Medical Record Review Standards

Purpose: The Medical Record Standards provide instructions, rules, regulations, parameters, and indicators for conducting medical record reviews using the Medical Record Review 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 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 with OB-GYN services, adult or pediatric preventive criteria and OB CPSP criteria will be reviewed.

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 to be reviewed *only* by a registered nurse (RN), nurse practitioner (NP), physician (MD), or physician assistant (PA) is labeled "**RN/NP/MD/PA".**

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 below 80%.

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.

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.

Directions: Score one point if criterion is met. Score zero points if criterion is not met. Do not score partial points for any criterion.

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 for all six sections.
(Format points given)
(Documentation points given)
(Coordination/Continuity-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.

Total points given / "Adjusted" total points possible

Example: 267 / 305 = 0.875 X 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. "Family charts" are not acceptable. https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html
A. Member identification is on each page.	Member identification includes first and last name, and/or a unique identifier established for use on clinical site. 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, and name of parent(s) /legal guardian if member is a minor. If member refused to provide information, "refused" is documented in the medical record. 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 a 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. 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. (For example, 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 primary care physician (PCP) is identified.	The assigned and/or rendering PCP is ***always*** identified when there is more than one PCP on site and/or when the member has selected health care from a non-physician medical practitioner. Since various methods are 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 "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

I. Format Criteria	
	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 (DHCS All Plan Letter 17 - 011).
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. **Note:** https://www.lep.gov/faqs/faqs.html#OneQ11; 22CCR Section 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 • 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 IHEBA/SHA, intake form, demographic form, EMR fields, consent forms, etc. All medical record documentation must be in English (ACA 2010 §1557).
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. https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/permitted-uses/index.html

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

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II. Documentation Criteria	
A. Allergies are prominently noted.	Allergies and adverse reactions are listed in a prominent, easily identified and consistent location in the medical record. If member has no allergies or adverse reactions, "No Known Allergies" (NKA), "No known Drug Allergies" (NKDA), or ∅ is documented. (22 CCR Section 70527, 28 CCR Section 1300.80)
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. (22 CCR Section 70527, 28 CCR Section 1300.80)
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. (22 CCR Section 70527, 28 CCR Section 1300.80)
D. Appropriate Consents are present.	Providers must obtain voluntary written consent prior to examination and treatment, with appropriate regard to the patient's age and following State and Federal laws. Consent also must be obtained prior to release of patient information. (22 CCR Section 73524; 45 CFR Section 164.524; 22 CCR Section 51009) Adults, parents/legal guardians of a minor or emancipated minors may sign consent forms for operative and invasive procedures.* Persons under 18 years 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. **Note:** Human sterilization requires DHCS Consent Form PM 330 if services are performed at the site. * 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 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).
E. Advance Health Care Directive information is offered. (Adults 18 years	Adult medical records include documentation of whether the member has been offered information or has executed an Advance Health Care Directive (California Probate Code, Sections 4701; 42 CFR 422.128:42 CFR 489.100, APL 05010).

II. Documentation Criteria	
or age or older; emancipated minors)	The Physician Orders for Life-Sustaining Treatment (POLST) form and Five Wishes are acceptable if appropriately completed and signed by necessary parties. (Assembly Bill No.3000 Chapter 266) 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 the 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. **Note:** In electronic records (EMR), methods to document signatures (and/or authenticate initials) will vary, and must be individually evaluated. Signature page may be located 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 print-outs of entries. **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. https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-officestaff-factsheet.pdf
G. Errors are corrected according to legal medical documentation standards.	The person that makes the documentation error corrects the error. One correction method is (single line drawn through the error, with the writer's initial and date written above or near the lined-through entry). Similar variations such as (single line and initial) are also used. The corrected information is written as a separate entry and includes date of the entry, signature (or initials), and title. 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.

II. Documentation Criteria	

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

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III. Coordination/Continuity of Care 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 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 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. Each problem need not be addressed at every visit. Documentation demonstrates that the practitioner follows up with members about treatment regimens, recommendations, and counseling.
F. There is evidence of practitioner review of consult/referral reports and diagnostic test results.	There is documented evidence of practitioner review of records such as diagnostic studies, lab tests, X-ray reports, consultation summaries, inpatient/discharge records, emergency and urgent care reports, and all abnormal and/or "STAT" reports. Evidence of review may include the practitioner's initials or signature on the report, notation in the progress notes, or other site-specific method of documenting practitioner review. **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

III. Coordination/Continuity of Care Criteria	
G. There is evidence of follow-up of specialty referrals made, and results/reports of diagnostic tests, when appropriate.	Consultation reports and diagnostic test results are documented 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:** Any abnormal test results/diagnostic reports without follow-up documentation for specific pediatric or adult preventive screening criteria or other 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.
H. Missed primary care appointments and outreach efforts/follow-up contacts are documented.	Documentation includes incidents of missed/broken appointments, cancellations or "No shows" with the PCP office. Attempts to contact the member or parent/guardian and the results of follow-up actions are documented in the medical record. If appointments are documented in a separate system from medical records, they must be readily accessible and meet the medical retention requirements. **Notes:** Reviewer must assess the process of outreach efforts/follow-up contacts and documentation of attempts. The process must include at minimum one attempt for outreach/follow-up contact.

Rationale: Pediatric preventive services are provided in accordance with current American Academy of Pediatrics (AAP) bright future and US Preventive Task Force (USPSTF) recommendations.

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IV. Pediatric Preventive Criteria	
A. Initial Health Assessment (IHA) includes H&P and IHEBA	**New Members**: The IHA (comprehensive history, and IHEBA) enables the PCP to assess current acute, chronic and preventive needs and to identify those Members whose health needs require coordinated services with appropriate community resources/other agencies not covered by the Plan. IHA must be completed within 120 days of plan enrollment, or documented within the 12 months prior to Plan enrollment. (References: IHA PL 08 – 003 https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2008/PL08-003.PDF or current version; IHEBA PL 13-001https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2013/PL13-001.pdf or current version)
1) Comprehensive History and Physical	**New members**: The history must be comprehensive to assess and diagnose acute and chronic conditions which includes History of present illness; past medical history; social history, review of organ systems. 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.
2) **Individual Health Education Behavioral Assessment (IHEBA)**	**New members**: An age-appropriate IHEBA ("Staying Healthy" or other DHCS-approved tool such as AAP bright Future) is completed by the member or parent/guardian within 120 days of the effective date of enrollment into the Plan, or within the 12 months prior to Plan enrollment. Staff may assist. The IHEBA has evidence of practitioner review such as signature/initials, and dates and intervention codes, which may be documented on the IHEBA form, in progress notes, or other areas of the paper or electronic medical record system. If an initial IHEBA is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented. (SHA Questionnaires: http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx)
B. Subsequent Comprehensive Health Assessment	Existing /Current Members: The examination must be comprehensive and also focus on specific assessments that are appropriate for the child's or adolescent's age, developmental phase, and needs. This portion of the visit builds on the history gathered earlier. The physical examination also 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. https://brightfutures.aap.org/Bright%20Futures%20Documents/Physical%20Examination.pdf
1) Comprehensive History and Physical exam completed at age	Health assessments containing age-appropriate requirements are provided according to the most recent AAP periodicity schedule for pediatric preventive health care. Assessments and identified

appropriate frequency	problems are documented in the progress notes. Follow-up care or referral is provided for identified physical health problems as appropriate. **Note**: Where the AAP periodicity exam schedule is more frequent than the 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. (Resources: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf
2) Subsequent Periodic IHEBA	An age-appropriate IHEBA is re-administered when the member has reached the next specific age interval designated by MCQMD. The PCP must review previously completed SHA questionnaires with parent, guardian or adolescent annually before reaching the next age group. Documentation requirements are the same as the initial IHEBA. (SHA Questionnaires: http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx)
C. Well-child Visit	The Bright Futures/American Academy of Pediatrics (AAP) developed a set of comprehensive health guidelines for well-child care, known as the "periodicity schedule." It is a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence. https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx
1) Alcohol/Drug Misuse: Screening and Behavioral Counseling	Per AAP, screen all children 11 years and older at each well visit for alcohol/drug misuse. If 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 complete the following when applicable: 1) 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. The following are validated screening tools for screening members for alcohol misuse: a) Alcohol Use Disorder Identification Test (AUDIT) b) Alcohol Use Disorder Identification Test Consumption (AUDIT-C) or c) A single-question, such as asking, “How many times in the past year have you had 4 (for women and all adults older than 65 years) or 5 (for men) or more drinks in a day?” 2) 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. 3) Offer behavioral counseling intervention(s) to those members that a provider identifies as having risky or hazardous alcohol use when a member response affirmatively to the alcohol question in the IHEBA, provides responses on the expanded screening that indicate hazardous use, or when otherwise identified.

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	Note: 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. Behavioral counseling interventions may be deliver by face-to-face sessions, written self-help materials, Computer or Web-based programs, or telephone counseling. https://www.aap.org/en-us/documents/periodicity_schedule.pdf https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-014.pdf or current version.
2) Anemia Screening	Perform risk assessment or screening at 4, 15, 18, 24, 30 months and 3 years old, then annually thereafter; and serum hemoglobin at 12 months old. https://www.aap.org/en-us/documents/periodicity_schedule.pdf
3) Anthropometric measurements	Length/Height and weight are documented at each well-child exam. Include head circumference for infants up to 24 months. Anthropometric measurements are plotted on World Health Organization (WHO) growth chart for each well child exam for ages 0- 2 years and Centers for Disease Control and Prevention (CDC) growth chart for children 2 years and older. Note: Site is deficient if anthropometric measurements are not plotted on the appropriate growth chart. https://www.cdc.gov/growthcharts/
4) Anticipatory Guidance	Age Appropriate Anticipatory Guidance must be document at each well child visit. Anticipatory guidance is given by the health care provider to assist parents or guardians in the understanding of the expected growth and development of their children. Anticipatory guidance, 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/Anticipatory%20Guidance.pdf
5) Autism Spectrum Disorder Screening	Autism Spectrum Disorder Screening must be performed at 18 months and 24 months based on AAP periodicity “Bright Futures”. The Autism Spectrum Disorder Screening tools that may be used are: a. Ages and Stages Questionnaires (ASQ) b. Communication and Symbolic Behavior Scales (CSBS) c. Parents' Evaluation of Developmental Status (PEDS) d. Modified Checklist for Autism in Toddlers (MCHAT) e. Screening Tool for Autism in Toddlers and Young Children (STAT) (Refer to APL 18-006 and APL 18-007 or current versions

