In accordance with the Arkansas Medicaid PCMH Addendum, practices must complete and document the PCMH activities. During our onsite visit, please ensure that you have all needed documentation **PRINTED** to support each of the 2017 PCMH **12-month** activities. The PCMH QA team will *review* all supporting documentation for each of the Activities listed below.

To assist you in preparing for PCMH QA validation, we have created a checklist of items to prepare for our visit.

12-Month Activities

✓	***ACTIVITY:***
	Activity F: Childhood/adult vaccination strategy • Describe the practice's implemented process to deliver immunization to both the pediatric and adult population leading to administration of immunization for the upcoming year • Indicate the ability to document historic immunization data into an EHR and review on each visit • Indicate the capability to submit data electronically to immunization registries or immunization information

	Activity G: Indicate if the practice has joined SHARE • If practice has joined SHARE, the practice must have the ability to access inpatient discharge and transfer information via SHARE • If the practice has not joined SHARE, the practice must participate in a network that delivers hospital discharge information to the practice within 48 hours The practice should provide a description of the network in which the practice participates that delivers hospital discharge information to the practice

	Activity H: Indicate if the practice has incorporated e-prescribing into the practice workflow • Describe the technology platform used to e-prescribe • Be prepared to demonstrate how the e-prescribe is used

	Activity I: The care plan activity will NOT be validated during the onsite visit. During the review process each care plan submitted must include all the following: 1. Documentation of the beneficiary's appropriate problem list; active, significant clinical condition 2. Instruction for follow-up. Documentation should include the timing of a future follow-up visit (related to the problem). 3. Assessment of progress to date: Documentation and assessment of each problem (stability or change of condition)

	4. Updated at least twice within a 12-month period: Documented update to the plan of care that would include active problems

	Activity J: Health literacy screening administered to at least 50 beneficiaries • Provide an example of the tool used to assess health literacy • Provide a description of the overall results of the assessment • Develop and describe a plan to help low-health literacy beneficiaries understand instructions and education materials

	Activity K: Indicate if the practice has implemented a process to obtain feedback from patients • Describe the method used to obtain feedback from patients • Explain who in the practice reviews the feedback • Describe the capacity in which the feedback is shared with others within the practice • Describe how the feedback is used to make improvements in the practice

	Activity L: Provide an after-visit summary of the relevant and actionable information as well as instructions from patient's last visit • Describe how information regarding any lab tests is relayed to the patient within three days of visit • How does the practice ensure patient gets the results?

	Activity M: Define the practice's medication reconciliation process • Document updates to the active medication list in the EHR at least twice a year for high-priority beneficiaries • Describe the process of how the medication list is updated on a timely basis from the last visit • Provide a short synopsis of the medication reconciliation process

	Activity N: Indicate if the practice has a written policy or process for monitoring follow-up visits/phone calls within 10 days of an inpatient stay • Produce documentation of a follow-up visit or follow-up phone call • Random selection of documentation from beneficiaries with an inpatient stay within the performance period will be made for validation