



Policy Name: Quality Site Visit Standards
Policy Number: Quality Improvement – 1
Effective Date: 12/1/09
Revision Date: **Review Date:**

**Approval
Signature:**

Medical Director

HMO Illinois, Blue Advantage HMO

Previous Name HCM QI 1 Quality Site Visit
Standards

Approved QI: 12/2/09

Approved P&P: 11/12/09

Policy:

The Managed Care Products of Blue Cross and Blue Shield of Illinois (BCBSIL) onsite audit staff will adhere to Quality Site Visit Standards when conducting quality onsite site visit audits for participating **HMO Illinois and BlueAdvantage HMO** Primary Care Physicians (PCPs) and high volume Behavioral Health Practitioners. Quality site visits are performed for all HMO PCPs every two years to comply with Illinois Department of Public Health requirements. A site visit review will be performed when the HMO receives at least two member complaints within 12 months for a network practitioner. If the complaint indicates a potential patient safety issue, a site visit will be done after one complaint. The site visit will be completed within 60 days of receipt of the complaint in the quality onsite review department.

High volume Behavioral Health Practitioners (those practitioners who see greater than 25 unique patients per year) are determined on an **annual** basis through IPA reporting **and/or analysis of encounter data** of unique patient visits for each Behavioral Health Practitioner.

Purpose:

To audit managed care practitioners against established Quality Site Visit standards including information related to the following:

- Accessibility;
- Office site;
- Emergency Preparedness;
- Medical Record Review; and
- Preventive Services. (Not audited for Behavioral Health)

Procedure:

- A. BCBSIL auditors will schedule a visit with the practitioner office, provide a copy of the onsite standards by which the practitioner will be evaluated and conduct an inspection of the office site which includes, but is not limited to:
1. Member's ability to access health care.
 2. Inspection of the office site including a patient examination room to evaluate compliance with standards.
 3. Medical record review of **at least five medical records** per PCP to evaluate compliance with medical record and preventive care **standards**.

I. ACCESSIBILITY STANDARDS

Purpose:

- To evaluate whether members have appropriate access to medical services.

Procedure:

- A. BCBSIL has specific service expectations for participating Managed Care Practitioners. They are as follows:
1. Physician response to an emergency call within 30 minutes.
 2. Schedule urgent visits within 24 hours.
 3. Schedule routine appointments within 10 business days or two weeks of request, whichever is sooner.
 4. Schedule extended visits (i.e., comprehensive exam, preventive care appointment, etc.) within four weeks of request.
 5. Arrange for an answering system after office hours that members can access through the usual office protocol:
 - ⇒ Response to emergency phone calls should be within 30 minutes.

II. SITE REVIEW STANDARDS

Purpose:

- To assess whether members have appropriate access to healthcare services in a clean and safe environment.

Procedure:

1. Environment:

- The site should be clean and well organized to accommodate patient services.
- Restrooms, doorways and hallways should be easily accessible.
- The waiting room should have adequate seating for the volume of patients.
- There should be an adequate number of exam rooms based on the number of practitioners.
- The site should be accessible to those with disabilities. Please note: **The building must be compliant with ADA (American Disabilities Act) guidelines. If any ADA guideline is not met, the practitioner will have two years from the date of the site review to become compliant with the ADA guideline. Continued non-compliance with the guideline(s) may result in deparicipation from the HMO network(s).**
 - There should be at least one entrance to the office that is accessible to those with impaired mobility or those in a wheel chair.
 - There should be at least one exam room that can be accessed by doorways and hallways that are at least 36 inches wide.

- There should be at least one restroom that can be accessed by doorways and hallways that are at least 36 inches wide.

2. Safety Measures:

- The Practitioner and his/her staff should follow the Centers for Disease Control **and Prevention** Universal Precautions guidelines when providing patient care.
- Bio-hazardous waste must be discarded according to OSHA guidelines.
- Sharp disposal containers must be available.
- Fire Extinguisher must be accessible.

3. Lab Specimens and Medication Maintenance/Storage:

- Sample drugs, over-the-counter medications, prescription drugs, and vaccines should be stored in restricted patient areas.*
- Controlled substances, if present, should be stored in a locked area along with an inventory list.
- **Offices should have policies and procedures for checking medications for expiration dates and for discarding expired medications.****
- All medications should be routinely monitored for expiration dates.
- **Opened medications should be labeled with the date the item was opened.****
- Medication and/or lab refrigerators should be free of food. (Medications and lab specimens may be stored in the same refrigerator if stored in separate areas).

