Care Coordination Business Analyst Clinical Advisor- RN Policy Analyst Senior Program Manager Program Manager I Program Manager II Customer Service Representative, CC **Updated JD Title:** Case Management Supervisor-RN to Supervisor of Case Management-RN	Health Services

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
		Updated JD for Behavioral Health Clinical Specialist-LCSW or LMFT to include: Collaborates and coordinates care as part of the multidisciplinary team to evaluate and advocate for the medical, behavioral and psychosocial needs of the member while promoting quality and cost-effective outcomes **Protected Health Information (Page 17) Updated:** The Partnership Director of Regulatory Affairs and Program Development also serves as the Partnership Privacy Officer	

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCP~~P~~QP1022 (previously QP100122)</td><td colspan="3">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Site Review Requirements and Guidelines</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 10/30/2002
(vs. 10/16/2002)</td><td colspan="4">Next Review Date: ~~03/13/2025~~03/11/2026
Last Review Date: ~~03/13/2024~~03/12/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="3">☐ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="3">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~03/13/2024~~03/12/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCQP1052 - Physical Accessibility Review Survey – SR Part C
B. MPQP1016 - Potential Quality Issue Investigation and Resolution
C. MCUP3101 - Screening and Treatment for Substance Use Disorders
D. MCQP1021 - Initial Health Appointment
E. MPCR601 - Fair Hearing and Appeal Process for Adverse Decisions
F. MPPR208 - Provider Notification of Provider Termination, Site Closure or Change in Location Information
G. MCQG1015 - Pediatric Preventive Health Guidelines
H. MCQG1005 - Adult Preventive Health Guidelines
I. CMP36 - Delegation Oversight and Monitoring
J. MCUG3118 - Prenatal & Perinatal Care
K. MPCR12 - Credentialing of Independent and Private Duty Nurses Under EPSDT
L. MPCR300 – Provider Credentialing and Re-credentialing Requirements

II. IMPACTED DEPTS:

A. Provider Relations
B. Health Services
C. Compliance
D. Grievance and Appeals

III. DEFINITIONS:

Primary Care Practice Site: a facility that provides services such as family medicine, internal medicine, pediatrics, and/or obstetrics and gynecology.

IV. ATTACHMENTS:

A. Facility Site Review Tool
B. Facility Site Review Standards
C. Medical Record Review Tool
D. Medical Record Review Standards
E. Cognitive Assessment Addendum to Site Review
F. Non-Accredited Facility Site Review Tool
G. Non-Accredited Facility Review Standards
H. Private Duty Nursing Site Review Tool and Standards
I. Supplemental Facility/Mobile Unit/Street Medicine Facility Site Review Tool

Policy/Procedure Number: MPQP1022 (previously QP100122)			Lead Department: Business Unit: Quality Improvement
Policy/Procedure Title: Site Review Requirements and Guidelines			☒ External Policy ☐ Internal Policy
Original Date: 10/30/2002 (vs. 10/16/2002)		Next Review Date: ~~03/13/2025~~03/11/2026 Last Review Date: ~~03/13/2024~~03/12/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

~~I.~~J. Master Trainer Application
~~J.~~K. Interim Review Template
~~K.~~L. Provider Certificate

V. PURPOSE:

A. To provide primary care practice sites a comprehensive guideline for Site Review (SR) requirements and processes. A Site Review (SR) is comprised of a Facility Site Review (FSR) and a Medical Record Review (MRR). The FSR and MRR tools were developed by a collaborative coalition made up of staff from Department of Health Care Services (DHCS) and Medi-Cal Managed Care health plans (MCP). The purpose of the SR is to ensure that practicing sites have sufficient capacity to:
   1. Provide appropriate services;
   2. Carry out processes that support continuity and coordination of care;
   3. Maintain patient safety standards and practices;
   4. Operate in compliance with applicable federal, state, and local laws and regulations.

B. Findings of the SR are used to:
   1. Provide information for credentialing/re-credentialing decisions;
   2. Identify areas where education and technical assistance is needed;
   3. Identify and share best practices in patient safety, medical error prevention, and provision of quality care.

VI. POLICY / PROCEDURE:

A. Requirements
   1. Site Review Personnel
      The Partnership HealthPlan of California (Partnership~~PHC~~) Chief Medical Officer (CMO) is ultimately responsible for SR activities completed by Partnership~~PHC~~ personnel. Partnership~~PHC~~ has designated a minimum of one Registered Nurse (RN) to be certified as a Master Trainer by the Department of Health Care Services (DHCS).
      a. Site Review Training and Certification
         1) ~~The PHC~~Partnership's Certified Master Trainer (CMT) is responsible for training, supervising and certifying Site Reviewers in addition to monitoring reviews and evaluating Certified Site Reviewers (CSR) for accuracy.
         2) Site Review activities comply with the Site Reviewers' scope of practice as defined by state law, in accordance with the state licensing and certification agencies and are appropriate to the Site Reviewers' level of education and training.
         3) Licensed physicians (MDs or DOs), nurse practitioners (NPs), physician assistants (PAs), clinical nurse midwifes (CNM), licensed midwife (LM), and registered nurses (RNs), are eligible to be a Site Reviewer and may perform a SR independently and sign off on the FSR and MRR tools.
         4) Site Reviewers can independently make determinations regarding implementation of appropriate reporting or referral of abnormal review findings for further review.
         5) DHCS will recertify the Master Trainer(s) every three years.
         6) ~~PHC's~~ Partnership's CMT will recertify CSRs every three years. Upon certification and recertification, Site Reviewers will receive written verification of certification from ~~PHC~~Partnership.
         7) MDs, DOs, NPs, PAs, CNM, LM, and/or RNs that are designated to be a CMT or CSR must meet the certification and recertification requirements outlined in the table below.

Policy/Procedure Number: MPQP1022 (previously QP100122)			**Lead Department:** Business Unit**: Quality Improvement**
Policy/Procedure Title: Site Review Requirements and Guidelines			☒ **External Policy** ☐ **Internal Policy**
Original Date: 10/30/2002 (vs. 10/16/2002)		**Next Review Date:** ~~03/13/2025~~03/11/2026 **Last Review Date:** ~~03/13/2024~~03/12/2025	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

Initial Certification Requirements	**Certified Master Trainer (CMT)**	**Certified Site Reviewer (CSR)**
Possess a current registered nurse (RN), Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), NP, ~~or~~ PA, CNM or LM license	x	x
Be employed or subcontracted with ~~PHC~~Partnership	x	x
Have experience in conducting training in a health related field, or conducting quality improvement activities, such as medical audits, Site Reviews, or utilization management activities within the last three years.	x	
Complete 20 FSRs and 20 MRRs and one year experience as a CSR. Achieve an inter-rater score within 5% of FSR and 5% of MRR from the DHCS Nurse Evaluator.	x	
Attend didactic Site Review training or completion of DHCS Site Review training modules on the current Site Review tools under supervision of a CMT.		x
Complete 10 FSRs and 10 MRRs with a CSR or CMT.		x
Achieve an Inter-rater score of 10% in FSR and 10% in MRR with designated CMT.		x

Recertification Requirements	**Certified Master Trainer**	**Certified Site Reviewer**
Possess a current registered nurse (RN), Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), NP, ~~or~~ PA, CNM or LM license	x	x
Be employed or subcontracted with ~~PHC~~Partnership	x	x
Be responsible for staff training on the most current DHCS Site Review tools and standards	x	
Participate in DHCS sponsored Site Review trainings as well as Site Review Work Group (SRWG) meetings and teleconferences.	x	
Maintain CMT certification.	x	
Complete a minimum of 30 Site Reviews following initial certification or recertification. (every 3 years)	x	x
Attend DHCS sponsored inter-rater workshops in person or virtually every three years.	x	x
Achieve a 5 % variance on the MRR, on the inter-rater score as defined by the SRWG and DHCS	x	
Achieve a 10 % variance on the MRR, on the inter-rater score as defined by the SRWG and DHCS		x

b. Inter-Rater Review (IRR) Process
   1) CMT and CSR candidates must complete an inter-rater review (IRR) as part of the initial certification and the recertification process.
      a) The IRR process requires the CMT candidate to concurrently complete and score a Site Review with a DHCS Nurse Evaluator utilizing the DHCS FSR and MRR tools and standards.

b) The IRR process requires the CSR to concurrently complete and score a Site Review with the ~~PHC~~ Partnership CMT according to the DHCS FSR and MRR tools and standards.

2) If the CMT or CSR does not meet the appropriate inter-rater score variance (see chart above), he or she may repeat the process one time. The appropriate inter-rater and candidate with the failing inter-rater score will jointly assess training needs and implement a training plan prior to conducting the second inter-rater review.

a) CMT and CSR candidates that do not meet the appropriate inter-rater variance score for the second inter-rater review must wait 6 months to reapply for certification.

2. Full-Scope Site Review

A full-scope SR consists of a CSR or CMT conducting both the FSR and the MRR using the most current tools and standards required by the DHCS. (See Attachments A-D.) All ~~PHC~~ Partnership contracted sites who serve ~~PHC~~ Partnership members must receive a minimum passing score of 80% on both tools to be considered as having passed the Site Review. All PCP sites are held to the same standards and the site review status of each PCP site is documented and monitored.

a. FSR is a review of the practice's site, processes, and covers the following areas:
   1) Access/Safety
   2) Personnel
   3) Office Management
   4) Clinical Services
   5) Preventive Services
   6) Infection Control

b. MRR areas include:
   1) Format (All sites)
   2) Documentation (All Sites)
   3) Continuity/Coordination (All sites)
   4) Pediatric Preventive (Family Practice & Pediatric sites, and OB/GYN sites if applicable)
   5) Adult Preventive (Family Practice, Adult Medicine sites, and OB/GYN sites)
   6) OB/CPSP Preventive (PCP sites that provide OB services and OB/GYN sites)

3. Additional ~~PHC~~ Partnership developed reviews conducted by CSR/CMT's include:

a. Non-Accredited Sites is a review (refer to Attachments F-G) of the practice's site, processes, and covers the following areas:
   1) Access/Safety
   2) Personnel
   3) Office Management/Medical Records
   4) Clinical Services
   5) Preventive Services
   6) Infection Control
   7) Quality Assurance Performance Improvement

b. Private Duty Nursing (PDN) Site Reviews (refer to Attachment H) are conducted to oversee the quality of care provided by RNs or Licensed Vocational Nurses (LVNs) for in-home medical services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Supplemental Services (SS) Program and Private Duty patient care under DHCS All Plan Letter (APL) 20-012.
   1) A PDN Site Review covers the following areas:
      a) Access/Safety
      b) Personnel
      c) Office Management
      d) Clinical Services

e) Infection Control

2) The Private Duty Nurse must receive a score greater than 80% on the combined FSR and MRR tool prior to credentialing and up to every three years for re-credentialing.
3) For an Independent Nurse Provider (INP), the site audit will be in the member's home.
4) Corrective Acton Plans (CAPs) will be completed using a standard format and form. CAPs will be due within 30 days of the site review and will be verified via document submission.

3. Initial Site Review (SR) Process
   a. An initial SR consists of an initial FSR and an initial MRR.
   b. The FSR is conducted first to ensure the site operates in compliance with all applicable local, state, and federal laws and regulations. Members are not assigned to providers until the site has received a passing score and all CAP items are completed and signed off. An initial FSR is not required when a new provider joins a site that has a current passing FSR score.
   c. DHCS releases sets of DHCS Site Identification (DHCS Site ID) numbers per county and ~~PHC~~ Partnership issues individual ID'S to each site based on the county identification ID'S provided by DHCS. In the event of an ownership change, a new DHCS Site ID will be assigned.
      1) Pre-contracted providers who do not pass the initial FSR within two attempts may reapply to ~~PHC~~ Partnership after six months.
   d. An initial MRR must be completed within 90 days of the date that members were first assigned to the site.
      1) This may be deferred an additional 90 calendar days only if the new PCP does not have enough assigned members to complete the MRR on the required minimum number of records. (See section 4.a.1)d)i.)
      2) If after 180 days following assignment of members and the site still has fewer than the required number of medical records, a MRR on the total number of records available will be completed. Scoring on the MRR tool will be adjusted according to the number of medical records reviewed.
      3) MRR's may be conducted virtually or on-site. The virtual process must comply with all applicable Health Insurance Portability Accountability Act (HIPAA) standards at all times.
   e. An Initial Site Review is required when:
      1) A new site is added to the ~~PHC~~ Partnership network;
      2) A newly contracted provider assumes a site with a previous failing FSR and/or MRR score within the last three years;
      3) A site is returning to the ~~PHC~~ Partnership network and has not had a passing FSR within the last three years;
      4) Identification of multiple independent practices that occupy the same site;
      5) There is a change of name or ownership of an existing provider site;
      6) A site relocation requires that ~~PHC~~ Partnership must:
         a) Complete an initial FSR within 60 days of notification or discovery of the completed move;
         b) Allow existing members to continue to see the provider;
         c) New members will not be assigned to the site until the site receives a passing FSR and MRR score.
   f. If ~~PHC~~ Partnership expands to a new service area, the FSR portion of the initial Site Review must be completed prior to the start of new or expanding operations. Requirements are outlined as following:
      1) Five percent of the PCP sites in the new network service area, or 30 sites, whichever is greater in number;
      2) All of the remaining PCP sites in the new network service area within the first six months of expansion;

3) All of the PCP sites in the new network service area if there are 30 or fewer PCP sites;
4) ~~PHC~~ Partnership may use site reviews of existing county MCP's as evidence of completion of the initial site reviews;
5) ~~PHC~~ Partnership must submit data and relevant information to DHCS in the format and timeframe to be specified by DHCS for expansion.

4. Supplemental Facilities-Mobile, Satellite, School Based, and Other Extension Clinics
   a. Supplemental facilities that provide primary care services will undergo an initial Site Review and a subsequent site review at least every three years thereafter, with a focus on areas relevant to the services being provided by the supplemental facilities.
5. Subsequent Site Reviews
   a. Subsequent SRs consist of a FSR and MRR at least every three years, beginning no later than three years after the initial FSR. Site Reviews may be conducted more frequently per county collaborative discussions, when determined necessary based on monitoring or evaluation, or for CAP follow up issues.

VII. Scoring

A. FSR and MRR scores are based on available documented evidence, demonstration of the criteria, and verbal interviews with site personnel. If a site reviewer chooses to review additional criteria not included on the FSR or MRR tools, the site reviewer must not include the additional criteria in the existing scoring method. Scores are based on established scoring procedures, located in the FSR and MRR tools. Sites will receive a separate score for the FSR and/ or MRR.

1. FSR Scoring
   a. The FSR is composed of critical and non-critical elements. Critical Elements (CE) are indicated on the tool by bold and underlined text. CEs have the largest potential for adverse effects on patient health and safety and therefore, have a scored weight of two points, while non-critical elements have a scored weight of one point.
   b. The Site Reviewer will advise the practice site of any deficiencies in critical elements during the SR.
   c. The FSR tool points will differ from site to site because the "not applicable" items do not factor into the scoring where noted. All standards where review determinations result in a "N/A" (non-applicable) or "No" shall include an explanation regarding this finding
2. MRR Scoring
   a. All MRR tool elements have a score weight of one point each
   b. The MRR score is based on a standard review of randomly selected member medical records that represents the assigned member population.
      1) For sites that only serve pediatric or adult patients, all records must be reviewed using the appropriate preventative care criteria for adults, pediatrics (pregnant under 21 years) and/or obstetrics.
      2) Pediatric preventative services are provided to members under 21 years of age in accordance with current AAP bright futures recommendations.
      3) Adults age 21 years and older, preventative services are provided in accordance with USPSTF A and B recommendations.
      4) OB/GYN acting as a PCP must provide care in accordance with American College of Obstetricians and Gynecologists (ACOG) and Comprehensive Prenatal Standards Program (CPSP).
         a) All medical records must be reviewed using the preventative care criteria for adults or pediatrics (pregnant members under the age of 21 years) and obstetrics.
         b) During the MRR review, reviewers have the option to request additional medical records for review. If the Site Reviewer chooses to review additional medical records, the scores must be calculated accordingly.

c) If the site has multiple providers using the same medical record, this is considered a shared medical record system. In a shared medical record system, medical records are not identifiable as separate records belonging to any specific provider.
   i. The minimum number of records to be reviewed in a "shared" medical record relationship is determined by the number of providers at the site, unless otherwise approved by DHCS. See chart below

# Practitioners	# Medical Records to be reviewed
1-3	10
4-6	20
7 or more	30

d) In the event that there are multiple providers in one office that do not share medical records, each provider must be reviewed separately and receive a separate score.
e) MRR's may be conducted on-site or virtually and must comply with all HIPAA standards.
f) The MRR total points will differ from site to site, depending on the number of physicians and types of records that are selected. The "N/A" items do not factor into the scoring where noted. All standards where review determinations result in a "N/A" shall include an explanation regarding this finding. Compliance level categories include: Exempted Pass, Conditional Pass, and Fail. See correlating table.

3. Failing score
   a. If a site fails the FSR or MRR, new members will not be assigned to the site until a CAP is initiated, completed, and closed.
   b. If the site receives two consecutive failing Site Review scores (FSR or MRR), then on the third attempt the site must receive a minimum passing score on the FSR and/or MRR to remain in the ~~PHC~~ Partnership provider network.
   c. If the site fails on the third consecutive attempt, the site will be removed from the ~~PHC~~ Partnership provider network and its members will be reassigned. Members will receive a 30-day notice.
4. Focused Review
   a. A focused review is a targeted review of one or more specific areas of the FSR or MRR. ~~PHC~~ Partnership must not substitute a focused review for a SR. Focused reviews may be used to monitor providers between SRs to investigate problems identified through monitoring activities or to follow up on corrective actions.
   b. Site Reviewers may utilize the appropriate sections of the FSR and MRR tools for the focused review, or other methods to investigate identified deficiencies or situations.
   c. All deficiencies identified in a focused review must require the completion and verification of corrective actions according to CAP timelines.

Compliance Category	FSR Score	MRR Score
Exempted Pass	90% or above *with NO* deficiencies in Critical Elements, Pharmaceutical Services, or Infection Control **CAP not required**	90% or above with all section scores at 80% and above **CAP not required**
Conditional Pass	90% or above with deficiencies in Critical Elements/Pharmaceutical Services or Infection Control **OR** Score of 80-89% regardless of deficiencies **CAP required**	90% and above with one or more section scores below 80% **OR** Score of 80-89% regardless of deficiencies. **CAP required**
Fail	79% and below **CAP required**	79% and below **CAP required**

5. Corrective Action Plan (CAP) Requirements and Timelines
   a) CAP Documentation:
      1) CAPs will be completed using a standard format and form. CAPs may be verified via document submission, virtual platform, or an on-site review per nurse reviewer discretion.
      2) The minimum elements to be included on CAP:
         a) Specific deficiency,
         b) Corrective actions needed,
         c) CAP due dates,
         d) Instructions for CAP submission,
         e) ~~PHC~~ Partnership Contact information
   b. Closed CAP documentation shall include:
      1) Documentation of problems in completing corrective actions (if any),
      2) Education and/or technical assistance provided by ~~PHC~~Partnership,
      3) Evidence of the correction,
      4) Completion and closure date, and
      5) Name and title of Site Reviewer.
      6) Timeline for CAP notification and completion:

Policy/Procedure Number: MPQP1022 (previously QP100122)			**Lead Department:** Business Unit**: Quality Improvement**
Policy/Procedure Title: Site Review Requirements and Guidelines			☒ **External Policy** ☐ **Internal Policy**
Original Date: 10/30/2002 (vs. 10/16/2002)		**Next Review Date:** ~~03/13/2025~~03/11/2026 **Last Review Date:** ~~03/13/2024~~03/12/2025	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

CAP Timeline	CAP Action(s)
FSR and/or MRR Survey Day	~~PHC~~ Partnership will provide the site the following: • Verbal notification of any CE findings and a signed attestation by the PCP/site designee and the MCP staff confirming that a discussion regarding CE findings occurred. (This serves as the start of the CE-CAP timeline.) • A formal written request for CAPs to address all CEs, if applicable, the day of the site visit but no later than one business day after site visit completion • The FSR and/or MRR scores the day of the site visit but no later than one business day after the site visit completion;
Within 10 Business days of the FSR and/or MRR	• PCP site must submit CAP and evidence of corrections to ~~PHC~~ Partnership for all deficient CE's if applicable. • ~~PHC~~ Partnership will review, approve, or request additional information on the submitted CAP(s) for all Non-CE • ~~PHC~~ Partnership will provide a report to the PCP site containing FSR and/or MRR findings, along with a formal written request for CAPs for all Non-CE deficiencies. (This serves as the start of the Non-CE CAP timeline) • ~~PHC~~ Partnership will provide educational support and technical assistance to sites as needed.
Within 30 calendar days of the FSR and/or MRR	~~PHC~~ Partnership will verify all aspects of the CE CAPs are completed unless an extension was granted (not to exceed 60 calendar days from the date of the FSR). • PCP site must submit a CAP for all Non-CE deficiencies to ~~PHC~~Partnership. • ~~PHC~~ Partnership will provide educational support and technical assistance to sites as needed.
Within 60 calendar days from the date of the FSR and/or MRR	• ~~PHC~~ Partnership will review, approve, or request additional information on the submitted CAP for non-critical findings. • ~~PHC~~ Partnership will provide educational support and technical assistance to sites as needed.
Within 90 calendar days from the date of the FSR and/or MRR	• All CAPs must be closed. • The Site can request a definitive time specific extension period to complete the CAP not to exceed 120 calendar days from the date of the initial report of FSR and/or MRR findings.

Beyond 120 days from the date of the FSR and/or MRR	• ~~PHC~~ Partnership will request approval from DHCS to complete a CAP review for extenuating circumstances that prevented completion of a CAP within the established timeline. • ~~PHC~~ Partnership will stop assigning members to sites that do not correct Site Review deficiencies within the established CAP timelines. • Any provider that does not come into compliance with review criteria and CAP compliance within the established timelines will be removed from the network and their members will be reassigned. Members will receive a 30-day notice. • ~~PHC~~ Partnership will conduct a FSR and MRR within 12 months if provider completes CAP and remains in the network.
~~PHC~~ Partnership may require a CAP regardless of score for other findings identified during the survey that require correction. See APL 22-017 page 11.	

6. Provider Certificates
   a. Upon the completion of a passing SR score (FSR and MRR) and completed CAP, ~~PHC~~ Partnership will issue a provider site certificate using the most up to date DHCS template. The certificate will contain the signature of both the Chief Medical Officer (CMO) and CMT.
   b. The provider site certification will be valid for a maximum of three years.
7. Non-Compliance with Corrective Action Process
   a. Providers who fail to correct deficiencies within established CAP timelines, fail to ask for an extension, or request an extension but do not turn in any CAP documentation within 90 days of the Site Review will be sent a "Notice of Overdue Corrective Action Plan" to be drafted by the CSR or CMT and signed by the CMO or Medical Director informing the site that if the CAP is not received within 30 days the site will be closed to new ~~PHC~~ Partnership members.
   b. If the site does not complete the CAP within 30 days of the first notice, then a 2nd "Notice of Review" will be drafted by the CSR or CMT and signed by the CMO or Medical Director. Further escalation, such as referring to the Credentialing team. will be directed by CMO or Medical Director.
      1) Actions taken by the Credentialing team may include, but are not limited to:
         a) Reassignment of existing members
         b) Termination of the site from the provider network

      Actions taken will be effective until corrections are verified and the CAP is closed. If ~~PHC~~ Partnership chooses to remove the site from the network, members will be reassigned and given a 30-day notice.

      DHCS requires health plans to remove a provider from the network regardless of survey scores if criteria is not met or deficiencies are not resolved within established CAP timeline. Refer to MPPR208 - Provider Notification of Provider Termination, Site Closure, or Change in Location (Related Policy F) for the specific procedures.
8. Provider Appeals

   Refer to MPCR601 - Fair Hearing and Appeal Process for Adverse Decisions (Related Policy E). If evidence of correction of deficiencies is submitted and the decision to terminate the provider from the network is reversed, ~~PHC~~ Partnership will repeat a full-scope SR. If the decision is not reversed, and the provider is terminated from the network, the practice may reapply to become a network provider and ~~PHC~~ Partnership will complete an initial full-scope SR.
9. Systematic Monitoring Between SRs
   a. Monitoring between regularly scheduled SRs will include, but is not limited to, data gathered through the following sources:

1) Member grievances and appeals (reviewed when identified);
2) Potential Quality Issue (PQI) information (reviewed when identified);
3) Focused review or other on-site visit ;
4) Healthcare Effectiveness Data and Information Set (HEDIS®) data collection (annually);
5) Interim Review Template – see Attachment J.

b. Problems identified through these mechanisms will require at a minimum:
1) Informing the Provider of concern, and
2) Issuing a CAP when a problem is verified. (Follow the above CAP process.)

c. Interim Review Process
1) ~~PHC~~ Partnership will request a self-assessment of DHCS standards by provider site staff at the midpoint between SRs. This assessment will include all critical element criteria and previously identified deficiencies noted during the last SR.
a) The Reviewer may require an onsite Interim Review in lieu of a self-assessment based on the provider site's previous SR scores or lack of response to self-assessment.
2) Upon receipt of the provider's self-assessment, a reviewerwill review the assessment and determine approval status. Any identified areas of concerns will be clarified and a new CAP will be issued if required. Additional follow up activities may include an additional site visit, referral to the CMO and Provider Relations' Credentialing team.

10. As part of its monitoring and oversight of MCPs, DHCS conducts Site Reviews on randomly chosen PCP sites. ~~PHC~~ Partnership collaborates with DHCS on these reviews by notifying selected sites of the upcoming review and processing any corrective action plans that result from the DHCS reviewer findings.
11. Physical Accessibility Review Survey (PARS)
During the Initial Site Review and subsequent Periodic SR, a PARS review will be performed in accordance with MMCD Policy Letter 12-006. (Reference B.) This will be reviewed every three years at all sites within the ~~PHC~~ Partnership Medi-Cal network. Refer to (Related Policy A) MCQP1052 - Physical Accessibility Review Survey – SR Part C.
12. In the case that the below listed contracted providers are not accredited and have not had State or Centers for Medicare and Medicaid Services (CMS) reviews conducted, ~~PHC~~ Partnership will conduct periodic SRs at a minimum of every three years. The Site Review tool specific to these provider types is Attachment G.
a. Hospitals
b. Home Health Agencies
c. Skilled Nursing Facilities
d. Free Standing Surgical Centers
e. Ambulatory Behavioral Health Facilities
f. Free Standing Urgent Care Center
g. Free Standing Radiology Center
h. Community Based Adult Services (CBAS)
i. Dialysis Centers

B. Delegation of Site Review functions
1. Organizations or groups who have one or more DHCS Certified Site Reviewer may be determined eligible, at ~~PHC~~ Partnership discretion, to perform SR functions. Eligible organization or groups will perform these functions under a formal delegation agreement.
2. A formal delegation agreement is inclusive of a detailed grid outlining key functions and responsibilities of both ~~PHC~~ Partnership and the delegated entity.
3. Delegated entities will perform SR functions for all PCP sites no less than every three years.
4. Results from oversight and monitoring activities shall be presented to the Delegation Oversight Review Sub-Committee (DORS) for review and approval.

5. Delegated organizations and/or groups will provide timely copies of all SRs conducted at the site level, within ~~PHC's~~ Partnership's service area, no less than semi-annually.
6. ~~PHC's~~ Partnership's Quality Improvement (QI) department will track all SRs conducted by the delegated entities.
7. For organizations and groups that are more than one year past due for a SR at the site level or otherwise missing a SR, the QI department will refer them to ~~PHC's~~ Partnership's DORS, which is managed by ~~PHC's~~ Partnership's compliance unit within the Administration department, for action.
8. In addition to providing ~~PHC~~ Partnership copies of all SRs conducted at the site level, ~~PHC~~ Partnership will ensure the delegated entity will provide timely copies and results of Site Reviews to DHCS according to DHCS standards. DHCS has processes in place for overseeing and auditing the quality of SR functions.
9. As part of the oversight process, ~~PHC~~ Partnership may perform one or more repeat SRs on sites that have had the SR performed by a delegated entity.

C. Potential Quality of Care Issues
Potential Quality of Care Issues identified during the course of a Site Review will be processed in accordance with MPQP1016 – Potential Quality Issue Investigation and Resolution. The Site Reviewer will complete a Potential Quality Issue (PQI) Referral via the PQI Referral Intake System for follow up, and review.

D. Data Submission to DHCS
SR data will be submitted by ~~PHC~~ Partnership to DHCS every six months (July 31 for the period January-June and January 31 for the period July-December) in an approved format uploaded to a designated DHCS secure site. ~~PHC~~ Partnership is permitted to submit data more frequently than every six months. For preoperational and expansion site reviews, ~~PHC~~ Partnership must submit site review data to DHCS at least six weeks prior to site operation. ~~PHC~~ Partnership will include data for SRs conducted by delegated entities in these submissions. ~~PHC~~ Partnership will submit the required PHI (collected via the MRR process) in the bi-annual data submission to DHCS as required.

E. Local Collaboration
In an effort to streamline the regulatory process and reduce redundant SR reviews, ~~PHC~~ Partnership may collaborate with other health plans having contracts with mutual providers. ~~PHC~~ Partnership may accept the SR score assigned by other health plans if the DHCS tools are used and the SR is completed by appropriate certified staff. A site with a non-passing score by a collaborating health plan, that has received SR certification as addressed in of this policy, shall be considered to have a non-passing score by ~~PHC~~Partnership. ~~PHC~~ Partnership may choose to repeat the FSR/MRR of a site that had passed a FSR/MRR by another health plan's reviewers.

VIII. REFERENCES:

A. California Department of Health Care Services (DHCS) All Plan Letter (APL) 24-001 Street Medicine Provider: Definitions and Participation on Managed Care (Jan. 12, 2024 supersedes APL 22-023)
B. DHCS APL 22-017 Primary Care Provider Site Review: Facility Site Review and Medical Record Review (Sept. 22, 2022 supersedes APL 20-006)
C. DHCS APL 20-016 Blood Lead Screening of Young Children (revised Nov. 2, 2020 supersedes APL 18-017)
D. DHCS APL 20-012 Private Duty Nursing Case Management Responsibilities For Medi-Cal Eligible Members Under The Age Of 21 (May 15, 2020)
E. DHCS Policy Letter 12-006 (Aug. 9, 2012 supersedes PL 11-013)
F. 3 CCR §504; 24 CCR (CA Building Standards Code); 28 CFR §35 (American Disabilities Act of 1990, Title II, Title III)

Policy/Procedure Number: MPQP1022 (previously QP100122)			**Lead Department:** Business Unit**: Quality Improvement**
Policy/Procedure Title: Site Review Requirements and Guidelines			☒ **External Policy** ☐ **Internal Policy**
Original Date: 10/30/2002 (vs. 10/16/2002)		**Next Review Date:** ~~03/13/2025~~03/11/2026 **Last Review Date:** ~~03/13/2024~~03/12/2025	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

IX. DISTRIBUTION:

A. ~~PHC~~ Partnership Provider Manual
B. ~~PHC~~ Partnership Department Directors

X. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer (CMO)

XI. REVISION DATES:

Medi-Cal
8/20/03; 10/20/04; 3/15/06; 3/21/07, 3/19/08; 3/18/09; 6/17/09; 9/15/10; 3/16/11; 2/20/13; 5/15/13; 5/21/14; 11/19/14; 11/18/15; 10/19/16; 3/15/17, 10/18/17; *10/10/18; 11/13/19; 04/08/20; 06/10/20; 08/12/20; 01/13/21; 02/10/21; 03/09/22; 08/10/22; 01/11/23; 03/08/23; 03/13/24; 03/12/25

*Through 2017, Approval Date reflective of the Quality Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

Healthy Kids (Healthy Kids program ended 12/01/2016)
MPQP1022 – 2/20/13, 5/15/13; 5/21/14; 11/19/14; 11/18/15; 10/19/16 to 12/01/16
HKQP1032 – 4/18/2007 to 2/20/2013

Partnership Advantage
3/21/2007 to 11/19/2014

Healthy Families
10/01/2010 to 3/01/2013

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

January 1, 2024

Primary Care Provider- Site Review Tool

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

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

Site Name: _____ **Provider Address:** _____

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

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

Contact person/title: _____

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

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

Site Scores

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

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

Scoring Procedure

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

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

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

Compliance Rate

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

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

_____ **Fail: 79% and Below**

_____ CAP Required

_____ Other follow-up

Next Site Review Due: _____

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

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

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

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

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

I. Access/Safety Criteria, continued	Yes	No	N/A	Wt.	Site Score
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week. 8 CCR §3220; 22 CCR §51056, §53216, §75031; 28 CCR §1300.67, §1300.80; American Academy of Family Practice (AAFP)					
1) Personnel are trained in procedures/action plan to be carried out in case of medical emergency on site.	1)	1)	1)	1	
2) Emergency equipment is stored together in easily accessible location and is ready to be used.	2)	2)	2)	1	
3) Emergency phone number contacts are posted, updated annually, and as changes occur.	3)	3)	3)	1	
Emergency medical equipment appropriate to practice/patient population is available on site:					
4) **Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag.**	**4)**	**4)**	**4)**	**2**	
5) Emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia. Epinephrine 1mg/ml (injectable) and Diphenhydramine (Benadryl) 25 mg (oral) or Diphenhydramine (Benadryl) 50 mg/ml (injectable), Naloxone, chewable Aspirin 81 mg, Nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), and glucose (any type of glucose containing at least 15 grams). Appropriate sizes of ESIP needles/syringes and alcohol wipes.	**5)**	**5)**	**5)**	**2**	
6) Medication dosage chart for all medications included with emergency equipment (or other method for determining dosage) is kept with emergency medications.	6)	6)	6)	1	
There is a process in place on site to:					
7) Document checking of emergency medication, equipment and supplies for expiration and operating status at least monthly.	7)	7)	7)	1	
8) Replace/re-stock emergency medication, equipment and supplies immediately after use.	8)	8)	8)	1	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VI. Infection Control Criteria	Yes	No	N/A	Wt.	Site Score
A. Infection control procedures for Standard/Universal precautions are followed. 8 CCR §5193; 22 CCR §53230; 29 CFR §1910.1030; Federal Register 1989, §54:23042					
1) Soap or antiseptic hand cleaner and running water are available in exam and/or treatment areas for hand washing.	1)	1)	1)	1	
2) A waste disposal container is available in exam rooms, procedure/treatment rooms, and restrooms.	2)	2)	2)	1	
3) Site has procedure for effectively isolating infectious patients with potential communicable conditions.	3)	3)	3)	1	
B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. 8 CCR §5193 (Cal OSHA Health Care Worker Needlestick Prevention Act, 1999); HSC, §117600-118360 (CA Medical Waste Management Act, 1997, updated January 2017); 29 CFR §1910.1030; 49 CCR §173.6; 49 CFR, Section 173.6; CDC Core Infection Prevention and Control Practices -Centers for Disease Control and Prevention (CDC) The Healthcare Infection Control Advisory Committee (HICPAC), 2016; 2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare settings.					
1) **Personal Protective Equipment (PPE) for Standard Precautions is readily available for staff use.**	**1)**	**1)**	**1)**	**2**	
2) Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport or shipping.	**2)**	**2)**	**2)**	**2**	
3) **Needlestick safety precautions are practiced on site.**	**3)**	**3)**	**3)**	**2**	
4) All sharp injury incidents are documented.	4)	4)	4)	1	
5) Biohazardous (non-sharp) wastes are contained separate from other trash/waste.	5)	5)	5)	1	
6) Storage areas for regulated medical wastes are maintained secure and inaccessible to unauthorized persons.	6)	6)	6)	1	
7) Contaminated laundry is laundered at the workplace or by a commercial laundry service.	7)	7)	7)	1	
8) Transportation of regulated medical wastes is only by a registered hazardous waste hauler or to a central location of accumulation in limited quantities (up to 35.2 pounds).	8)	8)	8)	1	

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

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

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

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

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

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

Primary Care Provider- Site Review Standards

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

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

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

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

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

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

Scoring Example:

Step 1: Add the points given in each section.

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

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

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

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

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

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

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

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

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

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

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

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

[6] 29 CFR section 1910.38

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

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

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

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

Criteria	I. Access/Safety Standards

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

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

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

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

Oropharyngeal airways are no longer required.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Criteria	II. Personnel Standards
	• Per Business and Professions Code Section 2069 (a) (1), a supervising physician and surgeon at a "community clinic" licensed under Health and Safety Code section 1204(a) may, at their discretion, in consultation with the nurse practitioner, nurse midwife, or physician assistant provide written instructions to be followed by a medical assistant in the performance of tasks or supportive services. • The written instructions may provide that the supervisory function for the medical assistant in performing these tasks or supportive services may be delegated to the nurse practitioner, nurse midwife, or physician assistant and that those tasks may be performed when the supervising physician and surgeon is not on site. **II.C.1) Documentation of education/training for non-licensed medical personnel is maintained on site.** • Training may be administered under a licensed physician; or under an RN, LVN, NP, PA, or other qualified medical assistant acting under the direction of a licensed physician. The supervising physician is responsible for determining the training content and ascertaining proficiency of the MA. Training documentation maintained on site for the MA must include the following: • Diploma or certification from an accredited training program/school, or • Letter/statement from the current supervising physician that certifies in writing: date, location, content, and duration of training, demonstrated proficiency to perform current assigned scope of work, and signature. • For facilities that have pediatric patients (under 21 years old) obtain evidence of completed training (valid for 4 years) in: ○ Audiometric screening ○ Vision screening ○ Anthropometric measurements, including obtaining Body Mass Index (BMI) percentile ○ Dental screening and fluoride varnish application • **C.2) (CE) Only qualified/trained personnel retrieve, prepare or administer medications.** Medication administration by an MA means the direct application of pre-measured medication orally, sublingually, topically, vaginally or rectally; or by providing a single dose to a patient for immediate self-administration by inhalation or by simple injection. • **All medications including vaccines must be verified with (shown to) a licensed person prior to administration.**

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

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

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

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

Criteria	II. Personnel Standards
	d) Failure to maintain a Practice Agreement is a violation of the PA Regulations and is grounds for disciplinary action by the Medical Board of California against a physician assistant's licensure. • Supervising Physician's Responsibility for Supervision of PAs' Practice Agreement: Defines supervision responsibilities and methods required by Title 16, section 1399.545 of the Physician Assistant Regulations, and is signed by the physician. The following procedures must be identified: ○ Emergency transport of patients and back-up procedures (e.g., can call 911, name of hospital to transport patient included in Practice Agreement) for when the supervising physician is not on the premises. **Note:** • A Delegation of Services Agreement (DSA) in effect prior to January 1, 2020, shall be updated to meet the current requirements.[19] • DSAs that still reflect components that are no longer required by BPC section 3502.3 should be enforced since the DSA is the currently established agreement between the PA and the supervising physician. • The reviewer should assess the site's process for compliance with the DSA. • Any deficiency shall result in a CAP requesting the site to adhere to the DSA components or establish a new Practice Agreement. **II.D.3) Standardized Procedures, Practice Agreements, and Supervisory Guidelines are revised, updated, and signed by the supervising physician and NPMP when changes in scope of services occur.** • Standardized Procedures, Practice Agreements shall undergo periodic review, with signed, dated revisions completed at each change in scope of work by supervising physician. • Frequency of the review to identify changes in scope of service shall be specified in writing. **II.D.4) Each NPMP that prescribes controlled substances has a valid DEA Registration Number.** **DEA:**

[19] BPC 3502.3

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

E. Non-physician medical practitioners (NPMP) are supervised according to established standards.  **RN/NP/CNM/LM/MD/PA**	**The designated supervising physician(s) on site:**
	
	II.E.1) Ratio to number of NPMPs does not exceed established ratios in any combination.
	NPMPs:
	• The supervising physician holds ultimate responsibility for the practice of each supervised NPMP.
	• The maximum number of NPMPs who may be supervised by a single primary care physician (PCP) is limited to the following at any given time/shift in any of their locations:[20]
	  ○ 4 NPs with furnishing license (there is no limit to the number of NPs the physician may supervise if the NP does not hold a furnishing license);
	  ○ 4 CNMs; and
	  ○ 4 PAs.
	
	This ratio is based on each physician, not the number of offices. A PCP, an organized outpatient clinic, or a hospital outpatient department cannot utilize more NPMPs than can be supervised within these stated limits.
	
	Physician Assistant Board (PAB) is at https://www.pab.ca.gov/ or the PAB office at 916-561-8780.
	
	II.E.2) The designated supervising or back-up physician is available in person or by electronic communication at all times when a NPMP is caring for patients.
	Supervising Physician:
	• "Supervision" means that a licensed physician and surgeon oversee the activities of, and accept responsibility for, the medical services rendered by a PA.
	• Supervising or back-up physician is available in person or by electronic communication at all times when a NPMP is caring for patients.

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

Criteria	II. Personnel Standards
	II.E.3) Evidence of NPMP supervision. **<u>Evidence of NPMP Supervision:</u>** • Standardized Procedures for NP or CNM should identify the furnishing of drugs or devices, extent of physician or surgeon supervision, method of periodic review of competence, including peer review, and review of provisions in the Standardized Procedures.[21] • Standardized Procedures shall undergo periodic review, with signed, dated revisions completed at each change in scope of work. • Evidence of supervision of NPMP(s) are verifiable through on-site observation of supervisory processes, documentation, or supervisor/NPMP's knowledge of the process.
F. Site personnel receive safety training. **RN/NP/CNM/LM/MD/PA**	**II.F. There is evidence that site staff has received training on the following:** **1) Infection Control/Universal Precautions (annually)** **2) Bloodborne Pathogens Exposure Prevention (annually)** **3) Biohazardous Waste Handling (annually)** Training occurs ***prior to*** initial exposure to potentially infectious and/or biohazardous materials. Review and re-training sessions occur ***<u>at least annually</u>***. Training content is appropriate (language, educational level, etc.) to personnel on site. Training *minimally* includes the following: ○ Universal/standard precautions ○ Use of personal protective equipment ○ Accessible copy of Bloodborne Pathogens Standard ○ Work practice controls/exposure prevention ○ Modes of transmitting bloodborne pathogens ○ Epidemiology/symptoms of HBV and HIV ○ Recognition of activities with exposure element ○ Handling and labeling of biohazardous waste(s) ○ Hepatitis B vaccination protocol and requirements ○ Explanation of emergency procedures ○ Post exposure reporting/evaluation/follow-up procedures ○ Decontamination of equipment/work areas ○ Site's written bloodborne pathogen exposure plan ○ Opportunity for discussion/questions

[21] BPC 2834

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

[22] 8 CCR 5193

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

Criteria	II. Personnel Standards
	Abuse Reporting: Site personnel have specific knowledge of local reporting requirements, agencies, and procedures, and know *where to locat*e information on site and *how to use* information. **Note:** • Health practitioners (e.g., physicians, surgeons, licensed nurses, licensed social workers, paramedics) in a health facility, (e.g., clinic, physician's office, public health clinic) are legally mandated reporters of known or reasonably suspected cases of child abuse, elder abuse and domestic violence. • Legally mandated reporters must make telephone and written reports according to timeliness standards established by the designated local law enforcement agencies in each county. "Reasonably suspected" means having objectively reasonable suspicion based upon facts that could cause a reasonable person in a like position, drawing when appropriate on his or her training and experience, to suspect abuse (CA Penal Code 11164). • Failure to report by legally mandated reporters can result in criminal or civil prosecutions, punishable by monetary fines and/or county jail confinement. Any person entering employment, which makes him/her a mandated reporter, must sign a statement, provided and retained by the employer, that the employee has knowledge of the Child Abuse reporting law and will comply with its provision.[23] **II.G.6) Sensitive Services/Minors' Rights** • Site personnel have received information and/or training on sensitive services/minors' rights. Sensitive Services include family planning, pregnancy, sexually transmitted infections, etc. • PCP sites must have basic information on sensitive services that are appropriate to their practice office and be prepared to provide information to patients when needed. • Minor's Rights: California Family Code provides that a minor may, without parental consent, receive a number of sensitive services including outpatient mental health treatment and counseling for children 12 years and older. **II.G.7) Health Plan Referral Process/Procedures/Resources**

[23] Penal Code section 11166.5

Criteria	II. Personnel Standards
	• Site personnel have received information and/or training on health plan referral process/procedures/resources. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written health plan referral process/procedures/resources information on site and explain how to use information. **II.G.8) Cultural and Linguistic Training** • Site personnel have received information and/or training on cultural and linguistic appropriate services. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written cultural and linguistic information on site and explain how to use information. Cultural and Linguistic Training- Culturally and Linguistically Appropriate Services (CLAS) mandates are Federal requirements for all recipients of Federal funds.[24] **II.G.9) Disability Rights and Provider Obligations** • Site personnel have received information and/or training on patient rights and provider obligations under the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and/or Section 1557 of the Affordable Care Act • Training content should include information about physical access, reasonable accommodations, policy modifications, and effective communication in healthcare settings. **https://www.hhs.gov/sites/default/files/ocr/civilrights/resources/factsheets/504.pdf** **https://www.hhs.gov/sites/default/files/section-1557-final-rule-faqs.pdf** **https://www.hhs.gov/sites/default/files/1557-fs-lep-508.pdf**

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

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

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

[26] 16 CCR 1366(b)

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

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

Criteria	III. Office Management Standards
	III.E.2 (CE) Physician Review and follow-up of referral/consultation reports and diagnostic test results. • There is a documented process of the practitioner review of diagnostic tests/consultations and subsequent outreach to follow-up with the patient to communicate results and provide next steps. • Practitioner review is evidenced by date and signature/initials on the report of the reviewing practitioner.
F. Member grievance/ complaint processes are established on site.	**III.F.1) Phone number(s) for filing grievances/complaints are located on site.** • At least one telephone number for filing grievances is posted on site or is readily available upon request. **III.F.2) Complaint forms and a copy of the grievance procedure are available on site.** • Complaint forms and a copy of the grievance procedure are readily available on site and can be provided to members promptly upon request. • Includes The Department of Managed Health Care Help Center 1-888-466-2219 and Ombudsman 1-888-452-8609. **Note:** A "grievance" is defined as any written or oral expression of dissatisfaction and shall include any complaint, dispute, and request for reconsideration or appeal made by an enrollee or their representative to a Plan or entity with delegated authority to resolve grievances on behalf of the Plan.
G. Medical records are available for the practitioner at each scheduled patient encounter.	**III.G.1) Medical records are readily retrievable for scheduled patient encounters.** • The process/system established on site provides for the availability of medical records (paper and electronic), including outpatient, inpatient, referral services, and significant telephone consultations for patient encounters.

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

[27] 22 CCR 75055

Criteria	III. Office Management Standards
	• Security protection includes an off-site backup storage system, an image mechanism with the ability to copy documents, a mechanism to ensure that recorded input is unalterable, and file recovery procedures. • Confidentiality protection may also include use of encryption, detailed user access controls, transaction logs, and blinded files. **III.H. 3) Medical record release procedures are compliant with State and federal guidelines.** **<u>Record Release</u>:** • Medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released. • The release terms, such as to whom records are released and for what purposes, and the expiration date of the consent to medical record release should also be described. • This does not prevent release of statistical or summary data, or exchange of individual identifiable medical information between individuals or institutions providing care, fiscal intermediaries, research entities and State or local official agencies.[28] **III.H.4) Storage and transmittal of medical records preserves confidentiality and security.** **<u>Storage and transmittal:</u>** • Health care services rendered under the Medi-Cal program or any other health care program administered by the department or its agents or contractors, shall confidentially and securely keep and maintain records of each service rendered under the Medi-Cal program or any other health care program administered by the department or its agents or contractors, the beneficiary or person to whom rendered, the date the service was rendered, and any additional information as the department may by regulation require. • FAX cover sheet shall have confidentiality statement. **III.H.5) Medical records are retained for a minimum of 10 years.** **<u>Record Retention:</u>** • Records required to be kept and maintained under this section (including minors under 18 years old) shall be retained by the provider for a period of 10 years from the final date of the contract

[28] 45 CFR 164.524

Criteria	III. Office Management Standards
	period between the plan and the provider, from the date of completion of any audit, or from the date the service was rendered, whichever is later, in accordance with 42 CFR 438.3(u).[29]

[29] WIC 14124.1

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

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

Criteria	IV. Clinical Services - Pharmaceutical Standards
	this area by unauthorized persons and authorized clinic personnel remain in the immediate area at all times. At all other times, all drugs (including sample and over the counter), medication supplies, prescription pads and hazardous substances must be securely locked. **IV.A.3) Controlled drugs are stored in a locked space accessible only to authorized personnel.** **<u>Controlled substances</u>**: • Controlled substances are stored separately from other drugs in a securely locked, substantially constructed cabinet accessible only to authorized personnel.[35] **IV.A.4) A dose-by-dose controlled substance distribution log is maintained.** • Written records are maintained of controlled substances inventory list(s) that includes: 1) Provider's DEA number 2) Name of medication 3) Original quantity of drug 4) Dose 5) Date 6) Name of patient receiving drug 7) Name of authorized person dispensing drug and 8) Number of remaining doses • Control substances include all Schedule I, II, III, IV, and V substances listed in the CA Health and Safety Code, Sections 11053-11058, and do not need to be double locked. • Personnel with authorized access to controlled substances include physicians, dentists, podiatrists, PAs, licensed nurses, and pharmacists and specifically authorized employees.[36] **IV.A.5) Written site-specific policy/procedure for dispensing of sample drugs are available on site.** • A list of drugs available for use in the clinic shall be maintained. Site should have written site-specific policies and procedures (P&Ps) for use of sample medications including governing activities of pharmaceutical manufacturers' representatives American Society of hospital

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

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

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

Criteria	IV. Clinical Services - Pharmaceutical Standards

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[54] BPC 1200-1213

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

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

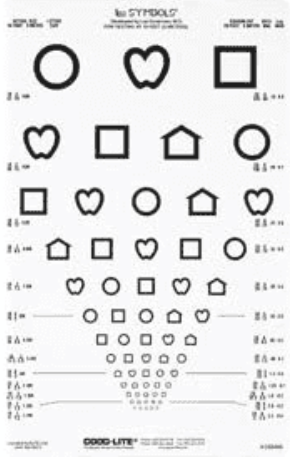
[55] 21 CFR 900

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

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

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

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

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

Criteria	V. Preventive Services Standards

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

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

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

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

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

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

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

[60] 29 CFR 1919.1030

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

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

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

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

[63] 29 CFR 1910.1030

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

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

[65] 8 CCR 5193

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

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

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

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

Criteria	VI. Infection Control Standards
	VI.B.8) Transportation of regulated medical wastes is only by a registered hazardous waste hauler or to a central location of accumulation in limited quantities (up to 35.2 pounds). **Medical Waste Disposal:** California adopted statutes into HSC affecting medical waste transporters in October 1993.[68] • Only medical waste transporters listed with CDPH can transport medical waste. • All medical waste transporters must carry paperwork issued by CDPH in each vehicle while transporting medical waste. • Medical wastes are hauled to a permitted offsite medical waste treatment facility, transfer station, or other registered generator by a registered hazardous waste transporter. • Limited-quantity exemption is not required for Small Quantity Generator (up to 35.2 pounds). However, a medical waste-tracking document that includes the name of the person transporting, number of waste containers (e.g., three sharps containers, or five biohazard bags), types of medical wastes, and date of transportation, is kept a minimum of 3 years for large waste generators and 2 years for small generators. For the CDPH list of current medical waste transporters, visit: https://www.cdph.ca.gov/Programs/CEH/DRSEM/CDPH%20Document%20Library/EMB/MedicalWaste/Haulist_012921.pdf For information on the United States Postal Service mailability standards for medical waste (including sharps) refer to the Domestic Mail Manual, section 601.10.17: https://pe.usps.com/Archive/HTML/DMMArchive20100607/601.htm CDPH Medical Waste Management Program: https://www.cdph.ca.gov/Programs/CEH/DRSEM/Pages/EMB/MedicalWaste/MedicalWaste.aspx CDPH Medical Waste Management Program Transporter Checklist: https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8660.pdf CDPH Medical Waste Transporter Annual Verification: https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8668.pdf

[68] HSC 117600-11836

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

[69] 29 CFR 1910.1030

Criteria	VI. Infection Control Standards
	○ **Frequency of cleaning/decontamination** ○ **Employee responsible for determining and implementing the written schedule** All equipment and environmental and work surfaces shall be cleaned and decontaminated after contact with blood or OPIM no later than at the end of the shift. Cleaning and decontamination of equipment and work surfaces is required more often as specified below: ○ Location within the facility ○ Type of surface or equipment to be treated ○ Type of soil or contamination present ○ Tasks or procedures being performed in the area Contaminated work surfaces shall be cleaned and decontaminated with an appropriate disinfectant immediately or as soon as feasible when: ○ Surfaces become overtly contaminated. ○ There is a spill of blood or OPIM. ○ Procedures are completed. ○ At the end of the work shift if the surface may have become contaminated since the last cleaning. **Spill Procedure:** Personnel can identify procedures for prompt decontamination of blood/body fluid spills, the disinfectant used, and the responsible person(s). **Disinfectant solutions used on site are:** **VI.C.3) Approved by the Environmental Protection Agency (EPA).** **VI.C.4) Effective in killing HIV/HBV/TB.** **VI.C.5) Follow manufacturer instructions.** **Disinfectant Products:** ○ Products used for decontamination have a current EPA-approved status. ○ Effectiveness in killing HIV/HBV/TB is stated on the manufacturer's product label. ○ Decontamination products are used according to manufacturer's guidelines for decontamination and contact times.

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

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

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

Criteria	VI. Infection Control Standards
	• Prior to undergoing the sterilization process, soiled instruments/equipment are thoroughly cleaned using enzymatic detergent, rinsed, dried, and inspected for the presence of dried blood or other debris. **Cold chemical sterilization/high level disinfection:** **VI.D.3a) (CE) Staff demonstrate /verbalize necessary steps/process to ensure sterility and/or high-level disinfection of equipment.** • Personnel can demonstrate or verbally explain procedure(s) used for cleaning prior to sterilization, and to locate written directions on site. • Product efficacy tests (i.e. test strips) shall be performed according to manufacturer's guidelines. **Cold Chemical Sterilization/High Level disinfection:** • Product manufacturer's directions are strictly followed for instrument pre-soaking treatment, solution preparation, solution exposure procedures, safety precautions (e.g., room temperature, area ventilation), and post-sterilization processes. • Sterilization and or high-level disinfection exposure times and solution expiration date and time are available to staff. • Written procedures for cold sterilization and/or high-level disinfection is available on site to staff. **VI.D.3b) Confirmation from manufacturer item(s) is/are heat sensitive.** • Per CDC,[71] the use of liquid chemical germicides to sterilize instruments ("cold sterilization") are limited. Sterility is not verified or assured with cold chemical sterilization. The first choice is always heat sterilization. The CDC refers to heat sterilization as "the method of choice when sterilizing instruments and devices. If an item is heat sensitive, it is preferable to use a heat-stable alternative or disposable item". • The use of a liquid chemical sterilant should be restricted to reprocessing devices that are heat-sensitive and incompatible with other sterilization methods. All other items should be heat sterilized or disposable.

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

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

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

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

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

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

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

Criteria	VI. Infection Control Standards
	VI.D.4.d) (CE) Management of positive mechanical, chemical, and biological indicators of the sterilization process. **Autoclave/Steam Sterilization Mechanical, Chemical, and Biological Indicators:[75]** • Sterilization failure can occur for reasons such as slight variation in the resistance of the spores, improper use of the sterilizer, and laboratory contamination during the culture. • Per CDC, the autoclave/steam sterilization procedure should be monitored routinely by using a combination of: ○ Mechanical Indicator: monitor sterilization process with a daily assessment of cycle time and temperature by examining the temperature record chart and an assessment of pressure via the pressure gauge (e.g., graphs, gauges, printouts) ○ Chemical Indicator: are usually either heat-or chemical-sensitive inks that change color when one or more sterilization parameters (e.g., steam-time, temperature, and/or saturated steam; ETO-time, temperature, relative humidity and/or ETO concentration) are present. ○ Biological: spore test – an indicator to evaluate the sterilizing conditions and indirectly the microbiologic status of the processed items ○ Staff should adhere to site-specific protocol and/or manufacturer/product label for management of positive indicator(s). • Written procedures for for handling positive spore test results are available on site to staff. • For positive spore tests, the autoclave is removed from service immediately until inspection is completed and a negative retest occurs. Procedures include: ○ Report problem ○ Repair autoclave ○ Retrieve all instruments sterilized since last negative spore test ○ Re-test autoclave ○ Re-sterilize retrieved instruments • Biologic spore test products vary and are designed for use based on specific autoclave type. Biologic control testing challenges the autoclave sterilization cycle with live, highly resistant, nonpathogenic spores. If spores are killed during processing, it is assumed that all other microorganisms are also killed and that the autoclave load is sterile.

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

Criteria	VI. Infection Control Standards

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

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

Primary Care Provider-Medical Record Review Tool

Health Plan: _____

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

Address: _____

City and Zip Code: _____

Phone: _____ **Fax:** _____

No. of Physicians: _____

Review Date: _____

Reviewer name/title: _____

Reviewer name/title: _____

Reviewer name/title: _____

Reviewer name/title: _____

Collaborating MCP(s): **1.** _____

2. _____

Contact person/title: _____

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

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

Medical Record Review: Onsite _____ Remote Access _____

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

Number of Records Reviewed: _____

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

Medical Record Scores

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

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

Scoring Procedure

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

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

_____ ÷ _____ = _____ x 100 = _____%

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

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

Compliance Rate

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

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

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

____ **Fail: 79% and Below**

____ CAP Required

____ Other follow-up

Next Review Due: _____

Medical Records Reference:

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

* Whichever is more recent

I. Format Criteria

RN/NP/MD/PA/CNM/LM

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

II. Documentation Criteria

RN/NP/MD/PA/CNM/LM

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

III. Coordination of Care Criteria

RN/NP/MD/PA/CNM/LM

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

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

RN/NP/MD/PA/CNM/LM

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

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

RN/NP/MD/PA/CNM/LM

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

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

RN/NP/MD/PA/CNM/LM

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

V. Adult Preventive Criteria

RN/NP/MD/PA/CNM/LM

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

V. Adult Preventive Criteria

RN/NP/MD/PA/CNM/LM

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

V. Adult Preventive Criteria

RN/NP/MD/PA/CNM/LM

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

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

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

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

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

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

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

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

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

VI. OB/CPSP Preventive Criteria

RN/NP/MD/PA/CNM/LM

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

Primary Care Provider-Medical Record Review Standards

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

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

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

Example for determining the number of medical records to review:

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

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

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

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

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

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

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

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

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

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

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

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

Scoring Example:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RN/NP/MD/PA/CNM/LM

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

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

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

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

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

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

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

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

[12] ACA Section 1557

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

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

RN/NP/MD/PA/CNM/LM

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

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

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

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

RN/NP/MD/PA/CNM/LM

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

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

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

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

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

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

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

<table>
<tr><th colspan="2">IV. Pediatric Preventive Criteria</th></tr>
<tr><td></td><td>Chronic conditions to assess that are associated with anemia:
A diet consistently low in iron, vitamin B-12 and folate
Heavy Menstruation. See link for signs of heavy menstrual bleeding: https://www.acog.org/womens-health/faqs/heavy-menstrual-bleeding
Pregnancy
Slow, chronic blood loss from an ulcer; Crohn's disease, celiac disease, cancer, kidney failure, diabetes, etc.
The Bright Futures/AAP periodicity schedule is available at: https://www.aap.org/en-us/documents/periodicity_schedule.pdf.

See the National Institutes of Health information on Anemia, available at: https://www.nhlbi.nih.gov/health-topics/anemia#:~:text=Some%20people%20are%20at%20a,such%20as%20chemotherapy%20for%20cancer.

See the Center for Disease Control and Prevention’s (CDC) information on heavy menstrual bleeding, available at: https://www.cdc.gov/ncbddd/blooddisorders/women/menorrhagia.html.</td></tr>
<tr><td>3) Anthropometric measurements</td><td>For each well exam:
Infants up to 24 months old: assess for length/height and head circumference (HC). Measurements are plotted in a World Health Organization (WHO) growth chart.
2-21 years old: assess for height, weight, and body mass index (BMI) measurements are plotted in a CDC growth chart.
Provider should measure and track BMI to identify patient at risk for being overweight, obese, or underweight. Patients identified as overweight and/or obese are provided counseling for nutrition to promote healthy eating habits and regular physical activity.
For additional information on anthropometric measurements, refer to the following link: https://www.dhcs.ca.gov/services/chdp/Documents/HAG/4AnthropometricMeasure.pdf</td></tr>
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IV. Pediatric Preventive Criteria	
	Note: Site is deficient if anthropometric measurements are not plotted on the appropriate growth chart.[15]
4) Anticipatory Guidance	• Must be documented at each well child visit. • Is given by the health care provider to assist parents or guardians in the understanding of the expected growth and development of their children. • Specific to the age of the patient, includes information about the benefits of healthy lifestyles and practices that promote injury and disease prevention https://brightfutures.aap.org/Bright%20Futures%20Documents/BF_PreventiveServices_Tipsheet.pdf#search=document%20anticipatory%20document
5) Autism Spectrum Disorder (ASD) Screening	ASD screening must be performed at 18 months and 24 months of age based on AAP periodicity "Bright Futures". If the patient is positive for risk factors, provider shall offer and document appropriate follow-up intervention(s). ASD screening tools examples: ○ Ages and Stages Questionnaires (ASQ) ○ Communication and Symbolic Behavior Scales (CSBS) ○ Parents' Evaluation of Developmental Status (PEDS) ○ Modified Checklist for Autism in Toddlers (MCHAT) ○ Screening Tool for Autism in Toddlers and Young Children (STAT) ○ Survey of Well-being of Young Children (SWYC) screening tools (assess three domains of child functioning: developmental domain, emotional/behavioral domain, and family context) Refer to APL 19-014, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21, and APL 19-010, Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21, or any superseding APLs for more information on ASD. Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder"

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

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

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

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

Order or perform blood lead screening tests on all child members in accordance with the following:

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

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

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

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

Evidence of provider compliance of blood lead screening test if not performed:

- The provider must document the reason(s) for not performing the blood lead screening test in the child member's medical record.
- In cases where consent has been withheld, the provider must obtain a signed statement of voluntary refusal by parent or guardian.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

	questions directed toward SCA and SCD detection for which a positive response suggested an increased risk for SCA and SCD • Have you ever fainted, passed out, or had an unexplained seizure suddenly and without warning, especially during exercise or in response to sudden loud noises, such as doorbells, alarm clocks, and ringing telephones? • Have you ever had exercise-related chest pain or shortness of breath? • Has anyone in your immediate family (parents, grandparents, siblings) or other, more distant relatives (aunts, uncles, cousins) died of heart problems or had an unexpected sudden death before age 50? This would include unexpected drownings, unexplained auto crashes in which the relative was driving, or SIDS • Are you related to anyone with HCM or hypertrophic obstructive cardiomyopathy, Marfan syndrome, ACM, LQTS, short QT syndrome, BrS, or CPVT or anyone younger than 50 years with a pacemaker or implantable defibrillator? A positive response from the 4 questions above or an abnormal ECG should prompt further investigation that may include referral to a pediatric cardiologist or pediatric electrophysiologist. https://www.aap.org/en/news-room/news-releases/aap/2021/american-academy-of-pediatrics-all-children-should-be-screened-for-potential-heart-related-issues/ https://publications.aap.org/pediatrics/article/148/1/e2021052044/179969/Sudden-Death-in-the-Young-Information-for-the
21)Tobacco Use Screening	Tobacco Use Screening, Prevention, and Cessation Services • Screen all children 11 years and older at each well child visit for tobacco products use.

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

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

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

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

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

RN/NP/MD/PA/CNM/LM

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

V. Adult Preventive Criteria	

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

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

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

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

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

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

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

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

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

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

	test is done in the morning in a fasting state; blood glucose concentration is measured 2 hours after ingestion of a 75-g oral glucose load. • The diagnosis of IFG, IGT, or type 2 diabetes should be confirmed; repeated testing with the same test on a different day is the preferred method of confirmation. See the USPSTF recommendation on Prediabetes and Type 2 Diabetes Screening, available at: https://uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-prediabetes-and-type-2-diabetes. See APL 18-018, Diabetes Prevention Program, or any superseding APL for additional information. • When reviewing medical records of patients with a diagnosis of Diabetes, the reviewer should score based on documented routine comprehensive diabetic care/screening: retinal exams, podiatry, nephrology, etc. • Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life. With support from health care providers, patients can manage their diabetes with self-care, taking medications as instructed, eating a healthy diet, being physically active, and quitting smoking. See the National Community for Quality Assurance guidance on Comprehensive Diabetes Care, available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. See the USPSTF recommendation on Prediabetes and Type 2 Diabetes Screening, available at: https://uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-prediabetes-and-type-2-diabetes.
	Assess all adults at each well visit for drug misuse. If at any time the PCP identifies a potential drug use problem the provider shall:

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

	recipients whose brief assessment demonstrates probable substance use disorder. Drug brief interventions includes misuse counseling and counseling a member regarding additional treatment options, referrals, or services. Brief interventions must include the following: • Providing feedback to the patient regarding screening and assessment of results. • Discussing negative consequences that have occurred and the overall severity of the problem. • Supporting the patient in making behavioral changes. • Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated. <u>Documentation Requirements</u> Member medical records must include the following: • The service provided, for example: screen and brief intervention. • The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electric health record). • The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record). • If and where a referral to an alcohol or substance use disorder program was made. A recommended substance abuse assessment tool is available at: http://crafft.org. Please refer to the following link to the Medi-Cal Provider Manual: https://www.dhcs.ca.gov/formsandpubs/publications/Pages/Manuals.aspx.
9) Dyslipidemia Screening	USPSTF recommends that adults without a history of cardiovascular disease (CVD) (e.g., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all the following criteria are met: 1) They are aged 40 to 75 years; 2) They have one or more CVD risk factors (e.g., dyslipidemia, diabetes, hypertension, or smoking); and

V. Adult Preventive Criteria	
	3) They have a calculated 10-year risk of a cardiovascular event of 10% or greater. Screen universal lipids at every well visit for those with increased risk of heart disease and at least every 6 years for healthy adults. The USPSTF Grade A and B Recommendations are available at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.
10) Folic Acid Supplementation	• The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.[29] • USPSTF and WHO categorize women in the age range of 12-49 years as "women who are capable of becoming pregnant".
11) Hepatitis B Virus Screening	Assess all adults for risk of acquiring Hepatitis B Virus (HBV) at each well visit. Screening those at risk should include testing to three HBV screening seromarkers (HBsAg, antibody to HBsAg [anti-HBs], and antibody to hepatitis B core antigen [anti-HBc]) so that persons can be classified into the appropriate hepatitis B category and properly recommended to receive vaccination, counseling, and linkage to care and treatment. Important risk groups for HBV infection with a prevalence of ≥2% that should be screened include: • Persons born in countries and regions with a high prevalence of HBV infection (≥2%), such as sub-Saharan Africa and Central and Southeast Asia (Egypt, Algeria, Morocco, Libya, Afghanistan, Vietnam, Cambodia, Thailand, Philippines, Malaysia, Indonesia, Singapore, etc.). • U.S.-born persons not vaccinated as infants whose parents were born in regions with a very high prevalence of HBV infection (≥8%).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RN/NP/MD/PA/CNM/LM

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VI. OB/CPSP Preventive Criteria	
	"Maternal mental health condition" means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression. • USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. • CMS Technical Specifications include screening using validated tools and documentation of a follow-up plan if the depression screening is positive that aligns with USPSTF's referral and documentation of counseling or interventions with those found at risk for perinatal depression. • Patient is screened for depression on the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen. Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. • Edinburgh Postnatal Depression Scale (EPDS), • Patient Health Questionnaire (PHQ) 9 Follow-Up Plan – Documented follow-up for a positive depression screening must include one or more of the following: • Additional evaluation or assessment for depression • Suicide Risk Assessment • Referral to a practitioner who is qualified to diagnose and treat depression • Pharmacological interventions • Other interventions or follow-up for the diagnosis or treatment of depression Additional information on CMS Technical Specifications, is available at: https://www.medicaid.gov/license/form/6466/4391.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[61] HSC 123640

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

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

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

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

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

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

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

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

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

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

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

[74] HSC 125107

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Cognitive Assessment
Addendum to Facility Site Review Tool

PCP Name:					
PCP Site Name:	0				
Address:	0			Suite:	0
City:	0	State:	CA	ZIP:	0
Phone Number:	-				
Fax Number:	-				
Name of Individual responsible for securing & maintaining the security of medical records:				0	
Reviewers:	**First Last Name, RN DHCS-CSR**				
Date of Review:	**1/0/1900**				

	Yes	No	NA	Corrective Action (Note Date corrected as well as document correction
1. Was a cognitive assessment performed for all eligible members 65 years and older?				
Total:	0	0	0	
ADM Passed:	Yes		n/a	**Score Percentage**
CAP required:				
CAP approved:				
Guidelines for Cognitive Assessment:			**Date approved**	

Per APL 22-025 PCPs should include an annual cognitive assessment for Members who are 65 years of age or older and who do not have Medicare Coverage.

Documentation in the medical record should include:
- The screening tool or tools that were used.
- Verification that screening results were reviewed by the Provider
- The results of the screening
- The interpretation of the results
- Details discussed with the member and/or authorized representative and any appropriate actions taken in regards to the screening results.

Acceptable patient assessment screening tools include, but are not limited to:

Patient Assessment Tools:
- General Practitioner Assessment of Cognition (GPCOG)
- Mini-Cog
- Memory Impairment Screen (MIS) (Medicare Approved Tool)

Informant Tools (family members and close friends)
- Eight-item Informant Interview to Differentiate Aging and Dementia
- GPCOG
- Short Informant Questionnaire on Cognitive Decline in the Elderly
- Quick Dementia Rating System (Medicare Approved Tool)

11.28.22

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

Non-Accredited Facility Site Review Tool

HealthPlan: PHC	**Site ID:**	**Site NPI:**	**Last Review Date:** **Review Date:**
Clinic Name:	**Phone:** **Fax:**		**Contact Name/Title:**
Clinic Address:			**Contact Email:**
Reviewer/title:	**Reviewer/title:**		**Current Fire Clearance? Y/N**

Visit Purpose	Site-Specific Certification(s)	Clinic Type
_____ Initial Full Scope _____ Monitoring _____ Periodic Full Scope _____ Follow-up _____ Focused _____ Ed/TA _____Other _____ (type)	_____ AAAHC _____ JC _____ CHDP _____ NCQA _____ CPSP _____ None _____ PCMH _____ Other_____	_____ Hospital _____ Skilled Nursing Facility _____ Home Health _____ Free-standing Surgical Center _____ Ambulatory Behavioral Health Facility _____ Free Standing Urgent Care _____ CBAS _____ Free Standing Radiology Center _____ Dialysis Centers

Site Scores

	Total Points Poss.	Points Given	No Points	N/As	CE*
I. Access/Safety	**32**				
II. Personnel	**31**				
III. Office Management	**25**				
IV. Clinical Services	**40**				
V. Preventive Services	**13**				
VI. Infection Control	**34**				
VII. Quality Assurance Performance Improvement	**6**				
Totals	**181**				

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

Scoring Procedure

1) Add points given in each section.
2) Add total points given for all six sections.
3) Adjust score for "N/A" criteria (if needed), by subtracting N/A points from 181 total points possible.
4) Divide total points given by "adjusted" total points.
5) Multiply by 100 to get the compliance (percent) rate.

__181__ - _____ = _____
N/A Points **Adjusted Points**

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

Compliance Rate

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

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

_____ **Fail: 79% and Below**

_____ CAP Required

_____ Other follow-up

Next Site Review Due: _____

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

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

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

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

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

I. Access/Safety Criteria, continued	Yes	No	N/A	Wt.	Site Score
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week. 8 CCR §3220; 22 CCR §51056, §53216, §75031; 28 CCR §1300.67, §1300.80; American Academy of Family Practice (AAFP)					
1) Personnel are trained in procedures/action plan to be carried out in case of medical emergency on site.	1) _____	1) _____	1) _____	1	
2) Emergency equipment is stored together in easily accessible location and is ready to be used.	2) _____	2) _____	2) _____	1	
3) Emergency phone number contacts are posted, updated annually, and as changes occur.	3) _____	3) _____	3) _____	1	
Emergency medical equipment appropriate to practice/patient population is available on site:					
4) **Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag.**	**4)** _____	**4)** _____	**4)** _____	**2**	
4a) Hospital emergency equipment includes: defibrillator, suction, airway management, and medications.	4a)____	4a)____	4a)____	1	
5) Emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia. Epinephrine 1mg/ml (injectable) and Diphenhydramine (Benadryl) 25 mg (oral) or Diphenhydramine (Benadryl) 50 mg/ml (injectable), Naloxone, chewable Aspirin 81 mg, Nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), and glucose (any type of glucose containing at least 15 grams). Appropriate sizes of ESIP needles/syringes and alcohol wipes.	**5)** _____	**5)** _____	**5)** _____	1	
6) Medication dosage chart for all medications included with emergency equipment (or other method for determining dosage) is kept with emergency medications.	6) _____	6) _____	6) _____	1	
There is a process in place on site to:					
7) Document checking of emergency medication, equipment and supplies for expiration and operating status at least monthly.	7) _____	7) _____	7) _____	1	
8) Replace/re-stock emergency medication, equipment and supplies immediately after use.	8) _____	8) _____	8) _____	1	

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

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

I. Access/Safety Criteria, continued	Yes	No	N/A	Wt.	Site Score
E. Medical and lab equipment used for patient care is properly maintained. 28 CCR §1300.80; 21 CFR §800-1299; 22 CCR §75062; §53230					
1) Medical equipment is clean.	1)_____	1)_____	1)_____	1	
2) Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines.	2)_____	2)_____	2)_____	1	
F. The facility has a waiting area of sufficient size to accommodate patients comfortably and to assure privacy during registration.	1)_____	1)_____	1)_____	1	
(3) Comments: Write comments for all "No" (0 points) and "N/A" scores. **(32) TOTALS**					

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

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

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

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

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

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

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

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

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

II. Personnel Criteria, continued	Yes	No	N/A	Wt.	Site Score
H. There is an established organizational structure with defined functions and responsibilities. (May be an organization chart or other document)	1)_____	1)_____	1)_____	1	
I. Contract and Temporary Staff are identified and monitored appropriately.					
1. Facility clearly identifies contracted services and temporary staff	1)_____	1)_____	1)_____	1	
2. Contracted and temporary staff are appropriately reviewed annually.	2)_____	2)_____	2)_____	1	
J. Staff with Advance Life Support (ALS) and/or Basic Life Support (BLS) are identified and their certification is current.	1)_____	1)_____	1)_____	1	
(4) Comments: Write comments for all "No" (0 points) and "N/A" scores. **(31) TOTALS**					

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

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

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

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

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

III. Office Management Criteria, continued	Yes	No	N/A	Wt.	Site Score
G. Medical records are available for the practitioner at each scheduled patient encounter. 22 CCR §75055; 28 CCR §1300.80					
1) Medical records are readily retrievable for scheduled patient encounters.	1)_____	1)_____	1)_____	1	
2) Medical documents are filed in a timely manner to ensure availability for patient encounters.	2)_____	2)_____	2)_____	1	
H. Confidentiality of personal medical information is protected according to State and federal guidelines.					
1) Exam rooms and dressing areas safeguard patients' right to privacy.	1)_____	1)_____	1)_____	1	
2) Procedures are followed to maintain the confidentiality of personal patient information.	2)_____	2)_____	2)_____	1	
3) Medical record release procedures are compliant with State and federal guidelines.	3)_____	3)_____	3)_____	1	
4) Storage and transmittal of medical records preserves confidentiality and security.	4)_____	4)_____	4)_____	1	
5) Medical records are retained for a minimum of 10 years.	5)_____	5)_____	5)_____	1	
(7) Comments: Write comments for all "No" (0 points) and "N/A" scores. **(25) TOTALS**					

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

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

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

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

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

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

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

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

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

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

IV. Clinical Services: Radiology Services Criteria	Yes	No	N/A	Wt.	Site Score
E. Site meets CDPH Radiological inspection and safety regulations. 17 CCR §30110, §30111, §30255, §30305, §30404, §30405; https://www.cdph.ca.gov/rhb or (916) 327-5106					
1) Site has current CA Radiologic Health Branch Inspection Report and Proof of Registration if there is radiological equipment on site.	1)_____	1)_____	1)_____	1	
The following documents are <u>posted</u> on site: 2) Current copy of Title 17 with a posted notice about availability of Title 17 and its location.	2)_____	2)_____	2)_____	1	
3) "Radiation Safety Operating Procedures" posted in highly visible location.	3)_____	3)_____	3)_____	1	
4) "Notice to Employees Poster" posted in highly visible location.	4)_____	4)_____	4)_____	1	
5) "Caution, X-ray" sign posted on or next to door of each room that has X-ray equipment.	5)_____	5)_____	5)_____	1	
6) Physician Supervisor/Operator certificate posted *and* within current expiration date.	6)_____	6)_____	6)_____	1	
7) Technologist certificate posted *and* within current expiration date.	7)_____	7)_____	7)_____	1	
The following radiological protective equipment is present on site: 8) Operator protection devices: radiological equipment operator must use lead apron or lead shield.	8)_____	8)_____	8)_____	1	
9) Gonadal shield (0.5 mm or greater lead equivalent): for patient procedures in which gonads are in direct beam.	9)_____	9)_____	9)_____	1	
(9) Comments: Write comments for all "No" (0 points) and "N/A" scores. **(40) TOTALS**					

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

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

V. Preventive Services: Health Education Criteria	Yes	No	N/A	Wt.	Site Score
B. Health education services are available to Plan members. 22 CCR §53851; 28 CCR 1300.67 Health education materials and Plan-specific resource information are: 1) Readily accessible on site or are made available upon request.	1)_____	1)_____	1)_____	1	
2) Applicable to the practice and population served on site.	2)_____	2)_____	2)_____	1	
3) Available in threshold languages identified for county and/or area of site location.	3)_____	3)_____	3)_____	1	
(3) Comments: Write comments for all “No” (0 points) and “N/A” scores. **(13) TOTALS**					

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

VI. Infection Control Criteria	Yes	No	N/A	Wt.	Site Score
A. Infection control procedures for Standard/Universal precautions are followed. 8 CCR §5193; 22 CCR §53230; 29 CFR §1910.1030; Federal Register 1989, §54:23042					
1) Soap or antiseptic hand cleaner and running water are available in exam and/or treatment areas for hand washing.	1)_____	1)_____	1)_____	1	
2) A waste disposal container is available in exam rooms, procedure/treatment rooms, and restrooms.	2)_____	2)_____	2)_____	1	
3) Site has procedure for effectively isolating infectious patients with potential communicable conditions.	3)_____	3)_____	3)_____	1	
B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. 8 CCR §5193 (Cal OSHA Health Care Worker Needlestick Prevention Act, 1999); HSC, §117600-118360 (CA Medical Waste Management Act, 1997, updated January 2017); 29 CFR §1910.1030; 49 CCR §173.6; 49 CFR, Section 173.6; CDC Core Infection Prevention and Control Practices -Centers for Disease Control and Prevention (CDC) The Healthcare Infection Control Advisory Committee (HICPAC), 2016; 2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare settings.					
1) Personal Protective Equipment (PPE) for Standard Precautions is readily available for staff use.	**1)**_____	**1)**_____	**1)**_____	**2**	
2) Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport or shipping.	**2)**_____	**2)**_____	**2)**_____	**2**	
3) Needlestick safety precautions are practiced on site.	**3)**_____	**3)**_____	**3)**_____	**2**	
4) All sharp injury incidents are documented.	4)_____	4)_____	4)_____	1	
5) Biohazardous (non-sharp) wastes are contained separate from other trash/waste.	5)_____	5)_____	5)_____	1	
6) Storage areas for regulated medical wastes are maintained secure and inaccessible to unauthorized persons.	6)_____	6)_____	6)_____	1	
7) Contaminated laundry is laundered at the workplace or by a commercial laundry service.	7)_____	7)_____	7)_____	1	
8) Transportation of regulated medical wastes is only by a registered hazardous waste hauler or to a central location of accumulation in limited quantities (up to 35.2 pounds).	8)_____	8)_____	8)_____	1	

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

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

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

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

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

VI. Infection Control Criteria, continued	Yes	No	N/A	Wt.	Site Score
D.Reusable medical instruments are properly sterilized after each use. 22 CCR §53230, §53856; CDC guideline for disinfection and sterilization; Food and Drug Administration: Reprocessing medical equipment in health care setting.					
1) Written site-specific policy/procedures or manufacturer's instructions for instrument/equipment sterilization are available to staff.	1)_____	1)_____	1)_____	1	
Staff adheres to site-specific policy and/or manufacturer/product label directions for the following procedures: 2) Cleaning reusable instruments/equipment prior to sterilization.	2)_____	2)_____	2)_____	1	
3) Cold chemical sterilization/high level disinfection: **a) Staff demonstrate/verbalize necessary steps/process to ensure sterility and/or high-level disinfection of equipment.**	**3a)**____	**3a)**____	**3a)**____	**2**	
b) Confirmation from manufacturer item(s) is/are heat sensitive.	3b)____	3b)____	3b)____	1	
c) Appropriate PPE is available, exposure control plan, Material Safety Data Sheets and clean up instructions in the event of a cold chemical sterilant spill.	**3c)**____	**3c)**____	**3c)**____	**2**	
4) Autoclave/steam sterilization. a) Staff demonstrate/verbalize necessary steps/process to ensure sterility.	4a)____	4a)____	4a)____	1	
b) Autoclave maintenance per manufacturer's guidelines.	4b)____	4b)____	4b)____	1	
c) **Spore testing of autoclave/steam sterilizer with documented results (at least monthly).**	**4c)**____	**4c)**____	**4c)**____	**2**	
d) **Management of positive mechanical, chemical, and biological indicators of the sterilization process.**	**4d)**____	**4d)**____	**4d)**____	**2**	
e) Sterilized packages are labeled with sterilization date and load identification information.	4e)____	4e)____	4e)____	1	
f) Storage of sterilized packages.	4f)____	4f)____	4f)____	1	
(15) Comments: Write comments for all "No" (0 points) and "N/A" scores. **(34) TOTALS**					

VII. Quality Assurance Performance Improvement

RN/MD Review only

Quality Assurance Performance Improvement Survey Criteria	Yes	No	N/A	Wt.	Site Score
1) Is there a QAPI committee which meets regularly and keeps minutes?	1)_____	1)_____	1)_____	**1**	
2) The QAPI committee reviewed performance standards for medical records, infection control, environment, personnel and other areas of concern.	2)_____	2)_____	2)_____	**1**	
3) The QAPI identified concerns, initiated corrective actions plans, monitored the results of the plans, and made appropriate changes based on an analysis of the data.	3)_____	3)_____	3)_____	**1**	
4) The QAPI committee is aware of serious events (sentinel events, abuse allegations, privacy breaches, complaints and grievances) and takes appropriate actions.	4)_____	4)_____	4)_____	**1**	
5) The QAPI committee has reviewed surveys, inspections, and reports submitted by outside agencies. Corrective action plans are available.	5)_____	5)_____	5)_____	**1**	
6) Is there a designated QA & PI Coordinator?	6)_____	6)_____	6)_____	**1**	
(6) Comments: Write comments for all "No" (0 points) and "N/A" scores. **(6) Totals**					

California Department of Health Care Services
Managed Care Quality and Monitoring Division
Non-Accredited Facility Site Review Standards

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

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

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

A corrective action plan (CAP) is required for a total score less than 90%, *OR* for a total score of 90% or above if there are deficiencies in Critical Elements, Pharmaceutical Services or Infection Control. Compliance rates are based on 181 total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer. Reviewers are expected to determine how to ascertain information needed to complete the review. Review criteria that shall be reviewed *only* by a registered nurse (RN), nurse practitioner (NP), Certified Nurse Midwife (CNM), Licensed Midwife (LM), physician (MD), or physician assistant (PA) is labeled "**RN/NP/CNM/LM/MD/PA".**

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

1) Add the points given in each section.
2) Add points given for all seven (7) sections to determine total points given for the site.
3) Subtract all "N/A" items from 181 total possible points to determine the "adjusted" total possible points. If there are no "N/A" items, calculation of site score will be based on 181 points.
4) Divide the total points given by 181 or by the "adjusted" total. Multiply by 100 to calculate percentage rate.

Scoring Example:

Step 1: Add the points given in each section.	**Step 2**: Add points given for all seven (7) sections. Example: 32 (Access/Safety) 31 (Personnel) 25 (Office Management) 40 (Clinical Services) 13 (Preventive Services) 34 (Infection Control) 6 (QAPI) **181 (POINTS GIVEN)**
Step 3: Subtract "N/A" points from 181 total points possible. 181 (Total points possible) - 5 (N/A points) 176 ("Adjusted" total points possible)	**Step 4**: Divide total points given by the "adjusted" points, then multiply by 100 to calculate percentage rate. Points given / "Adjusted" total or 168 / 176 = 0.9545 x 100 = **95%**

Criteria	I. Access/Safety Standards
A. Site is accessible and useable by individuals with physical disabilities.	**Sites must have the following safety accommodations for physically disabled persons:** **Americans with Disabilities Act (ADA) Regulations:** • Site must meet city, county, and state building structure and access ordinances for persons with physical disabilities. A site/facility includes the building structure, walkways, parking lots, and equipment. • All facilities designed, constructed; or altered by, on behalf of, or for the use of a public entity must be readily accessible and usable by individuals with disabilities, if the construction or alteration was begun after January 26, 1992.[1] • Any alteration to a place of public accommodation or a commercial facility, after January 26, 1992, must be made to ensure that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and useable by individuals with disabilities, including individuals who use wheelchairs.[2]
	I.A.1) Clearly marked (blue) curb or sign designating disabled-parking space near accessible primary entrance. **Parking:** • Parking spaces for persons with physical disabilities are located in close proximity to accessible building entrances. • Each parking space reserved for persons with disabilities is identified by a permanently affixed reflectorized sign posted in a conspicuous place. • If the provider has no control over availability of accessible parking within lot or nearby street spaces for persons with disabilities, the provider must have a plan in place for making program services available to persons with physical disabilities.
	I.A.2) Pedestrian ramps have a level landing at the top and bottom of the ramp. **Ramps:** • A clear and level landing is at the top and bottom of all ramps and on each side of an exit door. • Any path of travel is considered a ramp if its slope is greater than a 1-foot rise in 20 feet of horizontal run. • Ramps must be a minimum of 36-inches wide. Some areas require wider ramps. • All edges must be protected to keep anyone from slipping off. • All ramps that are 5 feet long shall have a level top and bottom landings. • Ramps must have handrails on both sides if length is longer than 6 feet.
	I.A.3) Exit and exam room doorway openings allow for clear passage of a person in a wheelchair. **Exit Doors:** • All entrances and exterior and interior exit doors, regardless of the occupant load shall be made accessible to persons with disabilities. • Exam room and exit doorways have a minimum opening of 32 inches with the door open at 90 degrees that will allow for passage of wheelchairs. • Door hardware = operable with a single effort without requiring ability to grasp hardware. • Effort to operate doors = a maximum pressure of 5 pounds at interior doors. • Door hardware height = 30” – 44” above floor. • Exit doors include all doors required for access, circulation and use of the building and facilities, such as primary entrances and passageway doors. Furniture and other items do not obstruct exit doorways or interfere with door swing pathway.

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

Criteria	I. Access/Safety Standards
A. Site is accessible and useable by individuals with physical disabilities.	**I.A.4) Accessible passenger elevator or reasonable alternative for multi-level floor accommodation.** **Elevators:** • If there is no elevator, a freight elevator may be used to achieve program accessibility if it is upgraded for general passenger use and if passageways leading to and from the elevator are well-lit, neat, and clean.
	I.A.5) Clear floor space for wheelchair in waiting area and exam room. **Clear Floor Space:** • Clear space in waiting/exam areas is sufficient (at least 30-in. x 48-in.) to accommodate a single, stationary adult wheelchair and occupant. • A minimum clear space of 60-inch diameter or square area is needed to turn a wheelchair.
	Sanitary Facilities: **I.A.6) Wheelchair accessible restroom facilities.** • A wheelchair accessible restroom stall allows sufficient space for a wheelchair to enter and permits the door to close. • Sufficient knee clearance space underneath the sink allows wheelchair users to safely use a lavatory sink for hand washing. • If wheelchair-accessible restrooms are not available within the office site, reasonable alternative accommodation are provided such as a wheelchair-accessible restroom located within the building. Other reasonable alternatives may include, but is not limited to, urinal, bedpan, or bedside commode in a private area.
	IA.7) Wheelchair accessible handwashing facilities or reasonable alternative. • Restroom and hand washing facilities are accessible to able-bodied and physically disabled persons. • If wheelchair-accessible handwashing facilities are not available within the office site, reasonable alternative accommodation are provided such as sanitizers and wheelchair-accessible restroom located within the building.
	Note: • A public entity may not deny the benefits of its program, activities, and services to individuals with disabilities because its facilities are inaccessible.[3] • Every feature need not be accessible, if a reasonable portion of the facilities and accommodations provided is accessible.[4] • Reasonable Portion and/or Reasonable Alternatives are acceptable to achieve program accessibility. • Reasonable Portion applies to multi-storied structures and provides exceptions to the regulations requiring accessibility to all portions of a facility/site. • Reasonable Alternatives are methods other than site structural changes to achieve program accessibility, such as acquisition or redesign of equipment, assignment of assistants/aides to beneficiaries, provision of services at alternate accessible sites, and/or other site-specific alternatives to provide services.[5] • Points shall not be deducted if Reasonable Portion or Reasonable Alternative is made available on site. **Specific measurements are provided strictly for "*reference only*" for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.**

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

Criteria	I. Access/Safety Standards
B. Site environment is maintained in a clean and sanitary condition.	**I.B.1) All patient areas including floor/carpet, walls, and furniture are neat, clean, and well maintained.** • The physical appearance of floors/carpets, walls, furniture, patient areas, and restrooms are clean and well maintained.
	I.B.2) Restrooms are clean and contain appropriate sanitary supplies. • Appropriate sanitary supplies, such as toilet tissue, hand washing soap, cloth/paper towels or antiseptic towelettes are made available for restroom use. • Environmental safety includes the "housekeeping" or hygienic condition of the site. • Clean means unsoiled, neat, tidy, and uncluttered. • "Well maintained" means being in good repair or condition.
C. Site environment is safe for all patients, visitors and personnel.	**Ordinances:** • Sites must meet city, county, and state fire safety and prevention ordinances. • Reviewers should be aware of applicable city and county ordinances in the areas in which they conduct reviews. **There is evidence staff has received safety training and/or has safety information available on the following:** **I.C.1) Fire safety and prevention.**
	I.C.2) Emergency non-medical procedures (e.g. site evacuation, workplace violence). **Emergency Action Plans:** • Non-medical emergencies include incidents of fire, natural disaster (e.g. earthquakes), workplace violence, etc. • Specific information for handling fire emergencies and evacuation procedures is available on site to staff. Personnel know ***where to locate*** information on site, and ***how to use*** information.[6]
	I.C.3) Lighting is adequate in all areas to ensure safety. **Illumination:** Lighting is adequate in-patient flow working and walking areas such as corridors, walkways, waiting and exam rooms, and restrooms to allow for a safe path of travel.
	I.C.4) (CE) Exit doors and aisles are unobstructed and egress (escape) accessible. **Access Aisle:** • Accessible pedestrian paths of travel (ramps, corridors, walkways, lobbies, elevators, etc.) between elements (seats, tables, displays, equipment, parking spaces, etc.) provide a clear circulation path. • The minimum clear passage needed for a single wheelchair is 36 inches along an accessible route but may be reduced to a minimum of 32 inches at a doorway. • Means of egress (escape routes) are maintained free of obstructions or impediments to full instant use of the path of travel in case of fire or other type of emergency. • Building escape routes provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied. • Cords (including taped cords) or other items are not placed on or across walkway areas.
	I.C.5) Exit doors are clearly marked with "Exit" signs. **Exits:** Exit doorways are unobstructed and clearly marked by a readily visible "Exit" sign.[7]
	I.C.6) Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location at all elevators, stairs and exits. **Evacuation Routes**: • Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location at all elevators, stairs and exits.[8]

[6] 29 CFR section 1910.38
[7] 29 CFR 1910.37
[8] 29 CFR 1910.33-39, 19 CCR 3.09 (a) (1) (B).

Criteria	I. Access/Safety Standards
C. Site environment is safe for all patients, visitors and personnel.	**I.C.7) Electrical cords and outlets are in good working condition.** **Electrical Safety:** • Electrical cords are in good working condition with no exposed wires, frayed or cracked areas. Cords are not affixed to structures, placed in or across walkways, extended through walls, floors, and ceiling, or under doors or floor coverings. • Extension cords are not used as a substitute for permanent wiring. • All electrical outlets have an intact wall faceplate. • Sufficient clearance is maintained around lights and heating units to prevent combustible ignition.
	I.C.8) Fire Fighting Equipment in accessible location. **Firefighting equipment:** **There is firefighting equipment that must be in accessible locations on site. At least one of the following types of fire safety equipment is on site:** • **Fire Extinguisher:** The employer shall provide portable fire extinguishers and shall mount, locate, and identify them so that they are readily accessible. Fire extinguishers are maintained in a fully charged and operable condition and kept in their designated places at all times except during use.[9] • Smoke Detector with intact batteries. • Automatic Sprinkler System With a 10-inch clearance between sprinkler heads and stored materials.
	I.C.9) An employee alarm system. **Employee Alarm System:** • Employers must install and maintain an operable employee alarm system that has a distinctive signal to warn employees of fire or other emergencies, unless employees can promptly see or smell a fire or other hazard in time to provide adequate warning to them.[10] OSHA: For those employers with 10 or fewer employees in a workplace, direct voice communication is an acceptable procedure for sounding the alarm provided all employees can hear the alarm. Such workplaces do not need a back-up system. **Note:** Specific measurements are provided strictly for "*reference only"* for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week. **RN/NP/CNM/LM/MD/PA**	**I.D. 1) Personnel are trained in procedures/action plan to be carried out in case of medical emergency on site.** **Site Specific Emergency Procedures:** • Staff can describe site-specific actions or procedures for handling medical emergencies until the individual is stable or under care of local emergency medical services (EMS). • There is a written procedure for providing immediate emergent medical care on site until the local EMS is on the scene. Although site proximity to emergency care facilities may be considered when evaluating medical emergency procedures, the key factor is the ability to provide immediate care to patients *on site* until the patient is stable or EMS has taken over care/treatment. • When the physician or non-physician medical practitioner (NPMP) is not on site, staff/MA may call 911, and CPR-certified staff may initiate CPR if needed. • Non-CPR-certified staff may only call 911 and stay with the patient until help arrives.

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

Criteria	I. Access/Safety Standards
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week. **RN/NP/CNM/LM/MD/PA**	**I.D.2) Emergency equipment is stored together in easily accessible location and is ready to be used.** **Emergency Medical Equipment:** During business hours providers are prepared to provide emergency services for management of emergency medical conditions that occur on site ***until*** the emergent situation is stabilized and/or treatment is initiated by the local 911 Emergency Medical Service (EMS) system. Minimum emergency equipment is available on site to: ○ Establish and maintain a patent/open airway. ○ Manage emergency medical conditions. Emergency equipment and medication, appropriate to patient population served, are available in an accessible location and ready for use. • An accessible location is one that is reachable by personnel standing on the floor, or other permanent working area, without locating/retrieving step stool, ladder or other assistive devices. • For emergency "Crash" cart/kit, contents are appropriately sealed and are within the expiration dates posted on label/seal. • Site personnel are appropriately trained and can demonstrate knowledge and correct use of all medical equipment they are expected to operate within their scope of work. https://www.aafp.org/afp/2007/0601/p1679.html
	I.D. 3) Emergency phone number contacts are posted, updated annually and as changes occur. **Emergency Phone Number list:** Posted in an accessible and prominent location(s) and includes: ○ Local emergency response services (e.g., fire, police/sheriff, ambulance). ○ Emergency contacts (e.g., responsible managers, supervisors). ○ Appropriate State, County, City, and local agencies (e.g., local poison control number). ○ The list should be dated, and telephone numbers updated annually and as changes occur.
	Emergency medical equipment appropriate to practice/patient population is available on site: **I.D. 4) (CE) Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag:** Without the ability to adequately maintain the patient's airway, all other interventions are futile. Minimum airway control equipment with various sizes of airway devices appropriate to patient population within the practice and examples of oxygen delivery systems include: ○ Wall oxygen delivery system ○ Portable oxygen tank ○ Portable oxygen concentrator (POC) All oxygen delivery systems must be able to be regulated up to 6 liters of oxygen per minute, maintained for a minimum of 15 minutes. This flow rate establishes a minimum total oxygen delivery capacity of 90 liters for these devices:[11] ○ Nasal cannula or mask ○ Bulb syringe ○ Ambu bag as appropriate to patient population served. Mask should be replaced when they no longer make a solid seal. ○ Portable oxygen tanks are maintained at least ¾ full. There is a method/system in place for oxygen tank replacement. If oxygen tanks are less than ¾ full at time of site visit, site has a back-up method for supplying oxygen if needed ***and*** a scheduled plan for tank replacement. ○ Oxygen tubing does not need be connected to oxygen tank, but must be kept in close proximity to tank. ○ Oropharyngeal airways are no longer required. **I.D.4a)** Hospital emergency equipment includes: defibrillator, suction, airway management, and medications.

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

Criteria	I. Access/Safety Standards
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week. **RN/NP/CNM/LM/MD/PA**	**I.D.5) (CE) Emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia:** Severe allergic reaction can cause urticaria (hives), hypotension, bronchospasm, wheezing, and pulmonary edema. Per the American Academy of Family Practice (AAFP), the minimum equipment to manage emergency anaphylactic reaction, asthma exacerbation, chest pain, opioid overdose, and hypoglycemia, based on the patient population served, shall include: ○ Epinephrine 1mg/mL (injectable) ○ Diphenhydramine 25 mg (oral) or 50 mg/ml (injectable) ○ Naloxone[12] ○ Chewable aspirin 81 mg[13] ○ Nitroglycerin spray/tablet[14] ○ Bronchodilator medication (solution for nebulizer or metered dose inhaler) ○ Glucose (any type of glucose containing at least 15 grams) ○ Appropriate sizes of ESIP needles/syringes[15] and alcohol wipes • The typical adult strength to address cardiac emergencies is 325 mg (four doses of 81 mg chewable aspirin or one dose of 325 non-enteric coated aspirin). • If the site is seeing adults, the reviewer shall assess whether the appropriate number of chewable aspirin tablets of 81 mg is available (at least four tablets).
	I.D.6) Medication dosage chart for all medications included with emergency equipment (or other method for determining dosage) is kept with emergency medications. • There is a current medication administration reference (e.g. medication dosage chart) available for readily identifying the correct medication dosages (e.g. adult, pediatric, infant, etc.). • Package inserts are not acceptable as dosage charts. • All emergency medications in the emergency kit/ crash cart must have dosage charts. • Score should be either a **Yes or No only**
	There is a process in place on site to: **I.D.7) Document checking of emergency equipment/supplies for expiration and operating status at least monthly.** Documented evidence that emergency medication and equipment is checked at least monthly may include a log, checklist or other appropriate method(s).
	I.D.8) Replace/re-stock emergency medication, equipment, and supplies immediately after use. A receipt or documentation showing medication is ordered is acceptable for any medication shortage.
	Note: An "emergency medical condition" is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: 1) placing the health of the individual (or unborn child of a pregnant woman) in serious jeopardy 2) serious impairment to bodily functions 3) serious dysfunction of any bodily organ or part "Emergency services" means those services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death.

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

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

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

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

Criteria	I. Access/Safety Standards
E. Medical and lab equipment used for patient care is properly maintained.  **RN/NP/CNM/LM/MD/PA**	**I.E.1) Medical equipment is clean.** **Medical and Laboratory Equipment:** All equipment used to measure or assess patient health status/condition is clean.
	I.E.2) Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines. **Documentation:** • There is documented evidence that standard operating procedures have been followed for routine inspection/maintenance, calibration, repair of failure or malfunction, and testing and cleaning of all specialized equipment. • Appropriate written records include calibration or other written logs, work orders, service receipts, dated inspection sticker, etc. • All equipment used to measure or assess patient health status/condition is functioning properly. All specialized equipment (e.g., ultrasonography equipment, electrocardiogram (EKG) machine, defibrillator, audiometer, hemoglobin meter, glucometer, scales, etc.) are adequately maintained according to the specified manufacturer's guidelines for the equipment or is serviced annually by a qualified technician. • Blood pressure cuffs, monitors, and other related equipment need not be calibrated unless required by the manufacturer. Manufacturer guidelines must be available on site, indicating that it is not necessary to calibrate the equipment. **Note:** The term monitor includes, but not limited to, glucometers, EKG, BP monitors, hemocues, and audiometers.
F. Waiting Area	The facility has a waiting area of sufficient size to accommodate patients comfortably and to assure privacy during registration.

Criteria	II. Personnel Standards		
A.1. Professional health care personnel have current California licenses and certifications.	**Medical Professional**	**License/Certification**	**Issuing Agency**
	Certified Nurse Midwife (CNM)	RN License & Nurse-Midwife Certificate. Drug Enforcement Agency (DEA) Registration, *if appropriate*	CA Board of Registered Nursing DEA
	Certified Radiological Technologist (CRT)	CRT Certificate.	California Department of Public Health (CDPH), Radiologic Health Branch
	Doctor of Osteopathy (DO)	Physician's & Surgeon's Certificate DEA Registration	Osteopathic Medical Board of CA DEA
	Licensed Midwife (LM)	Licensed Midwife Certificate. Drug Enforcement Agency (DEA) Registration, *if appropriate*	Medical Board of CA DEA
	Licensed Vocational Nurse (LVN):	LVN License	CA Board of Vocational Nursing and Psychiatric Technicians
	Nurse Practitioner (NP)	RN License w/NP Certification & Furnishing Number DEA Registration, *if appropriate*	CA Board of Registered Nursing DEA
	Pharmacist (Pharm. D)	Pharmacist License	CA State Board of Pharmacy
	Physician/Surgeon (MD)	Physician's & Surgeon's Certificate DEA Registration	Medical Board of CA DEA
	Physicians' Assistant/ Associate (PA)	PA License DEA Registration, *if appropriate*	Physician Assistant Examining Committee/Medical Board of CA DEA
	Radiological Technician	Limited Permit	CDPH, Radiologic Health Branch
	Registered Dietitian (RD)	RD Registration Card	Commission on Dietetic Registration
	Registered Nurse (RN)	RN License	CA Board of Registered Nursing
	II.A.1) All required Professional Licenses and Certifications, issued from the appropriate licensing/certification agency, are current. **Note:** All medical professional licenses and certifications must be current and issued from the appropriate agency for practice in California, and available on site. Although sites with centralized personnel departments are not required to keep documents or copies on site, copies and/or lists of currently certified or credentialed personnel must be readily available when requested by reviewers.		

<table>
<tr><th>Criteria</th><th colspan="2">II. Personnel Standards</th></tr>
<tr><td rowspan="2">A.2. All required professional licenses and certifications, issued from the appropriate licensing/certification agency, are current.</td><td><u>Note</u>:
Effective June 27, 2010, MDs (does not apply to Osteopaths) shall provide notification to each patient that states the MD(s) on site is licensed and regulated by the Board, and includes the following:[16]

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

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

The notice to consumers above shall be provided by one of the following methods:
○ Prominently posted sign in an area visible to patients in at least 48-pt Arial font.
○ A written statement signed and dated by the patient (or patient's representative) and kept in the medical record, stating the patient understands that the MD is licensed and licensed and regulated by the board (for PA's, that the PA is licensed and regulated by the PA Board).
○ A statement on letterhead, discharge instructions or other document given to the patient (or patient's representative), where the notification is placed immediately above the signature line for the patient in at least 14-pt font.</td></tr>
<tr><td>B. Health care personnel are properly identified.</td><td colspan="2">II.B.1) Health care personnel wear identification badges/tags printed with name and title.
• Health care personnel shall disclose, while working, their name and title on a name tag at least 18-point type.
• It is acceptable for health care personnel in a practice or an office, whose license is prominently displayed, to opt not to wear a nametag.

<u>Note</u>:
• In the interest of public safety and consumer awareness, it shall be unlawful for any person to use the title "nurse" in reference themselves, in any capacity, except for an individual who is a registered nurse, or a licensed vocational nurse.
• "Health care practitioner" means any person who engages in acts that are the subject of licensure or regulation under Business and Professions Code (Sections 680-681). If a health care practitioner or licensed clinical social worker is working in a psychiatric setting or in a setting that is not licensed by the state, the employing entity or agency shall have the discretion to make an exception from the nametag requirement for the individual safety or therapeutic concerns.</td></tr>
</table>

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

Criteria	II. Personnel Standards
C. Site personnel are qualified and trained for assigned responsibilities.  **RN/NP/CNM/LM/MD/PA**	**II.C.1) Unlicensed Personnel:** Medical assistants (MAs) are unlicensed health personnel, at least 18 years of age, who perform basic administrative, clerical, and non-invasive routine technical supportive services under the supervision of a licensed physician, surgeon, or podiatrist in a medical office or clinic setting. • "Supervision" means the licensed physician must be physically present in the treatment facility during the performance of authorized procedures by the MA. • Per Business and Professions Code Section 2069 (a) (1), a supervising physician and surgeon at a "community clinic" licensed under Health and Safety Code section 1204(a) may, at their discretion, in consultation with the nurse practitioner, nurse midwife, or physician assistant provide written instructions to be followed by a medical assistant in the performance of tasks or supportive services. • The written instructions may provide that the supervisory function for the medical assistant in performing these tasks or supportive services may be delegated to the nurse practitioner, nurse midwife, or physician assistant and that those tasks may be performed when the supervising physician and surgeon is not on site. **II.C.1) Documentation of education/training for non-licensed medical personnel is maintained on site.** • Training may be administered under a licensed physician; or under an RN, LVN, PA, or other qualified medical assistant acting under the direction of a licensed physician. The supervising physician is responsible for determining the training content and ascertaining proficiency of the MA. Training documentation maintained on site for the MA must include the following: • Diploma or certification from an accredited training program/school, or • Letter/statement from the current supervising physician that certifies in writing: date, location, content, and duration of training, demonstrated proficiency to perform current assigned scope of work, and signature.
	II.C.2) (CE) Only qualified/trained personnel retrieve, prepare or administer medications. Medication administration by an MA means the direct application of pre-measured medication orally, sublingually, topically, vaginally or rectally; or by providing a single dose to a patient for immediate self-administration by inhalation or by simple injection. • **All medications including vaccines must be verified with (shown to) a licensed person prior to administration.** • Unlicensed staff (e.g. MAs) have evidence of appropriate training and supervision in all medication administration methods performed within their scope of work. • To administer medications by subcutaneous or intramuscular injection, or to perform intradermal skin tests or venipunctures for withdrawing blood, an MA must have completed at least the minimum number of training-hours established in CCR, Title 16, Section 1366.1. **Note:** • **MAs cannot administer anesthetics, including local anesthetic agents (such as Rocephin hydrated with Xylocaine).** [18] • MAs may not place an intravenous needle, start or disconnect the intravenous infusion tube, administer medications or injections into an intravenous line, or administer anesthesia. The supervising physician must specifically authorize all medications administered by an MA. "Authorization" means a specific written or standing order prepared by the supervising physician.

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

Criteria	II. Personnel Standards
C. Site personnel are qualified and trained for assigned responsibilities.  **RN/NP/CNM/LM/MD/PA**	**II.C.3) Site has a procedure in place for confirming correct patient, correct medication/vaccine, correct dosage, and correct route prior to administration.** To help reduce the risk of medication errors, staff shall follow procedures for confirming the correct patient, correct medication/vaccine, correct dosage, and correct route prior to administration.
	II.C.4) Only qualified/trained personnel operate medical equipment. **Medical Equipment:** • Provider and/or staff can demonstrate appropriate operation of medical equipment used in their scope of work. Not all staff is required to be proficient in use of all equipment but at any given time, a staff must be prepared to operate equipment that is not routinely needed by every patient such as patient lifts and accessible scales. Health care personnel at the site must demonstrate that they can turn on the oxygen tank and tell when an oxygen tank needs to be replaced and/or refilled. **Note:** • Personnel on site must be qualified for their responsibilities and adequately trained for their scope of work. • Site staff should have a general understanding of the systems/processes in place, appropriate supervision, and knowledge of the available sources of information on site. • Family members and personal care assistants, whether paid or unpaid, are not "unlicensed personnel" or otherwise captured within the scope of this tool.
D. Scope of practice for non-physician medical practitioners (NPMP) is clearly defined.  **RN/NP/CNM/LM/MD/PA**	**II.D.1) Standardized Procedures provided for NPs and/or CNMs.** • The scope of practice for NPs and CNMs is clearly defined including the delegation of the supervision of MAs when supervising physician is off premises. • Documents may be utilized to determine and/or clarify practice procedures and supervisory processes on site. • Reviewers are expected to verify that NP and/or CNM standardized procedures, and PA Practice Agreement and Supervision Physician's Responsibility documentation are present on site. • Reviewers are ***not*** expected to make in-depth evaluation of "appropriateness" of the NPMP's scope of practice. **NPs:** • NPs are prepared through education and experience to provide primary care and to perform advanced procedures. • The extent of required supervision must be specified in the Standardized Procedures. • Standardized procedures legally define the expanded scope of nursing practice that overlaps the practice of medicine. • Standardized Procedures should identify the furnishing of drugs or devices, extent of physician or surgeon supervision, method of periodic review of competence, including peer review, and review of provisions in the Standardized Procedures. **CNM:** • The certificate to practice nurse-midwifery authorizes the holder, under supervision of a licensed physician or surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family planning care for the mother, and immediate care for the newborn. • The supervising and back-up physician or surgeon for the CNM must be credentialed to perform obstetrical care in the same delivering facility in which the CNM has delivery privileges. **Note:** CNMs and NPs operate under written Standardized Procedures that are collaboratively developed and approved by the supervising physician, the NP and administration within the organized health care facility/system in which standardized procedures will be used.

Criteria	II. Personnel Standards
D. Scope of practice for non-physician medical practitioners (NPMP) is clearly defined. **RN/NP/CNM/LM/MD/PA**	**II.D.2) A Practice Agreement defines the scope of services provided by PAs and Supervisory Guidelines define the method of supervision by the Supervising Physician.** **PA:** • Practice Agreement: a) Defines specific procedures identified in practice protocols or specifically authorized by the supervising physician, and must be dated and signed by physician and PA. b) The delegation of the supervision of MAs when supervising physician is off premises. c) An original or copy must be readily accessible at all practice sites in which the PA works. d) Failure to maintain a Practice Agreement is a violation of the PA Regulations and is grounds for disciplinary action by the Medical Board of California against a physician assistant's licensure. • Supervising Physician's Responsibility for Supervision of PAs' Practice Agreement: Defines supervision responsibilities and methods required by Title 16, section 1399.545 of the Physician Assistant Regulations, and is signed by the physician. The following procedures must be identified: ○ Emergency transport of patients and back-up procedures (e.g., can call 911, name of hospital to transport patient included in Practice Agreement) for when the supervising physician is not on the premises. **Note:** • A Delegation of Services Agreement (DSA) in effect prior to January 1, 2020, shall be updated to meet the current requirements.[19] • DSAs that still reflect components that are no longer required by BPC section 3502.3 should be enforced since the DSA is the currently established agreement between the PA and the supervising physician. • The reviewer should assess the site's process for compliance with the DSA. • Any deficiency shall result in a CAP requesting the site to adhere to the DSA components or establish a new Practice Agreement.
	II.D.3) Standardized Procedures, Practice Agreements, and Supervisory Guidelines are revised, updated, and signed by the supervising physician and NPMP when changes in scope of services occur. • Standardized Procedures, Practice Agreements shall undergo periodic review, with signed, dated revisions completed at each change in scope of work by supervising physician. • Frequency of the review to identify changes in scope of service shall be specified in writing.
	II.D.4) Each NPMP that prescribes controlled substances has a valid DEA Registration Number. **DEA:** Each NP, CNM, and PA that prescribes controlled substances is required to have a valid DEA Registration Number.

[19] BPC 3502.3

Criteria	II. Personnel Standards
E. Non-physician medical practitioners (NPMP) are supervised according to established standards.  **RN/NP/CNM/LM/MD/PA**	**The designated supervising physician(s) on site:** **II.E.1) Ratio to number of NPMPs does not exceed established ratios in any combination.** **NPMPs:** • The supervising physician holds ultimate responsibility for the practice of each supervised NPMP. • The maximum number of NPMPs who may be supervised by a single primary care physician (PCP) is limited to the following at any given time/shift in any of their locations:[20] ○ 4 NPs with furnishing license (there is no limit to the number of NPs the physician may supervise if the NP does not hold a furnishing license); ○ 4 CNMs; and ○ 4 PAs. This ratio is based on each physician, not the number of offices. A PCP, an organized outpatient clinic, or a hospital outpatient department cannot utilize more NPMPs than can be supervised within these stated limits. Physician Assistant Board (PAB) is at https://www.pab.ca.gov/ or the PAB office at 916-561-8780.
	II.E.2) The designated supervising or back-up physician is available in person or by electronic communication at all times when a NPMP is caring for patients. **Supervising Physician**: • "Supervision" means that a licensed physician and surgeon oversee the activities of, and accept responsibility for, the medical services rendered by a PA. Supervising or back-up physician is available in person or by electronic communication at all times when a NPMP is caring for patients.
	II.E.3) Evidence of NPMP supervision. **Evidence of NPMP Supervision:** • Standardized Procedures for NP or CNM should identify the furnishing of drugs or devices, extent of physician or surgeon supervision, method of periodic review of competence, including peer review, and review of provisions in the Standardized Procedures.[21] • Standardized Procedures shall undergo periodic review, with signed, dated revisions completed at each change in scope of work. • Evidence of supervision of NPMP(s) are verifiable through on-site observation of supervisory processes, documentation, or supervisor/NPMP's knowledge of the process.

[20] BPC 3516(b), Welfare and Institutions Code (WIC) section 14132.966
[21] BPC 2834

Criteria	II. Personnel Standards
F. Site personnel receive safety training.  **RN/NP/CNM/LM/MD/PA**	**II.F. There is evidence that site staff has received training on the following:** **1) Infection Control/Universal Precautions (annually)** **2) Bloodborne Pathogens Exposure Prevention (annually)** **3) Biohazardous Waste Handling (annually)** Training occurs ***prior to*** initial exposure to potentially infectious and/or biohazardous materials. Review and re-training sessions occur ***at least annually***. Training content is appropriate (language, educational level, etc.) to personnel on site. Training *minimally* includes the following: ○ Universal/standard precautions ○ Use of personal protective equipment ○ Accessible copy of Bloodborne Pathogens Standard ○ Work practice controls/exposure prevention ○ Modes of transmitting bloodborne pathogens ○ Epidemiology/symptoms of HBV and HIV ○ Recognition of activities with exposure element ○ Handling and labeling of biohazardous waste(s) ○ Hepatitis B vaccination protocol and requirements ○ Explanation of emergency procedures ○ Post exposure reporting/evaluation/follow-up procedures ○ Decontamination of equipment/work areas ○ Site's written bloodborne pathogen exposure plan ○ Opportunity for discussion/questions Personnel must know ***where to locate*** information/resources on site about infection control, the Bloodborne Pathogens Exposure Plan, and ***how to use*** the information. Evidence of training must be verifiable. Evidence of training may include: ○ Informal in-services ○ New staff orientation ○ External training courses ○ Educational curriculum ○ Participation lists, etc. Training documentation must contain: 1) Employee's name 2) Job titles 3) Training date(s) 4) Type of training 5) Contents of training session 6) Names/qualifications of trainers Records must be kept for three (3) years. **Note:** Site personnel treat all blood and other potentially infectious materials (OPIM) as if these *are* infectious. Site personnel who are reasonably anticipated to have eye, skin, mucous membranes and potential exposure to blood and/or OPIM receive training as required by the Bloodborne Pathogens Standard.[22]

[22] 8 CCR 5193

Criteria	II. Personnel Standards
G. Site personnel receive training on member rights.  **RN/NP/CNM/LM/MD/PA**	**II.G. There is evidence that site staff has received information and/or training on the following:** **II.G.1) Patient Confidentiality** • Site personnel have received information and/or training about patient confidentiality and must be prepared to provide information on how patient confidentiality is protected at the site. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written patient confidentiality information on site and explain how to use information.
	II.G.2) Informed Consent, including Human Sterilization • Site personnel have received information and/or training on informed consent, including human sterilization. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written informed consent, including human sterilization information on site and explain how to use information.
	II.G.3) Prior Authorization Requests • Site personnel have received information and/or training on prior authorization requests. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written prior authorization requests information on site and explain how to use information.
	II.G.4) II.F.4) Grievance/Complaint Procedure • Site personnel have received information and/or training on grievance/complaint procedure. Staff must be prepared to provide information to patient when requested. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written grievance/complaint procedures information on site and explain how to use information.
	II.G.5) Child/Elder/Domestic Violence Abuse **Abuse Reporting**: Site personnel have specific knowledge of local reporting requirements, agencies, and procedures, and know *where to locate* information on site and *how to use* information. **Note:** • Health practitioners (e.g., physicians, surgeons, licensed nurses, licensed social workers, paramedics) in a health facility, (e.g., clinic, physician's office, public health clinic) are legally mandated reporters of known or reasonably suspected cases of child abuse, elder abuse and domestic violence. • Legally mandated reporters must make telephone and written reports according to timeliness standards established by the designated local law enforcement agencies in each county. "Reasonably suspected" means having objectively reasonable suspicion based upon facts that could cause a reasonable person in a like position, drawing when appropriate on his or her training and experience, to suspect abuse (CA Penal Code 11164). • Failure to report by legally mandated reporters can result in criminal or civil prosecutions, punishable by monetary fines and/or county jail confinement. • Any person entering employment, which makes him/her a mandated reporter, must sign a statement, provided and retained by the employer, that the employee has knowledge of the Child Abuse reporting law and will comply with its provision.[23]

[23] Penal Code section 11166.5

Criteria	II. Personnel Standards
G. Site personnel receive training on member rights.  **RN/NP/CNM/LM/MD/PA**	**II.G.6) Sensitive Services/Minors' Rights** • Site personnel have received information and/or training on sensitive services/minors' rights. Sensitive Services include family planning, pregnancy, sexually transmitted infections, etc. • PCP sites must have basic information on sensitive services that are appropriate to their practice office and be prepared to provide information to patients when needed. • Minor's Rights: California Family Code provides that a minor may, without parental consent, receive a number of sensitive services including outpatient mental health treatment and counseling for children 12 years and older.
	II.G.7) Health Plan Referral Process/Procedures/Resources • Site personnel have received information and/or training on health plan referral process/procedures/resources. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written health plan referral process/procedures/resources information on site and explain how to use information.
	II.G.8) Cultural and Linguistic Training • Site personnel have received information and/or training on cultural and linguistic appropriate services. • Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • If there is no verifiable evidence of staff training, staff is able to locate written cultural and linguistic information on site and explain how to use information. Cultural and Linguistic Training- Culturally and Linguistically Appropriate Services (CLAS) mandates are Federal requirements for all recipients of Federal funds.[24]
	II.G.9) Disability Rights and Provider Obligations • Site personnel have received information and/or training on patient rights and provider obligations under the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and/or Section 1557 of the Affordable Care Act • Training content should include information about physical access, reasonable accommodations, policy modifications, and effective communication in healthcare settings. **https://www.hhs.gov/sites/default/files/ocr/civilrights/resources/factsheets/504.pdf** **https://www.hhs.gov/sites/default/files/section-1557-final-rule-faqs.pdf** **https://www.hhs.gov/sites/default/files/1557-fs-lep-508.pdf**
H. Org Chart	There is an established organizational structure with defined functions and responsibilities. (May be an organization chart or other document.)
I. Staff Monitoring	**Contract and temporary staff are identified and monitored appropriately.** **I.1)** Facility clearly identifies contracted services and temporary staff. **I.2)** Contracted and temporary staff are appropriately reviewed annually.
J. Life Support	**J.** Staff with Advanced Life Support (ALS) and/or Basic Life Support (BLS) are identified and their certification is current.

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

Criteria	III. Office Management Standards
A. Physician coverage is available 24 hours a day, 7 days a week.	**III.A.1) Clinic office hours are posted or readily available upon request.** Current clinic office hours are posted within the office or readily available upon request. **III.A.2) Provider office hour schedules are available to staff.** **III.A.3) Arrangement/schedule for after-hours, on-call, supervisory back-up physician coverage is available to site staff and members after-hours.** Current site-specific resource information is available to site personnel and members about physician office hour schedule(s), local and/or Plan-specific systems for after-hours urgent care, emergent physician coverage available 24 hours a day, 7 days per week, and system for providing follow-up care. **III.A.4) Contact information for off-site physician(s) is available at all times during office hours.** When a physician is not on site during regular office hours, personnel are able to contact the physician (or covering physician) at all times by telephone, cell phone, pager, etc. **III.A.5) Routine, urgent and after-hours emergency care instructions/telephone information is made available to patients.** **Note:** One objective of effective clinic office management is to support the provision of appropriate, coordinated health care services. The review of clinic office management is to evaluate if effective systems are in place and whether site personnel appropriately follow established site-specific procedures.
B. There are sufficient health care personnel to provide timely, appropriate health Care services. **RN/NP/CNM/LM/MD/PA**	**III.B.1) Appropriate personnel handle emergent, urgent, and medical advice telephone calls.** • In addition to the physician, only appropriately licensed medical personnel such as a CNM, LM, NP, RN, or PA handles emergency, urgent, and medical advice/triage telephone calls. • The California Board of Vocational Nursing and Psychiatric Technician Examiners has determined that the Licensed Vocational Nurse Practice Act does not permit the LVN to perform triage independently.[25] • The LVN may perform that part of the triage process that includes observation and data collection relative to basic physical assessment. • The LVN may not perform that part of the triage process that includes independent evaluation, interpretation of data, and determination of treatment priorities and levels of care. • Unlicensed personnel, such as medical assistants, may provide patient information or instructions only as authorized by the physician.[26] **Note:** Telephone triage is the system for managing telephone calls during ***and*** after office hours.

[26] 16 CCR 1366(b)

Criteria	III. Office Management Standards
B. There are sufficient health care personnel to provide timely, appropriate health Care services.  **RN/NP/CNM/LM/MD/PA**	**III.B.2) Telephone answering machine, voice mail system, or answering service is used whenever office staff does not directly answer phone calls.** Telephone answering machine, voice mail system, or answering service is used whenever office staff does not directly answer phone calls.
	III.B.3) Telephone system, answering service, recorded telephone information, and recording device are periodically checked and updated. Telephone system, answering service, recorded telephone information, and recording device are periodically checked and updated.
C. Health care services are readily available.  **RN/NP/CNM/LM/MD/PA**	**III.C.1) Appointments are scheduled according to patients stated clinical needs within the timeliness standards established for Plan members.** **Note:** Medi-Cal Managed Care Health Plans *require* the following timeliness standards for access to appointments: ○ Urgent Care: 48 hours ○ Access to the first Prenatal Visit: 10 business days ○ Non-urgent (Routine) Care: 10 business days
	III.C.2) Patients are notified of scheduled routine and/or preventive screening appointments. • The process established on site provides timely access to appointments for routine care, urgent care, prenatal care, pediatric periodic health assessments/immunizations, adult initial health assessments, specialty care, and emergency care. • Systems, practices, and procedures used for making services readily available to patients will vary from site to site.
	III.C.3) There is a process in place verifying follow-up on missed and canceled appointments. • An organized system must be evident (in use) for scheduling appointments appropriately, notifying, and reminding members of scheduled appointments, and following up on missed or canceled appointments. • Missed and/or canceled appointments and contact attempts must be documented in the patient's medical record.
D. There is 24-hour access to interpreter services for non- or limited-English proficient (LEP) members.	**III.D.1) Interpreter services are made available in identified threshold languages specified for location of site.** • Sites must provide 24-hour interpreter services for all members either through telephone language services or interpreters on site.

Criteria	III. Office Management Standards
D. There is 24-hour access to interpreter services for non- or limited-English proficient (LEP) members.	**III.D.2) Persons providing language interpreter services, including sign language on site, are trained in medical interpretation.** • Site personnel used as interpreters have been assessed for their medical interpretation performance skills/capabilities. • Reviewer should ask for a written policy which includes the languages spoken by bilingual providers and staff. **Note:** https://www.lep.gov; 22 CCR 51309.5 • If bilingual staff are asked to interpret or translate, they should be qualified to do so. Assessment of ability, training on interpreter ethics and standards, and clear policies that delineate appropriate use of bilingual staff, staff or contract interpreters and translators, will help ensure quality and effective use of resources. • Those utilizing the services of interpreters and translators should request information about certification, assessments taken, qualifications, experience, and training. Quality of interpretation should be a focus of concern for all recipients. • Family or friends should not be used as interpreters, unless specifically requested by the member's circumstances. Minors, under 18 years old, accompanying members shall not be used as interpreters. • The Affordable Care Act of 2010, Section 1557: prohibits from using low-quality video remote interpreting services or relying on unqualified staff, translators when providing language assistance services. • A request for or refusal of language/interpreter services must be documented in the member's medical record. Sign language interpreter services may be utilized for medically necessary health care services and related services such as: ○ Obtaining medical history and health assessments ○ Obtaining informed consents and permission for treatments ○ Medical procedures ○ Providing instructions regarding medications ○ Explaining diagnoses ○ Treatment and prognoses of an illness ○ Providing mental health assessment ○ Therapy or counseling
E. Procedures for timely referral/ consultative services are established on site. **RN/NP/CNM/LM/MD/PA**	**Office practice procedures allow timely provision and tracking of:** **III.E.1) Processing internal and external referrals, consultant reports, and diagnostic test results.** • An organized, timely referral system is evident for making and tracking referrals, reviewing reports, providing/scheduling follow-up care and filing reports in medical records. • Referral informational resources are readily available for use by site personnel. • Site staff can demonstrate (e.g., "walk through") the office referral process from beginning to end Systems, practices, and procedures used for handling referrals will vary from site-to-site. **III.E.2 (CE) Physician Review and follow-up of referral/consultation reports and diagnostic test results.** • There is a documented process of the practitioner review of diagnostic tests/consultations and subsequent outreach to follow-up with the patient to communicate results and provide next steps. • Practitioner review is evidenced by date and signature/initials on the report of the reviewing practitioner.

Criteria	III. Office Management Standards
F. Member grievance/ complaint processes are established on site.	**III.F.1) Phone number(s) for filing grievances/complaints are located on site.** • At least one telephone number for filing grievances is posted on site or is readily available upon request. **III.F.2) Complaint forms and a copy of the grievance procedure are available on site.** • Complaint forms and a copy of the grievance procedure are readily available on site and can be provided to members promptly upon request. • Includes The Department of Managed Health Care Help Center 1-888-466-2219 and Ombudsman 1-888-452-8609. **Note:** A "grievance" is defined as any written or oral expression of dissatisfaction and shall include any complaint, dispute, and request for reconsideration or appeal made by an enrollee or their representative to a Plan or entity with delegated authority to resolve grievances on behalf of the Plan.
G. Medical records are available for the practitioner at each scheduled patient encounter.	**III.G.1) Medical records are readily retrievable for scheduled patient encounters.** • The process/system established on site provides for the availability of medical records (paper and electronic), including outpatient, inpatient, referral services, and significant telephone consultations for patient encounters. **III.G.2) Medical documents are filed in a timely manner to ensure availability for patient encounters.** • Medical records are filed in a timely manner that allows for ease of accessibility within the facility or in an appropriate health record storage facility if stored off-premises.[27]
H. Confidentiality of personal medical information is protected according to State and federal guidelines. **RN/NP/CNM/LM/MD/PA**	**III.H.1) Exam rooms and dressing areas safeguard patients' right to privacy.** **Privacy:** • Patients have the right to privacy for dressing/undressing, physical examination, and medical consultation. • Practices are in place to safeguard patient privacy. • Because dressing areas and examination room configurations vary greatly, reviewers will make site-specific determinations.
	III.H.2) Procedures are followed to maintain the confidentiality of personal patient information. **Confidentiality:** • Personnel follows site policy/procedures for maintaining confidentiality of individual patient information. • Individual patient conditions or information is not discussed in front of other patients or visitors, displayed or left unattended in reception and/or patient flow areas (this includes unattended electronic devices, patient registration sign-in sheets with more than one unique patient identifier). • There must be a confidentiality agreement between the provider and the cleaning service agency/persons if the medical records are kept in an open space and/or are unsecured. **Electronic Records:** • Electronic record-keeping system procedures have been established to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures, and maintain upkeep of computer systems. • Security protection includes an off-site backup storage system, an image mechanism with the ability to copy documents, a mechanism to ensure that recorded input is unalterable, and file recovery procedures. • Confidentiality protection may also include use of encryption, detailed user access controls, transaction logs, and blinded files.

[27] 22 CCR 75055

Criteria	III. Office Management Standards
H. Confidentiality of personal medical information is protected according to State and federal guidelines.  **RN/NP/CNM/LM/MD/PA**	**III.H. 3) Medical record release procedures are compliant with State and federal guidelines.** **Record Release:** • Medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released. • The release terms, such as to whom records are released and for what purposes, and the expiration date of the consent to medical record release should also be described. • This does not prevent release of statistical or summary data, or exchange of individual identifiable medical information between individuals or institutions providing care, fiscal intermediaries, research entities and State or local official agencies.[28]
	III.H.4) Storage and transmittal of medical records preserves confidentiality and security. **Storage and transmittal:** • Health care services rendered under the Medi-Cal program or any other health care program administered by the department or its agents or contractors, shall confidentially and securely keep and maintain records of each service rendered under the Medi-Cal program or any other health care program administered by the department or its agents or contractors, the beneficiary or person to whom rendered, the date the service was rendered, and any additional information as the department may by regulation require. • FAX cover sheet shall have confidentiality statement.
	III.H.5) Medical records are retained for a minimum of 10 years. **Record Retention:** • Records required to be kept and maintained under this section (including minors under 18 years old) shall be retained by the provider for a period of 10 years from the final date of the contract period between the plan and the provider, from the date of completion of any audit, or from the date the service was rendered, whichever is later, in accordance with 42 CFR 438.3(u).[29]

[28] 45 CFR 164.524
[29] WIC 14124.1

Criteria	IV. Clinical Services - Pharmaceutical Standards
A. Drugs and medication supplies are maintained secured to prevent unauthorized access.	**Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, disposition, etc.) must be addressed in a corrective action plan. **IV.A.1) Drugs are stored in specifically designated cupboards, cabinets, closets or drawers.** **Security**: • All drugs for dispensing are stored in an area that is secured at all times.[30] The Medical Board defines "area that is secure" to mean a locked storage area within a physician's office. • Keys to locked storage area are available only to staff authorized by the physician to have access.[31] • The Medical Board of California interprets "all drugs" to also include both sample and over-the-counter drugs.[32]
	IV.A.2) Drugs, drug samples, and over-the-counter drugs, hypodermic needles/syringes, all medical sharp instruments, hazardous substances and prescription pads are securely stored in a lockable space (cabinet or room) within the office/clinic. • All drugs (including sample and over the counter), medication supplies, hazardous substances and prescription pads are securely stored in a lockable space (room, closet, cabinet, drawer) within the office/clinic.[33] (CA B&P Code, 4051.3) • A secure area means that drugs and biologicals are stored in a manner to prevent unmonitored access by unauthorized individuals. Drugs and biologicals must not be stored in areas that are readily accessible to unauthorized persons. (42 CFR 482.13-CMS Manual System; 42 CFR Part 482.25) • Keys to the locked storage area are available only to staff authorized by the physician to have access.[34] (16 CCR, Chapter 2, Division 3, Section 1356.32) • During business hours, the lockable space may remain unlocked ONLY if there is no access to this area by unauthorized persons and authorized clinic personnel remain in the immediate area at all times. At all other times, all drugs (including sample and over the counter), medication supplies, prescription pads and hazardous substances must be securely locked.
	IV.A.3) Controlled drugs are stored in a locked space accessible only to authorized personnel. **Controlled substances**: • Controlled substances are stored separately from other drugs in a securely locked, substantially constructed cabinet accessible only to authorized personnel.[35]

[30] BPC 4172
[31] 16 CCR 1356.3
[32] 22 CCR 75032 and 75033
[33] BPC 4051.3
[34] 16 CCR 1356.32
[35] 21 CFR 1301.75

Criteria	IV. Clinical Services - Pharmaceutical Standards
A. Drugs and medication supplies are maintained secured to prevent unauthorized access.	**IV.A.4) A dose-by-dose controlled substance distribution log is maintained.** • Written records are maintained of controlled substances inventory list(s) that includes: 1) Provider's DEA number 2) Name of medication 3) Original quantity of drug 4) Dose 5) Date 6) Name of patient receiving drug 7) Name of authorized person dispensing drug and 8) Number of remaining doses • Control substances include all Schedule I, II, III, IV, and V substances listed in the CA Health and Safety Code, Sections 11053-11058, and do not need to be double locked. • Personnel with authorized access to controlled substances include physicians, dentists, podiatrists, PAs, licensed nurses, and pharmacists and specifically authorized employees.[36]
	IV.A.5) Written site-specific policy/procedure for dispensing of sample drugs are available on site. • A list of drugs available for use in the clinic shall be maintained. Site should have written site-specific policies and procedures (P&Ps) for use of sample medications including governing activities of pharmaceutical manufacturers' representatives American Society of hospital pharmacist (ASHP) Guidelines: Minimum Standard for pharmaceutical services in ambulatory care).[37] • Each clinic, which provides drug distribution services, shall have written policy and procedures for the safe and effective distribution, control, storage, use and disposition of drugs. **Note:** During business hours, the drawer, cabinet or room containing drugs, medication supplies or hazardous substances may remain unlocked ***only*** if there is no access to area by unauthorized persons. Whenever drugs, medication supplies or hazardous substances are unlocked, authorized clinic personnel must ***always remain*** in the immediate area. At all other times, drugs, medication supplies, and hazardous substances must be securely locked. Controlled substances are ***always locked***.
B. Drugs are handled safely and stored appropriately. **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan (CAP). **IV.B.1) Drugs are prepared in a clean area or "designated clean" area if prepared in a multi-purpose room.** **Drug Preparation:** Drugs shall be drawn up in a designated clean medication preparation area that is not adjacent to potential sources of contamination, including sinks or other water sources. The drug preparation area should be cleaned and disinfected on a regular basis. CDC guidelines for drug preparation and safety: https://www.cdc.gov/injectionsafety/providers/provider_faqs_med-prep.html

[36] 21 CFR 1301.72

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

Criteria	IV. Clinical Services - Pharmaceutical Standards
B. Drugs are handled safely and stored appropriately. 🗣 🗁 **RN/NP/CNM/LM/MD/PA**	**IV.B.2) Drugs for external use are stored separately from drugs for internal use.** **Storage:** • Drugs shall be separated by route of administration, especially ophthalmic and otic preparations. • Vaccines and other drugs should be stored separately from food, lab specimens, human specimens, cleaning supplies, and other items that may potentially cause contamination. • The Center for Disease Control (CDC) recommends avoiding storing other medications and biological products such as lab specimens/human specimens in a vaccine storage unit.

	IV.B.3) Items other than medications in refrigerator/freezer are kept in a secured, separate compartment from drugs.
	• Storing food, other medications, and biological products with vaccines put vaccines at risk for temperature fluctuation, excessive light exposure, administration errors, and contamination.
	  ○ If food, other medications and biological products must be stored in the same refrigerator with vaccines, they must be in the sealed containers and stored below vaccines on the different shelves.
	• Drugs are stored under appropriate conditions of temperature, humidity, and light so that the identity, strength, quality, and purity of the drug product are not affected.[38]
	• Room temperature where drugs are stored does not exceed 30ºC (86ºF).[39]
	• A drug or device is considered "adulterated" if it contains any filthy, putrid, or decomposed substance, or if it has been prepared, packed or held under unsanitary conditions.[40]
	• A drug is considered contaminated if it has been held under unsanitary conditions that may have been contaminated with filth or rendered injurious to health.
	• Drugs that are unused are considered by the Environmental Protection Agency (EPA) to be toxic wastes and must be disposed in accordance with 40 CFR, part 261.
	American College of Physician guidelines state sound management procedures include:
	  ○ Routinely checking for expiration dates.
	  ○ Keeping medicines off the floor.
	  ○ Labeling the sample medicines or writing prescribing information directly on the sample package.
	  ○ Keeping a log of sample medicines given. In case of a recall, keeping a log allows to track down a patient to whom the recalled drug had been prescribed.
	  ○ When a medication sample is given to a patient, the name and strength of the medication, instructions for use and the quantity or duration of therapy is always documented in the patient's chart.
	ASHP guidelines for minimum standard for pharmaceutical services in ambulatory care:
	  ○ Site should have written site-specific policies and procedures (P&Ps) for use of sample medications including governing activities of pharmaceutical manufacturers' representatives.
	  ○ Each clinic, which provides drug distribution services, shall have written policy and procedures for the safe and effective distribution, control, storage, use and disposition of drugs.[41]
	Immunobiologics:[42]
	• Sites should have a written Vaccine Management Plan for routine and emergency vaccine management (required for Vaccines for Children (VFC) providers).
	• Vaccines are refrigerated immediately upon receipt on site and stored according to specific instructions on the package insert for each vaccine.
	• Diluent does not need refrigeration if vaccine is administered right after diluent is added.
	• Vaccines are not stored in the doors, floors, vegetable bins, or under or near cooling vents of a refrigerator or freezer.

Criteria	IV. Clinical Services - Pharmaceutical Standards

[38] 21 CFR 211.142
[39] 22 CCR 75037(d)
[40] Title 21, United States Code (USC), section 351. USC is searchable at: https://uscode.house.gov/search/criteria.shtml.
[41] The ASHP Guidelines for Minimum Standard for Ambulatory Care Pharmacy Practice is available at: https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/anticoagulation/guidelines-minimum-standard-ambulatory-care-pharmacy.ashx?la=en&hash=ABF816352CAF1AB846B7C339A45AA74D80F820A6.
[42] See the FDA's webpage on Vaccines, available at: https://www.fda.gov/vaccines-blood-biologics/vaccines/questions-about-vaccines.

B. Drugs are handled safely and stored appropriately.  **RN/NP/CNM/LM/MD/PA**	**IV.B.4) Refrigerator thermometer temperature is 36º-46º Fahrenheit or 2º-8º Centigrade (at time of site visit).** **Refrigerator:** Vaccines are kept in a refrigerator **maintained at 2-8ºC or 36-46ºF,** and include, but are not limited to, DTaP, Td, Tdap, Hepatitis A, Hepatitis B, IPV, Pneumococcal, Rotavirus, Hib, Influenza (inactivated and FluMist), MCV, HPV, recombinant Zoster, or any combinations of these listed vaccines.[43]
	IV.B. 5) Freezer thermometer temperature is 5º Fahrenheit or –15º Centigrade, or lower (at time of site visit). **Freezer:** Varicella and MMRV vaccines are stored in the **freezer at -15ºC or 5ºF, or lower,** and are always protected from light. ○ MMR may be stored in a refrigerator or freezer; VFC recommends MMR be stored in the freezer with MMRV. ○ Never freeze vaccine diluents.
	IV.B. 6) Site utilizes drugs/vaccine storage units that are able to maintain required temperature. CDC recommends for both temporary and long-term storage refrigerators and freezers using: ○ Purpose-built units designed to either refrigerate or freeze (can be compact, under-the counter style or large units). ○ Stand-alone household units. ○ Units dedicated to storage of biologics. ○ Measures should be in place to ensure that vaccine storage units are not accidentally physically disconnected from the power supply, such as "Do Not Disconnect" labels and not plugging units into surge protectors with an on/off switch. **Do not store any vaccine in a dormitory-style or bar-style combined refrigerator/freezer unit under any circumstances.[44]**
	IV.B. 7) Daily temperature readings of drugs/vaccines refrigerator and freezer are documented. Refrigerator and freezer temperatures are documented at least once a day (required twice daily for VFC providers). CDC recommends use of a continuous temperature monitoring device (digital data loggers). ○ Digital data loggers (DDL) should have a minimum accuracy of +/- 1°F (0.5°C) ○ Equipped with buffered probe ○ Active temperature display outside of the unit ○ Capacity for continuous monitoring and recording where the data can be routinely downloaded ○ Calibrated at least every 2 years, to monitor vaccine storage unit temperatures ○ At least one back-up device should be readily available for emergency vaccine transport or when primary DDL is sent in for calibration.
	IV.B. 8) Has a written plan for vaccine protection in case of power outage or malfunction of the refrigerator or freezer. • A written plan for vaccine protection in case of power outage or malfunction of the refrigerator or freezer is required. www.cdc.gov https://www.cdc.gov/disasters/poweroutage/vaccinestorage.html • Site personnel must be able to verbalize the procedures in the plan used to promptly respond to OUT OF RANGE TEMPERATURES. • Quarantine vaccines until guidance is obtained. • Action is taken when temperatures are identified to be outside of the recommended range. • Contacting VFC (http://eziz.org/vfc/overview/) or manufacturer are acceptable procedures. • For VFC providers, follow program requirements for documentation and reporting. • Consultation with CDC is available when necessary.[45] www.cdc.gov

Criteria	IV. Clinical Services - Pharmaceutical Standards

[43] See the CDC Vaccine Recommendation and Guidelines of the Advisory Committee on Immunization Practices, available at: https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/storage.html, and the CDC Vaccine Storage and Handling Toolkit, available at: https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf.

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

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

B. Drugs are handled safely and stored appropriately. **RN/NP/CNM/LM/MD/PA**	**IV.B. 9) Drugs and vaccines are stored separately from test reagents, germicides, disinfectants, and other household substances.** • As these items may potentially cause contamination to verify that drugs are stored separately from test reagents, germicides, disinfectants, and other household substances. **IV.B.10) Hazardous substances are appropriately labeled.** **IV.B.11) Site has method(s) in place for drug and hazardous substance disposal.** **Hazardous Substances Labeling and Disposal**: • Safety practices are followed in accordance with current/updated CAL-OSHA standards and 29 CFR 1910.1030. • The manufacturer's label is not removed from a container (bag, bottle, box, can, cylinder, etc.) only if the hazardous material or residues of the material remain in the container. • Containers for biohazard waste shall comply with United States Department of Transportation requirements when prepared for transport offsite from the facility. • A hazardous waste transporter transporting medical waste shall maintain a completed tracking document and provide a copy of that document to the medical waste generator (clinic, etc.). All portable containers of hazardous chemicals and secondary containers into which hazardous substances are transferred or prepared require labeling. Labels must provide the following information: 1) Identity of hazardous substance 2) Description of hazard warning: can be words, pictures, symbols 3) Date of preparation or transfer **Exception**: Labeling is not required for portable containers into which hazardous chemicals are transferred from labeled containers, and which are intended only for the immediate use of the individual who performs the transfer. **Note:** The purpose of hazard communication is to convey information about hazardous substances used in the workplace. A hazardous substance is any substance that is a physical or health hazard.
C. Drugs are dispensed according to State and federal drug distribution laws and regulations. **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan. **IV.C.1) There are no expired drugs on site.** **Expiration Date:** • The manufacturer's expiration date must appear on the labeling of all drugs and formulas. • All prescription drugs not bearing the expiration date are deemed to have expired. • If a drug is to be reconstituted at the time of dispensing, its labeling must contain expiration information for both the reconstituted and unreconstituted drug. • Expired drugs may not be distributed or dispensed. • Per CDC – Medication Vials should be discarded whenever sterility is compromised or questionable. • Per CDC "If a multi-dose has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial". • Per VFC "For multi-dose vials that do not require reconstitution, doses that remain after withdrawal of a dose can be administered until the expiration date printed on the vial unless otherwise specified by the manufacturer (Polio, meningococcal polysaccharide vaccine (MPSV4), PPSV, TIV, IPV, and yellow fever that are available in multi-dose vials)".[46] • Both CDC and VFC recommend to follow the manufacturer's product information.

[46] See the CDC Frequently Asked Questions regarding Multi-dose vials, available at: https://www.cdc.gov/injectionsafety/providers/provider_faqs_multivials.html, and the CDC Vaccine Storage and Handling Toolkit, available at: https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf.

Criteria	IV. Clinical Services - Pharmaceutical Standards
C. Drugs are dispensed according to State and federal drug distribution laws and regulations. 🗁 **RN/NP/CNM/LM/MD /PA**	**IV.C.2) Site has a procedure to check expiration date of all drugs (including vaccines and samples), and infant and therapeutic formulas.** • Site has a procedure to check expiration date of all drugs (including vaccines and samples) and infant and therapeutic formula AT LEAST monthly.
	IV.C.3) All stored and dispensed prescription drugs are appropriately labeled. **Prescription Labeling**: • Labels shall be carefully preserved, and all medications shall be stored in their original containers. • Each prescription medication dispensed is in a container that is not cracked, soiled, or without secure closures.[47] • Each commercial container of a controlled substance shall have printed on the label the symbol designating the schedule in which such controlled substance is listed. • Drug container is labeled with the provider's name, patient's name, drug name, dose, frequency, route, quantity dispensed, and manufacturer's name and lot number. • California Pharmacy Law *does not* prohibit furnishing a limited quantity of sample drugs if dispensed to the patient in the package provided by the manufacturer, no charge is made to the patient, and appropriate documentation is made in the patient's medical record.[48] **Drug Distribution:** • Each clinic that provides drug distribution services has written policies and procedures for the safe and effective distribution control, storage, use and disposition of drugs. • In order to prevent inadvertent exposure to out-of-range temperatures, vaccines should never be re-distributed beyond the manufacturer/distributer-to-clinic distribution chain unless during an emergency. • In the event of necessary vaccine transport (emergency/power outage), vaccines must be packaged following CDC recommendations and include temperature monitoring devices during transport (approval is required for VFC providers prior to any vaccine transfer).

[47] 22 CCR 75037(A)
[48] BPC 4170 and 4171

Criteria	IV. Clinical Services - Pharmaceutical Standards
C. Drugs are dispensed according to State and federal drug distribution laws and regulations. 🗁 **RN/NP/CNM/LM/MD /PA**	**IV.C.4) (CE) Only lawfully authorized persons dispense drugs to patients.** **Drug Dispensing:** • Drug dispensing complies with all applicable State and federal laws and regulations. • Drugs are dispensed only by a physician, pharmacist, or other persons (e.g., NP, CNM, RN, PA) lawfully authorized to dispense medications upon the order of a licensed physician or surgeon. • Personnel such as MAs, office managers, and receptionists do not dispense drugs. • Drugs are not offered for sale, charged or billed to Medi-Cal members.[49] • A record of all drugs and formulas dispensed shall be entered in the patient's medical record. **Drug Administration:** • Basic safe practices for medication/vaccine administration, assess and document: 1) Patient's identity 2) Correct medication 3) Correct dose 4) Correct route 5) Appropriate time CMS Manual System;[50] • Proper preparation is critical for maintaining the integrity of the vaccine during transfer from the vial to the syringe. • Personnel can demonstrate or verbally explain procedure(s) used on site to confirm correct patient, medication/vaccine, dosage and route and vaccine are prepared and drawn only prior to administration. • Proper vaccine administration is critical to ensure that vaccination is safe and effective. • CDC recommends that all health care personnel who administer vaccines receive comprehensive, competency-based training on vaccine administration policies and procedures before administering vaccines. • Comprehensive, skills-based training should be integrated into existing staff education programs such as new staff orientation and annual education requirements.
	IV.C.5) (CE) Drugs and Vaccines are prepared and drawn only prior to administration. ACIP discourages the routine practice of providers' prefilling syringes. • Vaccines have a similar appearance after being drawn into a syringe, prefilling may result in administration errors. • Unused, provider prefilled syringes must be discarded if not used within the same day that they are filled. • Unused syringes that are prefilled by the manufacturer and activated (i.e., syringe cap removed, or needle attached) should be discarded at the end of the clinic day. • In certain circumstances in which a single vaccine type is being used (e.g., in preparation for a community influenza vaccination campaign), filling a small number (10 or fewer) of syringes may be considered (*5*). The doses should be administered as soon as possible after filling, by the same person who filled the syringes. • The Center for Biologics Evaluation and Research (CBER) at the FDA offers information concerning the storage and use of temperature-sensitive biological products that have been involved in a temporary electrical power failure or flood conditions.[51]

[49] BPC 4193
[50] 42 CFR 482.23(c)
[51] See the CDC's Vaccine Recommendations and Guidelines of the ACIP, available at: https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/administration.html.

