SAN FRANCISCO HEALTH PLAN
Here for you

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Interim Medi-Cal Managed Care Monitoring Review

PCP/ Clinic Name:	**DHCS ID:**	**IPA:**
Site Address:	**City:**	**CA** **ZIP:**
Site Contact(s):	**Phone:**	**Fax:**
Email:	**EMR:**	**Date Sent:**

Circle the appropriate Yes/ No/ NA response below & include any comments.

Critical Element	Compliant		Non-Compliant	Comments
1. Exit doors and aisles are unobstructed and egress (escape) accessible.	**Yes**		**No**	
2. Airway management: oxygen delivery system, oral airways, nasal cannula or mask, Ambu bag.	**Yes**		**No**	Name of person checking supplies:
3. Emergency medicine such as asthma, chest pain, hypoglycemia and anaphylactic reaction management: Epinephrine 1:1000 (injectable), and Benadryl 25 mg. (oral) or Benadryl 50 mg./ml. (injectable), Naloxone, chewable Aspirin, Nitroglycerine spray/tablet, nebulizer or metered dose inhaler and glucose. Appropriate sizes of ESIP needles/syringes and alcohol wipes.	**Yes**		**No**	Name of person checking supplies:
4. Only qualified/trained personnel retrieve, prepare or administer medications.	**Yes**		**No**	Name of *MD/NURSE ONLY* checking MA administered meds:
5. Physician Review and follow-up of referral/consultation reports and diagnostic test results.	**Yes**		**No**	Name of person tracking referrals:
6. Only lawfully authorized persons dispense drugs to patients.	**Yes**		**No**	Name of *MD/NURSE* dispensing drugs:
7. Drugs and Vaccines are prepared and drawn only prior to administration.	**Yes**		**No**	
8. Personal Protective Equipment for Standard Precautions is readily available for staff use.	**Yes**		**No**	
9. Needlestick safety precautions are practiced on site.	**Yes**		**No**	
10. Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport or shipping.	**Yes**		**No**	Name of contracted waste hauler:
11. Staff demonstrates /verbalizes necessary steps/process to ensure sterility and/or high level disinfection to ensure sterility/disinfection of equipment.	**Yes**	**NA**	**No**	
12. Appropriate PPE is available, exposure control plan, MSDS and clean up instructions in the event of a cold chemical sterilant spill.	**Yes**	**NA**	**No**	
13. Spore testing of autoclave/steam sterilizer with documented results (at least monthly).	**Yes**	**NA**	**No**	Date of last spore test:
14. Management of positive mechanical, chemical, and/or biological indicators of the sterilization process.	**Yes**	**NA**	**No**	Method:

"I attest that these statements of compliance are accurate."

PCP/Representative Signature & Title **Date**

MEDICAL GROUP OR HEALTH PLAN USE ONLY	
Interim Review Approved: ☐ Yes ☐ No	Date CAP Due:
Follow-up Required: ☐ Yes ☐ No	Date Follow-up Due:
Nurse Comments:	
Nurse Reviewer Signature:	Date: