OKLAHOMA Health Care Authority

SoonerCare

2023 Patient-Centered Medical Home (PCMH) Compliance Review Tool

Requirement		Requirement Description	Level
A.	Medical Record Availability	The Provider makes medical records available to OHCA staff upon request.	REQUIRED All Levels
B.	Patient Encounter Documentation	Each visit note includes at a minimum: chief complaint, history and physical (H&P) relative to complaint (subjective and objective), physician's medical impression, plan, treatment, follow-up plan and status of unresolved problems from previous visits.	REQUIRED All Levels
C.	Legibility	The medical record must be legible to someone other than the writer.	REQUIRED All Levels
D.	Authentication	All entries, including dictation, must be identified by the author and authenticated by his or her entry. This includes electronic signatures in the Electronic Medical Record (EMR).	REQUIRED All Levels
E	Problem List	Within the medical record, significant illnesses and medical conditions must be indicated on the problem list. The list must include those conditions which were referred for further evaluation and/or referred to a specialist.	REQUIRED All Levels
F.	Medication List & Review	The medical record must include a complete and detailed list of past and current medications. The list must include all medications, over the counter supplements, and herbs the member is taking, including those prescribed and/or provided by other practitioners. Each listed medication, supplement and herb must include the name, dosage, frequency, quantity, start and stop date.	REQUIRED All Levels
G.	Allergy Documentation	Medication, substance, and food allergies must be documented in a uniform location in each medical record. If there are no medication allergies "no known drug allergies" (NKDA) must be documented.	REQUIRED All Levels

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H.	History Content	Documentation within the member medical record must be done on the initial visit and at least annually. Documentation must include: member's past medical surgical, family and social history. For children <13 months, the history information must include the pregnancy and delivery information (term/preterm, birth weight, length, head circumference, etc.) Document "not applicable" in lieu of absent documentation.	REQUIRED All Levels
I.	History Authentication	Patient history must be reviewed and authenticated by the Provider's signature/e-signature annually.	REQUIRED All Levels
J.	Patient Education / Instructions	Provider supplies patient/family education and support utilizing varying forms of educational materials appropriate for individual patient needs/medical conditions to improve understanding of the medical care provided and plan of treatment. An example would include patient education handouts. This education must be documented within the patient medical record.	REQUIRED All Levels
K.	Physical Assessment	Physical assessment is documented within the medical record. The physical assessment is relevant to the chief complaint, supports medical decision making including the plan of care and diagnosis.	REQUIRED All Levels
L.	Immunization Records	The medical record includes a complete history of immunizations received if member is <21 years of age, and an appropriate history for adults. The provider must provide an Oklahoma State Immunization Information System (OSIIS) pin number and submit data to OSIIS as appropriate.	REQUIRED All Levels

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M.	Referral Documentation	Documentation within the medical records must support the referral process and reflect the current status, results, and patient follow up for all referrals. Copies of the referral and referral response or consult report should be included in the medical record. If unable to obtain the results, provider may show attempts to obtain the results or consultation report in the medical record or in a tracking system.	REQUIRED All Levels
N.	Diagnostic Tests Documentation	Documentation within the medical records must support the diagnostic process and reflect the current status and/or results for all diagnostic orders and testing. Documentation must demonstrate follow up with patient of all diagnostic tests and procedure results. This includes initial orders, ongoing tracking, consult reports, and ordering provider's actions to address the results or outcomes.	REQUIRED All Levels
O.	Preventive Services	Preventive services are to be provided in accordance with the national standard Guidelines of Bright Future EPSDT periodicity schedule for children <21 years of age. An unclothed exam of all body systems reviewed for patients <21 years of age at each EPSDT visit. Medical record documentation must include all required components for each EPSDT visit including appropriate screenings, immunizations & anticipatory guidance. Preventive services are also required for each adult patient based on the US Preventive Task Force Guidelines.	REQUIRED All Levels
P.	Care Coordination	Provider will coordinate the delivery of primary care services with any specialist, case manager, and community-based provider involved with the member (WIC, and Children's First program, home health, hospice, DME, etc.) This includes but is not limited to: referrals, lab/diagnostic testing, preventive services and behavioral health screening.	REQUIRED All Levels

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Q.	Behavioral Health Screening	Behavioral health screening is an annual requirement for all members ages 5 and up. Provider must use a measurable screening tool, brief intervention and referral for treatment if indicated.	REQUIRED All Levels
R	Transitional Care Coordination	Provider coordinates transitional care for all panel members. This is the coordination and follow-up for any care/services received by the member in any outpatient and inpatient facilities. Information obtained from the member, OHCA or the facility should be documented within the medical record and added to the problem list. Upon notification of member activity, the provider attempts to contact member and schedule a follow up appointment as appropriate.	REQUIRED Advanced and Optimal Levels
S.	Post-Visit Follow up	Provider implements post-visit outreach. The outreach effort should be done after an acute or chronic visit and is documented within the member's medical record. Outreach is overseen and directed by the provider but may be performed by the appropriate designated staff. (Examples of outreach include phone calls to monitor medication changes, weight checks, blood glucose, blood pressure monitoring, etc.)	REQUIRED Advanced and Optimal Levels
T	Health Risk Assessment	Provider utilizes standard health risk assessment tools to identify potential member needs and risks (developmental or symptom specific.) Tool may address demographics, lifestyle, medical history, illness, etc. Examples include AAP standardized developmental screening tool such as MCHAT, disease specific high risk assessment tools (e.g., diabetes, COPD, sleep apnea, asthma, fall risk, and social support screenings.)	REQUIRED Advanced and Optimal Levels

Entry Level = Requirements A - Q
Advanced & Optimal Levels = Requirements A - T