Criteria	IV. Clinical Services - Pharmaceutical Standards
C. Drugs are dispensed according to State and federal drug distribution laws and regulations. 🗣 🗁 **RN/NP/CNM/LM/MD /PA**	**IV.C.6) Current Vaccine Information Sheets (VIS) for distribution to patients are present on site.** **Vaccine Immunization Statements**: • Since 1994, the National Childhood Vaccine Injury Act, Section 2126 of the Public Health Service Act, mandates that parents/guardians or adult patients be informed before vaccinations are administered. • Health care providers must present and offer a VIS to patients prior to any vaccine.[52] As of 2009, CDC allows providers to present a current VIS (such as a laminated copy in a binder, etc.) to the patient/parent/guardian and allow time for the patient to read and ask questions. Staff should also offer a copy each time.[53] • The date the VIS was given (or presented and offered) *and* the publication date of the VIS must be documented in the patient's medical record. • Federal law allows up to 6 months for a new VIS to be used. The most current VIS are available from state and local health departments or can be downloaded from the CDC web site at: http://www.cdc.gov/vaccines/pubs/vis/default.htm or by calling the CDC Immunization Hotline at (800) 232-2522. VFC contains current VIS and provider notifications at: http://www.eziz.org/
	IV.C.7) If there is a pharmacy on site, it is licensed by the CA State Board of Pharmacy. **Pharmacy:** • If a pharmacy is located on site and owned by the clinic, the license issued by the CA State Board of Pharmacy must be present on site. • Every pharmacy that dispenses a controlled substance must be registered with the DEA and be licensed by the CA State Board of Pharmacy. • A licensed pharmacist monitors drug distribution and policies and procedures for medication dispensing and storage. **Note:** "Dispensing" of drugs means the furnishing of drugs or devices directly to a patient or upon a prescription from a physician, dentist, optometrist, podiatrist, veterinarian, or upon an order to furnish drugs or transmit a prescription from a certified nurse midwife, nurse practitioner, physician assistant or pharmacist acting within the scope of his or her practice.
	IV.C.8) Site utilizes California Immunization Registry (CAIR) or the most current version. **Immunization Registry Utilization: Scoring must be No or Yes.** • DHCS requires documentation of immunizations in the California CAIR or the local registry. • If the clinic does not offer vaccines administration, the site staff shall be able to utilize the registry to access the member's immunization record. Contractor shall ensure that member-specific immunization information is periodically reported to an immunization registry (is) established in the Contractor's Service Area(s) as part of the Statewide Immunization Information System. Reports shall be made following the Member's initial health assessment and all other health care visits which result in an immunization being provided. Reporting shall be in accordance with all applicable State and Federal laws. DHCS Contract; CDC Recommendations at: www.cdc.gov/vaccines.

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

Criteria	IV. Clinical Services – Laboratory Review
D. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations.	**IV.D.1) Laboratory test procedures are performed according to current site-specific CLIA certificate.** **CLIA Certificates**: • All sites that perform laboratory testing for human health assessment, diagnosis, prevention, or treatment of disease has a current, unrevoked, unsuspended site-specific Clinical Laboratory Improvement Amendment (CLIA) certificate, or evidence of renewal. • Acceptable documentation such as the original certificate, copy of the original certificate, renewal receipt or other evidence of renewal submission is present on site or readily available upon request. The CLIA certificate or evidence of renewal should include the current site/clinic address. **Note:** Per 42 CFR, 493.35(b)(1-3), 493.43(b)(1-3) and 493.55(b)(1-3), laboratories must file a separate application for each laboratory location, with the following *exceptions*: 1) Laboratories that are not at a fixed location, that is, laboratories that move from testing site to testing site, such as mobile units providing laboratory testing, health screening fairs, or other temporary testing locations may be covered under the certificate of the designated primary site or home base, using its address. 2) Not-for-profit or Federal, State, or local government laboratories that engage in limited (not more than a combination of 15 moderately complex or waived tests per certificate) public health testing may file a single application, or 3) Laboratories within a hospital that are located at contiguous buildings on the same campus and under common direction may file a single application or multiple applications for laboratory sites within same physical location or street address. 4) A multi-site CLIA waiver can be used at all affiliated locations. A copy of the CLIA waiver must be at each individual location with the address of the main location on the waiver. A copy of the CLIA application must be reviewed by the CSR to verify the locations included for old and new locations. The CLIA Certificate on site includes one of the following: ○ Certificate of Waiver: Site can perform only exempt waived tests ○ Certificate for Provider-Performed Microscopy (PPM): Physicians, dentists, or NPMPs can perform PPM procedures and waived tests ○ Certificate of Registration: Allows moderate and/or high complexity lab testing to be conducted until compliance with CLIA regulations are determined by survey ○ Certificate of Compliance: Lab has been surveyed and found in compliance with all applicable CLIA requirements ○ Certificate of Accreditation: Lab is accredited by an accreditation organization approved by CMS **Waived Tests**: • If only waived tests are performed, site has a current CLIA Certificate of Waiver. • There are no specific CLIA regulations regarding the performance of waived tests. • Site personnel are expected to follow the test manufacturer's instructions. • Laboratories with certificates of waiver may not be routinely inspected by DHCS Laboratory Field Services Division but may be inspected as part of complaint investigations and on a random basis to determine whether only waived tests are being performed. **Moderate and High Complexity Tests:** Tests not listed as waived are divided into one of two categories, moderate complexity or high complexity, based on the complexity of the testing procedure. CLIA regulations for these categories list specific requirements for laboratory proficiency testing, patient test management, quality control, quality assurance, personnel, and inspections.

Criteria	IV. Clinical Services – Laboratory Review
D. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations.	**IV.D.2) Testing personnel performing clinical lab procedures have been trained.** **Personnel Training:** • Prior to testing biological specimens, personnel have been appropriately trained for the type and complexity of the laboratory services performed. • Personnel have demonstrated the ability to perform all testing operations reliably and to report results accurately. • Site personnel that perform CLIA waived tests have access to and can follow test manufacturer's instructions. • When requested, site personnel can provide a step-by-step verbal explanation or demonstration of test procedure and how to determine test results. • The required training and certification are established by legislation for personnel performing moderate and high complexity tests.[54] Reviewers are not expected to complete an in-depth evaluation of personnel performing moderate and high complexity tests.
	IV.D.3) Lab supplies (e.g. vacutainers, vacutainer tubes, culture swabs, test solutions) are inaccessible to unauthorized persons.
	IV.D.4) Lab test supplies are not expired. Lab supplies are disposed of by manufacturer's expiration date.
	IV.D.5) Site has a procedure to check expiration date and a method to dispose of expired lab test supplies. **Note:** Any site that performs tests or examinations on human biological specimens derived from the human body is, by definition, "laboratories" under State and federal law, and includes locations such as nurses' stations within hospitals, clinics, surgical centers, physician offices, and health fairs. The current listing of waived tests may be obtained at www.cms.gov or www.fda.gov includes an evaluation every two years (or sooner of complaint driven) by CDPH of personnel licenses/training, laboratory site inspection and demonstration of testing proficiency for moderate and high-complexity test sites. **Contact CDPH Laboratory Field Services (510) 620-3800 or LFSrecep@cdph.ca.gov for CLIA certification, laboratory license, or personnel questions.**

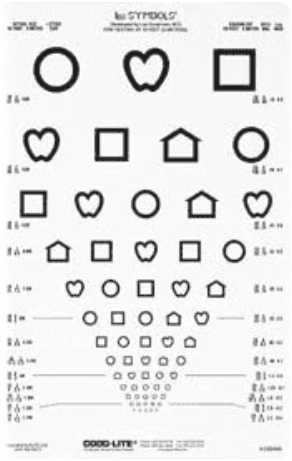
[54] BPC 1200-1213

Criteria	IV. Clinical Services – Radiology Review
E. Site meets CDPH Radiological inspection and safety regulations	**IV.E.1) Site has current CA Radiologic Health Branch Inspection Report and Proof of Registration if there is radiological equipment on site.** **CDPH Radiologic Health Branch (RHB) Inspection Report**: If site has ***current*** documentation of one of the following, give the full 9 points and survey items 2-9 will not need to be surveyed. Acceptable documentation is: ○ Inspection Report and Proof of Registration, ***or*** ○ Inspection Report and Proof of Registration *and* Short Form Sign-off sheet, ***or*** ○ Inspection Report and Proof of Registration *and* Notice of Violation form *and* approval letter for corrective action plan from the CA RHB The Radiologic Inspection Report and Proof of Registration (receipt of payment or cancelled check), issued by the RHB, must be present if there is radiology equipment on site. If any violations are found, one of two documents are issued to the site: ○ "Short Form Sign-off sheet" is issued for minimal problems that are easily corrected. ○ "Notice of Violation" form, requiring a site corrective action plan, is issued if there are more violations that are serious. All "Notice of Violation" corrective action plans must be accompanied by an approval letter from the CA RHB. **If documents are not available on site, or if reviewer is uncertain about the "status of documents on site, proceed to score all items 1-9.**
	The following documents are posted on site: IV.E.2) Current copy of Title 17 with a posted notice about availability of Title 17 and its location.
	IV.E.3) "Radiation Safety Operating Procedures" posted in highly visible location.
	IV.E.4) "Notice to Employees Poster" posted in highly visible location.
	IV.E.5) "Caution, X-ray" sign posted on or next to door of each room that has X-ray equipment.
	IV.E.6) Physician Supervisor/Operator certificate posted and within current expiration date.
	IV.E.7) Technologist certificate posted and within current expiration date.
	The following radiological protective equipment is present on site: IV.E.8) Operator protection devices: radiological equipment operator must use lead apron or lead shield.
	IV.E.9) Gonadal shield (0.5 mm or greater lead equivalent): for patient procedures in which gonads are in direct beam. **Radiological Equipment:** Equipment inspection, based on a "priority" rating system, is established by legislation. https://blink.ucsd.edu/_files/safety-tab/rad/Title-17-CCR.pdf • Mammography equipment is inspected annually, and must have federal FDA Certification on site ***and*** CA Mammography X-ray Equipment and Facility Accreditation Certification posted on the machine.[55] • High Priority equipment (e.g. fluoroscopy, portable X-ray) is inspected every three years. • Medium Priority equipment is inspected every 4-5 years depending on the volume of patients, frequency of x-ray equipment uses, and likelihood of radiation exposure. If reviewer is uncertain about the "status of equipment inspection, call the RHB.

[55] 21 CFR 900

Criteria	IV. Clinical Services – Radiology Review
E. Site meets CDPH Radiological inspection and safety regulations	**Radiology Personnel:** • All certificates/licenses are posted and show expiration dates. • If there are many technicians, a list of names, license numbers, and expiration dates may be substituted. • The Certified Radiological Technologist (CRT) certificate permits the technologist to perform all radiology films except mammography and fluoroscopy, which require separate certificates. • The "Limited Permit" restricts the technician to one of the ten-(10) x-ray categories specified on the limited certificate: Chest, Dental laboratory, Dermatology, Extremities, Gastrointestinal, Genitourinary, Leg-podiatric, Skull, Torso-skeletal, and X-ray bone densitometry. **Note:** • Per RHB, dexascanners do not require lead aprons or gonadal shields, however, criteria 1-7 are still required. • RHB uses the ALARA (As Low As Reasonably Achievable) principle, which is the foundation of all radiation safety programs. The ALARA principle means to minimize exposure to radiation doses by employing all *reasonable* methods. • Dexascanners manufacturer guidelines do not require gonadal shielding or lead aprons due to very low radiation output, and potential for the shield to obscure the area being scanned, possibly rendering the scan non-diagnostic. With the focused beam, operators do not need aprons, the amount of exposure of "scattered" beams to an operator seated near the scanner is about the same level as that found in the natural environment. A traditional x-ray machine used for bone density testing, is not a dexascanner, and *may* require shielding/apron. **Note:** The RHB of the Food, Drug, and Radiation Safety Division of CDPH enforces the Radiation Control Laws and Regulations designed to protect both the public and employees against radiation hazards. Enforcement is carried out through licensing, registration and periodic inspection of sources of radiation, such as radiation machines. For questions regarding radiologic safety (e.g. expired or no inspection letters on site), call CDPH RHB at (916) 327-5106. For Radiation Emergency Assistance, call 1-800-*852*-7550. Ref: CCR, Title 17, Chapter 5, Subchapter 4 regulations at https://www.cdph.ca.gov/rhb

Criteria	V. Preventive Services Standards
A. Preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases.	**Examination equipment, appropriate for primary care services, is available on site:** **V.A.1) Exam tables and lights are in good repair.** **Examination Table and Lights:** • Lights and exam tables shall be in good repair. "Good repair" means clean and well maintained in proper working order. • Examination tables must have a protective barrier such as paper which is changed between patients, to cover the exam surface.
	V.A.2) Stethoscope and sphygmomanometer with various size cuffs (e.g. child, adult, obese, thigh).
	V.A.3) Thermometer with a numeric reading.
	V.A.4) Basic exam equipment: in addition to items mentioned above, offices should have the following: o Percussion hammer o Tongue blades o Patient gowns
	V.A.5) Scales: Standing balance beam and infant scales. **Scales:** • Infant scales are marked and accurate to increments of one (1) ounce or less and have a capacity of at least 35 pounds. • Standing floor scales are marked and accurate to increments of one-fourth (1/4) pound or less and have a capacity of at least 300 pounds. • Balance beam scales have an adjustment mechanism and zeroing weight to enable routine balancing at zero. • Electronic or digital scales have automatic zeroing and lock-in weight features. • Spring balance scales (e.g. bathroom scales) are unsatisfactory for clinical use as, over time, the spring counterbalance mechanism loses its accuracy.
	V.A.6) Measuring devices for stature (height/length) measurement and head circumference measurement. **Measuring Devices:** Equipment on site for measuring stature (length/height) and head circumference includes: o Rigid 90º right angle headboard block that is perpendicular to the recumbent measurement surface. o Vertical to the wall-mounted standing measurement surface. o Flat, paper or plastic non-stretchable tape or yardstick, marked to one-eighth (1/8 in. or 1 mm) or less, attached to a firm, flat surface. The "0" of the tape is exactly at the base of the headboard for recumbent measurement, or exactly at foot level for standing measurement. o Moveable, non-flexible footboard at 90º right angle perpendicular to the recumbent measurement surface, or a flat floor surface for standing. o A non-stretchable tape measuring device marked to one-eighth (1/8 in. or 1 mm) or less for measuring head circumference (re-usable measuring device must be appropriately cleaned in between use).

Criteria	V. Preventive Services Standards
A. Preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases.	**V.A.7) Eye charts (literate and illiterate) and occluder for vision testing.** **Vision Testing:**[56] • Site has both literate (e.g., Snellen) and illiterate eye charts • The current preferred optotypes (figures or letters of different sizes) for patients who cannot distinguish letters are the LEA or HOTV symbols (see figures below)   • Wall mounted eye charts should be height adjustable and positioned at the eye-level of the patient • Examiners shall stand their patients with their heels to the line unless the eye chart that is being used to screen specifically instructs the patient to be positioned elsewhere. “Heel” lines are aligned with center of eye chart at 10 or 20-feet depending on whether the chart is for the 10-foot or 20-foot distance. • Eye charts are in an area with adequate lighting and at height(s) appropriate to use Effective occlusion, such as with tape or an occlusive patch of the eye not being tested, is important to eliminate the possibility of peeking.
	V.A.8) Ophthalmoscope. • Ophthalmoscope is in good working condition.
	V.A.9) Otoscope with adult and pediatric ear speculums. • Otoscope with multi-size ear speculums appropriate to the population served.

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

Criteria	V. Preventive Services Standards

A. Preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases.	**V.A.10) A pure tone, air conduction audiometer is located in a quiet location for testing.**
	Hearing Testing:[57]
	• The pure tone audiometer must have the minimum ability to:
	  ○ Produce intensities between 0 to 80 dB
	  ○ Have a headset with right and left earphones
	  ○ Be operated manually
	  ○ Produce frequencies at 1000, 2000, 3000, 4000, 6000, and 8000 Hz
	• Offices that provide pediatric preventive services should have a pure tone; air conduction audiometer available, audiometric testing is required at preventive health visits starting at 4 years of age.
	• PCP offices (such as Family Practitioners or General Practitioners) that refer all members to another provider for audiometric testing, must have a system in place that clearly demonstrates that the PCP office verifies that audiometric testing has been completed and that those results are returned to the PCP for review.

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

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

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

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

Criteria	VI. Infection Control Standards
A. Infection control procedures for Standard/Universal precautions are followed. 🗣 🗁 **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan (CAP). **Hand Washing Facilities:**[59] • Hand washing facilities are available in the exam room and/or utility room, and include an adequate supply of running potable water, soap and single use towels or hot air-drying machines. • Sinks with a standard faucet, foot-operated pedals, 4-6-inch wing-type handle, automatic shut-off systems or other types of water flow control mechanism are acceptable. • Staff can demonstrate infection control "barrier" methods used on site to prevent contamination of faucet handle, door handles and other surfaces until hand washing can be performed. • On occasions when running water is not readily available, an antiseptic hand cleanser, alcohol-based hand rub, or antiseptic towelettes is acceptable until running water is available.[60] **VI.A.1) Soap or antiseptic hand cleaner and running water are available in exam and/or treatment areas for hand washing.** **Soap or Antiseptic Hand Cleaner:** Hand washing prevents infection transmission by removing dirt, organic material and transient microorganisms from hands. ○ Hand washing with plain (non-antimicrobial) soap in any form (e.g., bar, leaflet, liquid, powder, granular) is acceptable for general patient care (Association for Professionals in Infection Control and Epidemiology, Inc., 1995). ○ Antimicrobial agents or alcohol-based antiseptic hand rubs are used for hand washing when indicated to remove debris and destroy transient microorganisms (e.g., before performing invasive procedures, after contact with potentially infectious materials). ○ Plain and antiseptic hand wash products are properly maintained and/or dispensed to prevent contamination.
	VI.A.2) A waste disposal container is available in exam rooms, procedure/treatment rooms, and restrooms. **Waste Disposal Container:**[61] • Contaminated wastes (e.g. dental drapes, band-aids, sanitary napkins, soiled disposable diapers) are disposed of in regular solid waste (trash) containers, and are maintained to prevent potential contamination of patient/staff areas and/or unsafe access by infants/children. • Closed containers are not required for regular, solid waste trash containers.
	VI.A.3) Site has procedure for effectively isolating infectious patients with potential communicable conditions. **Isolation Procedures**:[62] • Personnel can demonstrate or verbally explain procedure(s) used on site to isolate patients with potentially contagious conditions from other patients. • If personnel are unable to demonstrate or explain site-specific isolation procedures *and* cannot locate written isolation procedure instructions, site is considered deficient. • Isolation procedures may vary from site to site. **Note:** • Infection Control standards are practiced on site to minimize risk of disease transmission. • Site personnel are expected to apply the principles of "Standard Precautions" (CDC, 1996), used for all patients regardless of infection status. • Standard precautions apply to blood, all body fluids, non-intact skin, and mucous membranes, which are treated as potentially infectious for HIV, HBV or HCV, and other bloodborne pathogens. • "Universal precautions" refer to the OSHA mandated program that requires implementation of work practice controls, engineering controls, bloodborne pathogen orientation/education, and record keeping in healthcare facilities.

[59] See the World Health Organization's Hand Hygiene guidelines, available at: https://www.who.int/gpsc/5may/Hand_Hygiene_Why_How_and_When_Brochure.pdf.
[60] 29 CFR 1919.1030
[61] HSC 118275-118320. Also see the OSHA Standards for Bloodborne Pathogens, available at: https://www.hercenter.org/rmw/osha-bps.php.
[62] See the CDC's Guidelines for Isolation Precautions, available at: https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html.

Criteria	VI. Infection Control Standards
B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. **RN/NP/CNM/LM/MD/ PA**	**Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan. **VI.B.1) (CE) Personal Protective Equipment for Standard Precautions is readily available for staff use.** **Personal Protective Equipment (PPE):** PPE must be readily available.[63] PPE for protection against bloodborne pathogen hazards is available on site and must include: 1) Gloves 2) Water repellent clothing barrier/gown 3) Face/eye protection (e.g., goggles/face shield) 4) Respiratory infection protection (e.g., mask) PPE does not include general work clothes (e.g., uniforms, cloth lab coats) that will permit liquid to soak through. • The storage of PPE should be adequate to protect the PPE from contamination, loss, damage, water or sunlight. • Proper storage often requires a dry and clean place that is not subject to temperature extremes.
	VI.B.2) (CE) Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport or shipping. **Blood and Other Potentially Infectious Materials (OPIM):** • OPIM are all human body fluids, any unfixed tissue or organ (other than intact skin) from a human (living or dead), and HIV or HBV-containing blood, cells, tissue, organs, cultures, medium or solutions. • Containers for blood and OPIM are closable, leak proof, and labeled and/or color-coded. Double bagging is required only if leakage is possible. **Labels:** • A warning label is affixed to red-bagged regulated wastes, sharps containers, refrigerators/freezers containing blood or OPIM, containers used to store or transport blood or OPIM, and contaminated laundry or equipment for storage or transporting. • The international biohazard symbol with word "BIOHAZARD" *or* the words "Biohazardous Waste" label (fluorescent orange or red orange with contrasting lettering/symbols) is part of, or affixed to, the container. • Sharps containers are labeled with the words "Sharps Waste" or with the international biohazard symbol and the word "BIOHAZARD". • Individual containers of blood or OPIM are exempted from warning labels if placed inside a labeled secondary container for storage, transport, or disposal. • Alternative marking or color coding may be used to label contaminated laundry or specimen containers if the alternative marking permits employees on site to recognize that container requires compliance with Universal Precautions.

[63] 29 CFR 1910.1030

Criteria	VI. Infection Control Standards
B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. **RN/NP/CNM/LM/MD/PA**	**VI.B.3) (CE) Needlestick safety precautions are practiced on site.** **Needlestick Safety:**[64] • Contaminated sharps are discarded immediately. • Sharps containers are located close to the immediate area where sharps are used and are inaccessible to unauthorized persons. • Sharps are not bent, removed from a syringe, or recapped. Recapping, bending, or removing contaminated needles is permissible only if there is no feasible alternative or if such actions are required for a specific medical procedure. If recapping, bending, or removal is necessary, employers must ensure that workers use either a mechanical device or a one-handed technique. Needleless systems, needles with Engineered Sharps Injury Protection (ESIP) devices, and non-needle sharps are used (incl. in emergency kits), unless exemptions have been approved by Cal/OSHA.[65] • Security of portable containers in patient care areas is always maintained. • Any device capable of cutting or piercing (e.g. syringes, hypodermic needles, needleless devices, blades, broken glass, slides, vials) are placed in a closable, puncture-resistant, labeled, leak-proof container. If these requirements are met, containers made of various materials (e.g., cardboard, plastic) are acceptable. • Containers are not overfilled past the manufacturer's designated fill line, or more than ¾ full. • Supply of containers on hand is adequate to ensure routine change-out when filled.
	VI.B.4) All sharp injury incidents are documented. **Sharps Injury Documentation:**[66] • Site has a method in place to document sharps injuries. • The Sharps Injury Log must contain, at a minimum, information about the injury, the type and brand of device involved in the injury (if known), the department or work area where the exposure occurred, and an explanation of how the incident occurred. • The incident must be recorded in the log within 14 business days of the date the incident is reported to the employer and maintained in such a manner to protect the confidentiality of the injured employee (e.g., removal of personal identifiers) and follow-up care is documented within 14 days of injury incident. • Sites with 10 or fewer employees are exempt from OSHA recordkeeping requirements and are exempt from recording and maintaining a Sharps Injury Log, however, it is recommended to have a method in place to document sharps injuries regardless of the number of employees.
	Regulated Waste Storage: Regulated wastes include: ○ **Biohazardous wastes**, e.g., laboratory wastes, human specimens/tissue, blood/contaminated materials "known" to be infected with highly communicable diseases for humans and/or that require isolation. ○ **Medical wastes**, e.g., liquid/semi-liquid blood or OPIM, items caked with dry blood or OPIM and capable of releasing materials during handling, and contaminated sharps. **VI.B.5) Biohazardous (non-sharp) wastes are contained separate from other trash/waste.**

[64] See the OSHA Needlestick Safety Frequently Asked Questions, available at: https://www.osha.gov/needlesticks/needlefaq.html, and the OSHA Standards for Bloodborne Pathogens, available at: https://www.hercenter.org/rmw/osha-bps.php.
[65] 8 CCR 5193
[66] See 8 CCR 5193, and the National Institute for Occupational Safety and Health's guidance on Preventing Needlesticks and Sharps Injuries, available at: https://www.cdc.gov/niosh/topics/bbp/sharps.html.

Criteria	VI. Infection Control Standards
B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. **RN/NP/CNM/LM/MD/ PA**	**VI.B.6) Storage areas for regulated medical wastes are maintained secure and inaccessible to unauthorized persons.**[67] • Regulated waste is contained separately from other wastes (e.g., contaminated wastes)* and placed in red biohazardous bags with Biohazard label and stored in a closed container that is not accessible to unauthorized persons. • If stored outside the office, a lock secures the entry door, gate or receptacle lid, and posted warning sign(s) in English and Spanish are visible for 25-feet: "CAUTION-BIOHAZARDOUS WASTE STORAGE AREA- UNAUTHORIZED PERSONS KEEP OUT" and CUIDADO-ZONA DE RESIDUOUS-BIOLOGICOS PELIGROS-PROHIBIDA LE ENTRADA A PERSONAS NO AUTHORIZADAS". • See HSC Sections 117915-117946, 49 CFR, Section 173.6; Core Infection Prevention and Control Practices -Centers for Disease Control and Prevention (CDC) The Healthcare Infection Control Advisory Committee (HICPAC), 2016.
	VI.B.7) Contaminated laundry is laundered at the workplace or by a commercial laundry service. **Contaminated Laundry:** • Contaminated laundry (soiled with blood/OPIM) is laundered by a commercial laundry service, or a washer and dryer on site. • Contaminated laundry should not contain sharps, and when transported, should have the appropriate warning label. • Manufacturer's guidelines are followed to decontaminate and launder reusable protective clothing. • Ensure that laundry areas have handwashing facilities and products and appropriate PPE available for staff. • Laundry requirements are "not applicable" if only disposable patient gowns and PPE are used on site.
	VI.B.8) Transportation of regulated medical wastes is only by a registered hazardous waste hauler or to a central location of accumulation in limited quantities (up to 35.2 pounds). **Medical Waste Disposal:** California adopted statutes into HSC affecting medical waste transporters in October 1993.[68] • Only medical waste transporters listed with CDPH can transport medical waste. • All medical waste transporters must carry paperwork issued by CDPH in each vehicle while transporting medical waste. • Medical wastes are hauled to a permitted offsite medical waste treatment facility, transfer station, or other registered generator by a registered hazardous waste transporter. Limited-quantity exemption is not required for Small Quantity Generator (up to 35.2 pounds). However, a medical waste-tracking document that includes the name of the person transporting, number of waste containers (e.g., three sharps containers, or five biohazard bags), types of medical wastes, and date of transportation, is kept a minimum of 3 years for large waste generators and 2 years for small generators.

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

[68] HSC 117600-11836

Criteria	VI. Infection Control Standards
B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act.  **RN/NP/CNM/LM/MD/PA**	For the CDPH list of current medical waste transporters, visit: https://www.cdph.ca.gov/Programs/CEH/DRSEM/CDPH%20Document%20Library/EMB/MedicalWaste/Haulist_012921.pdf For information on the United States Postal Service mailability standards for medical waste (including sharps) refer to the Domestic Mail Manual, section 601.10.17:https://pe.usps.com/Archive/HTML/DMMArchive20100607/601.htm • CDPH Medical Waste Management Program: https://www.cdph.ca.gov/Programs/CEH/DRSEM/Pages/EMB/MedicalWaste/MedicalWaste.aspx • CDPH Medical Waste Management Program Transporter Checklist: https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8660.pdf • CDPH Medical Waste Transporter Annual Verification: https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8668.pdf • CDPH Medical Waste Transfer Stations and Offsite Treatment Facilities: https://www.cdph.ca.gov/Programs/CEH/DRSEM/Pages/EMB/MedicalWaste/Transfer-and-Treatment.aspx • CDPH Medical Waste Transporters Data Submission Protocol: https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8666.pdf • Department of Toxic Substances Control-Managing Hazardous Waste Transporters Registration https://dtsc.ca.gov/transporters/ ***Note:** Contaminated wastes include materials soiled with blood during their use but are not within the scope of regulated wastes. Contaminated waste items need not be disposed as regulated waste in labeled red bags but can be discarded as solid waste in regular trash receptacle.
C. Contaminated surfaces are decontaminated according to Cal-OSHA standards. **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan (CAP). **VI.C.1) Equipment and work surfaces are appropriately cleaned and decontaminated after contact with blood or other potentially infectious material.** **Routine Decontamination:** ○ Contaminated work surfaces are decontaminated with an appropriate disinfectant.[69] ○ Written "housekeeping" schedules have been established and are followed for regular routine daily cleaning. ○ Staff can identify cleaning and disinfection of surfaces and equipment, the disinfectant used and responsible personnel in between patients use.

[69] 29 CFR 1910.1030

Criteria	VI. Infection Control Standards
C. Contaminated surfaces are decontaminated according to Cal-OSHA standards.  **RN/NP/CNM/LM/MD/ PA**	**VI.C.2) Routine cleaning and decontamination of equipment/work surfaces is completed according to site-specific written schedule. The written schedule for cleaning and decontamination of the work site as follows:** ○ **Area cleaned/decontaminated** ○ **Frequency of cleaning/decontamination** ○ **Employee responsible for determining and implementing the written schedule** All equipment and environmental and work surfaces shall be cleaned and decontaminated after contact with blood or OPIM no later than at the end of the shift. Cleaning and decontamination of equipment and work surfaces is required more often as specified below: ○ Location within the facility ○ Type of surface or equipment to be treated ○ Type of soil or contamination present ○ Tasks or procedures being performed in the area Contaminated work surfaces shall be cleaned and decontaminated with an appropriate disinfectant immediately or as soon as feasible when: ○ Surfaces become overtly contaminated. ○ There is a spill of blood or OPIM. ○ Procedures are completed. ○ At the end of the work shift if the surface may have become contaminated since the last cleaning. **Spill Procedure:** Personnel can identify procedures for prompt decontamination of blood/body fluid spills, the disinfectant used, and the responsible person(s).
	Disinfectant solutions used on site are: **VI.C.3) Approved by the Environmental Protection Agency (EPA).**
	VI.C.4) Effective in killing HIV/HBV/TB.
	VI.C.5) Follow manufacturer instructions. **Disinfectant Products:** ○ Products used for decontamination have a current EPA-approved status. ○ Effectiveness in killing HIV/HBV/TB is stated on the manufacturer's product label. ○ Decontamination products are used according to manufacturer's guidelines for decontamination and contact times. **10% Bleach Solution:** ○ 10% bleach solution that is EPA registered and effective against TB, is changed/reconstituted ***every*** 24 hours (due to instability of bleach once mixed with water). ○ Surface is cleaned prior to disinfecting (due to presence of organic matter (e.g., dirt, blood, excrement) inactivates active ingredient, sodium hypochlorite). ○ Surface is air-dried or allowed appropriate time (stated on label) before drying. ○ Manufacturer's directions, *specific* to every bleach product, are followed carefully. **Note:** "Contamination" means the presence or reasonably anticipated presence of blood or OPIM on any item or surface. "Decontamination" is the use of appropriate physical or chemical means to remove, inactivate or destroy bloodborne pathogens so that a surface or item is no longer capable of transmitting infectious particles and is rendered safe for handling, use or disposal.[70] Current EPA product lists and information is available from the EPA, Antimicrobial Division at (703) 305-1284, or at 29 CFR 1910.1030.

[70] 8 CCR 5193. Also see CalOSHA's Best Practices Approach for Reducing Bloodborne Pathogen Exposure, available at: https://www.dir.ca.gov/dosh/dosh_publications/BBPBest1.pdf.

Criteria	VI. Infection Control Standards
D. Reusable medical instruments are properly sterilized after each use.  **RN/NP/CNM/LM/MD/PA**	**Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan (CAP). **VI.D.1) Written site-specific policy/procedures or manufacturer's instructions for instrument/equipment sterilization are available to staff.** If site uses an autoclave or cold chemical solution to achieve sterilization and/or high level disinfection (HLD) of instruments/equipment, site shall have specific policy/procedures or manufacturer's instructions addressing instrument/equipment pre-treatment, cleaning and preparation, the management of chemical solutions, autoclave loading and operation, safety guidelines and precautions, and other required processes, which are available to staff to follow.
	Staff adheres to site-specific policy and/or manufacturer/product label directions for the following procedures: **VI.D.2) Cleaning reusable instruments/equipment prior to sterilization.** **Cleaning Prior to Sterilization:** Prior to undergoing the sterilization process, soiled instruments/equipment are thoroughly cleaned using enzymatic detergent, rinsed, dried, and inspected for the presence of dried blood or other debris.
	Cold chemical sterilization/high level disinfection: **VI.D.3a) (CE) Staff demonstrate /verbalize necessary steps/process to ensure sterility and/or high-level disinfection of equipment.** • Personnel can demonstrate or verbally explain procedure(s) used for cleaning prior to sterilization, and to locate written directions on site. • Product efficacy tests (i.e. test strips) shall be performed according to manufacturer's guidelines. **Cold Chemical Sterilization/High Level disinfection:** • Product manufacturer's directions are strictly followed for instrument pre-soaking treatment, solution preparation, solution exposure procedures, safety precautions (e.g., room temperature, area ventilation), and post-sterilization processes. • Sterilization and or high-level disinfection exposure times and solution expiration date and time are available to staff. • Written procedures for cold sterilization and/or high-level disinfection is available on site to staff.
	VI.D.3b) Confirmation from manufacturer item(s) is/are heat sensitive. • Per CDC,[71] the use of liquid chemical germicides to sterilize instruments ("cold sterilization") are limited. Sterility is not verified or assured with cold chemical sterilization. The first choice is always heat sterilization. The CDC refers to heat sterilization as "the method of choice when sterilizing instruments and devices. If an item is heat sensitive, it is preferable to use a heat-stable alternative or disposable item". • The use of a liquid chemical sterilant should be restricted to reprocessing devices that are heat-sensitive and incompatible with other sterilization methods. All other items should be heat sterilized or disposable.

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

Criteria	VI. Infection Control Standards
D. Reusable medical instruments are properly sterilized after each use.  **RN/NP/CNM/LM/MD/PA**	**VI.D.3c) (CE) Appropriate PPE is available, exposure control plan, Material Safety Data Sheets (MSDS) and clean up instructions in the event of a cold chemical sterilant spill.** **Cold Chemical Sterilants Spillage:** The OSHA Hazard Communication Standard requires manufacturers and importers of hazardous chemicals to develop MSDS for each chemical or mixture of chemicals.[72, 73] ○ Employers must have the data sheets for cold chemical sterilants readily available to employees who work with the products to which they could be exposed. ○ Staff should attend training classes in safety awareness about the use and exposure to cold chemical sterilants used on site. ○ Personnel are familiar with and can recognize signs and symptoms of exposure to cold chemical sterilants used on site. ○ Staff must be aware of the procedures for clean up in the event of spillage. ○ Staff can demonstrate or verbally explain procedure(s) used on site for chemical spill cleanup. ○ If personnel are unable to demonstrate or explain site-specific chemical spill cleanup procedures *and* cannot locate written chemical spill cleanup procedure instructions, site is considered deficient. ○ Cleanup procedures may vary from site to site depending on the cold chemical sterilants used. ○ The appropriate PPE for cold chemical sterilants clean up must be readily available. National Institute for Occupational Safety and Health (NIOSH) with the Centers for Disease Control and Prevention. Environmental Health and Safety guidelines for disinfectants and sterilization methods. MSDS for cold chemical sterilants. The American National Standard (ANSI)/Advancing Safety in Medical Technology (AAMI) ST58:2013.
	Control Methods and Work Practices: are in place to prevent or reduce exposure to the cold chemical sterilants. Cold chemical sterilants have toxic properties and are hazardous. • Cold chemical sterilants must be used strictly in accordance with the manufacturer's directions. Always consult the manufacturer for safety precautions and MSDS information. • The appropriate PPE must be used to avoid inhalation or skin contact exposure to during the cold chemical sterilization/high level disinfection process. Examples of cold chemical sterilants include: ○ Glutaraldehyde (Cidex) ○ Peracetic acid ○ Hydrogen peroxide-based solutions Glutaraldehyde is a common cold chemical sterilants. Exposure to glutaraldehyde can cause the following health effects: throat and lung irritation, breathing difficulty, nose irritation, nosebleed, burning eyes and conjunctivitis, rash, hives, headaches, and nausea. Exposure to glutaraldehyde may be prevented or reduced by using the following control methods and work practices: ○ Use local exhaust ventilation. ○ Keep glutaraldehyde baths under a fume hood where possible.[74] ○ Avoid skin contact (use appropriate PPE-gloves and aprons made of nitrile or butyl rubber wear goggles and face shields). ○ Use only enough sterilants to perform the required sterilization procedure. ○ Seal or cover all containers holding the sterilants. ○ Attend training classes.

[72] 29 CFR 1910.1200, 1915.99, 1917.28, 1918.90, 1926.59, and 1928.21.
[73] See CDC guidelines on sterilizing heat sensitive dental instruments, available at: https://oshareview.com/2013/10/cdc-guidelines-sterilizing-heat-sensitive-dental-instruments-dental-infection-control/. 29 CFR 1910.1030(d)(3)(i), 29 CFR 1910.1030(d)(3)(ii), 29 CFR 1910.1030(d)(4)(ii)(A), 29 CFR 1910.1030(d)(4)(iii)(B), 29 CFR 1910.132, 29 CFR 1910.134. See the CDC Guidelines for Disinfection and Sterilization in Healthcare Facilities, available at: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/sterilization/index.html.
[74] For more information on glutaraldehyde exposure and safety tips, refer to the CDC guidance, available at: https://www.cdc.gov/niosh/docs/2001-115/default.html.

Criteria	VI. Infection Control Standards
D. Reusable medical instruments are properly sterilized after each use. **RN/NP/CNM/LM/MD/PA**	**Autoclave/Steam Sterilization:** **VI.D.4a) Staff demonstrate/verbalize necessary steps/process to ensure sterility.** • Autoclave manufacturer's directions are strictly followed for instrument pre-cleaning, machine loading, operation safety precautions, minimum time-temperature criteria, and post sterilization processes. • Written operating procedures for autoclave are available on site to staff. • Documentation of sterilization loads include date, time and duration of run cycle, temperature, steam pressure, and operator of each run. • If instruments/equipment are transported off-site for sterilization, equipment handling, and transport procedures are available on site to staff. • Documentation of instruments and personnel transporting must be maintained.
	VI.D.4 b) Autoclave maintenance per manufacturer's guidelines. **Autoclave Maintenance:** Autoclave is maintained and serviced according to manufacturer's guidelines. Documentation of maintenance should include: ○ Mechanical problems ○ Inspection dates ○ Results/outcome of routine servicing ○ Calibration ○ Repairs, etc. **Note:** If the manufacturer's guidelines are not present on site, then the autoclave is serviced annually by a qualified technician. A dated sticker on the autoclave or a service receipt is acceptable documentation of appropriate maintenance.
	VI.D.4c) (CE) Spore testing of autoclave/steam sterilizer with documented results (at least monthly). **Spore Testing:** • Autoclave spore testing is performed *at least monthly*, unless otherwise stated in manufacturer's guidelines. • Documentation of biological spore testing includes: ○ Date ○ Results ○ Types of spore test used ○ Person performing/documenting test results • Written procedures for performing routine spore testing and for handling positive spore test results are available on site to staff. • For positive spore tests, the autoclave is removed from service immediately until inspection is completed and a negative retest occurs. Procedures include: ○ ***Report*** problem ○ ***Repair*** autoclave ○ ***Retrieve*** all instruments sterilized since last negative spore test ○ ***Re-test*** autoclave ○ ***Re-sterilize*** retrieved instruments • Biologic spore test products vary and are designed for use based on specific autoclave type. Biologic control testing challenges the autoclave sterilization cycle with live, highly resistant, nonpathogenic spores. If spores are killed during processing, it is assumed that all other microorganisms are also killed and that the autoclave load is sterile. **Note: Documentation of monthly spore testing must be maintained onsite even for sterilization that is performed offsite.**

Criteria	VI. Infection Control Standards
D. Reusable medical instruments are properly sterilized after each use.  **RN/NP/CNM/LM/MD/PA**	**VI.D.4.d) (CE) Management of positive mechanical, chemical, and biological indicators of the sterilization process.** **Autoclave/Steam Sterilization Mechanical, Chemical, and Biological Indicators:**[75] • Sterilization failure can occur for reasons such as slight variation in the resistance of the spores, improper use of the sterilizer, and laboratory contamination during the culture. • Per CDC, the autoclave/steam sterilization procedure should be monitored routinely by using a combination of: ○ Mechanical Indicator: monitor sterilization process with a daily assessment of cycle time and temperature by examining the temperature record chart and an assessment of pressure via the pressure gauge (e.g., graphs, gauges, printouts) ○ Chemical Indicator: are usually either heat-or chemical-sensitive inks that change color when one or more sterilization parameters (e.g., steam-time, temperature, and/or saturated steam; ETO-time, temperature, relative humidity and/or ETO concentration) are present. ○ Biological: spore test – an indicator to evaluate the sterilizing conditions and indirectly the microbiologic status of the processed items ○ Staff should adhere to site-specific protocol and/or manufacturer/product label for management of positive indicator(s).
	VI.D.4.e) Sterilized packages are labeled with sterilization date and load identification information. **Package and storage of sterilized items:** • Following the sterilization process, medical and surgical devices must be handled using aseptic technique in order to prevent contamination. • Storage areas for sterilized packages are clean, dry and separated from non-sterile items by a functional barrier (e.g., shelf, cabinet door, and drawer). • Sterilized package labels include: ○ Date of sterilization ○ Load run identification information ○ Initials of staff member ○ General contents (e.g. suture set) each item in a sterile package need not be listed on the label if a master list of package contents is available elsewhere on site
	VI.D.4.f) Storage of sterilized packages. **Storage of sterilized packages:**[76] • Storage areas for sterilized packages are clean, dry and separated from non-sterile items by a functional barrier (e.g., shelf, cabinet door, and drawer). • Maintenance of sterility is event related, not time related. • Sterilized items are considered sterile until use, unless an event causes contamination. • Sterilized items are not considered sterile if package is opened, wet/moist, discolored or damaged, and should be kept removed from sterile package storage area. • Site has a process for routine evaluation of sterilized packages.

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

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

RN/MD Review only

Criteria	VII. Quality Assurance Performance Improvement Guidelines
1. QAPI committee	Facilities must have a Quality Assurance Performance Improvement (QAPI) committee which meets regularly and keeps minutes.
2. QAPI review of performance standards	The QAPI committee reviews performance standards for medical records, infection control, environment, personnel and other areas of concern.
3. QAPI committee quality monitoring	The QAPI committee identifies concerns, initiates corrective action plans, monitors the results of the plans, and makes appropriate changes based on an analysis of the data.
4. QAPI aware of and takes action on serious events	The QAPI committee is aware of serious events (sentinel events, abuse allegations, privacy breaches, complaints and grievances) and takes appropriate actions.
5. QAPI oversight of outside agencies	The QAPI committee reviews surveys, inspections, and reports submitted by outside agencies. Corrective action plans are available.
6. QAPI staff	Facility has a designated QA & PI coordinator.

Full Scope

Private Duty Nurse Site Review

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

Health Plan PHC **Site ID No.**_____ **Review Date:** _____ **Last review:** _____

Provider/Address _____ **Phone** _____ **Fax** _____

Contact person/title_____ **Email** _____

Reviewer/title _____

Fire Clearance Current: ❑ **Yes** ❑ **No**

Visit Purpose	**Provider Type**	**Clinic Type**
_____ Initial Full Scope _____ Periodic Full Scope _____ Monitoring _____ Follow-up _____ Focused	❑ Private Duty Nurse	❑ Private Home

Site Scores

		Points Poss.	Yes Pts. Given	No's	N/A's	CE's
I.	Access/Safety	(8)				
II.	Personnel	(4)				
III.	Office Management	(13)				
IV.	Clinical Services	(13)				
V.	Infection Control	(3)				
		(41)				
		Total Pts. Poss.	Yes Pts. Given	No's	N/A's	CE's

Scoring Procedure

1) Add points given in each section.
2) Add total points given for all five sections.
3) Adjust score for "N/A" criteria (if needed), by subtracting N/A points from 41 total points poss.
4) Divide total points given by 41 or by "adjusted" total points.
5) Multiply by 100 to get the compliance (percent) rate.

_____ ÷ _____ = _____ X 100 = _____%

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

Compliance Rate

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

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

_____ **Not Pass: 79%**

_____ CAP Required

_____ Other follow-up

Next Review Due: _____

Private Duty Nurse Site Review

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

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

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

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

A corrective action plan (CAP) is required for a total score less than 90%, *OR* for a total score of 90% or above if there are deficiencies in Pharmaceutical Services or Infection Control. Compliance rates are based on 41 total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer. Reviewers are expected to determine how to ascertain information needed to complete the survey. Survey criteria to be reviewed only by a R.N. or physician is labeled **RN/MD Review only**

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

1) Add the points given in each section.
2) Add points given for all five (5) sections to determine total points given for the site.
3) Subtract all "N/A" items from 41 total possible points to determine the "adjusted" total possible points. If there are no "N/A" items, calculation of site score will be based on 41 points.
4) Divide the total points given by 41 or by the "adjusted" total. Multiply by 100 to calculate percentage rate.

Scoring Example:

Step 1: Add the points given in each section.	**Step 2**: Add Yes points given for all five (5) sections. Example: 7 (Access/safety) 3 (Personnel) 11 (Office Management) 10 (Clinical Services) 3 (Infection Control) **34 (POINTS)**
Step 3: Subtract "N/A" points from 41 total points possible. 41 (Total points possible) – 5 (N/A points) 36 ("Adjusted" total points possible)	**Step 4**: Divide total points given by 41 or by the "adjusted" points, then multiply by 100 to calculate percentage rate. Points given / 41 or "adjusted" total or 34 / 36 = 0.9444 X 100 = **94%**

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Criteria	I. Access/Safety Reviewer Guidelines
A. Site environment is safe for all patients, visitors, and personnel.	• **Illumination**: Lighting is adequate. • **Access Aisle**: Building escape routes provide an accessible, unobstructed path of travel. Cords (including taped cords) are not a trip hazard. • **Exits**: Exit doorways are unobstructed. • **Electrical Safety**: Electrical cords are in good working condition with no exposed wires, or frayed or cracked areas. • **Fire Fighting/Protection Equipment**: There is firefighting/protection equipment in an accessible location on site at all times. At least one of the following types of fire safety equipment is on site: 1) Smoke Detector with intact, working batteries. 2) Fire Alarm Device. 3) Automatic Sprinkler System. 4) Fire Extinguisher in an accessible location and not expired.
B. Emergency health care services are available and accessible 24 hours a day, 7 days a week.	• **Site Specific Emergency procedures**: Licensed Professional is able to describe site-specific actions or procedures for handling medical emergencies. • **Emergency phone number list**: Posted list includes local emergency response services (e.g., fire, police/sheriff, and ambulance), emergency contacts and appropriate State, County, City and local agencies (e.g., local poison control number). The list should be dated, and updated annually.
C. Medical and lab equipment used for patient care is properly maintained.	• Medical and laboratory equipment: All equipment used to measure or assess patient health status/condition is clean. • Documentation: There is documented evidence that standard operating procedures have been followed for routine inspection/ maintenance, calibration, repair of failure or malfunction, and testing and cleaning of all specialized equipment. Appropriate written records include calibration or other written logs, work orders, service receipts, dated inspection sticker, etc. • All equipment used to measure or assess patient health status/condition is functioning properly. All specialized equipment are adequately maintained according to the specified manufacturer's guidelines for the equipment, or is serviced annually by a qualified technician.

I. Access/Safety (continued on next page)

Site Access/Safety Survey Criteria	Yes	No	N/A	Wt.	Site Score
A. Site environment is safe for all patients, visitors, and personnel. 8 CCR §3220; 22 CCR §53230; 24 CCR, §2, §3, §9; 28 CCR §1300.80; 29 CFR §1910.301, §1926.34					
The following fire and safety precautions are evidenced on site:					
1) Lighting is adequate in all areas to ensure safety.	1)_____	1)_____	1)_____	**1**	
2) Exit doors and aisles are unobstructed and egress (escape) accessible.	2)_____	2)_____	2)_____	**1**	
3) Electrical cords and outlets are in good working condition.	3)_____	3)_____	3)_____	**1**	
4) At least one type of firefighting/protection equipment is accessible at all times.	4)_____	4)_____	4)_____	**1**	
B. Emergency health care services are available and accessible 24 hours a day, 7 days a week. 22 CCR §51056, §53216; 28 CCR §1300.67					
1) Personnel are trained in procedures/action plan to be carried out in case of medical emergency on site.	1)_____	1)_____	1)_____	**1**	
2) Emergency phone number contacts are posted.	2)_____	2)_____	2)_____	**1**	
C. Medical and lab equipment used for patient care is properly maintained. CA Health & Safety Code §111255; 28 CCR §1300.80; 21 CFR §800-1299					
1) Medical equipment is clean.	1)_____	1)_____	1)_____	**1**	
2) Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines.	2)_____	2)_____	2)_____	**1**	
Comments: Write comments for all "No" (0 points) and "N/A" scores. Total points possible: 8					
Totals					

<table>
<tr><th>Criteria</th><th colspan="3">II. Personnel Reviewer Guidelines</th></tr>
<tr><td rowspan="4">A. Professional health care personnel have current California licenses and certifications.</td><td>Medical Professional</td><td>License/Certification</td><td>Issuing Agency</td></tr>
<tr><td>Registered Nurse (RN)</td><td>RN License.</td><td>CA Board of Registered Nursing</td></tr>
<tr><td>Licensed Vocational Nurse (LVN)</td><td>LVN License</td><td>CA Board of Vocational Nursing and Psychiatric Technicians</td></tr>
<tr><td colspan="3"><u>Note:</u> All medical professional licenses and certifications must be current and issued from the appropriate agency for practice in California, and available on site.
• License cannot be on probationary status and/or have any disciplinary action currently or pending investigation.</td></tr>
<tr><td>B. Have and maintain current certifications based on patient level of care.</td><td colspan="3">• Copy of Current CPR certification based on patient level of care. (BLS, ACLS, PALS)
• The nurse provider must possess the knowledge and abilities related to the overall care of the beneficiary including use of specialized equipment such as ventilators, phrenic nerve pacers, CPAP, Bi-PAP, etc. Partnership HealthPlan of California (PHC) has no jurisdiction in the area of qualifications of the nurse, however an EPSDT nursing supplemental service provider must be licensed and practice accordingly under his/her nurse practice act B. Currently no other requirements exist in this area (P&P Code, Division 2, Chapter 6, Section 2732.05).</td></tr>
<tr><td>C. Site personnel receive training and/or information on PHC processes</td><td colspan="3">• The identified nurses for each case have the responsibility for providing the required documentation to PHC for initial and subsequent authorization of services requested (TARs), and to Provider Enrollment to process the EPSDT Supplemental Services provider number. The nurse is responsible for submission of ongoing, periodic submission of TARs as determined by PHC for nursing services rendered and a time lag may be experienced in the reimbursement process</td></tr>
<tr><td>D. CEUs</td><td colspan="3">• Copy of CEU’s, which are approved by your licensing agency, at least once per year.</td></tr>
</table>

II. Personnel (continued on next page)

Site Personnel Survey Criteria	Yes	No	N/A	Wt.	Site Score
A. Professional health care personnel have current California licenses and certifications. CA Business & Professional (B&P) Code §2050, §2085, §2725, §2746, §2834, §3500, §4110; CCR, Title 16, §1355.4, §1399.547 1) All required Professional Licenses and Certifications, issued from the appropriate licensing/certification agency, are current.	1)_____	1)_____	1)_____	**1**	
B. Have and maintain current certifications based on patient level of care.	1)_____	1)_____	1)_____	**1**	
C. Site personnel receive training and/or information on: 1) PHC's Treatment Authorization Request (TAR) Process and Requirements	1)_____	1)_____	1)_____	**1**	
D. Site personnel maintain documentation of current CEUs with approval by licensing agencies annually.	1)_____	1)_____	1)_____	**1**	
Comments: Write comments for all "No" (0 points) and "N/A" scores. Total pts possible: 4 **Totals**					

RN/MD Review only (#E)

Criteria	III. Office Management Reviewer Guidelines
A. Coordination of Care with other Specialties	Licensed professional is following up an all appointments (labs, diagnostics, and medical offices) and making medical changes as instructed/documented by specialists.
B. Member grievance/ complaint processes are established on site.	A phone is available for filing grievances. Complaint forms are accessible.
C. Medical records are available for the practitioner at each scheduled patient encounter.	The process/system established on site provides for the availability of medical records (paper and electronic), including outpatient, inpatient, referral services, and significant telephone consultations for patient encounters. Medical records are filed that allows for ease of accessibility within the facility, or in an approved health record storage facility off the facility premises (22 CCR, § 75055).
D. Confidentiality of personal medical information is protected according to State and federal guidelines.	Confidentiality: Licensed professional maintains confidentiality of individual patient information. Individual patient conditions or information is not discussed in front of unauthorized individuals.

III. Office Management (continued on next page)

RN/MD Review only (#E)

Office Management Survey Criteria	Yes	No	N/A	Wt.	Site Score
A. Procedures for timely referral/consultative services are established on site. 22 CCR §53851; 28 CCR §1300.67 and §1300.80 Office practice procedures allow timely provision and tracking of: 1) Coordination of Care with other specialties	1)_____	1)_____	1)_____	**1**	
B. Member Grievance/Complaint processes are established on site. 22 CCR §53858, §56260 1) Phone number(s) for filing grievances/complaints are located on site. 2) Complaint forms and a copy of the grievance procedure(s) are available on site.	1)_____ 2)_____	1)_____ 2)_____	1)_____ 2)_____	**1** **1**	
C. **Medical records are available for the practitioner at each scheduled patient encounter.** 22 CCR §75055; 28 CCR §1300.80 1) A confidential medical record will be maintained at the bedside.	1)_____	1)_____	1)_____	**1**	
D. **Confidentiality of personal medical information is protected according to State and federal guidelines.** 22 CCR §51009, §53861, §75055; §28 CCR §1300.80; CA Civil Code §56.10 (Confidentiality of Medical Information Act) 1) Procedures are followed to maintain the confidentiality of personal patient information. 2) Storage and transmittal of medical records preserves confidentiality and security. **3)** Medical records are retained according to PHC standards	1)_____ 2)_____ 3)_____	1)_____ 2)_____ 3)_____	1)_____ 2)_____ 3)_____	**1** **1** **1**	

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

RN/MD Review only

Criteria	III. Office Management Reviewer Guidelines
E. All entries are signed, dated and legible.	**Signature:** includes the first initial, last name, and title of health care personnel providing care. Initials may be used only if signatures are specifically identified elsewhere in the medical record (e.g. signature page). Stamped signatures are acceptable, but must be authenticated, meaning the stamped signature can be verified, validated, confirmed, and is countersigned or initialed. **Date:** includes the month/day/year. Only standard abbreviations are used. Entries are in reasonably consecutive order by date. Handwritten documentation does not contain skipped lines or empty spaces where information can be added. Entries are not backdated or inserted into spaces above previous entries. Omissions are charted as a new entry. Late entries are explained in the medical record, signed, and dated. **Legibility:** means the record entry is readable by a person other than the writer. Handwritten documentation, signatures, and initials are entered in ink that can be readily/clearly copied.
F. Errors are corrected according to legal medical documentation standards.	The person that makes the documentation error corrects the error. One correction method is (single line drawn through the error, with the writer's initial and date written above or near the lined-through entry). Similar variations such as (single line and initial) are also used. The corrected information is written as a separate entry and includes date of the entry, signature (or initials), and title. There are no unexplained cross-outs, erased entries, or use of correction fluid. Both the original entry and corrected entry are clearly preserved. • The identified nurse documents patient care in accordance with professional standards.
G. Treatment plans are documented and evaluated regularly.	• Treatment plan is consistent with diagnosis and is updated dependent on patient condition and response to treatment. • The nurse is responsible for the development and periodic updates of the Plan of Treatment (POT). This is a nursing responsibility since the contents serve as the orders for the nursing care to be rendered and should be beneficiary specific. CCR, Title 22, Sections 51337, 74697 and 74701 provides specific information that is to be included on the POT and the receipt of orders for treatments and medications • For RNs acting as a coordinator, their responsibilities primarily involve reviewing the overall case, assessing the beneficiary and his/her response to the POT, identification of problems with a plan for resolution, follow-up and coordinating the care provided. This information is to be provided to the PHC Special Programs Liaison in a written report for each visit made to the beneficiary.
H. Documentation of provider orders for treatment and medications	Documentation for orders, treatment, and medications are readily available on-site for nurse verification process.
I. Documentation of visit type and person providing care.	Documentation supports visit type and person providing care (PT, OT, ST, Wound Care etc.)
J. Provide name of PHC Special Programs Liaison	For RNs acting as a coordinator, their responsibilities primarily involve reviewing the overall case, assessing the beneficiary and his/her response to the POT, identification of problems with a plan for resolution, follow-up and coordinating the care provided. This information is to be provided to the PHC Special Programs Liaison in a written report for each visit made to the beneficiary.

III. Office Management (continued from previous page)

RN/MD Review only (#H)

Office Management Survey Criteria	Yes	No	N/A	Wt.	Site Score
E. All entries are signed, dated and legible.	1)_____	1)_____	1)_____	**1**	
F. Errors are corrected according to legal medical documentation standards.	1)_____	1)_____	1)_____	**1**	
G. Treatment plans are documented and evaluated regularly.	1)_____	1)_____	1)_____	**1**	
H. Documentation of provider orders for treatment and medications	1)_____	1)_____	1)_____	**1**	
I. Documentation of visit type and person providing care.	1)_____	1)_____	1)_____	**1**	
J. Provide name of PHC special programs liaison	1)_____	1)_____	1)_____	**1**	
Comments: Write comments for all “No” (0 points) and “N/A” scores. **Totals**					

Criteria	IV. Clinical Services - Pharmaceutical Reviewer Guidelines
A. Drugs and medication supplies are maintained secured to prevent unauthorized access.	**Controlled substances**: Written records are maintained of controlled substances inventory list(s) that includes: name of medication, original quantity of drug, dose, date, name of patient receiving drug, name of authorized person dispensing drug, and number of remaining doses. Controlled substances are stored separately from other drugs in a secured area.
B. Drugs are handled safely and stored appropriately.	• **Drug preparation**: Drugs are prepared in a clean area. • **Storage**: Medications are kept separate from food, lab specimens, cleaning supplies, and other items that may potentially cause contamination. • **Drug Disposal:** Drugs are disposed through a proper agency or at a designated location. Disposal log is maintained.

IV. Clinical Services - Pharmaceutical (continued on next page)

Pharmaceutical Services Survey Criteria	Yes	No	N/A	Wt.	Site Score
A. Drugs and medication supplies are maintained secure to prevent unauthorized access. CA B&P Code §4172; 22 CCR §75037(a-g), §75039; 21 CFR §1301.75, §1301.76, §1302.22; 16 CCR §1356.3					
1) Drugs are stored in specifically designated cupboards, cabinets, closets, or drawers.	1)_____	1)_____	1)_____	**1**	
2) Prescription, over-the counter drugs, hypodermic needles/syringes, are securely stored in an inaccessible space (cabinet or room).	2)_____	2)_____	2)_____	**1**	
3) Controlled drugs are stored in a space accessible only to authorized personnel.	3)_____	3)_____	3)_____	**1**	
4) A dose-by-dose controlled substance distribution log is maintained.	4)_____	4)_____	4)_____	**1**	
B. Drugs are handled safely and stored appropriately. 22 CCR §75037(a-g), §75039; 21 CFR §211.137; 21 USC §351					
1) Drugs are prepared in a clean area.	1)_____	1)_____	1)_____	**1**	
2) Drugs are stored separately from germicides, disinfectants and other household substances.	2)_____	2)_____	2)_____	**1**	
3) Site has method(s) in place for drug disposal.	3)_____	3)_____	3)_____	**1**	

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

Criteria	IV. Clinical Services - Pharmaceutical Reviewer Guidelines
C. Drugs are dispensed according to State and federal drug distribution laws and regulations.	• **Expiration date**: The manufacturer's expiration date must appear on the labeling of all drugs. All prescription drugs not bearing the expiration date are deemed to have expired. If a drug is to be reconstituted at the time of dispensing, its labeling must contain expiration information for both the reconstituted and unconstituted drug. Expired drugs may not be dispensed. • **Prescription labeling**: Each prescription medication dispensed is in a container that is not cracked, soiled or without secure closures (Title 22, CCR, Section 75037 (a)). Drug container is labeled with the provider's name, patient's name, drug name, dose, frequency, route, quantity dispensed, and manufacturer's name and lot number.

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

Pharmaceutical Services Survey Criteria	Yes	No	N/A	Wt.	Site Score
C. Drugs are dispensed according to State and federal drug distribution laws and regulations. CA B&P Code §4024, §4076, §4170, §4171, §4173, §4174; 22 CCR §75032, §75033, §75036, §75037(a-g), §75038, §75039; 16 CCR §1718.1; 21 CFR §211.137; 42 USC 6A §300AA-26					
1) There are no expired drugs on site.	1)_____	1)_____	1)_____	**1**	
2) Site has a procedure to check expiration date of all drugs and therapeutic formulas.	2)_____	2)_____	2)_____	**1**	
3) All stored and dispensed prescription drugs are appropriately labeled.	3)_____	3)_____	3)_____	**1**	

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

Criteria	IV. Clinical Services – Laboratory Reviewer Guidelines
D. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations.	• Lab supplies are inaccessible to unauthorized persons. • Lab supplies are not expired • Site has a procedure in place to check expiration dates of lab supplies (i.e. logbook)

IV. Clinical Services - Laboratory

Laboratory Services Survey Criteria	Yes	No	N/A	Wt.	Site Score
D. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations. 17 CCR §1050; 22 CCR §51211.2, §51137.2; B&P Code §1220; 42 USC 263a; Public Law 100-578					
1) Lab supplies (e.g. vacutainers, vacutainer tubes, culture swabs, test solutions) are inaccessible to unauthorized persons.	1)_____	1)_____	1)_____	**1**	
2) Lab test supplies are not expired.	2)_____	2)_____	2)_____	**1**	
3) Site has a procedure to check expiration date and a method to dispose of expired lab test supplies.	3)_____	3)_____	3)_____	**1**	
Comments: Write comments for all "No" (0 points) and "N/A" scores. Total					

RN/MD Review only

Criteria	VI. Infection Control Reviewer Guidelines
A. Infection control procedures for Standard/Universal precautions are followed.	• **Hand washing facilities**: Hand washing facilities are available and include an adequate supply of running potable water, soap. On occasions when running water is not readily available, an antiseptic hand cleanser, alcohol-based hand rub, or antiseptic towelettes is acceptable until running water is available (29 CFR 1919.1030). • **Antiseptic hand cleaner**: Hand washing prevents infection transmission by removing dirt, organic material, and transient microorganisms from hands. Hand washing with plain (non-antimicrobial) soap in any form (e.g., bar, leaflet, liquid, powder, granular) is acceptable for general patient care (Association for Professionals in Infection Control and Epidemiology, Inc., 1995). Antimicrobial agents or alcohol-based antiseptic hand rubs are used for hand washing when indicated to remove debris and destroy transient microorganisms (e.g., before performing invasive procedures, after contact with potentially infectious materials). Plain and antiseptic hand wash products are properly maintained and/or dispensed to prevent contamination. **Note:** Infection Control standards are practiced on site to minimize risk of disease transmission. Site personnel are expected to apply the principles of "Standard Precautions" (CDC, 1996), used for all patients regardless of infection status. Standard precautions apply to blood, all body fluids, non-intact skin, and mucous membranes, which are treated as potentially infectious for HIV, HBV or HCV, and other bloodborne pathogens. "Universal precautions" refer to the OSHA mandated program that requires implementation of work practice controls, engineering controls, bloodborne pathogen orientation/education, and record keeping in healthcare facilities.
B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act.	• **Needlestick Safety:** Contaminated sharps are discarded immediately. Sharps containers are located close to the immediate area where sharps are used, and are inaccessible to unauthorized persons. Sharps are not bent, removed from a syringe, or recapped except by using a one-handed technique. Needleless systems, needles with Engineered Sharps Injury Protection (ESIP) devices, and non-needle sharps are used (incl. in emergency kits), unless exemptions have been approved by Cal/OSHA (8CCR, Section 5193). Security of portable containers in patient care areas is maintained at all times. Any device capable of cutting or piercing (e.g. syringes, hypodermic needles, needleless devices, blades, broken glass, slides, vials) are placed in a closable, puncture-resistant, labeled, leak-proof container. If these requirements are met, containers made of various materials (e.g., cardboard, plastic) are acceptable. Containers are not overfilled past manufacturer's designated fill line, or more than ¾ full. Supply of containers on hand is adequate to ensure routine change-out when filled. • **Sharps Injury documentation:** Site has a method in place to document sharps injuries. Date, time, description of exposure incident, sharp type/brand, follow-up care is documented within 14 days of injury incident.

VI. Infection Control (continued on next page)

RN/MD Review only

Infection Control Survey Criteria	Yes	No	N/A	Wt.	Site Score
A. Infection control procedures for Standard/Universal precautions are followed. 8 CCR §5193; 22 CCR §53230; 29 CFR §1910.1030; Federal Register 1989, §54:23042					
1) Antiseptic hand cleaner and running water are available.	1)_____	1)_____	1)_____	**1**	
B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. 8 CCR §5193 (Cal OSHA Health Care Worker Needle stick Prevention Act, 1999); H& S Code, §117600-118360 (CA Medical Waste Management Act, 1997); 29 CFR §1910.1030.					
1) Needle stick safety precautions are practiced on site**.**	1)_____	1)_____	1)_____	**1**	
2) All sharp injury incidents are documented.	2)_____	2)_____	2)_____	**1**	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **Total**					

Facility Site Review Tool
Supplemental Facility • Mobile Unit • Street Medicine

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

Service area(s): _____ **Site ID:** _____ **Site NPI:** _____

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

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

Office Phone: _____ **Fax:** _____ **Mobile Phone:** _____ **Fax:** _____ **Email:** _____

Mobile Unit contact person/title: _____ **Office contact person/title:**

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

Visit Purpose	Site-Specific Certification(s)	Provider Type	Supplemental Facility Type
_____ Initial Full Scope _____ Periodic Full Scope _____ Focused _____ Monitoring _____ Follow-up _____ Ed/TA _____Other _____ (type)	_____ AAAHC _____ CHDP _____ CPSP _____ PCMH _____ JC _____ NCQA _____ None _____ VFC/VFA _____ Other_____	_____ Family Practice _____ Pediatrics _____General Practice _____ Internal Medicine _____ OB/GYN _____ Specialist)	_____ Primary Care _____ Mobile Unit _____ School Site _____ Extension/Satellite Clinic _____ Other _____ (type) _____ Community _____ FQHC _____ Solo

Site Scores

	Total Points Poss.	Points Given	No Points	N/As	CE*
I. Access/Safety	**37**				
II. Personnel	**28**				
III. Office Management	**27**				
IV. Clinical Services	**41**				
V. Preventive Services	**13**				
VI. Infection Control	**34**				
Totals	**180**				

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

Scoring Procedure

1) Add points given in each section.
2) Add total points given for all six sections.
3) Adjust score for "N/A" criteria (if needed), by subtracting N/A points from 169 total points possible.
4) Divide total points given by "adjusted" total points.
5) Multiply by 100 to get the compliance (percent) rate.