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	https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
6) Blood Lead Testing	Children receiving health services through publicly funded programs for low-income children must receive anticipatory guidance performed at each periodic health assessment, starting at 6 months of age and continuing until 72 months of age. Blood Lead Level (BLL) testing preferably using venous blood as follows: 1) At 12 month and 24 months of age, 2) Between 12 months and 24 months of age if there is no documented evidence of BLL testing at 12 months or thereafter, and 3) Between 24 months and 72 months of age if there is no documented evidence of BLL testing at 24 months or thereafter. California law requires laboratories and health care providers performing blood lead analysis on all blood, blood specimens drawn in California to electronically report all results to CLPPB, along with specified patient demographic, ordering physician, and analysis data on each test performed. Refer to California Department of Public Health (CDPH) California Lead Prevention Program Branch (CLPPB) and CDC for recommended actions based on BLL levels: https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/CLPPBhome.aspx https://www.cdc.gov/nceh/lead Refer to APL 18-017 or current version: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx For children at risk of led exposure, see “Prevention of Childhood Lead Toxicity” http://pediatrics.aappublicatons.org/content/138/1/e20161493 and “Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention https://www.cdc.gov/nceh/lead/acclpp/final_document_030712.pdf
7) Blood Pressure Screening	Blood pressure screening starts at 3 years old. In persons aged three to 18 years, the prevalence of hypertension is 3.6 percent.[1] Evidence suggests that elevated BP in childhood increases the risk for adult HTN and metabolic syndrome. https://brightfutures.aap.org/Bright%20Futures%20Documents/Physical%20Examination.pdf https://www.aap.org/en-us/professional-resources/quality-improvement/Project-RedDE/Pages/Blood-Pressure.aspx
8) Dental Assessment	Inspection of the mouth, teeth and gums is perform at every health assessment visit. Documentation of “HEENT” is acceptable. Children are referred to a dentist at any age if a dental problem is detected or

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	suspected. Beginning at 12 months of age, all children must be referred annually to a dentist regardless of whether a dental problem is detected or suspected. See link below for caries-risk assessment and management for infants, children, and adolescents. https://www.aapd.org/media/Policies_Guidelines/BP_CariesRiskAssessment.pdf http://pediatrics.aappublications.org/content/134/3/626
a. Dental Home	Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment and refer to a dental home. The American Academy of Pediatric Dentistry (AAPD) supports the concept of a dental home for all infants, children, adolescents, and persons with special health care needs. The AAPD encourages parents and other care providers to help every child establish a dental home. Every child should have a dental home established by 12 months of age. https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Oral-Health/Pages/Oral-Health-Practice-Tools.aspx
b. Fluoride Supplementation	The American Academy of Pediatrics (AAP) recommend brushing with fluoride toothpaste in the proper dosage for age. See link below on "Maintaining and Improving the Oral Health of Young Children" for further details. In addition. Fluoride supplements may be prescribed for children ages 6 months to 16 years who are at high risk for tooth decay and whose primary drinking water has a low fluoride concentration. 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. http://pediatrics.aappublications.org/content/134/6/1224 https://pediatrics.aappublications.org/content/134/3/626 https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/AAP-Recommends-Fluoride-to-Prevent-Dental-Caries.aspx
c. Fluoride Varnish	Fluoride varnish is a dental treatment that can help prevent tooth decay, slow it down, or stop it from getting worse. Fluoride varnish is made with fluoride, a mineral that can strengthen tooth enamel (outer coating on teeth). Once teeth are present, fluoride varnish may be apply to all children every 3-6 months in the primary care or dental office. Documentation of "seeing a dentist" without specific notation that fluoride varnish was applied at the dentist office does not meet the criterion since not all dentists routinely apply fluoride varnish during routine dental visits. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2007/MMCDAPL07008.pdf https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/AAP-Recommends-Fluoride-to-Prevent-Dental-Caries.aspx
9) Depression Screening	USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18

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	years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. Adolescent depression screening begins routinely at 12 years of age http://pediatrics.aappublications.org/content/126/5/1032 https://www.aap.org/en-us/advocacy-and-policy/state-advocacy/Documents/MaternalDepressionScreeningGuidance.pdf
a. Maternal Depression Screening	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. Assembly Bill (AB) 2193 would require provider who provides prenatal or postpartum care for a patient to offer to screen or appropriately screen a mother for maternal mental health conditions. Maternal depression screening at 1-, 2-, 4-, and 6-month visits. "Screening should occur per 'Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice' (http://pediatrics.aappublications.org/content/126/5/1032)." https://www.acog.org/Patients/FAQs/Postpartum-Depression https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening1 https://www.womenshealth.gov/mental-health/mental-health-conditions/postpartum-depression
10) Developmental Disorder Screening	Developmental Disorder Screening for developmental disorders at the 9th, 18th and 30th month visits. 30 month screening could be done at 24 months. Standardized developmental screening tools are used to identify concerns about a child's development and for children who appear to be at low risk of a developmental disorder. https://pediatrics.aappublications.org/content/118/1/405
11) Developmental Surveillance	Developmental surveillance is a component of every well care visit. Children identified with potential delays require further assessment and/or referral. https://pediatrics.aappublications.org/content/118/1/405
12) Dyslipidemia Screening	Obesity, Diabetes, Hypertension, family history of heart disease are commonly associated with a combined 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, and again at 17 and 21 years old to identify children with genetic dyslipidemia or more lifestyle-related dyslipidemia. https://www.nhlbi.nih.gov/node/80308 https://brightfutures.aap.org/Pages/default.aspx

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13) Folic Acid Supplementation	USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8mg (400 to 800ug) of folic acid. Documentation of Folic Acid counseling and/or patient refusal of Folic Acid supplementation meet the criterion. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/folic-acid-to-prevent-neural-tube-defects-preventive-medication
14) Hearing Screening	Non-audiometric screening for infants/children (2 months to 3 years) includes family and medical history, physical exam and age-appropriate screening. Audiometric screening for children and young adults (4 -20) is done at each health assessment visit and includes follow-up care as appropriate. A failed audiometric screening is follow 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, provider must make a referral to a specialist. Follow AAP recommendations. https://www.cdc.gov/ncbddd/hearingloss/recommendations.html
15) Hepatitis B Screening	USPSTF recommends screening for hepatitis B virus (HBV) infection in persons at high risk for infection: -

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	intervals between subsequent HIV testing are determined by risk level. Provider shall make every effort to preserve confidentiality of the adolescent. http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm https://www.aap.org/en-us/documents/periodicity_schedule.pdf 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-screening1
17) Intimate Partner Violence Screening	The Centers for Disease Control and Prevention defines intimate partner violence (IPV) as a pattern of coercive behaviors that may include repeated battering and injury, psychological abuse, sexual assault, progressive social isolation, deprivation, and intimidation. "Intimate partner" includes current and former spouses and dating partners. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy. Per the USPSTF, clinicians shall screen for intimate partner violence (regardless of sexual activity) and provide or refer those who screen positive to ongoing support services. The USPSTF recommendations apply to asymptomatic women of reproductive age and elderly and vulnerable adults. Reproductive age is define across studies as ranging from 14 to 46 years, with most research focusing on women age 18 years or older. A vulnerable adult is a person age 18 years or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired because of a mental, emotional, long-term physical, or developmental disability or dysfunction or brain damage. Types of abuse that apply to elderly and vulnerable adults include physical abuse, sexual abuse, emotional or psychological abuse, neglect, abandonment, financial or material exploitation, and self-neglect. https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening https://pediatrics.aappublications.org/content/125/5/1094
18) Nutrition Assessment/Breast Feeding Support	Screening includes: breastfeeding and infant feeding status, food/nutrient intake and eating habits (including evaluation of problems/conditions/needs of the breastfeeding mother). Based on problems/conditions identified, nutritionally at-risk children under 5 years of age are referred to the Women, Infants and Children (WIC) Supplemental Nutrition Program for medical nutrition therapy or other in-depth nutritional assessment.
19) Obesity Screening	Includes weight and body mass index (BMI). Body Mass Index (BMI) starting at 24 months. Screen for overweight (BMI>/=25) and obesity (BMI >/=30) in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status. BMI percentile is plotted on growth chart for each well child exam ages 2-20 years.

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	Note: Children screened positive for overweight and/or obesity are provided counseling for nutrition to promote healthy eating habits and regular physical activity. Provider checked off on counseling interventions on SHA and/or documentation on progress note i.e. counseling for nutrition and physical activity" meet the criteria.http://www.aap.org/advocacy/releases/july08lipidscreening.htm https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ https://www.cdc.gov/obesity/resources/strategies-guidelines.html
20) 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. See 'Promoting Optimal Development: Screening for Behavioral and Emotional Problems' http://pediatrics.aappublications.org/content/135/2/384 and 'Poverty and Child Health in the United States' http://pediatrics.aappublications.org/content/early/2016/03/07/peds.2016-0339" https://www.aap.org/en-us/Documents/periodicity_schedule.pdf
21) Sexual Activity Assessment	Sexual activity shall be assessed at every well child visit starting at 11 years old. If adolescents are identified as sexually active (by report or on the IHEBA form), the clinician shall proceed with Questions 21a-21b and document discussion, intervention, referral, and/or treatment where applicable. https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/adolescent-sexual-health/Pages/default.aspx
a. Contraceptive Care	Responsibility of providers includes helping teens reduce risks and negative health consequences associated with adolescent sexual behaviors, including unintended pregnancies and sexually transmitted infections
b. STI screening on all sexually active adolescents, including chlamydia, Gonorrhea, and Syphilis	All sexually active adolescents should be screened for sexually transmitted infections (STIs): Chlamydia, gonorrhea, and syphilis. High-risk adolescents (15-21 years) who are pregnant, men having sex with men (MSM), or persons with HIV should be screened for syphilis. Providers should address prevention, screening, and treatment of STIs with their sexually active adolescent and young adult patients as part of their regular annual health care visits. https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/adolescent-sexual-health/Pages/STI-Screening-Guidelines.aspx https://pediatrics.aappublications.org/content/134/1/e302

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22) Skin Cancer Behavior Counselling	USPSTF recommends counseling young adults and parents of young children about minimizing exposure to Ultraviolet (UV) radiation for persons aged 6 months to 24 years to reduce the risk of skin cancer. https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
23) Tobacco Products Use: Screening and Prevention and Cessation Services	AAP recommendation is to 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. 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; and/or 5) Prevention of tobacco use in children and adolescents (including counseling and pharmacotherapy. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-014.pdf or current version.
24) Tuberculosis Screening	All children are assessed for risk of exposure to tuberculosis (TB) at each health assessment. There are two kinds of tests that are used to detect TB bacteria in the body: the TB skin test (TST) (Mantoux) and TB blood tests Quantiferon. 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. https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-Pediatric-TB-Risk-Assessment.pdf https://www.cdc.gov/tb/topic/testing/default.htm
25) Vision Screening	Age-appropriate visual screening occurs at each health assessment visit, with referral to optometrist/ophthalmologist as appropriate. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. 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.