4. Medical Supply and Equipment Maintenance/Storage:

- Sharps should be stored in restricted patient areas.*
- Prescription pads should be stored in restricted patient areas.*
- **Medical equipment should be monitored for sterilization and a maintenance log should be maintained for equipment.****
- **Sterile supplies should be monitored for expiration dates.****

5. Medical Record System:

- Medical records should be handled in a confidential manner. The office must have a written policy that addresses Health Insurance Portability and Accountability Act (HIPAA) requirements regarding Protected Health Information (PHI).
- **The office must have a confidentiality of medical records policy and follow the policy.****
- The Practitioner should have a written policy/procedure detailing how medical record information is to be released.

6. Patient Education:

- Educational materials or literature regarding at least three preventive services and at least two medical conditions relevant to the practitioner's practice must be available for patient use. Examples of preventive materials might be: information about breast self-exam, mammography, Pap smears, pediatric immunizations, coronary risk reduction, or prostate screening. Materials about conditions relevant to the practitioner's practice could cover topics such as asthma management, diabetes management, management of abnormal Pap smears, and pregnancy care.

*Restricted Patient Area – a separate storage space away from the patient care area or a locked receptacle within the patient care area.

**Indicates non-scored item.

III. EMERGENCY PREPAREDNESS

Procedure:

1. Emergency Preparedness

--- The Practitioner should have a written procedure on how to handle a medical emergency for members accessing care at his/her facility. This procedure must be posted in a prominent location or easily accessible through a central file/manual.

--- At least one staff member who has Cardiopulmonary Resuscitation (CPR) Certification should be available during patient care hours. This certification must be kept current and documentation of certification must be available for verification upon request. A valid CPR card will be accepted via fax within one week of the onsite visit.

IV. MEDICAL RECORD REVIEW

Purpose:

BCBSIL requires member medical records to be maintained in a manner that is current, detailed, organized, and easily accessible. All patient data should be filed in the medical record, (i.e., lab, x-ray, consultation notes, etc.) Documentation of a member's care should facilitate communication, coordination and continuity of care and promote efficiency and effectiveness of treatment.

Procedure:

Please note: A history form can include many of the required documentation items. This form can be completed by the patient, office staff or physician. The physician should review the form for completeness, sign and date the form. Blank areas on the form will be scored as non-compliant. The form must be updated at least every three years for adults and at least every five years for the pediatric patient. Preventive care services must be performed according to the dates required per element.

- 1. Past Medical History:** There should be documentation of a past medical history obtained by the third visit or within one year of the first visit, whichever comes first. The past medical history should be updated at least every three years for adults and every five years for pediatric patients.
- 2. Family History:** There should be documentation of a family medical history obtained by the third visit or within one year of the first visit, whichever comes first. The family medical history should be updated at least every three years for adults and every five years for pediatric patients.
- 3. Social History:** There should be documentation of a social history (including, but not limited to, information about family and occupation, and assessment of **tobacco**, alcohol and **illicit** substance use) obtained by the third visit or within one year of **the** first visit, whichever comes first. For pediatric patients, the developmental milestones may be included. The social history should be updated at least every three years for adults and every five years for pediatric patients.

4. **Physical Activity Assessment/ Counseling:** There should be documentation of assessment and/or counseling regarding physical activity obtained by the third visit or within one year of the first visit, whichever comes first. The physical activity assessment/ counseling should be updated at least every two years (ages 18 and above) or every one year (ages 3-17).
5. **Body Mass Index (BMI):** There should be documentation of the patient's BMI (BMI percentile for children) by the third visit or within one year of first visit, whichever comes first. The BMI should be updated every two years for ages 18-74 and the BMI percentile every year for children ages 2-17.**
6. **Weight Management Counseling:** *There should be documentation of education regarding weight management for adults with a BMI over 30 and children with a BMI percentile over 85% by the third visit or within one year of first visit, whichever comes first.***
7. **Nutrition Counseling for Children:** There should be documentation of nutrition counseling every year for patients ages 2-17 years.
8. **Adult Alcohol Use:** There should be documentation regarding alcohol use obtained by the third visit or within one year of the first visit, whichever comes first, for adults age 18 and over. If the member is currently using alcohol, it should be noted. The history of alcohol use should be updated at least every three years. ***In 2010, annual evaluation of alcohol use will be audited, but not scored.*** **
9. **Utilization of an Alcohol Assessment Tool for an Adult:** There should be documentation of the use of an alcohol assessment tool if the patient answers "yes" to alcohol use. **
10. **Adolescent Alcohol Use:** There should be documentation regarding alcohol use obtained by the third visit or within one year of the first visit, whichever comes first, for adolescents age 12-17. If the adolescent is currently using alcohol, it should be noted. The history of alcohol use should be updated every three years. ***In 2010, annual evaluation of alcohol use will be audited and not scored.*****
11. **Utilization of an Alcohol Assessment Tool for an Adolescent:** There should be documentation of the use of an alcohol assessment tool if the patient answers "yes" to alcohol use. **
12. **Adult Inappropriate/ Illicit Substance Use:** There should be documentation regarding inappropriate/ illicit **substance** use obtained by the third visit or within one year of the first visit, whichever comes first, for adults age 18 and over. If the member is currently using illicit **substances**, it should be noted. The history of **substance** use should be updated every three years.
13. **Recommendation for Adult Inappropriate/Illicit Substance Use Treatment:** Instructions and/or education about recommendation for treatment should be provided to members who are identified as using inappropriate/illicit **substances**.**
14. **Adolescent Inappropriate/Illicit Substance Use:** There should be documentation regarding inappropriate/ illicit **substance** use obtained by the third visit or within one year of the first visit, whichever comes first, for adolescents age 12-17. If the member is currently

using illicit **substances**, it should be noted. The history of **substance** use should be updated at least every three years. ***In 2010, annual update of use will be audited and not scored.*** **

- 15. Recommendation for Adolescent Inappropriate/Illicit Substance Use Treatment:** Instructions and/or education about recommendation for treatment should be provided to adolescents age 12-17 who are identified as using inappropriate/ illicit **substances.****
- 16. Smoking History for Adults:** There should be documentation of a smoking history obtained by the third visit or within one year of the first visit, whichever comes first, on adults age 18 and over. If the member is currently smoking, it should be noted. The smoking history should be updated every two years. ***If the patient has not smoked for more than five years, this should be documented then smoking history does not need to be noted every two years.***
- 17. Recommendation for Smoking Cessation for Adults:** Instructions and/or education about smoking cessation should be provided to members age 18 and over who are identified as smokers. If the patient smokes, update the smoking history at least every two years and provide smoking cessation advice at least annually.
- 18. Smoking History for Adolescents:** There should be documentation of a smoking history obtained by the third visit or within one year of first visit, whichever comes first, on adolescents age 12-17. The smoking history should be updated at least every two years.**
- 19. Recommendation for Smoking Cessation for Adolescents:** Instructions and/or education about smoking cessation should be provided to adolescents age 12-17 who are identified as smokers. If the patient smokes, update the smoking history at least every two years and provide smoking cessation advice at least annually. **
- 20. Coordination between Medical and Behavioral Health Care:** If the member is seeing a Behavioral Health Practitioner, there should be documentation of communication between the Behavioral Health Practitioner and the referring physician. Documentation should include, but not be limited to, follow-up regarding coexisting medical and behavioral health disorders and medication management. If the member refuses to allow such communication, this should be documented.
- 21. Immunization Documentation:** Documentation of immunizations administered by the office staff should include the date the vaccine was administered, the manufacturer and lot number, and the name and title of the person administering the vaccine. If the office maintains an immunization log, the medical record must have documentation of the site, the name and title of the person administering the vaccine, and the type of vaccine. The lot number may be documented in the log. The log must be provided for review.
- 22. Chief Complaint/History Relevant to Problem:** Subjective information identifying why the patient is seeking medical attention should be documented. The description should include pertinent history, symptoms, and other related information.
- 23. Physical Examination:** A pertinent physical examination, relevant to the problem, should be documented.

