PCMH Recognition Checklist

Standard	Requirement
PCMH1: Enhance Access and Continuity	
Element A - Access During Office Hours ~ MUST PASS	
1 Providing same-day appointments	Policy ☐ AND 1 week call log ☐
2 Providing timely clinical advice by telephone during office hours	Policy ☐ AND 1 week report ☐
3 Providing timely clinical advice by secure electronic messages during office hours	Policy ☐ AND 1 week report ☐
4 Documenting clinical advice in the medical record.	Policy ☐ AND 1 month report (N/D) OR 3 examples☐
Element B - After-Hours Access	
1 Providing access to routine and urgent-care appointments outside regular business hours	Policy ☐ AND Proof of hours (website, brochure, etc.) ☐
2 Providing continuity of medical record information for care and advice when the office is not open	Policy ☐
3 Providing timely clinical advice by telephone when the office is not open	Policy ☐ AND 1 week report ☐
4 Providing timely clinical advice using a secure, interactive electronic system when the office is not open	Policy ☐ AND 1 week report ☐
5 Documenting after-hours clinical advice in patient records.	Policy ☐ AND 1 month report (N/D) OR 3 examples☐
Element C - Electronic Access	
1 More than 50 percent of patients who request an electronic copy of their health information (including problem list, diagnoses, diagnostic test results, medication lists, allergies) receive it within three business days	3 month report (N/D) 1 ☐
2 At least 10 percent of patients have electronic access to their current health information (including lab results, problem list, medication lists, and allergies) within four business days of when the information is available to the practice	3 month report (N/D) 2 ☐
3 Clinical summaries are provided to patients for more than 50 percent of office visits within three business days	3 month report (N/D) 3 ☐
4 Two-way communication between patients/families and the practice	Screen Shot demonstrating capability 4 ☐
5 Request for appointments or prescription refills	Screen Shot demonstrating capability 5 ☐
6 Request for referrals or test results	Screen Shot demonstrating capability 6 ☐

PCMH Recognition Checklist

Element D - Continuity

#	Item	Policy	Documentation
1	Expecting patients/families to select a personal clinician	Policy ☐	
2	Documenting the patient's/family's choice of clinician		Screen Shot demonstrating capability☐
3	Monitoring the percentage of patient visits with a selected clinician or team.		1 week report☐

Element E - Medical Home Responsibilities

#	Item	Policy	Documentation
1	The practice is responsible for coordinating patient care across multiple settings	Policy☐ AND	Has materials it provides to patients such as:
2	Instructions on obtaining care and clinical advice during office hours and when the office is closed		-Patient Brochure 1☐ -Written Statement 2☐
3	The practice functions most effectively as a medical home if patients/families provide a complete medical history and information about care obtained outside the practice		-Link to online video 3☐ -Web Site 4☐ -Patient Compact
4	The care team gives the patient/family access to evidence-based care and self-management support		

Element F - Culturally and Linguistically Appropriate Services

#	Item	Policy	Documentation
1	Assessing the racial and ethnic diversity of its population	Policy ☐	Overall Report☐
2	Assessing the language needs of its population	Policy ☐	Overall Report☐
3	Providing interpretation or bilingual services to meet the language needs of its population	Policy ☐	Example of service☐
4	Providing printed materials in the languages of its population		Screen shot or Supporting Documentation☐

Element G - Practice Team

#	Item	Policy	Documentation	
1	Defining roles for clinical and nonclinical team members		Job Descriptions	☐
2	Having regular team meetings or a structured communication process	Policy ☐	Minutes from meeting, Agenda, Etc.	☐
3	Using standing orders for services		Example of Written Standing Orders	☐
4	Training and assigning care teams to coordinate care for individual patients	Policy ☐	Description of training schedule 4☐ 5☐ 6☐ 7☐	
5	Training and assigning care teams to support patients and families in self-management, self-efficacy and behavior change	Policy ☐		
6	Training and assigning care teams for patient population management	Policy ☐		
7	Training and designating care team members in communication skills	Policy ☐		
8	Involving care team staff in the practice's performance evaluation and quality improvement activities	Policy ☐	Proof of staff roles **OR minutes from meeting**	☐

PCMH Recognition Checklist

PCMH2: Identify and Manage Patient Populations

Element A - Patient Information

Item	Documentation	Check
1 Date of birth		1☐
2 Gender		2☐
3 Race		3☐
4 Ethnicity		4☐
5 Preferred language		5☐
6 Telephone numbers	3 month report (N/D)	6☐
7 E-mail address		7☐
8 Dates of previous clinical visits		8☐
9 Legal guardian/health care proxy		9☐
10 Primary caregiver		10☐
11 Presence of advance directives (NA for pediatric practices)		11☐
12 Health insurance information		12☐

