Person-Centered Medical Home (PCMH) Readiness Evaluation Questionnaire

Revision E – 06.01.2025

PCMH READINESS EVALUATION QUESTIONNAIRE

*** Please complete all required fields marked by an asterisk ***

A. PRACTICE DEMOGRAPHIC INFORMATION

FIELD NUMBER AND REQUIRED INFORMATION		PRACTICE RESPONSE
*A.1	**Practice Name**	
*A.2	**Main Contact First Name**	
*A.3	**Main Contact Last Name**	
*A.4	**Address Line 1**	
A.5	**Address Line 2**	
*A.6	**Practice City**	
*A.7	**Practice State**	
*A.8	**Practice Zip Code**	
*A.9	**Practice Telephone Number**	Ext.
*A.10	**Practice Fax Number**	
*A.11	**Main Contact Email Address**	

B. PRACTICE INFORMATION

FIELD NUMBER AND REQUIRED INFORMATION		PRACTICE RESPONSE
*B.1	**Is your practice CMAP Enrolled?**	☐ Yes ☐ No
*B.2	**If No, are you willing to enroll in CMAP?**	☐ Yes ☐ No
*B.3	**Indicate type of practice**	☐ Independent Private Practice ☐ Federally Qualified Health Center ☐ Hospital Outpatient Clinic ☐ Other If other, enter type: Note: For purposes of the DSS PCMH Program, hospital outpatient primary care clinics must enroll as a practitioner group to bill outpatient professional services. Per DSS policy, Provider Bulletin 2016-06, as of July 1, 2016, hospital outpatient primary care clinics need to create and enroll as a practitioner group(s) in the Connecticut Medical Assistance Program (CMAP).
*B.4	**Are you aware of Connecticut's Department of Social Services Person-Centered Medical Home program?**	☐ Yes ☐ No
*B.5	**Have the key decision makers in your practice read the**	☐ Yes ☐ No

B. PRACTICE INFORMATION

FIELD NUMBER AND REQUIRED INFORMATION		PRACTICE RESPONSE
	CT DSS current rules and regulations regarding the PCMH Program located on the HUSKY Health website?	
*B.6	**What is your practice type? (Check all that apply)**	☐ Family Practice ☐ Internal Medicine ☐ Geriatrics ☐ Pediatrics
*B.7	**How many site locations do you have?**	
*B.8	**How many full-time equivalent Primary Care Providers are in your practice?**	
*B.9	**Do you have any of the following as part of your practice? (Check all that apply)**	☐ Hospital-Based Clinic ☐ Accountable Care Organization (ACO) ☐ School-Based Health Center ☐ Mobile Van ☐ Homeless Shelter ☐ Behavioral Health Integration (BHI)
*B.10	**Does your practice have Primary Care Providers that do NOT manage a panel of patients?**	☐ Yes ☐ No
*B.11	**Which types of Practitioners are in your practice? (Check all that apply)**	☐ M.D. ☐ D.O. ☐ APRN ☐ P.A. ☐ Community Preceptor ☐ Psychologist ☐ LCSW ☐ Other Behavioral Health Clinician

C. PERSON-CENTERED MEDICAL HOME

FIELD NUMBER AND REQUIRED INFORMATION		PRACTICE RESPONSE
*C.1	**Is your practice familiar with the NCQA Person-Centered Medical Home?**	☐ Yes ☐ No ☐ Somewhat familiar
*C.2	**Is your practice NCQA PCMH recognized, and if so, under which Standards and Guidelines?**	☐ 2017 ☐ 2014 Level 1 ☐ 2014 Level 2 ☐ 2014 Level 3 *If recognized, please go to question C.6* ☐ Not recognized/Have not applied
*C.3	**If not NCQA PCMH recognized, are you interested in obtaining recognition?**	☐ Yes ☐ No ☐ Not Sure
C.4	**What is the target timeframe?**	

C. PERSON-CENTERED MEDICAL HOME

C.5	**Is your practice aware of any financial incentive reimbursements available from any other carriers to assist you in reaching NCQA PCMH recognition?**	☐ Yes ☐ No
C.6	**Is your practice aware of any financial incentive reimbursements available from any other carriers after your practice achieved or achieves NCQA PCMH recognition?**	☐ Yes ☐ No *If your practice is already NCQA recognized, please go to question C.12*
C.7	**Has your practice reviewed the NCQA PCMH Standards and Guidelines**	☐ Yes ☐ No
C.8	**Has your practice reviewed or participated in any NCQA PCMH Trainings/Webinars?**	☐ Yes ☐ No
C.9	**Has your practice reviewed the NCQA PCMH eligibility criteria and pricing information?**	☐ Yes ☐ No
C.10	**Has your practice enrolled in Quality Performance Assessment Support System (Q-PASS)**	☐ Yes as a Single Site ☐ Yes as a Multi-Site ☐ No
C.11	**If your practice is pursuing or obtained NCQA PCMH recognition, are you or did you work with an outside company or consultant?**	☐ Yes ☐ No
C.12	**If YES, name of company/consultant**	

D. HEALTH INFORMATION TECHNOLOGY

FIELD NUMBER AND REQUIRED INFORMATION		PRACTICE RESPONSE
*D.1	**Does your practice use an Electronic Health Record (EHR/EMR)? Please answer YES if you are implementing or scheduled to implement an EHR.**	☐ Yes *Please go to question D.2* ☐ No *Please go to question D.7*
D.2	**If YES, enter vendor name?**	
D.3	**If YES, enter product name and version?**	Product Name: Version:
D.4	**How long has your EHR been in place?**	
D.5	**If YES, Is your EHR ONC Certified?**	☐ Yes – Complete ☐ Yes – Modular ☐ No ☐ Not Sure
D.6	**Choose the statement that reflects EHR Meaningful Use (MU) Incentive payments in your practice**	☐ Have attested and currently receiving MU incentive payments ☐ Have attested but did not receive MU incentive payments ☐ Will be attesting in next: months (enter number)

		☐ Have no plans to attest for MU ☐ Practice not eligible for EHR. MU incentives. *Please go to question D.11*
D.7	**If NO EHR, what is your practice plan for using an EHR?**	☐ No plans for using an EHR *If No, Please go to question D.13* ☐ Yes, considering an EHR
D.8	**If considering an EHR, what is your timeline for considering?**	
D.9	**If considering an EHR, what vendor(s) are you considering?**	
D.10	**If considering an EHR, and working with a consultant, please provide name of consultant.**	
D.11	**Have you discussed the capability of your EHR to provide features and reports needed for Meaningful Use with your vendor/consultant?**	☐ Yes ☐ No
D.12	**Have you discussed the capability of your EHR to deliver the reports needed for NCQA PCMH documentation with your vendor/consultant?**	☐ Yes ☐ No
*D.13	**Do you have an electronic billing system currently in place?**	☐ Yes ☐ No
D.14	**If YES, enter vendor name?**	
D.15	**Does the system include an electronic scheduling system?**	☐ Yes ