



Facility Standards

Primary Care and Specialty Care Practitioners

For purposes of a site visit or credentialing site visit, the passing score is 90% and inclusive of the designated “must pass” categories. (*)

1. Facility maintenance and physical appearance
 - a. The facility must be generally maintained and have adequate lighting.
 - b. Physical appearance of the facility shall be clean and safe.
 - c. The furnace room must be clean and orderly.

2. Radiology/mammography
 - a. General radiology equipment must be properly licensed.
 - b. Mammography equipment must be properly licensed and accredited by ACR (American College of Radiology).

3. Laboratory
 - a. Laboratory services and equipment must be properly licensed through CLIA, when applicable.

4. Medications
 - a. Medications and solutions must be stored appropriately and labeled identifying the contents and expiration date.
 - b. Scheduled drugs must be securely locked in e.g., a cabinet/drawer/cupboard.
 - c. Scheduled drugs (and samples) must be signed/logged out when dispensed.
 - d. Expired medications must be purged from supplies on a routine basis.
 - e. Refrigerators must be maintained and used appropriately (medications, including vials and syringes, laboratory specimens or food items, are not stored together).
 - f. All prescription and drug prescription pads must be stored in a non-public area.

5. Syringes (*)
 - a. Syringes must be stored in a non-public area.
 - b. Syringes must be disposed of in a safe and recommended manner.

6. Sterilization (*)
 - a. If an autoclave is used, all sterilized items must be properly wrapped and dated with the “run” date. Autoclave items are considered sterile if packaging integrity is maintained, e.g., no tear in packaging or water damage to paper package.
 - b. All sterilized items must be stored properly in a clean and dry area.
 - c. Each autoclave must be quality checked appropriate to the frequency of operation as follows:
 - Weekly with a live spore test on equipment operated on a daily or weekly basis;
 - If patient items are processed less frequently than weekly (e.g., every 10 days, bi-weekly, or monthly), a live spore test must be performed with each run.
 - A heat indicator test strip is to be included in every load.
 - All results of live spore and heat indicator testing must be logged, dated and signed.

- d. Cold sterilization must be performed using the correct solution containing an FDA approved high-level disinfectant/sterilant. Example: solutions containing 2% Gluteraldehyde.
 - e. Daily indicator tests must be performed on cold sterilization soaking solutions to assess solution concentrations. This will ensure the concentration is adequate to achieve disinfection. (For example, water collected on the instruments from washing and rinsing prior to immersion in the solution dilutes the solution.) All results must be logged, dated and signed.
 - f. Disinfectant containers must be labeled with the name of the solution and date solution is to be changed/or expires. Note: Please refer to the instructions on the cold sterilant container, contact the company or discuss with infection control staff at your affiliated hospital.
7. Examination rooms/treatment rooms and waiting areas
- a. All exam rooms must be equipped with or have access to a sink.
 - b. Soap dispensers must be utilized for hand washing.
 - c. Paper towels must be utilized for hand drying.
 - d. Clean/sterile medical and patient care supplies must not be stored under the sink area or directly on the floor.
 - e. Thermometers should be cleaned and stored according to current recommended guidelines.
 - f. There should be a separate designated area for clean and dirty supplies and equipment and separate cleaning (i.e. utility) area.
 - g. Examination table paper or appropriate disinfectant is to be utilized between patients to clean the exam table (as well as patient use equipment).
 - h. Examination and treatment rooms and waiting areas shall have adequate space and seating (in accordance with MDCH/ADA handicap access and maneuverability requirements).
 - i. Examination and treatment rooms and waiting areas shall provide patient's adequate privacy.
 - j. Personal protective equipment is provided.
8. Safety
- a. Toxic materials must be appropriately labeled.
 - b. Toxic materials must be properly stored.
 - c. Toxic materials must be disposed of properly.
 - d. All gas tanks must be checked for volume and secured appropriately.
 - e. Combustible items must not be stored near the furnace or water heater.
 - f. Exits and corridors must be clear and have adequate lighting.
 - g. All corridors, entrances and exits must be physically accessible, clear and obstruction free.
 - h. The facility must have access to adequate parking.
 - i. The facility is ADA compliant-handicapped accessible with wheelchair maneuverability (ramp, elevator when facility has multiple floors, handrails, entrances, doorways, and designated parking etc.in facilities constructed after 1972).
 - j. Facility restroom must be ADA compliant-handicapped accessible with (i.e. rails, doorway, wheelchair accommodations, sink, toilet).
 - k. Standard Precautions (formerly known as Universal Precautions) must be utilized as appropriate per recognized OSHA Standards.
 - l. State Bio-Medical Waste Registration must be current and posted, if applicable.

9. Medical treatment record keeping practices (*)
 - a. The medical record shall be stored where access is limited to authorized personnel only and kept locked when not in use and during off hours (e.g., separate file room, file cabinets, etc.). Electronic medical records (EMR) must be password protected and compliant with HIPAA.
 - b. The information contained in the medical record shall be treated as confidential and shall be disclosed only with an authorization for release of information.
 - c. Medical records shall be retained in accordance with HAP's retention policy.
 - d. An individual medical record shall be established and maintained for each patient.
 - e. The medical record shall be legible, and format shall facilitate the review and retrieval of information, e.g., organized, chronologically ordered or divided by type of information, e.g., labs, consults, etc.
 - f. All entries into the medical record shall be signed and dated by the provider of service. Initials may be used providing there is a signature log on file showing the typed name, provider signature and provider initials. Each entry into the clinical record is to be dated e.g. date of visit, telephone communication, lab results or other tests communicated from the facility to the patient. Prescription refill calls should also be documented.
 - g. There is a process and appropriate documentation to ensure the review of diagnostic and consult reports by the physician, as well as process for timely communication of results to the patient.
 - h. Medical records shall be available in the physician office during the patient visit.
 - i. Advanced Directives are addressed with each adult patient and the completed documents are maintained in the patient record. Advanced care planning recommendation, discussion and appropriate information is provided to the patient and documented in the chart accordingly.

10. Appointment wait time (*) (applies to PCP and Gyn)
 - a. Well visits (non-symptomatic) shall be accommodated within **1-30 days** of patient request.
 - b. Routine visits (symptomatic/non-urgent) shall be accommodated within **2-4 days** of patient request.
 - c. Urgent visits (serious, non-emergency injury/illness) shall be accommodated within the **same or next day** of patient request.