SDI TOOL MONITORING INSTRUCTIONS
FY 2007

Reviews are based on requirements found in the Policy Manual. These instructions highlight review procedures. Please note that the manual should always be referred to as the complete reference.

REVIEW CRITERIA	INSTRUCTIONS
I. PROGRAM MANAGEMENT	
1. The agency has an Informational & Educational Advisory Committee (I&E), which consists of five to nine members who are broadly representative of the community/population to be served. There is documentation (meeting minutes, literature evaluation forms) of committee review and approval of all educational materials.	The agency I & E Committee consists of 5-9 members who are representative of the community being served. The I & E Committee has reviewed and approved all informational and educational materials developed by or made available through the agency prior to distribution to assure the materials or information is suitable for the population and community for which they are intended. The reviewer verifies the above and examines documentation of meeting minutes, literature evaluation forms/records, etc**. This is required of Title X contractors only.**
2. The agency current SDI Contractor Manual is accessible to staff members who use SIEBRS at all sites.	The reviewer verifies that current SDI Policies and User Manual version FY06-1 is available at all sites and may be downloaded from the SIEBRS main menu. The agency has ensured that staff responsible for SDI services is familiar with the manual and have access to it.
3. The agency has computer security processes to ensure that:	
a. Employees who use SIEBRS keep user IDs and computer passwords confidential.	The agency has a process whereby SIEBRS users do not share their SIEBRS IDs and passwords with others. It is preferred that they be memorized, but if written down, they should be kept in a secure place and NEVER given for anyone else to use.
b. Employees do not share access to SIEBRS by sharing login time.	The agency has a process verified through policy or interview whereby employees are to use SIEBRS only under their own login
c. Each computer used to access the SIEBRS website has a timed, password protected screen saver to prevent unauthorized access.	The agency has a process verified though policy or interview that each computer that accesses SIEBRS has a password protected, timed screensaver.

REVIEW CRITERIA	INSTRUCTIONS
II. Eligibility	Prior to the on-site visit, the team leader will obtain a list of client records with service information for review from SIEBRS (contact SDI staff for assistance). Ten (10) records are reviewed. If the agency provides services at several sites, 10 records with a sampling from all services are reviewed at each of the sites visited by the Quality Management team. When possible, the list includes 1 client on presumptive eligibility and 1 confidential teen. If a record is not available, select another record for review and inform the team leader so a determination can be made regarding how to mark this section. A finding related to the unavailability of records is noted at the end of the tool in the "Other pertinent information as noted by reviewer" section. To receive a "Yes," at least 80% of the records reviewed are in compliance with that component. That is, of 10 records reviewed, 8 (or 80%) must receive a "Yes" on that component. **NOTE THE FOLLOWING EXCEPTIONS THAT ARE AUTOMATIC FINDINGS: (1) an eligibility finding resulting in the client's actual ineligibility; (2) overcharging the client for covered services; and (3) billing for services not documented in the client's record.** If a contractor/provider is out of compliance with a component, the "No" is marked with an explanation of which component is not in compliance. The 80% compliance level is applied per site visited. If the agency does not have at least 7 records that contain visits since the agency began the program or since the last review, this service is not reviewed and the team leader will be notified.
1. For screening, the whole household is entered into SIEBRS.	When using the screening component of SIEBRS, the SAM (Service Access Manager) enters all members of the client's household, not just their family. SIEBRS will then apply the various program rules, screen for potential eligibility, and group household members into family units. Reviewer verifies through agency policy or interview
2. The client is given a copy of the referral letter, which also includes the referred agency's address, contact person, and phone number.	After screening, the referral letter is printed and given to the client if any referral is given to any member of the household. (If all members were referred to SDI eligibility and no additional program referrals, no referral letter will be generated.) Reviewer verifies through policy or interview. The SAM adds contact information about the agency to which the client is being referred to include the agency name, address, contact person, if possible, and phone number.

REVIEW CRITERIA	INSTRUCTIONS
3. The Statement of Client's Rights and Responsibilities Form is signed and dated by the client and agency representative. One copy is filed in the record, and one copy is given to the client.	A representative of each eligible family (or possible multiple families in the household) signs and dates the Statement of Client's Rights & Responsibility (CR&R) Form. The SAM also signs and dates the CR&R. The client is given a copy or original and a copy or the original is kept in the client record. There is a CR&R signed and dated by both parties each time the client/family is made eligible or re-certified. Reviewer verifies by policy, interview, or review of eligibility records.
III. Billing	
1. The agency bills Medicaid, private insurance, or other third party payers for program services.	The reviewer confirms through policy review or interview that: 1. All SDI contractors are Medicaid providers 2. The agency bills Medicaid for Medicaid eligible clients 3. Whether agency bills other 3rd party payers.
2. Billing in SIEBRS matches documentation in the client (or other) records.	The reviewer verifies that client or other records (such as "super bills") match the information in SIEBRS with regard to date of service and procedure code.
3. The actual service documented in the client record matches the service code billed in SIEBRS.	Reviewer verifies that the services documented in the client record match the service codes billed. (Example of non-compliance for this standard: Service code 99204 (office visit for new client is billed in SIEBRS for 9/10/05 but the medical record indicates that it was an office visit for an established client documented as 99213.)

REVIEW CRITERIA	INSTRUCTIONS
IV. Clinical Record Review	Prior to the on site visit, the team leader will obtain a list of client records with service information for review from SIEBRS. Each component of the record review criteria is reviewed individually for compliance. To receive a "Yes," at least 80% of the records reviewed are in compliance with that component. That is, of 10 records reviewed, 8 (or 80%) must receive a "Yes" on that component. If a contractor/provider is out of compliance with a component, the "No" is marked with an explanation of which component is not in compliance. Ten (10) records from each service (family planning, prenatal, child health, dysplasia, other) provided by the agency and from each clinic site scheduled for review are selected, preferably, the same records used for the billing and eligibility portion of the review. In some cases, more records will need to be reviewed for this section than for the billing and eligibility section. The monthly billing logs are used to select those additional records. The 80% compliance level is applied per site visited. In the case where a record is not available for review, select another record to review and inform the team leader. A finding related to the unavailability of records is noted at the end of the tool in the "Other pertinent information as noted by reviewer" section. If the agency does not have at least 7 records that contain visits since the agency began the program or since the last review, this service is not reviewed and the team leader will be notified. Related to Child Health, all components (unless medically contraindicated) must be completed and documented for the visit to be considered a comprehensive well child medical checkup. The provider is expected to attempt to schedule and provide routine well child preventive health examinations in addition to the sick child office visits.
1. Consent forms (to include Method specific and HIV consent forms, if applicable) are completed and signed.	The record contains the following consents: 1. General Consent for treatment (NOTE: Minors may consent to their care related to pregnancy) **(Note: Scored on the Core Tool)** 2. Method Specific Consent for prescription method of contraception, if applicable, for Family Planning services (NOTE: Minors may consent for Family Planning services provided under Title X only, Title X/XX or Title XIX)

REVIEW CRITERIA	INSTRUCTIONS
	3. HIV consent given verbally or in writing is documented, if applicable (NOTE: Minors may consent to HIV/STD screening and testing) 4. Sterilization Consent Form, if applicable
2. History (initial and interval as appropriate) is completed to include allergies, a risk assessment/identification (family violence, TB, lead, etc.) and immunization status.	The record contains the following history and risk information as appropriate to the client: 1. Reason for visit 2. Current health status, including acute and chronic medical conditions **(not required for Dysplasia services)** 3. Occupational hazards or environmental factors 4. Significant past illness, including hospitalizations 5. Previous surgery/biopsies 6. Blood transfusions and other exposure to blood products **(not required for Dysplasia services)** 7. Current medications, including over the counter and alternative medications 8. Allergies, sensitivities or reactions to medicines or other substance(s) 9. Use of tobacco/alcohol/illicit drugs (including type, duration, frequency, route) 10. Immunization status, including rubella status (non-pregnant female clients of childbearing age with unknown or inadequate rubella immunity must be provided vaccination on-site or referred), tetanus-diphtheria (Td) status for adults, influenza and pneumococcal vaccine status for clients 65 and over **(not required for Dysplasia services)** 11. Pertinent history of immediate family **(not required for Dysplasia services)** 12. Assessment of family violence (including safety assessment, if indicated) **(not required for Dysplasia services)** 13. TB history (BCG, skin test, prior exposure, treatment of disease/infection) 14. Reproductive health history a. Sexual behavior history, including family planning practices, number of partners, sexual orientation, sexual

REVIEW CRITERIA	INSTRUCTIONS
	abuse b. STDs (including hepatitis B and C) and HIV risks and exposure c. Urologic conditions d. Additional *female* reproductive health history elements include: i. Menstrual history ii. Obstetrical history iii. Gynecological conditions iv. Cervical cancer screening history v. In utero exposure to diethylstilbestrol (DES) Additionally, a child's/adolescent's health history includes: 1. Neonatal (inpatient to 2 weeks of age), as indicated 2. Mental health history 3. Developmental history 4. Nutrition and feeding problems history 5. Risk factors for lead, TB, hyperlipidemia/cholesterol (a Risk Assessment for Lead Exposure Questionnaires (E/S) is available in the TMPPM Appendix C (2006) for well child visits through 6 years of age and TB risk assessment forms are also available in Appendix C) Applicable interval histories are obtained.
3. Physical and developmental assessments are documented.	As an integral part of the complete health assessment, the physical exam is based upon the client's presenting symptoms, review of systems (ROS), past history and health risk factors. The record documents a complete physical assessment as applicable. The record documents a complete physical assessment as applicable, including: 1. Height measurement (children, adolescents and annually for females 20 years of age or younger until 2 years post menarche and females 55 years of age or older) 2. Weight measurement (for maternity clients note pre-pregnancy weight and assess on return prenatal visits) 3. BMI or appropriate assessment for overweight/obesity

REVIEW CRITERIA	INSTRUCTIONS
	4. Vision and hearing, age 65 years 5. Blood Pressure evaluation (ages 3 and older) 6. Cardiovascular assessment 7. Clinical Breast exam for females 20 years of age and older 8. Visual inspection of external genitalia and anal area 9. Pelvic exam, including vulvar evaluation and bimanual exam for females (including sexually active adolescents) 10. Palpation of prostate for males as indicated by history 11. Other systems as indicated by history, risk profile, other findings Additional assessments for maternity clients include: 1. Uterine size for gestational age </= 14 weeks or fundal height for gestational age >/= 14 weeks 2. Fetal heart rate (> 12 weeks) 3. Fetal lie/position (> 30 weeks) Additional assessments for children and adolescents include: 1. General head-to-toe exam appropriate to the purpose of the visit. For any portion of the examination that is deferred, the reason(s) for deferral is documented in the client record. 2. BMI (clients 2-20 years of age) 3. Fronto-occipital head circumference (clients under age 2) 4. Nutritional assessment (Refer to Appendix C (2006) for THSteps Nutritional Assessments for more information) 5. Developmental assessment, including a review of milestones 6. Mental health assessment 7. Vision and hearing screening appropriate to age (Refer to the Texas Medicaid Provider Procedures Manual (TMPPM), Texas Health Steps, Vision and Sensory Screening for more information) 8. Age appropriate immunizations 9. Dental assessment **NOTE: Dysplasia visits include a problem-focused physical exam.**
4. Appropriate lab/diagnostic tests are ordered, tracked, results reviewed, and the client was notified of abnormal findings.	The record contains documentation that lab/diagnostic tests were ordered and tracked, the results were reviewed, and the client was notified of abnormal findings. **For Dysplasia clients Consensus Guidelines for the Management of Women with Cervical Cytological Abnormalities are followed).**

REVIEW CRITERIA	INSTRUCTIONS
	Other lab/diagnostic test as indicated by risk assessment, history, and/or physical including: 1. Fecal occult and/or sigmoidoscopy 2. Mammography Laboratory tests for Family Planning and Prenatal clients include: 1. Cervical cancer screening (may be delayed until three years after sexual debut or at age 21 years, whichever comes first) 2. Sexually transmitted disease testing (including Syphilis serology, Hepatitis B Antigen (HbsAg), HIV, Gonorrhea, Chlamydia) (Chlamydia and Gonorrhea testing should be done on sexually active females age 24 or younger at least annually and all pregnant clients) 3. Pregnancy test as indicated by history or physical 4. Rubella serology, if status not previously established 5. TB skin test as indicated by risk assessment, history, or physical 6. Other lab/diagnostic test as indicated by risk assessment, history, and/or physical Additional laboratory tests for Prenatal clients include: 1. Blood type, Rh and antibody screen 2. Hgb/Hct initially (recheck at 32-36 weeks) 3. Hemoglobinopathy screening, as indicated 4. Urine screen or culture 5. Ultrasound, only as clinically indicated 6. Maternal Serum alpha-fetoprotein testing or multiple marker serum screening when indicated and elected by client (15-20 weeks) 7. Prenatal fetal screening/diagnosis, offered to clients age >/= 35, or otherwise at increased risk for trisomy 21 or other fetal genetic disorders (e.g. chorionic villus sampling at 10-12 weeks or amniocentesis at 15-18 weeks) 8. Diabetes screen (24-28 weeks) and Glucose Tolerance test for abnormal screen 9. Antibody screen for RH negative clients, not previously known to be sensitized, between 24-28 weeks (to assess need for Anti-D immune globulin to be given at approximately 28 weeks) 10. Group B Streptococcus screen (between 35-37 weeks if using

REVIEW CRITERIA	INSTRUCTIONS
	"screened-base approach) 11. Non-stress Test (NST) to assess fetal well-being, as clinically indicated 12. Biophysical Profile (BPP)/Fetal Biophysical Profile (FBPP) with Non-Stress Test to assess fetal well-being, as clinically indicated Laboratory tests for children and adolescents include: 1. Newborn Hereditary/Metabolic Testing (NBS) up to 12 months of age (Newborn screening (hereditary/metabolic testing hypothyroidism, PKU, galactosemia, sickle Hgb, and CAH) is required by Texas law before hospital discharge and again between 1 and 2 weeks of age. Date and results of the second newborn screening are to be documented. NBS results may be available from the DSHS Lab by calling 512-458-7578.) 2. Hgb/hct (testing results from WIC clinic or other providers are acceptable if completed within one month of visit, refer to the TMPPM for more information) 3. Hemoglobin Type as indicated when a disorder associated with abnormal forms of hemoglobin (hemoglobinopathy) is suspected. Hgb type results may be available from the DSHS Lab by calling 512-458-7578 (refer to the TMPPM for additional information) 4. Urinalysis as indicated 5. Lead blood testing as indicated by risk assessment 6. Cholesterol screening based on family history, as indicated by risk assessment 7. Iron deficiency anemia screen for menstruating, non-pregnant adolescent females according to risk and history 8. Sexually transmitted disease testing if indicated by risk assessment (age 11 and older) 9. Cervical cancer screening test (Pap Smear) at age 21, 3 years from onset of sexual activity or at another age based on provider's discretion 10. TB skin test as indicated 11. Other labs as indicated
5. Education/counseling/anticipatory guidance is documented, as appropriate.	The record contains documentation of client-centered education and counseling including:

REVIEW CRITERIA	INSTRUCTIONS
	1. All patients: a. Violence b. Injury prevention c. Behavior d. Nutrition e. Health promotion 2. Family Planning: a. Initial Education including: i. Making informed family planning decisions ii. Being aware of available contraceptive methods, including benefits and efficacy iii. Reducing risks of STD's and HIV ➢ Discussion about personal risks ➢ Risk reduction and infection prevention information addressing sexual abstinence, mutual monogamy with an uninfected partner, and/or condom use iv. Understanding the range of services available and how to access specific services v. Understanding the importance of recommended screening tests, health promotion and disease prevention strategies (i.e., cervical cancer screening, colorectal cancer screening, smoking cessation, proper diet or physical activity) vi. Performing breast or testicular self-examination b. Method Specific Counseling including: i. Results of physical exam and evaluation ii. Correct use of client's selected method of contraception including side effects and complications iii. Back up methods, including emergency contraception and discontinuation issues iv. Access for urgent and emergency care, including 24-hour emergency telephone number

REVIEW CRITERIA	INSTRUCTIONS
	3. Prenatal - Note: SDI contractors are not required to cover topics at specific visits but should cover all topics listed under initial and return visits during the course of prenatal services. Additionally, information on the following legislative mandates may be provided at anytime during prenatal, delivery or postpartum services and must be documented: a. Child immunization schedule b. Newborn screening including appropriate schedule for follow-up procedures c. Postpartum depression resource list d. Shaken baby syndrome and coping techniques e. Initial prenatal visit i. Nutrition and weight gain counseling ii. Family violence/abuse iii. Physical activity and exercise iv. Sexual activity v. Environmental or work hazards vi. Travel vii. Tobacco viii. Alcohol use ix. Substance abuse x. Breastfeeding xi. When and where to obtain emergency care xii. HIV and other prenatal test xiii. Seat belt use xiv. Toxoplasmosis precautions xv. Referral to WIC xvi. Use of medications xvii. Information on parenting and postpartum counseling f. Return prenatal visits i. Signs and symptoms of preterm labor (beginning 2nd trimester) ii. Warning signs and symptoms of pregnancy induced hypertension

REVIEW CRITERIA	INSTRUCTIONS
	iii. Selecting provider for infant iv. Postpartum family planning g. Postpartum i. Physiologic changes ii. Signs and symptoms of common complications iii. Care of breast, perineum and abdominal incision iv. Physical activity and exercise v. Breastfeeding/Infant feeding vi. Resumption of sexual activity vii. Family planning/contraception viii. Preconception counseling 4. Dysplasia (includes appropriate pre and post procedure education and counseling) 5. Child/Adolescent Health Initial Well Visit based on health history, risk assessment and physical exam: a. Anticipatory guidance including injury prevention, behavior, health promotion and nutrition (must be face-to-face with the child's parent/caretaker and face-to-face with adolescents) b. Child development c. Immunizations d. When and where to obtain emergency care e. Risk factors identified during visit f. Referral to WIC g. Information on parenting and postpartum counseling 6. Other education and counseling is provided as indicated by risk assessment, history and physical exam
6. Problem management/treatment.	The record contains documentation that problems were managed or treated.
7. Referrals as indicated.	The record contains documentation of referrals, as applicable, including the provision of pertinent client information to the referral source in compliance with HIPAA regulations. For Child Health, dental referrals are given for all patients beginning at 1 year of age.

REVIEW CRITERIA	INSTRUCTIONS
8. Follow-up to include return visit date, missed appointments, and referral outcome.	The record contains documentation of follow-up, including, the return visit date, missed appointments, and referral outcome, as appropriate. If a child comes under care for the first time at any point on the periodicity schedule or if any procedures are not accomplished at the appropriate age, the client must be brought up-to-date with required procedures as soon as possible.
Other pertinent information as noted by reviewer.	