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	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. Follow AAP recommendations. https://pediatrics.aappublications.org/content/137/1/e20153596
D. Childhood Immunizations	Reference: https://www.cdc.gov/vaccines/acip/index.html
1) Given according to ACIP guidelines	Immunization status is assessed at each health assessment visit. Practitioners are required to ensure the provision of immunizations according to CDC's most recent Advisory Committee on Immunization Practices (ACIP) guidelines, unless medically contraindicated, vaccine shortage or refused by the parent.
2) Vaccine administration documentation	The name, manufacturer, date of administration, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries, in accordance with the National Childhood Vaccine Injury Act.
3) Vaccine Information Statement (VIS) documentation	Vaccine Information Statements (VISs) are information sheets produced by the CDC that explain both the benefits and risks of a vaccine to the vaccine recipients. Federal law requires that healthcare staff provide a VIS to a patient, parent, or legal representative before each dose of certain vaccines. 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. **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

V. Adult Preventive Criteria	
A. Initial Health Assessment (IHA Includes H&P and IHEBA)	New Members: The IHA (comprehensive history and IHEBA) enables the PCP to assess current acute, chronic and preventive needs *and* to identify those Members whose health needs require coordinated services with appropriate community resources/other agencies not covered by the Plan. IHA must be completed within 120 days of plan enrollment, or documented within the 12 months prior to Plan enrollment Reference: PL 08 – 003 https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2008/PL08-003.PDF or current version; PL 13-001 https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2013/PL13-001.pdfor current version
1) Comprehensive History and Physical	**New members**: The history must be comprehensive to assess and diagnose acute and chronic conditions, which includes history of present illness; past medical history; social history, review of organ systems 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.
2) Individual Health Education Behavioral Assessment (IHEBA)	**New members**: An age-appropriate IHEBA ("Staying Healthy" or other DHCS-approved tool) is completed by the member within 120 days of the effective date of enrollment into the Plan, or within the 12 months prior to Plan enrollment. Staff may assist. The IHEBA has evidence of practitioner review such as signature/initials, and dates and intervention codes, which may be documented on the IHEBA form, in progress notes, or other areas of the paper or electronic medical record system. If an initial IHEBA is not found in the medical record, the reasons (e.g., member's refusal, missed appointment) and contact attempts to reschedule are documented. (SHA Questionnaires: http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx)
B. Periodic Health Evaluation according to most recent USPSTF guidelines	Periodic health evaluations occur in accordance with the frequency that is appropriate for individual risk factors. The type, quantity and frequency of preventive services will depend on the most recent USPSTF recommendations. 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.

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	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.
C. Subsequent Periodic IHEBA	The adult or senior assessment must be re-administered every 3 to 5 years, at a minimum. The PCP must review previously completed SHA questionnaires with the patient every year, except years when the assessment is re-administered. Documentation requirements are the same as the initial IHEBA. For subsequent annual reviews, PCP must sign, print name and date "SHA Annual Review" section (last page) to verify the annual review was conducted and discussed with the patient (SHA Questionnaires: http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx)
D. Adult Preventive Care Screenings	If the following specific preventive care screening tests (as listed below) 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.). Please use the following scoring methodology under adult preventive care screenings: • If ordered and result found, score as 1 • If ordered and patient refused, score as 1 • If ordered and no result found, but outreach efforts are documented, score as 1 • If ordered but no result or outreach efforts documented, score as 0
1) Abdominal Aneurysm Screening	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.
2) Alcohol Misuse: Screening and Behavioral Counseling	Screen all adults at each well visit for alcohol misuse. If at any time the PCP identifies a potential alcohol misuse problem, (i.e. patient answered "yes" to the alcohol question in the IHEBA), the provider shall: (1) 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 (2) use the Alcohol Use Disorder Identification Test (AUDIT) or Alcohol Use Disorder Identification Test-Consumption (AUDIT-C) (3) 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 document by the member's provider (4) offer behavioral counseling intervention(s) to those members that a provider identifies as having risky or hazardous alcohol use when a member response affirmatively to the alcohol question in the IHEBA, provides responses on the expanded screening that indicate hazardous use, or when otherwise identified. 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.

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	https://pubs.niaaa.nih.gov/publications/arh28-2/78-79.htm https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-016.pdf or Current Version **Note:** Score: NA if answer to SHA question on alcohol is "No".
E. 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. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/breast-cancer-screening
F. Cervical Cancer Screening	Screening for cervical cancer in women age 21 to 65 years with cytology (Pap smear) every 3 years or, for women age 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) co-testing every 5 years. Follow-up of abnormal test results is documented. Routine Pap testing may not be required for the following: 1) women who have undergone hysterectomy in which the cervix is removed (total Hysterectomy), unless the hysterectomy was performed because of invasive cancer, 2) women 66 years and older who have had regular previous screening in which the smears have been consistently normal. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening
G. Colorectal Cancer Screening	All adults are screened for colorectal cancer beginning at age 50 years and concluding at age 75 years to include: 1. Annual screening with high-sensitivity fecal occult blood testing, **or** 2. Sigmoidoscopy every 5 years with high sensitivity fecal occult blood testing every 3 years, **or** 3. Screening colonoscopy every 10 years. 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. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/colorectal-cancer-screening
H. Depression Screening	Per USPSTF, screen for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. Depression screening must be performed at each adult visit Depression screening must be performed. Recommended screening using the Patient Health Questionnaire (PHQ) in various forms, Hospital Anxiety and Depression Scales in adults, Geriatric Depression Scale in older adults and the Edinburgh Postnatal Depression Scale (EPDS) pregnant and postpartum. IHEBA forms when used solely for depression screening do not have

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	psychometric properties and may not be reliable screening tools for depression. https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-adults-screening1
I. Diabetic Screening and Comprehensive Diabetic Care	Per the USPSTF, screen for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 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 is a measure of long-term blood glucose concentration and is not affected by acute changes in glucose levels due to stress or illness. Because 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. https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/screening-for-abnormal-blood-glucose-and-type-2-diabetes https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-018.pdf
J. Dyslipidemia Screening	Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years. USPSTF recommends that adults without a history of cardiovascular disease (CVD) (i.e. symptomatic coronary artery disease or ischemic stroke), use a low- to moderate-dose statin for the prevention of CVD events and mortality, when all of the following criteria are met: 1) Ages 40 to 75 years 2) 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); 3) A calculated 10-year risk of a cardiovascular event of 10% or greater. https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.
K. 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.