24. **Vital Signs:** Vital signs, consistent with the patient's chief complaint, relevant problem and/or diagnosis, should be documented.
25. **Diagnosis/Assessment:** A diagnosis and/or assessment, consistent with the findings, should be documented.
26. **Treatment Plan/Plan of Care:** A plan of diagnosis (lab testing, x-rays, etc.) and management (medication dose, frequency, and duration, as well as other interventions), consistent with the assessment, should be documented. ***If an abnormal lab or x-ray finding is identified in the medical record, the plan of care should address these findings.*****

Education relevant to the patient's conditions or treatment must be documented at least annually.**

27. **Previous Problems:** Unresolved problems and/or chronic problems from previous office visits should be addressed in subsequent visits.
28. **Continuity of Care, Follow-Up Care, Calls or Visits:** Follow-up care, communication of test results, calls/visits should be documented to indicate continuity of care.
29. **Consultations:** Documentation of response/feedback from a referral for consultation to a specialist should be present in the record and should be signed/initialed by the practitioner and/or there should be a notation in the progress notes indicating that the feedback from the specialist has been reviewed.
30. **Chart Organization:** The Practitioner should maintain a uniform medical record system of clinical recording and reporting with respect to services which includes separate sections for progress notes and the results of diagnostic tests.
31. **Biographical Information:** Each medical record should contain the patient's address, employer, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant. Biographical information should be updated at least every three years.
32. **Patient Identifiers:** Patient identifiers should appear on each page of the medical record (patient name or unique ID number).
33. **Date and Signature:** All entries are to be dated and signed/initialed by the author. Author identification may be a handwritten signature, unique electronic identifier or initials.
34. **Legibility:** All entries should be legible.
35. **Allergy Status:** Medication allergies should be noted in a prominent location in the medical record. If the member has no known allergies or history of adverse reactions, this should be prominently ***and consistently*** noted. Allergies to environmental allergens, food, pets, etc., should also be noted. Allergy histories should be obtained every three years for adults and every five years for pediatric patients. ***Allergies should be updated at least annually, but will not be scored in 2010.*****

- 36. Problem List:** There should be a current problem list, either kept separately or within each practitioner progress note, which includes significant illnesses and medical conditions. A health maintenance record should be present if there are no documented relevant problems. The problem list must be inclusive of all problems whether a separate list or within each practitioner's note.
- 37. Medication List:** There should be a current medication list, either kept separately or within each practitioner progress note. The medication list must be inclusive of all medications, whether a separate list or within each Practitioner progress note, and include prescription initial or refill dates.
- 38. Lab/X-Ray/Diagnostic Results:** The results of all labs, x-rays and diagnostic testing, should be posted in the chart. The reports should be signed or initialed by the practitioner and/or there should be a notation in the progress notes indicating that they have been reviewed.

** This standard will not be included in the scoring results.

V. PREVENTIVE SERVICES

Purpose:

To ensure that members have appropriate access to preventive care services.

Procedure:

BCBSIL has specific Preventive Health Care Guidelines based on national recommendations. Practitioners should provide services in accordance with these guidelines. The offer of services and the subsequent results or the member's refusal to accept services should be documented in the member's medical record. If the service was provided by another practitioner (example: OB/GYN), document in the medical record that the service was provided, with the date and the results. Preventive care services should be provided by the third visit or within one year of the first visit, whichever comes first. The date of service and results or findings should be documented in the medical record. The medical records will be reviewed for performance of the following preventive care services:

A. Adult Female:

- 1. Non-fasting cholesterol** should be performed every five years on members over age 45. The medical record should document the date and results or findings. Only medical records for members age 46 and over will be audited for this measure.
- 2. Pap Smear(s) (Age 21-69)** should be performed approximately three years after becoming sexually active, but no later than age 21. Screen every year with conventional PAP tests or every two years using liquid-based Pap tests. At or after age 30, women who have had three consecutive normal tests may get screened every two to three years with cervical cytology or every three years with an HPV DNA test plus cervical cytology. Women 70 years of age and older who have had three or more normal Pap tests and no abnormal Pap tests in the last ten years may choose to stop cervical cancer screening. Women who have had a total hysterectomy may choose to stop screening. The medical record should document the date of Pap smear service and results or findings. Only medical records for members age 22-69 will be audited for this measure.

3. **Mammography** should be performed every one to two years for members age 40 and over, and date of service and results or findings, should be documented in the medical record. Members who have had bilateral mastectomies should be excluded from screening, and should have the dated history of bilateral mastectomies documented in the medical record. Medical records for members age 42-69 will be audited for this measure. .
 4. **Colorectal cancer screening** should be performed for members age 50-75, by means of ONE of the following screening options:
 - Fecal occult blood test within the past 12 months (FOBT performed during a physical exam on a specimen obtained from a digital rectal exam does not count, because it is not specific or comprehensive enough to screen for colorectal cancer.)
 - Flexible sigmoidoscopy within the past five years
 - Fecal occult blood annually plus flexible sigmoidoscopy within the past five years
 - Colonoscopy within the past 10 yearsOnly medical records for members age 52-75 will be audited for this measure. The chart must include the date, type of test and results.
 5. **Influenza vaccinations** should be administered annually to members at high risk for complications from influenza and to those members age 65 and over. (The medical records audited will include adult members with asthma, diabetes, and cardiovascular disease (CVD) and members age 65 and over). Documentation of immunizations administered by the office should include the date the vaccine was administered, the manufacturer and lot number, and the name of the person administering the vaccine. If the office maintains an immunization log, the medical record must have documentation of the site, the name and title of the person administering the vaccine, and the type of vaccine. The lot number may be documented in the log. The log must be provided for review. ***Ages 50-65 will be audited.*****
 6. ***Bone Density Testing for Osteoporosis should be performed at least once for women after age 65.*****
- B. **Adult Male:**
1. **Non-fasting cholesterol** should be performed every five years on members over the age of 35. The medical record should document the date and results or findings. Only medical records for members age 36 and over will be audited for this measure.
 2. **Colorectal cancer screening** should be performed for members age 50-75, by means of ONE of the following screening options:
 - Fecal occult blood test (FOBT) within the past 12 months (FOBT performed during a physical exam on a specimen obtained from a digital rectal exam does not count, because it is not specific or comprehensive enough to screen for colorectal cancer.)
 - Flexible sigmoidoscopy within the past five years
 - Fecal occult blood annually plus flexible sigmoidoscopy within the past five years
 - Colonoscopy within the past 10 yearsOnly medical records for members age 52-75 will be audited for this measure. The chart must include the date, type of test and results.
 3. **Influenza Vaccinations** should administered annually to members at high risk for complications from influenza and to those members age 65 and over. (The medical records audited will include adult members with asthma, diabetes, and CVD and members age 65 and over). Documentation of immunizations administered by the office should include the

date the vaccine was administered, the manufacturer and lot number, and the name and title of the person administering the vaccine. If the office maintains an immunization log, the medical record must have documentation of the site, the name and title of the person administering the vaccine, and the type of vaccine. The lot number may be documented in the log. The log must be provided for review. **Ages 50-65 will be audited.****

4. **Discussion regarding prostate cancer screening should be documented for males age 50 and over.** Discussion should include information regarding their risk of prostate cancer and potential benefits and harms of prostate cancer screening. Only medical records for members age 52 and over will be audited for this measure.

C. **Children:**

1. **Immunizations** should be performed according to the Preventive Healthcare Guidelines, which are based on the Recommended Childhood Immunization Schedule, United States, as approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

Parent refusal of such services should be documented in the medical record. **These will be scored as non-compliant.**

For members who have transferred from another practitioner, immunization records should be obtained and reviewed for completeness.

Documentation of immunizations administered by the office should include the date the vaccine was administered, the manufacturer and lot number, and the name and title of the person administering the vaccine.

All records for children between the ages of **two** to five years will be audited. The medical records will be audited and scored for immunizations due between the ages of one and two as identified in Table A. The immunizations audited are: DTaP, IPV, Hib, MMR, Hep B, Varicella, and Pneumococcal.

Information will be collected for:

- A.) For children born between 1/1/05 and 12/31/08, the record will be reviewed for at least one influenza vaccination given between the dates 8/1/08 and 3/1/10.**
- B.) Records will be audited for at least one Hepatitis A given between one and two years of age.**
- C.) Records will be audited for at least one rotavirus given before the first birthday.**

****Denotes non-scored item.**

TABLE A

Immunization	Birth	2 mo.	4 mo.	6 mo.	12 mo.	15 mo.	18 mo.	2yr.	4 – 6 yrs.
DTaP		X	X	X		Between 15-18 months			X
IPV		X	X		Between 6-18 months				X
Hib		X	X	(X)+	Between 12-15 months				
MMR					Between 12-15 months				X
Hepatitis B	X	X			Between 6-18 months				
Varicella					Between 12-15 months				X
Rotavirus		X	X	(X)+					
Hepatitis A					Two doses between 12 and 23 months				
Pneumococcal Conjugate (Prevnar)		X	X	X	Between 12-15 months				
Influenza					Annually age 6-59 months				

(X)+ = Whether this dose is needed depends on the brand of vaccine used.

Table B:

Combination Vaccines

Immunization
DTaP + Hep B + IPV (Pediarix)
DTaP + HiB (TriHIBit)
Hep B + HiB (Comvax)
MMR + VZV (ProQuad)
DTaP + IPV+HiB (Pentacel)

Table C:

Contraindications for Childhood Immunizations

Immunization	Contraindication
Any particular vaccine	Anaphylactic reaction to the vaccine or its components
DTaP	Encephalopathy
IPV	Anaphylactic reaction to streptomycin, polymyxin B or neomycin
MMR and VZV	Immunodeficiency, including genetic (congenital) immunodeficiency syndromes
MMR and VZV	HIV disease; asymptomatic HIV
MMR and VZV	Cancer of lymphoreticular or histiocytic tissue
MMR and VZV	Multiple myeloma
MMR and VZV	Leukemia
MMR and VZV	Anaphylactic reaction to neomycin
HiB	None
Hepatitis B	Anaphylactic reaction to common baker's yeast
Pneumococcal conjugate	None

STANDARDS FOR BEHAVIORAL HEALTH PRACTITIONERS

I. ACCESSIBILITY STANDARDS

Purpose:

To evaluate whether members have appropriate access to Behavioral Health services.

Procedure:

- A. BCBSIL has specific service expectations for participating Behavioral Health Care Practitioners. They are as follows:
1. Provide and/or refer for life-threatening emergency care.
 2. Provide and/or refer for non-life-threatening emergency care within six hours.
 3. Schedule and provide urgent care within 24 hours.
 4. Schedule routine appointments within 10 business days or within two weeks of request, whichever is sooner. This includes initial evaluation.
 5. Arrange for an answering system after office hours that members can access through the usual office protocol:
 - ⇒ Response to emergency phone calls should be within 30 minutes.
 - ⇒ Response to urgent phone calls should be within one hour.
 - ⇒ For life-threatening emergencies, members should be referred to the appropriate Health Care Facility.
 6. Arrange for telephone access to screening and triage, if applicable, as follows:
 - ⇒ Callers reach a non-recorded voice within 30 seconds and
 - ⇒ Abandonment rates do not exceed five percent at any given time.

II. SITE STANDARDS FOR BEHAVIORAL HEALTH

Purpose:

To assess whether members receive Behavioral Health care services in a clean and safe environment.

Procedure:

1. Environment:

- The site should be clean and well organized to accommodate patient services.
- Restrooms, doorways and hallways should be easily accessible.
- The waiting room should have adequate seating for the volume of patients.
- The site should be accessible to those with disabilities:

- There should be at least one entrance to the office that is accessible to those with impaired mobility or those in a wheel chair. Please note: **The building must be compliant with ADA (American Disabilities Act) guidelines. If any ADA guideline is not met, the practitioner will have two years from the date of the site review to become compliant with the ADA guideline. Continued non-compliance with the guideline(s) may result in departicipation from the HMO network(s).**
- There should be at least one exam room that can be accessed by doorways and hallways that are at least 36 inches wide.
- There should be at least one restroom that can be accessed by doorways and hallways that are at least 36 inches wide.

2. Safety Measures:

- Sharp disposal containers must be available (if applicable).
- Fire Extinguisher must be accessible.

3. Medication Maintenance/Storage:

- Sample drugs, over-the-counter medications, prescription drugs, and vaccines (if applicable) should be stored in restricted patient areas*
- Controlled substances, if present, should be stored in a locked area along with an Inventory list.
- **Offices should have policies and procedures for checking medications for expiration dates, and for discarding expired medications.****
- All medications should be routinely monitored for expiration dates.
- **Opened medications should be labeled with the date the item was opened.****

4. Medical Supply Maintenance/Storage:

- Sharps should be stored in restricted patient areas* (if applicable)
- Prescription pads should be stored in restricted patient areas* (if applicable)

5. Medical Record System:

- Medical records should be handled in a confidential manner. The office must have a written policy that addresses HIPAA requirements regarding Protected Health Information (PHI).
- **The office must have a confidentiality of medical records policy and follow the policy.****
- The practitioner should have a written policy/procedure detailing how medical record information is to be released.

6. Patient Education:

- Educational materials or literature regarding at least two (mental health or chemical dependency related conditions) medical conditions relevant to the practitioner's practice must be available for patient use.

* *Restricted Patient Area – a separate storage space away from the patient care area or a locked receptacle within the patient care area.*

***Indicates non-scored item.*

III. EMERGENCY PREPAREDNESS

Procedure:

1. Emergency Preparedness

--- The Practitioner should have a written procedure on how to handle a medical emergency for members accessing care at his/her facility. This procedure must be posted in a prominent location or easily accessible through a central file/manual.**

IV. Medical Record Review for Behavioral Health Practitioners

Purpose:

BCBSIL requires member medical records to be maintained in a manner that is current, detailed, organized, and easily accessible. All patient data should be filed in the medical record, (i.e., lab, x-ray, consultation notes, etc.) Documentation of a member's care should facilitate communication, coordination and continuity of care and promote efficiency and effectiveness of treatment.

Procedure:

Please note: A history form can include many of the required documentation items. This form can be completed by the patient, office staff or practitioner. The practitioner should review the form for completeness, sign and date the form. Blank areas on the form will be scored as non-compliant. The form must be updated at least every three years for adults and at least every five years for the pediatric patient.

- 1. Past Medical History:** There should be documentation of a past medical history obtained by the third visit or within one year of the first visit, whichever comes first. The past medical history should be updated at least every three years for adults and every five years for pediatric patients.
- 2. Family History:** There should be documentation of a family medical history obtained by the third visit or within one year of the first visit, whichever comes first. The family medical history should be updated at least every three years for adults and every five years for pediatric patients.
- 3. Social History:** There should be documentation of a social history (including, but not limited to, information about family and occupation, and assessment of cigarette, **tobacco**, alcohol and illicit substance use) obtained by the third visit or within one year of first visit, whichever comes first. For pediatric patients, the developmental milestones may be included. The social history should be updated at least every three years for adults and every five years for pediatric patients.
- 4. Adult Alcohol Use:** There should be documentation regarding alcohol use obtained by the third visit or within one year of the first visit, whichever comes first, for adults age 18 and over. If the member is currently using alcohol, it should be noted. The history of alcohol use should be updated at least every three years. ***In 2010, annual evaluation of alcohol use will be audited.*****

**Indicates non-scored item.

5. **Utilization of an Alcohol Assessment Tool for an Adult:** There should be documentation of the use of an alcohol assessment tool if the patient answers yes to alcohol use.**
6. **Adolescent Alcohol Use:** There should be documentation regarding alcohol use obtained by the third visit or within one year of the first visit, whichever comes first, for adolescents age 12-17. If the adolescent is currently using alcohol, it should be noted. The history of alcohol use should be updated at least every three years. ***In 2010, annual evaluation of alcohol use will be audited.*****
7. **Utilization of an Alcohol Assessment Tool for an Adolescent:** There should be documentation of the use of an alcohol assessment tool if the patient answers yes to alcohol use.**
8. **Adult Inappropriate/Illicit Substance Use:** There should be documentation regarding inappropriate/ illicit **substance** use obtained by the third visit or within one year of the first visit, whichever comes first, for adults age 18 and over. If the member is currently using **substances**, it should be noted. The history of **substance** use should be updated at least every three years.
9. **Recommendation for Adult Inappropriate/Illicit Substance Use Treatment:** Instructions and/or education about recommendation for treatment should be provided to members who are identified as using inappropriate/illicit **substances**.**
10. **Child/Adolescent Inappropriate/Illicit Substance Use:** There should be documentation regarding inappropriate/ illicit **substance** use obtained by the third visit or within one year of the first visit, whichever comes first, for **children/** adolescents age. If the **child/** adolescent is currently using **substances**, it should be noted. The history of **substance** use should be updated at least every three years. ***In 2010, annual update of use will be audited.*****
11. **Recommendation for Child/Adolescent Inappropriate/Illicit Substance Use Treatment:** Instructions and/or education about recommendation for treatment should be provided to **children/**adolescents age who are identified as using inappropriate/ illicit **substances**.**
12. **Chief Complaint/History Relevant to Problem:** Subjective information identifying why the patient is seeking Behavioral Health services should be documented. The description should include pertinent history, symptoms, and other related information.
13. **Mental Status Examination:** A pertinent mental status examination, relevant to the problem should be documented. Mental Status Examination should include a risk assessment documenting the patient's potential for danger to self, danger to others and/or gross impairment. Additional information that should be documented, but will not be scored for 2010, includes ***at least three of the following assessments: appearance, motor evaluation, speech, affect, thought content, thought process, perception, intellect, insight (awareness of illness), orientation, attention span, memory, judgment.*****

**Indicates non-scored item.

14. **Diagnosis/Assessment:** A diagnosis and/or assessment, consistent with the findings, should be documented. Include documentation of a DSM_IV diagnosis.
15. **Treatment Plan/Plan of Care:** A plan of diagnosis (lab testing, x-rays, etc.) and management (medication dose, frequency, and duration, as well as other interventions), consistent with the assessment, should be documented. Document goals and estimated timeframes for goal attainment or problem resolution.

Education relevant to the patient's conditions or treatment must be documented at least annually.**

16. **Previous Problems:** Unresolved problems from previous office visits should be addressed in subsequent visits.
17. **Continuity of Care, Follow-Up care, Calls or Visits:** Follow-up care, communication of test results, calls or visits should be documented to indicate continuity of care.
18. **Consultations:** Documentation of response/feedback from a referral for consultation to a specialist should be present in the record and should be signed or initialed by the practitioner and/or there should be a notation in the progress notes indicating that the feedback from the specialist has been reviewed.
19. **Chart Organization:** The Practitioner should maintain a uniform medical record system of clinical recording and reporting with respect to services which includes separate sections for progress notes and the results of diagnostic tests.
20. **Biographical Information:** Each medical record should contain the patient's address, employer, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant. Biographical information should be updated at least every three years.
21. **Patient Identifiers:** Patient identifiers should appear on each page of the medical record (patient name or unique ID number).
22. **Date and Signature:** All entries are to be dated and signed/initialed by the author. Author identification may be a handwritten signature, unique electronic identifier or initials. Include the responsible clinician's name, professional degree.
23. **Legibility:** All entries should be legible.
24. **Allergy Status:** Medication allergies should be noted in a prominent location in the medical record. If the member has no known allergies or history of adverse reactions, this should be prominently ***and consistently*** noted. Allergies to environmental allergens, food, pets, etc, should also be noted, as they can affect patient behavior. Allergy histories should be obtained by the first visit and updated at least every three years for adults and every five years for pediatric patients. ***For 2010, allergies should be updated at least annually.*****(This will be scored only for those practitioners who prescribe medication).
25. **Problem List:** There should be a current problem list, either kept separately or within each practitioner progress note. The problem list must be inclusive of all problems whether a separate list or within each practitioner progress note.

*****Indicates non-scored item.***

- 26. Medication List:** There should be a current medication list, either kept separately or within each practitioner progress note. The medication list must be inclusive of all medications whether a separate list or within each practitioner progress note, and include prescription initial or refill dates.
- 27. Lab/X-Ray/Diagnostic Results:** The results of all labs, x-rays and diagnostic testing, should be posted in the chart. The reports should be signed or initialed by the practitioner and/or there should be a notation in the progress notes indicating that they have been reviewed.
- 28. *Lithium Assessment: If Lithium is prescribed, documentation of annual creatinine, Lithium level and thyroid test results with documentation of any follow-up. (Psychiatrists only).*****
- Depakote Assessment: If Depakote is prescribed, documentation of annual liver function test results with documentation of any follow-up. (Psychiatrists only).****
- 29. Coordination between Behavioral Health Care and Referring Practitioner:** There should be documentation of communication with a signed release of information form allowing for communication between the Behavioral Health Practitioner and referring practitioner. Documentation should include, but not be limited to, follow-up regarding coexisting medical and behavioral disorders and education management. If the member refuses to allow such communication, this should be documented.

**MINIMUM SCORE TO PASS SITE VISIT
HMOs of Blue Cross and Blue Shield of Illinois and BlueChoice**

Effective January 1, 2010

HMO IPAs and PCPs

2010 Passing Thresholds

Standards Category	Current HMO IPA	Current HMO PCP
Accessibility, Facility, Emergency Care	90%	90%
Medical Record Review, Preventive	90%	90%

NOTE:

Any practitioner failing to meet the minimum passing threshold requirement will be re-audited within six months.

****Any practitioner failing two consecutive site visits must submit a corrective action plan (CAP) within 60 days of receipt of the letter requesting a CAP. Failure to submit a CAP may result in de-participation from the network without a third site visit.

Any practitioner failing three consecutive site reviews may be departed from all networks.