Element B - Clinical Data

Item	Documentation	Check
1 An up-to-date problem list with current and active diagnoses for more than 80 percent of patients		1☐
2 Allergies, including medication allergies and adverse reactions, for more than 80 percent of patients		2☐
3 Blood pressure, with the date of update for more than 50 percent of patients 2 years and older	3 month report (N/D)	3☐
4 Height for more than 50 percent of patients 2 years and older		4☐
5 Weight for more than 50 percent of patients 2 years and older		5☐
6 System calculates and displays BMI (NA for pediatric practices)	Screen Shot demonstrating capability	6 ☐
7 System can plot and display growth charts (length/height, weight and head circumference (less than 2 years of age) and BMI percentile (2–20 years) (NA for adult practices)		7 ☐
8 Status of tobacco use for patients 13 years and older for more than 50 percent of patients (NA for pediatric practices if all patients <13 years)	3 month report (N/D)	8☐
9 List of prescription medications with the date of updates for more than 80 percent of patients		9☐

PCMH Recognition Checklist

Element C - Comprehensive Health Assessment

1. Documentation of age- and gender-appropriate immunizations and screenings
2. Family/social//cultural characteristics
3. Communication needs
4. Medical history of patient and family
5. Advance care planning (NA for pediatric practices)
6. Behaviors affecting health
7. Patient and family mental health/substance abuse
8. Developmental screening using a standardized tool (NA for practices with no pediatric patients)
9. Depression screening for adults and adolescents using a standardized tool.

Policy demonstrating how the information is consistently collected ☐

OR

Completed Patient Assessment 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐

Element D - Use Data for Population Management ~ MUST PASS

1. At least three different preventive care services
2. At least three different chronic care services
3. Patients not recently seen by the practice
4. Specific medications.

Reports showing need for services

1☐☐☐ 2☐☐☐ 3☐ 4☐

AND

Materials showing how patients are notified

PCMH3: Plan and Manage Care

Element A - Implement Evidence-Based Guidelines

1. The first important condition
2. The second important condition
3. The third condition, related to unhealthy behaviors or mental health or substance abuse.

Supporting documentation showing evidence based guidelines and implementation for each condition 1☐ 2☐ 3☐

Element B - Identify High-Risk Patients

1. Establishes criteria and a systematic process to identify high-risk or complex patients
2. Determines the percentage of high-risk or complex patients in its population.

Policy ☐

Non-descript report (N/D)☐

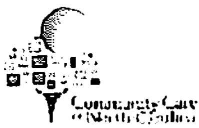
PCMH Recognition Checklist

Element C - Care Management ~MUST PASS

Factor	Documentation	Factors met
1 Conducts pre-visit preparations		1☐
2 Collaborates with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit		2☐ 3☐ 4☐
3 Gives the patient/family a written plan of care	3 Month report (N/D)	5☐
4 Assesses and addresses barriers when the patient has not met treatment goals		6☐ 7☐
5 Gives the patient/family a clinical summary at each relevant visit	OR	
6 Identifies patients/families who might benefit from additional care management support	Record Review Workbook	
7 Follows up with patients/families who have not kept important appointments	☐	

Element D - Medication Management

Factor	Documentation	Factors met
1 Reviews and reconciles medications with patients/families for more than 50 percent of care transitions		1☐
2 Reviews and reconciles medications with patients/families for more than 80 percent of care transitions		2☐ 3☐
3 Provides information about new prescriptions to more than 80 percent of patients/families	3 Month report (N/D)	4☐ 5☐
4 Assesses patient/family understanding of medications for more than 50 percent of patients with date of assessment		6☐
5 Assesses patient response to medications and barriers to adherence for more than 50 percent of patients with date of assessment	OR	
6 Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients/families, with the date of updates	Record Review Workbook ☐	



PCMH Recognition Checklist

Element E - Use Electronic Prescribing

1	Generates and transmits at least 40 percent of eligible prescriptions to pharmacies		1☐
2	Generates at least 75 percent of eligible prescriptions	3 Month report (N/D)	2☐
3	Enters electronic medication orders into the medical record for more than 30 percent of patients with at least one medication in their medication list		3☐
4	Performs patient-specific checks for drug-drug and drug-allergy interactions	Screen Shot demonstrating capability	4☐ 5☐
5	Alerts prescribers to generic alternatives		6☐
6	Alerts prescribers to formulary status		

PCMH4: Provide Self-Care Support and Community Resources

Element A - Support Self-Care Process ~ MUST PASS

1	Provides educational resources or refers at least 50 percent of patients/families to educational resources to assist in self-management	3 Month report (N/D)	1☐ 2☐
2	Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients, if appropriate		3☐ 4☐
3	Develops and documents self-management plans and goals in collaboration with at least 50 percent of patients/families		5☐ 6☐
4	Documents self-management abilities for at least 50 percent of patients/families	OR	
5	Provides self-management tools to record self-care results for at least 50 percent of patients/families	Record Review Workbook ☐	
6	Counsels at least 50 percent of patients/families to adopt healthy behaviors		

Element B - Provide Referrals to Community Resources

1	Maintains a current resource list on five topics or key community service areas of importance to the patient population	Sample List of Resources☐
2	Tracks referrals provided to patients/families	One month tracking report☐
3	Arranges or provides treatment for mental health and substance abuse disorders	Policy☐
4	Offers opportunities for health education programs (such as group classes and and peer support).	Policy☐