__180__ - _____ = _____
N/A Points **Adjusted Points**

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

Compliance Rate

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

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

_____ **Fail: 79% and Below**

_____ CAP Required

_____ Other follow-up

Next Site Review Due: _____

I. Access/Safety Criteria	Yes	No	N/A	Wt.	Site Score
A. Site is accessible and useable by individuals with physical disabilities. Title 24, California Code of Regulations (CCR) (CA Building Standards Code); Title 28 Code of Federal Regulations (CFR) §35 (American Disabilities Act of 1990, Title II, Title III) All facilities designed, altered, or constructed after January 26, 1992, for the use of public entity must be readily accessible and usable by persons with disabilities. Sites must have the following safety accommodations for physically disabled persons:					
1) Written plan and/or verbal description of plan of reasonable accommodations to provide services for persons with disabilities, if services cannot be provided in the Mobile Unit or in the field **OR**	1)	1)	1)	1	
2) Ramp with level landing at the top and bottom	2)	2)	2)	1	
3) A mechanical lift is available with safety features in place	3)	3)	3)	1	
4) Exit and exam room doorway openings allow for clear passage of a person in a wheelchair.	4)	4)	4)	1	
5) Clear floor space for wheelchair in waiting area and exam room	5)	5)	5)	1	
6) Wheelchair accessible restroom facilities or reasonable alternative.	6)	6)	6)	1	
7) Wheelchair accessible handwashing facilities or reasonable alternative.	7)	7)	7)	1	
8)Outdoor areas with appropriate protection from inclement weather and other external factors.	8)	8)	8)	1	

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

I. Access/Safety Criteria, continued	Yes	No	N/A	Wt.	Site Score
B. Site environment is maintained in a clean and sanitary condition. 28 CCR §1300.80; 22 CCR §75062					
8) All patient areas including floor/carpet, walls, and furniture are neat, clean, and well maintained.	1)	1)	1)	1	
9) Restrooms are clean and contain appropriate sanitary supplies	2)	2)	2)	1	
C. Site environment is safe for all patients, visitors, and personnel. 8 CCR §3220, §2299-2989; 22 CCR §53230; 24 CCR, §2, §3, §9; 28 CCR §1300.80; 29 CFR §1910.37, §1910.38, §1910.157, §1910.301, §1926.34; H & S Code section 1765.101-1765.175; H&S Code Division 2 CH 9 Section 1765.101-1765.175 There is evidence staff has received safety training and/or has safety information available on the following:					
1) Fire safety and prevention.	1)	1)	1)	1	
2) Emergency non-medical procedures and general safety (e.g., site evacuation, workplace violence, field work safety, adverse event, de-escalation). (SM)	2)	2)	2)	1	
3) Lighting is adequate in all areas including inside and around the perimeter of the mobile unit and while in the field to ensure safety.	3)	3)	3)	1	
4) <u>Vehicle doors can be opened from the inside, are unobstructed and egress (escape) accessible.</u>	**4)**	**4)**	**4)**	**2**	
5) Exit doors are clearly marked with “Exit” signs.	5)	5)	5)	1	
6) Clearly diagramed “Evacuation Routes” for emergencies are posted in a visible location.	6)	6)	6)	1	
7) Electrical cords and outlets are in good working condition, with efforts in place to minimize safety hazards.	7)	7)	7)	1	
8) Two (2) Fire Fighting Equipment meeting “mobile health care vehicle” requirements is available and is in accessible location	8)	8)	8)	1	
9) All equipment and supplies are stored securely for transport to minimize shifting while in route.	9)	9)	9)	1	
10)An employee alarm/alert system is in place to communicate during an emergency.	10)	10)	10)	1	

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

I. Access/Safety Criteria, continued	Yes	No	N/A	Wt.	Site Score
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week. 8 CCR §3220; 22 CCR §51056, §53216, §75031; 28 CCR §1300.67, §1300.80; American Academy of Family Practice (AAFP)					
1) Personnel are trained in procedures/action plan to be carried out in case of medical emergency on site. (SM)	1)	1)	1)	1	
2) Emergency equipment is stored together in easily accessible location and is ready to be used.	2)	2)	2)	1	
3) Emergency phone number contacts are posted, updated annually, and as changes occur. (SM)	3)	3)	3)	1	
Emergency medical equipment *appropriate to practice/patient population* is available on site:					
4) **Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag, appropriate to care setting.** (SM)	**4)**	**4)**	**4)**	**2**	
5) Emergency medicine and supplies for anaphylactic reaction management, opioid overdose, chest pain, asthma, hypoglycemia and other medical emergencies. Epinephrine 1mg/ml (injectable) and Diphenhydramine (Benadryl) 25 mg (oral) or Diphenhydramine (Benadryl) 50 mg/ml (injectable), Naloxone, chewable Aspirin 81 mg, Nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), glucose (any type of glucose containing at least 15 grams), quick clot/tourniquet . Appropriate sizes of ESIP needles/syringes and alcohol wipes. (SM)	**5)**	**5)**	**5)**	**2**	
6) Medication dosage chart for all medications included with emergency equipment (or other method for determining dosage) is kept with emergency medications. (SM)	6)	6)	6)	1	
There is a process in place on site to:					
7) Document checking of emergency medication, equipment and supplies for expiration and operating status at least monthly.(SM)	7)	7)	7)	1	
8) Replace/re-stock emergency medication, equipment and supplies immediately after use. (SM)	8)	8)	8)	1	
9) Unit is powered when delivering patient care.	9)	9)	9)	1	
10) Management of Mobile Unit:					
a) Unit is maintained/stored in a secure manner with access to authorized personnel only.	10a)	10a)	10a)	1	
b) The driver of the mobile unit available during office hours	10b)	10b)	10b)	1	
c) Resources available to manage mobile unit mechanical issues	10c)	10c)	10c)	1	

Comments: (Write comments for all "No" (0 points) and "N/A" scores.)
🗁 **RN/NP/CNM/LM/MD/PA only**

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

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

II. Personnel Criteria	Yes	No	N/A	Wt.	Site Score
A. Current California licenses and certifications CA Business & Professional Code (BPC) §2050, §2099.5, §2506**,** §2725, §2746, §2835, §3500, §4110; CCR, Title 16, §1355.4, §1399.547, **CA Codes (hsc:1765.101-1765.175)**					
1) All required Professional Licenses and Certifications, issued from the appropriate licensing/certification agency, are current. (SM)	1)	1)	1)	1	
2) Notification is provided to each member that the MD(s) is licensed and regulated by the Medical Board, and that the Physician Assistant(s) is licensed and regulated by the Physician Assistant Committee.	2)	2)	2)	1	
3) The mobile unit has current licensure (e.g. CDPH) and is posted/available in the unit	3)	3)	3)	1	
B. Health care personnel are properly identified. BPC §680					
1) Health care personnel wear identification badges/tags printed with name and title.(SM)	1)	1)	1)	1	
C. Site personnel are qualified and trained for assigned responsibilities. BPC §2069; 16 CCR §1366 - 1366.4					
1) Site Personnel are qualified, trained and operating within their scope and role. (SM)	1)	1)	1)	1	
2) Documentation of education/training for non-licensed medical personnel is maintained on site.(SM)	**2)**	**2)**	**2)**	**2**	
2) Only qualified/trained personnel retrieve, prepare, or administer medications. (SM)					
3) Site has a procedure in place for confirming correct patient/medication/vaccine dosage and route prior to administration. (SM)	3)	3)	3)	1	
4) Only qualified/trained personnel operate medical equipment.(SM)	4)	4)	4)	1	

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

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

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

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

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

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

III. Office Management Criteria	Yes	No	N/A	Wt.	Site Score
A. Physician coverage is available 24 hours a day, 7 days a week. 22 CCR §56500, §53855 The following are maintained current on site:					
1) Mobile Unit hours and travel schedule are readily available upon request.	1)	1)	1)	1	
2) Provider office hour schedules are available to staff.	2)	2)	2)	1	
3) Arrangement/schedule for after-hours, on-call, supervisory back-up physician coverage is available to site staff.	3)	3)	3)	1	
4) Contact information for off-site physician(s) is available at all times during office hours. (SM)	4)	4)	4)	1	
5) Routine, urgent and after-hours emergency care instructions/telephone information is made available to patients, and may include providing contact information (business card) for future calls, posting contact information in a common area, provide a cell phone for communication needs. (SM)	5)	5)	5)	1	
B. There are sufficient health care personnel to provide timely, appropriate health care services. 22 CCR §53855; 28 CCR §1300.67.1, §1300.80; HSC 1765.101					
1) Appropriate personnel handle emergent, urgent, and medical advice telephone calls and in-person communications.	1)	1)	1)	1	
2) The mobile unit has a telecommunication device and internet servies.	2)	2)	2)	1	
3) Telephone answering machine, voice mail system, or answering service is used whenever office staff does not directly answer phone calls.	3)	3)	3)	1	
4) Telephone system, answering service, recorded telephone information, and recording device are periodically checked and updated.	4)	4)	4)	1	

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

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

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

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

III. Office Management Criteria, continued	Yes	No	N/A	Wt.	Site Score
G. Medical records are available for the practitioner at each scheduled patient encounter. 1 CR §75055; 28 CCR §1300.80; HSC 1765.160(h)(1-3)					
1) Medical records are readily retrievable for scheduled patient encounters, with an adequate back-up plan in place in the event EHR access is not available. (SM)	1)	1)	1)	1	
2) Medical documents are filed in a timely manner to ensure availability for patient encounters.	2)	2)	2)	1	
3) Mobile unit services log is maintained: Patient chart number/or identification number, name, age, sex, site, date, time, and as appropriate, duration of visit	3)	3)	3)	1	
H. Confidentiality of personal medical information is protected according to State and federal guidelines.					
1) Exam and dressing areas safeguard patients' right to privacy.	1)	1)	1)	1	
1) 2) Procedures are followed to maintain the confidentiality of personal patient information. Confidentiality of personal medical information is protected according to State and federal guidelines. (SM)	2)	2)	2)	1	
	3)	3)	3)	1	
3) Medical record release procedures are compliant with State and federal guidelines.	4)	4)	4)	1	
4) Storage and transmittal of medical records preserves confidentiality and security, to include secure transport measures when appropriate.	5)	5)	5)	1	
5) Medical records are retained for a minimum of 10 years.					
Comments: Write comments for all "No" (0 points) and "N/A" scores. **TOTALS**					

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

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

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

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

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

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

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

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

IV. Clinical Services: Laboratory Services Criteria	Yes	No	N/A	Wt.	Site Score
D. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations. 22 CCR §51211.2, §51137.2; BPC §1200-1214, §1229, §1220; 42 USC 263a; Public Law 100-578; www.cms.gov; www.fda.gov					
1) Laboratory test procedures are performed according to current site-specific CLIA certificate. (SM)	1)	1)	1)	1	
2) Testing personnel performing clinical lab procedures have been trained.	2)	2)	2)	1	
3) Lab supplies (e.g. vacutainers, vacutainer tubes, culture swabs, test solutions) are inaccessible to unauthorized persons in both the mobile unit and separate storage area.	3)	3)	3)	1	
4) Lab test supplies are not expired.	4)	4)	4)	1	
5) Site has a procedure to check expiration date and a method to dispose of expired lab test supplies. (SM)	5)	5)	5)	1	
6) Site has a procedure to transport and/or arrange for pickup of collected lab samples.	6)	6)	7)	1	

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

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

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

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

V. Preventive Services: Health Education Criteria	Yes	No	N/A	Wt.	Site Score
B. Health education services are available to Plan members. 22 CCR §53851; 28 CCR 1300.67 Health education materials and Plan-specific resource information are: (SM)- left it high level					
1) Readily accessible on site or are made available upon request, via handouts, verbal instruction or electronic access via website links or QR codes.	1)	1)	1)	1	
2) Applicable to the practice and population served on site.	2)	2)	2)	1	
3) Available in threshold languages identified for county and/or area of site location.	3)	3)	3)	1	
Comments: Write comments for all “No” (0 points) and “N/A” scores. **TOTALS**					

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

VI. Infection Control Criteria	Yes	No	N/A	Wt.	Site Score
A. Infection control procedures for Standard/Universal precautions are followed. 8 CCR §5193; 22 CCR §53230; 29 CFR §1910.1030; Federal Register 1989, §54:23042					
1) Soap or antiseptic hand cleaner and running water are available in exam and/or treatment areas for hand washing.	1)	1)	1)	1	
2) A waste disposal container is available in exam/treatment areas and restrooms.	2)	2)	2)	1	
3) Site has procedure for effectively isolating infectious patients with potential communicable conditions, according to care setting, and may include self-isolation, education, the availability, use and disposal of staff/member PPE, and an appropriate cleaning process	3)	3)	3)	1	

VI. Infection Control Criteria	Yes	No	N/A	Wt.	Site Score
B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. (SM) 8 CCR §5193 (Cal OSHA Health Care Worker Needlestick Prevention Act, 1999); HSC, §117600-118360 (CA Medical Waste Management Act, 1997, updated January 2017); 29 CFR §1910.1030; 49 CCR §173.6; 49 CFR, Section 173.6; CDC Core Infection Prevention and Control Practices -Centers for Disease Control and Prevention (CDC) The Healthcare Infection Control Advisory Committee (HICPAC), 2016; 2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare settings.					
1) **Personal Protective Equipment (PPE) for Standard Precautions is readily available for staff use.** (SM)	**1)**	**1)**	**1)**	**2**	
2) Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport or shipping, according to care setting (i.e. mobile unit, direct care in encampment)(SM)	**2)**	**2)**	**2)**	**2**	
	3)	**3)**	**3)**	**2**	
3) **Needlestick safety precautions are practiced on site, including proper management/security of sharps and storage/collection containers while in use according to care setting (i.e. mobile unit, direct care in encamp.** (SM)	4)	4)	4)	1	
	5)	5)	5)	1	
4) All sharp injury incidents are documented. (SM)					
5) Biohazardous (non-sharp) wastes are contained separate from other trash/waste in both the mobile unit and separate storage area. (SM)	6)	6)	6)	1	
6) Storage areas for regulated medical wastes are maintained secure and inaccessible to unauthorized persons both on the mobile unit and designated separate storage area, according to care setting (i.e. mobile unit, direct care in encampment) (SM)	7)	7)	7)	1	
	8)	8)	8)	1	
7) Contaminated laundry is laundered at the workplace or by a commercial laundry service.					
8) Transportation of regulated medical wastes is only by a registered hazardous waste hauler or to a central location of accumulation in limited quantities (up to 35.2 pounds). (SM)					

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

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

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

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

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

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

APPLICATION FOR DHCS SITE REVIEW MASTER TRAINER CERTIFICATION

Attachment A

Initial Certification: _____ **Recertification: _____** **Date: _____**		
Last Name:	**First Name:**	**M.I.:**
Managed Care Health Plan:	**License Number:** **Expiration Date:**	**Credentials:** **MD ☐ DO ☐ PA ☐ NP ☐ RN ☐**

Trainings:

Date:	Summary of Course Content:	Instructor:

Site Reviews Completed in the past 12 months: Use extra sheet for additional sites

Site NPI Number:	Provider Name:	Address:	Date:	FSR and/or MRR Scores:	CAPs Issued (Y/N):

APPLICATION FOR DHCS SITE REVIEW MASTER TRAINER CERTIFICATION

QI Experience in the last 5 years:

Date	Employer	Title and Primary Responsibilities

APPLICATION FOR DHCS SITE REVIEW MASTER TRAINER CERTIFICATION

DHCS Use ONLY:

Provider: **Family Practice ☐ Pediatrics ☐ OB/GYN ☐ Gen. Practice ☐ Internal Medicine ☐**			
Provider Name and NPI Number:			
Provider Address and Telephone Number:			
Inter-Rater Date: **Findings:**			
Inter-Rater Score:	**MT Candidate**	**FSR:**	**MRR:**
Inter-Rater Score	**DHCS**	**FSR:**	**MRR:**

APPLICATION FOR DHCS SITE REVIEW MASTER TRAINER CERTIFICATION

Approved: ☐	**Certificate Number:**
Issue Date:	**Recertification Date:**
Denied: ☐ **Please provide comments/actions/recommendations:**	
Completed By:	**Date:**

Site Reviews Completed:					
Site NPI Number	**Provider Name and NPI Number**	**Address**	**Date**	**FSR and/or MRR Score**	**CAPs issued**

Partnership Health Plan of California
Interim Compliance Self-Assessment

Contact:
Facility Name:
Address:
Phone/Fax
Site ID:
Site Review Date:
Interim Review Sent Date
XX/XX/20XX
Interim Review Due Date
XX/XX/20XX

Site Review Survey Critical Element CAP (Standard)

Criteria	Standard	CAP Response	Is your site currently compliant with this standard?
I AS C4	Exit doors and aisles are not obstructed and egress (escape) is accessible.	NOT PREVIOUSLY DEFICIENT - PLEASE INDICATE CURRENT COMPLIANCE IN THE NEXT COLUMN >>>	___ Yes ___ No
I AS D4	Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag.	NOT PREVIOUSLY DEFICIENT - PLEASE INDICATE CURRENT COMPLIANCE IN THE NEXT COLUMN >>>	___ Yes ___ No
I AS D5	Emergency medical equipment appropriate to practice/patient population is available on site: 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.	NOT PREVIOUSLY DEFICIENT - PLEASE INDICATE CURRENT COMPLIANCE IN THE NEXT COLUMN >>>	
II P C2	Only qualified/trained personnel retrieve, prepare or administer medications.	NOT PREVIOUSLY DEFICIENT - PLEASE INDICATE CURRENT COMPLIANCE IN THE NEXT COLUMN >>>	___ Yes ___ No
III OM E2	Evidence of physician review and follow-up of referral/consultation reports and diagnostic test results is	NOT PREVIOUSLY DEFICIENT - PLEASE INDICATE CURRENT COMPLIANCE IN THE NEXT COLUMN >>>	___ Yes ___ No
IV CS C4	Only lawfully authorized persons dispense drugs to patients.	NOT PREVIOUSLY DEFICIENT - PLEASE INDICATE CURRENT COMPLIANCE IN THE NEXT COLUMN >>>	___ Yes ___ No
IV CS C5	Drugs and Vaccines are prepared and drawn only prior to administration.		
VI IC B1	Personal Protective Equipment for Standard Precautions is readily available for staff use.	NOT PREVIOUSLY DEFICIENT - PLEASE INDICATE CURRENT COMPLIANCE IN THE NEXT COLUMN >>>	___ Yes ___ No
VI IC B2	Blood, other potentially infectious material and regulated wastes are placed in appropriate leak proof, labeled containers for	NOT PREVIOUSLY DEFICIENT - PLEASE INDICATE CURRENT COMPLIANCE IN THE NEXT COLUMN >>>	___ Yes ___ No
VI IC B3	Needle stick safety precautions are practiced on site.	NOT PREVIOUSLY DEFICIENT - PLEASE INDICATE CURRENT COMPLIANCE IN THE NEXT COLUMN >>>	___ Yes ___ No

Partnership Health Plan of California
Interim Compliance Self-Assessment

Site Review Survey Critical Element CAP (Standard)			
VI IC D3a	Staff demonstrate /verbalize necessary steps/process to ensure sterility and/or high level disinfection to ensure sterility/disinfection of equipment.	NOT PREVIOUSLY DEFICIENT - PLEASE INDICATE CURRENT COMPLIANCE IN THE NEXT COLUMN >>>	___ Yes ___ No
VI IC D3c	Cold chemical sterilization/high level disinfection: Appropriate PPE is available, exposure control plan, Material Safety Data Sheets and clean up instructions in the event of a cold chemical sterilant spill.	NOT PREVIOUSLY DEFICIENT - PLEASE INDICATE CURRENT COMPLIANCE IN THE NEXT COLUMN >>>	
VI IC D4c	Autoclave/steam sterilization: Spore testing of autoclave/steam sterilizer with documented results (at least monthly)	NOT PREVIOUSLY DEFICIENT. PLEASE INDICATE CURRENT COMPLIANCE IN THE NEXT COLUMN >>> *If your site does not autoclave - please tell us what you do instead to sterilize your equipment and mark yes if you are following that process.	
VI IC D4d	Autoclave/steam sterilization: Management of positive mechanical, chemical, and/or biological indicators of the sterilization process.	NOT PREVIOUSLY DEFICIENT - PLEASE INDICATE CURRENT COMPLIANCE IN THE NEXT COLUMN >>>	

Site Review CAP Criteria

Criteria	Standard	CAP Response	Is your site currently compliant with this standard?
	#N/A		___ Yes ___ No
	#N/A		___ Yes ___ No
	#N/A		___ Yes ___ No
	#N/A		___ Yes ___ No

Partnership Health Plan of California
Interim Compliance Self-Assessment

Medical Record Review CAP Criteria

Criteria	Standard	CAP Response	Is your site currently compliant with this standard?
	#N/A		___ Yes ___ No
	#N/A		___ Yes ___ No
	#N/A		___ Yes ___ No
	#N/A		___ Yes ___ No
	#N/A		___ Yes ___ No

PHC Addendum CAP Criteria

Criteria	Standard	CAP Response	Is your site currently compliant with this standard?
	#N/A		___ Yes ___ No

* Please attach documentation explaining reason(s) for non-compliance

"I attest that the above statements of compliance are accurate"

PCP or designee signature and title: _____ Date: _____

HEALTH PLAN USE ONLY BELOW THIS LINE

Approved by: _____ Date: _____

Follow up Required: Yes / No

Medi-Cal Managed Care Certified Provider Site

Clinic Name

Address, City, Zip

This site has successfully completed the Department of Health Care Services (DHCS) Site Review Survey and is deemed as a DHCS Certified Primary Care Site under the provisions of DHCS All Plan Letter (APL) 22-017 or any superseding APL issued by DHCS.

Certificate No: _____

Date(s) of Review: _____

Date Issued: _____

Expiration Date: _____

_____
Managed Care Plan Signature

_____
Managed Care Plan

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

Guideline/Procedure Number: MP~~C~~QG1005 (previously MC~~P~~QG1005 & QG1001050)			**Lead Department: Health Services** Business Unit: Quality Improvement	
Guideline/Procedure Title: Adult Preventive Health Guidelines			☒**External Guideline** ☐ **Internal Guideline**	
Original Date: 04/25/1994		**Next Review Date: ~~04/10/2025~~03/12/2026** **Last Review Date: ~~04/10/2024~~03/12/2025**		
Applies to:	☐ **Employees**	☒**Medi-Cal**	☒**Partnership Advantage** [1]	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date: ~~04/10/2024~~03/12/2025**	

I. RELATED POLICIES:
MCQP1021 – Initial Health Appointment
MPQP1022 – Site Review Requirements and Guidelines
MCUP3047 – Tuberculosis Related Treatment
MCUP3052 – Medical Nutrition Services
MCUP3101 – Screening and Treatment for Substance Use Disorders
MCCP2026 – Diabetes Prevention Services

II. IMPACTED DEPTS:
A. Health Services
B. Claims
C. Provider Relations

III. DEFINITIONS:
N/A

IV. ATTACHMENTS:
A. Adult Preventive Health Screening Guidelines
B. TB Screening Recommendations (Flowcharts)

V. PURPOSE:
To specify and define Partnership Health Plan of California ((~~PHC~~Partnership) –guidelines for adult health screening and preventive services provided by primary care providers to adults aged 18 and over, as recommended by the United States Preventive Services Task Force (USPSTF) and other nationally recognized standards of practice. These include the American Academy of Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Physicians (ACP). These guidelines address periodic health and behavioral risk screening and preventive services for ~~low-risk~~average risk asymptomatic adults.

[1] This policy may also apply in part to Partnership Advantage, the HealthPlan's Medicare product effective Jan. 1, 2026 in eight counties: Del Norte, Humboldt, Mendocino, Lake, Marin, Sonoma, Napa, and Solano, and may be subject to change based on Centers for Medicare and Medicaid Services (CMS) rules.

Guideline/Procedure Number: MP~~C~~QG1005 (previously MPQG1005 & QG100105)		Lead Department: Health Services Business Unit: Quality Improvement	
Guideline/Procedure Title: Adult Preventive Health Guidelines		☒ External Guideline ☐ Internal Guideline	
Original Date: 04/25/1994		**Next Review Date: 04/10/2025** **Last Review Date: 04/10/2024**	
Applies to:	☐ Employees	☒Medi-Cal	☒Partnership Advantage

Individuals identified as being at high risk for a given condition may require screening at intervals that are more frequent or the performance of additional screening tests specific to the condition. High-risk individuals are defined as those individuals whose risk behaviors, family history, socioeconomic status, or lifestyle is associated with a higher tendency towards a specific disease. "Required" and "recommended" screening interventions for various conditions as adapted from the USPSTF guidelines and other resources are listed in Attachment A. (See VI.C below for Preventive Care for Medicare recipients.) Required interventions are an integral component of primary care. Partnership audits the compliance of each primary care provider (PCP) performing these services at least once every three years during Medical Record Review (MRR). Recommended interventions are considered to constitute good clinical care but are not required by Partnership and are not considered as audit criteria.

VI. GUIDELINE / PROCEDURE:

A. An Initial Health Appointment (IHA) must be completed for all Members within 120 days of assignment to ~~PHC~~Partnership and periodically re-administered per Department of Health Care Services' Contract and CalAIM: Population Health Management (PHM) Policy Guide requirements.
   1. An IHA must be performed by a provider within the primary care medical setting.
   2. An IHA is not necessary if the Member's PCP determines that the Member's medical record contains complete information that was updated within the previous 12 months.
      a. If a Member is new to a PCP's practice and received health-screening services from another provider within the past 12 months, the new PCP should request those medical records from the former provider.
   3. If a Member has not been seen for an IHA or for a periodic health-screening visit, the PCP should perform the indicated screening, behavioral risk assessment, and preventive interventions during episodic visits or recommend that the Member schedule a health-screening appointment.
   4. An IHA must be provided in a manner culturally and linguistically appropriate to the Member.
   5. An IHA must be documented in the Member's medical record and include all of the following:
      a. A history of the Member's physical and mental health;
      b. An identification of risks;
      c. An assessment of need for preventive screenings or services;
      d. Health education offered, and
      e. The diagnosis of and plan for treatment of any diseases.
   6. A subsequent risk assessment should be completed annually or as indicated by the Member's needs and according to the provider's clinical judgment.

B. Documentation
   1. Preventive services offered and/or performed, as well as health education provided either verbally or in writing, must be documented in the Member's medical record. Completed and outstanding preventive services should be easily identifiable.
   2. Providers must ensure timely provision of immunizations to Members in accordance with the most recent schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP), regardless of the Member's age, sex, or medical condition, including pregnancy. Providers must document each Member's need for ACIP-recommended immunizations as part of all regular health visits. All provided immunizations must be documented in the California Immunization Registry (CAIR2).
   ~~2.~~3. PCPs are required to provide annual cognitive assessments for Members who are 65 years of age or older and who do not have Medicare coverage. (Reference APL 22-025.) ~~PHC~~Partnership verifies whether providers have completed the required DHCS Dementia Care Aware cognitive health assessment training, using the list of providers who have completed the training provided by DHCS. Providers must complete the required training ~~in order to~~to bill and receive reimbursement from ~~PHC~~Partnership. As part of new provider training, ~~PHC~~Partnership educates its providers to bill appropriately for an annual cognitive health assessment according to the Provider billing requirements outlined in APL 22-025.

a. To receive reimbursement for this assessment, providers must complete the DHCS Dementia Care Aware cognitive health assessment training **prior to** billing for the annual cognitive assessments.
b. Once certified, providers will perform the annual cognitive health assessment as a part of an Evaluation and Management (E&M) visit and have readily available documentation based on APL guidelines in the Member's medical record. Approved assessment screening tools include the General Practitioner assessment of Cognition (GPCOG) and the Mini-Cog. Informant tools for family members and close friends, which include the Eight-item Informant Interview to Differentiate Aging and Dementia, the GPCOG, and the Short Informant Questionnaire on Cognitive Decline in the Elderly.

c. Providers who bill for the annual cognitive assessment must provide appropriate follow-up care based on assessment scores including, but not limited to, additional assessments or specialist referrals.
d. Certified providers should use the CPT code 1494F for billing. ~~**PHC**~~**Partnership is not required to reimburse non-certified providers.**

C. Medicare Preventive Care
1. All recommendations described in Attachment A apply to Medicare recipients, provided age and other individual specific criteria are met.
2. All adult vaccinations recommended by the current CDC's Advisory Committee on Immunization Practices apply.
3. The following services are available to both Medicare and Medi-Cal recipients:
   a. Medical Nutrition Services (MNT) as outlined in Partnership policy MCUP3052 – Medical Nutrition Services.
   b. Diabetes Prevention Services (DPP) as outlined in Partnership policy MCCP2026 – Diabetes Prevention Services.
4. Medicare-specific preventive care visits as outlined on the Medicare website at http://www.medicare.gov/coverage/preventive-screening-services including, but not limited to
   a. A "Welcome to Medicare" visit
   b. An annual "adult wellness visit" (AWV)
   c. A cardiovascular behavioral therapy visit (performed by the PCP)
   d. An obesity behavioral therapy visit (performed by the PCP).

~~C.~~D. Monitoring and Quality Improvement
1. Documentation of adult preventive health services is reviewed as a component of the Medical Record Review.

VII. REFERENCES:

A. California Department of Health Care Services' (DHCS) CalAIM: Population Health Management (PHM) Policy Guide (updated ~~January~~ May 2024) https://www.dhcs.ca.gov/CalAIM/Documents/PHM- Policy-Guide.pdf
B. DHCS All Plan Letter (APL) 24-008 Immunization Requirements (June 21, 2024, supersedes APL 18-004)
~~B.~~C. DHCS APL 22-030, Initial Health Appointment (Dec. 22, 2022, supersedes APL 13- 017)
~~C.~~D. DHCS APL 22-025, Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older (Nov. 28, 2022)
~~D.~~E. DHCS APL 21-014 Alcohol and Drug Screening, Assessment, Brief Intervention and Referral to Treatment (Oct. 11, 2021 supersedes APL 18-014)

~~E.~~F. American Cancer Society Screening Guidelines: http://www.cancer.org/healthy/findcancerearly/cancerscreeningguidelines/american-cancer-society-

guidelines-for-the-early-detection-of-cancer

F.G. American Academy of Family Physicians (AAFP) 2023 list of assessments that differ from USPSTF: Clinical Preventive Services Recommendations https://www.aafp.org/family-physician/patient- care/clinical-recommendations/aafp-cps.html

D. American College of Obstetricians & Gynecologists (ACOG): http://www.acog.org/ (requires subscription)
E. American College of Physicians (ACP): http://www.acponline.org/clinical_information/guidelines/
F. Centers for Disease Control, Vaccines and Immunizations https://www.cdc.gov/vaccines/schedules/index.html
G. American Society for Colposcopy and Cervical Pathology: http://www.asccp.org
H. Adult Vaccination Schedule; https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule-bw.pdf
K. United States Preventive Services Task Force (USPSTF) https://uspreventiveservicestaskforce.org/uspstf/home
L. California Welfare and Institutions Code 14132.171, Annual cognitive health assessment
M. Medicare Preventive & Screening Services – https://www.medicare.gov/coverage/preventive-screening-services
N. California Assembly Bill 2132 Health Care Services: Tuberculosis (Sept. 29, 2024) https://leginfo.legislature.ca.gov/

VIII. DISTRIBUTION:
A. PHCPartnership Department Directors
B. PHCPartnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:
Medi-Cal
HS-4 - 12/27/95; 08/05/97; 10/10/97 [name change only]; 02/10/99; 06/21/00, 06/20/01; 06/19/02; 10/30/02; 10/20/04; 05/17/06; 09/19/07; 03/18/09; 10/20/10; 03/21/12; 04/17/13; 04/16/14; 04/15/15; 05/18/16;

Guideline/Procedure Number: MPCQG1005 (previously MPQG1005 & QG100105)			**Lead Department: Health Services** Business Unit: Quality Improvement
Guideline/Procedure Title: Adult Preventive Health Guidelines			☒ **External Guideline** ☐ **Internal Guideline**
Original Date: 04/25/1994		**Next Review Date: 04/10/2025** **Last Review Date: 04/10/2024**	
Applies to:	☐ **Employees**	☒**Medi-Cal**	☒**Partnership Advantage**

04/19/17; *06/13/18; 06/12/19; 06/10/20; 06/09/21; 02/09/22; 09/14/22; 03/08/23; 04/10/24; 03/12/25

*Through 2017, Approval Date reflective of the Quality Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee meeting date.

PREVIOUSLY APPLIED TO:
Partnership Advantage
MPQG1005 - 09/19/2007 to 01/01/2015

Healthy Families
MPQG1005 - 10/20/2010 to 03/01/2013

Healthy Kids
MPQG1005 - 09/19/2007 to 04/17/2013

ADULT PREVENTIVE HEALTH SCREENING GUIDELINES

These guidelines for adult health screening and preventive services are derived from the most recent United States Preventive Services Task Force (USPSTF) and other nationally recognized standards of practice from organizations such as: American Academy of Family Physicians (AAFP), American College of Obstetricians and Gynecologists (ACOG), American Cancer Society (ACS), American College of Physicians (ACP), and others. Age, sex and risk factor specific USPSTF recommendations can be found using the ePSS app found on the USPSTF website.

Required interventions are italicized and considered to be an integral component of primary care. Consequently, Partnership HealthPlan of California (PHC) audits the compliance of each PCP performing these services at least once every three years during the Medical Record Review (MRR).

*The U.S. Preventive Services Task Force (USPSTF) recommends clinicians discuss these preventive services with eligible patients and offer them as a priority. All these Services have received an "A" (strongly recommended) or a "B" (recommended) grade from the Task Force

PREVENTIVE CARE	FREQUENCY/DETAILS
Aspirin for the Primary Prevention of Cardiovascular Events*	A meta-analysis in the Jan 22, 2019 issue of JAMA concluded that there was no net benefit for use of aspirin for primary prevention of cardiovascular disease. The USPSTF (April 2022) recommends for adults aged 40 to 59 years with a 10% or greater 10-year cardiovascular disease (CVD) risk, the decision to initiate low-dose aspirin for the primary prevention of CVD should be an individual one. Evidence indicates that the net benefit of aspirin use in this group is small. Persons who are not at increased risk for bleeding and are willing to take low-dose aspirin daily are more likely to benefit. (Grade C). For adults 60 years or older, the USPSTF recommends against initiating low- dose aspirin use for the primary prevention of CVD (Grade D). Cardiovascular risk can be calculated by the heart risk calculator found at www.cvriskcalculator.com or the ASCVD Risk Calculator Plus for mobile devices.
Assessment for Hearing Impairment	Age 65+ at the time of the periodic health examination. To best screen for individuals likely to take action based on abnormal results, consider a three- question screening: 1. Do you have difficulty with your hearing? 2. How bothered are you by your hearing loss? 3. How motivated are you to do something about it? (Affirmative responses to all three warrants referral for diagnostic evaluation and possible treatment). Reference: *JAMA March 23/30, 2021, pages 1162-1163.* The USPSTF concludes current evidence is insufficient Re: screening for hearing loss in older adults.
High Blood Pressure Screening*	Upon initial entry into PCP practice, then at least every 2 years. If elevated, the USPSTF (April 2021) recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment, when feasible.
Hypertensive Disorders of Pregnancy Screening	The USPSTF (September 2023) recommends screening for hypertensive disorders in pregnant persons with blood pressure measurements at each prenatal visit. This includes all pregnant people without a known diagnosis of a hypertensive disorder of pregnancy or chronic hypertension. (Grade B)

ADULT PREVENTIVE HEALTH SCREENING GUIDELINES

PREVENTIVE CARE	FREQUENCY/DETAILS
Colorectal Cancer Screening *	The USPSTF (May 2021) recommends performing screening for colorectal cancer in adults ages 50 to 75 (Grade A) and ages 45 to 49 (Grade B). • Modalities include Fecal occult blood test (FOBT) or Fecal Immunochemical Test (FIT) annually, OR Colonoscopy every 10 years, OR Flexible Sigmoidoscopy every 5 years OR FIT-DNA test every 3 years (See USPSTF for other variations) CT colonography is technically difficult and Partnership requires a Treatment Authorization Request (TAR). • Recommendations for adults ages 50 to 75 (Grade A) differs from those aged 76 to 85. For adults aged 76 to 85 years, the decision to screen for colorectal cancer is an individual one, taking into account the patient's overall health and prior screening history (Grade C). Adults in this age group who have never been screened for colorectal cancer are more likely to benefit. • The USPSTF does not comment on screening for colorectal cancer in adults older than age 85 years.
Height & Weight	• Initial entry into PCP practice. • Age 18 to 64: weight at least every 2 years. • Age 65+: weight at least annually.
HIV Screening and Pre-exposure Prophylaxis to Prevent Acquisition of HIV*	The USPSTF (June 2019 – currently under review) recommends that each adolescent and adult ages 15 to 65 without risk factors be tested for HIV once in their lifetime. In addition, all individuals at increased risk for HIV, regardless of age, should be tested every year. Pregnant persons should be tested with each pregnancy, including those presenting in labor or at delivery whose HIV status is unknown. The Centers for Disease Control and Prevention (CDC) recommends prenatal testing for syphilis and HIV during a pregnant person's first prenatal visit and repeat testing for "high-risk" pregnant persons during the third trimester (preferably 28-32 weeks). (CDC-April 19, 2022) The USPSTF (August 2023) also recommends that clinicians prescribe preexposure prophylaxis using effective antiretroviral therapy to persons who are at increased risk of HIV acquisition to decrease the risk of acquiring HIV.
Hepatitis C screening*	The USPSTF (~~June 2019~~March 2020) recommends a ~~1 time~~onetime screening for average risk adults ages 18 to 79. In addition, adults at increased risk of contracting Hepatitis C (for example those using injectable drugs of abuse), should be screened periodically (ungraded recommendation). There is limited evidence to determine how often to screen persons at increased risk.
Lung Cancer Screening*	The USPSTF (March 2021) recommends annual screening for lung cancer with low-dose computed tomography (LDCT; CPT code 71271) in adults ages 50 to 80 years who have a 20+ pack-year smoking history and IN ADDITION currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery (Grade B). Full dose CT scans are not approved for screening.

ADULT PREVENTIVE HEALTH SCREENING GUIDELINES

PREVENTIVE CARE	FREQUENCY/DETAILS
Syphilis Infection, Screening – non-pregnant and pregnant persons*	The USPSTF (September 2022) recommends screening persons at increased risk for syphilis. (Grade A). At highest risk are men who have sex with men and persons living with HIV. Other risk factors are history of incarceration, history of commercial sex work, male younger than 29 years old, and (in Partnership regions) current homelessness and current use of methamphetamines. The USPSTF (September 2018) recommends early screening for syphilis infection in all pregnant persons. Those presenting in labor or at delivery whose syphilis status is unknown should be tested at that time (Grade A). The Centers for Disease Control and Prevention (CDC) recommends prenatal testing for syphilis and HIV during a pregnant person's first prenatal visit and repeat testing for "high-risk" pregnant persons during the third trimester (preferably 28-32 weeks). (CDC-April 19, 2022) Screen and confirm- Options for testing ~~include:Traditional~~include: Traditional screening algorithm: Screen with an initial nontreponemal test (e.g., Venereal Disease Research Laboratory [VDRL] or rapid plasma reagin [RPR] test). If positive, confirm with a treponemal antibody detection test (e.g., *T pallidum* particle agglutination [TP- PA] test) and Reverse sequence algorithm: Screen with an initial automated treponemal test (e.g., enzyme-linked or chemiluminescence immunoassay). If positive, confirm with a nontreponemal test.
Latent Tuberculosis Infection (LTBI) Screening	The USPSTF (May 2023) recommends screening for latent tuberculosis infection (LTBI) in populations at increased risk (Grade B). (See MCQG1005 Attachment B – TB Screening Overview for more specifics.) This recommendation meets the requirements of California's new Tuberculosis screening law, Assembly Bill 2132, which was signed into law Sept. 29, 2024 and took effect Jan. 1, 2025.
Glaucoma Screening	AAFP and USPSTF (May 2022) find insufficient evidence for or against (Grade I). Medicare recommends screening for those in these high-risk categories: 1. Persons with diabetes, 2. Family history of glaucoma, 3. African American and age 50 or older, or 4. Hispanic and age 65 or older.
Hyperlipidemia Screening (needed for full cardiovascular risk factor evaluation)	The USPSTF recommendations covering lipid screening in adults are archived. UpToDate® ("Screening for lipid disorders in adults" August 2, 2021) recommends obtaining a fasting or non-fasting lipid profile when an adult enters care at a new practice to screen for familial hypercholesterolemia and for cardiovascular risk assessment, with rescreening as part of a cardiovascular risk analysis every 5 years. Earlier re-screening may be indicated depending on patient-specific factors.
Statin Use for Primary Prevention of Cardiovascular Disease (CVD)	The USPSTF (August 2022) recommends prescribing statins for the primary prevention of CVD for adults aged 40 to 75 years with 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension or smoking), AND a 10-year cardiovascular risk of ≥10% (Grade B) or 7.5% to <10% (Grade C). Current evidence is insufficient to assess benefits versus harms in adults >75 years (Grade I). Cardiovascular risk can be calculated by the heart risk calculator found at www.cvriskcalculator.com or the ASCVD Risk Calculator Plus for mobile devices.

ADULT PREVENTIVE HEALTH SCREENING GUIDELINES

PREVENTIVE CARE	FREQUENCY/DETAILS
Vaccination	Based on age and risk factors. For updated schedule, reference the CDC guidelines. https://www.cdc.gov/vaccines/schedules/
Diabetes Mellitus in Adults, Screening for Type 2 and Prediabetes*	The USPSTF (August 2021) recommends screening all adults aged 35 to 70 years who have overweight or obesity (Grade B). The screening interval is uncertain, but every 3 years "may be reasonable". 2023 Standards of the American Diabetes Association: 1. Testing for prediabetes and DM2 in asymptomatic people should be considered in any overweight adult (BMI > 25) [1] with one or more risk factor. Risk factors include a first-degree relative with diabetes, high-risk race/ ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander), history of CVD, hypertension, HDL cholesterol level <35 mg/dL (0.90 mmol/L) and triglyceride level >250 mg/dL (2.82mmol/L), polycystic ovary syndrome, physical inactivity, and/ or other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans). 2. Screen all adults beginning at age 35 years. 3. If test results are normal, screen every 3 years. 4. Acceptable screening tests include fasting plasma glucose, 2-h plasma glucose during a 75-g GTT, and HgbA1c. 5. People with HIV should be screened using a fasting glucose test before starting antiretroviral therapy, when switching therapies, and 3-6 months after starting therapy, and then annually, if screening results are normal. [1] *The ADA suggests different BMI parameters for Asian Americans; however, PHC does not endorse this differentiation.*
Dental disease and referral to dental provider	The USPSTF (November 2023) concludes that the current evidence is insufficient to assess the balance of benefits and harms of routine screening performed by primary care clinicians for oral health conditions, including dental caries or periodontal-related disease, in adults. The AAFP recognizes the PCP may act as a first line of defense, by promoting good oral health during patient visits. Their recommendation is to assess for and promote oral health. Ask about brushing and flossing, use of tobacco and other smoked products, consumption of sugary drinks and advocating and assisting with identifying a primary dental office. Frequency includes initial entry into PCP practice, then yearly or as indicated by the PCP and/or dental care provider.

ADULT PREVENTIVE HEALTH SCREENING GUIDELINES

BEHAVIORAL CONDITIONS	DETAILS
Alcohol andDrugMisuse and Behavioral counseling Interventions*	The USPSTF (November 2018- currently under review) recommends screening for unhealthy alcohol use in primary care settings in adults 18 years and older, including pregnant persons. Screen all adults annually; if present, offer behavioral interventions to reduce ~~un-healthy~~unhealthy alcohol use. (Grade B) The USPSTF (June 2020) recommends asking about unhealthy drug use in adults ~~age~~aged 18 years or older. When screening is positive, offer or refer for appropriate treatment. California Department of Health Care Services (DHCS) All Plan Letter (APL) 21-014 – Alcohol and Drug Screening, assessment, Brief Intervention and Referral to Treatment – Oct. 11, 2021)
Diet, Behavioral Counseling in Primary Care to Promote a Healthy Lifestyle – recommendations for adults with and without known CVD risks*	The USPSTF (July 2022 – currently under review) recommends for adults **without** known CVD risk factors individualizing the decision to offer to refer to behavioral counseling interventions to promote a healthy diet and physical activity. The USPSTF (November 2020- currently under review) recommends offering or referring adults **with** one of the following: 1. Hypertension 2. Dyslipidemia 3. Mixed multiple risk factors such as metabolic syndrome or a ≥7.5% estimated 10-year CVD risk to intensive behavioral/counseling interventions to promote a healthful diet and physical activity for CVD prevention. This recommendation no longer includes adults with other known modifiable CVD risk factors such as abnormal blood glucose levels, obesity and smoking, as these populations are covered by other USPSTF recommendations. Individuals with a diagnosis of prediabetes should be referred to participate in a Diabetes Prevention Program, if available.
Screening for Depression and Suicide Rrisks * in Aadults and Perinatal Depression	The USPSTF (June 2023) recommends screening for depression in the general adult population, including pregnant persons and post-partum persons (Grade B). Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow up. There is little evidence regarding optimal timing for screening. The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for suicide risk in the adult population, including pregnant and postpartum persons, as well as older adults. (Grade I) The USPSTF (February 2019- currently under review) also recommends that pregnant persons at risk of depression should be referred for counselling even if not currently depressed. (Grade B) Risk factors include low socio-economic status. Consequently, all pregnant PHC members should be referred for at least one counselling session. The California Perinatal Services Program (CPSP) includes provision of counseling services. If a CPSP program is available, all Partnership members should be referred to a CPSP program, for counselling and other services.

ADULT PREVENTIVE HEALTH SCREENING GUIDELINES

BEHAVIORAL CONDITIONS	DETAILS
Anxiety*	The USPSTF recommends screening for anxiety disorders in adults 64 years or younger, including pregnant and post-partum persons who have no recognized signs or symptoms of anxiety. (Grade B) The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for anxiety disorders in older adults 65 years or older. (Grade I)
Obesity*	The AAFP recommends screening all adults for obesity (using BMI >30). This is a 2012 statement based on what were the current, but since retired USPSTF recommendations. The current USPSTF (September 2018 – currently under review) recommendation is clinicians should offer or refer patients with a BMI of 30 or greater to intensive, multicomponent behavioral interventions. (Grade B). $BMI = \left(\frac{\text{Weight in Pounds}}{(\text{Height in inches}) \times (\text{Height in inches})} \right) \times 703$
Tobacco Use and Tobacco Caused Disease Counseling* ~~to Prevent*~~, including for Pregnant Persons*	For all adults who are not pregnant, the USPSTF (January 2021) recommends that clinicians ask about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and USDA (FDA) approved pharmacotherapy for cessation. (Grade A) For all pregnant persons, the USPSTF recommends that clinicians ask about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco. (Grade A)
Unintended pregnancy *	Screen all reproductive aged persons at risk for unintended pregnancy (and males who may cause unintended pregnancy); offer counseling and access to contraceptives, including emergency contraception. Recommended screening question: "modified one key question": "Do you, or any of your sensual or sexual partners, want to become pregnant in the coming year?"

ADULT PREVENTIVE HEALTH SCREENING GUIDELINES

OTHER SCREENINGS	DETAILS
Abdominal Aortic Aneurysm Screening*	The USPSTF (December 2019) recommends one-time screening for abdominal aortic aneurysm by ultrasound in persons assigned as male at birth 65-75 who have ever smoked (Grade B).
Prostate Cancer screening (Prostate Specific Antigen blood test*)	USPSTF recommendations (May 2018 – currently under review) • Asymptomatic average risk persons with a prostate ages 55 to 69 years should have shared decision making with their clinician about the pros and cons of screening (Grade C) • Persons with a prostate age 70 years and older should not be screened (Grade D). • Persons with a prostate with prostate symptoms may have a PSA as part of their diagnostic evaluation
Screening for Intimate Partner Violence*	Adapted* from USPSTF (October 2018- currently under review) recommendations: Screen all patients of childbearing age for intimate partner violence when a routine health maintenance exam is performed (Grade B). Providers should refer patients who screen positive to ongoing support services. **~~language~~Language** *updated to be non-gender specific*
Breast Cancer Screening by Mammography*	~~The USPSTF (January 2016) recommends biennial screening~~The USPSTF (April 2024) recommends biennial mammography for persons with breasts and assigned as female at birth ages ~~50~~ 40 to 74 years (Grade B). ~~Persons with breasts and assigned as female at birth ages 40 to 49 should be counseled on risks and benefits of mammography; mammography is covered if the person chooses it (Grade C). NOTE – this recommendation is currently under review by the USPSTF.~~ Transgender and Gender Diverse persons: The "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8" from the World Professional Association for Transgender Health (WPATH) recommends, "…health care professionals follow local breast cancer screening guidelines developed for cisgender women in their care of transgender and gender diverse people who have received estrogens, taking into consideration length of time of hormone use, dosing, current age, and the age at which hormones were initiated". Shared decision making is recommended.
Breast Cancer, Chemoprevention*	The USPSTF (September 2019- currently under review) recommends clinicians offer to prescribe risk reducing medications, such as tamoxifen, raloxifene or aromatase inhibitors, to persons at high risk for breast cancer and at low risk for adverse effects of chemoprevention (Grade B) A breast cancer risk assessment tool is available at www.cancer.gov/bcrisktool

ADULT PREVENTIVE HEALTH SCREENING GUIDELINES

OTHER SCREENINGS	DETAILS
Breast and Ovarian Cancer Susceptibility, genetic risk Assessment and BRCA Mutation Testing*	Adapted* The USPSTF (August 2019 – currently under review) recommends assessment with an appropriate brief family risk assessment tool for persons at high risk of breast and ovarian cancer. Persons with a positive result should be offered genetic counseling and, if indicated after counseling, genetic testing (Grade B). See policy on Genetic Testing (MCUP3131) for details.
Breastfeeding, Behavioral Interventions to Promote*	The USPSTF (October 2016 – update in progress) recommends interventions during pregnancy and after birth to promote and support breastfeeding (Grade B).
Cervical Cancer Screening*	USPSTF Recommendations (August 2018- currently under review) • Persons with a cervix ages 21 to 29 should have cytology screening every 3 years. Persons with a ~~cervix ages~~cervix aged 30 to 65 may have cytology screening every 3 years or may have high-risk HPV testing every 5 years (Grade A) • Persons with a cervix under age 21 should not be screened (Grade D). • Persons with a cervix over age 65 should only be screened if they have never been screened previously, or if one of their last three screenings had any type of cervical atypia (Grade D). • Routine cervical cytology testing should be discontinued (regardless of age) in persons with a history of a total hysterectomy (removal of the cervix along with the uterus) for noncancerous reasons, as long as they have no history of high-grade CIN (Grade D). • Note: although the American Cancer Society changed its recommendations in 2020 to recommend later initiation of screening, less frequent screening, and use of HPV screening only under age 30, PHC continues to recommend following the recommendations of USPSTF/ACOG.
Chlamydia Screening* Gonorrhea Screening*	USPSTF Recommendations (September 2021) Annual screening recommended for sexually active women 24 years or younger and for women ~~age~~aged 25 years or older at increased risk for infection. Risks include previous or current STI, a new or >1 sex partner, a sex partner who has other sex partners, a sex partner with a STI, inconsistent condom use when indicated, a history of exchanging sex for money or drugs, and a history of incarceration. (Grade B) Transgender and gender-diverse persons — Gonorrhea and chlamydia screening recommendations should be adapted based on anatomy (i.e., screening recommendations for cisgender females should be extended to all transgender males and gender-diverse people with a cervix). Screening at the pharyngeal and rectal site for gonorrhea and chlamydia should be considered based on reported sexual behaviors and exposure. (UpToDate®, March 2024)

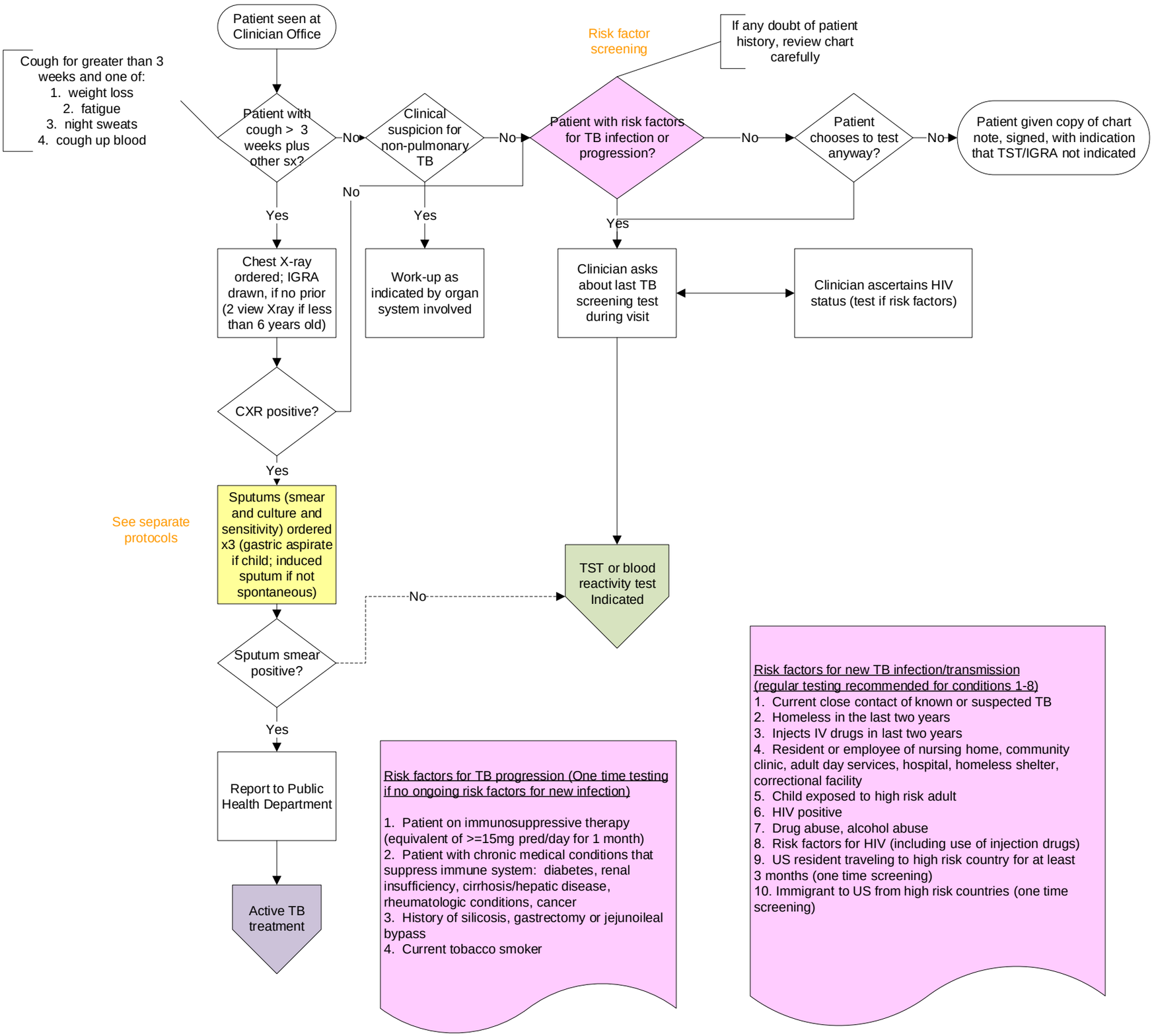
ADULT PREVENTIVE HEALTH SCREENING GUIDELINES

OTHER SCREENINGS	DETAILS
Osteoporosis in Postmenopausal Persons Assigned as Female at ~~Birth ,~~Birth, Screening	USPSTF Recommendation (~~June 2018~~January 2025) Screen persons assigned as female at birth age 65 years and older with bone measurement testing to prevent osteoporotic fractures (Grade ~~D~~B). For postmenopausal persons assigned as female at birth younger than 65 years, apply a formal clinical risk assessment tool such as the FRAX tool, found at: https://www.sheffield.ac.uk/FRAX/tool.aspx?country=9 to determine the appropriate need for bone measurement testing (Grade B). The USPSTF does not speak to the frequency of or interval between ~~testing~~testings. ACOG (September 2021) recommends repeat testing no earlier than two years after initial screening in those with a borderline result or a change in risk factors. A one-year follow-up test is recommended for patients on chronic glucocorticoid treatment. The "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8" provides osteoporosis screening recommendations based on surgical and hormonal histories of transgender and gender diverse individuals.
Vitamin D, Calcium or Combined Supplementation for the Primary Prevention of Fractures in ~~Osteoporosis in~~ Postmenopausal Persons Assigned as Female at ~~Birth ,~~Birth, ~~Prevention~~	The USPSTF (April 2018 – currently under review) recommends against daily supplementation with 400 IU or less of Vitamin D and 1000 mg or less of Calcium for the primary prevention of fractures in postmenopausal persons assigned as female at birth. (Grade D)~~-~~ The USPSTF (April 2018) finds inconclusive evidence that the benefits outweigh the risks for daily Calcium doses greater than 1000 mg or Vitamin D supplementation greater than 400 IU to prevent fractures (Grade I). The "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8" provides osteoporosis prevention recommendations based on surgical and hormonal histories of transgender and gender diverse individuals.

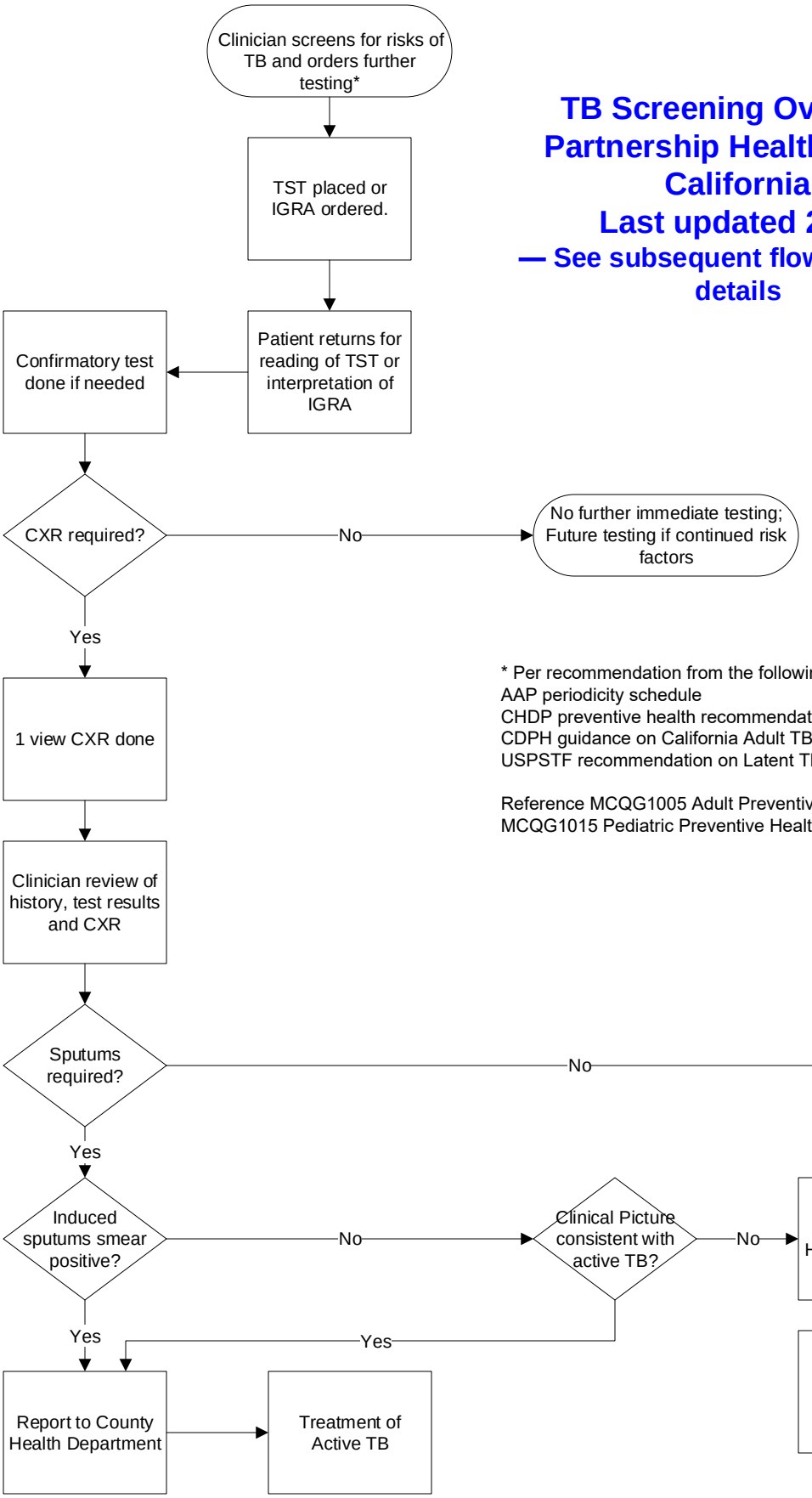
Resources: United States Preventive Services-Task Force recommendations, American Academy of Family Physicians (AAFP), American College of Obstetricians & Gynecologists (ACOG), American College of Physicians (ACP), UpToDate®, The American Diabetes Association, Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, Centers for Disease Control and Prevention (CDC).

Distribution: Provider Manual, Department Heads

TB Screening Guidelines
Partnership HealthPlan of California
Last updated:2024



TB Screening Overview Partnership HealthPlan of California Last updated 2024 — See subsequent flow charts for details



* Per recommendation from the following agencies:
AAP periodicity schedule
CHDP preventive health recommendations
CDPH guidance on California Adult TB Risk Assessment
USPSTF recommendation on Latent TB infection screening

Reference MCQG1005 Adult Preventive Health Guidelines and MCQG1015 Pediatric Preventive Health Guidelines

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPQP1016 (previously QP100116)</td><td colspan="3">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Potential Quality Issue Investigation and Resolution</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 01/20/1996</td><td colspan="4">Next Review Date: ~~06/12/2025~~03/12/2026
Last Review Date: ~~06/12/2024~~03/12/2025</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~06/12/2024~~03/12/2025</td></tr>
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I. RELATED POLICIES:

A. CMP30 - Records Retention and Access Requirements
B. CMP36 - Delegation Oversight and Monitoring
C. MPCR200 - Credentialing Committee and CMO Credentialing Program Responsibilities
D. MPCR600 - Range of Actions to Improve Practitioner Performance
E. MPCR601 - Fair Hearing and Appeal Process for Adverse Decisions
F. MPCR602 – Reporting Actions to Authorities
G. MPQD1002 – Quality and Performance Improvement Program Description
H. MPQP1053 – Peer Review Committee

II. IMPACTED DEPTS:

A. Health Services
B. Provider Relations
C. Grievance and Appeals

III. DEFINITIONS:

A. Potential Quality Issue (PQI): A possible adverse variation from expected clinician performance, clinical care, or outcome of care. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists. Not all PQIs represent quality of care issues.
B. Quality Issue: A confirmed adverse variation from expected clinician performance, clinical care, or outcome of care, as determined through the PQI process.
C. Clinician or Provider: Any individual or entity engaged in the delivery of health care services licensed or certified by the State to engage in that activity if licensure or certification is required by State law or regulation.
~~D.~~ Corrective Action Plan (CAP): A directive from the Peer Review Committee specifying required actions/ activities to be undertaken by a provider of concern. CAPs are given to educate the provider/facility on the identified issue/concern, with the goals of helping to prevent identified issues from recurring and improving member safety. CAPs contain clearly stated goals and timeframes for completion. ~~A plan approved by the Peer Review Committee to help ensure that a related quality issue does not occur in the future. CAPs contain clearly stated goals and timeframes for completion.~~

[1] This policy may also apply in part to Partnership Advantage, the HealthPlan's Medicare product effective Jan. 1, 2026 in eight counties: Del Norte, Humboldt, Mendocino, Lake, Marin, Sonoma, Napa, and Solano, and may be subject to change based on Centers for Medicare and Medicaid Services (CMS) rules.

D.

E. Severity ~~Level~~Rating: Refer to Attachment A: Practitioner Performance and Systems Scores Grid

F. Egregious Lapse: Where the quality of care was significantly outside accepted and common standards of practice and/or where the adverse outcome of the care provided was especially serious.

G. Quality Investigator: A Registered Nurse (RN) responsible for assessing and improving the quality of care provided by the providers serving Partnership HealthPlan of California (Partnership) members. These nurses perform the PQI Investigations and prepare the files for review by the CMO/ physician designee.

H. Provider of Concern (POC): The clinician, service provider, vendor, agency, facility or organization under review during a PQI investigation.

IV. ATTACHMENTS:

A. Practitioner Performance and Systems Scores Grid

V. PURPOSE:

To provide a systematic method for the identification, reporting, and processing of a Potential Quality Issue (PQI), to determine opportunities for improvement in the provision of care and services to Partnership members, and to direct appropriate actions for improvement based upon outcome, risk, frequency, and severity.

VI. POLICY / PROCEDURE:

A. IDENTIFICATION OF POTENTIAL QUALITY ISSUES

1. PQIs are identified through the systematic review of a variety of sources, including but not limited to:
   a. Information gathered through concurrent, prospective, and retrospective utilization review;
   b. Referrals from any health plan staff;
   c. Facility Site Reviews;
   d. Claims and encounter data;
   e. Pharmacy utilization data;
   f. Health Effectiveness Data Information Set (HEDIS®) medical record abstraction process;
   g. Medical record audits;
   h. Grievances and Appeals
2. PQI reviews shall be conducted on services provided by:
   a. Contracted clinicians or providers, including subcontractors and pharmacists, who provide inpatient and/or outpatient services;
   b. Non-contracted providers: complaints involving non-contracted providers will be discussed with the Chief Medical Officer (CMO)/designee to determine next steps prior to ordering medical records;
   c. Durable Medical Equipment (DME), medical transportation and respiratory supply vendors;
   d. Hospitals, skilled nursing facilities, long-term care and rehabilitation facilities, and Home Health agencies.
   e. Ancillary service providers including, but not limited to laboratory and radiology, physical therapy, acupuncturists.
   f. Behavioral Health: the Behavioral Health Clinical Director reviews complaints regarding behavioral health for investigation, intervention, and resolution as part of the general PQI review process.

B. PQI REFERRAL

1. A PQI may be reported by any of the following:
   a. Any Partnership staff member~~;~~

b. Anonymously using the Partnership "confidential line" which is available 24 hours a day, 7 days a week (1-800-601-2146)~~;~~
c. Any member of the community~~;~~
d. Any contracted or non-contracted clinician or provider.

2. A PQI is referred internally to the Quality Improvement (QI) department via the PQI Referral Intake System found on PHC4ME. For external PQI referrals and general PQI inquiries, send a secure email via PQI@Partnershiphp.org. The email must be encrypted through a secure messaging system.
3. Timeframe limitations: Partnership will not routinely investigate a PQI which occurred more than two years prior to the notification of the concern to the QI department.

a. Cases occurring more than two years before reporting involving a potentially serious matter or egregious lapse in care may be reviewed on an ad-hoc basis upon the discretion of the CMO/physician designee.

C. PQI REVIEW PROCESS

During case review, professionally recognized standards of care will be used to assess the care provided. A PQI may be a single event or occurrence or may involve several events or recurrences. While one report alone may not represent a quality issue, trending of similar events may reveal a quality issue and may lead to the re-opening of a case previously reviewed or closed.

1. PRIMARY REVIEW BY QUALITY INVESTIGATOR REGISTERED NURSE (RN) – Upon receipt of a PQI referral, the ~~Patient~~ Member Safety-Quality Investigations ~~team's Project~~team's Project Coordinator opens a new case file in the PQI database, and assigns the case to a Quality Investigator-RN (Investigator) to conduct the primary review and manage the case to completion.
   a. The Investigator will begin an investigation within 30 ~~days~~calendar days of receiving the PQI case referral. This includes conducting ~~conducts~~ a thorough internal investigation on all potential quality issues (provider performance and/or system issues), including a review of the incident as reported or alleged, as well as relevant medical records, and gathers responses from providers or other Partnership departments, when appropriate. The Investigator then presents a summary of the case at the internal PQI team rounds for a secondary review and assignment of the severity ~~level~~ rating by the CMO/physician designee. (See Attachment A - Practitioner Performance and Systems Scores Grid.)
   b. If the issue is urgent or the potential severity may represent an egregious lapse in the quality of care, the Investigator will immediately contact the CMO/physician designee for resolution and next steps. The CMO/physician designee may refer to an outside Peer Review Organization (PRO) depending on the case and availability of an appropriate PRO.
   c. If the PQI occurred at an organization with an accredited PRO responsible for oversight of the care provided by the Clinician or Providers of Concern (POC), the PQI is found to be urgent, and the potential severity of the PQI has been determined by the CMO/physician designee to reflect an egregious lapse in quality, the PQI will be referred to the outside PRO. A response will be required from the PRO acknowledging receipt of the notification regarding the concern. When a PQI is referred to the outside PRO, a copy will be sent to the Chief of Quality and Quality Director at the outside organization and the POC will be notified of the PRO referral. If the severity ~~score~~ rating is not determined prior to the referral, the case will be leveled as Provider, Unable to Determine (PUTD) or System, (SUTD).
      i. Notification that another PRO is reviewing a case does not prevent Partnership from investigating a case through the Partnership PQI and Peer Review process.
   d. If the Investigator determines that the member needs immediate assistance beyond the scope of peer review, appropriate information will be forwarded to other appropriate departments for action and follow-up (e.g., Member Services or Care Coordination).

2. SECONDARY REVIEW BY CMO/PHYSICIAN DESIGNEE – The CMO/physician designee review includes assessment of, but not limited to~~,~~: appropriate level of care; appropriate diagnostics; therapy and treatment; technical expertise; referral; consultation; timeliness; and adequate documentation. During the CMO/physician designee review, the CMO/physician designee may:
   a. Notify (by secure email and certified letter) the POC describing the issue and requesting investigational response and may also request additional documentation including related to system issues. If no response is received within the requested timeline (usually 14 calendar days, although providers may request extensions), an attempt to contact the provider will be made via any or all of the following methods: a certified letter, telephone call, fax, or secure email. A severity ~~level~~ rating may be determined based upon available documentation.
   b. Assign a severity rating~~level~~ (see Attachment A - Practitioner Performance and Systems Scores) and instruct the Investigator to close the case or prepare the case for presentation to the Peer Review Committee (PRC) depending on the severity rating~~level~~ of the findings. Additional information such as licensing board information and Partnership's Grievance, Credentialing, and PQI history may be used to determine an appropriate score and/or actions.
   c. Notify the POC (see Attachment A - Practitioner Performance and Systems Scores) for the action/follow-up recommended or required, based upon the severity rating~~level~~ assigned and as determined by the reviewing physician(s).
   d. Upon determination that a PQI case requires a second opinion review by a specialty physician or subject matter expert, a request for investigational review and response will be sent.
   e. Emergency action: If the CMO/physician designee determines that a situation exists where immediate action is required to protect the life or well-being of a Partnership member or any person, or to reduce substantial and imminent likelihood of significant impairment of the life or safety of any patient or person, the CMO (or, if the CMO is unreachable, the Partnership Physician Chair of the Credentials Committee or other physician designee) may summarily suspend the POC's credentialed status. See policy MPCR601 – Fair Hearing and Appeal Process for Adverse Decisions.
   f. Upon determination that a PQI case is out of Partnership's jurisdiction (e.g., serious mental health cases) the case will be referred to the appropriate oversight body (e.g., County Mental Health).
3. TERTIARY REVIEW BY THE PEER REVIEW COMMITTEE (PRC) – Upon determination by the CMO/physician designee that a PQI case requires review by the PRC, the Project Coordinator and Investigator prepare the PQI case file for Peer Review. See MPQP1053 for the Peer Review Committee policy.
   a. All PQI cases designated a severity rating of ~~level~~ P2 or S2 or higher (see Attachment A for descriptions) by the CMO/ physician designee must be referred to the PRC for review and determination of next steps.
   b. The PRC reviews the worksheets developed by the Investigator and CMO/physician designee, the medical records related to the case, any notifications to and responses from POCs and all other relevant documentation and correspondence related to the case.
      i. Following review and discussion of the case, the PRC may uphold the original rating ~~scoring~~ determination, may level a lower or higher score, or may direct the Investigator to obtain more information for further review.
      ii. If a~~-~~ severity rating is assigned~~score is leveled~~, the PRC will direct the Member Safety-Quality Investigations team in the next actions to take, as outlined in the Practitioner Performance and Systems Scores Grid

c. PRC recommendations for cases determined to be S3/P3 may be forwarded to the Credentials Committee for possible action.

d. In cases where the PRC recommends a Corrective Action Plan (CAP):

i. Notice shall be given to the POC within seven calendar days of the recommendation of a CAP being required. Grounds for recommending a CAP include but are not limited to:

a) failure to provide professional services of acceptable quality;
b) failure to follow Partnership utilization review policies;
c) failure to follow Partnership quality improvement policies;
d) failure to treat patients for whom the provider is responsible;
e) failure to adhere to the provider contract or Partnership policies;
f) acts constituting disruptive behavior or an inability to work collaboratively with others;
g) failure to report adverse action by another peer review body or a hospital

ii. If a CAP is recommended, it is included in the PQI case file. A CAP includes the goals, objectives, desired outcomes, timeframes, persons responsible, follow-up, and CAP evaluation. ~~The timeframe for clinicians to respond to a CAP is 30 calendar days.~~ The timeframe for clinicians to acknowledge receipt and initiation of a CAP is 30 calendar days. ~~The POC will be sent a reminder notice on day 15. If the CAP is not received by Partnership by day 31, the Investigator will contact the POC~~ If the CAP is not acknowledged and initiated by calendar day 31, the Investigator will contact the POC. A. ~~A~~ 15-calendar day~~s~~ extension may be granted for reasonable concerns. If the ~~CAP~~ POC has not acknowledged and initiated the CAP by calendar day 46, the Investigator will forward ~~been received by day 46, the case is forwarded~~ the case to the CMO/physician designee for further determination, including possible review by the Credentials Committee.

~~ii.~~iii. –Upon completion, the CMO/ physician designee reviews the CAP and notifies the POC acknowledging completion with no further action ~~required, or~~required or sends communication (certified letter or secure email) outlining what areas still need to be addressed and submitted, again within 14 calendar days of receipt of the follow-up notification. CAP results are reported to the PRC.

~~iii.~~iv. The CAP may include but is not limited to:

a) required completion of continuing education programs applicable to the issue identified and approved by Partnership~~;~~
b) required training/re-training and/or certification/re-certification for performance of those procedures that require specific training and professional certification~~;~~
c) continuing concurrent trend analysis of the adverse quality issues identified in the clinician's practice patterns~~;~~
d) monitoring of POC's medical record documentation by physicians selected by the PRC for a prescribed length of time; and
e) in-service training for clinicians and/or their staff.
~~e)~~f) Coaching/counseling from the POC~~provider~~'s Medical Director.

~~iv.~~v. For appropriate quality concerns, the PRC may instruct the Member Safety team to conduct periodic reviews of the POC to verify that the deployed corrective action is effective and eliminates the noted deficiencies.

4. The PRC may also recommend that the Credentials Committee review the POC's status, including but not limited to the following:

a. clinician or provider contract changes, including modification, restriction, or termination of participation privileges with Partnership;
b. summary suspension: immediate suspension from credentialed status based on the need to take immediate action to protect the life or well-being and or reduce the possibility of

substantial or imminent threat to the life, health, or safety of any Partnership member or other person;

c. recommendation of counseling for behavior modification;
d. focused review of the provider's cases including but not limited to:
   a) second opinion for invasive procedures;
   b) retrospective or prospective medical claims reviews;
e. preceptorship with a physician of the same specialty;
f. institute a monitoring process through proctoring by another qualified, specialty-matched physician; or
g. implementation of a practice improvement plan.

5. In the following situations, in addition to the other measures applicable to S3/P3 cases, immediate referral will be made to the CMO for consideration of the need for immediate follow-up and potential rapid escalation to the Credentials Committee, Board of Commissioners, Medical Board of California or other regulatory agency, and/or law enforcement agencies, depending the severity of the concern:
   a. actions or omissions constituting unethical or unprofessional conduct;
   b. sexual misconduct with or sexual harassment of a patient;
   c. discriminatory actions or behavior towards a patient based on race, gender, gender identity, religious beliefs, disability status, socioeconomic status, or other factors generally viewed as constituting unfair bias.
6. Any POC has the right to request a Fair Hearing for certain adverse actions as outlined in Partnership policy MPCR601 Fair Hearing Process for Adverse Actions. This policy also describes reporting requirements to the Partnership Board of Commissioners.
7. A report is filed per policy MPCR601 Fair Hearing and Appeal Process for Adverse Action and MPCR602 Reporting Actions to Authorities as required by Section 805.01 of the California Business and Professions Code. Pursuant to Section 805.01, when a peer review body makes a final decision following a formal investigation of one of the categories of misconduct identified below, it must file a report with the Medical Board of California and proposed action must be given to the practitioner within 15 calendar days after the peer review body makes the recommendation or final decision. A similar approach is applied to all clinical professionals credentialed by Partnership with a report filed with the appropriate professional licensing agency. The investigation findings trigger reporting obligations when the following "may" have occurred:
   a. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public;
   b. The use of, or prescribing for or administering to themselves of any controlled substance, any dangerous drug (as specified), or alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or to the extent that the licentiate's ability to practice safely is impaired by that use;
   c. Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing or furnishing of controlled substances without a good faith effort prior examination of the patient and the medical reason therefore (note that in no event shall a physician or surgeon who is lawfully treating intractable pain be reported for excessive prescribing, and if a report is made, the licensing board must promptly review any such report to ensure these standards are properly applied); and
   d. Sexual misconduct with one or more patients during a course of treatment or an examination.
8. All PRC/Credentials Committee recommendations and necessary attachments are forwarded to the CMO for coordination of any recommended action. If a quality issue has multiple clinicians or providers involved in care who are separately evaluated by a clinical reviewer or the PRC, determinations of severity ratings will not be final until all involved clinicians have been

assigned final severity ratings. If any data is pending before making a final determination for one involved clinician, the others clinicians' determinations will be pending and notifications will not be made until all determinations are complete.

9. For contracted providers who are not individuals (e.g., hospitals, skilled nursing facilities, community clinics), where a final determination is an S1, S2, or S3, the case will be referred in writing to the quality assurance committee, Medical Director or other designated authority of the facility involved. This referral will request acknowledgement that the issue has been reviewed and assurance that action has or will be taken to prevent similar system issues in the future. These system issues will be recorded ~~tracked~~ and reviewed at the time of the facility's re-contracting. If the CMO or PRC determines that the system issue at a facility places Partnership members at risk of adverse health outcomes, they may recommend that the contract with this facility be suspended or terminated.
10. The Partnership Board of Commissioners has the ultimate authority for final decisions regarding credentialing and appeals. Credentials Committee recommendations for adverse action are forwarded to the next regularly scheduled Board of Commissioners meeting for a final decision.

D. OPPORTUNTITIES FOR DISCUSSION BY THE CLINICIAN OR PROVIDER OF CONCERN (POC)

1. The POC will be notified of concern depending on the ~~severity level~~severity rating assigned. The notification will include the following:
   a. patient name and demographics;
   b. brief statement explaining the purpose of quality review activities;
   c. brief summary of the background of the case;
   d. confidentiality statement; and
   e. CMO/physician designee signature.
2. The POC will be given an opportunity to discuss the case by one of these methods: written, telephonic, in-person, or by encrypted e-mail. The POC will have 14 calendar days to respond.
3. If the POC fails to provide additional information within the required timeframe, the Investigator will send reminder notification with an immediate response required. If no response is received, the CMO or designee may choose to ~~level~~ rate the case using the information on hand. If an individual clinician is a member of a contracted medical group, the Director of the Quality Assurance (QA) department and/or Medical Director of the group will also be sent a copy of the request for additional information. In addition to the content in the original notification, the following will be included:
   a. A reminder that the organization's Partnership contract requires them to adhere to Partnership policies and procedures, which includes timely response to potential quality incidents; and
   b. An additional 14 calendar day~~s~~ deadline for response.
4. If there is no response from the POC following the second request, the CMO or designee may contact the POC to ensure the notification was received and request a response.
5. When additional information is received from the POC, the CMO or designee may refer the case to the PRC, a physician on the PRC with the same or a similar specialty, or to an outside physician with the same specialty. The original reviewer should be among those who review the additional information. In all such cases, the initial physician reviewer will conduct final review and recommend a level, which is then presented to the PRC for final determination.
6. The POC will receive a final determination notification that will include the following:
   a. a summary of the case findings, including a preferred or required course of action;
   b. final severity rating~~level~~ and any actions to be taken;
   c. a statement of opportunity to provide any additional information;
   d. confidentiality statement; and,

e. CMO/physician designee signature.

7. Phone conversations between a POC and a peer reviewer or the CMO/physician designee will be documented with written notes, which will be entered into the peer review file and sent to the clinician in a subsequent peer review notification, to offer the opportunity to make corrections.

E. TRACK AND TREND REPORTS

1. Track and trend reports by provider and ~~by level of severity~~by severity rating are reported to CMO or physician designee every six months. This includes adverse event trend analysis to assess providers and site rates of adverse events over time. In addition, providers and/or facilities who a~~w~~ere given a severity rating of P2 or S2 and above at PRC will be monitored for at least the following year via the track and trend reports to determine if the identified concern is ongoing. If through this process, any additional concerns are identified, further investigation or actions may be implemented.
2. The CMO or physician designee may consider a focused review, or other actions as outlined in section VI.C.4 when any practitioner demonstrates performance below acceptable standards of care or if there is evidence of poor quality that could affect the health and safety of Partnership members. The CMO or physician designee will implement a Practice Improvement Plan as needed. This will include specifics regarding the area of focus that requires improvement, timeframes and required documentation of completion.
3. Thresholds for consideration of a focused review:
   a. Two or more P2 or above ~~quality of care~~severity rating scores in the last 24 months; or
   b. Significant trend of service or quality complaints exceeding the established threshold.
4. A monthly report of ~~-~~the number of PQI referrals, open cases, and cases pending PRC presentation will be sent to the CMO and to the Medical Director ~~o~~for Quality.

F. MEDICAL RECORD REQUESTS

1. Upon determination that medical records and other related documents are required for the case review, the POC is requested to submit documents to the Partnership QI department within 30 calendar days from the date of the request.
2. If the information requested is not received within that timeframe, attempts to contact the facility will be made to follow up on the request. The CMO/physician designee will use all available information to rate the PQI. If the PQI cannot be rated due to the lack of medical records, the PQI may be referred to the licensing body that oversees the clinician or facility for investigation and disposition. Notification will be sent to the CMO of the POC or facility of concern informing them of the lack of response to the information request.

G. CASE COMPLETION

1. All PQI cases will be processed and closed with a final severity rating~~level~~ within 120 days from the date the case is received by the QI department. If a PQI investigation cannot be completed within the timeframe, a 30~~-~~ calendar day~~s~~ extension may be granted with the approval of the CMO/physician designee. The rationale for the extension approval shall be documented in the case file.
2. If the reviews are not completed in a timely manner, the CMO/physician designee will institute plans for compliance with standards for completion and timeliness.
3. While under review, all PQI cases and related documentation, when not in electronic form, are kept in a secure file cabinet in the QI investigation team~~department~~ and only designated personnel have access to these files. Access to the electronic files is password protected and limited only to staff directly involved in the PQI process.

H. REPORTING REQUIREMENTS

1. If a recommendation is made to revoke, suspend, or restrict the privileges of a clinician, or to terminate the provider's contract with Partnership, the following individuals and committees will be notified:
   a. Chief Executive Officer (CEO) of Partnership.

b. Credentials Committee recommendations are forwarded to the next regularly scheduled Board of Commissioners meeting for final action.
c. Chief of Staff and Hospital Administrators of facilities where clinician has hospital privileges.
d. The CEO of the medical group that employs the clinician, if applicable, and/or the Medical Director of the clinic where the clinician is employed.
e. DHCS requires Partnership to notify them when a provider has been terminated from being a Medi-Cal or Medicare provider and has been placed on the Suspended and Ineligible Provider list. Providers on the Medi-Cal/Medicaid suspended and ineligible provider list cannot participate in the Partnership provider network.
f. If the provider is ~~a~~an ~~member~~ employee of a medical group or clinic, a paraphrased summary of the final determinations for the ~~of~~ ~~levels~~ severity ratings of S1, S2, S3, P1, P2, and P3 will be reported to the supervising Medical Director. For ~~If~~ the final determination of ~~is an~~ P3/S3, the CEO of the institution may also be notified.

I. INTER-RATER RELIABILITY (IRR)
1. Inter-rater reliability studies will be performed at least twice a year by the CMO or physician designee to ensure cases are appropriately reviewed, to ensure that the reliability of the PQI case scoring process can be evaluated, and, for cases reviewed in PRC, review actions are appropriate and implemented.

J. RECORD RETENTION
1. Please refer to Policy CMP30 Records Retention and Access Requirements.

K. CONFIDENTIALITY
1. Peer review records proceedings as well as records obtained for the quality/peer review process are protected by California Evidence Code § 1157 and are not subject to discovery when confidentiality has been maintained. To maintain confidentiality, peer review records are retained by the Quality department and are not released to anyone for purposes other than peer review. Records are maintained in secure electronic format or in a locked file cabinet with access restricted to the CMO, Medical Director for Quality, and members of the ~~Manager of~~ Member Safety & Quality Investigations, ~~the RN Investigators, the QI Project Coordinator.~~ While records are being reviewed, or during transport to peer review meetings, a QI staff person accompanies them at all times. If a subpoena is served to Partnership regarding a peer review case, the Manager of Member Safety & Quality Investigations may act as the "certifier of the medical records" being requested.

L. SUBCOMMITTEES
1. Refer to policy MPQP1053 Peer Review Committee.

M. DELEGATION OVERSIGHT AND MONITORING
1. Partnership may delegate Potential Quality Issue (PQI) investigation including Peer Review Committee activities oversight.
2. A formal agreement will be maintained and inclusive of all delegated functions.
3. Partnership will review related policies and procedures and annual summary reports of findings and actions taken as a result of the PQI review process and provide feedback as part of Partnership annual oversight audit.
4. Results from Oversight and Monitoring activities shall be presented to the Delegation Oversight Review Sub-Committee (DORS) for review and approval.

VII. REFERENCES:

Exhibit A, Attachment III, Section 2.2 in the 2024 DHCS Contract

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

Policy/Procedure Number: MPQP1016 (previously QP100116)			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Potential Quality Issue Investigation and Resolution			☒**External Policy** ☐**Internal Policy**
Original Date: 01/20/1996		**Next Review Date:** ~~06/12/2025~~03/12/2026 **Last Review Date:** ~~06/12/2024~~03/12/2025	
Applies to:	☐**Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Quality Investigator RN

X. REVISION DATES:
Medi-Cal 07/01/96; 06/02/97; 10/10/97 (name change only); 01/13/99; 06/16/99; 06/21/00; 05/16/01; 05/15/02; 08/20/03; 04/20/05; 07/16/08; 10/19/11; 08/20/14; 11/19/14; 05/20/15; 06/17/15; 06/15/16; 06/21/17; *06/13/18; 06/12/19; 06/10/20; 06/09/21; 06/08/22; 06/14/23; 06/12/24; 03/12/25

*Through 2017, Approval Date reflective of the Quality Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee meeting date.

PREVIOUSLY APPLIED TO:
Healthy Families
MPQP1016 - 10/19/2011 to 03/01/2013

Healthy Kids (Healthy Kids Program ended 12/01/2016)
07/16/08; 10/19/11; 08/20/14; 11/19/14; 05/20/15; 06/17/15; 06/15/16 to 12/01/16

PRACTITIONER PERFORMANCE AND SYSTEMS SCORES

P Score	Definition	Action/Follow-up
P0	Care is appropriate.	No action required.
P1	Minor opportunity for improvement. Potential for or actual minor adverse outcome to member.	The reviewer will send a letter and/or secure email to the provider. Response may or may not be required.
P2	Moderate opportunity for improvement and/or care deemed inappropriate. Potential or actual minor or moderate adverse outcome to member.	Send certified letter and secure email to provider of concern, requiring a response. May impose a CAP and/or other interventions.
P3	Significant opportunity for improvement and/or care deemed inappropriate. Potential for or actual significant adverse outcome to member.	ASAP communication by certified letter, secure email and/or direct phone call to provider of concern requiringes a response. Requires a CAP and/or other interventions. May be referred to Credentials Committee with recommendations from the PRC.
PUTD	Use whenever the PQI cannot be scored through the usual process.	Referral to Peer Review Organization (PRO) of the Facility of Concern (FOC) or the Provider of Concern (POC). If none identified, may be through direct contact with management of the FOC or with oversight of the POC. Refer to the appropriate licensing entity, if indicated.

S Score	Definition	Action/Follow-up
S0	No system issue.	No action required.
S1	Minor opportunity for improvement. Potential for or actual minor adverse outcome to member.	The reviewer will send a letter and/or secure email to the provider. Response may or may not be required.
S2	Moderate opportunity for improvement and/or care deemed inappropriate. Potential for or actual minor or moderate adverse outcome to member.	Send certified letter and secure email to provider of concern, requiring a response. May impose a CAP and/or other interventions.
S3	Significant opportunity for improvement and/or care deemed inappropriate. Potential for or actual significant adverse outcome to member.	ASAP communication by certified letter, secure email and/or direct phone call to FOC/POC, requiring a requires a response. Requires a CAP and/or other interventions. May be referred to Credentials Committee with recommendations from the PRC.
SUTD	Use whenever the PQI cannot be scored through the usual process.	Referral to the PRO of the FOC or the system of concern (SOC). If none identified, may require direct contact with management of the FOC or with oversight of the SOC. Refer to the appropriate licensing entity, if indicated.

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MCUP3103			**Lead Department: Health Services** Business Unit: Behavioral Health	
Policy/Procedure Title: Coordination of Care for Child Welfare-Involved Members ~~in Foster Care~~			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 04/21/2010		**Next Review Date:** ~~05/08/2025~~03/12/2026 **Last Review Date:** ~~05/08/2024~~03/12/2025		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~05/08/2024~~~~TBD~~03/12/2025	

I. RELATED POLICIES:

A. MCUP3039 - Direct Members
B. MCCP2024 - Whole Child Model for California Children's Services (CCS)
C. MCUP3142 - CalAIM Community Supports (CS)
D. MCCP2032 - CalAIM Enhanced Care Management (ECM)
E. MPQD1001- Quality and Performance Improvement Program Description

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Assembly Bill 2083: (Chapter 815, Statutes of 2018) System of Care for Children and Youth Memorandum of Understanding (MOU). This assembly bill requires each county to develop and implement an MOU outlining~~s~~ the roles and responsibilities of the various local entities that serve children and youth in foster care who have experienced severe trauma. Entities must develop a coordinated, timely, and trauma-informed system-of-care approach, implementing related MOUs on the county level and establishing a joint interagency resolution team on the state level to assist counties in serving those children and youth.

~~A.~~B. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.

C. Child Welfare-Involved Youth: Children and youth who meet one or more of the following conditions:

1. Are under age 21 and are currently receiving foster care in California
2. Are under age 21 and previously received foster care in California or another state within the last 12 months
3. Have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state
4. Are under age 18 and are eligible for and/or in California's Adoption Assistance Program;
5. Are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the last 12 months

~~B.~~D. Children in Foster Care: Children who are in out-of-home placement under the care and custody of county welfare and probation departments.

~~C.~~E. Direct Member: Direct Members are those whose service needs are such that Primary Care Provider

(PCP) assignment would be inappropriate. Assignment to Direct Member status may be based on the ~~member~~Member's aid code, prime insurance, demographics or administrative approval based on qualified circumstances. A Referral Authorization Form (RAF) is not required for Direct Members to see Partnership network providers and/or certified Medi-Cal providers willing to bill Partnership for covered services. However, many specialists will still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP.

F. Enhanced Care Management (ECM) Provider: A Provider of ECM. ECM Providers are community- based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.

G. ECM Lead Care Manager : A Member's designated care manager for ECM, who works for the ECM Provider organization. The Lead Care Manager operates as part of the Member's multidisciplinary care team and is responsible for coordinating all aspects of ECM and any Community Support (CS). To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non- duplication of services.

H. Medical Home: The provider identified as the ~~member~~Member's medical home or primary care provider (PCP) is responsible for managing the ~~member~~Member's primary care needs.

~~D.~~I. Resource Family: In California, a Resource Family is a caregiver who provides out-of-home care for children in foster care. The Resource Family is approved to provide care on a temporary (foster care) and/or permanent (adoption and legal guardianship) basis and includes all types of caregivers in the child welfare and probation systems, formerly known as foster parents, approved relatives or approved Non-Relative Extended Family Member.

~~E.~~J. Whole Child Model: ~~In participating counties, t~~This program provides comprehensive treatment for the whole child and care coordination in the areas of primary, specialty, and behavioral health for Partnership HealthPlan of California (Partnership) pediatric ~~member~~Members with a CCS-eligible condition(s).

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe Partnership HealthPlan of California's ~~(Partnership's)~~ coordination of care for child welfare-involved youth.~~members identified as being placed in a foster care program.~~

VI. POLICY / PROCEDURE:

A. ~~Policies and Procedures apply to all Partnership covered members including children in foster care.~~ Partnership communicates with foster care agencies, group homes and ~~foster~~resource ~~parents~~ families for those Members ~~if~~ identified as child welfare-involved by the Medi-Cal Eligibility Data System (MEDS) ~~for complex medical issues relating to members~~.

B. If a ~~member~~Member is identified as being ~~placed in foster care~~a child welfare-involved youth, a review of medically necessary services that require prior authorization will be performed by Partnership's Utilization Management (UM) Department.

1. Foster care ~~member~~Members will be assigned to Direct Member status. (See policy MCUP3039 Direct Members)
2. Medically necessary services will be authorized to the in-network or out-of-network provider when indicated and medically necessary and appropriate.
3. Members identified as being high risk are referred to case management. Referrals are indicated for ~~member~~Members who are in need of multiple referrals and services, complex medical needs, or need for coordination of services with multiple agencies.
4. Child welfare-involved youth ~~Foster care members~~ who are also medically eligible for services under

the Whole Child Model (CCS children) are assigned a medical home. The provider identified as the child's medical home is responsible for managing the child's primary care needs and coordinating the child's care for both the CCS-eligible condition(s) and the non-CCS-eligible condition(s).[1]

5. Family caregivers of foster care program beneficiaries may be eligible for respite services through CalAIM Community Supports Services as per Partnership policy MCUP3142.

C. The Child Welfare Liaison shall be the primary internal and external contact for any concerns or assistance needed for child welfare-involved youth.
   1. Effective January 1, 2024, as per the Department of Health Care Services (DHCS) All Plan Letter (APL) 24-013 "Managed Care Plan Child Welfare Liaison," Partnership designates a Child Welfare Liaison to ensure the needs of Members involved with child welfare and foster care are met.
   2. Partnership designates an appropriate number of staff to serve as Child Welfare Liaison(s) to meet the health care needs of children and youth involved in child welfare in each county of Partnership's service area.
      a. Additional Child Welfare Liaisons are designated as needed to ensure the health care needs of children and youth involved in child welfare are met. Staffing is commensurate to the number of Members involved in child welfare enrolled with Partnership.
      b. Partnership reassesses staffing levels at regular intervals to ensure effectiveness in serving children and youth involved in child welfare throughout Partnership's service areas.
   3. Roles and Responsibilities of the Child Welfare Liaison
      a. The Child Welfare Liaison assists staff who coordinate care on behalf of children and youth involved in child welfare to ensure the health care needs of these Members are met.
      b. The Child Welfare Liaison serves as a leader within Partnership to advocate on behalf of children and youth involved in child welfare by serving as a point of contact to identify and resolve escalated case specific, systematic, and operational obstacles for accessing services.
      c. The Child Welfare Liaison provides assistance and resources to staff responsible for the Member's care coordination, including contracted ECM Lead Care Manager or the Children and Youth Involved in Child Welfare Population of Focus and applicable county child welfare staff as described in APL 24-013.
      d. The Child Welfare Liaison's duties are not intended to duplicate care coordination activities provided by other staff members or Providers, but rather to support and act as a resource to solve escalated issues regarding Partnership's services as they arise.
      e. The Child Welfare Liaison's roles and responsibilities include, but are not limited to, the following:
         1) Technical Assistance: Supports internal and external staff in care coordination and issue resolution
         2) Contact Point: Serves as a contact for resolving member service access issues
         3) Referral Pathways: Collaborates with County Child Welfare as well as internal and external ECM staff to ensure effective ECM referral processes
         4) Enrollment Support: Assists with member enrollment/disenrollment during County changes
         5) Service Coordination: Navigates and coordinates various benefits and services
         6) Internal Coordination: Works with additional internal liaisons for specific member populations
         7) County Liaison Coordination: Collaborates with designated county liaisons as needed

[1] ~~For Members under age 21 with a CCS-eligible condition, services and supplies for the CCS-eligible condition will either be authorized by Partnership under the Whole Child Model program (see policy MCCP2024 Whole Child Model for California Children's Services (CCS), or by the State CCS program (see policy MPCP2002 California Children's Services). In Partnership's service area, 14 counties participate in the Whole Child Model program (Del Norte, Humboldt, Lake, Lassen, Marin, Modoc, Mendocino, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo). As of January 1, 2024, the following 10 counties in Partnership's service area are participants in the State's CCS program and are not participants in Partnership's Whole Child Model program: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba.~~

8) Quarterly Meetings: Attends meetings with county child welfare agencies
9) Quality Improvement Input: Participates in quality improvement activities
10) Training Compliance: Ensures adherence to training provisions of the MOU
11) Foster Youth Rights: Educates staff on the Foster Youth Bill of Rights
12) Trauma-Informed Care: Promotes trauma-informed approaches in interactions

4. To enhance relationships between Partnership and county child welfare agencies for youth involved in child welfare, the Child Welfare Liaison shall:
   a. Participate in Partnership's Community Advisory Committee (CAC), the Quality Improvement Health Equity Committee (QIHEC) Committee, and additional committees and meetings that potentially impact Members involved in child welfare and foster care.
   b. Collaborate with Counties to identify opportunities for coordination of, and alignment with, each County Interagency Leadership Team's efforts in implementing the AB 2083 System of Care for Children and Youth MOU, and participate in the Systems of Care Local Interagency Leadership Team meetings to which Partnership is invited.
   c. Collaborate with other Child Welfare Liaisons internally and with Child Welfare Liaisons in other Managed Care Plans to discuss best practices, lessons learned, and sharing of information and resources.
5. Partnership designates staff for the Child Welfare Liaison position who can competently fulfill their roles and responsibilities and meet the criteria of having the expertise, demonstrable experience, or sufficient training in the following programs, processes, and practices:
   a. Child welfare services and county behavioral health services
   b. County care coordination and assessment processes, which may include, the full spectrum of requirements pertaining to service coordination, including referral requirements and processes, care management, and authorization processes
   c. Trauma-informed care practices
6. The Child Welfare Liaison's additional expertise, experience, and training shall include, but is not limited to, the following:
   a. Have a Master's degree and/or other additional training in social work, public health nursing, or another related field
   b. Have familiarity with Medi-Cal enrollment and disenrollment processes, as well as county social services agency processes for updating addresses and other eligibility information
   c. Have experience or training in coordinating care within child welfare services and juvenile justice systems and understand the Foster Youth Bill of Rights.
~~4.~~7. Partnership will notify the county child welfare agency and DHCS of a change in the designated Child Welfare Liaison as soon as practicable, but no later than five working days from the change.
8. Partnership will submit the Child Welfare Liaison contact information to the "Liaison Directory" section available on the Managed Care Operations Division (MCOD)-MCP Submission Portal.
   a. For delegated Subcontractors that serve children and youth involved with child welfare, Partnership will submit contact information of the Subcontractor's Child Welfare Liaison(s) to the MCOD-MCP Submission Portal. Partnership shall ensure Subcontractors' compliance with the requirements of APL 24-013.
9. Partnership conducts quality improvement activities pursuant to policy MPQD1001 Quality and Performance Improvement Program Description.

D. As necessary, the Department of Social Services Foster Care Program's Social Workers may be contacted by Partnership Member Services Representatives, the County Child Welfare Liaison, and/or Health Services Case Management staff to facilitate coordination of care.

E. If the child has been placed outside of the counties Partnership serves, the County Child Welfare Liaison, ~~the~~ a Member Services Representative or the ~~Case Management~~Care Coordination Department will assist in the coordination of the change of county by connecting the foster caregiver, county welfare services agency,

county probation department, or any other person authorized to make medical decision to the Department of Health Care Services (DHCS) Ombudsman as per Assembly Bill (AB) 1512, Torrico Medi-Cal: Foster Children, October 2007.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All County Welfare Directors Letter (ACWDL) 97-02 "Participation of Foster Care and Adoption Assistance Program Children in Medi-Cal Managed Care" (January 13, 1997)
B. DHCS ACWDL 00-22 "Letter To Notify Counties of Three New Aid Codes For Children in the Kinship Guardian Assistance Payment and Adoption Assistance Programs" (April 10, 2000)
C. Other applicable DHCS All County Welfare Directors Letters (ACWDLs) regarding Foster Care as cataloged on this website: https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Pages/ACWDLbyyear.aspx
D. Assembly Bill (AB) 1512, Torrico. Medi-Cal: Foster Children approved and filed October 11, 2007.
E. DHCS All Plan Letter (APL) 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (10/11/2023)
   1. County Social Services Programs and Child Welfare MOU template (DHCS Contract Attachment B)
F. DHCS All Plan Letter (APL) 24-013 Managed Care Plan Child Welfare Liaison (09/18/2024)
~~F.~~G. California Foster Youth Bill of Rights

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 04/18/12; 02/18/15; 02/17/16; 02/15/17; *03/14/18; 03/13/19; 03/11/20; 02/10/21; 05/11/22; 05/10/23; 05/08/24; 03/12/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

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Partnership HealthPlan of California

CARE COORDINATION PROGRAM DESCRIPTION

MPCD2013

March 20254

Original Date: 01/20/2016
Revision Date(s): 06/21/17; *06/13/18; 11/14/18; 11/13/19; 04/08/20; 03/10/21; 03/09/22; 03/08/23; 03/13/24; 03/12/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

TABLE OF CONTENTS

TABLE OF CONTENTS

Table of Contents **2**
Program Purpose **3**
Introduction 3
Department Objectives & Goals 3
Scope of Services **4**
Identification and Referrals 5
Program Structure **5**
Basic Population Health Management 5
Acuity Level One: 5
Acuity Level Two: 7
Transitional Care Services 7
Acuity Level Three: 7
Complex Case Management (CCM) 9
Acuity Level Four: 9
Acuity Level Five: 10
Care Coordination Process 11
Program Support 11
Enhanced Care Management (ECM) Benefit 12
Team Roles and Responsibilities **12**
Care Coordination Program Quality Monitoring and Oversight **18**
Provider and Member Satisfaction 18
Annual Program Evaluation 19
Protected Health Information **19**
Statement of Confidentiality **19**
Non-Discrimination Statement **21**
Care Coordination Program Approval **22**

PROGRAM PURPOSE

To define the scope of services provided by Partnership HealthPlan of California's (PartnershipHC's) Care Coordination Department.

INTRODUCTION

Partnership HealthPlan of California's Care Coordination Department offers case management services to any plan member with care management needs who is willing to participate, and for whom PartnershipHC is either the primary source of coverage or for whom PartnershipHC may be responsible for the benefit, such as members eligible for California Children's Services (CCS). Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet the member's health and wellness needs. It is characterized by advocacy, communication, and resource management, while promoting quality and cost-effective interventions and outcomes. These services assist PartnershipHC in ensuring that we are fulfilling our mission to help the members and the communities we serve be healthy.

DEPARTMENT OBJECTIVES & GOALS

The objectives and goals of PartnershipHC's Care Coordination Department are to:

- Educate members about the resources available to them through their plan benefits and how to use these resources to optimize their wellness
- Assist members in understanding their health conditions and support members in becoming proficient in gaining/maintaining their optimum health and functionality
- Provide support for members with chronic illness
- Facilitate timely access to care and efficient delivery of health care services, supplies, and equipment
- Promote communication between the member, member's supports (i.e., caregiver, guardian, or other concerned parties), providers, community resources, and long-term support systems
- Connect members to resources within their communities to support and to assist them in self-management of their health and well-being
- Collaborate with multidisciplinary health agencies and non-profit partners to link members to available community resources, where accessible
- Minimize gaps between healthcare settings by coordinating transitions across the healthcare continuum of age, coverage, service type, and location
- Improve member and provider satisfaction
- Provide education to members, providers, and community-based organizations about case management services offered by PartnershipHC and encourage referrals when needs or barriers are identified

Care Coordination is not intended to replace or be a substitute for the physician's management of a member's medical conditions. PartnershipHC staff works collaboratively with the practitioner to coordinate clinical and support services for members to decrease the potential for fragmentation of care.

Services offered through PartnershipHC's Care Coordination Department are available to eligible members, and outreach efforts may target a particular population depending on regulatory requirements and identified population needs. The following are examples of populations who may benefit from Care Coordination:

- Members new to the health plan who require expedited care
- Children diagnosed with a California Children's Services (CCS) eligible condition
- Medi-Cal PartnershipHC eligible enrollees who are designated by aid code as Seniors or Persons with Disabilities (SPD) and who may be at risk for an adverse outcome without an Individualized Care Plan (ICP)
- Children with Special Health Care Needs (CSHCN)
- Children and adults with developmental disabilities in collaboration with the California Regional Centers
- Members identified as connected to the Genetically Handicapped Persons Program (GHPP) who require assistance and support
- Members who are chronically ill or who have multiple complex medical conditions
- Members preparing for an organ transplant
- Members who require assistance accessing community-based programs and/or services
- Members who are in a pivotal place with their healthcare needs due to transition across settings (e.g. acute hospital stay to home), across age groups (e.g. transition from pediatric to adult care), or across benefit structures (e.g. exhausting home health benefits or transitioning from curative care to hospice care)
- Members who have difficulties navigating the healthcare community
- Members who have cognitive or communication deficits that require an advocate to help them communicate their health care needs
- Members challenged with efficiently managing their health within PartnershipHC's managed care network
- Members involved in child welfare and ~~Children in f~~Foster c~~C~~are

SCOPE OF SERVICES

The Care Coordination Department offers a variety of evidence-based services and interventions to coordinate care for members. Our team of Nurse Case Managers, Medical Social Workers, and Health Care Guides help to ensure services are coordinated for the member across the healthcare continuum. Taking the member's, or their caregiver's, needs and preferences into account when communicating, the staff in the Care Coordination Department uses evidence-based practices such as Motivational Interviewing and principles from Dialectical Behavioral Therapy (DBT) to ensure that the member's goals are at the center of an Individualized Care Plan (ICP). With the use of these member engagement techniques, the team is able to assist the member in enhancing their autonomy and reaching their desired goals and outcomes. During the course of participation, goals and interventions are routinely identified and evaluated by PartnershipHC's Care Coordination staff to track the member's progress. Goals and interventions may be added and/or closed as care needs resolve. In accordance with Department of Health Care Services (DHCS) regulations and PartnershipHC's policies, PartnershipHC Care Coordination staff shall ensure there is no duplication of case management services or care coordination when actively working with a member; facilitating warm hand-offs with appropriate

providers/agencies if such duplication is identified.

IDENTIFICATION AND REFERRALS

The Care Coordination Department utilizes a variety of approaches to screen and identify members who may benefit from Case Management Services. These activities include:

- Internal reports, such as the Monthly Utilization Report, Monthly Pediatric Case Finding Report, Weekly Hospital Discharge Report, HEDIS Outreach Campaign List, etc.
- Review of referrals sent to the Care Coordination Department Help Desk email by both internal and external parties
- Heath Information Form (HIF)/Member Evaluation Tool (MET)
- Health Risk Assessment (HRA) Form
- Pediatric Health Risk Assessment (PHRA) Form
- Reports based on Fee-for-Service (FFS) -Claims Data provided by the State, etc.
- Risk stratification reports, including but not limited to, the Population Health Management (PHM) Service Risk Stratification and Segmentation (RSS)

Referrals for Case Management Services originate from a variety of both internal and external sources. Members are commonly referred for Case Management from Partnership~~HC~~'s internal departments such as Member Services, Pharmacy, Utilization Management, Population Health Management, Enhanced Health Services, Behavioral Health, and/or Grievance. Externally, members may self-refer, or they may be referred by their caregivers, Primary Care Providers (PCPs), Specialists, Hospital Case Managers/Discharge Planners, and/or County or Community Partners such as Public Health Nurses, Medical Therapy Programs, Grant Programs, or Home Visiting Program Providers, etc.

Referrals for Case Management can be sent to the department directly via email, phone, Partnership~~HC~~'s member portal, or the Provider website referral form. Members, providers, caregivers and/or community partners can contact the Care Coordination department directly to make a referral. Each referral sent to the department is reviewed by Care Coordination staff who, based on the information received upon intake, will identify the initial needs of the member and route the member to the appropriate team for case assignment.

PROGRAM STRUCTURE

Care Coordination services are based upon the acuity of the member's needs. Using a scale of one to five, the member's acuity determines the level of care coordination intervention. A member's acuity may be adjusted during the course of case management services as goals are met or additional barriers are encountered.

BASIC POPULATION HEALTH MANAGEMENT

Acuity Level One:

Members with Acuity Level One are the lowest risk members receiving services in Care Coordination. Their needs are generally resolved within 30 days of identification and the primary focus is to ensure these members are well-connected to their primary care providers or specialists who may be acting as primary care providers. Members assigned Acuity Level One include those referred through or requiring assistance with:

- New Member Health Information Forms (HIFs)
- Access to Care:
    - Primary or Specialty Care,
    - Specialty Mental Health Services (SMHS)
    - Substance Use Disorder (SUD) services
    - Early Intervention
    - Developmental Services (DD)
    - Behavioral Heath Therapy (BHT),
    - Early Periodic Screening Diagnostic and Treatment (EPSDT) services
    - Transportation to/from Medi-Cal covered services
- Those needing assistance with and needing closed loop referrals to:
    - County social service agencies and waiver agencies for In-Home Support Services (IHSS) and other home- and community-based services (HCBS)
    - Medi-Cal Dental
    - CalFresh, Women, Infants and Children (WIC), Meals on Wheels, etc.
    - Ancillary Services or Durable Medical Equipment (DME) covered by Medi-Cal
    - Prescriptions
    - Services provided by Community Health Workers (CHWs), peer counselors, and local community organizations
    - Transitioning to a new primary care or specialty provider, including pediatric members preparing to transition from pediatric to adult care
    - Arranging routine screening appointments, such as those monitored through Healthcare Effectiveness Data and Information Set (HEDIS) measures
    - Education for resources available in their area/community (housing, transportation, support groups, etc.)
    - Connecting to Enhanced Care Management (ECM)[1] and Community Supports (CS)[2]
- CCS member's annual re-assessment, risk review, and documentation to support redetermination of medical eligibility
- Members requesting to see out-of-network providers where an established relationship exists (Continuity of Care)

Interventions:

Members identified as an Acuity Level One will be assessed to identify their primary care coordination needs. Based on the member's stated goals, Care Coordination staff will assist the member in gaining access to necessary resources and supports. Typical interventions provided under Acuity Level One include, but are not limited to:

- Navigation and coordination of services (appointments, DME, transportation, etc.)
- Collaboration with county/community agencies

[1] For further information on ECM, refer to Partnership~~HC~~ policies MCCP2032 CalAIM Enhanced Care Management (ECM) and ~~MCUP3143~~ MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)

[2] For further information on CS, refer to Partnership~~HC~~ policies ~~MCUP3142~~ MCAP7003 CalAIM Community Supports (CS) and ~~MCUP3143~~ MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)

- Ensuring that the member has ongoing source of care that is appropriate and timely to meet the member's needs
- Closed loop referrals to physical health, mental health, oral health and/or community resources
- Linkages to other public benefit programs including but not limited to CalWorks, CalFresh, ~~Women, Infants and Children (~~WIC~~)~~, Supplemental Nutrition Program, Early Intervention Services, Supplemental Security Income (SSI), etc.

Care Coordination staff work to help members overcome barriers to health and wellness care. When a member's barriers cannot be resolved promptly, Care Coordination staff create an Individualized Care Plan (ICP) to assist the member in achieving health and wellness goals. Throughout the course of the case, Care Coordination staff will reassess the assigned acuity level for the case and make adjustments as needed to provide the right level of care at the right time, including escalation to Complex Case Management (CCM) or the Enhanced Care Management (ECM) benefit when warranted.

Acuity Level Two:

Members with Acuity Level Two have emerging risk of disease/disease exacerbation, and/or a newly diagnosed chronic illness. They benefit from health education and resources tailored to their condition along with a contact within the care coordination department should questions arise. Members assigned Acuity Level Two include those referred through or requiring assistance with:

- Maintenance of chronic conditions like diabetes, asthma, or mild to moderate mental illness
- High Risk Infant Follow Up (HRIF)
- Identified case management needs resulting from Population Health Management screenings

Interventions:

Members managed at an Acuity Level Two will be provided with Health Education resources supporting lifestyle management to maximize health and wellness, and to mitigate effects of chronic disease. Interventions provided for members with Acuity Level Two may include, but are not limited to:

- Emotional Support/ Active Listening
- Reinforcement of health maintenance screening and care
- Referrals to disease prevention/management programs, Population Health interventions, or Healthy Living classes
- Referrals to community support groups
- Coordination of Services (appointments, referrals, DME, medical supplies, etc.)
- Review of health education materials

Members in this acuity may require more intensive interventions should their condition warrant it or if the member requests additional support.

TRANSITIONAL CARE SERVICES (TCS)

Acuity Level Three:

Transitional Care Services [3] focus on members who are transitioning across settings including, but not limited to, discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports, post-acute care facilities, or long-term care (LTC) settings or across benefit structures (e.g. exhausting residential treatment service benefits for substance use disorder, or transitioning from curative care to hospice care). These members are vulnerable to lost information across the care continuum, fragmented care, may have difficulty navigating the health care system, or may need support ensuring a transition plan is executed as intended. Members considered Acuity Level Three may come from any source; however, the most common sources of referral are:

- Hospital Case Managers/Discharge Planners or Social Workers
- Weekly Hospital Discharge reports
- Admission, Discharge, and Transfer (ADT) feeds
- Other Care Coordination programs
- Referrals from Partnership~~HC~~'s Utilization Management team

Interventions:

Case Management activities for members tiered at Acuity Level Three ensure the member reconnects with primary care, specialty care (when needed), DME, pharmacy, and/or community resources that will support health and wellness following a transition of care. Upon referral to the Care Coordination department, staff will conduct an assessment and review any applicable medical documentation such as a discharge summary, plan of care, medical records, etc. Care Coordination staff will develop an ICP supporting the member's successful transition along the care continuum and provide education, advocacy and reinforcement for the transition plan. A copy of the ICP shall be made available to the member, their parent(s)/caregiver, and/or authorized representative. Typical interventions utilized during Transitional Care Services include, but are not limited to:

- Review of Discharge Summary/Plan
- Identification of ongoing care team roles and members
- Coordination of outpatient services (appointments, medication reconciliation, referrals, transportation, food banks, Community Supports, etc.)
- Ensuring necessary prior authorizations are in place (e.g. home health, medical supplies, DME, etc.)
- Coordination with hospitals and/or discharge planners to support the discharge plan, the member, and ensure no delays or gaps in care
- Ensuring members with Substance Use Disorder (SUD) and/or mental health needs receive treatment prior to discharge
- Closed loop referrals to ensure no gaps in care
- Assistance with accessing programs such as Long Term Support Services (LTSS), ~~Women, Infants, and Children (~~WIC~~)~~ Program, ~~In Home Support Services (~~IHSS~~)~~, or other social supports
- Ensuring collaboration, communication, and coordination with members and their families/support persons/guardians, hospitals, emergency departments (EDs), LTSS, physicians (including the member's PCP), nurses, social workers, discharge planners, service providers, and county/community agencies to facilitate safe and successful transitions while reducing duplication of efforts
- Motivational Interviewing to build on resiliencies

[3] For further information on TCS, refer to Partnership~~HC~~ policy MCCP2034 Transitional Care Services (TCS).

- Emotional Support/ Active Listening

If the member is receiving CCM or ECM, the member's existing assigned case manager is responsible for providing all Transitional Care Services. The interventions for Transitional Care Services are tailored in response to the member's assessed needs or stated goals. Members receiving Transitional Care Services, but not currently enrolled in either CCM or ECM, who are exhibiting ongoing, unresolved and/or complex care needs shall be referred to either Partnership~~HC~~'s CCM program or to a contracted Enhanced Care Management (ECM) provider for intensive care coordination support.

COMPLEX CASE MANAGEMENT (CCM)

Complex Case Management focuses on meeting the needs of the most fragile members through clinical intervention(s) and case management services. These may be members with multiple chronic medical conditions, or they may have fragmented care, have difficulty navigating the health care system, or have other challenges that threaten to compromise their well-being if not supported through an ICP.

Acuity Level Four:

These members require intensive support available through clinical and non-clinical case management activities and interventions, but are not otherwise eligible or decline to participate in Medi-Cal's Enhanced Care Management (ECM) benefit. Examples of members commonly enrolled in CCM are those with at least one CCS-eligible condition along with social support needs (in pediatric cases), and members who have two or more chronic conditions (in adult cases). Alternatively, these members may have mental illness or substance use disorders or other challenges that threaten to compromise the member's well-being if not supported through an ICP. Cases in this tier may reflect more than one recent hospitalization within the past 2 months or multiple emergency department visits relating to the eligible conditions. These cases have high risk of declining function, hospitalization, or readmission if appropriate interventions are not in place. Members assigned Acuity Level Four are often identified by:

- New Member Health Risk Assessments (HRAs) for new SPDs or CCS members
- Medical Therapy Programs/Units
- Hospital Discharge Planners or Social Workers
- Primary Care or Specialty Providers
- Internal case-finding reports (Monthly Utilization Report, Monthly Pediatric Case Finding Report, etc.)
- Care Coordination Help Desk email review
- Other internal Care Coordination services and activities
- Other internal departments (Utilization Management Inpatient Rounds, Quarterly Grievance Review, Provider Relations, etc.)
- Meetings with external organizations (Hospital Case Management Rounds, CCS county meetings, County Mental Health departments, Community-Based Organization collaborations, etc.)
- Risk stratification reports

Interventions:

The primary focus of case management for members tiered at Acuity Level Four is to help members regain optimum health or improved functional capacity in the right setting and in a cost-effective manner by coordinating both clinical, non-clinical, and social determinants of health (SDOH) needs for members with

complex needs. For those members with clinically complex needs, the PartnershipHC Care Coordination staff shall also provide community connections, social supports, and integration with long-term support services. Care Coordination staff will perform a comprehensive assessment evaluating the member's medical, psycho-social, mental, emotional, and behavioral needs. The member and Care Coordination staff member will develop an ICP. Care Coordination staff will collaborate with the member to identify prioritized goals and select interventions/behaviors intended to meet these goals. Together with PartnershipHC Care Coordination staff, the member, their parent/caregiver and/or authorized representative will work collaboratively to overcome identified barriers to meeting the identified and prioritized goals. Typical interventions utilized during Complex Case Management include, but are not limited to:

- Personalized assessments
- Individualized Care Plan (ICP)
- Motivational Interviewing to build on resiliencies
- Emotional Support/ Active Listening
- Transitional Care Services for tailored support across settings, benefit structure, or programs.
- Disease specific management support and education (e.g. Asthma, Diabetes, End-Stage Renal Disease, Cardiovascular Disease, Sickle Cell Anemia, Cystic Fibrosis, etc.)
- Teach-back techniques to promote health and support lifestyle choices based on healthy behavior
- Coordination of Services (appointments, referrals, DME, transportation, medical supplies, etc.)
- Closed loop referrals to address the needs of physical health, mental health, substance use disorder, oral health, developmental health, palliative care, Community Supports, and/or community agencies
- Identification of barriers to established goals or treatment plan adherence
- Review for medical necessity of complex services such as Pediatric Shift Nursing or Residential SUD Treatment Services
- Collaboration with the multi-disciplinary care team to ensure the member's care needs are expedited as well as reducing duplication of efforts amongst care team members
- Assistance and support in accessing programs such as LTSS, IHSS, WIC, or other social supports.

Interventions are tailored in response to the member's assessed needs or stated goals. A copy of the ICP is provided to the member's provider(s) and to the member, the member's parent/caregiver and/or authorized representative to facilitate collaboration and joint agreement on goals of care. The individualized care plan and corresponding goals are routinely evaluated to evaluate progress, update when necessary, and adjust the member's assigned acuity when appropriate or when requested by the member. Interdisciplinary case conferences may be scheduled with identified individuals from the member's care team, internal PartnershipHC staff, and external community level-partners and/or the member, their parent/caregiver and/or authorized representative to review the goals of the ICP and to support the member in achieving identified goals.

Acuity Level Five:

Members with Acuity Level Five are the highest risk members in Complex Case Management and they require more involvement than can be provided through telephonic forms of case management. These members experience extraordinary barriers to care, such as communication challenges, cognitive barriers, capacity issues, or a severely fragmented provider/health care delivery system and often require an onsite assessment(s) or multi-disciplinary conferences to meet their needs. Members considered for Acuity Level Five will be reviewed by a clinical supervisor for approval, with specific goals described for the face-to-face

meeting.

Interventions

Acuity Level Five is distinguished from other acuities in that it includes all the interventions for other acuity levels as well as a face-to-face interaction between the case manager and the member/member's representative for one or more visits. This interaction may take place in the member's home, but more optimally occurs in a provider's office. These meetings are pre-scheduled and may include the member/member's representative, clinical member(s) of the care team with non-clinical support as appropriate to the case, the provider and/or specialist, ancillary provider(s) such as members of the Medical Therapy Unit or therapists, and other individuals who are part of the member's multidisciplinary care team. Note: not all multidisciplinary care team meetings require a face-to-face visit; however, this intervention may be leveraged when the case complexity or communication challenges require extraordinary efforts for collaboration.

CARE COORDINATION PROCESS

When referred for Care Coordination, members are advised that these services are voluntary and the member is not required to participate. All case documentation of assessments, interventions, activity, and the member's ICP will be stored in the Care Coordination Department's Case Management software system. The Care Coordination team will also document each instance when a member declines to participate in case management or when they cannot be reached after multiple attempts, through multiple means of contact.

The guiding principles for PartnershipHC's case management services are identifying a member's goals of care and the barriers to meeting those goals, and then choosing interventions designed to overcome the barriers. When the identified goals are met, the case will be closed unless new goals, barriers, or needs are identified. At any time during the course of receiving services, if the member's status or needs change, the case will be evaluated by the assigned PartnershipHC Care Coordination staff member to determine acuity level appropriateness. Members who experience a change in condition, where their needs cannot be met by PartnershipHC's Care Coordination programs and services, will be screened and directed to other available services within, or external to, PartnershipHC when appropriate (e.g. Enhanced Care Management benefit).

In certain instances, PartnershipHC staff may close a case before completing the ICP or achieving the goals listed on the ICP. Examples of scenarios where Care Coordination may be discontinued include:

- Member is no longer responsive to outreach efforts after 45 calendar days and multiple attempts
- The member requests to have their case closed or expresses they no longer wish to participate in services
- Member is obtaining case management services through another agency that are duplicative of the services through PartnershipHC
- The member is referred to an alternative program or service that better meets the needs of the member
- Member loses Medi-Cal eligibility and/or is no longer assigned to PartnershipHC
- Continued inappropriate (derogatory, profane, abusive) behaviors towards PartnershipHC staff with no improvement after documented attempts to address behaviors
- Cases closed to Care Coordination may be re-evaluated if the member's condition, or desire to participate, changes

PROGRAM SUPPORT

The Care Coordination department is supported by a team of leaders and administrative staff within the

department. Leadership within the department provides supervision of staff & programs and evaluates program activities & outcomes; ensuring compliance, oversight, support and guidance for evidence-based case management and care coordination activities in alignment with PartnershipHC policies, Department of Health Care Services (DHCS) regulations and National Committee for Quality Assurance (NCQA) standards. The leadership and administrative support staff in the Care Coordination department also network and facilitate meetings with providers, community partners, and government agencies, to share information about PartnershipHC's Care Coordination programs and referral pathways, and to answer questions and promote collaboration of efforts to reduce/avoid duplication of services.

ENHANCED CARE MANAGEMENT (ECM) BENEFIT

PartnershipHC shall offer the CalAIM Enhanced Care Management (ECM) benefit for eligible members. The ECM benefit is unique and distinct from the care management services or programs offered by PartnershipHC. ECM is a whole-person, interdisciplinary approach to comprehensive care management that addresses the clinical and non-clinical needs of the highest need and/or highest cost members who meet the Population of Focus criteria established by DHCS. ECM is high-touch, person centered and occurs primarily in the community where the member lives and/or seeks care and focuses on systematic coordination of services through a single lead case manager.

PartnershipHC members may not be simultaneously enrolled in any of Partnership's Care Coordination programs and ECM. However, upon assessment of the member's needs and after obtaining the member's agreement to participate, PartnershipHC's Care Coordination department may refer the member to an ECM provider for services. Conversely, ECM providers may refer a member to one of Partnership's Care Coordination programs for support if indicated, or at the expressed desire by the member. For more information about the ECM benefit, see PartnershipHC policies MCCP2032 CalAIM Enhanced Care Management (ECM) and ~~MCUP3143~~ MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS).

TEAM ROLES AND RESPONSIBILITIES

Chief Health Services Officer-RN: Responsible for the executive management and operational leadership of the following Partnership Health Plan of California Health Services departments: Utilization Management (UM), Care Coordination (CC), Population Health Management (PHM), Health Equity, and associated initiatives under CalAIM. This position provides executive leadership in organizing the health plan's operations and~~,~~ interdepartmental communication, and participates in goal setting and strategic organizational planning in the development of new business lines and programs.

Senior Director of Care Management-RN: The Senior Director of Care Management (CM) is responsible for setting and carrying out the overarching strategic direction and goals of the Care Coordination and Utilization Management d~~D~~epartments. This position maintains and oversees proper delivery, coordination and execution of all related services and activities to improve the health outcomes of members. This role ~~will~~ oversees and manages a large team of clinical and non-clinical staff while working in cross-~~-~~collaboration with ~~both~~ Medical Directors and other senior departmental leaders.

Director of Care Coordination - RN: Provides oversight of all Care Coordination programs and services to

improve the health of PartnershipHC members in every office location. Works with the Chief Medical Officer, Senior Director of Health ServicesSenior Director of Care ManagementChief Health Services Officer, and Associate/Regional Directors to meet organization and department goals and objectives while developing and tracking measurable outcomes (e.g. financial, clinical, qualitative, etc.) of department staff, programs and services. Works collaboratively with identified Health Services staff to ensure appropriate integration of PartnershipHC, DHCS, and NCQA guidelines, policies, and procedures.

Associate Director of Care Coordination - RN: Under direction from the Director of Care Coordination, manages and provides direction to the Care Coordination (CC) Department Managers and Supervisors for all services. Responsible for establishing and maintaining reports that will support the efficacy of department activity and producing a summary at least annually, or upon request, of CC program activities with documentation of department services, member outcomes, return on investment, and quality improvement activities. A key component of this position is the enhancement and refinement of existing programs, and enthusiastic innovation in the development, management, integration, and refinement of new and existing programs.

Associate Director of Clinical Integration RN: Under direction from the Director of Care Coordination, manages and provides direction to the Care Coordination (CC) dDepartment's Clinical Integration tTeam's Managers, Supervisors, and Individual contributors. A key component of this position is the enhancement and refinement of existing programs, and enthusiastic innovation in the development, management, integration, and refinement of new and existing programs. The Associate Director of Clinical Integration identifies and communicates opportunities aligned with strategic initiatives, market, stakeholder, and regulatory needs. This position is a critical intersection of identification and intake of clinical, regulatory, and business needs from internal and external stakeholders across Care Coordination programs, and serves to aligns expected outcomes, plans roadmaps, and oversees alignment and execution of deliverables in collaboration with Care Coordination leaders and internal departments. This position works closely with Care Coordination's operational leaders, Associate Directors of Care Coordination and their regional case management teams, as the design and deliverable branch to support operations and department growth and performance. This Associate Director leads a multi-functional team responsible for the department's reporting, policy development and compliance, program development and associated deliverables, as well as the Care Coordination training team.

Manager of Clinical Integration: Under direction of the Associate Director of Clinical Integration, leads and supports the Cclinical Iintegration team in the enhancement and refinement of existing programs and the development, management, integration and refinement of new and existing programs. The Manager of Clinical Integration will ensure successful implementation of Care Coordination programs including working closely with Care Coordination's operational leaders and internal and external stakeholders to establish expected outcomes, plan roadmaps, and oversee alignment and execution of deliverables. The Manager of Clinical Integration will directly oversee and support the clinical integration team consisting of supervisors and individual contributors across the training team, program and project roles, and the business and data analysts.

Manager of Regulatory Performance CC - RN: Plans, manages and evaluates clinical department and/or PartnershipHC delegate(s) performance and compliance under DHCS and NCQA regulations. Responsibilities include annual DHCS Medical Audits for Care Coordination, delegation oversight and monitoring activities for applicable providers and entities, and on-going stewardship of NCQA activities to

support Partnership~~HC~~'s continued NCQA Accreditation.

Manager of Care Coordination - RN: Licensed clinician who leads and supports the department leadership in the development, implementation and evaluation of Partnership's clinical case management services. Collaborates with Supervisor(s) to oversee the department activities and provides guidance to manage these functions to enhance cost effectiveness, ensure compliance with applicable state and federal regulations, and to fulfill all contractual requirements.

~~Case Management~~ Supervisor of Case Management - RN: Licensed clinician who provides supervisory oversight during daily department operations for assigned team members through sustained leadership and support. Using best clinical expertise and sound judgment (and in consultation with providers and staff), designs and implements ~~high quality, cost effective~~high-quality, cost-effective care plans to enable members to achieve maximum medical improvement. Assists in determining appropriateness, quality and medical necessity of treatment plans.

Supervisor of Case Management – LVN: Provides daily oversight, leadership, support, training and direction of both non-clinical staff and clinical staff within scope of licensure. Supports and assists the Team Manager in developing and maintaining a cohesive team with a high level of productivity and accuracy to achieve the department's overall performance metrics. Designs and implements high quality, cost-effective care plans to enable members to achieve health goals.

Non-Clinical Supervisor: Provides supervisory oversight during daily department operations for assigned team members through sustained leadership and support. Using best expertise and sound judgment (and in consultation with clinical leaders, providers and staff), provides daily oversight, leadership, support, training and direction of non-clinical staff. Supports and assists the Team Manager and other Case Management Supervisors in developing and maintaining a cohesive team with a high level of productivity and accuracy to achieve the department's overall performance metrics.

Social Worker Supervisor - LCSW/MFT: Provides daily oversight, leadership, support, training and direction to assigned staff. Supports and assists departmental leadership in developing and maintaining a cohesive team with a high level of productivity, accuracy and quality to achieve Partnership~~HC~~ goals and business objectives.

Nurse Case Manager I - RN: Licensed registered nurse who initiates and coordinates a multidisciplinary team approach to case management with members, health care providers, Partnership~~HC~~'s Chief Medical Officer or physician designee, and with any patient-identified health care designee. The Nurse Case Manager will collaborate, assess, plan, facilitate, evaluate, and advocate in order to meet the comprehensive medical, behavioral, and psychosocial needs of the member while promoting quality and cost-effective outcomes. The Nurse Case Manager will assist members to become empowered to accept and self-manage their condition(s). This position may be assigned cases requiring case management, review of complex treatment authorization requests, disease management, or special initiative programs.

Nurse Case Manager II - RN: In addition to the Nurse Case Manager I duties, the Nurse Case Manager II has a higher level of experience, evaluates special requests, assists with benefit interpretation, serves as a liaison between the line staff and the supervisor, assists with training activities, participates in audit activities and shows initiative by suggesting improvements to department processes.

Behavioral Health Clinical Specialist – LCSW or LMFT: Licensed Practitioner of the Healing Arts

(LPHA)[4] who develops, implements, and coordinates medically necessary treatment services within PartnershipHC's Health Services for adults and children with behavioral health and/or substance use disorder needs. Collaborates and coordinates care as part of the multidisciplinary team to evaluate and advocate for the medical, behavioral and psychosocial needs of the member while promoting quality and cost-effective outcomes.

Social Worker I: Provides a range of social work services in collaboration with PartnershipHC staff to meet the psychosocial and care coordination needs of members. Responsible for the assessment and care coordination of the psychosocial needs of members, families and/or caregivers to help promote positive coping skills, reduce the risk of premature institutionalization, assist individuals in maintaining independence in the community and increase stabilization of social determinants.

Social Worker II: In addition to the Social Worker I duties, the Social Worker II serves as a liaison between the line staff and the supervisor, proactively identifies strategic partnerships and/or community-based activities to enhance psychosocial supports to members and/or families, and fosters professional working relationships with providers and/or community-based agencies on behalf of PartnershipHC.

Health Care Guide I/ CC: In collaboration with Care Coordination team members, this position provides support and guidance to members referred to the Care Coordination department for Case Management services and programs. The Health Care Guide (HCG) I works closely with members, families, providers, community agencies and the interdisciplinary care team to assist in coordination of benefits in a timely and cost-effective manner, while connecting members to available internal and external resources.

Health Care Guide II/ CC: In addition to the Health Care Guide I duties, the Health Care Guide II exercises a higher degree of judgment, discretion, initiative and independence when working with members, families, providers, community agencies and/or the interdisciplinary team.

Quality and Training Supervisor: Under the direction of the Care Coordination Management team, this position is responsible for the design and structure of the Care Coordination department's quality and training program. Organizes and implements identified training opportunities to department staff, maintains accurate records of standard training materials, and conducts presentations on PartnershipHC Care Coordination activities and programs to internal and external stakeholders alike.

Care Coordination Training Specialist: In collaboration with the Quality & Training Supervisor, the CC Training Specialist develops training program courses and materials in accordance with PartnershipHC policies & procedures and coordinates, conducts, and implements assigned training modules. The CC Training Specialist supports new and ongoing training and staff support needs within the Care Coordination department and collaborates with other department leaders to support departmental referral volumes, caseload distributions, systems and operational workflows.

Health Services Analyst I: Performs routine and ad-hoc reporting and data management for internal and

[4] Licensed Practitioner of the Healing Arts (LPHA): Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapist (LMFT), and licensed-eligible practitioners working under the supervision of licensed clinicians.

external users; assists in maintaining reporting systems within the department. Prepares, analyzes, reports, and manages data used for both plan-wide and regional decision making for evaluating performance in key quality measures and the effective use of health plan resources on a routine and ad hoc basis. Works collaboratively with departments company-wide to identify data needs, develop and maintain data queries and tools, and complete accurate reporting to support performance and process improvements.

Care Coordination Business Analyst: Designs, produces, and analyzes Care Coordination Department operational data in support of department objectives and goals. Works closely with business users and Configuration department to write business requirements, test plans, implementation plans, and other project documentation. Utilizes knowledge of numerous applications, databases, information systems, statistical tools and analytical principles to monitor and analyze information related to department operations. May assist Care Coordination Senior Program Manager on more complex projects.

Clinical Advisor-RN: Under guidance from the CC Manager of Regulatory Performance, the Clinical Advisor is responsible for drafting, editing, reviewing, auditing, tracking, monitoring and maintaining policies and procedures for Partnership HealthPlan of California. Alongside designated organizational leadership, ensures compliance with governing rules, regulations, and/or accreditation standards. Reviews both draft and final All Plan Letters (APLs) and/or regulatory changes and supports leaders with the research, planning, implementation and/or operational readiness submissions across the organization. The Clinical Advisor may support new and ongoing training and staff support needs within the Care Coordination department through the translation of regulatory requirements to operational training, and assist the Care Coordination leadership team on necessary audits and projects.

Policy Analyst: Responsible for drafting, editing, reviewing, auditing, tracking, monitoring and maintaining policies and procedures for Partnership HealthPlan of California. Alongside designated organizational leadership, ensures compliance with governing rules, regulations, and/or accreditation standards. Reviews both draft and final All Plan Letters (APLs) and/or regulatory changes and supports leaders with the research, planning, implementation and/or operational readiness submissions across the organization.

Senior~~Sr~~ Program Manager: To develop, implement, improve, and manage assigned programs. In addition to the Program Manager II duties, the Senior Program Manager is a leadership role, has a higher level of education/experience, more autonomy, exercises independent judgment, and provides coaching and guidance to less experienced program managers.

Program Manager I: To develop, implement, improve, and manage assigned programs. The Program Manager I is responsible for the overall success for the assigned program(s) and their role extends beyond completion of individual tasks. Programs are ongoing, which may include aligned projects and requires strategic planning and continuous improvement efforts after program startup.

Program Manager II: To develop, implement, improve, and manage assigned programs. In addition to the Program Manager I duties, the Program Manager II has a higher level of experience, more autonomy, exercises independent judgement, and conducts business analysis and program analytics. Programs are ongoing, which may include aligned projects and requires strategic planning and continuous improvement efforts after program startup.

~~***Program Manager:*** Under the direction of the Care Coordination leadership, works collaboratively internally~~

~~and externally to develop, implement, and manage assigned and ongoing programs and services. Engages with stakeholders internally and externally to support workflows, operations and communication needs. Identifies solutions to enhance program and/or service performance and prepares and facilitates meetings upon request.~~

Project Coordinator I: Provides routine and ad hoc reporting for key Health Services activities and initiatives. Works closely with designated department staff and leadership to gather, compile, and distribute reports and facilitates structured file and record management.

Coordinator I: Provides coordination and administrative support to department managers. Performs a variety of general clerical duties, including data entry and report generation, and develops forms and presentations. Distribution of referrals to department staff as directed.

Coordinator II: Coordinates assigned departmental projects and provides complex administrative support to senior management. Develops, implements and monitors processes, tools, and systems for collecting, tracking and managing information required for monitoring performance and deadlines. Develops and produces reports. In addition to the Coordinator I duties, the Coordinator II gives presentations, training, and guidance to internal Partnership~~HC~~ audiences. The Coordinator II also monitors inventory control processes, reporting schedules, and regulatory deadlines. Distribution of referrals to department staff as directed.

Customer Service Representative, CC: ~~To~~ ~~R~~responds to member and provider inquiries regarding case management telephonically. Ensures that callers' questions and/or problems are resolved or are directed to the appropriate person for resolution and/or entered as a referral for case management while providing the highest level of customer service.

Administrative Assistant I: Provides direct administrative assistance and support to the department leadership. Manages calendars, organizes meetings, and prepares documentation and written correspondences. Interfaces with other Partnership~~HC~~ department Administrative Assistants to organize meetings and activities, responds to requests, and maintains department policies and files.

****Note: Staffing subject to change based upon program need and organizational growth.***

CARE COORDINATION PROGRAM QUALITY MONITORING AND OVERSIGHT

PartnershipHC's programs have been developed using evidence from a number of resources, including but not limited to, evidence-based clinical practice guidelines and resources that have scientifically supported evidence of the effectiveness of services that improve health outcomes. Examples include:

Patient-Centered Management of Complex Patients Can Reduce Costs Without Shortening Life, Sweeney L., Halpert A., Waranoff J; The American Journal of Managed Care. 2007:13:84:92

The Playbook (2017). Institute for Healthcare Improvement. Retrieved from https://www.bettercareplaybook.org/.

Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home, American Academy of Pediatrics; Pediatrics. 2011; DOI: https://doi.org/10.1542/peds.2011-0969.

CMSA's Integrated Case Management - A Manual for Case Managers by Case Managers, Frasier, K., Perez, R., Latour, C. (2017). Retrieved from https://cmsa.org/education/~~https://www.cmsa.org/education/icm/~~.

Searching for a business case for quality in Medicaid managed care, Healthcare Management Review. 2008. vol. 33, issue 4, pg. 350-360. DOI: doi: 10.1097/01.HCM.0000318772.59771.b2.

Not less than annually, PartnershipHC's Care Coordination Department reviews population assessment data to ensure the department programs reflect current member needs. Member identification sources and referral practices are updated to ensure the member subpopulations with greatest need are offered care coordination services.

Vulnerable populations such as children, adolescents, members with disabilities, and mentally ill members are assessed along with the available community resources. Care Coordination programs are developed and refined to ensure that these services are coordinated to reduce duplication of effort while providing Care Coordination for those members who do not have access to appropriate alternatives. Revisions to the programs are made as necessary to continue to address the members' changing needs, or as required by PartnershipHC's contract with California's Department of Healthcare Services (DHCS) and/or National Committee for ~~on~~ Quality Assurance (NCQA) standards and guidelines.

Program quality is monitored through clinical audits performed monthly on randomly selected cases to ensure adherence to program guidelines and to support and guide care coordination staff toward best practices.

Monthly and annual utilization reports are used to evaluate program efficacy. Members participating in select programs are surveyed for satisfaction with case management services after their case is closed or annually, if the member remains open to that program for greater than 18 months. No less than annually, Care Coordination leadership reviews grievances filed by members enrolled in care coordination. The information garnered from the audits, reports, surveys, grievances, and anecdotal data is taken into consideration in revising the program offerings to better meet the needs of PartnershipHC's population.

PROVIDER AND MEMBER SATISFACTION

PartnershipHC conducts satisfaction surveys with both members and providers. Included in the evaluation

are questions that deal with both member and provider satisfaction with the CC program. The responses to the survey are reviewed by staff from Health Services, Member Services, and Provider Services. Thresholds are set and responses that fall below are considered for corrective action by the HealthPlan. The results, as well as any plans for corrective action, are reviewed and/or developed in conjunction with the Quality/Utilization Advisory Committee (Q/UAC). Corrective actions that were in place are evaluated at the time of the next annual survey unless the committee feels an expedited time frame needs to be implemented.

ANNUAL PROGRAM EVALUATION

The overall effectiveness of Care Coordination programs and/or services are evaluated at least annually and reviewed by Q/UAC and the Physician Advisory Committee (PAC). The results of these evaluations are shared not less than annually with the Population Health Management and Quality ~~Management~~ and Performance Improvement departments as part of Partnership~~HC~~'s overall Population Health and Quality Strategies. Information regarding the Care Coordination annual program evaluation or program performance may be provided to members or practitioners upon request. Partnership~~HC~~'s Care Coordination services and referral information are published to Partnership~~HC~~'s website and member portal as well as in the member and provider newsletters.

PROTECTED HEALTH INFORMATION

Partnership HealthPlan of California is fully compliant with the general rules, regulations and implementation specification as described in 45 Code of Federal Regulations Parts 160 and 164-HIPAA Privacy Rule-as of April 14, 2003. The Partnership Director of Regulatory Affairs and Program Development also serves as the Partnership Privacy Officer ~~The Privacy Officer, Government Relations Specialist also serves as the Privacy Officer for the Health Plan.~~ and has implemented a comprehensive program that includes "Notice of Privacy Practices" "~~"~~sent to ALL members, implementation of a confidential toll-free complaint line available to M~~m~~embers, providers and Partnership~~HC~~ staff, and Business Associate Agreements with all Partnership~~HC~~ vendors, extensive training of internal staff and external providers, and policy and procedures around documentation of complaints of violations.

STATEMENT OF CONFIDENTIALITY

Confidentiality of provider and member information is ensured at all times in the performance of CC activities through enforcement of the following:

- Members of the Q/UAC and PAC are required to sign a confidentiality statement that ~~will be~~is maintained in the QI files.
- CC documents are restricted solely to authorized Health Services Department staff, members of the PAC, Q/UAC, and Credentials Committee, and reporting bodies as specifically authorized by the Q/UAC.
- Confidential documents may include, but are not limited to, Q/UAC and Credentials meeting minutes and agendas, QI and Peer Review reports and findings, CC reports, or any correspondence or memos relating to confidential issues where the name of a provider or member is included.
- Confidential documents are electronically archived and stored on protected drives, or paper

documents are stored in locked file cabinets with access limited to authorized persons only.

- Confidential paper documents are destroyed by shredding when no longer in use.

NON-DISCRIMINATION STATEMENT

PartnershipHC complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

PartnershipHC will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily are exclusively available. Also, PartnershipHC will not otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.

PartnershipHC provides free aids and services to people with disabilities to communicate with us, such as:

- Qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries.
- Written information and materials (to include notice of action, grievance acknowledgement and resolution letters) are fully translated by qualified translators into threshold languages for PartnershipHC members according to regulatory timeframes, and into other languages or alternative formats as indicated in the member's record or upon request. Material formats include audio, large print and electronically for members with hearing and/or visual disabilities. Braille versions are available for members with visual disabilities. The organization may continue to provide translated materials in other languages represented by the population at the discretion of PartnershipHC, such as when the materials were previously translated or when translation may address Health Equity concerns.
- Use of California Relay Services for hearing impaired [TTY/TDD: (800) 735- 2929 or 711]

CARE COORDINATION PROGRAM APPROVAL

Robert Moore, MD, MPH, MBA	2/19/2025
Quality/Utilization Advisory Committee Chairperson	*Date Approved*

Steven Gwiazdowski, MD	3/12/2025
Physician Advisory Committee Chairperson	*Date Approved*

Kim Tangermann	4/23/2025
Board of Commissioners Chairperson	*Date Approved*

Complex Case Management (CCM) Program Evaluation for CY 2023

HealthAnalytics

January 2025

For questions contact:
Shivani Sivasankar (ssivasankar@partnershiphp.org)

EXECUTIVE SUMMARY

The objective of this analysis was to determine the efficacy of the CCM program for the calendar year 2023. This report reviewed and analyzed utilization metrics that evaluate member utilization such as ED visits, hospital stays, number of hospital days, PCP visits, specialty visits, number of medications and readmissions. The analysis is separated into four parts:

1. Case length analysis

We included all eligible members enrolled in the CCM program during 2023 and evaluated the utilization metrics by the number of days the members were enrolled in the CCM program using ANOVA. Based on the analysis, it was determined that members who were enrolled for less than 1 month indicated their case was not managed as they had: lower unique medications after the start of CCM program compared to members who were enrolled for 1-8 months, higher specialty visits after the end of CCM program compared to members who were enrolled for more than 8 months, lower unique medications after the end of CCM program compared to members who were enrolled for 1-2 months.

2. CCM group analysis

We included eligible members enrolled in the CCM program for more than 30 days and evaluated the utilization metrics across three measurement periods: 6 months prior to CCM program enrollment, 6 months from the start of CCM services and, 6 months after the case has been closed to CCM using Paired T-Test. Based on the analysis, it was determined that the CCM program had made a significant impact on reducing ED visits, reducing inpatient visits, reducing average inpatient days, PCP visits and reducing Total Allowed Amount after the start and end of the program as well as increasing specialty visits after the start of the program.

3. Identification of Significant Factors

We also identified significant parameters (utilization metrics before enrollment, gender, age, region and risk level of the member) that impact utilization metrics after starting the CCM program and following CCM closure using regression analysis

4. CCM group Vs Control Group Analysis

We identified a control group which included eligible members who were not enrolled in any case management program and were matched to the distribution of risk factors (identified in the regression analysis) and eligibility months of the CCM group. The utilization metrics were compared between the members in the CCM group and members in the control group across the previously mentioned three measurement periods. We did not identify any significant results when we performed ANOVA without adjusting for any covariates. However, when we adjusted for all the significant covariates using ANCOVA, we determined that, when compared to the members in the control group, members enrolled in the CCM program had statistically significantly lower: ED visits, inpatient visits, inpatient days and total amount for members after starting the CCM program as well as after the program closure; had higher: PCP visits, specialty visits and unique number of medications after the start of the program; and had lower PCP visits, specialty visits and unique number of medications after the end of the program.

OBJECTIVE

Complex Case Management (CCM) program is a voluntary program that provides interventions aimed at both improving the member's self-management of their health, and also increasing appropriate usage of health and medical resources while reducing the inappropriate utilization of healthcare resources. This report reviewed and analyzed utilization metrics that evaluate member utilization such as ED visits, hospital stays, number of hospital days, outpatient visits, number of medications and readmissions associated for members enrolled in PHC's complex case management services during 2023. The analysis compared the utilization metrics across three measurement periods: the 6 months prior to CCM program enrollment, 6 months from the start of CCM services and, 6 months after the case has been closed to CCM. The utilization metrics were also compared with members who were not enrolled in the CCM program to determine the efficacy of the CCM intervention.

PART 1 – Case Length Analysis

To test significant difference in the average utilization metrics before enrollment and after enrollment/following closure between the case length groups using Analysis of Variance (ANOVA) and Tukey's Test

We identified 229 members who were enrolled in the CCM program with start date and end date in 2023 and were eligible for at least 1 month during the measurement period. They were segregated by the duration of their case length (number of days enrolled in the CCM program) as follows:

Case Length (days)	Members
Less than 1 month	40
1 - 2 months	37
2- 5 months	55
5- 8 months	41
More than 8 months	56

ANOVA is used to test significant difference in utilization metrics before enrollment and after enrollment as well as difference in utilization metrics before enrollment and following closure between the case length groups. The ANOVA makes several assumptions which was met in this analysis, such as the observations are continuous, approximately normally distributed, groups have approximately equal variances (ANOVA is robust enough to handle some deviations) and observations are independent of one another. The F-ratio is a measure of the ratio of the variation explained by the model and the variation explained by unsystematic factors. Statistical significance is determined by p-value <0.05 which indicates that the utilization metric of at least one group is statistically different from the other groups. To identify which group is

statistically significantly different, we performed pairwise comparisons for all case length groups using Tukey's test. There were totally 384 comparisons (8 outcome measure x 5 groups (4!) x 2 scenario) and only the comparison groups which were statistically significant are highlighted below:

Measures	ANOVA by Case length Group between Before enrollment Vs After enrollment		Statistically significant Case Length Groups (days)	Mean utilization before the start of CCM program	Mean utilization after the start of CCM program	Significance of Tukey's test
	F value	P value				
ED Visits	0.68	0.6094	N/A	N/A	N/A	N/A
Inpatient visits	1.32	0.2618	N/A	N/A	N/A	N/A
Avg. Inpatient days	1.51	0.2012	N/A	N/A	N/A	N/A
PCP visits	1.76	0.1382	N/A	N/A	N/A	N/A
Specialty visits	0.44	0.7770	N/A	N/A	N/A	N/A
Readmissions	0.55	0.6983	N/A	N/A	N/A	N/A
Total Allowed Amount	1.22	0.3018	N/A	N/A	N/A	N/A
Unique drugs	4.99	0.0007 ***	**< 1 month (Reference)**	10.13	7.38	Reference
			1-2 months	6.22	7.24	0.0005***
			2-5 months	7.44	7.42	0.0104**
			5-8 months	5.63	5.85	0.0088**

* indicates $p < 0.05$; ** indicates $p < 0.01$; *** indicates $p < 0.001$

- Members enrolled for less than1 month in the CCM program had a statistically significantly lower number of unique drugs after enrolling into the CCM program when compared to members who were enrolled for 1-2 months, 2-5 months or 5-8 months.

Measures	ANOVA by Case length Group between Before enrollment Vs After closure		Statistically significant Case Length Groups (months)	Mean utilization before the start of CCM program	Mean utilization after the end of CCM program	Significance of Tukey's test
	F value	P value				
ED Visits	0.77	0.5432	N/A	N/A	N/A	N/A
Inpatient visits	1.06	0.3754	N/A	N/A	N/A	N/A
Avg. Inpatient days	1.37	0.2446	N/A	N/A	N/A	N/A
PCP visits	1.46	0.2143	N/A	N/A	N/A	N/A
Specialty visits	2.77	0.0280*	**< 1 month (Reference)**	1.40	1.98	
			> 8 months	2.02	1.23	0.0242*
Readmissions	1.19	0.3179	N/A	N/A	N/A	N/A
Total Allowed Amount	1.25	0.2903	N/A	N/A	N/A	N/A
Unique drugs	5.59	0.0003***	**< 1 month (Reference)**	10.13	7.13	N/A
			1-2 months	6.22	6.89	0.0156*
			> 8 months (Reference)	7.54	4.18	N/A
			1-2 months	6.22	6.89	0.0023**
			2-5 months	7.44	7.15	0.0152*
			5-8 months	5.63	5.22	0.0434

* indicates $p < 0.05$; ** indicates $p < 0.01$; *** indicates $p < 0.001$

- Members enrolled for less than 1 month in the CCM program had a statistically significantly higher specialty visits after the end of CCM program when compared to members who were enrolled for more than 8 months.
- Members enrolled for less than1 month in the CCM program had a statistically significantly lower number of unique drugs after the end of CCM program when compared to members who were enrolled for 1-2 months

- Members enrolled for more than 8 months in the CCM program had a statistically significantly lower number of unique drugs after the end of CCM program when compared to members who were enrolled for 1-2 months, 2-5 months or 5-8 months.

Note:

For members who were enrolled for less than 1 month, their cases might not have been managed and were closed due to reasons such as they were unable to reach the member or the member declined or the current care was deemed appropriate. Due to which, these members had a significantly higher specialty visits and lower number of unique drugs compared to other case length groups. Therefore, members who were enrolled for less than 30 days will be removed from further analyses to prevent any bias on the utilization metrics for CCM group due to case length

PART 2 – CCM group Analysis

Inclusion criteria for the CCM group:

- Members enrolled in the CCM program with start date and end date in 2023
- Members eligible for at least 1 month during the three following measurement periods:
  - Six months prior to CCM enrollment (Prior-utilization)
  - Six months from the start of CCM program (Concurrent-utilization)
  - Six months after the case has been closed to CCM (Post-utilization)
- Members enrolled for > 30 days in the CCM program

There were 189 members who fit the inclusion criteria for the CCM group.

To test the average utilization metrics before enrollment, after enrollment and following closure in the CCM group using Paired t-Test

The paired t-Test was used in this analysis to determine whether the mean difference between the paired observations (Prior-utilization Vs Concurrent-utilization) (Prior-utilization Vs Post-utilization) are significantly different from zero. As a parametric procedure (a procedure which estimates unknown parameters), the paired *t*-test makes several assumptions which was met in this analysis, such as the difference between the paired observations are continuous, difference approximately normally distributed (t-tests are robust enough to handle some deviations) and observations are independent of one another. Statistical significance is determined by looking at the *p*-value which gives the probability of observing the test results under the null hypothesis (the mean difference between the paired observations is zero). The lower the *p*-value, the lower the probability of obtaining a result like the one that was observed if the null hypothesis was true. The cutoff value for determining

statistical significance is usually a value of .05 or less which corresponds to a 5% (or less) chance of obtaining a result like the one that was observed if the null hypothesis was true. Effect sizes (Pearson's correlation coefficient- r) are useful as they provide an objective measure of the importance of an effect where r=.10 (small effect) explains 1% of total variance; r=.30 (medium effect) explains 9% of total variance; r=.50 (large effect) explains 25% of total variance;

CCM Group Evaluation Metrics	Before enrollment		After enrollment		After closure		Paired T-Test between before Vs after enrollment			Paired T-Test between before Vs after closure		
	Mean	SE	Mean	SE	Mean	SE	T-statistic	Pvalue	R	T-statistic	Pvalue	R
ED Visits	0.93	0.14	0.83	0.13	0.59	0.09	0.73	0.4667	0.05	2.42	0.0167	0.17
Inpatient Visits	0.48	0.06	0.33	0.06	0.19	0.04	2.25	0.0255	0.16	4.45	<0.0001	0.31
Average Inpatient days	5.36	1.71	1.74	0.57	1.62	0.64	2.05	0.0413	0.15	2.08	0.0387	0.15
PCP visits	2.22	0.18	2.24	0.19	1.59	0.15	-0.16	0.8718	0.01	3.81	0.0002	0.27
Readmission in 90 days	0.14	0.04	0.19	0.06	0.08	0.03	-0.94	0.3468	0.07	1.41	0.1596	0.1
Specialty visits	1.88	0.20	2.23	0.23	1.57	0.21	-1.97	0.0497	0.14	1.93	0.0550	0.14
Total allowed amount	$53,165	14,573	$22,903	5,429	$15,318	4710.78	2.07	0.0401	0.15	2.67	0.0083	0.19
Unique drugs	6.84	0.51	6.93	0.51	5.80	0.48	-0.35	0.7285	0.03	2.72	0.0072	0.19

*Statistically significant measures are highlighted above and explained below

On average, members who were enrolled in the CCM program:

- Had significantly lower ED visits after the end of CCM program [Mean=0.59, p=0.0167] when compared to before the start of the program [Mean =0.93].
- Had significantly lower inpatient visits after the start of CCM program [Mean =0.33, p=0.0255] and after the end of CCM program [Mean =0.19, p<0.0001] when compared to before the start of the program [Mean = 0.48].

- Had significantly lower average inpatient days after the start of CCM program [Mean =1.74, p=0.0413] and after the end of CCM program [Mean =1.62, p=0.0387] when compared to before the start of the program [Mean =5.36]
- Had significantly lower office visits after the end of CCM program [Mean =1.59, p=0.0002] when compared to before the start of the program [Mean=2.22]
- Had significantly higher specialty visits after the start of CCM program [Mean =2.23, p=0.0497] when compared to before the start of the program [Mean=1.88]
- Had significantly lower total allowed amount after the start of CCM program [Mean=$22,903, p =0.0401] and after the end of CCM program [Mean = $15,318, p=0.0083] when compared to before the start of the program [Mean= $53,165]]

PART 3 – Identification of Significant Factors

To identify significant parameters (factors) that impact utilization metrics after enrollment and following closure in the treatment group using Regression analysis

The regression analysis was performed to identify significant parameters that impact utilization metrics after enrollment and following closure in the treatment group. In this case in which most of the outcome variables (ED visits, inpatient visits, outpatient visits, readmissions, inpatient days, unique medications) are counts with a low arithmetic mean (typically < 10), standard ordinary least squares regression may produce biased results. The utilization metric, allowed amount is not a count but it was not normally distributed due to which modeling the outcome using standard linear regression model is not appropriate. Poisson regression models the log of the expected count of utilization after the start of CCM program and after the end of CCM program as a function of the predictor variables: gender, age, region, risk level and prior-utilization metric. Poisson regression makes the following assumptions where the counts must be positive and follow a Poisson distribution which was met in the analysis. Counts for ED visits, inpatient visits and readmissions had excess zeros due to which, zero-inflated Poisson regression was used on these variables so that the excess zeros can be modeled independently. The parameter estimates from the Poisson regression represent that for every unit change in the parameters, the difference in the logs of the expected count of utilization metric is expected to change by the respective regression coefficient, given the other predictor variables in the model are held constant. Costs (Total Allowed Amount) are continuous, non-negative and tend to be skewed to the right, with a large portion of observations having low expenditures but a fraction having very large expenditures. We used a Gamma regression model with a log link function which assumes a non-linear relationship.

Statistically significant parameters for the change in the utilization metrics after enrollment:

Measures	Parameter	Estimate	StdErr	ChiSq	PValue	Factor
ED Visits	Utilization before enrollment	-1.3101	0.3488	14.11	0.0002	0.27
Average inpatient days	Age Group (51 above)	-1.4565	0.1664	76.64	<0.0001	0.23
Average inpatient days	Age Group (21 - 50)	-2.3274	0.2405	93.67	<0.0001	0.10
Average inpatient days	Age Group (11 -20)	-0.6900	0.1613	18.29	<0.0001	0.50
Average inpatient days	Female	-0.4694	0.1272	13.61	0.0002	0.63
Average inpatient days	Utilization before enrollment	0.0058	0.0016	13.20	0.0003	1.01
Average inpatient days	Southern	1.2997	0.1884	47.57	<0.0001	3.67
Average inpatient days	High Risk	2.7490	0.2265	147.34	<0.0001	15.63
PCP visits	Age Group (51 above)	0.3393	0.1547	4.81	0.0283	1.40
PCP visits	Utilization before enrollment	0.1854	0.0153	147.13	<0.0001	1.20
Specialty Visits	Age Group (21 - 50)	-0.4267	0.1711	6.22	0.0126	0.65
Specialty Visits	Utilization before enrollment	0.1761	0.0136	168.78	<0.0001	1.19
Specialty Visits	Southern	0.6158	0.1331	21.41	<0.0001	1.85
Specialty Visits	High Risk	0.4150	0.1567	7.02	0.0081	1.51
Total Allowed Amount	Age Group (51 above)	-0.7083	0.3036	5.44	0.0197	0.49
Total Allowed Amount	Age Group (21 - 50)	-1.0083	0.3526	8.18	0.0042	0.36
Total Allowed Amount	Female	-0.5072	0.2269	5.00	0.0254	0.60
Total Allowed Amount	Utilization before enrollment	0.0000	0.0000	4.63	0.0315	1.00
Total Allowed Amount	Southern	0.8466	0.2465	11.80	0.0006	2.33
Total Allowed Amount	High Risk	2.3035	0.2907	62.79	<0.0001	10.01
Total Allowed Amount	Medium Risk	0.7455	0.2875	6.73	0.0095	2.11
Unique medications	Age Group (51 above)	0.2377	0.0936	6.45	0.0111	1.27
Unique medications	Age Group (21 - 50)	0.2619	0.0977	7.18	0.0074	1.30
Unique medications	Utilization before enrollment	0.0633	0.0033	374.25	<0.0001	1.07
Unique medications	High Risk	0.6752	0.1024	43.49	<0.0001	1.96
Unique medications	Medium Risk	0.5275	0.1015	27.03	<0.0001	1.69

* indicates $p < 0.05$; ** indicates $p < 0.01$; *** indicates $p < 0.001$

Interpretation of highly statistically significant parameters ($p<0.0001$) :

- One day increase in the average inpatient days after the start of CCM, when compared to members age less than 10 is 50% lower for members age 11-20, 90% lower for members age 21-50 and 77% lower for members age 51 above
- High risk members compared to low risk members are associated with a day increase in the average inpatient days after the start of CCM program by a factor of 15.63 times
- Members in the Southern region compared to the Northern region are associated with a day increase in the average inpatient days after the start of CCM program by a factor of 3.67 times
- A one visit increase in the number of PCP visits after the start of CCM is 20% higher for every additional PCP visit before the start of the CCM program
- A one visit increase in the number of specialty visits after the start of CCM is 85% higher for members in the Southern region when compared to members in the northern region
- A one visit increase in the number of specialty visits after the start of CCM is 19% higher for every additional specialty visit before the start of the CCM program
- High risk members compared to low risk members are associated with a dollar increase in the total allowed amount after the start of CCM program by a factor of 10.01 times
- A one unit increase in the number of unique medications after the start of CCM is 96% higher for high risk members and 69% higher for medium risk members when compared to low risk members
- A one unit increase in the number of unique medications after the start of CCM is 7% higher for every additional unique medication before the start of the CCM program

Statistically significant parameters for the change in the utilization metrics after closure:

Measures	Parameter	Reference	Estimate	StdErr	ChiSq	PValue	Factor
ED Visits	Female	Male	-1.03239	0.525198	3.864024	0.0493	0.36
ED Visits	Southern	Northern	-1.32925	0.589082	5.091697	0.0240	0.26
Average inpatient days	Age Group (51 above)	Age (0-10)	-2.57405	0.207768	153.4886	<0.0001	0.08
Average inpatient days	Age Group (21 - 50)	Age (0-10)	-1.31615	0.163844	64.52787	<0.0001	0.27
Average inpatient days	Age Group (11 -20)	Age (0-10)	-1.2604	0.18572	46.05793	<0.0001	0.28
Average inpatient days	Southern	Northern	2.810938	0.328389	73.26986	<0.0001	16.63
Average inpatient days	High Risk	Low Risk	3.728187	0.349527	113.7713	<0.0001	41.60
Average inpatient days	Medium Risk	Low Risk	1.232194	0.386405	10.16886	0.0014	3.43
PCP visits	Utilization before enrollment	-	0.168303	0.018169	85.80342	<0.0001	1.18
PCP visits	High Risk	Low Risk	0.402582	0.178297	5.098234	0.0240	1.50
Specialty Visits	Age Group (21 - 50)	Age (0-10)	-0.5933	0.210804	7.921114	0.0049	0.55
Specialty Visits	Utilization before enrollment	-	0.208258	0.01544	181.9305	<0.0001	1.23
Specialty Visits	High Risk	Low Risk	0.74634	0.206632	13.04605	0.0003	2.11
Specialty Visits	Medium Risk	Low Risk	0.429846	0.205607	4.370696	0.0366	1.54
Total Allowed Amount	Age Group (51 above)	Age (0-10)	-0.70831	0.30363	5.442015	0.0197	0.49
Total Allowed Amount	Age Group (21 - 50)	Age (0-10)	-1.00834	0.352624	8.176854	0.0042	0.36
Total Allowed Amount	Female	Male	-0.5072	0.226872	4.997956	0.0254	0.60
Total Allowed Amount	Utilization before enrollment	-	1.66E-06	7.71E-07	4.625725	0.0315	1.00
Total Allowed Amount	Southern	Northern	0.846576	0.246465	11.7983	0.0006	2.33
Total Allowed Amount	High Risk	Low Risk	2.303481	0.290706	62.7858	<0.0001	10.01
Total Allowed Amount	Medium Risk	Low Risk	0.745532	0.287454	6.72661	0.0095	2.11
Unique medications	Utilization before enrollment	-	0.056212	0.00359	245.1774	<0.0001	1.06
Unique medications	Southern	Northern	0.185203	0.074964	6.103593	0.0135	1.20
Unique medications	High Risk	Low Risk	1.005429	0.119297	71.03023	<0.0001	2.73
Unique medications	Medium Risk	Low Risk	0.725139	0.118405	37.50638	<0.0001	2.07

* indicates $p < 0.05$; ** indicates $p < 0.01$; *** indicates $p < 0.001$

Interpretation of highly statistically significant parameters ($p<0.0001$) :

- When compared to members age less than 10, a one day increase in the average inpatient days after the end of CCM, is 72% lower for members age 11-20, 73% lower for members age 21-50 and 92% lower for members age 51 above
- High risk members compared to low risk members are associated with a day increase in the average inpatient days after the end of CCM program by a factor of 41.6 times
- Members in the Southern region compared to the Northern region are associated with a day increase in the average inpatient days after the end of CCM program by a factor of 16.63 times
- A one visit increase in the number of PCP visits after the end of CCM is 18% higher for every additional PCP visit before the start of the CCM program
- A one visit increase in the number of specialty visits after the end of CCM is 23% higher for every additional specialty visit before the start of the CCM program
- High risk members compared to low risk members are associated with a dollar increase in the total allowed amount after the end of CCM program by a factor of 10.01 times
- A one unit increase in the number of unique medications after the end of CCM is higher by a factor of 2.73 times for high risk members and by a factor of 2.07 times higher for medium risk members when compared to low risk members
- A one unit increase in the number of unique medications after the end of CCM is 6% higher for every additional unique medication before the start of the CCM program

PART 3 – CCM group Vs Control Group Analysis

Inclusion criteria for the control group:

- Members who were 'referred to CCM' or 'CCM case not opened' status between 01/01/2023 and 12/31/2023
- Members not enrolled into any case management program 6 months before their CCM referred date or any time after their referred date
- Members eligible for at least one month during the three following measurement periods:
  - Six months prior to CCM referral (Prior-utilization)
  - Six months from the start of CCM referral (Concurrent-utilization)
  - Six months after imputed CCM referral end date* (Post-utilization)

*As the referred and case not opened status does not have an end date, the median case length for the CCM treatment group (154 days) was added to the referred start date to impute the CCM referral end date

There were 189 members who fit the inclusion criteria for the CCM group.

For the case –control analysis, the members in the control group were matched on the distribution of member eligibility, gender, region, age group and risk level of the 189 members in the CCM group using the case-control matching algorithm. The first step of the algorithm is to assign the members into one of the 280 different subsets. A subset was defined as the factorial combination of the variables, namely all the combinations of eligible months, gender, region, age group and risk level. We then calculated the frequency of CCM members in a subset and matched the exact frequency with the control group where the expected count of members were selected by Simple Random Sampling method. After the implementation of the case-control matching algorithm, there were 189 members in the control group. The frequency distribution of the covariates between the treatment (CCM) group and the control group is given below.

We tested significant difference of utilization metrics before vs after enrollment, before enrollment vs after closure between the control and CCM group for the following conditions:

a. Without adjusting for covariates
b. After adjusting for covariates

Covariates are variables which are highly variable, related to the outcomes and change the relationship between the CCM program and the outcomes. Therefore, it's necessary to identify the significant parameters and remove the bias from these covariates to account for the unexplained variation by controlling for them in the model.

Frequency distribution of the covariates between the treatment (CCM) group and the control group after case-control matching:

Parameters	CCM	Control
	N (%)	N (%)
Minimum Eligibility in the utilization period		
1 month	35 (19%)	35 (19%)
2 months	27 (14%)	27 (14%)
3 months	23 (12%)	23 (12%)
4 months	21 (11%)	21 (11%)
5 months	24 (13%)	24 (13%)
6 months	59 (31%)	59 (31%)
Gender		
Female	101 (53%)	107 (57%)
Male	88 (47%)	82 (44%)
Region		
Northern	65 (34%)	81 (43%)
Southern	124 (66%)	108 (57%)
Age Group		
0-10	70 (37%)	64 (34%)
11-20	40 (21%)	24 (13%)
21-50	29 (15%)	33 (17%)
51 above	50 (26%)	68 (36%)
Risk Level		
High Risk	77 (41%)	65 (34%)
Medium Risk	57 (30%)	61 (32%)
No or Low Risk	55 (29%)	63 (33%)

3a) To test significant difference of average utilization metrics before vs after enrollment, before enrollment vs after closure between the control and CCM group without adjusting for covariates using Analysis of Variance (ANOVA)

We used ANOVA (as explained before in Part 1) to identify if there are any significant difference of prior-utilization metrics and concurrent-utilization/post-utilization metrics between the control and CCM group without adjusting for covariates as shown below:

Measure	Measure	Control Group		CCM Group		ANOVA Before Vs After Enrollment		ANOVA Before Enrollment Vs After Closure	
		Mean	SE	Mean	SE	F value df (1)	P value	F value df (1)	P value
ED Visits	Before enrollment	0.57	0.09	0.93	0.14	0.256	0.613	2.377	0.124
	After enrollment	0.54	0.10	0.83	0.13				
	After closure	0.50	0.12	0.59	0.09				
Inpatient visits	Before enrollment	0.40	0.07	0.48	0.06	1.423	0.2337	0	1
	After enrollment	0.15	0.04	0.33	0.06				
	After closure	0.12	0.03	0.19	0.04				
Avg. Inpatient days	Before enrollment	2.65	0.57	5.36	1.71	2.288	0.1312	1.15	0.2841
	After enrollment	1.95	0.69	1.74	0.57				
	After closure	0.90	0.32	1.62	0.64				
PCP visits	Before enrollment	1.35	0.16	2.22	0.18	0.079	0.7787	3.84	0.0508
	After enrollment	1.31	0.12	2.24	0.19				
	After closure	1.21	0.14	1.59	0.15				
Readmissions	Before enrollment	0.13	0.05	0.14	0.04	1.772	0.1839	0.315	0.5752
	After enrollment	0.09	0.03	0.19	0.06				
	After closure	0.04	0.02	0.08	0.03				
Specialty visits	Before enrollment	0.80	0.14	1.88	0.20	0.615	0.4334	1.326	0.2503
	After enrollment	0.97	0.18	2.23	0.23				
	After closure	0.72	0.12	1.57	0.21				
Total Allowed Amount	Before enrollment	28859.35	6851.82	53165.06	14573.64	0.397	0.5291	1.589	0.2082
	After enrollment	8687.60	1753.79	22903.01	5429.47				
	After closure	10891.01	2807.84	15318.10	4710.78				
Unique drugs	Before enrollment	4.34	0.41	6.84	0.51	0.198	0.657	2.504	0.1144
	After enrollment	4.61	0.45	6.93	0.51				
	After closure	4.12	0.40	5.80	0.48				

Without controlling for prior-utilization metrics and other covariates, we can see that there were no significant results.

3b) To test significant difference of average utilization metrics before vs after enrollment, before enrollment vs after closure between the control and CCM group after adjusting for covariates using Analysis of Covariance (ANCOVA) analysis

ANCOVA compares several means, but adjusting for the effect of one or more variables. From the regression analysis results, we saw that parameters such as prior-utilization metrics, gender, age, and risk level influence utilization after enrollment and following closure. Therefore, including these variables and eligibility months as covariates in ANCOVA is ideally suited to remove the bias of these variables and will reduce within-group error variance allowing us to more accurately assess the effect of the groups (Control Vs CCM) on the utilization metric.

The ANCOVA analysis was designed to test significant difference in utilization metrics after enrollment and following closure, that are related to the effect of the controlled parameters (Control Vs Treatment group) while taking into account the influence of the uncontrolled covariates such as utilization of utilization metrics before enrollment, gender, age, region and risk level. In addition to the assumptions in ANOVA, ANCOVA has two other considerations: independence of the covariate and treatment effect and homogeneity of regression slopes, which was met in this analyses. Statistical significance is determined by p-value <0.05.

Table for the ANCOVA statistics and interpretation is provided below. The figures are provided in the appendix.

Measure	Measure	Control Group		CCM Group		ANCOVA Before Vs After Enrollment		ANCOVA Before Enrollment Vs After Closure	
		Mean	SE	Mean	SE	F value df (1)	P value	F value df (1)	P value
ED Visits	Before enrollment	0.57	0.09	0.93	0.14	11.337	0.0001	7.485	0.0001
	After enrollment	0.54	0.10	0.83	0.13				
	After closure	0.50	0.12	0.59	0.09				
Inpatient visits	Before enrollment	0.40	0.07	0.48	0.06	8.03	0.0001	6.42	0.0001
	After enrollment	0.15	0.04	0.33	0.06				
	After closure	0.12	0.03	0.19	0.04				
Avg. Inpatient days	Before enrollment	2.65	0.57	5.36	1.71	2.303	0.0049	2.565	0.0016
	After enrollment	1.95	0.69	1.74	0.57				
	After closure	0.90	0.32	1.62	0.64				
PCP visits	Before enrollment	1.35	0.16	2.22	0.18	16.724	0.0001	8.836	0.0001
	After enrollment	1.31	0.12	2.24	0.19				
	After closure	1.21	0.14	1.59	0.15				
Readmissions	Before enrollment	0.13	0.05	0.14	0.04	8.06	0.0001	8.128	0.0001
	After enrollment	0.09	0.03	0.19	0.06				
	After closure	0.04	0.02	0.08	0.03				
Specialty visits	Before enrollment	0.80	0.14	1.88	0.20	24.183	0.0001	23.177	0.0001
	After enrollment	0.97	0.18	2.23	0.23				
	After closure	0.72	0.12	1.57	0.21				
Total Allowed Amount	Before enrollment	28859.35	6851.82	53165.06	14573.64	4.697	0.0001	3.776	0.0001
	After enrollment	8687.60	1753.79	22903.01	5429.47				
	After closure	10891.01	2807.84	15318.10	4710.78				
Unique drugs	Before enrollment	4.34	0.41	6.84	0.51	68.638	0.0001	29.799	0.0001
	After enrollment	4.61	0.45	6.93	0.51				
	After closure	4.12	0.40	5.80	0.48				

After controlling for significant covariates, we see that the CCM program had significant impact on the following utilization metrics:

- Members who were enrolled in the CCM program had significantly lower ED visits after the start and end of CCM program (Avg $_{Pre}$, Avg $_{Mid}$, Avg $_{Post}$: 0.93,0.83,0.59) when compared to members in the control group (0.57,0.54,0.50) $f_{PreVsMid}$ (1) =11.33, p=0.0001; $f_{PreVsPost}$ (1) =7.485, p=0.0001
- Members in the control group had significantly lower inpatient visits after the start of CCM (Avg $_{Pre}$, Avg $_{Mid}$, Avg $_{Post}$: 0.40,0.15,0.12), while members who were enrolled in the CCM program had significantly lower inpatient visits after the end of CCM program (0.48,0.33,0.19), $f_{PreVsMid}$ (1) =8.03, p=0.0001; $f_{PreVsPost}$ (1) =6.42, p=0.0001
- Members who were enrolled in the CCM program had significantly lower average inpatient days after the start and end of CCM program (Avg $_{Pre}$, Avg $_{Mid}$, Avg $_{Post}$: 5.36,1.74,1.62) when compared to members in the control group (2.65,1.95,0.9) $f_{PreVsMid}$ (1) =2.3, p=0.0049; $f_{PreVsPost}$ (1) =2.56, p=0.0016
- Members who were enrolled in the CCM program had significantly higher PCP visits after the start of CCM program and lower PCP visits after the end of the CCM program (Avg $_{Pre}$, Avg $_{Mid}$ Avg $_{Post}$: 2.22,2.24,1.59) when compared to members in the control group (1.35,1.31,1.21), $f_{PreVsMid}$ (1) =16.7, p=0.0001; $f_{PreVsPost}$ (1) =8.8, p=0.0001;
- Members in the control group had significantly lower readmissions after the start and end of CCM (Avg $_{Pre}$, Avg $_{Mid}$, Avg $_{Post}$: 0.13,0.09,0.04), when compared to members enrolled in the CCM program(0.14,0.19,0.08), $f_{PreVsMid}$ (1) =8.06, p=0.0001; $f_{PreVsPost}$ (1) =8.12, p=0.0001;
- Members who were enrolled in the CCM program had significantly higher Specialty visits after the start of CCM program and lower Specialty visits after the end of the CCM program (Avg $_{Pre}$, Avg $_{Mid}$ Avg $_{Post}$: 1.88,2.23,1.57) when compared to members in the control group (0.8,0.97,0.72), $f_{PreVsMid}$ (1) =24.1, p=0.0001; $f_{PreVsPost}$ (1) =23.1, p=0.0001;
- Members who were enrolled in the CCM program had significantly lower total allowed amount after the start and end of CCM program (Avg $_{Pre}$, Avg $_{Mid}$, Avg $_{Post}$: $53K, $23K, $15K) when compared to members in the control group ($29K, $9K, $11K), $f_{PreVsMid}$ (1) =4.69, p=0.0001; $f_{PreVsPost}$ (1) =3.7, p=0.0001;
- Members who were enrolled in the CCM program had significantly higher unique medications after the start of CCM program and lower unique medications after the end of the CCM program (Avg $_{Pre}$, Avg $_{Mid}$ Avg $_{Post}$: 6.84,6.93,5.8) when compared to members in the control group (4.34,4.61,4.12), $f_{PreVsMid}$ (1) =68.6, p=0.0001; $f_{PreVsPost}$ (1) =29.7, p=0.0001

Conclusion

We analyzed eight different utilization metrics (Number of ED visits, Number of inpatient visits, Average inpatient days, Number of PCP visits, Number of readmissions within 90 days, Number of Specialty visits and the Total Allowed Amount and the number of unique drugs) during the three measurement periods. We performed fours parts of analysis: by case length; by CCM group, identifying significant factors and by CCM Vs Control group.

Based on the ANOVA results by case length group, we identified that members who were enrolled for less than 1 month indicated their case was not managed as they had: lower specialty visits after the start of CCM program compared to members who were enrolled for 1-8 months, higher specialty visits after the end of CCM program compared to members who were enrolled for more than 8 months, lower unique medications after the end of CCM program compared to members who were enrolled for 1-2 months.

Based on the paired t-test results we identified that CCM program had made a significant impact after the start and end of the program: on reducing ED visits, reducing inpatient visits, reducing average inpatient days, PCP visits and reducing Total Allowed Amount after the start and end of the program as well as increasing specialty visits after the start of the program. However, the disadvantage of this one group design is that there is no way to control the bias which is a threat to external validity and there is no way to compare the individual differences between the control and CCM group, which is a threat to internal validity.

We performed regression analysis and identified significant parameters (utilization metrics before enrollment, gender, age, region and risk level of the member) impact utilization metrics after starting the CCM program and following CCM closure.

We then performed an ANOVA without including the covariates which improves internal validity but fails to control the bias. An ANCOVA controlling for the significant covariates provides a more appropriate and informative analysis. The ANCOVA analysis indicated that the CCM program was effective in: reducing ED visits after the start and end of CCM program, reducing inpatient visits after the end of CCM program, reducing average inpatient days after the start and end of CCM program, reducing total allowed amount after the start and end of CCM program, increasing PCP visits, specialty visits and unique medications after the start of CCM program and reducing specialty visits and number of unique drugs after the end of CCM program when compared to the control group. However, it was not effective in reducing inpatient visits after the start of CCM, on reducing readmissions after the start or end of CCM or increasing PCP visits after the end of CCM program when compared to the control group.

Limitations

- Members who are enrolled in the CCM program might be more engaged when compared to members who are in the control group (who were referred to the program but were not enrolled due to several reasons – current care is appropriate or they did not respond), and this might result in a bias in the study results
- The proportion of high risk members in the control group is 6% lower and the proportion of members in the southern region is 9% lower than members in the CCM group which might vary the overall utilization but it shouldn't significantly affect the results as we are comparing the difference in utilization between the measurement periods. The control group had fewer high risk members before stratification which made it difficult to account for this difference in proportion.

Strengths

- Tested the utilization based on the minimum number of eligibility months which maximized the number of members that were included in the study
- Identified the importance of covariates on the outcome measures and accounted for it in the final model to reduce the overall bias
- Matched a very similar control group (represented by the pattern of utilization) and tested the utilization before and after the program, while controlling for the influence of significance covariates, which is the gold standard for determining the efficacy of interventions

Complex Case Management (CCM) Program Evaluation for CY 2023

HealthAnalytics

January 2025

Shivani Sivasankar

Table of Contents

01 OBJECTIVE & DATA ANALYSIS OVERVIEW

02 CASE LENGTH ANALYSIS

03 CCM GROUP ANALYSIS

04 IDENTIFICATION OF SIGNIFICANT FACTORS

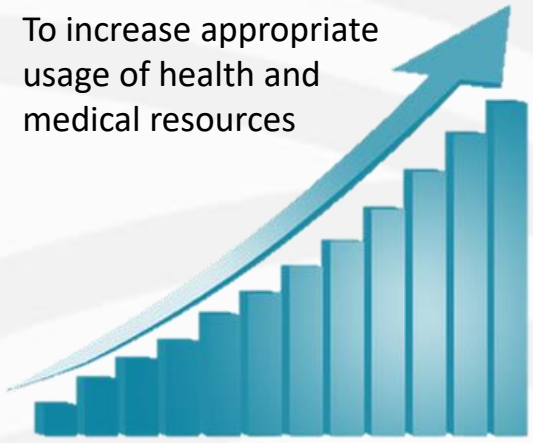
05 CCM GROUP VS CONTROL GROUP ANALYSIS

06 CONCLUSION

Objective

To evaluate the Complex Case Management (CCM) program for CY 2023

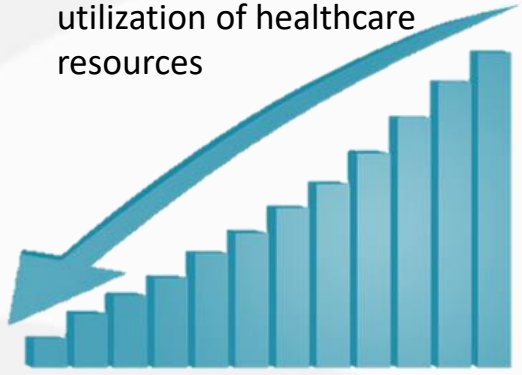
To increase appropriate usage of health and medical resources



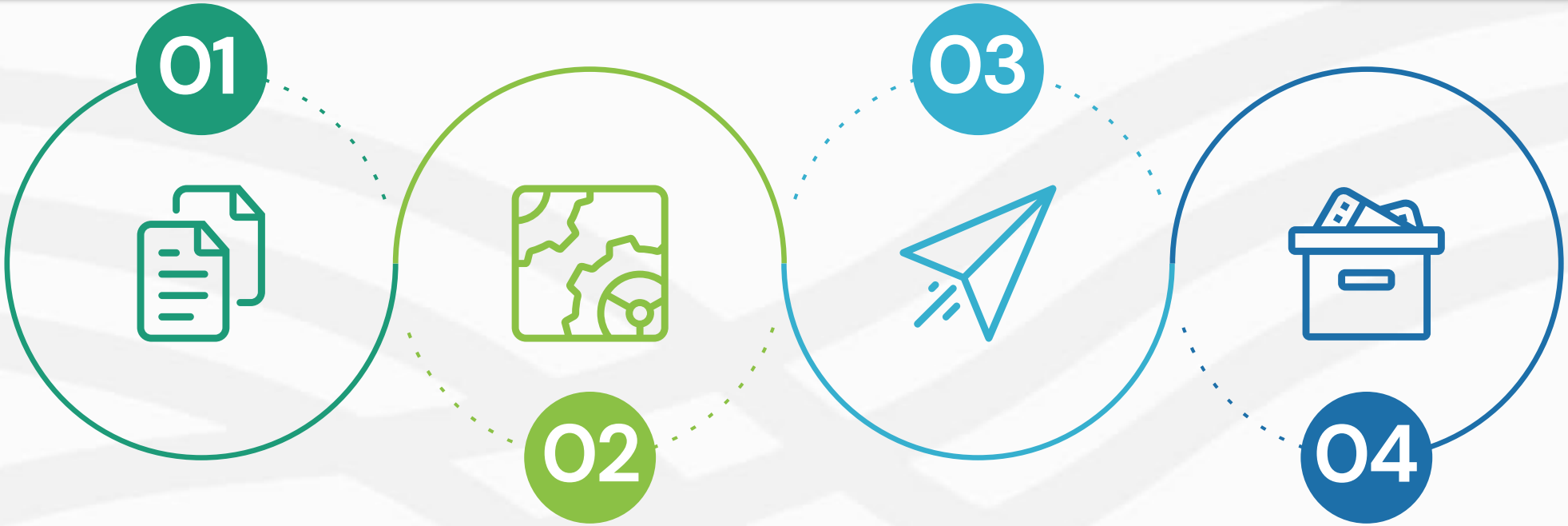
CCM

A voluntary program applying evidence-based practices to individual members to assist them with the coordination of their care and promote their well-being

To reduce inappropriate utilization of healthcare resources



Data Analysis Overview



Case Length Analysis

To test significant difference in the **average utilization metrics** before enrollment and after enrollment/ following closure between the **case length groups**

CCM group Analysis

To test the **average utilization metrics** before enrollment, after enrollment and following closure in the **CCM group**

Identify Significant Factors

To identify **significant parameters (factors)** that impact the utilization metrics after enrollment and following closure in the **CCM group**

CCM Vs Control Group Analysis

To test **significant difference in the average utilization metrics** before enrollment and after enrollment/ following closure between **the control and CCM group** before and after **adjusting for covariates**

Covariates are variables which are highly variable, related to the outcomes and change the relationship between the CCM program and the outcomes. Therefore, it's necessary to identify the significant parameters and remove the bias ('noise') from these covariates to account for the unexplained variation by controlling for them in the model.

Part 1 – Case Length Analysis Overview

01 Identify CCM enrolled members

CCM case status enrolled with start date or end date in 2023
There were 4 members who were enrolled in CCM multiple times with a gap less than 10 days and 135 members were enrolled in a CM program before or after the CCM program

02 Identify Member utilization period

Calculated the minimum number of months the CCM enrolled members were eligible before and after the CCM enrollment and closure to determine the utilization period

03 Determine utilization metrics

1. ED Visits
2. LOS
3. inpatient stays
4. Readmission
5. PCP visits
6. Specialty visits
7. Unique drugs
8. Total Allowed Amount

04 Case Length Analysis

Calculated a case length group determined from the start date and end date. Tested significant difference in the average utilization metrics before enrollment and after enrollment / following closure between the case length groups

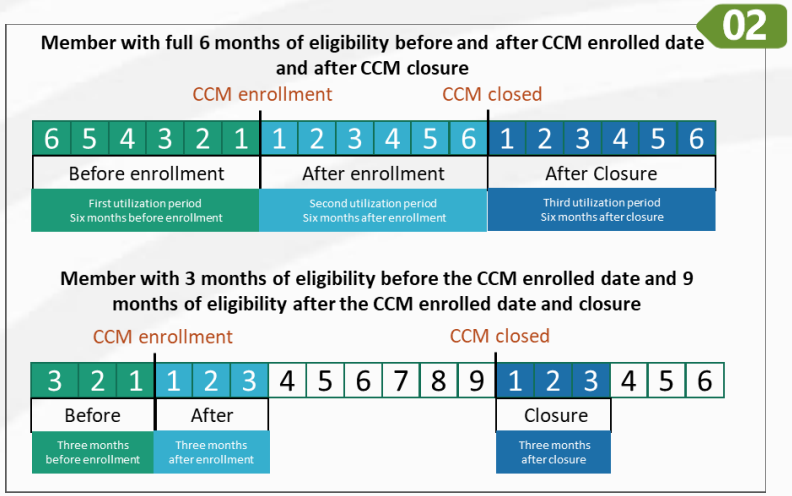
01 255 Members

02

Minimum months of continuous eligibility during the utilization period	Distinct Members
1	43
2	29
3	24
4	21
5	26
6	86
Total	**229**

Excluded 26 members with less than 30 days of eligibility in the utilization period

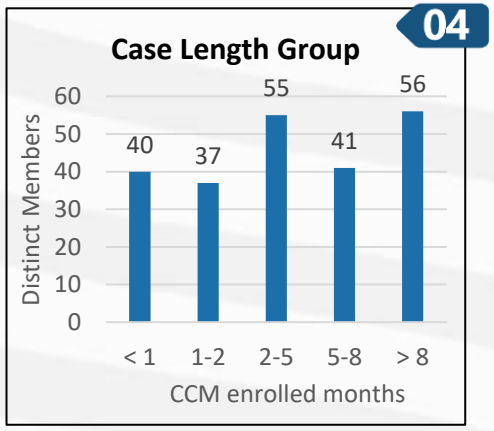
02



03

- ED Visits
- LOS
- inpatient stays
- Readmission
- PCP visits
- Specialty visits
- Unique drugs
- Total Allowed Amount

04



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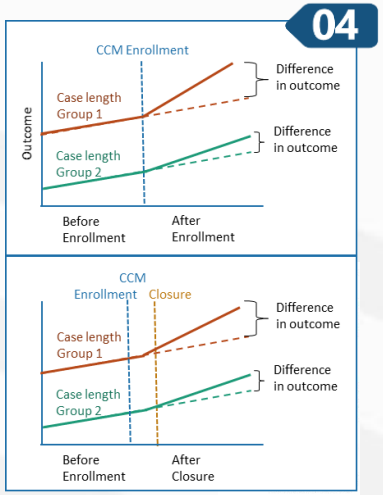
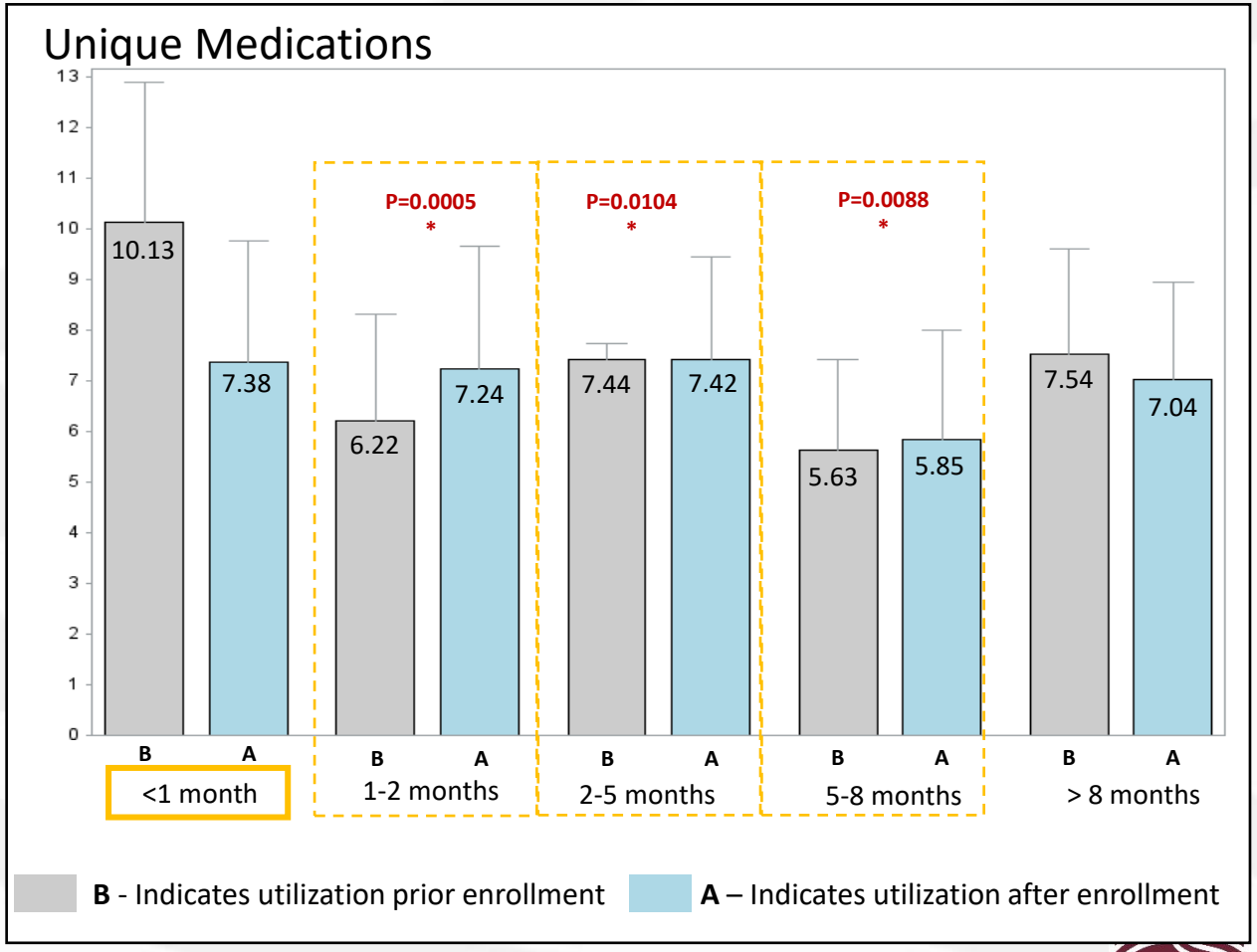


Part 1 – Case Length Analysis

To determine the efficacy of the CCM intervention by the number of days members were enrolled in the CCM program before enrollment Vs after enrollment

Evaluation Metrics	Significance by Case length Groups between Before enrollment Vs After enrollment			
	Mean Before	Mean After	F value	P value
ED Visits	0.97	0.83	0.68	0.6094
Inpatient visits	0.55	0.34	1.32	0.2618
Avg. Inpatient days	7.47	1.95	1.51	0.2012
PCP visits	2.25	2.18	1.76	0.1382
Specialty visits	1.79	2.19	0.44	0.7770
Readmissions	0.16	0.19	0.55	0.6983
Total Allowed Amount	69899.98	22691.51	1.22	0.3018
Unique drugs	7.41	7.01	4.99	0.0007 *

P<0.05 indicates the results are statistically significant

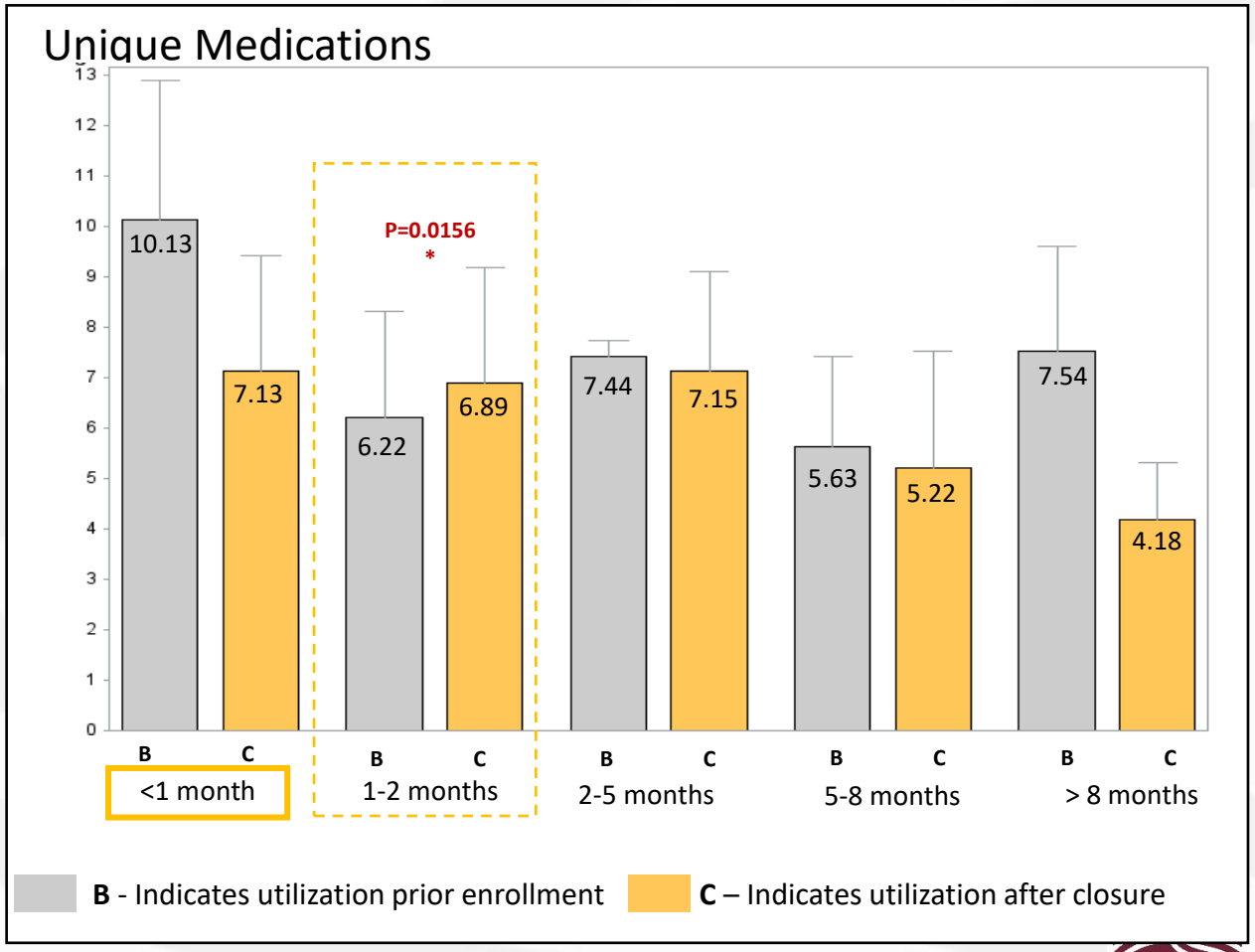


Part 1 – Case Length Analysis

To determine the efficacy of the CCM intervention by the number of days members were enrolled in the CCM program before enrollment Vs after closure

Evaluation Metrics	Significance by Case length Groups between Before enrollment Vs After closure			
	Mean Before Start	Mean After End	F value	P value
ED Visits	0.97	0.64	0.77	0.5432
Inpatient visits	0.55	0.21	1.06	0.3754
Avg. Inpatient days	7.47	1.84	1.37	0.2446
PCP visits	2.25	1.59	1.46	0.2143
Specialty visits	1.79	1.64	2.77	0.0280*
Readmissions	0.16	0.09	1.19	0.3179
Total Allowed Amount	69899.98	16150.57	1.25	0.2903
Unique drugs	7.41	6.03	5.59	0.0003*

P<0.05 indicates the results are statistically significant



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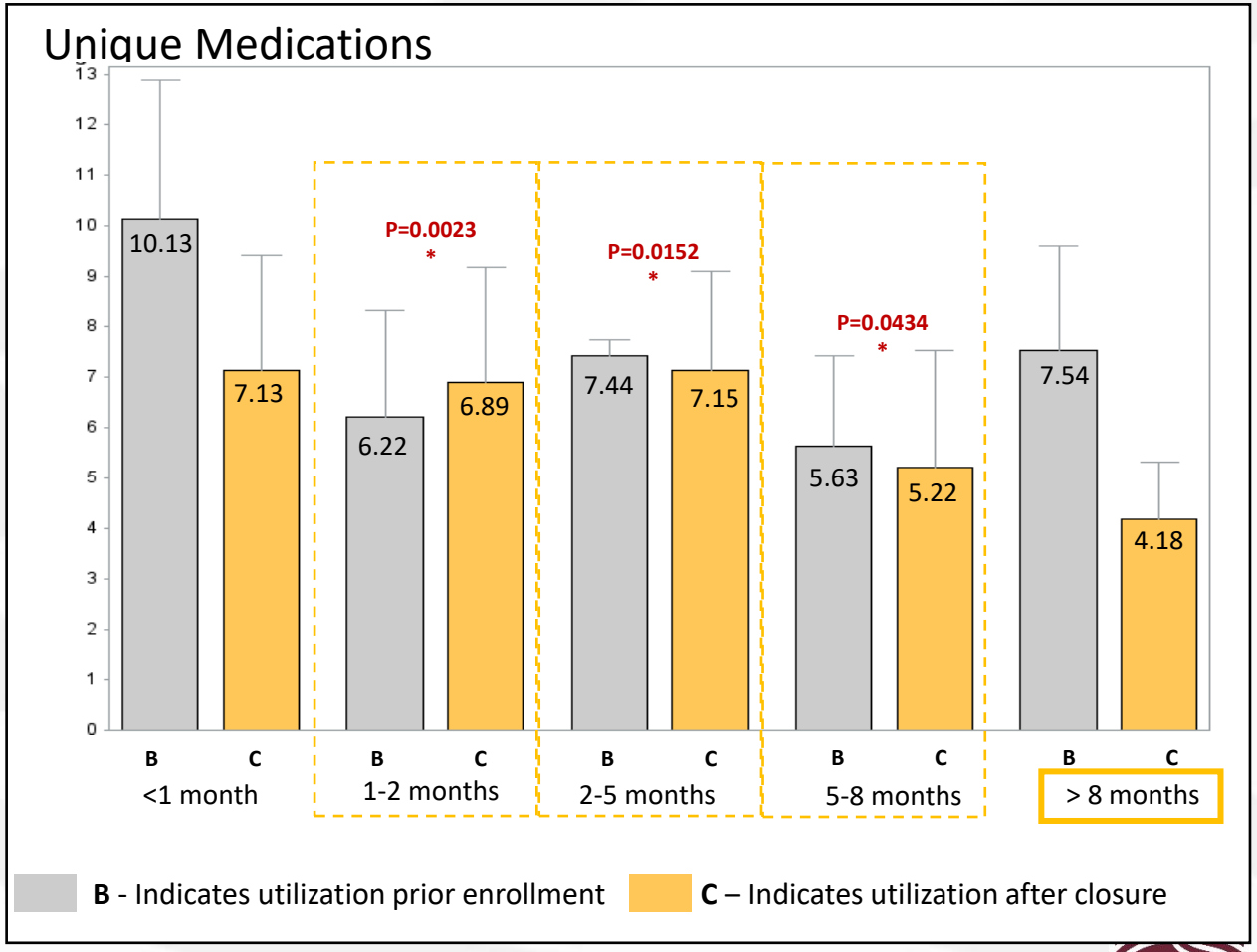

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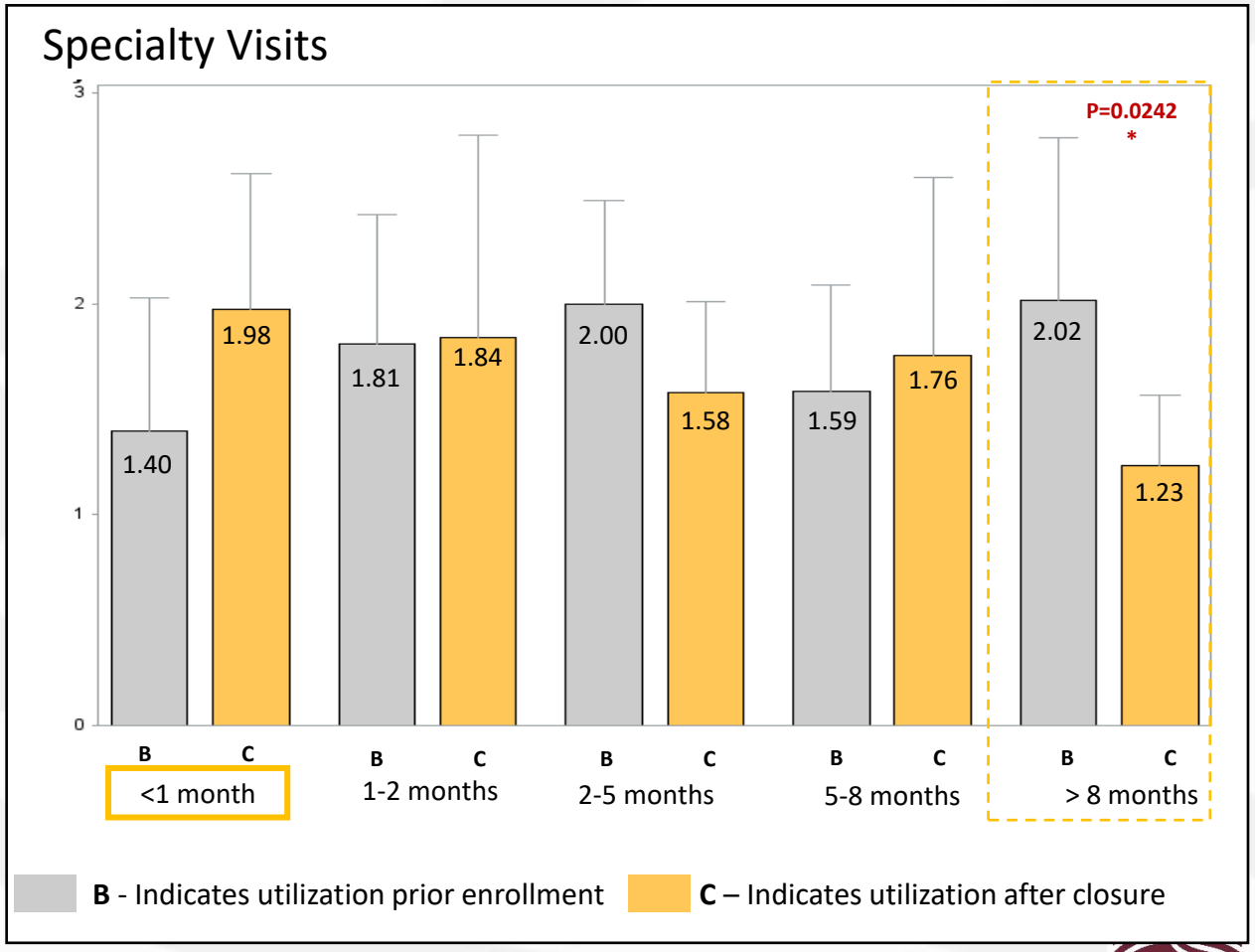


Part 1 - Key Findings

Members who were **enrolled for less than 1 month:**

Had lower unique medications after the start of CCM program compared to members who were enrolled for 1-8 months

Had lower unique medications after the end of CCM program compared to members who were enrolled for 1-2 months

Had higher specialty visits after the end of CCM program compared to members who were enrolled for more than 8 months

Based on these results, members who were **enrolled for less than 1 month** were excluded in the next analyses as their cases might not have been managed which could affect the utilization metrics for the CCM group

Part 2 – CCM Group Analysis Overview

01 Identify CCM enrolled members

CCM case status enrolled with start date or end date in 2023.
Eligible for at least 1 month during the utilization period.
Enrolled for more than 30 days in the CCM program

02 Identify Member utilization period

Calculated the minimum number of months the CCM enrolled members were eligible before and after the CCM enrollment and closure to determine the utilization period

03 Determine utilization metrics

1. ED Visits
2. LOS
3. inpatient stays
4. Readmission
5. PCP visits
6. Specialty visits
7. Unique drugs
8. Total Allowed Amount

04 CCM Group Analysis

Tested significant difference in the average utilization metrics before enrollment, after enrollment and following closure in the CCM group using paired T-test

01

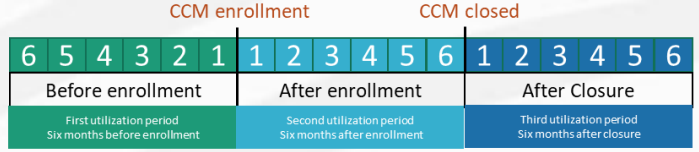
189 Members

02

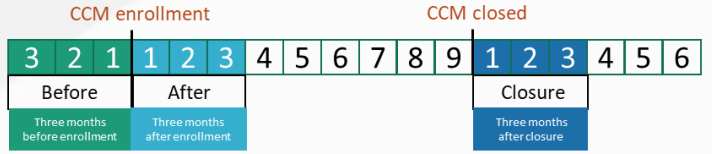
Minimum months of continuous eligibility during the utilization period	Distinct Members
1	35
2	27
3	23
4	21
5	24
6	59
Total	**189**

02

Member with full 6 months of eligibility before and after CCM enrolled date and after CCM closure



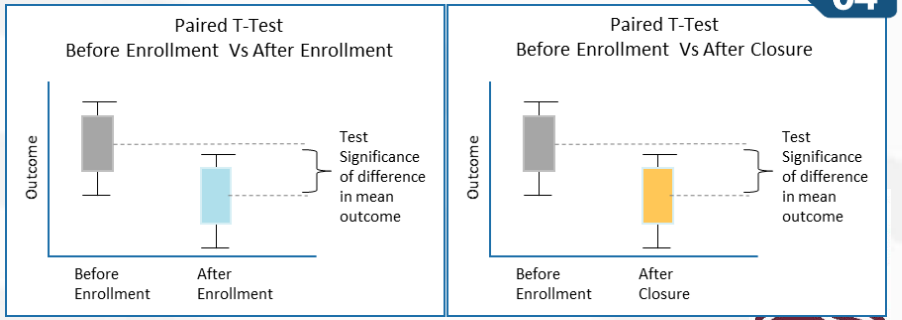
Member with 3 months of eligibility before the CCM enrolled date and 9 months of eligibility after the CCM enrolled date and closure



03

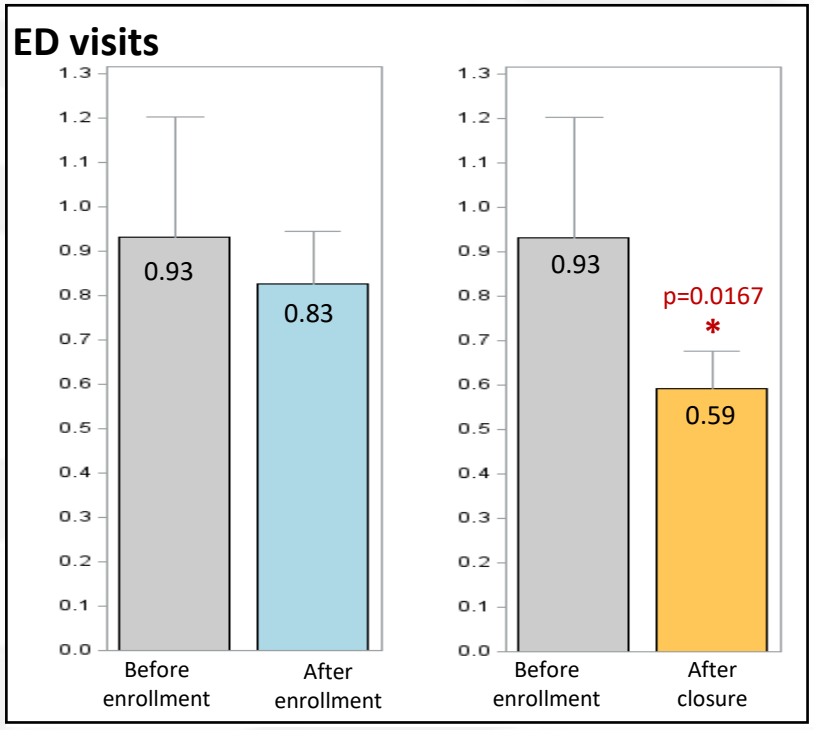
- ED Visits
- LOS
- inpatient stays
- Readmission
- PCP visits
- Specialty visits
- Unique drugs
- Total Allowed Amount

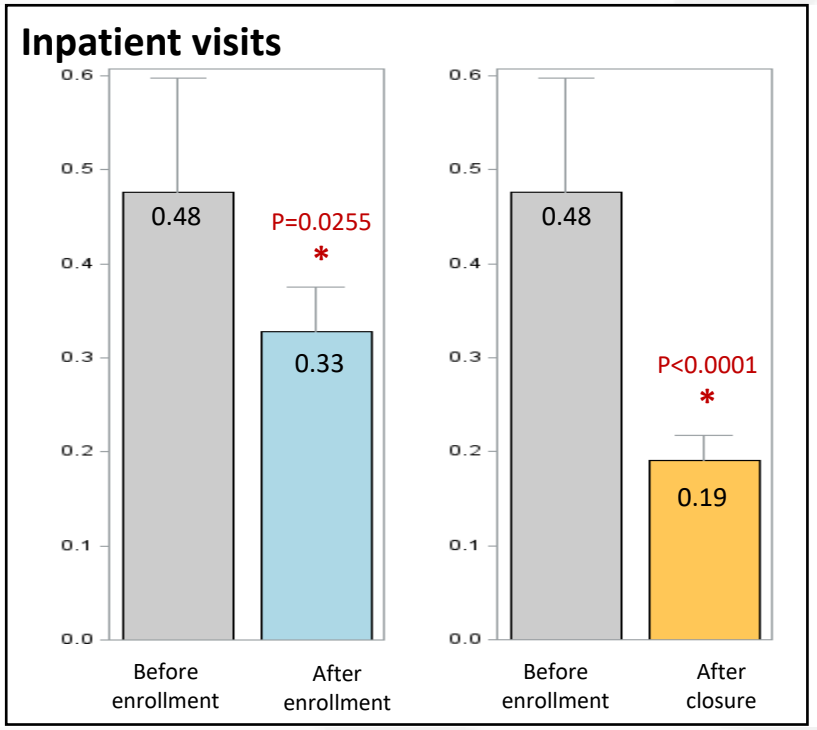
04

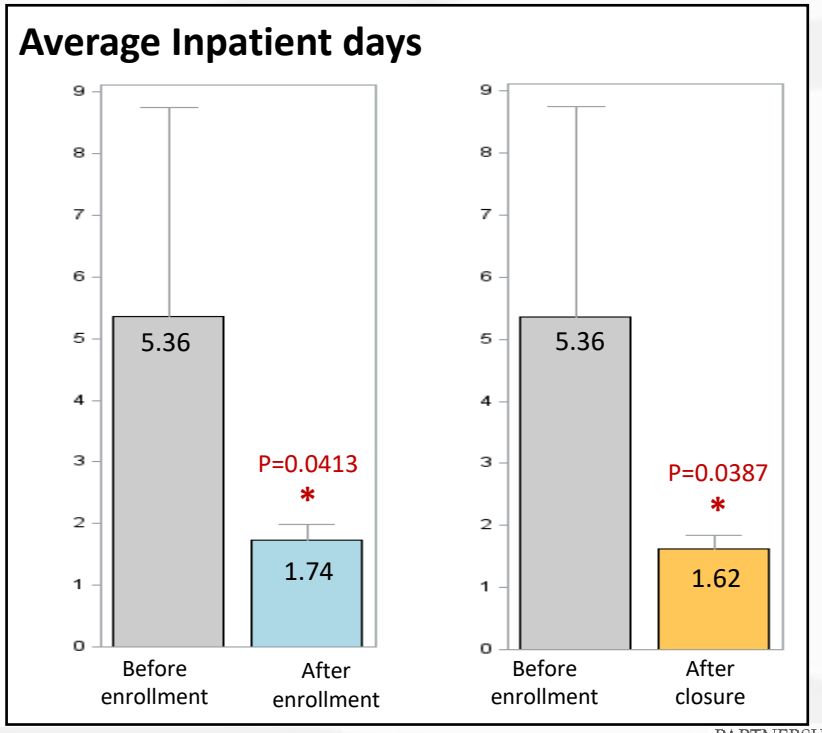


Part 2 – CCM Group Analysis

Tested the utilization metrics before enrollment, after enrollment and after closure in the CCM group



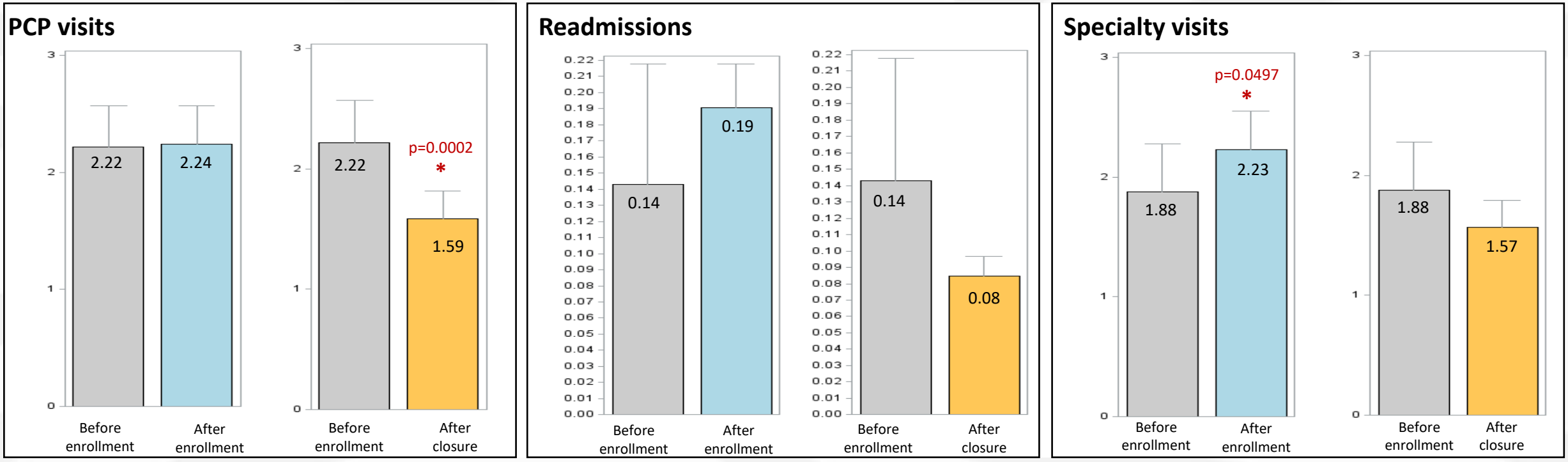




* Indicates the mean outcome measure utilization was found to be significantly different from the mean prior-utilization (p<0.05)

Part 2 – CCM Group Analysis

Tested the utilization metrics before enrollment, after enrollment and following closure in the CCM group



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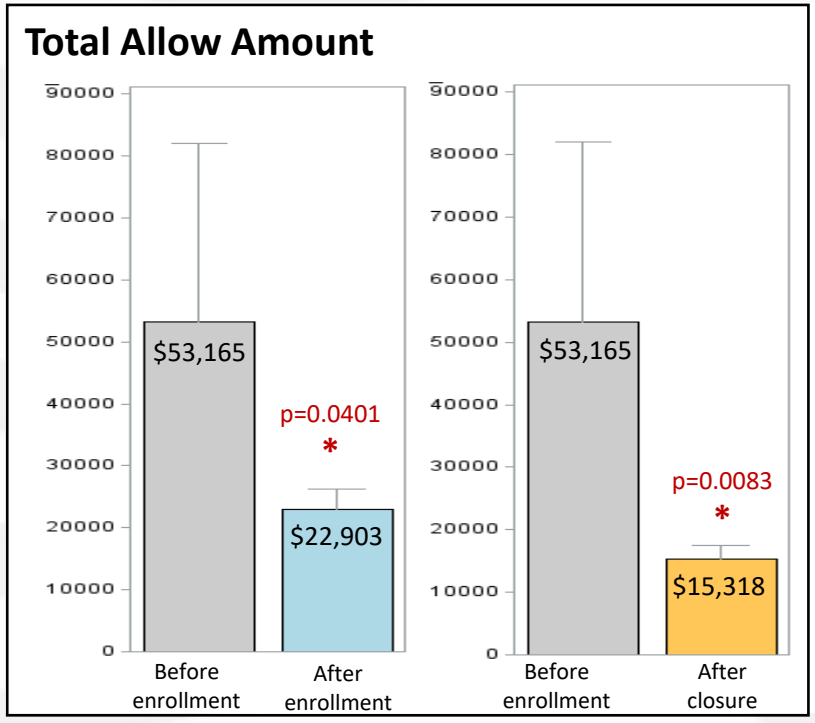
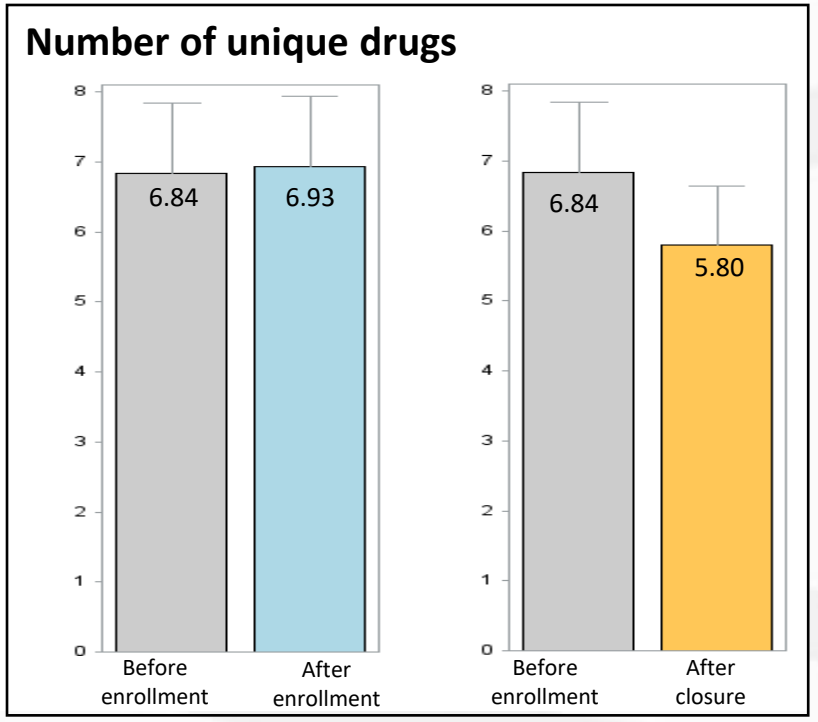
Part 2 – CCM Group Analysis

Tested the utilization metrics before enrollment, after enrollment and following closure in the CCM group





* Indicates the mean outcome measure utilization was found to be significantly different from the mean prior-utilization ($p<0.05$)

Part 2 – Key Findings

When compared to utilization before the start of the CCM program, members enrolled in the CCM program:

Had lower ED visits after the end of CCM program

Had lower PCP visits after the end of CCM program

Had lower inpatient visits after the start and end of CCM program

Had higher specialty visits after the start of CCM program

Had lower average inpatient days after the start and end of CCM program

Had lower total allowed amount after the start and end of CCM program

However, the disadvantage of this one group design is that there is no way to control the bias (affects external validity) and there is no way to compare the individual differences between the control and CCM group (affects internal validity)

Part 3 – Identification of Significant Factors Overview

01 Identify CCM enrolled members

CCM case status enrolled with start date or end date in 2023.
Eligible for at least 1 month during the utilization period.
Enrolled for more than 30 days in the CCM program

02 Identified Parameters

Determined the parameters like member demographics which might affect the utilization metrics after enrollment and following closure in the treatment group

03 Determine utilization metrics

1. ED Visits
2. LOS
3. inpatient stays
4. Readmission
5. PCP visits
6. Specialty visits
7. Unique drugs
8. Total Allowed Amount

04 Regression Analysis

Identified significant parameters (factors) that impact utilization metrics after enrollment and following closure in the treatment group using Regression analysis

01 189 Members

02

- Member Gender
- Member Region
- Member Age Group
- Member Risk Level

03

- ED Visits
- LOS
- inpatient stays
- Readmission
- PCP visits
- Specialty visits
- Unique drugs
- Total Allowed Amount

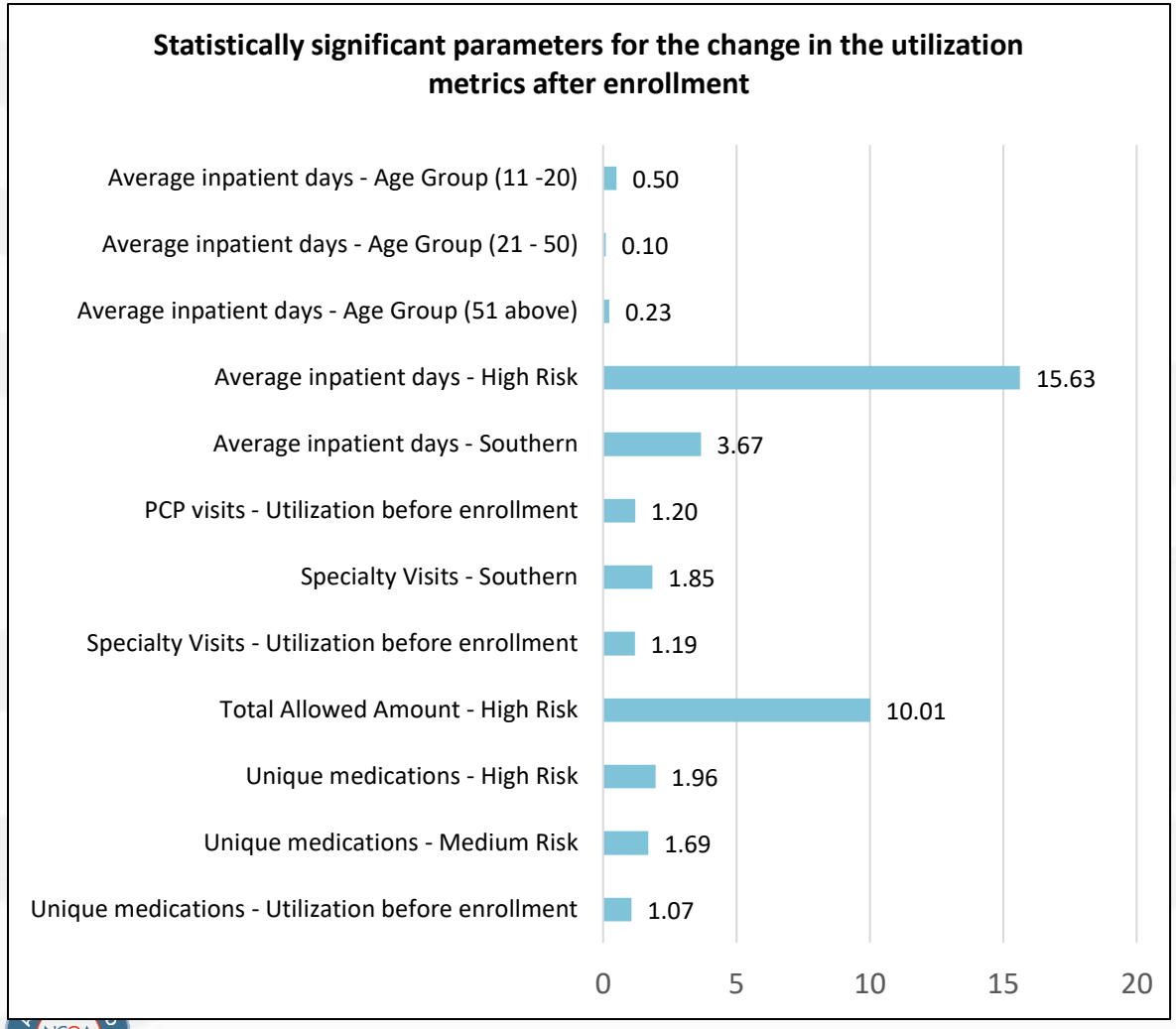
04

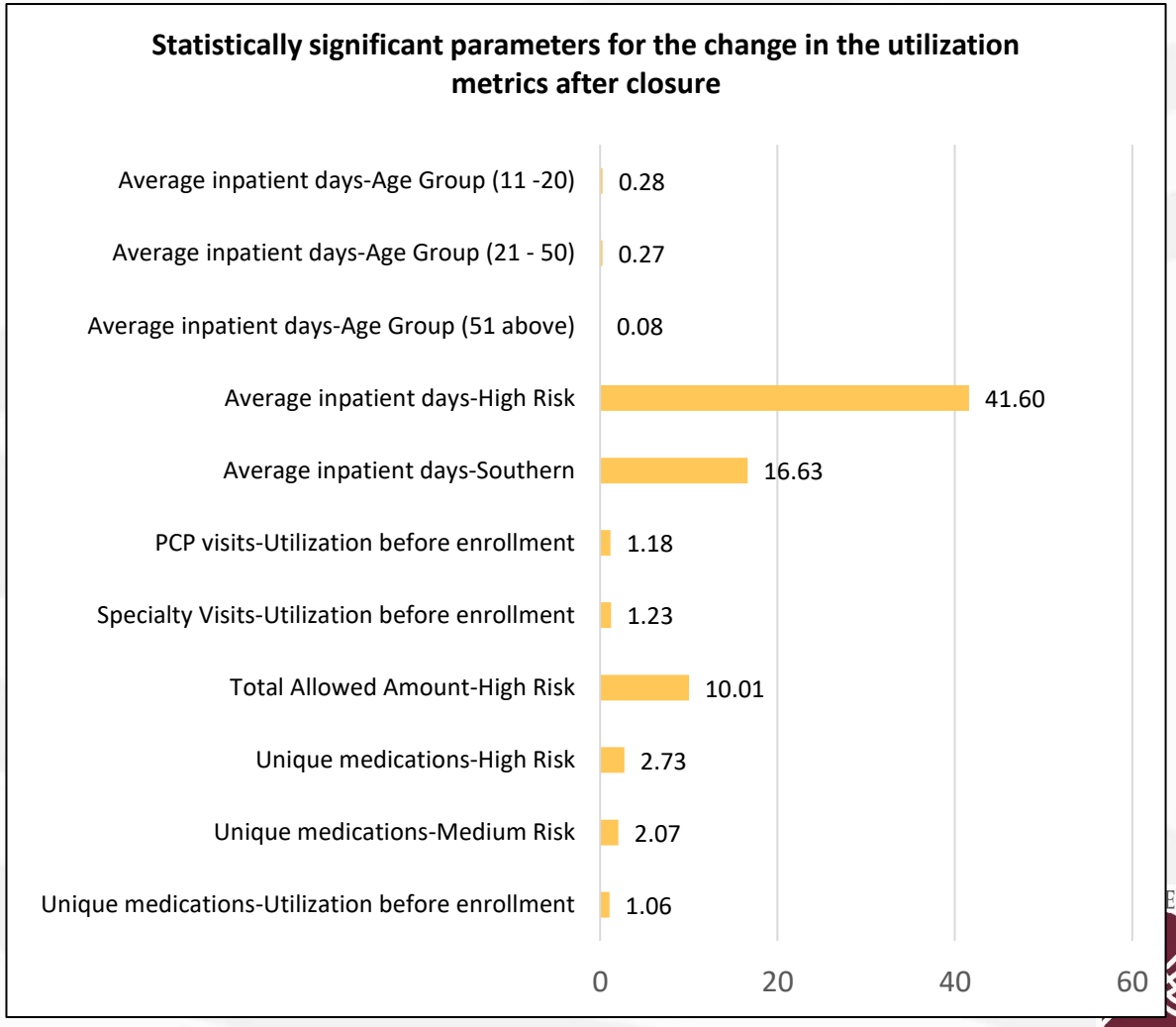
$$\text{Log (Utilization after enrollment)} = X_1(\text{Utilization before enrollment}) + X_2\,(\text{Gender}) + X_3\,(\text{Region}) + X_4\,(\text{Age group}) + X_5\,(\text{Risk Level})$$

$$\text{Log (Utilization after Closure)} = X_1(\text{Utilization before enrollment}) + X_2\,(\text{Gender}) + X_3\,(\text{Region}) + X_4\,(\text{Age group}) + X_5\,(\text{Risk Level})$$

- PCP visits, Specialty visits, Unique drugs – Poisson Regression
- ED visits, inpatient visits, LOS, Readmissions – Zero inflated Poisson regression
- Total Allowed Amount – Gamma regression

Part 3 – Identification of Significant Factors





Only highly statistically significant parameters (p<0.0001) are reported here. Please check the report for the interpretations of these estimates and for other significant parameters

Part 4 – CCM group Vs Control Group Analysis

01 Identify CCM enrolled members

CCM case status enrolled with start date or end date in 2023.
Eligible for at least 1 month during the utilization period.
Enrolled for more than 30 days in the CCM program

02 Identify Members in Control Group

Referred to CCM in 2023 and were not enrolled into any CM programs 6 months before and after their referred date.
Eligible for at least 1 month during their utilization period.
Calculated minimum member eligibility similar to CCM group

03 Identify Member utilization period

Calculated the minimum number of months the CCM referred members were eligible before and after the CCM referred date and end date to determine the utilization period.

04 Case Control Matching

Members in the control group were matched on the 280 different subsets of member eligibility gender, region, age group and risk level of the 189 members in the CCM group using the case-control matching algorithm

CCM Group

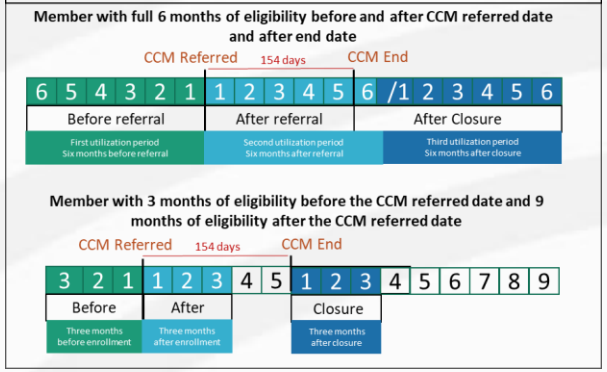
01 **189 Members**

Control Group

02 **517 Members**

03

** As the referred and case not opened status does not have an end date, the median case length for the CCM treatment group (154 days) was added to the referred start date to impute the CCM referral end date**



04

Before Matching

Parameters	CCM N (%)	Control N (%)
Minimum Eligibility in the utilization period		
1 month	35 (19%)	110 (21%)
2 months	27 (14%)	86 (17%)
3 months	23 (12%)	50 (10%)
4 months	21 (11%)	38 (7%)
5 months	24 (13%)	28 (5%)
6 months	59 (31%)	205 (40%)
Gender		
Female	101 (53%)	273 (53%)
Male	88 (47%)	244 (47%)
Region		
Northern	65 (34%)	275 (53%)
Southern	124 (66%)	242 (47%)
Age Group		
0-10	70 (37%)	169 (33%)
11-20	40 (21%)	82 (16%)
21-50	29 (15%)	57 (11%)
51 above	50 (26%)	209 (40%)
Risk Level		
High Risk	77 (41%)	82 (16%)
Medium Risk	57 (30%)	114 (22%)
No or Low Risk	55 (29%)	321 (62%)

Case control Matching on 280 different subsets of the CCM populations

After Matching

Parameters	CCM N (%)	Control N (%)
Minimum Eligibility in the utilization period		
1 month	35 (19%)	35 (19%)
2 months	27 (14%)	27 (14%)
3 months	23 (12%)	23 (12%)
4 months	21 (11%)	21 (11%)
5 months	24 (13%)	24 (13%)
6 months	59 (31%)	59 (31%)
Gender		
Female	101 (53%)	107 (57%)
Male	88 (47%)	82 (44%)
Region		
Northern	65 (34%)	81 (43%)
Southern	124 (66%)	108 (57%)
Age Group		
0-10	70 (37%)	64 (34%)
11-20	40 (21%)	24 (13%)
21-50	29 (15%)	33 (17%)
51 above	50 (26%)	68 (36%)
Risk Level		
High Risk	77 (41%)	65 (34%)
Medium Risk	57 (30%)	61 (32%)
No or Low Risk	55 (29%)	63 (33%)

Part 4 – CCM group Vs Control Group Analysis

05 Identify CCM and Control members

All the members after the case –control stratification are grouped as CCM or Control Members

CCM Group

05 **189 Members**

Control Group

05 **189 Members**

06 Determine utilization metrics

1. ED Visits
2. LOS
3. inpatient stays
4. Readmission
5. PCP visits
6. Specialty visits
7. Unique drugs
8. Total Allowed Amount

06

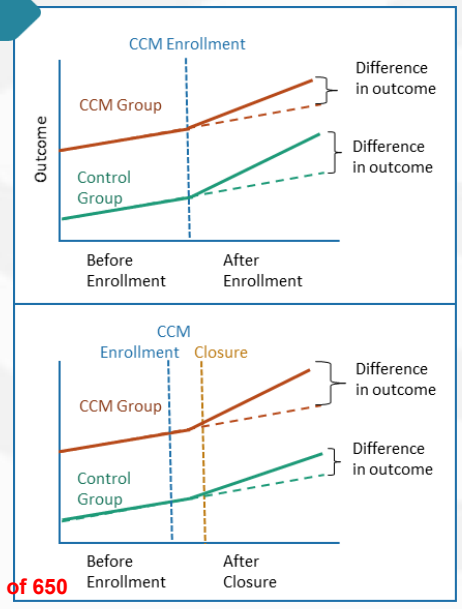
- ED Visits
- LOS
- inpatient stays
- Readmission
- PCP visits
- Specialty visits
- Unique drugs
- Total Allowed Amount

07 CCM Vs Control without covariates

Tested significant difference of utilization metrics before vs after enrollment, before enrollment vs after closure between the control and CCM group without adjusting for covariates using ANOVA

07

CCM Vs Control without covariates



08 CCM Vs Control with covariates

Tested significant difference of utilization metrics before vs after enrollment, before enrollment vs after closure between the control and CCM group adjusting for covariates using ANCOVA

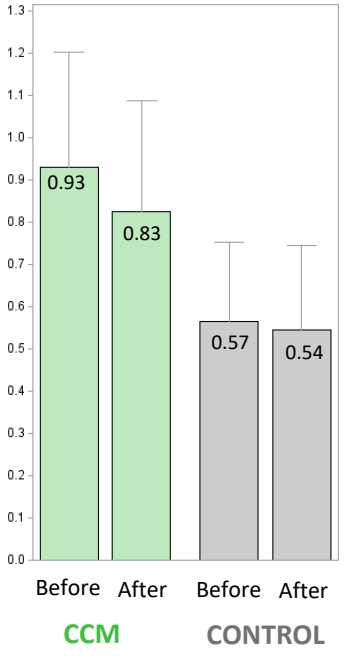
CCM Vs Control after adjusting covariates 08

Part 4 – CCM Group Vs Control Group Analysis

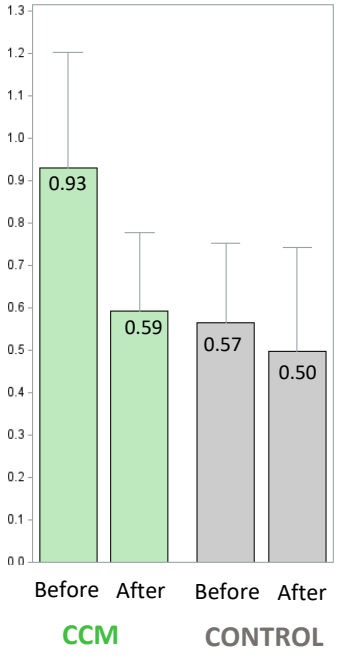
To test significant difference of average prior-utilization metrics and concurrent-utilization/post-utilization metrics between the control and CCM group ***without adjusting for covariates***

ED visits

Before Vs After Enrollment

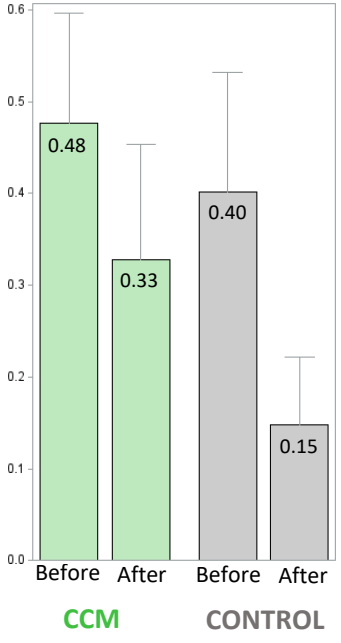


Before Vs After Closure

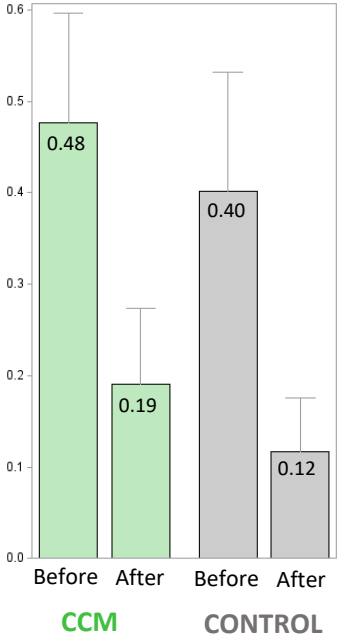


Inpatient visits

Before Vs After Enrollment

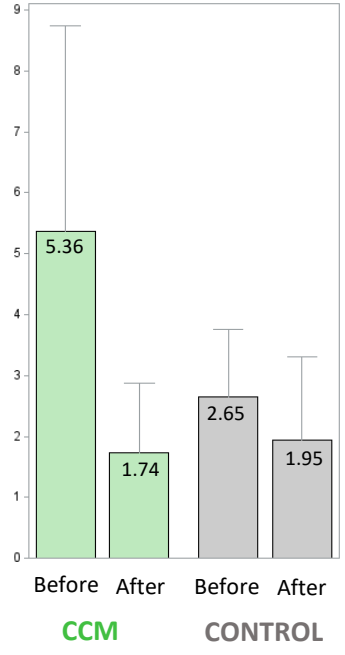


Before Vs After Closure

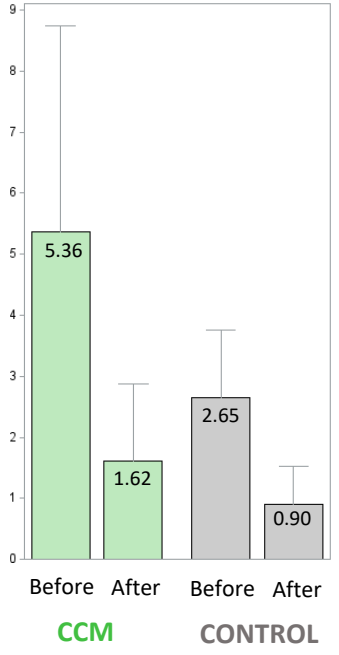


Average Inpatient days

Before Vs After Enrollment



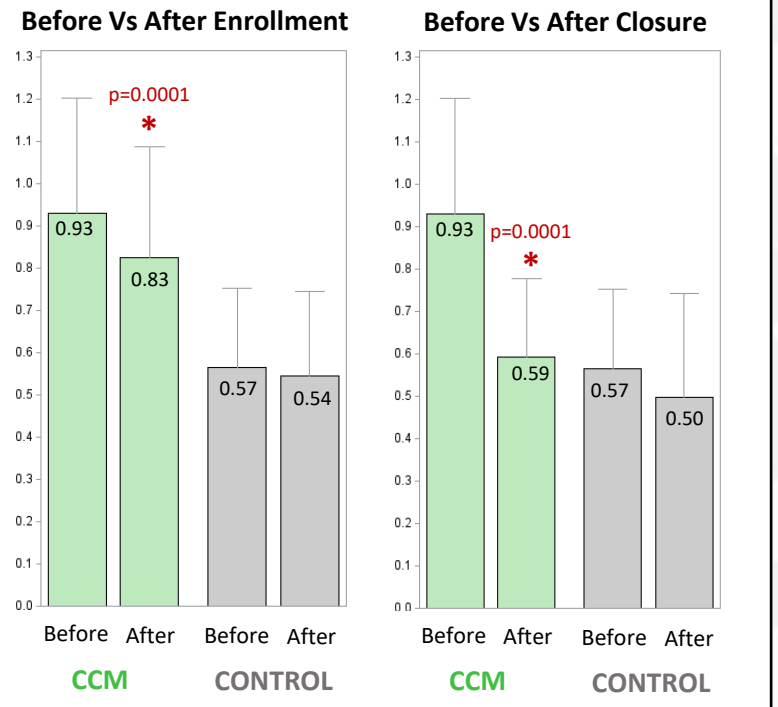
Before Vs After Closure



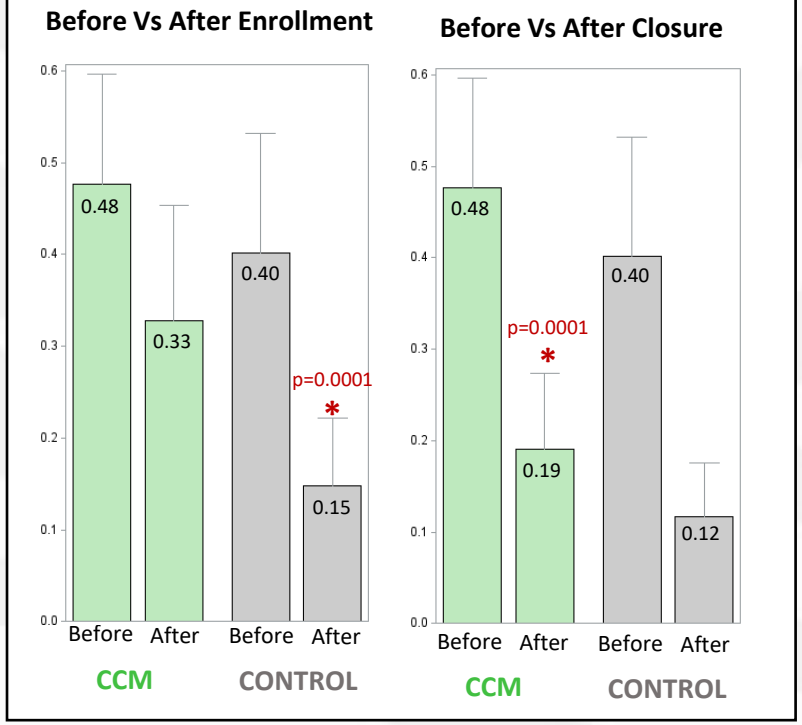
Part 4 – CCM Group Vs Control Group Analysis

To test significant difference of average prior-utilization metrics and concurrent-utilization/post-utilization metrics between the control and CCM group ***after adjusting for covariates***

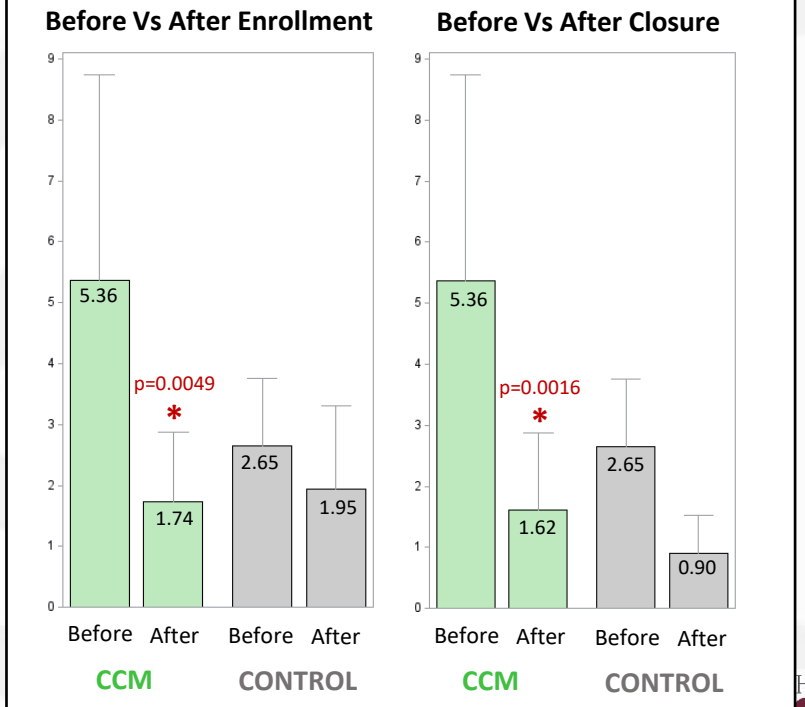
ED visits



Inpatient visits



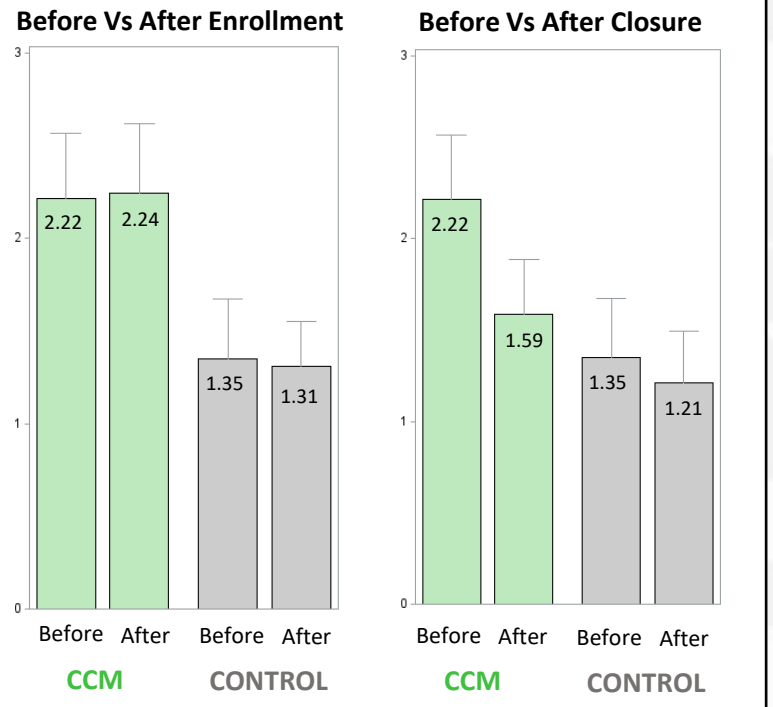
Average Inpatient days



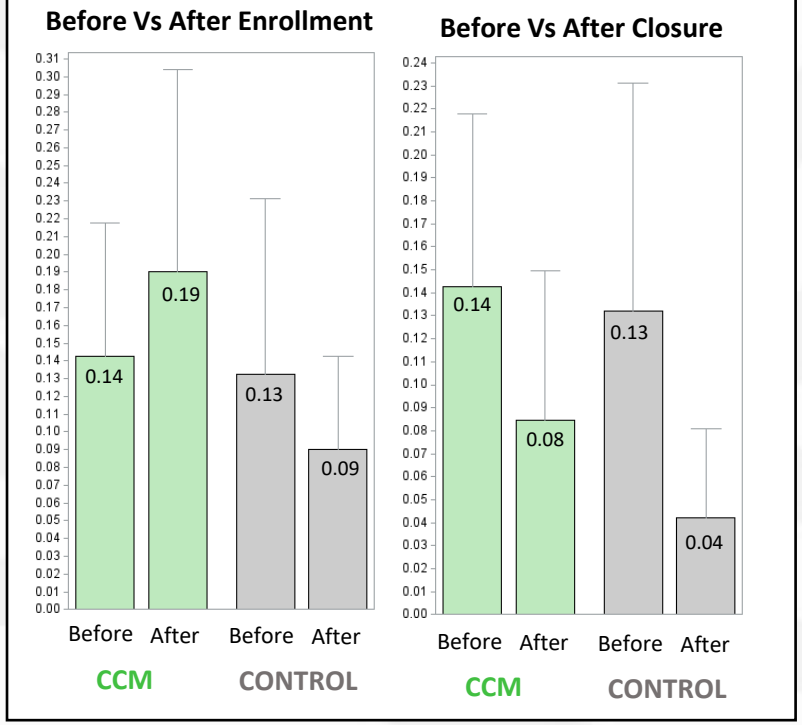
Part 4 – CCM Group Vs Control Group Analysis

To test significant difference of average prior-utilization metrics and concurrent-utilization/post-utilization metrics between the control and CCM group ***without adjusting for covariates***

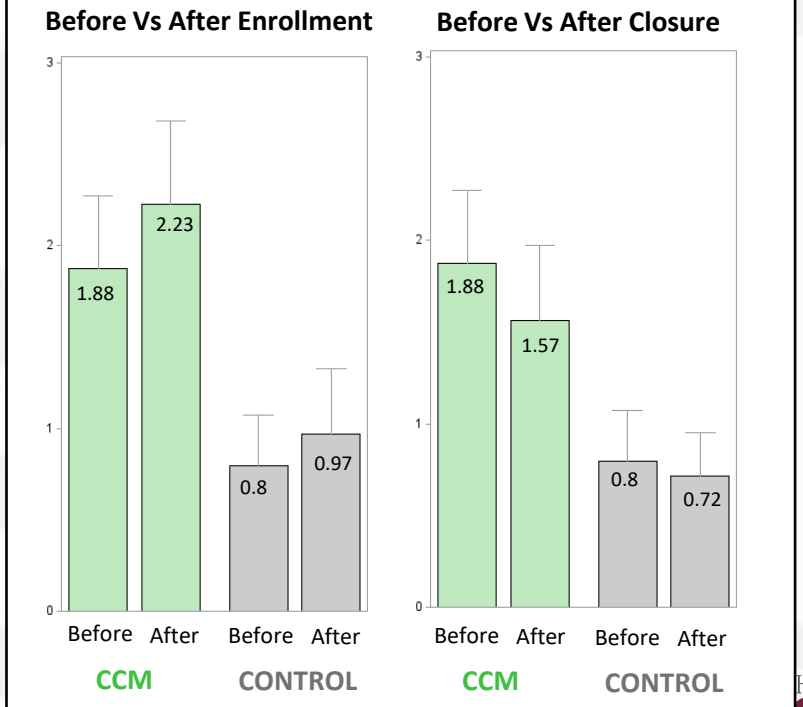
PCP visits



Readmissions



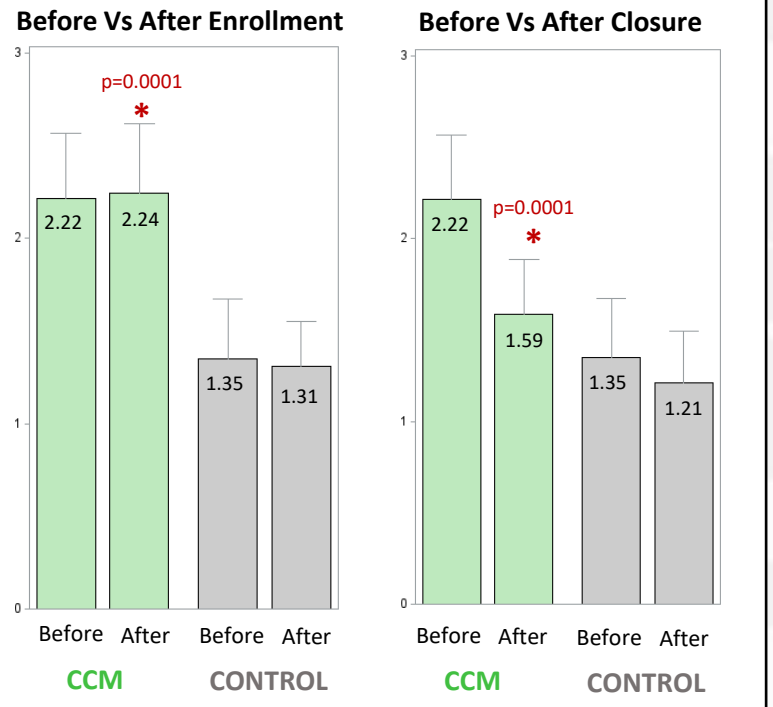
Specialty visits



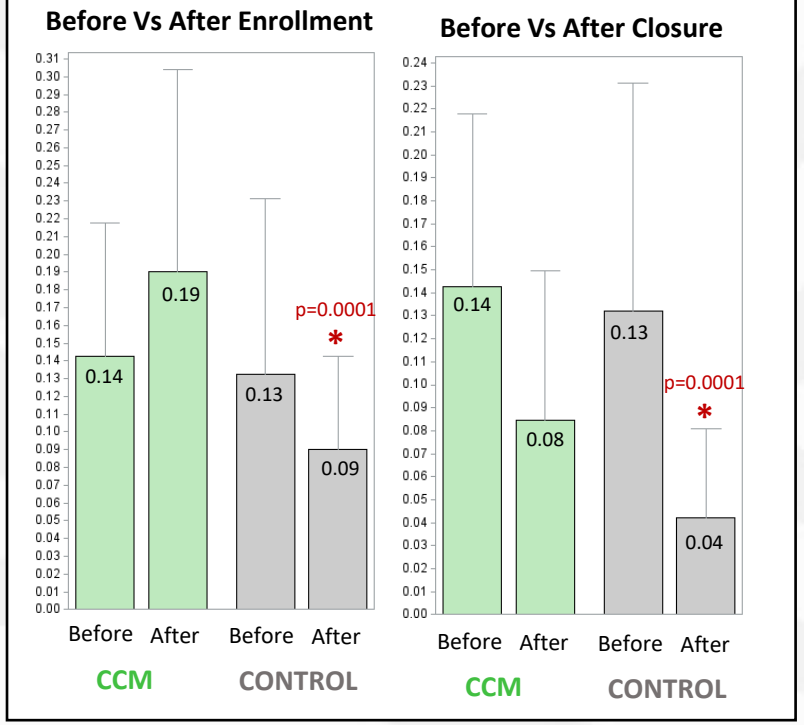
Part 4 – CCM Group Vs Control Group Analysis

To test significant difference of average prior-utilization metrics and concurrent-utilization/post-utilization metrics between the control and CCM group ***after adjusting for covariates***

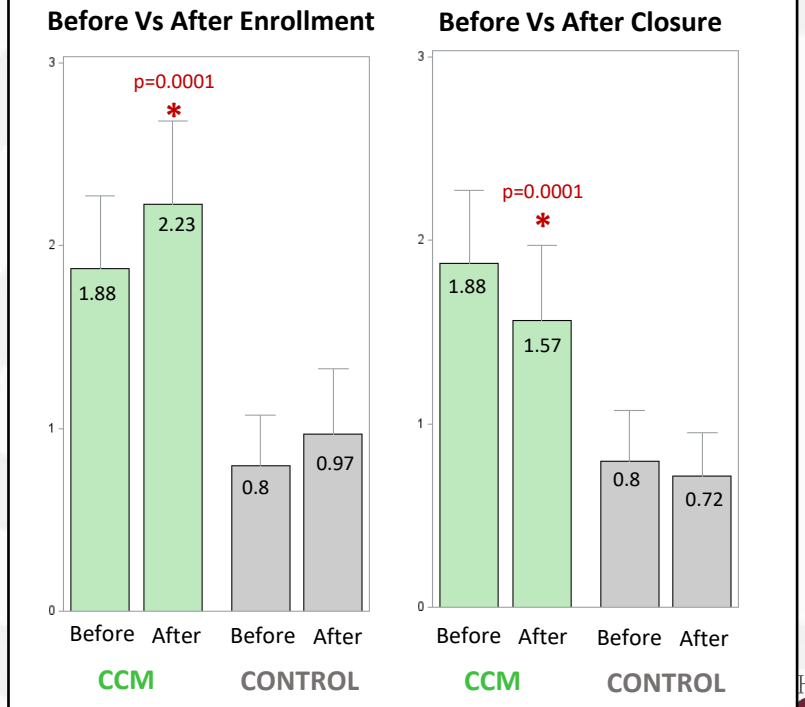
PCP visits



Readmissions

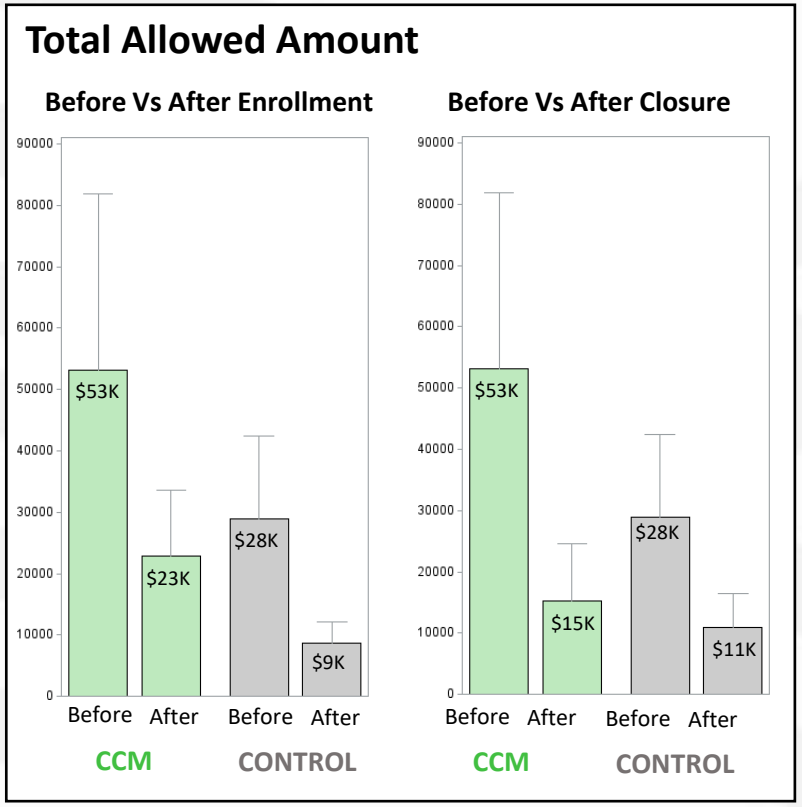


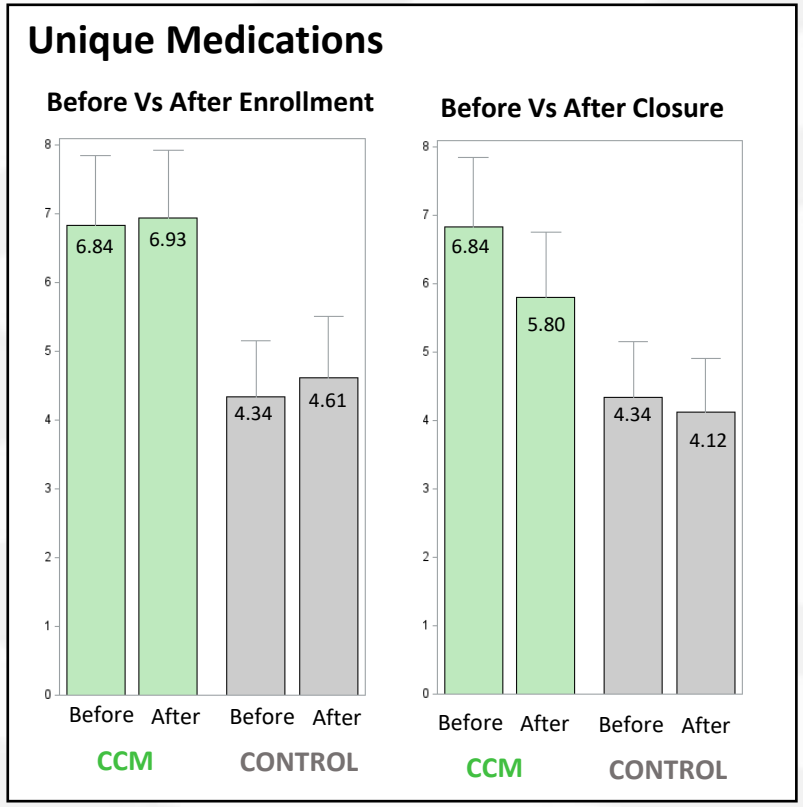
Specialty visits



Part 4 – CCM Group Vs Control Group Analysis

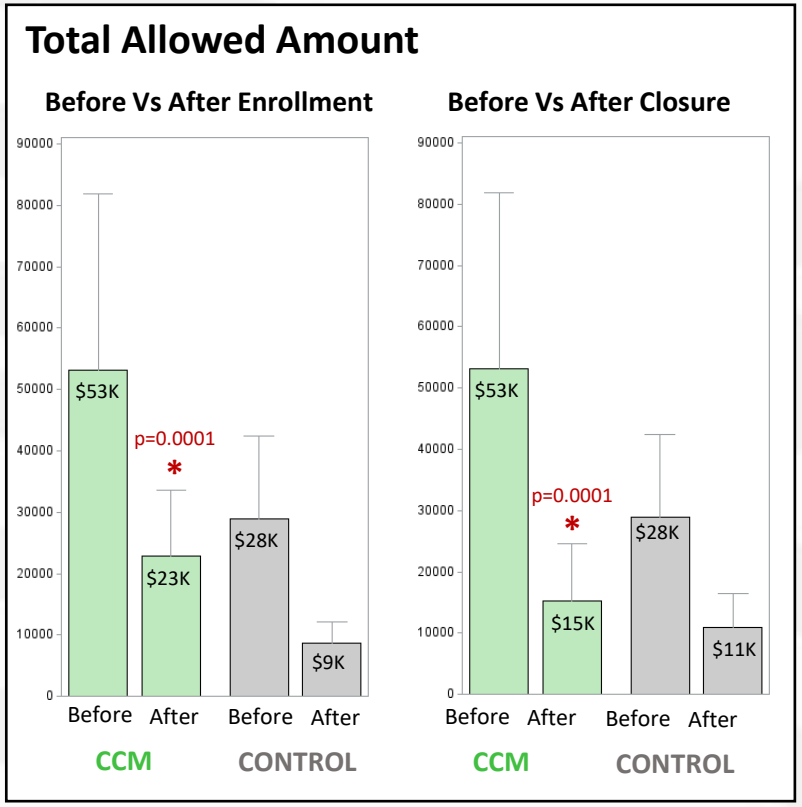
To test significant difference of average prior-utilization metrics and concurrent-utilization/post-utilization metrics between the control and CCM group ***without adjusting for covariates***

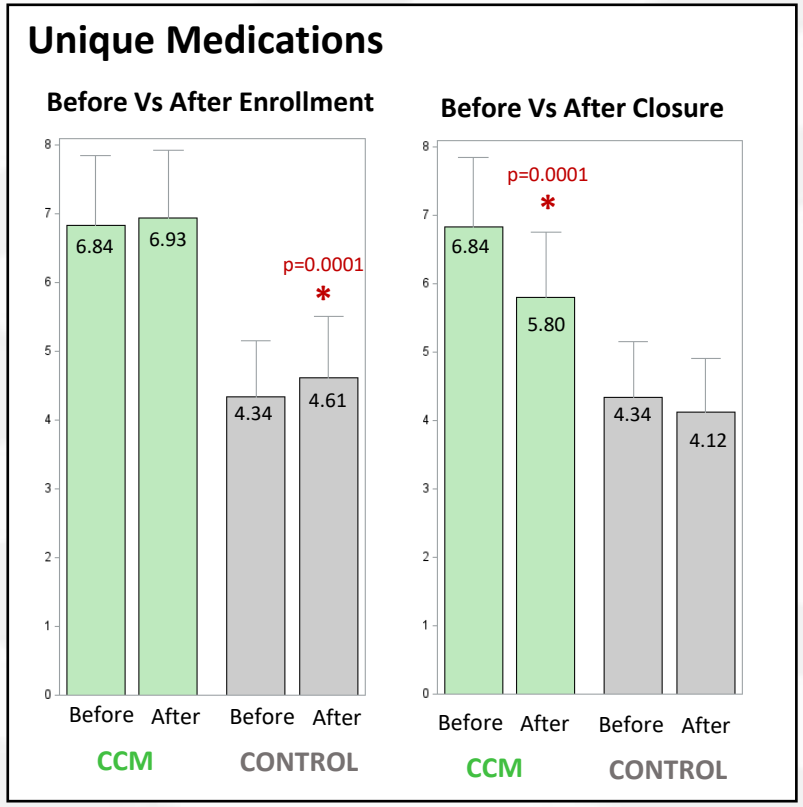




Part 4 – CCM Group Vs Control Group Analysis

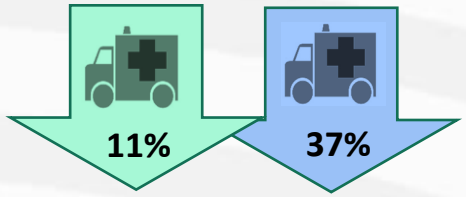
To test significant difference of average prior-utilization metrics and concurrent-utilization/post-utilization metrics between the control and CCM group ***after adjusting for covariates***



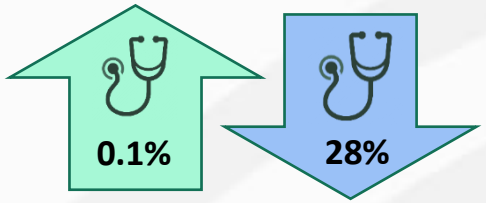


Part 3 – Key Findings

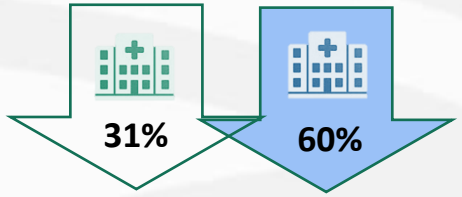
When compared to members in the control group, members enrolled in the CCM program had significantly:



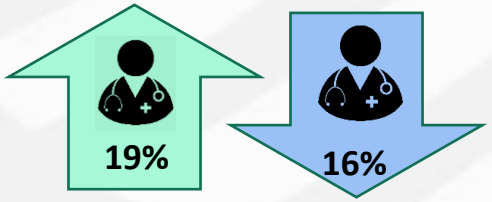
Lower ED visits after the start and end of CCM program



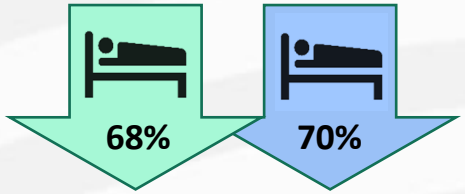
Higher PCP visits after the start of CCM program and lower visits after the end of CCM program



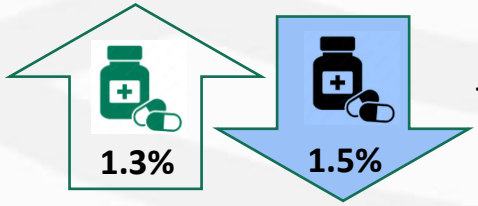
Lower inpatient visits after the end of CCM program



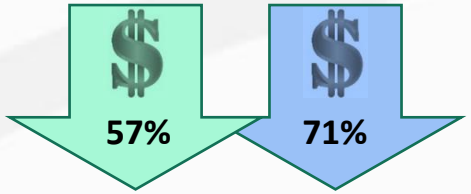
Had higher specialty visits after the start of CCM program and lower visits after the end of the program



Lower average inpatient days after the start and end of CCM program



Had lower unique medications after the end of CCM program



Had lower total allowed amount after the start and end of CCM program

Conclusions

When compared to the Control group,

CCM program was effective in :

- Reducing ED visits, average inpatient days, total allowed amount after the start and end of CCM program
- Increasing PCP visits, specialty visits and unique medications after the start of CCM program
- Reducing inpatient visits, specialty visits and number of unique drugs after the end of CCM program

CCM program was not effective in:

- Reducing inpatient visits after the start of CCM
- Reducing readmissions after the start and end of CCM
- Increasing PCP visits after the end of CCM program

Limitations

- Members who are enrolled in the CCM program might be more engaged when compared to members who are in the control group
- The proportion of high-risk members in the control group is 6% lower and the proportion of members in the southern region is 9% lower than members in the CCM group which might affect the overall utilization but not the difference in utilization between the measurement periods.

Questions

POTENTIAL QUALITY ISSUE (PQI) REPORT

PQI (Potential Quality Issue) is defined as a possible adverse variation from expected clinician performance, clinical care, or outcome of care. PQI requires further investigation to determine whether an actual quality issue or an opportunity for improvement exists. PQI is referred internally to the Quality Improvement (QI) department via the PQI Referral Intake System found on PHC4Me. Referrals from external sources are sent via the PQI@partnershiphp.org inbox using the PQI referral form.

PPC (Provider Preventable Condition) is specified and defined as Health Care Acquired Condition (HCAC or HAC) or Other Provider Preventable Condition (OPPC), which is a medical condition or complication that a patient develops during a hospital stay or ambulatory surgical encounter that was not present at admission. See Title 42 of the Code of Federal Regulations Sections§447.26, 434.6, 438.3 and Welfare and Institutions Code Section 14131.11 for original documentation related to these terms.

The Member Safety Quality Investigations team (QI), together with designated Partnership Medical Directors, review all PQI referrals. Cases receive a “P” score for “Provider Issues” and/ or an “S” score for “System Issues”. All PQI cases designated a severity level P2 or S2 or higher must be referred to the PRC for additional review, discussion, and final determination. Upon determination that a PQI case requires a second opinion review by a specialty physician or by a subject matter expert, a request for investigational review and response will be sent.

The Peer Review Committee (PRC) reviews the patient or practitioner complaints about the quality of clinical care provided to Partnership’s members by any providers and makes recommendations for corrective actions, if indicated. The PRC also reviews sentinel conditions identified as having quality concerns. PRC discussions and documents are protected by federal and state laws governing confidentiality of health care peer review activities conducted in good faith.

2024 PQI Case Summary

Referral count: 247

Completed/Closed cases: 207 (includes some cases received in 2023)

PRC reviewed a total of 16 PQI cases:

- Q1/Q2 2024: Seven PQI cases were reviewed (PQ860, PQ876, PQ913, PQ916, PQ934, PQ966, and PQ973).
- Q3/Q4 2024: 9 PQI cases were reviewed (PQ814, PQ917, PQ978, PQ989, PQ1024, PQ1058, PQ1106, PQ1164, and PQ1172).

The PRC issued Corrective Action Plans (CAP) to nine providers, and recommended six focus reviews, two of which are still underway. The CAPs mainly consisted of doing Continuing Education Units.

In addition to the recommendations of the PRC, the following are thresholds for consideration of a Focused Review:

1) Two or more P2 or above quality of care scores in the last 24 months; or

2) Significant trend of service or quality complaints exceeding the established thresholds.

Focus Review Summary Q1/Q2 2024:

Presented in the PQI and PPC report in the August 2024 IQI and QUAC meetings.

Focus Review Summary Q3/Q4 2024:

1) PQ814: The PRC recommended a focus review regarding surgeries performed. The PQI team is in the process of gathering supporting documentation.

2) PQ973: The PRC recommended a focus review with a goal to ensure the hospital's Emergency Department general practices followed their internal policies. The focus review was completed on 8/20/2024 and no significant issues were identified. No further actions were required from the hospital.

3) PQ1106: The PRC recommended a focus review to determine if there is a gap in the facility's internal processes related to laboratory results follow-up. Medical records have been requested.

PQI Report Q3/Q4 and CY 2024 for February 2025 IQI/QUAC Meetings

Provider Track and Trend Summary:

The Q1/Q2 2024 PQI Track and Trend summary reports, including Provider Sites/Individual practitioner with multiple PQIs, were presented to the PRC on Aug. 21, 2024. Two providers had multiple PQIs, however, there are no significant trends noted.

The Q3/Q4 2024 PQI Track and Trend summary reports, including Provider Sites/Individual practitioner with multiple PQIs, show multiple providers with multiple PQIs, however, there are no significant trends noted.

Going forward in 2025,

- Providers and/or facilities who are given a severity rating of P2 or S2 and above at PRC will be monitored for at least the following year via the track and trend reports to determine if the identified concern is ongoing. If through this process, any additional concerns are identified, further investigation or actions may be implemented.
- A monthly report capturing PQI referrals, open cases, and cases pending PRC presentation will be sent to both the CMO and the Medical Director for Quality.

2024 PQI Statistics

As expected, the number of PQI referrals have increased partly due to the expansion into 10 additional counties (identified as the Eastern Regions in this report): 2024 saw an 8% increase of PQI cases referred compared to 2023. The Eastern Region accounted for 49 (20%) of the 247 PQI cases referred.

Q3/Q4 2024 PQI Referrals Received:

Region	Q3 2024	Q4 2024	Grand Total
South	38	35	73
North	26	20	46
Eastern	17	14	31
Grand Total	81	69	**150**

Top 3 referral sources: Grievance & Appeals (119), Other (15), and Medical Directors (8)

Top 3 PQI count by Referral Type: Assessment/Treatment/Diagnosis (93), Continuity of Care (19), and Communication (10)

Top 3 PQI count by Provider Type: PCP (95), Hospital/ER (31), and Specialist (14)

PQI Report Q3/Q4 and CY 2024 for February 2025 IQI/QUAC Meetings

PQI Referral Trend: 3-year look back

Year	2022		2023		2024	
Quarter	**Q1/Q2**	**Q3/Q4**	**Q1/Q2**	**Q3/Q4**	**Q1/Q2**	**Q3/Q4**
PQI Referral Count	59	96	116	111	97	150
3-year PQI referral trend	**155**		**227**		**247**	

****Referrals in 2019: 210, 2020: 128, and 2021: 113**

Q3/Q4 2024 PQI Closed Cases:

Region	Q3 2024	Q4 2024	Grand Total
South	25	29	54
North	13	17	30
Eastern	8	12	20
Grand Total	46	58	**104**

PQI Closed Cases Trend: 3-year look back

Year	2022		2023		2024	
Quarter	**Q1/Q2**	**Q3/Q4**	**Q1/Q2**	**Q3/Q4**	**Q1/Q2**	**Q3/Q4**
PQI Closed Count	46	66	**118**	117	103	104
3-year PQI Closed trend	**112**		**235**		**207**	

****Cases closed in 2019: 155, 2020: 151, and 2021: 126**

PQI Report Q3/Q4 and CY 2024 for February 2025 IQI/QUAC Meetings

Q3/Q4 2024 Summary of Closed Cases by Provider County and Type:

117 practitioners/providers were involved in the 104 PQI processed and closed cases. The following is a breakdown of the types of providers and total per Provider County:

PROVIDER COUNTY	PCP	SPECIALIST	HOSPITAL/ER	SNF/LTC	OTHER	TOTAL
SHASTA (N)	12	5	4		1	22
SOLANO (S)	12	1	4			17
SONOMA (S)	9	1	3			13
YUBA (E)	7		2	1	1	11
YOLO (S)	5	2	2	1		10
*OTHER		3	5			8
BUTTE (E)		1	6			7
LAKE (S)	3	1	3			7
MENDOCINO (S)	3	1	1			5
NAPA (S)	2	2				4
PLACER (E)	3	1				4
HUMBOLDT (N)	2					2
SISKIYOU (N)	2					2
NEVADA (E)	2					2
TEHEMA (E)	1		1			2
MARIN (S)	1					1
TOTAL	**64**	**18**	**31**	**2**	**2**	**117**

(N) - Northern region, (S) - Southern region, (E) Eastern region, Provider County: OTHER (Non-Partnership Counties)

Assignment of Practitioner Performance and Systems Severity Scores:

Practitioner Performance (P Score)	Systems Issue (S Score)	Definition and Action
P0	S0	Care is appropriate, no action required
P1	S1	Minor opportunity for improvement. The reviewer will send a letter and/or secure email to the provider. Response may or may not be required.
P2	S2	Moderate opportunity for improvement and/or care deemed inappropriate. Potential for minor or moderate adverse outcome to member. A letter is sent to the provider of concern, requiring a response. May recommend CAP and/or other interventions.
P3	S3	Significant opportunity for improvement and/or care deemed inappropriate. Potential for significant adverse outcome to members. ASAP communication by certified letter, secure email and/or direct phone call to provider of concern requiring a response. Requires a CAP and/or other interventions. May be referred to Credential Committee with recommendations from the PRC.
PUTD	SUTD	Use whenever PQI cannot be leveled or unable to make a determination due to several factors. Referral to Peer Review Organization (PRO) of the Facility of Concern (FOC) or the Provider of Concern (POC). If none identified, may be through direct contact with management of the FOC or with oversight of the POC. Refer to the appropriate licensing entity, if indicated.

Summary by Severity: 3-year look back

	2022		2023		2024	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
# of PQI closed cases	46	66	118	117	103	104
# of Practitioners/Providers involved	65	84	156	146	104	117
# of severity rating higher than P1/S1	9	7	22	12	8	11

Q3/Q4 2024 Summary by Severity Rating:

Severity Score	Grand Total
P0	42
P1	13
P2	4
P3	2
S0	19
S1	24
S2	3
S0	0
SUTD	1
PUTD	2
PUTD/SUTD	1
P0/S0	3
P1/S1	1
P2/S0	1
P2/S1	1
Total	117

Q3/Q4 2024 PROVIDER PREVENTABLE CONDITIONS (PPC) – All reported to DHCS

PQI	Brief Synopsis	Findings	Confirmed PPC □ yes □ no
PQ966 Referral Date: 01/18/2024 Closed Date: 07/02/2024	OPPC-Other Provider Preventable Conditions: Surgery/invasive procedure performed on the wrong body part	Facility performance/System Issue: Moderate opportunity for improvement Provider Issue: Moderate opportunity for improvement	Yes, sent for recoupment review.
PQ1052 Referral Date: 05/06/2024 Closed Date: 07/05/2024	HCAC- Health Care - Acquired Conditions in an acute inpatient setting: Catheter-associated urinary tract infection	Facility performance/System Issue: Minor opportunity for improvement	Yes, however, no recoupment required.

PQI Report Q3/Q4 and CY 2024 for February 2025 IQI/QUAC Meetings

Member Safety Investigations Team Updates:

SugarCRM PQI application (PQI documenting and processing system) will be updated from version 8 to 14. Enhancement and improvements have also been requested to improve the overall process and enhance data reporting.

Compared to Q1/Q2 2024 and previous years, the number of PQI cases is significantly higher. There are multiple contributing factors, including higher-than-average referrals in Q3/Q4 2024 and cases that remained open beyond the 120-day timeframe due to several factors, for example cases needing medical records or more information, waiting for a provider response, and cases pending PRC review.

We have implemented new processes and enhanced existing processes. We updated our policies and procedures to be aligned with business operations, ever-changing regulatory standards and regulations, technological advancement and internal practices and adapt to evolving circumstances to remain effective. We have implemented the following:

1) Communication with providers of concern: We now require responses for moderate to severe findings and have imposed stricter and more specific corrective action plans directed at improving provider awareness and member safety. This new process is working well, with providers completing assigned CME and other activities. On more than one occasion, providers thanked and complimented us on this process.
2) Provider letters and follow-up: consistency in notifying providers/facilities of issues and concerns identified. The letters requiring a response are tracked on a letter tracker to ensure timely follow-up and to increase the response rate; the letters are sent by certified mail, fax, or email to the provider of concern and to a secondary staff (e.g. Quality Manager, CMO, Supervising Physician, etc.) to ensure receipt of the letter. This, in addition to follow-up by email or phone, has led to an increased response rate.
3) Continuing education: The Investigation team continues to provide education to facilities regarding the PQI process and PPC reporting. Two clinics were given a presentation on PQI process and three hospitals were given a presentation on PPC's.

PQI Report and Data Analysis provided by: Robert R Bides, RN
Manager, Member Safety Quality Investigations/Quality Improvement (QI)/Health Services
IQI/QUAC February 2025

Supporting documentation attached:

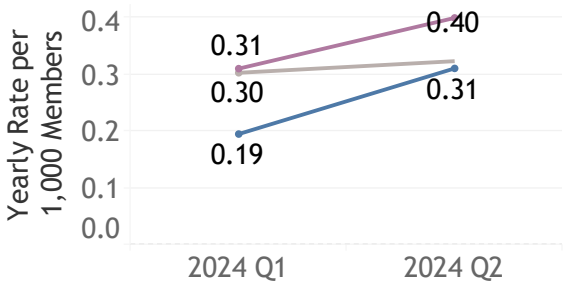
A. PQI Data Analysis Q1&Q2 2024
B. PQI Data Analysis Q3&Q4 2024
C. PQI Data Analysis CY2024

Potential Quality Issues
Referral Dates: Q1&Q2 2024

PQI Rate, Count and Membership

	2024 Q1			2024 Q2			Total
	EASTERN	NORTH..	SOUTH..	EASTERN	NORTH..	SOUTH..	
Member Months	590,453	706,539	1,481,574	777,503	739,405	1,637,259	5,932,733
PQI Count	6	11	25	12	15	28	97
Yearly Rate per 1,000 Members	0.12	0.19	0.20	0.19	0.24	0.21	0.20

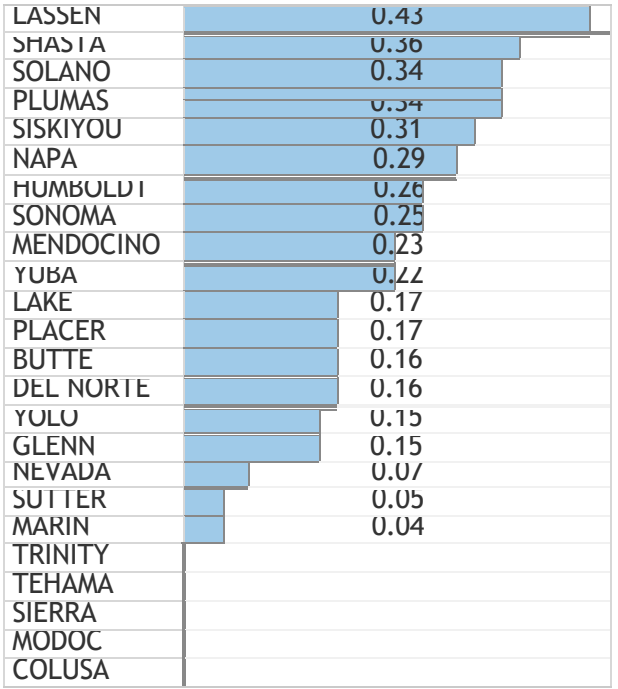
Trend of PQI Rate



Count, Membership and Rate per 1,000 Members by County

Mbr County	Member Months	PQI Count	Yearly Rate per 1,000 Members
LASSEN	55,409	2	0.43
SHASTA	435,914	13	0.36
SOLANO	665,158	19	0.34
PLUMAS	35,803	1	0.34
SISKIYOU	116,103	3	0.31
NAPA	164,371	4	0.29
HUMBOLDT	374,657	8	0.26
SONOMA	663,119	14	0.25
MENDOCINO	261,337	5	0.23
YUBA	218,628	4	0.22
LAKE	209,428	3	0.17
PLACER	359,434	5	0.17
BUTTE	513,731	7	0.16
DEL NORTE	74,677	1	0.16
YOLO	329,165	4	0.15
GLENN	82,632	1	0.15
NEVADA	172,081	1	0.07
SUTTER	265,355	1	0.05
MARIN	282,586	1	0.04
TRINITY	33,772		
TEHAMA	186,420		
SIERRA	5,177		
MODOC	24,965		
COLUSA	63,207		

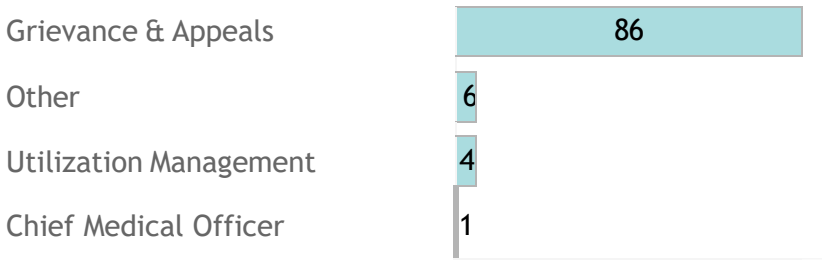
PQI Rate per 1,000 Members by County



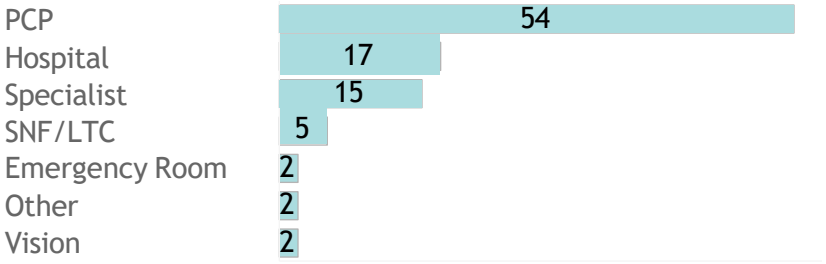
Yearly Rate per 1,000 is defined as: [(Number of PQIs)/(Membermonths)]*12,000
Created by: Liat Vaisenberg (lvaisenberg@partnershiphp.org)

Potential Quality Issues
Referral Dates: Q1&Q2 2024

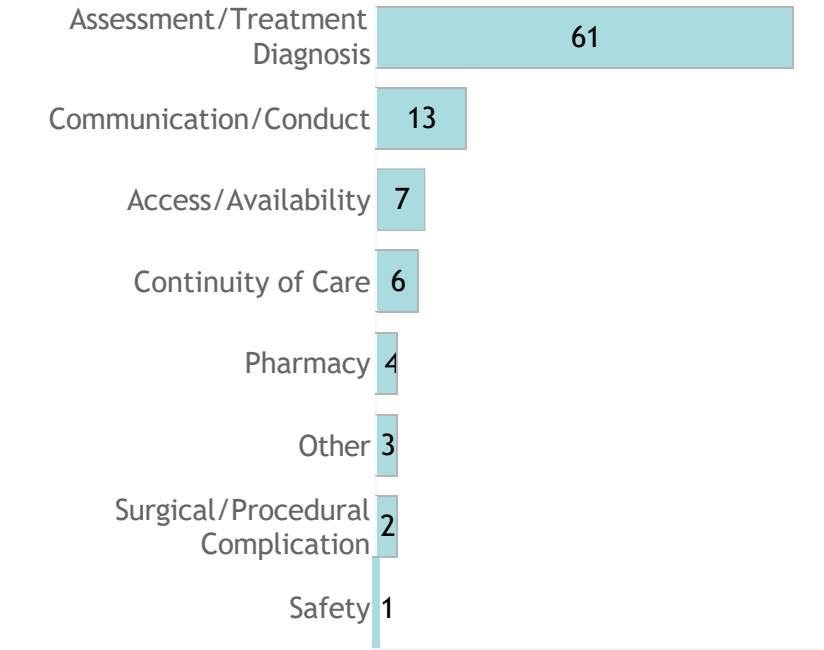
PQI Counts by Referral Source



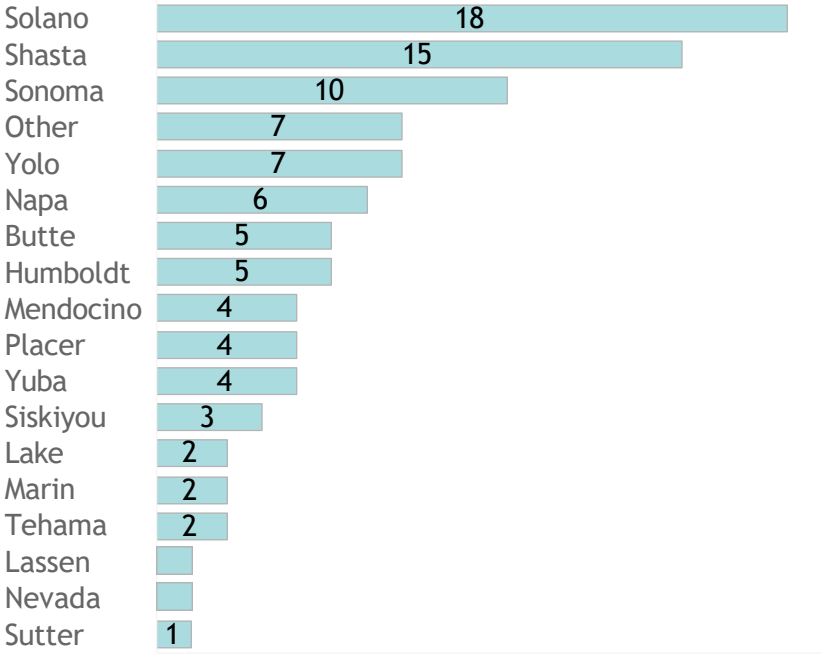
PQI Counts by Provider Type



PQI Counts by Referral Type



PQI Counts by Provider County

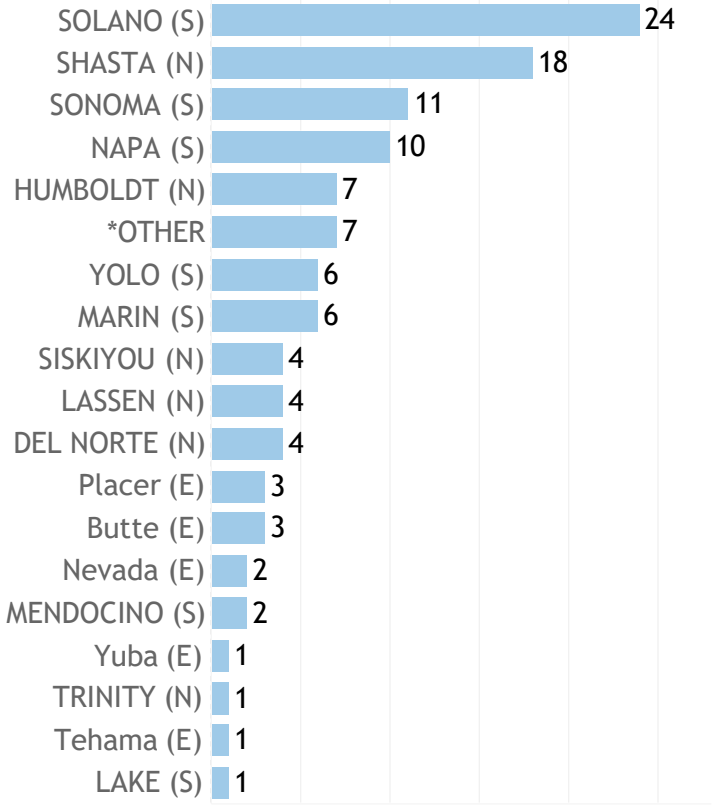


Created by: Liat Vaisenberg (lvaisenberg@partnershiphp.org)

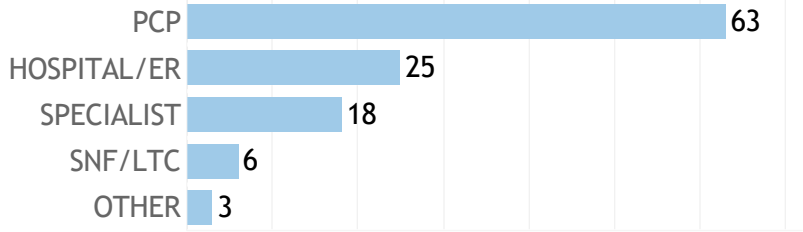
Potential Quality Issues

104 cases were closed and 115 practitioners/providers involved in Q1&Q2 2024

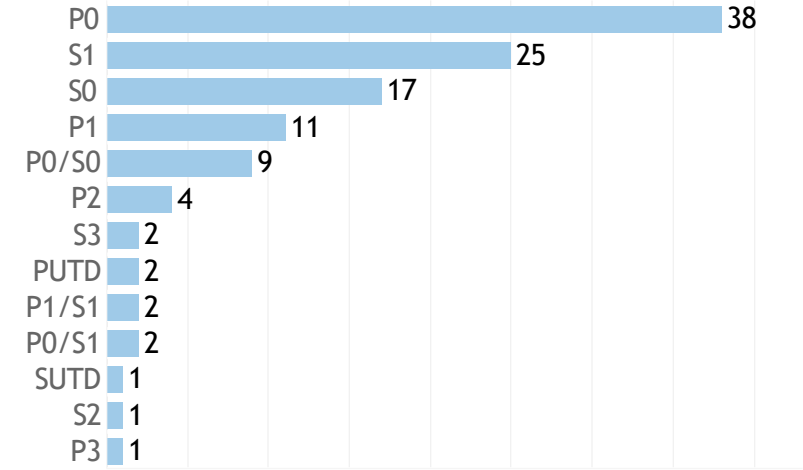
SUMMARY OF CLOSED CASES by Provider County



SUMMARY OF CLOSED CASES by Provider Type



SUMMARY OF CLOSED CASES by Severity Rating



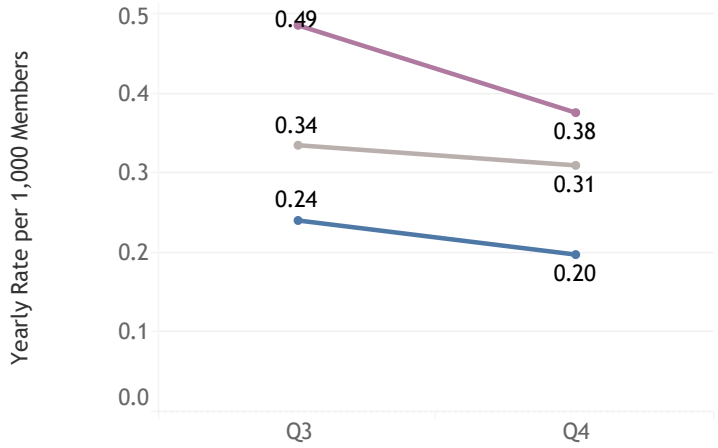
Created by: Liat Vaisenberg (lvaisenberg@partnershiphp.org)

Potential Quality Issues
Referral Dates: Q3&Q4 2024

PQI Rate, Count and Membership

	Q3			Q4			Total
	EASTERN	NORTHERN	SOUTHERN	EASTERN	NORTHERN	SOUTHERN	
Member Months	846,288	641,396	1,358,642	847,805	637,250	1,353,453	5,684,834
PQI Count	17	26	38	14	20	35	150
Yearly Rate per 1,000 Members	0.24	0.49	0.34	0.20	0.38	0.31	0.32

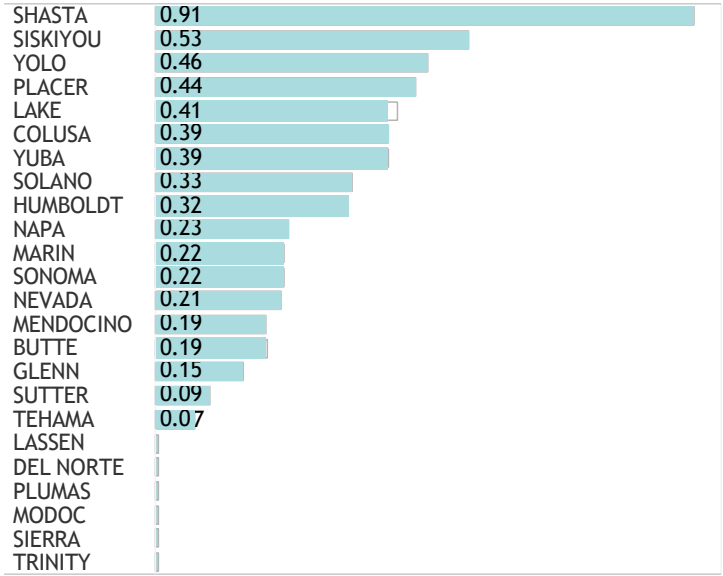
Trend of PQI Rate



Count, Membership and Rate per 1,000 Members by County

Mbr County	Member Months	PQI Count	Yearly Rate per 1,000 Members
SHASTA	422,938	32	0.91
SISKIYOU	113,842	5	0.53
YOLO	313,898	12	0.46
PLACER	356,498	13	0.44
LAKE	205,932	7	0.41
COLUSA	61,000	2	0.39
YUBA	213,593	7	0.39
SOLANO	831,420	23	0.33
HUMBOLDT	371,992	10	0.32
NAPA	159,741	3	0.23
MARIN	277,769	5	0.22
SONOMA	664,050	12	0.22
NEVADA	170,486	3	0.21
BUTTE	512,262	8	0.19
MENDOCINO	259,285	4	0.19
GLENN	81,554	1	0.15
SUTTER	258,159	2	0.09
TEHAMA	182,492	1	0.07
DEL NORTE	74,395		
TRINITY	32,648		
SIERRA	5,218		
PLUMAS	35,323		
LASSEN	55,617		
MODOC	24,722		

