Facility Site and Medical Record Review Preparation Checklist

California | Medi-Cal Managed Care

Anthem Blue Cross (Anthem) providers are requested to use this *Facility Site Review (FSR) and Medical Record Review (MRR) Preparation Checklist* to conduct an internal review of your practice to determine readiness for your upcoming FSR and/or MRR survey. You may reference the most current *California Department of Health Care Services (DHCS) Site Review and MRR Survey Standards*, the American Academy of Pediatrics (AAP), the U.S. Preventive Services Task Force (USPSTF), and other governing entity website links and health plan resources provided as embedded links (in blue) in the checklist below for more information. Reviewing the standards in the checklist (including directions/instructions, rules, regulation parameters, and/or indicators) prior to the FSR and MRR may improve and expedite the survey experience. Not all standards will be applicable to your location.

All new DHCS criteria are underlined. **All critical element criteria** are ***bolded and italicized***. Critical elements are related to potential adverse effects on patient health or safety and have a weighted score of two points. Each critical element found deficient during a full scope site survey, focused survey or monitoring visit shall be corrected by the provider within 10 business days from the survey date. All other criteria have a weighted score of one point and shall be corrected by the provider within 30 calendar days from the survey report date.

Please mark each criterion as "Yes" if your site complies with the requirement, or as "No" if your site does not comply. For each criteria marked as "No", you are encouraged to begin corrective actions prior to your actual survey. Before or at the start of your site visit, it would be useful for you to contact/inform your reviewer to discuss any non-compliant criteria.

We appreciate your cooperation and partnership in completing a successful review.

Facility Site Review				
Access/Safety		**Yes**	**No**	**Comments:**
1.	Clearly marked (blue) curb or sign designating disabled-parking space near accessible primary entrance			
2.	Pedestrian ramps have a level landing that is at least 5 feet long at the top and bottom of the ramp			
3.	Exit and exam room doorway openings allow for clear passage of a person in a wheelchair			
4.	Accessible passenger elevator or reasonable alternative for multilevel floor accommodation			
5.	Clear floor space for wheelchair in waiting area and exam room			
6.	Wheelchair accessible restroom facilities			
7.	Wheelchair accessible handwashing facilities or reasonable alternative			
8.	All patient areas including floor/carpet, walls and furniture are neat, clean, and well-maintained			

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Facility Site Review				
Access/Safety		**Yes**	**No**	**Comments:**
9.	Restrooms are clean and contain appropriate sanitary supplies			
10.	There is evidence that site staff has received safety training and knows where to locate established Clinic Policies and Procedures on the following: a. Fire safety and prevention b. Emergency nonmedical procedures (e.g., earthquake/disaster, site evacuation, workplace violence)			
11.	Lighting is adequate in all areas to ensure safety			
12.	***Exit doors and aisles are unobstructed and egress (escape) accessible*** https://www.osha.gov/lawsregs/regulations/standardnumber/1910/1910.37			
13.	Exit doors are clearly marked with Exit signs			
14.	Clearly diagramed Evacuation Routes for emergencies are posted in a visible location at all elevators, stairs, and exits			
15.	Electrical cords and outlets are in good working condition			
16.	Fire-fighting equipment in accessible location https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.157			
17.	An employee alert system utilized on site with back-up method to warn employees of a fire or other emergency shall be documented. For sites with 10 or fewer employees, direct verbal communication is acceptable and does not need a back-up system https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.37			
18.	Personnel are trained in procedures/action plan to be carried out in case of a medical emergency on site. There is evidence that site staff has received training and knows where to locate established Clinic Policies and Procedures.			
19.	Emergency equipment is stored together in easily accessible location and is ready to be used			
20.	Emergency phone number contact list is posted, dated, updated annually and as changes occur, and includes local emergency services (e.g., 911 for fire, police/sheriff, ambulance), emergency contacts (e.g., responsible managers/supervisors), and appropriate state, county, city, and local agencies (e.g., local poison control)			
21.	***Airway management equipment with sizes appropriate for patient population: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag***			
22.	***Emergency medicine for anaphylactic reaction management, opioid overdose, asthma, chest pain, and hypoglycemia: Epinephrine 1:1000 (injectable), and Benadryl 25 mg (oral) or Benadryl 50 mg/ml***			

Facility Site Review				
Access/Safety		**Yes**	**No**	**Comments:**
	(injectable), Naloxone, chewable Aspirin 81 mg (at least four tablets), nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), glucose containing at least 15 grams, appropriate sizes of ESIP needles/syringes and alcohol wipes https://www.aafp.org/afp/2007/0601/p1679.html			
23.	Medication dosage chart for all medications included with emergency equipment (or other method for determining dosage) is kept with emergency medications			
24.	There is a process in place on site to document checking of emergency equipment/supplies for expiration and operating status at least monthly			
25.	There is a process in place on site to replace/re-stock emergency medication, equipment and supplies immediately after use			
26.	Medical equipment is clean			
27.	Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines			

Personnel		**Yes**	**No**	**Comments:**
1.	All required professional licenses and certifications issued from the appropriate licensing/certification agency are current			
2.	Notification that includes a QR code is provided to each member that the Medical Doctor(s) (MD) is/are licensed and regulated by the Medical Board, and that the Physician Assistant(s) is/are licensed and regulated by the Physician Assistant Committee — www.mbc.ca.gov and http://www.pab.ca.gov			
3.	Healthcare personnel wear identification badges/tags printed with name and title			
4.	Documentation of education/training for non-licensed medical personnel is maintained on site. 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 BMI %), and dental screening/fluoride varnish application. https://www.dhcs.ca.gov/services/chdp/Pages/Training.aspx			
5.	***Only qualified/trained personnel retrieve, prepare, or administer medications*** https://www.mbc.ca.gov/Licensing/Physicians-and-Surgeons/Practice-Information/Medical-Assistants.aspx			
6.	Site has a procedure in place for confirming correct patient, medication/vaccine, dosage, and route prior to administration			
7.	Only qualified/trained personnel operate medical equipment			

Personnel		Yes	No	Comments:
	https://www.mbc.ca.gov/Download/Newsletters/newsletter-2015-10.pdf			
8.	Scope of practice for non-physician medical practitioners (NPMPs) is clearly defined including the delegation of the supervision of Medical Assistants when supervising physician is off premises: a. Standardized procedures provided for nurse practitioners (NPs) and/or certified nurse midwives (CNMs) https://www.rn.ca.gov/pdfs/regulations/npr-b-03.pdf https://www.rn.ca.gov/pdfs/regulations/npr-b-20.pdf b. A Practice Agreement defines the scope of services provided by physician assistants (PAs) and supervisory guidelines define the method of supervision by the supervising physician http://www.pab.ca.gov https://www.pab.ca.gov/forms_pubs/sb697faqs.pdf c. 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. Frequency of review to identify changes in scope of service shall be specified in writing. d. Each NPMP that prescribes controlled substances has a valid DEA registration number.			
9.	NPMPs are supervised according to established standards: a. The ratio of supervising physician to the number of NPMPs does not exceed established ratios in any combination at any given time/shift in any of the locations: • 1:4 NPs • 1:4 CNMs • 1:4 PAs (per shift in any given location) b. 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 c. There is evidence of NPMP supervision.			
10.	There is evidence that site staff has received training and knows where to locate established Clinic Policies and Procedures on the following: a. Infection Control/Universal Precautions (annually) b. Bloodborne Pathogens Exposure Prevention (annually) c. Biohazardous Waste Handling (annually) d. Patient Confidentiality e. Informed Consent, including Human Sterilization f. Prior Authorization Requests g. Grievance/Complaint Procedure h. Child/Elder/Domestic Violence Abuse i. Sensitive Services/Minors' Rights j. Health Plan Referral Process/Procedures/Resources k. Cultural and Linguistics https://www.health.pa.gov/topics/Documents/Health%20Equity/CLAS%20Standards%20FactSheet.pdf l. Disability Rights and Provider Obligations: a. Post notice of consumers civil rights;			

Personnel		Yes	No	Comments:
	b. For sites with 15 or more employees, have civil rights grievance procedure and an employee designated to coordinate compliance; and c. Information on physical access and reasonable accommodations https://www.hhs.gov/sites/default/files/ocr/civilrights/resources/factsheets/504.pdf https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html#General%20Questions https://www.hhs.gov/civil-rights/for-individuals/section-1557/fs-limited-english-proficiency/index.html https://www.ecfr.gov/search Notice of Nondiscrimination (sample)			

Office Management		Yes	No	Comments:
1.	Clinic office hours are posted or readily available upon request			
2.	Provider office hour schedules are available to staff			
3.	Arrangement/schedule for after-hours, on-call, supervisory back-up physician coverage is available to site staff and members			
4.	Contact information for off-site physician(s) is available at all times during office hours			
5.	Routine, urgent, and after-hours emergency care instructions/telephone information is made available to patients			
6.	Appropriate personnel handle emergent, urgent, and medical advice telephone calls			
7.	Telephone answering machine, voice mail system or answering service is used whenever office staff does not directly answer phone calls			
8.	Telephone system, answering service, recorded telephone information, and recording device are periodically checked and updated			
9.	Appointments are scheduled according to patients' stated clinical needs within the timeliness standards established for plan members			
10.	Patients are notified of scheduled routine and/or preventive screening appointments			
11.	There is a process in place verifying follow-up on missed and canceled appointments			
12.	Interpreter services are made available 24 hours in identified threshold languages specified for location of site https://www.federalregister.gov/documents/2003/08/08/03-20179/guidance-to-federal-financial-assistance-recipients-regarding-title-vi-prohibition-against-national			
13.	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			

Office Management		Yes	No	Comments:
	interpretation performance skills/capabilities. A written policy shall be in place.			
14.	Office practice procedures allow timely provision and tracking of: a. Processing internal and external referrals, consultant reports, and diagnostic test results. **b. *Physician review and follow-up of referral/consultation reports and diagnostic test results.***			
15.	Phone number(s) for filing grievances/complaints are located on site			
16.	Complaint forms and a copy of the grievance procedure are available onsite.			
17.	Medical records are readily retrievable for scheduled patient encounters.			
18.	Medical documents are filed in a timely manner to ensure availability for patient encounters.			
19.	Exam rooms and dressing areas safeguard patients' right to privacy.			
20.	Procedures are followed to maintain the confidentiality of personal patient information (sign-in sheets with only one patient identifier, signed confidentiality agreement from after-hours cleaning crew, etc.).			
21.	Medical record release procedures are compliant with state and federal guidelines.			
22.	Storage and transmittal of medical records preserves confidentiality and security.			
23.	Medical records are retained for a minimum of 10 years for both adults and pediatric medical records.			

Clinical Services		Yes	No	Comments:
1.	Drugs are stored in specifically designated cupboards, cabinets, closets, or drawers			
2.	Prescription, drug samples, over-the-counter drugs, hypodermic needles/syringes, all medical sharp instruments, hazardous substances (disinfectant solutions/wipes), and prescription pads are securely stored in a lockable space (cabinet or room) within the office/clinic			
3.	Controlled drugs are stored in a locked cabinet accessible only to authorized personnel.			
4.	A dose-by-dose controlled substance distribution log is maintained.			
5.	Written site-specific policy/procedure for dispensing of sample drugs are available on site. (A list of dispensed and administered medications shall be present on site).			
6.	Drugs are prepared in a clean area or designated clean area if prepared in a multipurpose room.			
7.	Drugs for external use are stored separately from drugs for internal use.			

Clinical Services		Yes	No	Comments:
8.	Items other than medications in refrigerator/freezer are kept in a secured, separate compartment from drugs.			
9.	Refrigerator thermometer temperature is 36° to 46° Fahrenheit or 2° to 8° Centigrade (at time of site visit).			
10.	Freezer thermometer temperature is 5° Fahrenheit, or -15° Centigrade or lower (at time of site visit).			
11.	Site utilizes drugs/vaccine storage units that are able to maintain required temperature. https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/storage.html https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf https://www.fda.gov/vaccines-blood-biologics/vaccines/questions-about-vaccines www.cdc.gov/vaccines			
12.	Daily temperature readings of drugs/vaccines refrigerator and freezer are documented. CDC recommends use of a continuous temperature monitoring device or digital data loggers (DDLs). Back-up DDL(s) for each transport storage unit shall be readily available for emergency vaccine transport or when primary DDL(s) is sent in for calibration.			
13.	Has a written plan for vaccine protection in case of power outage or malfunction of the refrigerator or freezer http://eziz.org/assets/docs/IMM-1122.pdf			
14.	Drugs and vaccines are stored separately from test reagents, germicides, disinfectants, and other household substances.			
15.	Hazardous substances are appropriately labeled			
16.	Site has method(s) in place for drug and hazardous substance disposal			
17.	There are no expired drugs on site.			
18.	Site has a procedure to check expiration date of all drugs (including vaccines and samples), and infant and therapeutic formulas			
19.	All stored and dispensed prescription drugs are appropriately labeled			
20.	***Only lawfully authorized persons dispense drugs to patients***			
21.	***Drugs and vaccines are prepared and drawn only prior to administration***			
22.	Current *Vaccine Information Sheets (VIS)* for distribution to patients are present on site. http://www.cdc.gov/vaccines/pubs/vis/default.htm http://www.eziz.org			
23.	If there is a pharmacy on site, it is licensed by the California State Board of Pharmacy			
24.	Site utilizes California Immunization Registry (CAIR) or most current version			

Clinical Services		Yes	No	Comments:
	Immunization requirements			

25.	Laboratory test procedures are performed according to current site-specific CLIA certificate https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html https://www.cms.gov or https://www.fda.gov			
26.	Testing personnel performing clinical lab procedures have been trained			
27.	Lab supplies (vacutainers, vacutainer tubes, culture swabs, test solutions) are inaccessible to unauthorized persons.			
28.	Lab test supplies are not expired.			
29.	Site has a procedure to check expiration date and a method to dispose of expired lab test supplies.			
30.	Site has current California Radiologic Health Branch Inspection Report (in the last 5 years) and proof of registration if there is radiological equipment on site https://www.cdph.ca.gov/rhb			
31.	The following documents are posted on site: a. Current copy of *Title 17* with a posted notice about availability of *Title 17* and its location b. Radiation Safety Operating Procedures posted in highly visible location c. Notice to Employees Poster posted in highly visible location d. Caution, X-ray sign posted on or next to door of each room that has X-ray equipment e. Physician supervisor/operator certificate posted and within current expiration date f. Technologist certificate posted and within current expiration date			
32.	The following radiological protective equipment is present on site: a. Operator protection devices: radiological equipment operator must use lead apron or lead shield b. Gonadal shield (0.5 mm or greater lead equivalent): for patient procedures in which gonads are in direct beam			

Preventive Services		Yes	No	Comments:
1.	Examination equipment appropriate for primary care services is available on site.			
2.	Exam tables and lights are in good repair.			
3.	Stethoscope and sphygmomanometer with various size cuffs appropriate for patient population served (e.g., neonatal, infant, small, regular, large, and thigh sizes)			
4.	Thermometer with a numeric reading			

Preventive Services		Yes	No	Comments:
5.	Basic exam equipment appropriate for patient population served: percussion hammer, tongue blades, patient gowns			
6.	Scales: standing balance beam and infant scales			
7.	Measuring devices for stature (height/length) measurement and head circumference measurement			
8.	Eye charts (literate and illiterate) and occluder for vision testing are available on site. 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. According to AAP, effective occlusion, such as with tape or an occlusive patch of the eye not being tested, is important to eliminate the possibility of peeking. If patches are not available or tolerated, acceptable occluders include a specially designed occlusion glasses, and for patients 10 years and older, a hand-held flip paddle occluder is acceptable. Small (Dixie) drinking cups, unless held in place over the eye by an adult other than the one being screened to prevent peeking, are not acceptable. The AAP recommended eye charts are as follows: • LEA symbols (children 3 to 5 years old) • HOTV chart (children 3 to 5 years old) • Sloan letters (preferred) or Snellen letters (children over 5 years old and adults)			
9.	Ophthalmoscope			
10.	Otoscope with adult and pediatric ear speculums			
11.	A pure tone, air conduction audiometer is in a quiet location for testing.			
12.	Health education materials and plan-specific resource information are: a. Readily accessible on site or are made available upon request b. Applicable to the practice and population served on site c. Available in threshold languages identified for county and/or area of site location			

Infection Control		Yes	No	Comments:
1.	Soap or antiseptic hand cleaner and running water are available in exam and/or treatment areas for hand washing.			
2.	A waste disposal container is available in exam rooms, procedure/treatment rooms, and restrooms.			
3.	Site has procedure for effectively isolating infectious patients with potential communicable conditions.			

Infection Control		Yes	No	Comments:
	https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html			
4.	***Personal protective equipment for standard precautions is readily available for staff use (e.g., gloves, water-repelling gowns, face/eye protection including goggles/face shields and masks)***			
5.	***Blood, other potentially infectious materials, and regulated wastes are placed in appropriate leak-proof, labeled containers for collection, handling, processing, storage, transport, or shipping.*** https://www.cdph.ca.gov/Programs/CEH/DRSEM/Pages/EMB/MedicalWaste/MedicalWaste.aspx https://www.cdph.ca.gov (Medical Waste Management Act)			
6.	***Needle-stick safety precautions are practiced on site. (Only safety needles and wall-mounted/secured sharps containers are used on site; Sharps containers are not overfilled; etc.)***			
7.	All sharp injury incidents are documented. https://www.cdc.gov/sharpssafety/pdf/appendixa-7.pdf			
8.	Contaminated laundry is laundered at the workplace or by a commercial laundry service.			
9.	Biohazardous (non-sharp) wastes are contained separate from other trash/waste.			
10.	Storage areas for regulated medical wastes are maintained secure and inaccessible to unauthorized persons.			
11.	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).			
12.	Equipment and work surfaces are appropriately cleaned and decontaminated after contact with blood or other potentially infectious material.			
13.	Routine cleaning and decontamination of equipment/work surfaces is completed according to site-specific written schedule.			
14.	Disinfectant solutions used on site: a. Are approved by the Environmental Protection Agency (EPA). b. Are effective in killing HIV/HBV/TB. c. Follow manufacturer instructions.			
15.	Written site-specific policy/procedures or manufacturer's instructions for instrument/equipment sterilization are available to staff.			
16.	Staff adheres to site-specific policy and/or manufacturer/product label directions for the following procedures: a. Cleaning reusable instruments/equipment prior to sterilization			
17.	Cold chemical sterilization/high level disinfection: a. Confirmation from manufacturer item(s) is/are heat-sensitive **b. *Staff demonstration /verbalize necessary steps/process to ensure sterility and/or high-level disinfection ensure sterility of equipment***			

Infection Control		Yes	No	Comments:
	c. ***Appropriate PPE is available, exposure control plan and clean up instructions in the event of a cold chemical sterilant spill — solution's MSDS shall be available on site*** https://oshareview.com/2013/10/cdc-guidelines-sterilizing-heat-sensitive-dental-instruments-dental-infection-control/ https://www.cdc.gov/infectioncontrol/guidelines/disinfection/sterilization/index.html			
18.	Autoclave/steam sterilization: a. Staff demonstration/verbalize necessary steps/process to ensure sterility Documentation of sterilization loads include date, time, and duration of run cycle, temperature, steam pressure, and operator of each run. b. Autoclave maintenance per manufacturer's guidelines **c. *Spore testing of autoclave/steam sterilizer with documented results (at least monthly)*** **d. *Management of positive mechanical, chemical, and/or biological indicators of the sterilization process*** https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html https://www.cdc.gov/infectioncontrol/guidelines/disinfection/sterilization/sterilizing-practices.html			
19.	Sterilized packages are labeled with sterilization date and load identification information			
20.	Storage areas for sterilized packages are clean, dry, and separated from non-sterile items by a functional barrier. Site has a process for routine evaluation of sterilized packages.			

Medical Record Review				
Format		**Yes**	**No**	**Comments:**
1.	Member identification is on each page. https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html			
2.	Individual personal biographical information is documented.			
3.	Emergency contact is identified; minor's primary emergency contact must be parent/legal guardian.			
4.	Medical records on-site are maintained and organized.			
5.	Member's assigned and/or rendering primary care physician (PCP) is identified.			
6.	Primary language and linguistic service needs of non- or limited-English proficient (LEP), or hearing/speech-impaired persons are prominently noted. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-011.pdf			
7.	Person or entity providing medical interpretation is identified.			

	https://www.federalregister.gov/documents/2003/08/08/03-20179/guidance-to-federal-financial-assistance-recipients-regarding-title-vi-prohibition-against-national			
8.	Signed copy of the Notice of Privacy https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/permitted-uses/index.html https://providers.anthem.com/docs/gpp/CA_MMP_NoticePrivacyForm.pdf?v=202111301527			

Documentation		**Yes**	**No**	**Comments:**
1.	Allergies are prominently noted.			
2.	Chronic problems and/or significant conditions are listed.			
3.	Current continuous medications are listed.			
4.	Appropriate consents are present: a. Release of medical records b. Informed consent for invasive procedures			
5.	Advanced Health Care Directive information is offered (reviewed at least every five years)			
6.	All entries are signed, dated and legible. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf			
7.	Errors are corrected according to legal medical documentation standards.			

Coordination/continuity of care		**Yes**	**No**	**Comments:**
1.	History of present illness or reason for visit is documented.			
2.	Working diagnoses are consistent with findings.			
3.	Treatment plans are consistent with diagnoses.			
4.	Instruction for follow-up care is documented.			
5.	Unresolved/continuing problems are addressed in subsequent visit(s).			
6.	There is evidence of practitioner review of consult/referral reports and diagnostic test results.			
7.	There is evidence of follow-up of specialty referrals made and results/reports of diagnostic tests, when appropriate.			
8.	Missed primary care appointments and outreach efforts/follow-up contacts are documented.			

Pediatric Preventive Care		**Yes**	**No**	**Comments:**
1.	Initial Health Appointment (IHA): a. Comprehensive history and physical: Complete within 120 days of enrollment (PCP effective date) OR within 12 months prior to enrollment CA_CAID_CompHealthAssmtForms.pdf (anthem.com) b. Member Risk Assessment: Complete at least one (1) of the following risk assessment domains within 120 days of			

Pediatric Preventive Care		Yes	No	Comments:
	enrollment (PCP effective date) OR within 12 months prior to enrollment: Pediatric ACEs and Related Life Events Screener (PEARLS), Adverse Childhood Experiences (ACEs), Health Information Form/Member Evaluation Tool (HIF/MET), or Social Determinants of Health (SDOH). https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf https://www.cdc.gov/about/sdoh/index.html https://www.acesaware.org/wp-content/uploads/2019/12/PEARLS-Tool-Child-Parent-Caregiver-Report-De-Identified-English.pdf https://www.acesaware.org/wp-content/uploads/2022/07/ACE-Questionnaire-for-Adults-Identified-English-rev.7.26.22.pdf			
2.	Periodic Health Evaluation according to the most current AAP/Bright Futures Periodicity a. Comprehensive History and Physical exam completed at age-appropriate frequency CA_CAID_CompHealthAssmtForms.pdf (anthem.com) b. Subsequent Risk Assessment: Complete at least one (1) of the following risk assessment domains annually: ACEs, HIF/MET, SDOH.			
3.	Alcohol Use Disorder (AUD) Screening and Behavioral Counseling: Per AAP recommendations, AUD 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) – see *SHA 9-11 Years* Q24, *SHA 12-17 Years* Q23 – 26 or *SHA Adult* Q19. If patient answered yes to the alcohol question in the IHEBA or at any time the PCP identifies a potential alcohol misuse problem, then the provider shall: 1) Use CRAFFT assessment tool; 2) Provide feedback to the patient regarding screening and assessment results; 3) Discuss negative consequences that have occurred and the overall severity of the problem; 4) Support the patient in making behavioral changes; and 5) Discuss and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated. http://crafft.org https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.134351281.198700501.1684252914-1873925258.1683739122 https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-014.pdf			

Pediatric Preventive Care		Yes	No	Comments:
	https://publications.aap.org/pediatrics/article/138/1/e20161211/52568/Substance-Use-Screening-Brief-Intervention-and			
4.	Anemia Screening: Perform risk assessments at 4, 15, 18, 24, 30 months and 3 years old, then annually thereafter; and serum hemoglobin at 12 months https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.134351281.198700501.1684252914-1873925258.1683739122 https://www.nhlbi.nih.gov/health-topics/anemia#:~:text=Some%20people%20are%20at%20a,such%20as%20chemotherapy%20for%20cancer			
5.	Anthropometric measurements: Perform at each well visit: • For infants up to 2 years old: assess for length/height and head circumference and plot in a World Health Organization (WHO) growth chart • For ages 2 to 20 years old: assess for height, weight, and body mass index (BMI) and plot in a CDC growth chart.			
6.	Anticipatory Guidance: Perform at each well visit to assist parents or guardians in the understanding of the expected growth and development of their children. This is specific to the age of the patient and includes information about the benefits of healthy lifestyles and practices that promote injury and disease prevention. https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf			
7.	Autism Spectrum Disorder (ASD) screening: Perform at 18 and 24 months using approved screening tools (e.g., ASQ, CSBS, PEDS, STAT, SWYC and M-CHAT) https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-006.pdf https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-007.pdf https://agesandstages.com https://pedstest.com			
8.	Blood Lead Testing and Education: Educate on lead exposure prevention at each well visit from 6 months to 6th birthday; complete blood lead test at 1 and 2 years old; complete a baseline blood lead test between 2 years old and 6th birthday if no documented evidence of testing by 2 years old. Refer to All Plan Letter 18-017 or most current version: https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/CLPPBhome.aspx https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/CDPH%20Document%20Library/Lead_HAGs_Table.pdf https://www.cdc.gov/nceh/lead/acclpp/final_document_030712.pdf			
9.	Blood Pressure Screening: Perform at each well visit starting at 3 years old			

Pediatric Preventive Care		Yes	No	Comments:
	https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf https://publications.aap.org/pediatrics/article/146/4/e2020018481/79709/Stability-of-Blood-Pressure-and-Diagnosis-of?searchresult=1			
10.	Dental/oral health assessment: inspection of the mouth, teeth, and gums at every health assessment visit — establish a dental home by 12 months of age and refer to a dentist if a dental problem is detected or suspected https://www.aapd.org/media/Policies_Guidelines/BP_CariesRiskAssessment.pdf https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Oral-Health/Pages/Oral-Health-Practice-Tools.aspx			
11.	Dental Fluoride Supplementation: Prescribe for members 6 months to 16 years old, who are at high risk for tooth decay and whose primary drinking water has a low fluoride concentration. https://pediatrics.aappublications.org/content/134/3/626 https://pediatrics.aappublications.org/content/134/6/1224			
12.	Dental Fluoride Varnish: Apply to members younger than 5 years old once teeth have erupted every 3 to 6 months. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1			
13.	Depression Screening: Perform maternal depression screening of infants at 1-, 2-, 4-, and 6-month-old visits; and annually for 12 years and older using the PHQ-9 Modified for Teens (PHQ9A), or other validated screening tools — The SHA is not a valid screening tool. Screening should be implemented at each well visit with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. Suicide Risk Screening: Starting at 12 years old, screen at each well visit using Ask Suicide-Screening Questions (ASQ), PHQ-9 Modified for Teens (PHQ9A) or other validated screening tools that consist of 3 suicide-related items ("thoughts of death," "wishing you were dead," and "feeling suicidal" within the past month). Refer patients at risk to behavioral health (psychotherapy, psychodynamic or interpersonal therapy). https://www.aap.org/en/patient-care/perinatal-mental-health-and-social-support/integrating-postpartum-depression-screening-in-your-practice-in-4-steps/ https://www.womenshealth.gov/mental-health/mental-health-conditions/postpartum-depression https://downloads.aap.org/AAP/PDF/Mental_Health_Tools_for_Pediatrics.pdf			

Pediatric Preventive Care		Yes	No	Comments:
	https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf 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/			
14.	Developmental Disorder Screening: Screen for developmental disorders at the 9-, 18- and 30- (or 24-) month visits using approved screening tools (e.g., ASQ, ASQ-3, PEDS, PEDS-DM, BDI-ST, BINS, Brigance Screens, CDI, IDI, and SWYC). ASQ-SE and MCHAT are not approved screening tools. https://pediatrics.aappublications.org/content/118/1/405 https://agesandstages.com https://pedstest.com			
15.	Developmental Surveillance: Assess developmental milestones at each well visit. https://pediatrics.aappublications.org/content/118/1/405			
16.	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 — see *SHA 12 to 17 Years* Q21, 25, and 26 or *SHA Adult* Q20. If patient answered *Yes* to the drug use related questions in the IHEBA or at any time the PCP identifies a potential drug misuse problem, the provider shall: 1) Use CRAFFT assessment tool; 2) 2) Provide feedback to the patient regarding screening and assessment results; 3) Discuss negative consequences that have occurred and the overall severity of the problem; 4) Support the patient in making behavioral changes; and 5) Discuss and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated. http://crafft.org https://publications.aap.org/pediatrics/article/138/1/e20161211/52568/Substance-Use-Screening-Brief-Intervention-and			
17.	Dyslipidemia Screening: Perform risk assessment at 2, 4, 6 and 8 years old, then annually thereafter; and one lipid panel between 9 and 11 years old, and again at 17 and 21 years old https://www.nhlbi.nih.gov/node/80308 https://brightfutures.aap.org/Pages/default.aspx			
18.	Hearing Screening: Perform risk assessments at each well visit until the child reaches 21 years old. Audiometric screenings are conducted at birth to 2 months old (only if AABR or OAE equipment is available on			

Pediatric Preventive Care		Yes	No	Comments:
	site); and at 4, 5, 8, and 10 years old, once between 11 to 14 years old, 15 to 17 years old, and 18 to 21 years old. https://www.cdc.gov/ncbddd/hearingloss/recommendations.html			
19.	Hepatitis B Virus Screening: Perform a risk assessment during the earliest well visit at least once for patients 0 to 21 years old. Risk factors include individuals or whose parents were born in Sub-Saharan Africa: Egypt, Algeria, Morocco, Libya, etc.; Central and Southeast Asia: Afghanistan, Vietnam, Cambodia, Thailand, Philippines, Malaysia, Indonesia, Singapore, etc.; HIV+, IV drug users, MSM, household contact with HBV infected individuals, infants born to HBsAg+ parents. 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. Infants born to HBsAg+ mothers or women whose HBsAG status remains unknown should have post-vaccination testing at 9-12 months of age or 1-2 months after the final dose of the vaccine series, if delayed. Clinicians should test all adults ages 18 years and older, even for those without the above risk factors for HBV infection at least once during their lifetime using the triple panel test. https://www.cdc.gov/hepatitis/hbv/index.htm https://www.cdc.gov/hepatitis/hbv/hbvfaq.htm			
20.	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. Per CDC, conduct universal testing at least once between ages 18 to 79, even for those without risk factors. Persons with increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually. Per CDC, conduct universal testing at least once between ages 18 to 79, even for those without risk factors. Hepatitis C testing is also recommended for all pregnant women during each pregnancy, those with HIV, prior recipients of transfusions or organ transplant before July 1992 or donor who later tested positive for HCV infection, persistently abnormal ALT levels, and those who received clotting factor concentrates produced before 1987. Testing should be initiated with anti-HCV. For those with reactive test results, the anti-HCV test should be followed with an HCV RNA. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening https://www.cdc.gov/hepatitis/hcv/guidelinesc.htm			
21.	HIV Screening: Per AAP, risk assessment shall be completed at each well visit starting at 11 years old. Those at high risk (i.e., having			

Pediatric Preventive Care		Yes	No	Comments:
	intercourse without a condom or with more than one sexual partner whose HIV status is unknown, IV drug users, MSM) shall be tested for HIV and offered pre-exposure prophylaxis (PrEP). Universal screening (test) for HIV infection once between the ages of 15 and 21 years, and annual reassessment and testing of persons at increased risk shall be performed, making every effort to preserve confidentiality of the adolescent. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.134351281.198700501.1684252914-1873925258.1683739122			
22.	Psychosocial Assessment (Behavioral/Social/Emotional): Perform at each well visit with assessments being family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. https://pediatrics.aappublications.org/content/135/2/384 https://downloads.aap.org/AAP/PDF/Mental_Health_Tools_for_Pediatrics.pdf https://brightfutures.aap.org/Bright%20Futures%20Documents/BF_IntegrateSDoH_Tipsheet.pdf https://www.cdc.gov/socialdeterminants/about.html			
23.	Sexually Transmitted Infection (STI) Screening and Counseling: Sexual activity shall be assessed at every well child visit starting at 11 years old – see *SHA 9 to 11 Years* Q27, *SHA 12 to 17 Years* Q28 to 34 or *SHA Adult* Q21 to 26. 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. 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*: a. Chlamydia and gonorrhea: Test pregnant women, all sexually active women under 25 years old (including transgender men and gender diverse people with a cervix) as well as older women who are at risk; male adolescents and young adults in correctional facilities; and MSM. b. Syphilis: Test pregnant women; male adolescents and young adults in correctional facilities; and MSM at least annually or 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.			

Pediatric Preventive Care		Yes	No	Comments:
	https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/adolescent-sexual-health/Pages/default.aspx https://pediatrics.aappublications.org/content/134/1/e302			
24.	Sudden Cardiac Arrest and Sudden Cardiac Death Screening: Starting at 11 years old, screen at each well visit and refer to a pediatric cardiologist or electrophysiologist if positive for any of the following: 1. Fainting, passing out, or sudden unexplained seizure(s) without warning, especially during exercise or in response to sudden loud noises, such as doorbells, alarm clocks, and ringing telephones; 2. Exercise-related chest pain or shortness of breath; 3. Family history of death from heart problems or had an unexpected sudden death before age 50. This would include unexpected drownings, unexplained auto crashes in which the relative was driving, or SIDS; or 4. Related to anyone with HCM or hypertrophic obstructive cardiomyopathy, Marfan syndrome, ACM, LQTS, short QT syndrome, BrS, or CPVT or anyone younger than 50 years with a pacemaker or implantable defibrillator. https://publications.aap.org/pediatrics/article/148/1/e2021052044/179969/Sudden-Death-in-the-Young-Information-for-the			
25.	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. If patient answered *Yes* to the smoke/tobacco questions in the IHEBA or 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 — see *SHA 9 to 11 Years* Q21 to 22, *SHA 12 to 17 Years* Q19 to 20 or *SHA Adult* Q17 to 18. Provider shall offer and document appropriate follow-up intervention(s) for patient whose screening reveal tobacco use. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-014.pdf			
26.	Tuberculosis (TB) Screening: All children are assessed for risk of exposure to TB at 1-, 6-, and 12-months old and annually thereafter. 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. 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			

Pediatric Preventive Care		Yes	No	Comments:
	of a positive test includes follow-up care (e.g., further medical evaluation, chest x-ray, diagnostic laboratory studies, and/or referral to specialist). https://www.cdc.gov/tb/topic/testing/default.htm			
27.	Vision Screening: Perform risk assessments at each health assessment visit and refer to optometrist/ophthalmologist as appropriate. Documentation of PERRLA under 3 years old is acceptable. 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. https://pediatrics.aappublications.org/content/137/1/e20153596			
28.	Childhood Immunizations: Immunization status must be assessed at periodic health evaluations with evidence of the following: a. Given according to Advisory Committee on Immunization Practices (ACIP) guidelines b. Vaccine administration documentation c. Vaccine Information Statement (VIS) documentation https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-004.pdf			

Adult Preventive Care		Yes	No	Comments:
1.	Initial Health Appointment (IHA): a. Comprehensive history and physical: Complete within 120 days of enrollment (PCP effective date) OR within 12 months prior to enrollment (including review of organ systems and dental assessment). CA_CAID_CompHealthAssmtForms.pdf (anthem.com) a. Member Risk Assessment: Complete at least one (1) of the following risk assessment domains within 120 days of enrollment (PCP effective date) OR within 12 months prior to enrollment: Adverse Childhood Experiences (ACEs), Cognitive Health Assessment (CHA) for seniors 65 years and older, Health Information Form/Member Evaluation Tool (HIF/MET), or Social Determinants of Health (SDOH). https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf https://www.cdc.gov/about/sdoh/index.html https://www.acesaware.org/wp-content/uploads/2022/07/ACE-Questionnaire-for-Adults-Identified-English-rev.7.26.22.pdf https://mini-cog.com/wp-content/uploads/2022/03/Standardized-English-Mini-Cog-1-19-16-EN_v1-low-1.pdf			
2.	Periodic health evaluation according to most current USPSTF guidelines			

Adult Preventive Care		Yes	No	Comments:
	a. Comprehensive History and Physical exam completed at age-appropriate frequency CA_CAID_CompHealthAssmtForms.pdf (anthem.com) b. Subsequent Risk Assessment: Complete at least one (1) of the following risk assessment domains annually: ACEs, CHA (for seniors 65 years and older), HIF/MET, or SDOH.			
3.	Abdominal Aneurysm Screening: Assess all patients during well-adult visits for past and current tobacco use. Men ages 65 to 75 years who have ever smoked at least 100 cigarettes in their lifetime shall be screened once by ultrasonography) https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/abdominal-aortic-aneurysm-screening			
4.	Alcohol Use Disorder (AUD) Screening and Behavioral Counseling: Assess all adults at each well-adult visit for AUD. If at any time the PCP identifies a potential AUD (e.g., patient answered *Yes* on *SHA Adult* Q19 or *SHA Senior* Q23), the provider shall: 1) Use CRAFFT, NIM-ASSIST, AUDIT/C or other validated assessment tools; 2) Offer behavioral counseling; 3) Refer to county program; and 4) Complete one expanded screening tool at least annually. http://crafft.org https://pubs.niaaa.nih.gov/publications/arh28-2/78-79.htm https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-016.pdf			
5.	Breast Cancer Screening: Perform a mammogram for women 50 to 75 years old, every 1 to 2 years. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/breast-cancer-screening			
6.	Cervical Cancer Screening: The USPSTF recommends screening for cervical cancer every three years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus hrHPV testing alone, or every 5 years with hrHPV testing in combination with cytology co-testing. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening			
7.	Colorectal Cancer Screening: Perform on adults 45 to 75 years old. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/colorectal-cancer-screening			
8.	Depression Screening: Per USPSTF, screen all adults at each well visit regardless of risk factors using PHQ-2, PHQ-9, or other validated			

Adult Preventive Care		Yes	No	Comments:
	screening tools. The SHA is not a valid screening tool. Screening should be implemented at each well visit with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-adults-screening			
9.	Diabetic Screening and Comprehensive Diabetic Care: Adults ages 35 to 70 who are overweight or obese should receive a screen for type II diabetes at each well visit. Glucose abnormalities can be detected by measuring HbA1c or fasting plasma glucose or with an oral glucose tolerance test. Offer or refer patients with glucose abnormalities to intensive behavioral counseling interventions to promote a healthful diet and physical activity. Patients with the diagnosis of IFG, IGT, or type 2 diabetes should be confirmed; repeat testing with the same test on a different day is the preferred method of confirmation. Patients with a diagnosis of diabetes, shall have documented evidence of routine comprehensive diabetic care/screening: retinal exams, podiatry, nephrology etc. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-prediabetes-and-type-2-diabetes https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-018.pdf			
10.	Drug Use Disorder Screening and Behavioral Counseling: Assess all adults at each well visit for drug misuse. If at any time the PCP identifies a potential drug use disorder (e.g., patient answered *Yes* on *SHA Adult* Q20 or *SHA Senior* Q24), the provider shall: 1) Use CRAFFT, NIM-ASSIST, or other validated assessment tools; 2) Offer behavioral counseling; 3) Refer to county program; and 4) Complete one expanded screening tool at least annually. http://crafft.org			
11.	Dyslipidemia Screening/Statin Use: 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: a. Ages 40 to 75 years b. One or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); c. 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.			

Adult Preventive Care		Yes	No	Comments:
	https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/statin-use-in-adults-preventive-medication			
12.	Folic Acid Supplementation: The USPSTF recommends that all women who are planning or capable of pregnancy (under 50 years old) take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/folic-acid-for-the-prevention-of-neural-tube-defects-preventive-medication			
13.	Hepatitis B Virus Screening: Perform a risk assessment at each well visit. Risk factors include individuals or whose parents were born in Sub-Saharan Africa: Egypt, Algeria, Morocco, Libya, etc.; Central and Southeast Asia: Afghanistan, Vietnam, Cambodia, Thailand, Philippines, Malaysia, Indonesia, Singapore, etc.; HIV+, IV drug users, MSM, household contact with HBV infected individuals, infants born to HBsAg+ parents. 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. Clinicians should test all adults ages 18 years and older, even those without the above risk factors for HBV infection at least once during their lifetime using the triple panel test. Conduct routine periodic testing for people with ongoing risk factors. https://www.cdc.gov/hepatitis/hbv/hbvfaq.htm			
14.	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 visit. Persons with increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually. Per CDC, conduct universal testing at least once between ages 18 to 79, even for those without risk factors. Hepatitis C testing is also recommended for all pregnant women during each pregnancy, those receiving long term hemodialysis, those with HIV, prior recipients of transfusions or organ transplant before July 1992 or donor who later tested positive for HCV infection, persistently abnormal ALT levels, and those who received clotting factor concentrates produced before 1987. Testing should be initiated with anti-HCV. For those with reactive test results, the anti-HCV test should be followed with an HCV RNA. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening https://www.cdc.gov/hepatitis/hcv/guidelinesc.htm			
15.	High Blood Pressure Screening: Screen at each well visit.			

Adult Preventive Care		Yes	No	Comments:
	https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hypertension-in-adults-screening			
16.	HIV Screening: USPSTF recommends risk assessment shall be completed at each well visit for patients 65 years old and younger. Those at high risk (i.e., having intercourse without a condom or with more than one sexual partner whose HIV status is unknown, IV drug users, MSM) regardless of age shall be tested for HIV and offered pre-exposure prophylaxis (PrEP). Lab results are documented. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/human-immunodeficiency-virus-hiv-infection-screening			
17.	Intimate Partner Violence (IPV) Screening: Perform at each well visit for female patients of reproductive age, regardless of sexual activity, using screening tools such as Humiliation, Afraid, Rape, Kick (HARK); Hurt, Insult, Threaten, Scream (HITS); Extended–Hurt, Insult, Threaten, Scream (E-HITS); Partner Violence Screen (PVS); and Woman Abuse Screening Tool (WAST). Reproductive age is defined across studies as ranging from 12 to 49 years, with most research focusing on women age 18 years or older. IPV describes physical, sexual, or psychological harm by a current or former partner or spouse. Provide or refer those who screen positive to ongoing support services. The Staying Healthy Assessment (SHA) forms only assess for presence of physical violence and lacks the questions to assess for emotional components of abuse to adequately screen for IPV. The SHA is an incomplete tool to screen for IPV. https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening			
18.	Lung Cancer Screening: Assess all individuals during well adult visits for past and current tobacco use. Adults ages 50 to 80 years who have a 20-pack-year smoking history (e.g., 1 pack per day for 20 years or 2 packs per day for 10 years) and currently smoke or have quit within the past 15 years, shall be screened annually with low-dose computed tomography. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/lung-cancer-screening			
19.	Obesity Screening and Counseling: Document weight and BMI at each well visit. The USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults (BMI 30 or greater).			

Adult Preventive Care		Yes	No	Comments:
	https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/obesity-in-adults-interventions			
20.	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 women 65 years and older and in women younger than 65 with one of the following risk factors: parental history of hip fracture, smoking, excessive alcohol consumption, or low body weight. https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/osteoporosis-screening			
21.	Sexually Transmitted Infection (STI) Screening and Counseling: Assess all individuals at each well visit for risk of STI and test those at risk and offer – see *SHA Adult* Q22 to 26 or *SHA Senior* Q25 to 28). Perform intensive behavioral counseling for adults who are at increased risk for STIs includes counseling on use of appropriate protection and lifestyle: a. Chlamydia and gonorrhea: Test all sexually active women under 25 years old and older women who have new or multiple sex partners. Test MSM regardless of condom use and persons with HIV at least annually. b. Syphilis: Test MSM regardless of condom use and persons with HIV at least annually. c. Trichomonas: Test all sexually active women seeking care for vaginal discharge, women who are IV drug users, women who exchange sex for payment, women with HIV or have history of STI. d. Herpes: Test all men and women requesting STI evaluation who have multiple sex partners, those with HIV and MSM with undiagnosed genital tract infection https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/sexually-transmitted-infections-behavioral-counseling https://www.cdc.gov/std/prevention/screeningreccs.htm https://www.cdc.gov/std/treatment-guidelines/STI-Guidelines-2021.pdf			
22.	Skin Cancer Behavioral Counseling: USPSTF recommends that young adults 24 years old and younger be counseled to minimize exposure to ultraviolet (UV) radiation to reduce their risk of skin cancer. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/skin-cancer-counseling			
23.	Tobacco Use Screening Counseling and Interventions: Assess all patients during well adult visits for tobacco use and document prevention and/or counseling services to potential/active tobacco users. If the PCP identifies tobacco use (i.e., patient answered *Yes* on IHEBA (see Adult SHA Q17 or Senior SHA Q21), documentation that the provider offered tobacco cessation services, behavioral counseling, and/or			

