Practitioner Office Site Review

Group Name:		Office Address:	
Provider Name(s):			*Street*
			Suite (if applicable)
			City *State* *Zip*
		Reviewer:	

			Y	N	N/A	Comments
A. Facility and Environment						
	1.	Clean, private restroom facility for patients				
	2.	Patient waiting and treatment areas clean and sanitary				
	3.	Patient care areas ensure privacy				
	4.	Handicap accessible What specific arrangements if not accessible?				
	5.	Waiting and treatment rooms adequate in size				
B. Office Operations						
	1.	Does the office have a policy on confidentiality for its staff, with signed documentation as such? If no, see policy statement at the end of this form.				
	2.	Does the office have a system for identifying and contacting patients who miss appointments?				
C. Access to Care						
	1.	What mechanism does the office employ that assures emergency coverage 24 hrs/day, 7 days/week?				
		a. A person to assist callers?				
		b. An answering machine with instructions on how to contact the physician or his/her on-call back-up?				
		c. Other? Explain:				
		d. Off- hour testing (call to office to confirm 24 hour coverage)				
	2.	Can a person with an urgent problem be seen within 24 hours? [non-Behavioral Health (BH)]				
	3.	Adult baseline health status exam (for new patient) within 12 weeks? (non-BH)				
	4.	Routine health maintenance (e.g. non-acute chronic condition, recheck, follow-ups) available within 4 weeks of request? (non-BH)				
	5.	Non-urgent sick visits within 48-72 hours? (non-BH)				
	6.	Well child visits within 4 weeks of request?(non-BH)				
	7.	Behavioral Health appointments for routine care available within 10 business days?				
	8.	Behavioral Health appointments for urgent care available within 48 hours?				
D. Pharmaceuticals						
	1.	Are prescription pads stored in a secure location, to prevent unattended patient access?				
	2.	Are sample prescription drugs to prevent unattended patient access?				

			Y	N	N/A	Comments
E. Office Record Maintenance						
	1.	Office records are kept in secure areas to maintain confidentiality and privacy?				
	2.	Are medical records kept for individual patients?				
	3.	Are records maintained for a minimum of years as required by law?				
	4.	Is there a system to assure all clinical information is reviewed by the practitioner?				
	5.	Are allergies to medications displayed prominently?				
	6.	Does each page in the record contain the patient's name or ID?				
	7.	Is there a consistent method to capture biographical and personal data?				
	8.	Is there a completed problem list in the chart?				

Additional medical record requirements *Not scored (will be scored at time of medical record review)*						
	a.	Office records are neat and legible?				
	b.	All entries are dated and sequential?				
	c.	All medial record entries are signed or initialed, signifying author?				
	d.	Appropriate past medical history in the record. Includes illnesses, surgeries/operations, and mental health history. For children 0-6 years, also includes prenatal care.				

Confidentiality Policy Statement

If the answer to question B1 is No, have the physician/practitioner complete and sign the statement below:

The office of _____ agrees not to disclose ANY patient or client information to anyone without legitimate reasons to know such information, without the patient's express written release, a court order, or unless otherwise required by law.

Physician Signature:

Date:

If one or more standards are not met, ask the physician to indicate below his/her plan to meet the standard and to sign the report. If the physician is not present, a copy of this report will be left with his/her office staff. The Plan expects the physician to indicate the plan for meeting the standard(s), sign the report, and return it to the attention of the Provider Relations representative within thirty days. The Plan will performed another review in six months to confirm that the change has taken place, and to verify compliance.

Standards that haven't been met:	
Plan for meeting these standards:	

Signature of Reviewer: _____ Date: _____

Signature of Provider or Representative: _____ Date: _____

Copy left with office staff for practitioner signature? o Yes o No

Signed copy due on Date: _____