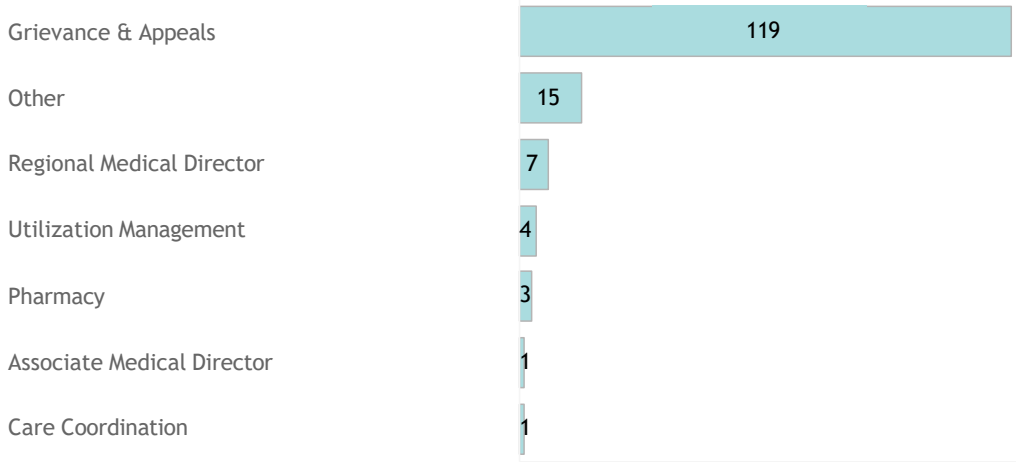
PQI Rate per 1,000 Members by County



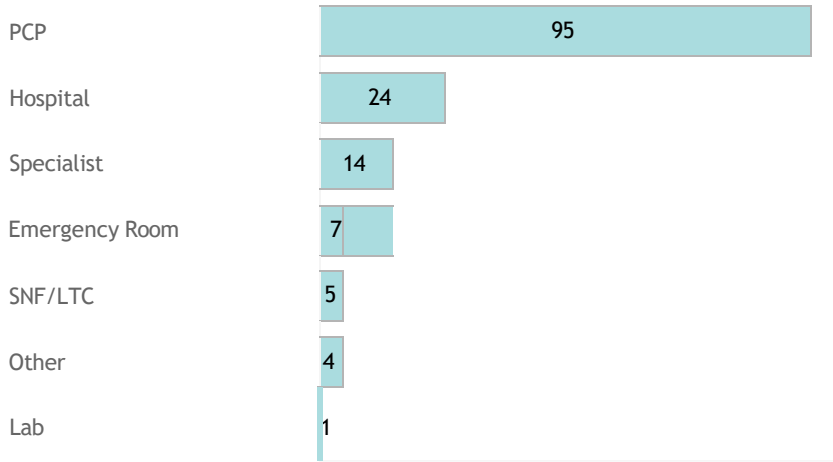
Yearly Rate per 1,000 is defined as: [(Number of PQIs)/(Membermonths)]*12,000
Created by: Liat Vaisenberg (lvaisenberg@partnershiphp.org)

Potential Quality Issues
Referral Dates: Q3&Q4 2024

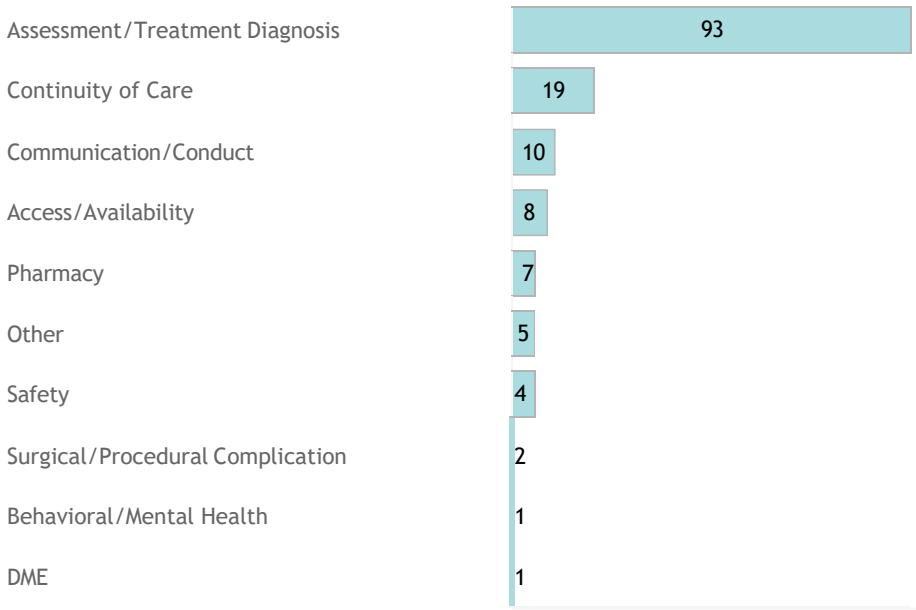
PQI Counts by Referral Source



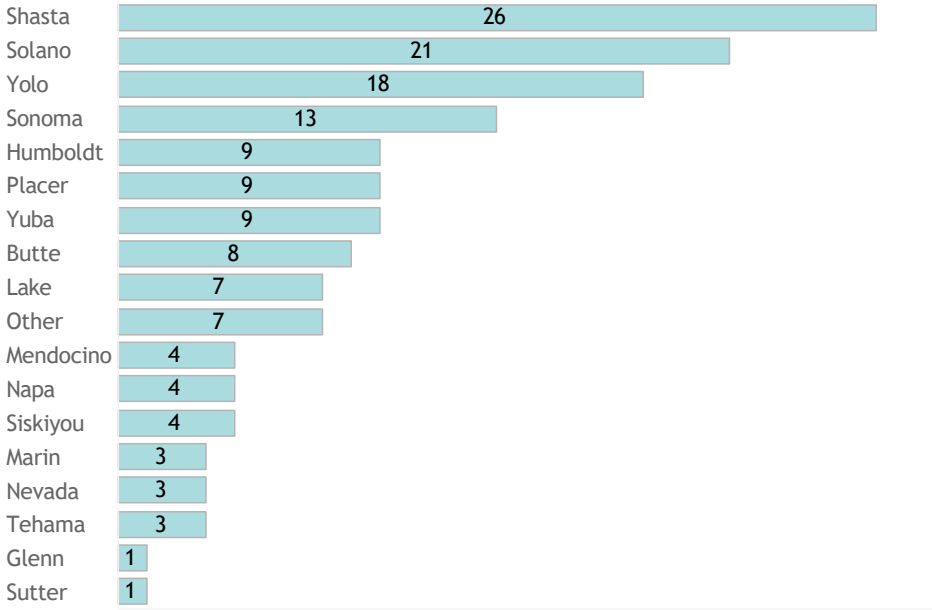
PQI Counts by Provider Type



PQI Counts by Referral Indicator



PQI Counts by Provider County

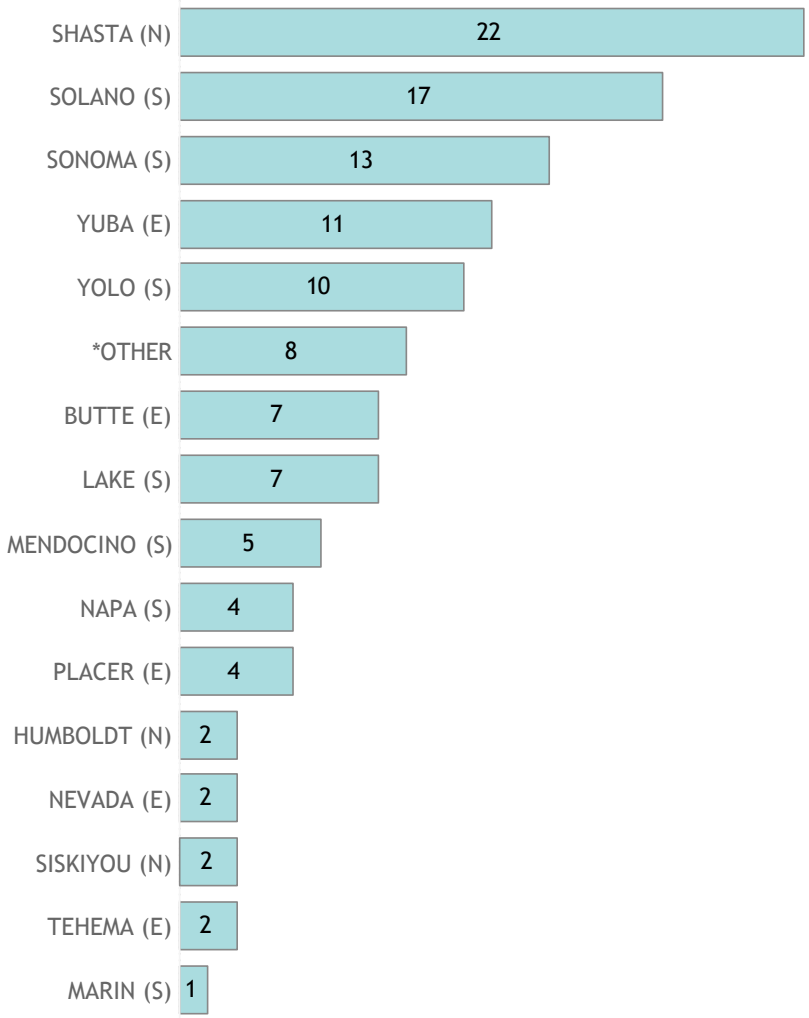


Created by: Liat Vaisenberg (lvaisenberg@partnershiphp.org)

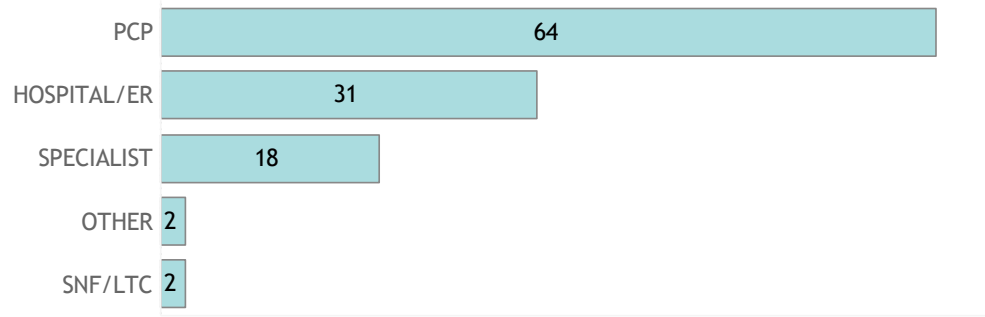
Potential Quality Issues

104 cases were closed and 117 practitioners/providers involved in Q3 & Q4 2024

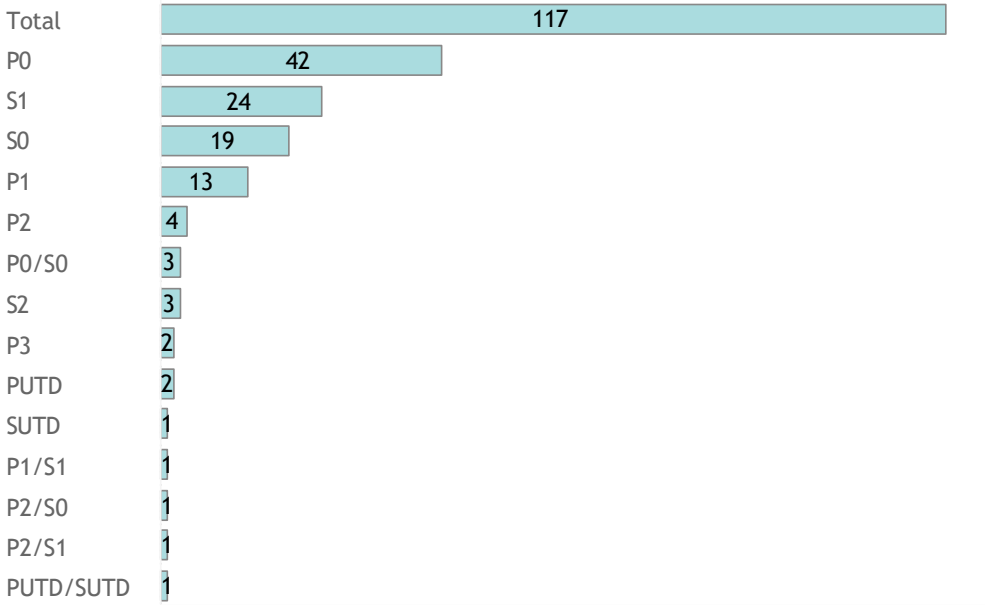
SUMMARY OF CLOSED CASES
by Provider County



SUMMARY OF CLOSED CASES
by Provider Type



SUMMARY OF CLOSED CASES
by Severity Rating



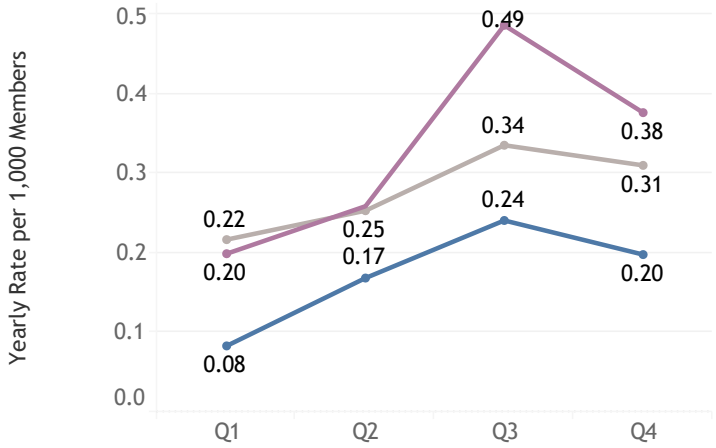
Created by: Liat Vaisenberg (lvaisenberg@partnershiphp.org)

Potential Quality Issues
Referral Dates: 2024

PQI Rate, Count and Membership

	EASTERN	NORTHERN	SOUTHERN	Grand Total
Member Months	3,411,853	2,589,914	5,468,356	11,470,123
PQI Count	49	71	127	247
Yearly Rate per 1,000 Members	0.17	0.33	0.28	0.26

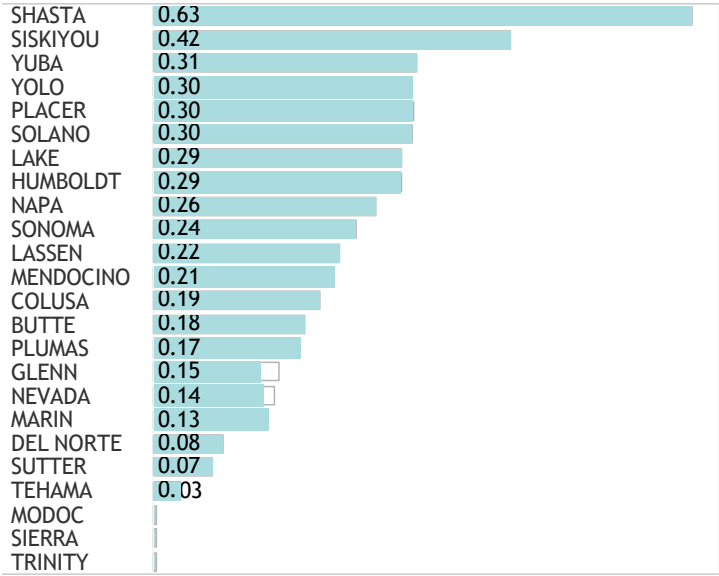
Trend of PQI Rate



Count, Membership and Rate per 1,000 Members by County

Mbr County	Member Months	PQI Count	Yearly Rate per 1,000 Members
SHASTA	862,345	45	0.63
SISKIYOU	230,895	8	0.42
YUBA	432,356	11	0.31
YOLO	643,601	16	0.30
PLACER	716,269	18	0.30
SOLANO	1,674,441	42	0.30
LAKE	415,501	10	0.29
HUMBOLDT	750,672	18	0.29
NAPA	324,264	7	0.26
SONOMA	1,327,491	26	0.24
LASSEN	111,425	2	0.22
MENDOCINO	522,451	9	0.21
COLUSA	124,258	2	0.19
BUTTE	1,026,586	15	0.18
PLUMAS	71,119	1	0.17
GLENN	164,285	2	0.15
NEVADA	342,782	4	0.14
MARIN	560,607	6	0.13
DEL NORTE	149,155	1	0.08
SUTTER	523,801	3	0.07
TEHAMA	369,178	1	0.03
TRINITY	66,483		
SIERRA	10,397		
MODOC	49,761		

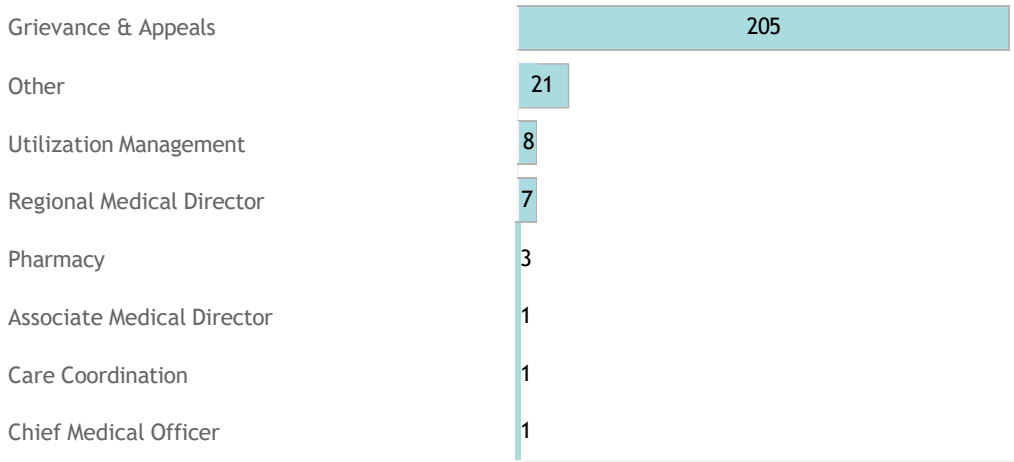
PQI Rate per 1,000 Members by County



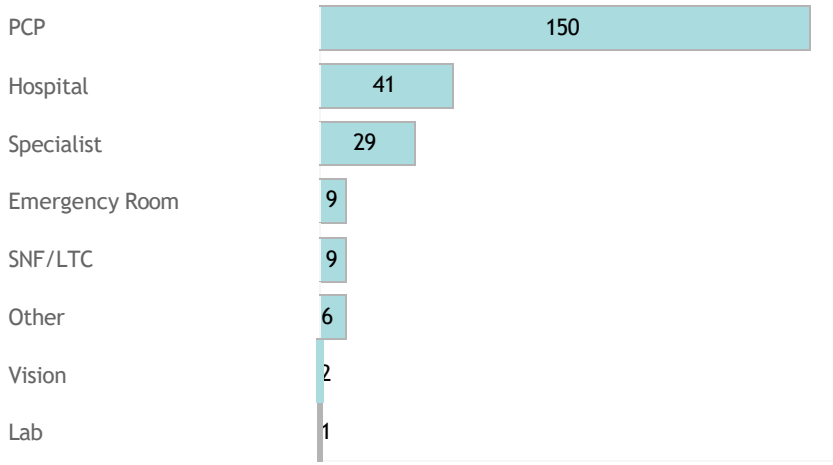
Yearly Rate per 1,000 is defined as: [(Number of PQIs)/(Membermonths)]*12,000
Created by: Liat Vaisenberg (lvaisenberg@partnershiphp.org)

Potential Quality Issues
Referral Dates: 2024

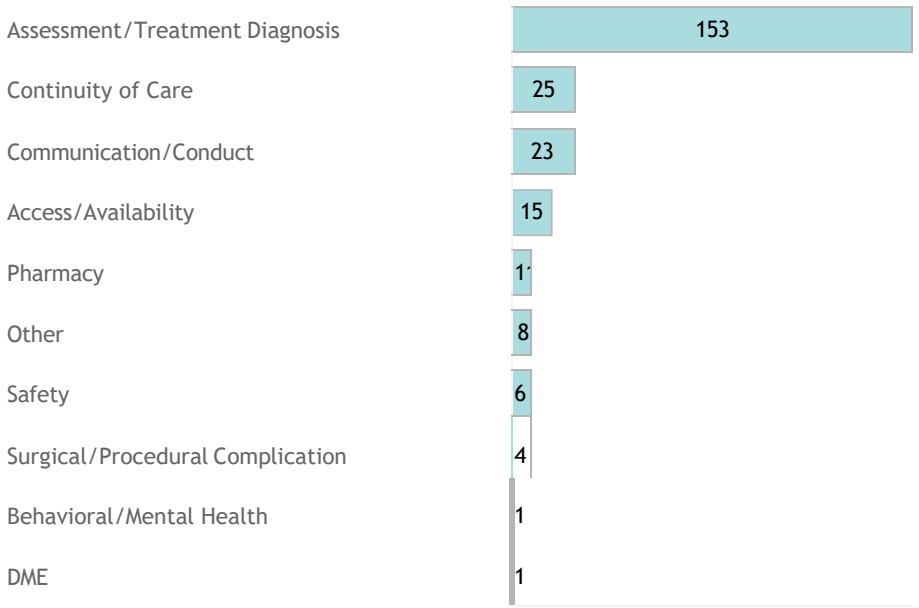
PQI Counts by Referral Source



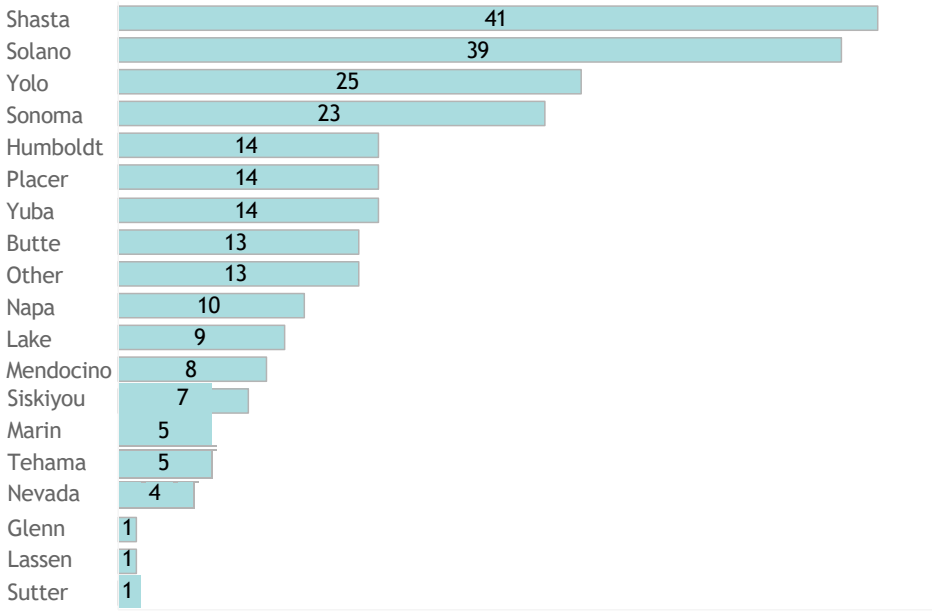
PQI Counts by Provider Type



PQI Counts by Referral Indicator



PQI Counts by Provider County



Created by: Liat Vaisenberg (lvaisenberg@partnershiphp.org)

Site Review Compliance Report - February 2025
Prepared By: Leah Imhoff, Project Manager
Presented by: Rachel Newman, RN, Manager of Clinical Compliance
Reporting Period: 1/1/2024 – 12/31/2024

Overview

A Site Review (SR) is comprised of a Facility Site Review (FSR) and a Medical Records Review (MRR) using tools developed by the California Department of Health Care Services (DHCS) and Managed Care Plans collectively. Contracted sites are reviewed as a condition of participation in our provider network and are conducted for credentialing and re-credentialing purposes.

There are two components of a Site Review:

Facility Site Review (FSR)

This is an assessment of the facility's physical site including the building, accessibility, equipment, and policies/procedures for all contracted sites at the time of initial contracting and up to every three years thereafter. This assessment is conducted by a registered nurse, who is a DHCS-certified site reviewer. The site review tool is used to determine compliance with the standards set by DHCS. The FSR portion looks at areas ranging from Access and Safety to Infection Control If any of the six domains fall below 80%, a Corrective Action Plan is required for the entire review.

1. Access/Safety
2. Personnel
3. Office Management
4. Clinical Services
5. Preventative Services
6. Infection Control

Medical Record Review (MRR)

This is a review of randomly selected medical records of members assigned to a practice site. This type of review is conducted three to six months after an initial FSR has been completed and is repeated up to every three years thereafter. The DHCS-approved tool and standards are used by the DHCS-certified site reviewer. The site can operate as usual during the review. An 80% overall score is required to pass. If any of the six domains fall below 80%, a Corrective Action Plan is required for the entire review.

1. Format
2. Documentation
3. Coordination of Care
4. Pediatric Preventive Care
5. Adult Preventive Care
6. OB/CPSP Preventive Care (if applicable)

Reviews are conducted in the following Regions

Eureka (Del Norte, Humboldt, Mendocino, Lake)
Redding (Siskiyou, Modoc, Trinity, Shasta, Lassen, Tehama)
Chico (Glenn, Butte, Yuba, Sutter, Colusa)
Fairfield (Napa, Solano, Yolo)
Auburn (Plumas, Sierra, Nevada, Placer)
Santa Rosa (Marin, Sonoma)

Site Review Compliance Report - February 2025
Prepared By: Leah Imhoff, Project Manager
Presented by: Rachel Newman, RN, Manager of Clinical Compliance
Reporting Period: 1/1/2024 – 12/31/2024

2024 Average FSR Scores by Region and County						
	Access & Safety	Personnel	Office Management	Clinical Services	Preventive Services	Infection Control
Auburn	96%	92%	97%	98%	97%	97%
Nevada	99%	87%	97%	96%	97%	96%
Sierra	*	*	*	*	*	*
Placer	98%	93%	96%	100%	96%	100%
Plumas	90%	98%	100%	96%	100%	93%
Chico	95%	89%	99%	98%	96%	98%
Butte	94%	93%	98%	99%	93%	99%
Glenn	92%	90%	99%	100%	96%	95%
Sutter	96%	87%	99%	98%	97%	98%
Colusa	*	*	*	*	*	*
Yuba	93%	95%	99%	97%	100%	98%
Eureka	96%	96%	100%	99%	99%	99%
Del Norte	99%	99%	100%	100%	100%	100%
Humboldt	95%	96%	100%	99%	99%	99%
Lake	97%	93%	100%	99%	98%	100%
Mendocino	95%	93%	100%	99%	100%	100%
Fairfield	95%	90%	98%	97%	98%	96%
Napa	94%	91%	98%	97%	99%	97%
Solano	94%	91%	98%	97%	97%	95%
Yolo	99%	87%	97%	97%	98%	97%
Redding	97%	95%	99%	98%	99%	97%
Lassen	97%	97%	96%	98%	99%	100%
Modoc	93%	94%	100%	98%	100%	96%
Shasta	97%	93%	99%	97%	99%	98%
Siskiyou	96%	97%	100%	98%	98%	95%
Tehama	98%	100%	100%	100%	100%	97%
Trinity	93%	96%	98%	98%	96%	89%
Santa Rosa	96%	95%	99%	99%	98%	98%
Marin	96%	96%	98%	98%	98%	99%
Sonoma	96%	93%	99%	99%	97%	98%
Grand Total:	96%	93%	99%	98%	98%	98%

*No reviews during the time period.

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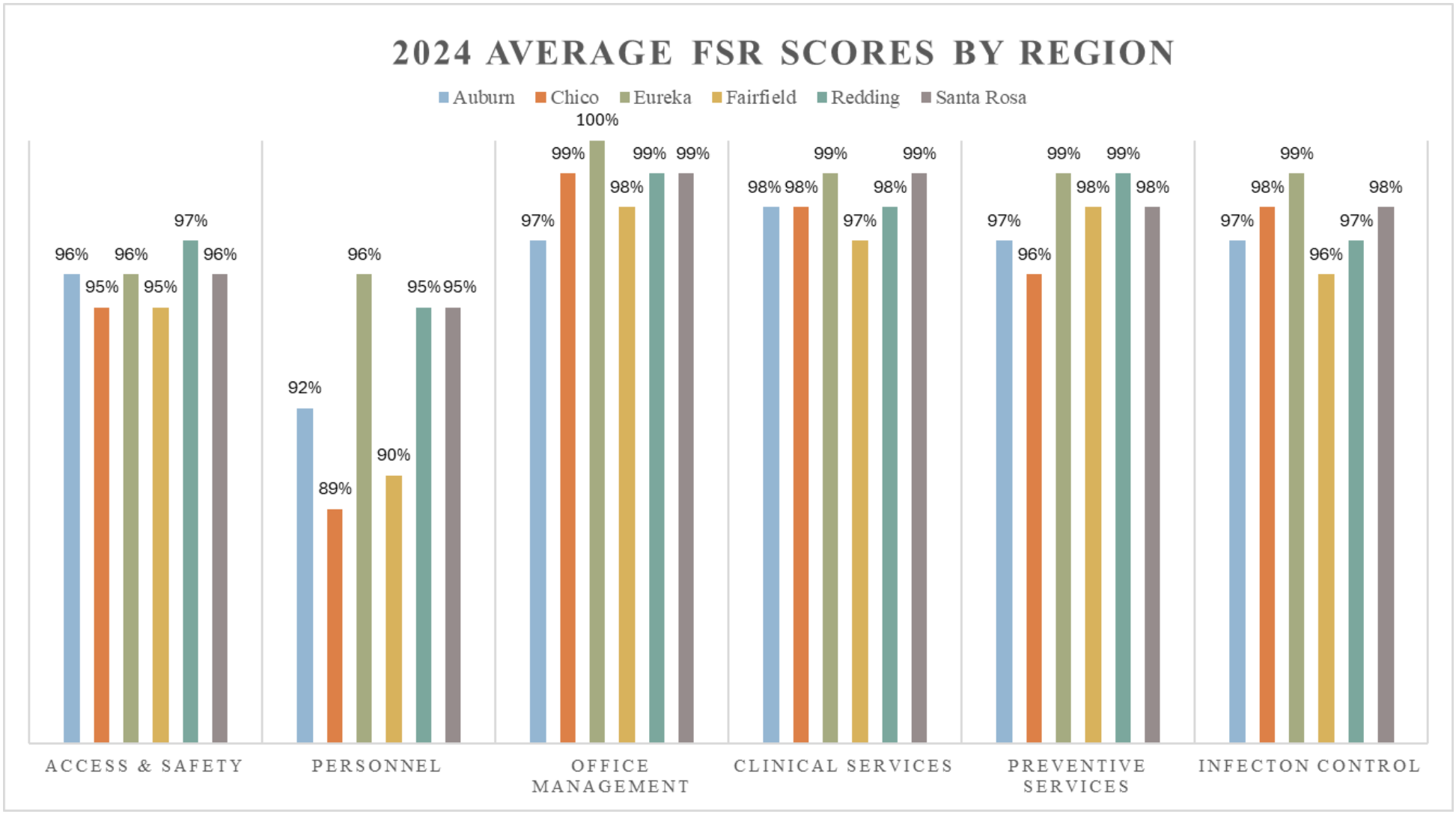

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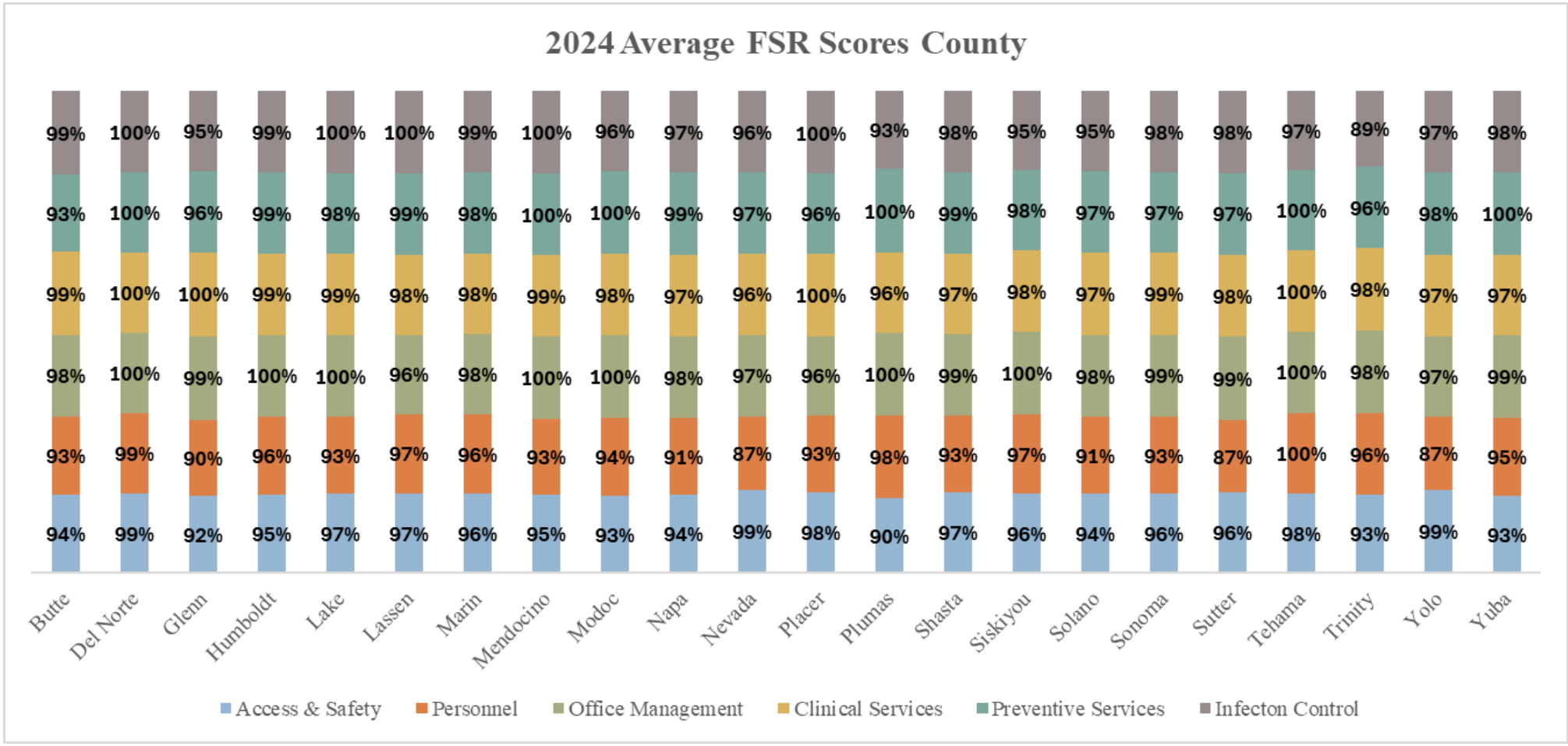

Site Review Compliance Report - February 2025
Prepared By: Leah Imhoff, Project Manager
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Reporting Period: 1/1/2024 – 12/31/2024

Year to Year Comparison of Average FSR Section Scores by Region						
	Auburn	**Chico**	**Eureka**	**Fairfield**	**Redding**	**Santa Rosa**
Number of Reviews						
2023	3	10	26	23	17	11
2024	9	27	30	31	41	29
Difference from 23-24	6	17	4	8	24	18
Access & Safety						
2023	97%	99%	95%	97%	96%	95%
2024	96%	95%	96%	95%	97%	96%
Difference from 23-24	-1%	-4%	1%	-2%	1%	1%
Personnel						
2023	96%	97%	96%	92%	90%	94%
2024	92%	89%	96%	90%	95%	95%
Difference from 23-24	-4%	**-8%**	0%	-2%	**5%**	1%
Office Management						
2023	100%	100%	98%	99%	96%	99%
2024	97%	99%	100%	98%	99%	99%
Difference from 23-24	-3%	-1%	2%	-1%	3%	0%
Clinical Services						
2023	99%	99%	96%	96%	96%	98%
2024	98%	98%	99%	97%	98%	99%
Difference from 23-24	-1%	-1%	3%	1%	2%	1%
Preventive Services						
2023	97%	100%	99%	99%	99%	99%
2024	97%	96%	99%	98%	99%	98%
Difference from 23-24	0%	-4%	0%	-1%	0%	-1%
Infection Control						
2023	100%	99%	99%	97%	97%	95%
2024	97%	98%	99%	96%	97%	98%
Difference from 23-24	-3%	-1%	0%	-1%	0%	3%

- ***Facility Site Review Opportunities for Improvement:***
  - All regions have opportunities for improvement in a couple different sections. The lowest scoring criteria weren't necessarily contained in one domain. Identified opportunities for improvement include: having a medication dosage chart, staff training in cultural and linguistics, staff training in disability rights and provider obligations, and having height adjustable eye charts. The majority of these items are new criteria that many providers are seeing for the first time.
  - The Chico region has an opportunity for improvement in the Personnel section: specifically, staff training on infection control/universal precautions and bloodborne pathogens exposure prevention, which are due annually. There also is an opportunity for improvement with staff training on disability rights and provider obligations, which are due at least once per hire (New Criteria).

Site Review Compliance Report - February 2025
Prepared By: Leah Imhoff, Project Manager
Presented by: Rachel Newman, RN, Manager of Clinical Compliance
Reporting Period: 1/1/2024 – 12/31/2024

2024 Average MRR Scores by Region and County						
	Format	Documentation	Coordination of Care	Pediatric Preventive	Adult Preventive	OB Care
Auburn	98%	95%	99%	81%	70%	*
Nevada	97%	94%	100%	82%	73%	*
Sierra	*	*	*	*	*	*
Placer	99%	93%	99%	85%	76%	*
Plumas	98%	100%	99%	69%	53%	*
Chico	97%	96%	98%	71%	72%	95%
Butte	97%	97%	93%	75%	67%	*
Glenn	99%	100%	100%	83%	82%	*
Sutter	96%	94%	99%	70%	69%	*
Colusa	*	*	*	*	*	*
Yuba	98%	95%	98%	65%	74%	95%
Eureka	98%	95%	98%	78%	75%	87%
Del Norte	99%	97%	98%	83%	81%	88%
Humboldt	98%	93%	98%	74%	72%	86%
Lake	99%	98%	98%	83%	78%	92%
Mendocino	93%	97%	96%	77%	77%	*
Fairfield	98%	94%	97%	82%	76%	89%
Napa	97%	97%	97%	84%	69%	*
Solano	98%	95%	97%	80%	75%	98%
Yolo	99%	92%	96%	82%	78%	88%
Redding	99%	93%	97%	78%	72%	85%
Lassen	100%	91%	98%	78%	74%	83%
Modoc	93%	96%	99%	80%	72%	*
Shasta	99%	93%	97%	79%	74%	87%
Siskiyou	99%	92%	94%	78%	71%	*
Tehama	98%	98%	100%	80%	79%	*
Trinity	99%	97%	95%	70%	62%	*
Santa Rosa	98%	92%	98%	83%	74%	94%
Marin	98%	94%	97%	73%	71%	*
Sonoma	99%	91%	98%	86%	76%	94%
Total Average:	98%	94%	97%	79%	74%	89%
* No records were reviewed during this time period.						

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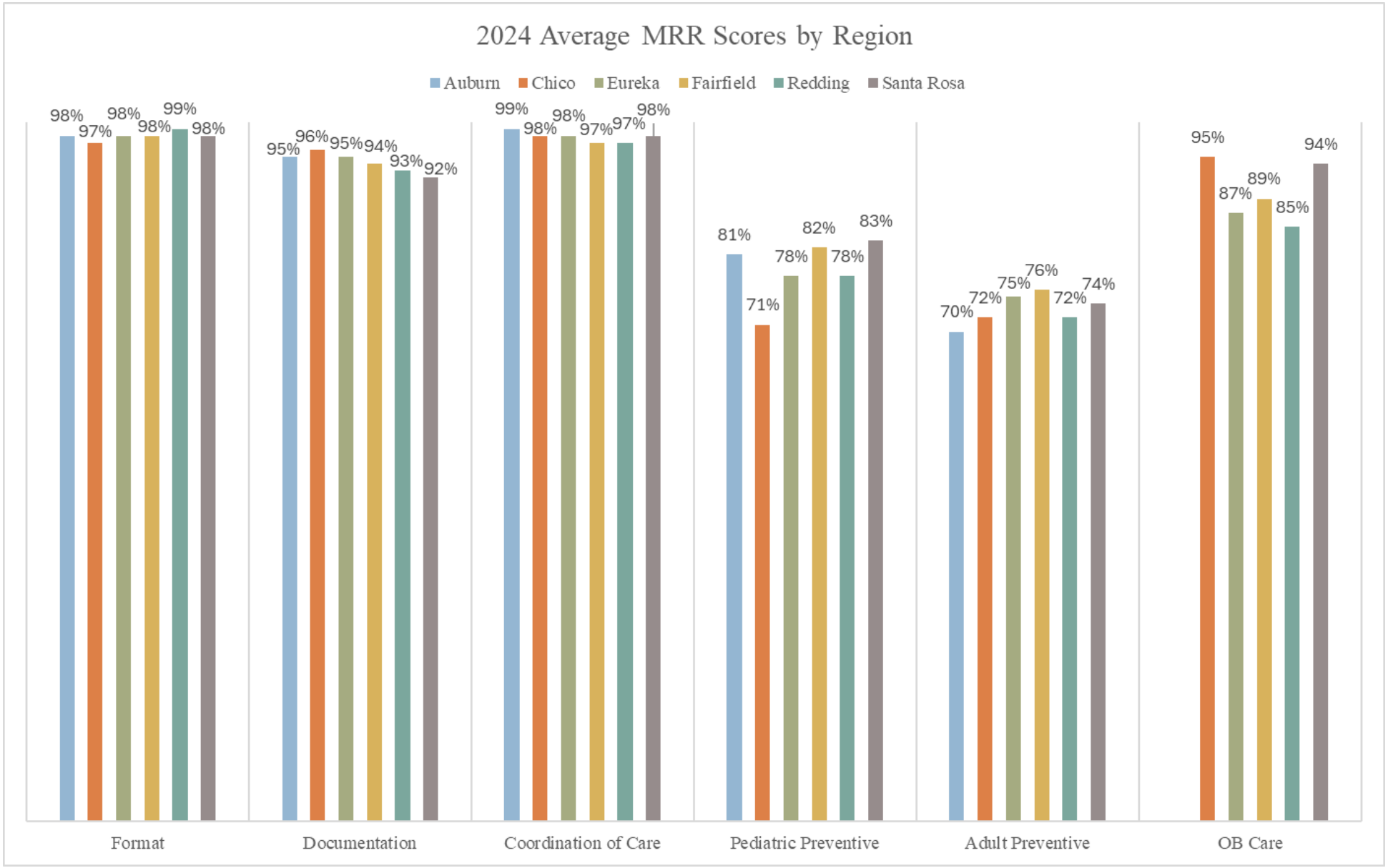

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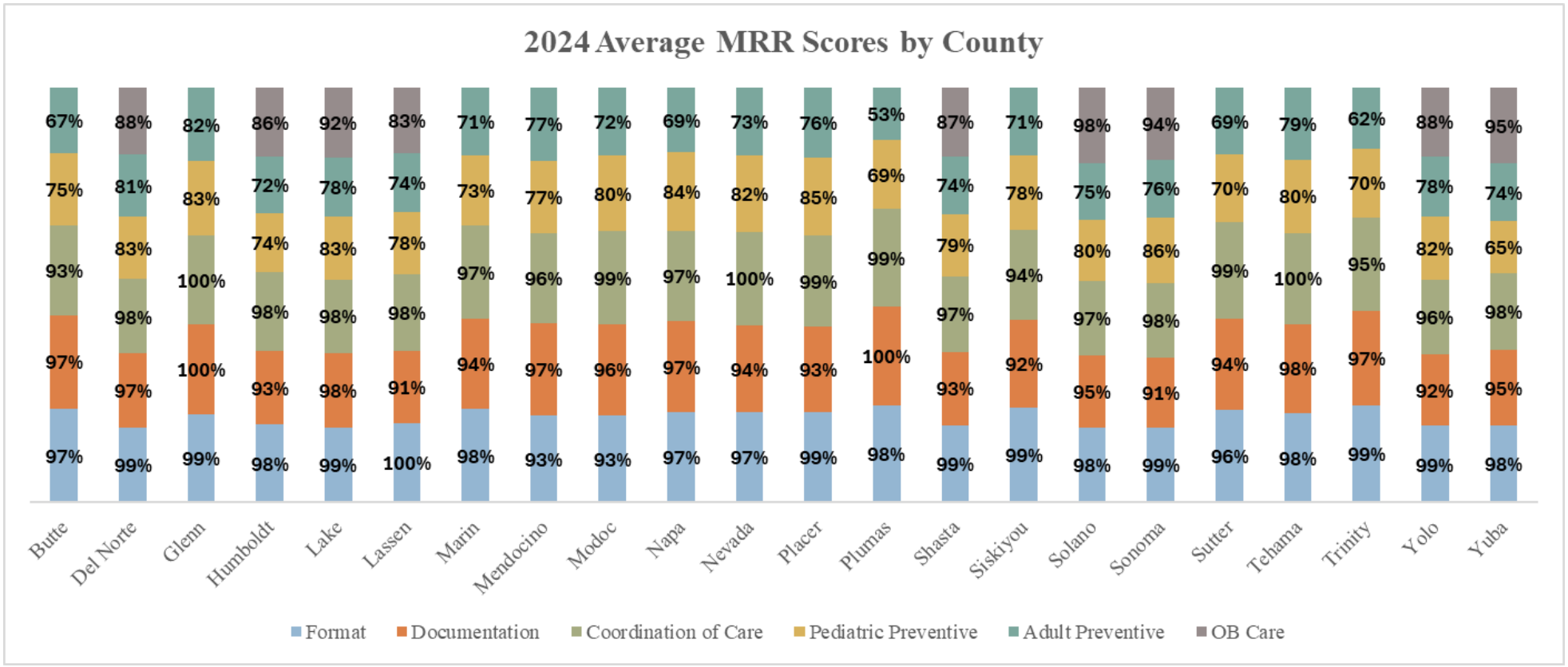

Year to Year Comparison of Average MRR Section Scores by Region						
	Auburn	**Chico**	**Eureka**	**Fairfield**	**Redding**	**Santa Rosa**
Number of Reviews						
2023	*	*	24	15	17	13
2024	12	26	28	31	31	23
Difference from 23-24	*	*	4	16	14	10
Format						
2023	*	*	99%	95%	98%	96%
2024	98%	97%	98%	98%	99%	98%
Difference from 23-24	*	*	-1%	3%	1%	2%
Documentation						
2023	*	*	92%	94%	93%	94%
2024	95%	96%	95%	94%	93%	92%
Difference from 23-24	*	*	3%	0%	0%	-2%
Coordination of Care						
2023	*	*	95%	96%	96%	97%
2024	99%	98%	98%	97%	97%	98%
Difference from 23-24	*	*	3%	1%	0%	1%
Pediatric Preventive						
2023	*	*	80%	88%	80%	86%
2024	81%	71%	78%	82%	78%	83%
Difference from 23-24	*	*	-3%	**-6%**	-2%	-3%
Adult Preventive						
2023	*	*	76%	78%	75%	78%
2024	70%	72%	75%	76%	72%	74%
Difference from 23-24	*	*	-2%	-2%	-3%	-4%
OB Preventive						
2023	*	*	*	97%	89%	*
2024	*	95%	87%	89%	85%	94%
Difference from 23-24	*	*	*	**-8%**	-4%	*
* No records were reviewed during this time period.						

- ***Medical Record Review Opportunities for Improvement:***
  - All regions have opportunities for improvement in Adult and Pediatric Preventive Health.
    - Since the release of the 2022 Site Review Tools, we have seen a decline in scores. The new tool includes many additions to adult and pediatric preventative sections. We are currently offering education to our providers on these new requirements.
    - With the addition of 10 new counties, which brings our total number to 24 counties, there are many opportunities for improvement within the site review standards. Partnership continues to offer extensive training provided by a Certified Site Review Nurse for all new site review criteria.

Continued Efforts and Upcoming Changes

- Monitor and report trended data to IQI and QUAC annually.
- Continually refining the logic for the Individual Health Appointment (IHA) report to ensure its accuracy and reliability.
- Educate sites during Site Review Exit Interview on the following:
  - IHA, including a 2-attempt tracker
  - Blood Lead Screening/Testing
  - Developmental Screening Tools (Prop 56/96110 Billing)
  - Billing Guide for Preventive Criteria
  - California Trainings
  - Including any other criteria that is needed to be reviewed
- Web-Ex Trainings on Preventive Criteria, Site Review, CHDP, and IHA upon request
- Focused Audits (23/24 FY Goal)
  - IHA
  - Blood Lead Screening/Testing
- Child Health and Disability Prevention Program (CHDP) training is in process with a live Web-Ex presentation or online via a recorded training.
- Work Plan (24/25 FY Goal)
  - Using the knowledge gleaned from the other QI teams' contacts with a PCP site, topics discussed will be reviewed with the site during the 1:1 time spent conducting the MRR to further drive quality improvements.
- Utilizing new Site Review Software (KSB)
  - Creates "Staff Writer," which consists of all Corrective Action Plan (CAP) criteria/standards for Sites deficiencies related to MRR. This allows the sites to better educate their staff.
  - Ability to create an FYI CAP to help educate sites on preventative standards.
- Virtual Medical Record Review
  - Virtual MRRs have proven a more efficient use of time with providers, per their feedback, and lessened risks of disagreement over deficiencies at the exit interview because the provider's staff was present during the entire MRR.
  - Virtual MRRs also provide a more tailored 1:1 educational opportunity with the site and less time spent onsite to complete the overall review.

Reporting Period: 01/01/2024-12/31/2024
Prepared by: Leah Imhoff, Program Manager I
Presented by: Rachel Newman, RN, Manager of Clinical Compliance

Physical Accessibility Review Survey (PARS) Report

A Physical Accessibility Review Survey is an assessment of how well members who are seniors or persons with disabilities (SPD) can navigate a practice site. Areas evaluated during this review include the parking lot, exterior building, interior building, restrooms, and exam rooms. Sites are assigned a designation of basic or limited accessibility based on the review findings. Partnership's Provider Directory is updated regularly for members to see which facilities meet their accessibility needs. Primary Care, OB, and High-Volume Specialty offices receive this review.

Provider sites are categorized into three types:

Level of Access / Domains:	**Definition**
Basic • Parking • Exterior Building • Interior Building • Restroom • Exam room	Facility met all 29 critical elements used to identify a sites capability of accommodating SPD members. *__All domains besides Medical Equipment are of a passing score.__
Limited • Missing one or more domains above	Demonstrates that the facility is deficient in one or more areas.
Medical Equipment • This is noted in addition to access level of Basic or Limited as appropriate.	PCP site has a height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus a patient). **This is noted in addition to level of Basic or Limited access as appropriate.

Reporting Period: 01/01/2024-12/31/2024
Prepared by: Leah Imhoff, Program Manager I
Presented by: Rachel Newman, RN, Manager of Clinical Compliance

Accessibility Level by Region/County

Access Level	Basic	Limited	Total
Auburn	6	5	11
Nevada	3	1	4
Placer	2	3	5
Plumas	1	1	2
Chico	5	23	28
Butte	NA	10	10
Glenn	2	2	4
Sutter	2	8	10
Yuba	1	3	4
Eureka	12	22	34
Del Norte	3		3
Humboldt	5	15	20
Lake	3	4	7
Mendocino	1	3	4
Fairfield	18	15	33
Napa	1	6	7
Solano	10	6	16
Yolo	7	3	10
Redding	20	18	38
Lassen	1	1	2
Modoc	1	1	2
Shasta	13	7	20
Siskiyou	4	4	8
Tehama	NA	4	4
Trinity	1	1	2
Santa Rosa	19	11	30
Marin	7	4	11
Sonoma	12	7	19
Grand Total	80	94	174

Out of Region Reviews

- There were 5 Physical Accessibility Reviews done in Sacramento and Alameda counties for continuity of care. (Not included on above chart)

Reporting Period: 01/01/2024-12/31/2024 Prepared
by: Leah Imhoff, Program Manager I
Presented by: Rachel Newman, RN, Manager of Clinical Quality and Patient Safety

Domain Level Accessibility by Region/County

	Parking			Exterior Building			Interior Building			Restroom			Exam Room			Med. Equip.		
	Deficient	Criteria Met	Avg % Passing	Deficient	Criteria Met	Avg % Passing	Deficient	Criteria Met	Avg % Passing	Deficient	Criteria Met	Avg % Passing	Deficient	Criteria Met	Avg % Passing	Deficient	Criteria Met	Avg % Passing
Auburn	1	10	91%	1	10	91%	2	9	82%	2	9	82%		11	100%	8	3	27%
Nevada	NA	4	100%	NA	4	100%	1	3	75%	NA	4	100%	NA	4	100%	4	NA	0%
Placer	NA	5	100%	1	4	80%	1	4	80%	1	4	80%	NA	5	100%	3	2	40%
Plumas	1	1	50%	NA	2	100%	NA	2	100%	1	1	50%	NA	2	100%	1	1	50%
Chico	5	23	82%	5	23	82%	5	23	82%	15	13	46%	3	25	89%	19	9	32%
Butte	NA	10	100%	1	9	90%	1	9	90%	8	2	20%	1	9	90%	8	2	20%
Glenn	1	3	75%	1	3	75%	NA	4	100%	2	2	50%	1	3	75%	3	1	25%
Sutter	2	8	80%	2	8	80%	3	7	70%	5	5	50%	1	9	90%	7	3	30%
Yuba	2	2	50%	1	3	75%	1	3	75%	NA	4	100%	NA	4	100%	1	3	75%
Eureka	9	25	74%	12	22	65%	10	24	71%	15	19	56%	2	32	94%	21	13	38%
Del Norte	NA	3	100%	NA	3	100%	NA	3	100%	NA	3	100%	NA	3	100%	1	2	67%
Humboldt	4	16	80%	9	11	55%	6	14	70%	10	10	50%	2	18	90%	14	6	30%
Lake	3	4	57%	2	5	71%	4	3	43%	2	5	71%	NA	7	100%	3	4	57%
Mendocino	2	2	50%	1	3	75%	NA	4	100%	3	1	25%	NA	4	100%	3	1	25%
Fairfield	4	29	88%	7	26	79%	9	24	73%	10	23	70%	1	32	97%	21	12	36%
Napa	1	6	86%	2	5	71%	4	3	43%	6	1	14%	1	6	86%	7	NA	0%
Solano	3	13	81%	2	14	88%	2	14	88%	3	13	81%	NA	16	100%	9	7	44%
Yolo	NA	10	100%	3	7	70%	3	7	70%	1	9	90%	NA	10	100%	5	5	50%
Redding	3	35	92%	8	30	79%	3	35	92%	14	24	63%		38	100%	29	9	24%
Lassen	1	1	50%	NA	2	100%	NA	2	100%	1	1	50%	NA	2	100%	2	NA	0%
Modoc	NA	2	100%	NA	2	100%	NA	2	100%	1	1	50%	NA	2	100%	2	NA	0%
Shasta	NA	20	100%	1	19	95%	2	18	90%	5	15	75%	NA	20	100%	13	7	35%
Siskiyou	1	7	88%	4	4	50%	NA	8	100%	4	4	50%	NA	8	100%	6	2	25%
Tehama	1	3	75%	2	2	50%	1	3	75%	2	2	50%	NA	4	100%	4	NA	0%
Trinity	NA	2	100%	1	1	50%	NA	2	100%	1	1	50%	NA	2	100%	2	NA	0%
Santa Rosa	3	27	90%	5	25	83%	6	24	80%	8	22	73%	4	26	87%	19	11	37%
Marin	3	8	73%	2	9	82%	3	8	73%	4	7	64%	2	9	82%	8	3	27%
Sonoma	NA	19	100%	3	16	84%	3	16	84%	4	15	79%	2	17	89%	11	8	42%
Grand Total	25	149	86%	38	136	78%	35	139	80%	64	110	63%	10	164	94%	117	57	33%

Reporting Period: 1/1/2023-12/31/2023
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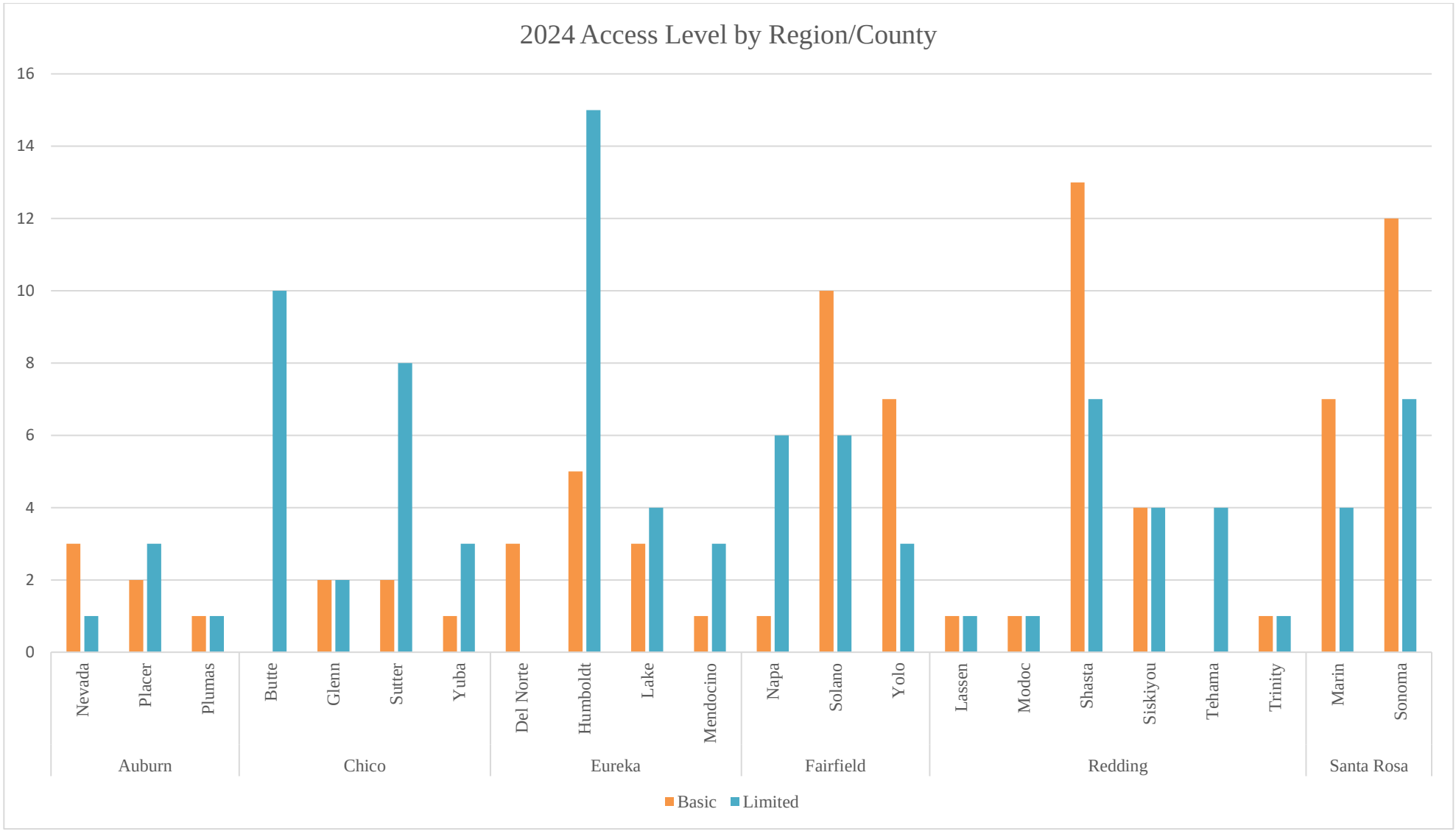

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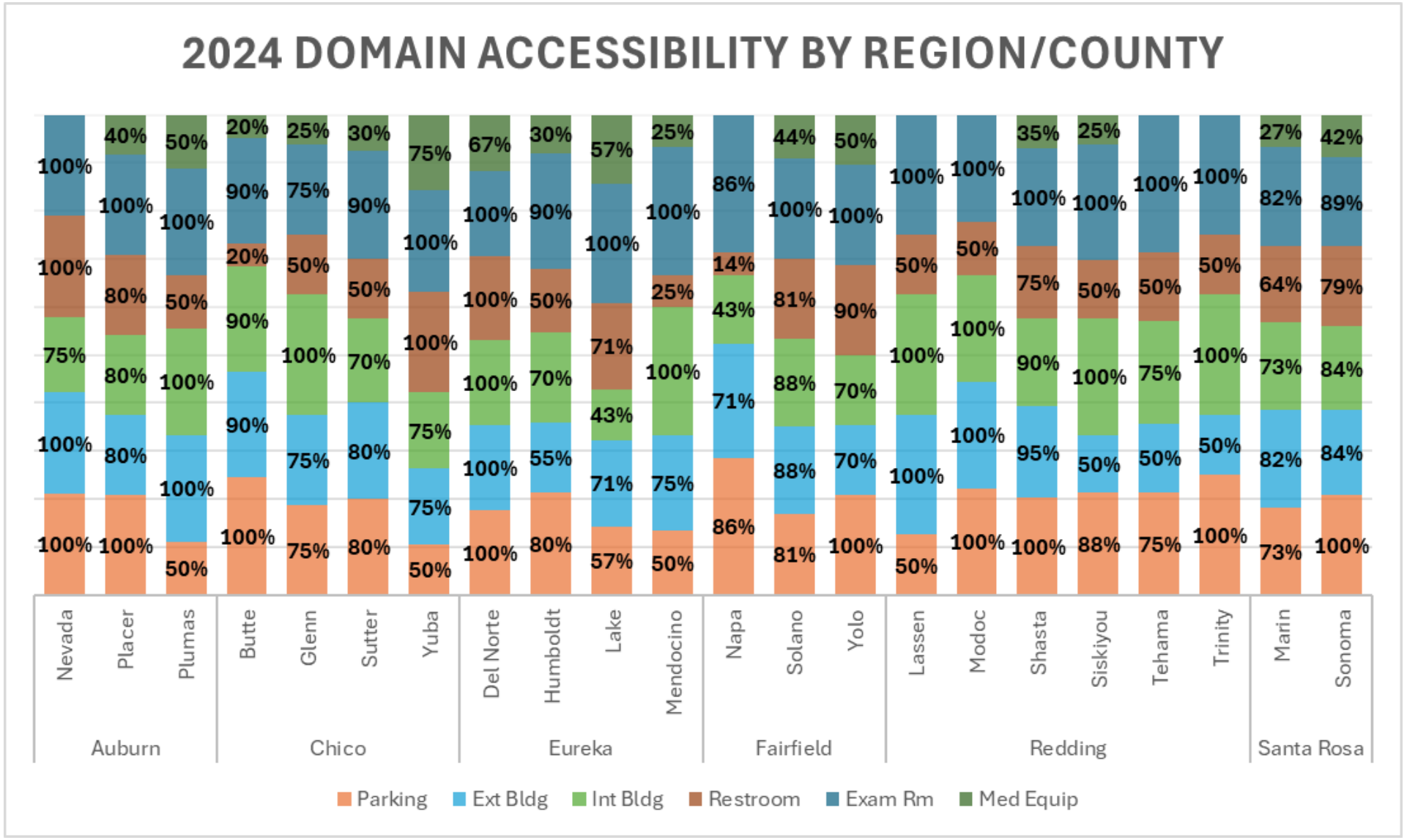

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D-SNP Model of Care

Dr. Kermit Jones Medical Director of Medicare Services

Kimberly Robertello, Ph.D. Sr. Medicare QI Program Manager

Overview of the Model of Care

Purpose and Requirements

What is the Model of Care (MOC)?

The MOC provides the basic framework under which the Special Needs Plan (SNP) will meet the needs of each of its enrollees. The MOC provides the foundation for promoting SNP quality, care management and care coordination processes.

NCQA reviews for approval each SNP's MOC based on standards and scoring criteria established by CMS.

NCQA MOC Guidance for CY2026

Scoring Clinical and Non-Clinical Elements

MOC 1: Description of the SNP population

MOC 2: Care coordination

MOC 3: SNP provider network

MOC 4: MOC quality measurement and performance improvement

Scoring

Sections — MOC1-4

Elements — 16 elements at 4 points each
64 possible TOTAL POINTS

Factors — Various numbers of factors within each element to address clinical and non-clinical requirements

A SNP is scored based on the percentage of points it receives out of the possible total.

3-year approval
85-100%
2-year approval
75-84%
1-year approval
70-74%

CMS outlines the requirements for a MOC.
NCQA is the agency which conducts the MOC scoring.

69% and under
Can do a "cure" and re-submit for no more than 1 year approval

DHCS MOC Requirements

All D-SNPs in California must have executed contracts with the Department of Health Care Services (DHCS). These contracts must meet several requirements including Medicare-Medicaid integration requirements. DHCS maintains the authority to contract or not contract with D-SNPs.

CalAIM D-SNP Policy Guide CY 2026

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Clinical and Non-Clinical Elements (MOC 1-4)

MOC 1: Description of the SNP population

- MOC 1 defines our expected Medicare D-SNP population with an emphasis on identifying our Most Vulnerable Population (MVP).
- Plans are tasked with describing how care will be delivered with special attention to providing care for the MVP.
- Plans are required to describe potential members and the MVP by age, gender, race, ethnicity and language spoken.

Member Risk Factors

County	Age > 65	5+ Co-morbid Conditions	% Non-English spoken at home	% Age 25+ Without High School Diploma	Poverty	% Homeless over 65 Years Old
Del Norte	5,619	29.7%	12.4%	20%	14.3%	3.4%
Humboldt	27,304	28.8%	44.4%	9.4%	19.8%	3.0%
Mendocino	22,654	23.3%	44.4%	13.3%	16.2%	2.5%
Lake	16,670	30.9%	14.1%	13.8%	12.3%	1.5%
Sonoma	62,745	34.0%	12.0%	10.9%	8.91%	1.1%
Napa	107,472	10.5%	33.9%	14.5%	7.89%	1.5%
Solano	80,908	17.0%	21.6%	11.3%	10.3%	1.1%
Marin	29,031	26.1%	33.9%	14.0%	6.9%	3.1%

MOC 2: Care Coordination

- The Care Coordination section focuses on specific CMS and DHCS care requirements. These requirements include:
  - Health Risk Assessment (HRA)
  - Individualized Care Plan (ICP)
  - Interdisciplinary Care Team (ICT)
- All D-SNP members are required to receive case management services and will be risk-stratified.

MOC 3: SNP Provider Network

- MOC 3 describes our proposed network in the eight-county region.
- Plans are required to describe network adequacy to ensure members, and most importantly the MVP, can receive the care and services which are needed.
- This includes an adequate number of primary care physicians and a broad representation of specialty care throughout the region.
- Care should most importantly be accessible.

MOC 4: MOC Quality Measurement and Performance Improvement

- MOC 4 defines how the D-SNP will track performance, guide improvement efforts, document progress and share information with stakeholders.
- To best evaluate quality care, Partnership has identified five areas of focus for the D-SNP population:
    - Improvements in care coordination and delivery of services through direct alignment of the HRAT, ICP and ICT
    - Ensuring access for the defined D-SNP population
    - Enhancing care transitions
    - Ensuring appropriate utilization of services for preventative health and chronic conditions
    - And improving member engagement

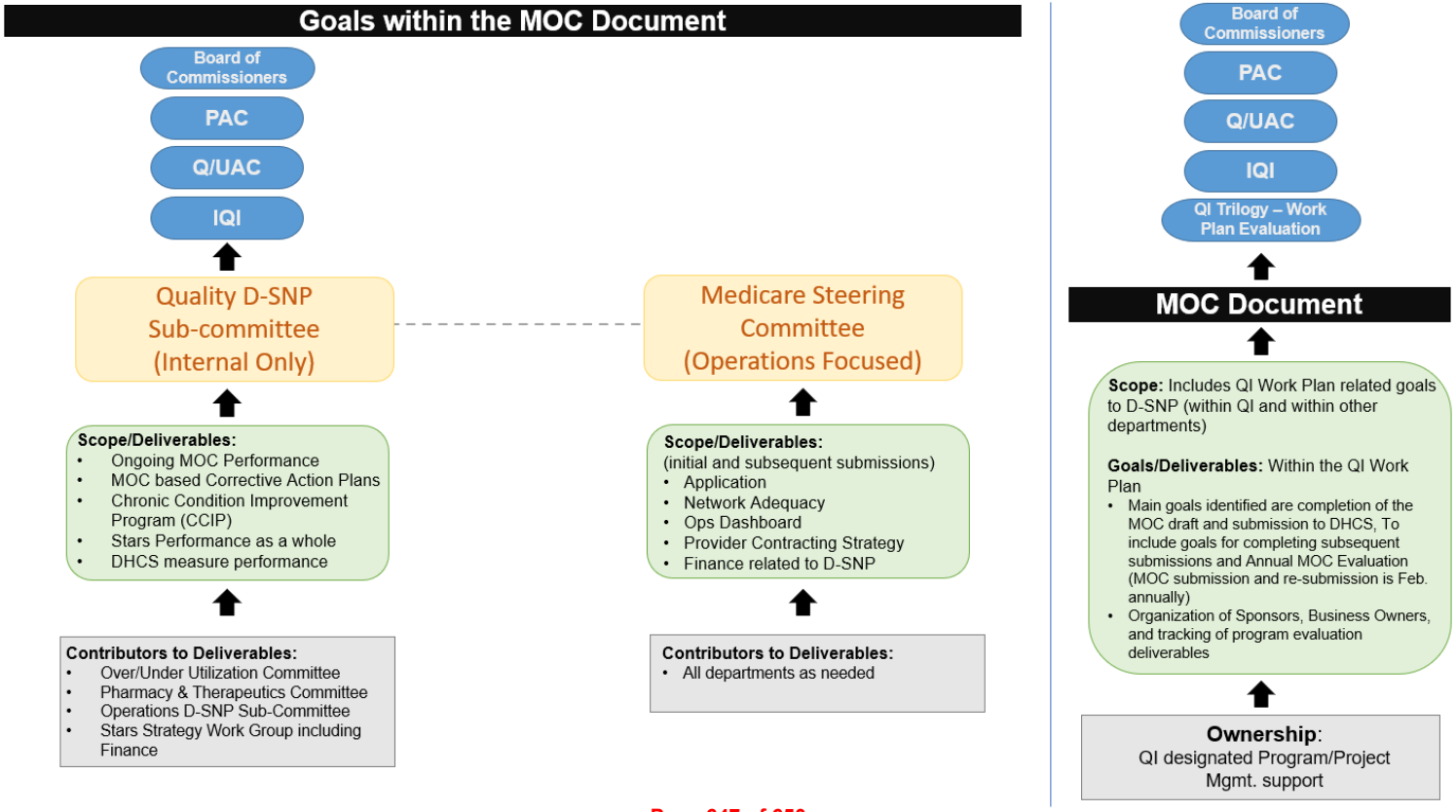
Quality Reporting

Partnership has identified nine performance metrics which will provide a measure of the five areas of focus:

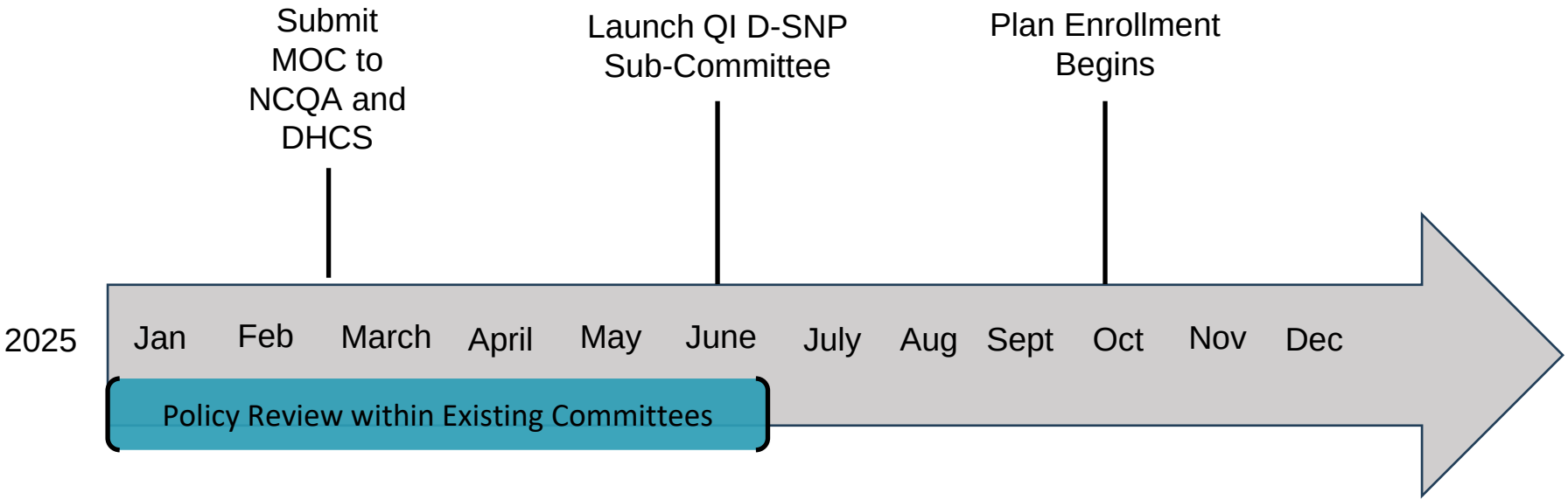
- Health risk assessment completion
- ICP completion
- ICT completion
- Member access preventative/ambulatory health services at least once per year
- Diabetes care – Blood sugar controlled
- Controlling high blood pressure
- Statin therapy for patients with cardiovascular disease
- Medication adherence – cholesterol
- Transitions of care – patient engagement post-discharge

MOC Oversight and Next Steps

MOC Reporting and Oversight



Important Dates



Next Steps

- Launch new D-SNP focused committee meetings and workgroups
- Build infrastructure to support D-SNP efforts throughout the organization for program launch in 2026
- Integrate D-SNP work into Medi-cal functions as able

Questions?

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