**KEYSTONE FIRST/AMERIHEALTH CARITAS PENNSYLVANIA/**
**AMERIHEALTH NORTHEAST**
**SITE VISIT EVALUATION FORM**

**(This form must be used in conjunction with Reviewer Guidelines – please write legibly)**

F PCP New Site F OB/GYN New Site F Credentialing

F PCP Relocation/Additional Site F OB/GYN Relocation/Additional Site

F Member Dissatisfaction Investigation F Expired Site Visit Evaluation

LOB: F 100 F 500/528 Provider #: _____

Date of Visit: _____ Provider Account Executive (PAE): _____

Provider Contracting Representative (PCR): _____

Name of Practice/Group: _____

Specialty Type: F PCP F OB/GYN F SPECIALIST (Specify) _____

Practice Address: _____

_____

County: _____

Practice: _____ _____ _____
Phone # Fax # E-mail address

Practice Contact Name: _____

Practice Limitations: _____ _____
Age Panel Size (PCP only)

Capitated Lab (if applicable): _____

Provider Type at site: (***01-Physicians***, ***01-Group, 10-Ind. Clinic, 20-Rural Health, 26-FQHC, 40-CRNP***)

| Provider Type | First Name | Last Name | Degree | PPID# | Hospital Affiliation(s) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**(Use additional sheet if necessary)**

**KEYSTONE FIRST/AMERIHEALTH CARITAS PENNSYLVANIA/**
**AMERIHEALTH NORTHEAST**
**SITE VISIT EVALUATION FORM**

***Physician Extenders at Site***

_____ _____
First Name Last Name Degree

_____ _____
First Name Last Name Degree

_____ _____
First Name Last Name Degree

Staffing Physicians # Full Time ☐ # Part Time ☐

Residents # _____ RNs #

LPNs # _____ PAs #

Medical Assistants # _____ Other # _____

***Physical Layout***

Square Footage Waiting Room _____ Square Footage Exam Room _____

Exam Rooms # _____ Lavatories # _____

Routine Office Hours (Total Hrs/wk must be PCP 20 and OB/GYN 12)

Mo _____ Tu _____ We _____ Th _____ Fr _____ Sat _____ Sun _____ Total Hours _____

Pertinent Patient Phone Calls Recorded: _____ _____
Yes No

How? _____

Twenty-four Hour Coverage (24/7) _____ _____
Yes No

***Method(s) Used:***

_____ Answering Service _____ Answering Machine

_____ Internal Coverage _____ External Coverage

_____ Pager _____ Cell Phone

**KEYSTONE FIRST/AMERIHEALTH CARITAS PENNSYLVANIA/**
**AMERIHEALTH NORTHEAST**
**SITE VISIT EVALUATION FORM**

***Covering Physician(s)***

| Physician(s) Name: | | Plan Participating: | |
|---|---|---|---|
| First Name | Last Name | Yes | No |
| First Name | Last Name | Yes | No |
| First Name | Last Name | Yes | No |
| First Name | Last Name | Yes | No |

If not Plan participating – collaborative agreement required – obtain in writing.

Do all covering physicians have admitting privileges? Yes No

(If no, how are admissions handled?)

# KEYSTONE FIRST/AMERIHEALTH CARITAS PENNSYLVANIA/ AMERIHEALTH NORTHEAST
# SITE VISIT EVALUATION FORM

| SITE VISIT REVIEW CRITERIA | PTS. | YES | NO | N/A | COMMENTS |
|---|---|---|---|---|---|
| | | | | | |
| **I. Facility Information** | | | | | |
| a. Office clearly marked. | 2 | | | | |
| b. Adequate parking. | 2 | | | | |
| c. Adequate seating in waiting room. | 2 | | | | |
| d. Office handicapped accessible. | 2 | | | | |
| e. Waiting room visible to receptionist. | 2 | | | | |
| f. Office hours clearly displayed. | 2 | | | | |
| | | | | | |
| **II. Safety** | | | | | |
| a. Smoke alarms in place and operational. | 2 | | | | |
| b. Fire extinguisher clearly marked. | 2 | | | | |
| c. Exit signs visible to patients. | 2 | | | | |
| d. Hallways unobstructed. | 2 | | | | |
| e. Emergency evacuation plan exists. | 2 | | | | |
| f. Overall office environment and equipment are clean & safe. | 2 | | | | |
| g. All rooms are adequately illuminated. | 2 | | | | |
| | | | | | |
| **III. Provider Accessibility** | | | | | |
| a. Are patients scheduled at a rate of 6 or less per hour? | 2 | | | | |
| b. Are patients with urgent/emergent conditions seen same day? | 2 | | | | |
| c. Are patients scheduled for routine visits within 10 days? | 2 | | | | |
| d. Are patients scheduled for complete physical within 3 weeks? **(PCP only)** | 2 | | | | |
| | | | | | |
| **IV. Emergency Preparedness** | | | | | |
| a. Is there a written medical emergency policy? | 4 | | | | |
| b. Are any staff CPR certified? | 4 | | | | |
| | | | | | |
| **V. Treatment Areas** | | | | | |
| a. Does office have 2 or more exam rooms? | 3 | | | | |
| b. Is patient restroom handicap accessible? | 3 | | | | |
| c. Do all exam rooms contain appropriate equipment? | 3 | | | | |
| d. Can patient's privacy be ensured? | 3 | | | | |
| e. Space in exam rooms are adequate? | 3 | | | | |
| | | | | | |
| **VI. Medication Administration** | | | | | |
| a. Medication accessible only to authorized staff? | 2 | | | | |
| b. Prescription pads, needles and syringes are inaccessible to patients and visitors. | 2 | | | | |
| c. Drug and sample medication expiration dates are monitored. | 2 | | | | |
| d. Controlled substances are secured. | 2 | | | | |
| | | | | | |
| **VII. Infection Control** | | | | | |
| a. Methods in place for disposal of hazardous waste. | 2 | | | | |
| b. Appropriate containers used for disposal of needles and syringes. | 2 | | | | |
| c. Note sterilization method for equipment/autoclave or disposable supplies are used primarily. | 2 | | | | |

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**AMERIHEALTH NORTHEAST**
**SITE VISIT EVALUATION FORM**

| SITE VISIT REVIEW CRITERIA (Cont.) | PTS. | YES | NO | N/A | COMMENTS |
|---|---|---|---|---|---|
| | | | | | |
| **VIII. Medical Record Keeping Practices** | | | | | |
| a. Patient name and ID on all pages. | 2 | | | | |
| b. Personal biographical data is included in the patient record. | 2 | | | | |
| c. All entries in the record contain the author's identification. | 2 | | | | |
| d. All entries dated. | 2 | | | | |
| e. Record is legible to someone other than the writer. | 2 | | | | |
| f. Each patient medial record is kept in a separate file (papers are fastened in the file). | 2 | | | | |
| g. Medical records are kept in a secure, confidential area. | 2 | | | | |
| h. Patient's immunization record is documented. | 2 | | | | |
| i. Records can be easily located. | 2 | | | | |
| j. Electronic medical record system. | 2 | | | | |
| | | | | | |
| **IX. General Information** | | | | | |
| a. The provider has never been denied participation in the Medical Assistance Program? | 3 | | | | |
| b. Office process for follow-up on missed appointments? | 3 | | | | |
| c. Appointment reminder system? | 3 | | | | |
| d. Is there an audiometer? **(PCP Only)** | 3 | | | | |
| e. Does the practice utilize a developmental test: Denver (up to age 5); Tanner (6 years and over)? **(PCP Only)** | 3 | | | | |
| f. Are there blood pressure cuffs available for adults? | 3 | | | | |
| g. Are there blood pressure cuffs available for peds? **(PCP Only)** | 3 | | | | |
| h. Is vision screening available? **(PCP Only)** | 3 | | | | |
| i. Are adult scales available? | 3 | | | | |
| j. Are infant scales available? **(PCP Only)** | 3 | | | | |
| k. Will provider administer immunizations? | 3 | | | | |
| l. Is there a separate refrigerator with a thermometer for vaccines? | 3 | | | | |
| m.Will provider treat all conditions within scope of ability? | 4 | | | | |
| **Total Score:** | | | | | |