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	https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/folic-acid-to-prevent-neural-tube-defects-preventive-medication
L. Hepatitis B Screening	Screening 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%) • HIV-positive persons • Injection drug users • Men who have sex with men • Household contacts or sexual partners of persons with HBV infection https://www.cdc.gov/hepatitis/hbv/hbvfaq.htm
M. Hepatitis C Screening	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: • Adults born between 1945 and 1965 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 https://www.cdc.gov/hepatitis/hcv/guidelinesc.htm https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
N. High Blood Pressure Screening	All adults 18 years and older including those without known hypertension are screened. A blood pressure (B/P) measurement for the normotensive adult is documented at least once every 2 years if the last systolic reading was below 120 mmHg and the diastolic reading was below 80 mmHg. B/P is measured annually if the last systolic reading was 120 to 139 mmHg and the diastolic reading was 80 to 89 mmHg. https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/high-blood-pressure-in-adults-screening

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O. HIV Screening	USPSTF recommends risk assessment shall be completed at each well visit for patients 15 to 65 years old. 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, 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-screening1
P. Intimate Partner Violence Screening	Per the USPSTF, clinicians shall screen for intimate partner violence (regardless of sexual activity) and provide or refer those who screen positive to ongoing support services. These recommendations apply to asymptomatic women of reproductive age and elderly and vulnerable adults. Reproductive age is defined across studies as ranging from 14 to 46 years, with most research focusing on women age 18 years or older. 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. A vulnerable adult is a person age 18 years or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired because of a mental, emotional, long-term physical, or developmental disability or dysfunction or brain damage. Types of abuse that apply to elderly and vulnerable adults include physical abuse, sexual abuse, emotional or psychological abuse, neglect, abandonment, financial or material exploitation, and self-neglect. https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening https://www.cdc.gov/violenceprevention/intimatepartnerviolence/
Q. Lung Cancer Screening	Per the USPSTF, screen annually for lung cancer with low-dose computed tomography in adult’s ages 55 to 80 years who have a 30 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. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/lung-cancer-screening
R. Obesity Screening and Counselling	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. Documentation shall include weight and body mass index (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

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	3-5 kg for 1 year 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. https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/obesity-in-adults-screening-and-counseling-2003
S. Osteoporosis Screening	The 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, as determined by a formal clinical risk assessment tool. These risk factors include parental history of hip fracture, smoking, excessive alcohol consumption, and low body weight. https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/osteoporosis-screening1
T. Sexually Transmitted Infection (STI) Screening	Chlamydia & Gonorrhea (Screen 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 screened at least annually).Syphilis (MSM or persons with HIV shall be screened at least annually). Trichomonas (women who are IV drug users, exchanging sex for payment, HIV+, have Hx of STD, etc.). Herpes (men and women requesting STI evaluation who have multiple sex partners shall be screened, HIV+, and MSM w/ undiagnosed genital tract infection) https://www.cdc.gov/std/tg2015/screening-recommendations.htm
U. Sexually Transmitted Infections Counseling	Intensive behavioral counselling for adults who are at increased risk for sexually transmitted infections.
V. Skin Cancer Behavioral Counseling	USPSTF recommends that young adults and parents of young children should be counseled to minimize exposure to Ultraviolet (UV) radiation for persons aged 6 months to 24 years to reduce their risk of skin cancer. https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
W. Tobacco Use Counseling and Interventions	Screen all individuals during well adult visits for tobacco use and document prevention and/or counseling services to potential/active tobacco users. If the PCP identifies tobacco use (i.e. Patient answered “Yes” on IHEBA). Tobacco cessation services must be documented in the patient’s medical record as follows: (1) Initial and periodic assessment of tobacco use (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

V. Adult Preventive Criteria	
	(4) Services for pregnant tobacco users (5) Prevention of tobacco use in children and adolescents (including counseling and pharmacotherapy). https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-014.pdf **Note: Score "NA" if answer to smoking question on SHA is a "No" or PCP documentation of "No" tobacco use.**
X. Tuberculosis Screening	Adults are screened for tuberculosis (TB) risk factors or symptomatic assessments upon enrollment and at periodic physical evaluations. The Mantoux skin test, or other approved TB infection screening test,* is administered to **all** asymptomatic persons at increased risk of developing TB irrespective of age or periodicity if they had not had a test in the previous year. Adults already known to have HIV or who are significantly immunosuppressed require annual TB testing. ** 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). Practitioners are required to follow current CDC and American Thoracic Society guidelines for TB diagnosis and treatment. * 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). http://www.ctca.org/guidelines/IIA2targetedskintesting.pdf https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-TB-Risk-Assessment-and-Fact-Sheet.pdf https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/latent-tuberculosis-infection-screening www.cdc.gov/tb/publications//
Y. Adult Immunizations	
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 Advisory Committee on Immunization Practices (ACIP) guidelines, unless medically contraindicated or refused by the member. Vaccination status must be assessed for the following: Td/Tdap (every 10 years), Flu (annually), and Pneumococcal (starting at age 65), Zoster (starting at age 50), Varicella and MMR. The name of the vaccines and date the member received the vaccines must be documented as part of the assessment. Documented evidence of immunity (i.e. titers, childhood acquired infection) in the medical record meets the criteria for Varicella and MMR. https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-004.pdf

V. Adult 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.
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.

Rationale: Perinatal assessments are provided according to the current American College of Obstetrics and Gynecologists (ACOG) standards and Comprehensive Perinatal Services Program (CPSP) Guidelines. (https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx)

RN/NP/MD/PA

VI. OB/CPSP Preventive Criteria	
A. Initial Comprehensive Prenatal Assessment (ICA)	**Initial Prenatal Visit- First entry to OB Care.** Physical exam: includes breast and pelvic exam and calculation of estimated date of delivery https://custom.cvent.com/C506006261F8428CB7CCB91AAA9A05B4/files/8a01c5b0dd744c0aa06f0dece9dec3f1.pdf
1) Initial Prenatal Visit	Documentation of initial prenatal visit completed within 4 weeks of entry to prenatal care.
2) Obstetrical and Medical History	Obstetric/medical: Health and obstetrical history (past/current), LMP, EDD.
3) Physical Exam	Physical exam: includes breast and pelvic exam.
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. https://www.preeclampsia.org/es/stillatrisk/53-noticias-informacion-de-salud/545-acog-recommends-routine-oral-health-assessment-at-first-prenatal-visit
5) Lab tests	
a) Bacteriuria Screening	The 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. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/asymptomatic-bacteriuria-in-adults-screening
b) Rh Incompatibility Screening	Rh incompatibility is a condition that occurs during pregnancy if a woman has Rh-negative blood and her baby has Rh-positive blood.Rh incompatibility screening: 24 -28 weeks' gestation https://www.acog.org/-/media/For-Patients/faq027.pdf https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/rh-d-incompatibility-screening https://www.nhlbi.nih.gov/health-topics/rh-incompatibility
c) Diabetes Screening	The USPSTF recommends screening for gestational diabetes mellitus **(**GDM**)** in asymptomatic pregnant women after 24 weeks of gestation • In the 2-step approach, the 50-g OGCT is performed between 24 and 28 weeks of gestation. A diagnosis of GDM is made when 2 or more glucose values fall at or above the specified glucose thresholds.

VI. OB/CPSP Preventive Criteria	
	• 1-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. https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/gestational-diabetes-mellitus-screening
d) Hepatitis B Virus Screening	All pregnant women are screened for Hepatitis B during their first trimester or prenatal visit, whichever comes first. https://www.cdc.gov/hepatitis/hbv/index.htm
e) Chlamydia Infection Screening	All pregnant women under 25 years old, and older pregnant women who are at increased risk, are screened for chlamydia during their first prenatal visit. Retest during the 3rd trimester for under 25 years of age or at risk. Include lab results https://www.cdc.gov/std/tg2015/screening-recommendations.htm https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/chlamydia-and-gonorrhea-screening
f) Syphilis Infection Screening	Clinicians screen all pregnant women for syphilis infection at first prenatal visit. Retest early in the third trimester and at delivery if at high risk. Include lab results. https://www.cdc.gov/std/tg2015/screening-recommendations.htm https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/syphilis-infection-screening
g) 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. Include lab results. References: https://www.cdc.gov/std/tg2015/screening-recommendations.htm https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/chlamydia-and-gonorrhea-screening
B. First Trimester Comprehensive Assessment	The Comprehensive Assessment may be completed over more than one visit during the trimester. A Comprehensive Assessment tool must be used and updated every trimester. https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/Assessment-and-Care-Plan-Forms.aspx
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**

VI. OB/CPSP Preventive Criteria	
	comprehensive assessment in each trimester and post-partum.
2) Nutrition	Dietary Evaluation, Height and weight are documented. Any needed interventions must be noted.
3) Psychosocial Assessment	Depression Assessment; Social and Mental History, Substance use /abuse including alcohol and tobacco; housing, transportation unintended pregnancy, support systems. Documentation of referrals as appropriate. https://custom.cvent.com/C506006261F8428CB7CCB91AAA9A05B4/files/8a01c5b0dd744c0aa06f0dece9dec3f1.pdf
a) Maternal Mental health Screening	*Health and Safety Code 123640: Licensed health care 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, 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.* The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
b) Social Needs Assessment	Social needs assessment including housing, food, transportation, unintended pregnancy, support system available.
c) Substance Use / Abuse Assessment	Substance use /abuse including alcohol and tobacco.
4) Health Education	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 (APL 18-016).
5) Preeclampsia Screening	The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/preeclampsia-screening1
6) Intimate Partner Violence Screening	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, and

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	referral to appropriate community service agencies (CA Health & Safety Code, Section 1233.5).
C. Second Trimester Comprehensive	
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.
2) Nutrition	Dietary Evaluation, Height and weight are documented. Any needed interventions must be noted.
3) Psychosocial Assessment	Depression Assessment, Social and Mental History, Substance use /abuse including alcohol and tobacco; unintended pregnancy, support systems. Documentation of referrals as appropriate. https://www.ncqa.org/wp-content/uploads/2019/02/20190208_08_Perinatal_Depression.pdf
a) Maternal Mental Health Screening	Health and Safety Code 123640: Licensed health care 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, 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. The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
b) Social Needs Assessment	Social needs assessment including housing, food, transportation, unintended pregnancy, support system available.
c) Substance Use / Abuse Assessment	Assessment of substance use /abuse including alcohol and tobacco.
4) 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 (APL 18-016).
5) Preeclampsia Screening	The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/preeclampsia-screening1

VI. OB/CPSP Preventive Criteria	
6) Intimate Partner Violence Screening	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, and referral to appropriate community service agencies (CA Health & Safety Code, Section 1233.5).
D. Third Trimester Comprehensive	
1) Individualized Care Plan (ICP)	ICP documentation includes specific obstetric, nutrition, psychosocial and health education risk problems/conditions, interventions, and referrals.
2) Nutrition	Dietary Evaluation, Height and weight is document.
3) Psychosocial Assessment	Depression Assessment; Social and Mental History, Substance use /abuse including alcohol and tobacco; unintended pregnancy, support systems. Documentation of referrals as appropriate. https://custom.cvent.com/C506006261F8428CB7CCB91AAA9A05B4/files/8a01c5b0dd744c0aa06f0dece9dec3f1.pdf
a) Maternal Mental Health Screening	Health and Safety Code 123640: Licensed health care 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, 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. The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
b) Social Needs Assessment	Social and Mental History (past and current) including housing, transportation and support system available.
c) Substance Use / Abuse Assessment	Substance use /abuse including alcohol and tobacco.
4) Health Education	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 (APL 18-016).
5) Preeclampsia Screening	The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure

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	measurements throughout pregnancy. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/preeclampsia-screening1
6) Intimate Partner Violence Screening	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, and referral to appropriate community service agencies (CA Health & Safety Code, Section 1233.5).
7) Screening for Strep B	All pregnant women are screened for Group B Streptococcus between their 35th and 37th week of pregnancy.
8) Tdap Immunization	Pregnant women should receive a single dose of Tdap during every pregnancy, preferably at 27 through 36 weeks gestation. 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 Advisory Committee on Immunization Practices (ACIP) guidelines, unless medically contraindicated or refused by the member. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/preeclampsia-screening1
E. Prenatal care visit periodicity according to most recent ACOG	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.
F. Influenza Vaccine	CDC and ACIP recommend that pregnant women gets vaccinated during any trimester of their pregnancy https://www.cdc.gov/vaccines/pregnancy/pregnant-women/index.html
G. Referral to WIC and assessment of Infant Feeding status	Pregnant and breastfeeding Plan members must be referred to WIC (Public Law 103-448, Section 203(e)). Referral to WIC is documented in the medical record (Title 42, CFR 431.635). Infant feeding plans are documented during the prenatal period, and infant feeding/breastfeeding status is documented

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	during the postpartum period (MMCD Policy Letter 98-10). **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.
H. HIV-related services offered	All pregnant women under 25 years of age and older if at increased risk. Repeat HIV testing in the third trimester preferably before 36 weeks of gestation. The USPSTF recommends that clinicians screen for HIV infection in all pregnant persons, including those who present in labor or at delivery whose HIV status is unknown. The ***offering*** of prenatal HIV information, counseling and HIV antibody testing is documented (CA Health & Safety Code, Section 125107). 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. https://www.cdc.gov/std/tg2015/screening-recommendations.htm https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Prenatal-and-Perinatal-Human-Immunodeficiency-Virus-Testing?IsMobileSet=false https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/human-immunodeficiency-virus-hiv-infection-screening1
I. 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 (CCR, Title 17, Sections 6521-6532). Genetic screening documentation includes: 1) Family history, 2) Triple marker screening tests: Alpha Fetoprotein (AF), unconjugated estriol (UE), human chorionic gonadotropin (HCG), 3) Member's consent or refusal to participate. **Note:** Member's participation is voluntary. Testing occurs through CDPH Expanded AFP Program, and only laboratories designated by CDPH may be used for testing.
J. Family Planning Evaluation	Family Planning counseling, referral or provision of services is documented (MMCD Policy Letter 98-11). Prenatal discussions should include the woman's reproductive life plans, including the desire for and timing of any future pregnancies.
K. Comprehensive Postpartum	Comprehensive postpartum visit. Timely follow-up is particularly important for women with chronic

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Assessment	medical conditions. This visit should serve as a transition to ongoing well-woman care and the timing of the visit should be individualized, woman-centered. The initial assessment should be followed up with ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth. https://www.acog.org/About-ACOG/News-Room/News-Releases/2018/ACOG-Redesigns-Postpartum-Care?IsMobileSet=false MMCD Policy Letter 12-003 or current version 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 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.**
2) Nutrition Assessment	Nutrition Assessment should include mother and infant including support for breast feeding. Any needed interventions must be noted. Documentation of referrals as indicated. https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Support-for-Breastfeeding-as-Part-of-Obstetric-Practice?IsMobileSet=false Infant feeding/breastfeeding status is documented during the postpartum period (MMCD Policy Letter 98-10 or current version).
3) Psychosocial Assessment	Psychosocial Assessment includes mood and emotional wellbeing; sleep and fatigue. https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Postpartum-Care?IsMobileSet=false https://www.acog.org/About-ACOG/News-Room/News-Releases/2018/ACOG-Redesigns-Postpartum-Care?IsMobileSet=false
a) Maternal Mental Health Screening	*Health and Safety Code 123640: Licensed health care 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 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.*

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	Post-Partum Depression – Assess for Mood and emotional well-being; Screen for postpartum depression and anxiety using a validated tool. Provide guidance on local resources for monitoring and support. Edinburgh Postnatal Depression Scale (EPDS) is most commonly used has been translated in 50 different languages.
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, transportation refer as appropriate.
c) Substance Use / Abuse Assessment	Screen for tobacco and alcohol use and provide counselling; Screen for substance use disorder and refer as indicated.
4) Health Education	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 (APL 18-016).
5) Comprehensive Physical Exam	Comprehensive Physical Exam includes assessments of physical recovery from child birth i.e. perineal or cesarean incision pain; presence of urinary and fecal incontinence, Chronic disease management, perform well-woman screening including Pap test and pelvic exam completed within 12 weeks after delivery. It is recommended that all women have contact with their obstetrician–gynecologists or other obstetric care providers within the first 3 weeks postpartum. This initial assessment should be followed up with ongoing care as needed. https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Postpartum-Care?IsMobileSet=false