TEXAS HEALTH STEPS (THSteps) TOOL MONITORING INSTRUCTIONS
FY 2007

Reviews are based on requirements found in the TMPPM 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. Clinical Record Review	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. The 80% compliance level is applied per site visited. If multiple sites are visited during a review, ten (10) records provided at each site visited are reviewed. In the case where a record is not available for review, select another record 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 is notified. **When evaluating clinical services by record review or observation, use the *Texas Medicaid Provider and Procedures Manual (TMPPM),* including the periodicity schedule. This manual is updated in January and is available with other helpful information at www.tmhp.com.** All components (unless medically contraindicated) must be completed and documented for the visit to be considered a THSteps comprehensive medical checkup. 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. NOTE: There are 3 required client questionnaires (Hearing, Lead and TB) that are available on the TMHP website.
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. HIV consent given verbally or in writing is documented, if

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	applicable (NOTE: Minors may consent to HIV/STD screening and testing)
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 information as appropriate to the client: 1. Family Medical History 2. Neonatal (inpatient to 2 weeks of age), for those aged 5 years or under 3. Physical history 4. Mental health history a. Depression and suicide risk assessment beginning at age 11 b. Learning problems beginning at age 11 5. Developmental history 6. Nutrition and feeding problems history (risk assessment for eating disorders beginning at age 11) 7. Immunization status 8. Significant past illness, including hospitalizations* 9. Previous surgery/biopsies** 10. Blood transfusions and other exposure to blood products** 11. Current medications, including over the counter and alternative medications** 12. Allergies, sensitivities or reactions to medicines or other substance(s)** 13. Use of tobacco/alcohol/illicit drugs (including type, duration, frequency, route) beginning at age 11 14. Assessment of family violence and physical, sexual and emotional abuse (including safety assessment, if indicated) 15. Risk factors for: a. Lead (a Risk Assessment for Lead Exposure Questionnaire (E/S) is available in the TMPPM. The Risk Assessment for Lead Exposure Questionnaire is given at well child visits through 6 years of age, except for the 12 and 24-month checkups when a blood level is drawn. b. TB: The reviewer checks for documentation of a tuberculosis screen and/or test appropriate to prevalence level of the area and client age. In areas of low prevalence, the TB Questionnaire is administered annually beginning

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	at 1 year of age. In areas of high prevalence (refer to the DSHS website), the TB skin test is administered at 1 year of age, once between 4 through 6 years of age and once between 11 through 17 years of age with the TB Questionnaire being administered beginning at 2 years of age and annually when the TB skin test is not administered. The reviewer checks for documentation the client returned for the provider to read the skin test or documentation of a good faith effort by the provider to read the TB test result. TB risk assessment forms are also available in the TMPPM. c. Hyperlipidemia/cholesterol: The reviewer checks the record for documentation of hyperlipidemia/cholesterol screening for those at risk of increased levels of cholesterol based on history, nutritional assessment and clinical findings. THSteps does not provide a formal questionnaire. Specific recommendations of the American Academy of Pediatrics (AAP) for selective testing of children and adolescents focus on parents and grandparents diagnosed with heart disease or having heart related surgeries at or before 55 years of age and parents with an elevated blood cholesterol level (240 mg/dL or higher). d. Type 2 Diabetes 16. Additional health history components for adolescents: a. Sexual behavior history, including family planning practices, number of partners, sexual orientation, sexual abuse b. STDs (including hepatitis B) and HIV risks and exposure (for sexually active or high-risk adolescents, screening includes evaluation for genital warts) c. Urologic conditions***** d. Additional *female* health history elements include***** i. Menstrual history***** ii. Obstetrical history***** iii. Gynecological conditions*****

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	iv. Cervical cancer screening history (first obtained 3 years after the onset of sexual activity or at 21 years of age, whichever comes first)***** Applicable interval histories are obtained. ***Recommended standard of practice but do not cite if not found in record.**
3. Physical and developmental assessments are documented.	The reviewer examines the client record for a documented comprehensive physical examination at each well child checkup. An age-appropriate complete unclothed physical exam is required at each checkup. Older children are to be appropriately draped. Based on clinician judgment, a pelvic exam is conducted on sexually active adolescents. For informational purposes only, refer to the WIC website, http://www.dshs.state.tx.us/wichd/secure%2Dpol/nutrassess.pdf, as a resource for specific information regarding measurements. The record documents a complete physical assessment as applicable, including: 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. Height measurement 3. Weight measurement (for maternity clients note pre-pregnancy weight and assess on return prenatal visits*) 4. BMI (clients 2-20 years of age) 5. Fronto-occipital head circumference (clients under age 2) 6. Blood Pressure evaluation (ages 3 and older) 7. Cardiovascular assessment 8. Clinical Breast exam for females 20 years of age and older ***** 9. Visual inspection of external genitalia and anal area***** 10. Pelvic exam, including vulvar evaluation and bimanual exam for females (including sexually active adolescents)***** 11. Palpation of prostate for males as indicated by history***** 12. Other systems as indicated by history, risk profile, other findings 13. Nutritional assessment (Refer to Guidelines for Nutrition Assessment for more information)

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	14. Developmental assessment, including a review of milestones - THSteps checkups completed by physicians, physician assistants, and advanced practice nurses (pediatric nurse practitioners and family nurse practitioners) for children birth up to and including the 6 year medical checkup include: a. A standardized developmental screen (the provider's choice of observational or parent questionnaire) for a child between 9 through 12 months of age, 18 through 24 months of age, and every other year thereafter b. Standardized screening is conducted if a parent expresses concern about the child's developmental progress c. Developmental screening at all other well child visits includes a review of milestones (gross and fine motor skills; communication skills, speech-language development; self-help/care skills; social, emotional, and cognitive development) and mental health Registered nurses conducting THSteps checkups for children birth through 6 years of age conduct: a. A standardized observational screen for children in the following age groups: 9 through 12 months of age, 18 through 24 months of age; and again at 24 months through 6 years of age if the child does not have a record of a standardized observational developmental screen b. A standardized parent questionnaire at all other periodic visits through the 6th year of age or when a parent expresses concern about the child's developmental progress 15. Mental health assessment 16. Vision screening appropriate to age: (Refer to the Texas Medicaid Provider Procedures Manual (TMPPM), Texas Health Steps, or the Periodicity Schedule for more information) The following defines when objective screening is to be completed starting at age 3 years: a. Birth through 2 years of age – Screening includes history of high risk conditions, observation, and physical examination

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	b. Ages 3 through 10, 12, 15 and 18 years of age – Screening includes using an age-appropriate vision chart. Documentation of test results from a school vision-screening program may be used if conducted within 12 months of the checkup. 17. Hearing screening appropriate to age (Refer to the Texas Medicaid Provider Procedures Manual (TMPPM), Texas Health Steps or Periodicity Schedule for more information) The following defines when objective screening is to be completed starting at age 4 years: a. Birth through 3 years of age – Screening includes history, observation, and screening by use of the Hearing Checklist for Parents (E/S) b. Ages 4 through 10, 12, 15, and 18 years of age – A puretone audiometer is used to screen hearing at checkups. Subjective screening may be completed at all other checkups. Documentation of results from a school audiometric screening program may be used if conducted within 12 months of the checkup 18. Age appropriate immunizations: The reviewer checks for documentation of immunizations provided or immunization status based on client age (using the Recommended Childhood Immunization Schedule for the United States). Clients are not referred to the local health department for immunizations. Vaccines are obtained from the Texas Vaccines for Children Program at DSHS and administered at the time of the checkup, unless medically contraindicated or because of parent's reasons of conscience including a religious belief. 19. Dental assessment ***Recommended standard of practice but do not cite if not found in record.**
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. 1. Newborn Hereditary/Metabolic Testing (NBS) up to 12 months of age (Newborn screening (hereditary/metabolic testing for hypothyroidism,

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	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 - Hgb type is part of the newborn screening. If Hgb type has been performed previously and results are documented in the client's chart, it does not need to be repeated. It may also be performed at the provider's discretion, as appropriate for age and population groups. 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 and at the discretion of the provider 5. Lead blood testing at 12 and 24 months of age 6. Fasting glucose, as indicated by risk assessment for Diabetes II and/or physical exam 7. Cholesterol screening based on family history, as indicated by risk assessment at the provider's discretion (if the history and physical indicates the client is at risk and there is no documentation in the record of actions to reduce the risk, interview the provider regarding their rationale not to test.) 8. Sexually transmitted disease testing if indicated by risk assessment, including cultures for gonorrhea and chlamydia and a blood test for syphilis (age 11 and older) 9. Cervical cancer screening test (Pap Smear) 10. TB skin test as indicated Other labs as indicated
5. Education/counseling/anticipatory guidance is documented, as appropriate.	The reviewer checks for documentation of anticipatory guidance. Counseling/anticipatory guidance is an integral part of each checkup and must be face-to-face with the child's parent/caretaker and face-to-face with adolescents. Anticipatory guidance include: 1. Developmental expectations (including adolescent development and becoming involved in health care decisions) 2. Dental health 3. Sleep

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	4. Feeding and nutrition (includes diet and fitness for adolescents) 5. Elimination 6. Lead poisoning risks 7. Healthy lifestyle/practices, including the following for adolescents: a. Avoiding tobacco, alcohol, high noise exposure, other abusable substances, and anabolic steroids b. Abstaining from vaginal, oral, and anal intercourse as the most effective way to prevent pregnancy and sexually transmitted diseases c. HIV transmission and that latex condoms are effective in reducing the risk of some STDs, including HIV d. Reinforcing responsible sexual behavior 8. Accident and disease prevention, including the following for adolescents: a. Avoiding alcohol/drugs while using motorized or recreational vehicles or when impaired judgment may lead to injury b. Use of safety devices (e.g., seat belts, motorcycle and bicycle helmets, athletic protective devices c. Resolving interpersonal conflicts without violence d. Avoiding the use of weapons and promoting weapon safety e. Obtaining appropriate physical conditioning before exercise 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 reviewer checks for documentation of a dental referral beginning at 1 year of age and every 6 months thereafter. (Patients are eligible for emergency dental treatment also)
8. Follow-up to include return visit date, missed appointments, and referral outcome.	The reviewer checks for documentation or other proof of appropriate follow-up. If a THSteps component cannot be completed, a follow-up visit must be scheduled to complete the necessary procedures.

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Other pertinent information as noted by reviewer.	