**KEYSTONE FIRST/AMERIHEALTH CARITAS PENNSYLVANIA/**
**AMERIHEALTH NORTHEAST**
**SITE VISIT EVALUATION FORM**

***HealthChoices Information***

1. The practice has capabilities to accept and treat patients with special needs:

| | | | |
|---|---|---|---|
| F | Hearing Impaired (T.T.D.) | F | Wheelchair Accessibility |
| F | Mentally Retarded Children | F | Mentally Retarded Adults |
| F | The Homebound | F | HIV and/or AIDS |
| F | None of the Above | | |

2. The office is in compliance with ADA Accessibility Guidelines:

_____ Parking (if applicable)
- There is a path of travel out of the parking lot that does not require stepping over a curb.

_____ Path of travel to an entrance
- The path of travel is at least 36" wide except at doorways and gates.
- There is a curb ramp where the path of travel crosses a curb.

_____ Entrance to the building
- The entrance door has a minimum clear opening width of 32".

_____ Entrance to provider office (if different from the building entrance)
- The entrance door to the provider's office has a minimum clear opening width of 32".

3. There is a person or persons employed by the practice who are fluent in a foreign language(s).

Yes ☐ No ☐

If the practice answered yes to foreign language capabilities, please provide name and language(s) spoken:

| First Name | Last Name | Language(s) Spoken |
|---|---|---|
| First Name | Last Name | Language(s) Spoken |
| First Name | Last Name | Language(s) Spoken |

**KEYSTONE FIRST/AMERIHEALTH CARITAS PENNSYLVANIA/**
**AMERIHEALTH NORTHEAST**
**SITE VISIT EVALUATION FORM**

***Results/Deficiencies***

Site Visit Score:

| | | |
|---|---|---|
| PCP | 111 | Percent: |
| OB/GYN | 94 | Percent: |

Medical Record Keeping Score: 20 Percent: _____

***Note***: A passing score is 85% or greater of the total possible score for Site Visit and Medical Record Keeping.

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Results of "after hours" telephone coverage verification:

Date Called: _____ Time Called: _____

| | Yes | No |
|---|---|---|
| Name of Practitioner/Practice Name provided | ☐ | ☐ |
| Is an answering machine the first point of contact for after-hours calls? | ☐ | ☐ |
| Are urgent/emergent instructions the first point of instruction? | ☐ | ☐ |
| Is the name of the covering practitioner stated? | ☐ | ☐ |
| Is a telephone number for after-hours physician access given? | ☐ | ☐ |

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| Deficiencies Identified | Recommended Corrective Action |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |

Site visit results, deficiencies and recommended corrective action (if any) were discussed with the office staff. Staff was informed that corrective action must be implemented within thirty (30) days. A revisit will be scheduled thirty (30) days from this visit.

***Findings reviewed with office staff:*** Yes ☐ No ☐

PAE/PCR Signature: _____ Date: _____

Office Contact Signature: _____ Date: _____

**KEYSTONE FIRST/AMERIHEALTH CARITAS PENNSYLVANIA/**
**AMERIHEALTH NORTHEAST**
**MEMBER DISSATISFACTION SITE VISIT EVALUATION FORM**

***Dissatisfaction Being Investigated:***

Environment Unsafe F Environment Dirty/Unsanitary/Offensive/Inadequate F

Equipment Unsanitary F Other: _____

LOB: F LOB 100 F LOB 500 Provider #: _____

Date of Visit: _____ PAE/PCR: _____

Name of Practice/Group: _____

***Results/Deficiencies:***

| Deficiencies Identified | Corrective Action Plan Required? |
|---|---|
| 1. | Yes F No F |
| 2. | Yes F No F |
| 3. | Yes F No F |
| 4. | Yes F No F |

***Additional Notes/Comments:***

_____

_____

_____

_____

_____

_____

_____

Site visit results, deficiencies and recommended corrective action (if any) were discussed with the office staff. Staff was informed that corrective action must be implemented within thirty (30) days. A revisit will be scheduled thirty (30) days from this visit.

***Findings reviewed with office staff***: Yes F No F

PAE/PCR Signature: _____ Date: _____

Office Contact Signature: _____ Date: _____