PCMH5: Track and Coordinate Care

PCMH Recognition Checklist

Element A - Test Tracking and Follow-Up

1 Tracks lab tests until results are available, flagging and following up on overdue results — Policy☐
2 Tracks imaging tests until results are available, flagging and following up on overdue results — Policy☐
3 Flags abnormal lab results, bringing them to the attention of the clinician — Policy☐
4 Flags abnormal imaging results, bringing them to the attention of the clinician — Policy☐
5 Notifies patients/families of normal and abnormal lab and imaging test results — Policy☐
6 Follows up with inpatient facilities on newborn hearing and blood-spot screening (NA for adults) — Policy☐
7 Electronically communicates with labs to order tests and retrieve results — Policy☐
8 Electronically communicates with facilities to order and retrieve imaging results — Policy☐

Example of how the process is met: 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐

9 Electronically incorporates at least 40 percent of all clinical lab test results into structured fields in medical records — 3 Month report (N/D) ☐
10 Electronically incorporates imaging test results into medical records. — Policy☐ Example of how the process is met ☐

Element B - Referral Tracking and Follow-Up ~MUST PASS

1 Giving the consultant or specialist the clinical reason for the referral and pertinent clinical information
2 Tracking the status of referrals, including required timing for receiving a specialist's report
3 Following up to obtain a specialist's report

1 week report: 1 ☐ 2 ☐ 3 ☐

4 Establishing and documenting agreements with specialists in the medical record if co-management is needed — Policy☐
5 Asking patients/families about self-referrals and requesting reports from clinicians — Policy☐

AND 3 Examples: 4 ☐ 5 ☐

6 Demonstrating the capability for electronic exchange of key clinical information (e.g., problem list, medication list, allergies, diagnostic test results) between clinicians — Screen Shot demonstrating capability ☐
7 Providing an electronic summary of the care record to another provider for more than 50 percent of referrals. — 3 Month report (N/D) ☐

Element C - Coordinate With Facilities and Care Transitions

	Item	Documentation
1	Demonstrates its process for identifying patients with a hospital admission and or patients with an emergency department visit	Policy☐
2	Demonstrates its process for sharing clinical information with the admitting hospitals and or emergency departments	Policy☐ AND 3 examples☐
3	Demonstrates its process for consistently obtaining patient discharge summaries from the hospital and other facilities	Policy☐ AND 3 examples☐
4	Demonstrates its process for contacting patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit	Policy☐ AND 1 month report (N/D) OR 3 examples☐
5	Demonstrates its process for exchanging patient information with the hospital during a patient's hospitalization	Policy☐ AND 1 example☐
6	Collaborates with the patient/family to develop a written care plan for patients transitioning from pediatric care to adult care (NA for adult-only practices)	Copy of a written transition of care☐
7	Demonstrates the capability for electronic exchange of key clinical information with clinicians in facilities	Screen Shot demonstrating capability☐
8	Provides an electronic summary-of-care record to another care facility for more than 50 percent of transitions of care.	3 Month report (N/D) ☐

PCMH6: Measure and Improve Performance

Element A - Measure Performance

1 At least three preventive care measures
2 At least three chronic or acute care clinical measures
3 At least two utilization measures affecting health care costs
4 Performance data stratified for vulnerable populations

Report showing performance and performance

1	2	3	4
☐☐☐	☐☐☐	☐☐	☐

Element B - Measure Patient/Family Experience

1 The practice conducts a survey (using any instrument) to evaluate patient/ family experiences on at least three categories
2 The practice uses the CAHPS PCMH survey tool
3 The practice obtains feedback on the experiences of vulnerable patient groups
4 The practice obtains feedback from patients/families through qualitative means.

Reports with summarized results

1	2	3	4
☐	☐	☐	☐

PCMH Recognition Checklist

	Element C - Implement Continuous Quality Improvement ~ MUST PASS		
1	Set goal and act to improve performance on at least three measures from Element A	Reports on Performance improvement measures	1☐
2	Set goals and act to improve performance on at least one measure from Element B	OR	2☐ 3☐
3	Set goals and address at least one identified disparity in care or service for vulnerable populations	Completed PCMH Quality Improvement Worksheet	
4	Involve patients/families in quality improvement teams or on the practice's advisory council.	Policy☐ AND Example of how the process is met ☐	

	Element D - Demonstrate Continuous Quality Improvement		
1	Tracking results over time	Reports on Performance improvement measures	1☐
2	Assessing the effect of its actions	OR	2☐
3	Achieving improved performance on one measure	Completed PCMH Quality Improvement Worksheet	3☐
4	Achieving improved performance on a second measure		4☐

	Element E - Report Performance			
1	Within the practice, results by individual clinician	Policy☐	AND	Blinded result reports
2	Within the practice, results across the practice	Policy☐		
3	Outside the practice to patients or publicly, results across the practice or by clinician.	Policy☐	AND	Example of how patients are told

	Element F - Report Data Externally		
1	Ambulatory clinical quality measures to CMS or states	Report showing exchange of data	1☐
2	Ambulatory clinical quality measures to other external entities		2☐
3	Data to immunization registries or systems	Report showing exchange of data	3☐
4	Syndromic surveillance data to public health agencies.		4☐