Adult Preventive Care		Yes	No	Comments:
	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 https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-014.pdf			
24.	Tuberculosis Screening: Adults are assessed for TB risk factors or symptomatic assessments upon enrollment and at periodic physical evaluations. The Mantoux skin test, or other approved TB infection screening test, is administered to all asymptomatic persons at increased risk of developing TB irrespective of age or periodicity if they had not had a test in the previous year. Adults already known to have HIV or who are significantly immunosuppressed require annual TB testing. 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). https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-TB-Risk-Assessment-and-Fact-Sheet.pdf https://www.cdc.gov/tb/topic/testing/default.htm https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/latent-tuberculosis-infection-screening https://www.cdc.gov/tb/publications			

Adult Preventive Care		Yes	No	Comments:
25.	Adult Immunizations: Immunization status must be assessed at periodic health evaluations with evidence of the following: • Given according to ACIP guidelines • Vaccine administration documentation • Vaccine Information Statement (VIS) documentation 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. https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-004.pdf			

OB/CPSP Preventive Care		Yes	No	Comments:
1.	Initial Comprehensive Prenatal Assessment (ICA) ICA completed within four weeks of entry to prenatal care https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx https://custom.cvent.com/C506006261F8428CB7CCB91AAA9A05B4/files/8a01c5b0dd744c0aa06f0dece9dec3f1.pdf http://publichealth.lacounty.gov/mch/cpsp/forms/Prenatal%20Assessment%20&%20ICP%20LAC%20CPSP%202017.pdf			
2.	Obstetrical and medical history			
3.	Physical exam			
4.	Dental assessment https://www.acog.org/en/Clinical/Clinical%20Guidance/Committee%20Opinion/Articles/2013/08/Oral%20Health%20Care%20During%20Pregnancy%20and%20Through%20the%20Lifespan			
5.	Healthy weight gain and behavior counseling			
6.	Bacteriuria screening at 12-16 weeks or 1st visit if later https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/asymptomatic-bacteriuria-in-adults-screening			
7.	Rh incompatibility screening at 24-28weeks https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/rh-d-incompatibility-screening			

OB/CPSP Preventive Care		Yes	No	Comments:
8.	Diabetes screening at 24-28 weeks https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/gestational-diabetes-screening			
9.	Hepatitis B virus screening at 1st prenatal visit https://www.cdc.gov/hepatitis/hbv/index.htm			
10.	Chlamydia infection screening at 1st prenatal visit for 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. Pregnant women with chlamydial infection should have a test-of-cure four weeks after treatment and be retested within three to six months. Women younger than 25 and those who remain at increased risk of infection should be retested during the 3rd trimester. https://www.cdc.gov/std/prevention/screeningreccs.htm https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/chlamydia-and-gonorrhea-screening			
11.	Syphilis infection screening at 1st prenatal visit https://www.cdc.gov/std/prevention/screeningreccs.htm			
12.	Gonorrhea infection screening at 1st prenatal visit for 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. Pregnant women with gonorrhea infection should be retested within three to six months after treatment. Women younger than 25 and those who remain at increased risk of infection should be retested during the 3rd trimester. https://www.cdc.gov/std/prevention/screeningreccs.htm https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/chlamydia-and-gonorrhea-screening			
13.	First trimester comprehensive assessments: a. Individualized care plan b. Nutrition c. Maternal mental health/social needs/substance use disorder assessments d. Breast feeding and other health education assessment e. Preeclampsia screening f. Intimate partner violence screening https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/preeclampsia-screening https://www.ncqa.org/wp-content/uploads/2019/02/20190208_08_Perinatal_Depression.pdf			
14.	Second trimester comprehensive assessment a. Individualized care plan updated b. Nutrition assessment c. Maternal mental health/social needs/substance use disorder assessments			

OB/CPSP Preventive Care		Yes	No	Comments:
	d. Breast feeding and health education assessment standards e. Preeclampsia screening f. Low dose aspirin g. Intimate partner violence screening h. Diabetes screening https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/preeclampsia-screening https://www.ncqa.org/wp-content/uploads/2019/02/20190208_08_Perinatal_Depression.pdf			
15.	Third trimester comprehensive assessment: a. Individual care plan updated and follow-up b. Nutrition assessment c. Maternal mental health/social needs/substance use disorder assessments d. Breastfeeding and other health education assessment standards e. Preeclampsia screening f. Low dose aspirin g. Intimate partner violence screening h. Screening for Strep B i. Screening for syphilis if high risk (28 weeks) j. Tdap immunization https://www.cdc.gov/vaccines/vpd/dtap-tdap-td/hcp/recommendations.html https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/preeclampsia-screening https://www.ncqa.org/wp-content/uploads/2019/02/20190208_08_Perinatal_Depression.pdf			
16.	Prenatal care visit periodicity according to most recent ACOG standards https://www.ncqa.org/wp-content/uploads/2019/02/20190208_08_Perinatal_Depression.pdf			
17.	Influenza vaccine https://www.cdc.gov/vaccines/pregnancy/index.html https://www.cdc.gov/flu/highrisk/pregnant.htm			
18.	COVID vaccine			
19.	Referral to special supplemental nutrition program for Women, Infants, and Children (WIC) and assessment of infant feeding status			
20.	HIV-related services offered: Repeat HIV 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. https://www.cdc.gov/std/prevention/screeningreccs.htm https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/human-immunodeficiency-virus-hiv-infection-screening			
21.	AFP/genetic screening offered			
22.	Family planning evaluation			
23.	Comprehensive postpartum assessment: a. Individualized care plan			

OB/CPSP Preventive Care		Yes	No	Comments:
	b. Nutrition assessment c. Maternal mental health/postpartum depression screening/social needs/substance use disorder assessments d. Breastfeeding and other health education assessment standards e. Comprehensive physical exam completed and within 12 weeks after delivery https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care http://publichealth.lacounty.gov/mch/cpsp/forms/Postpartum%20Assessment%20&%20ICP%20tool%20LAC%20CPSP%202017.pdf			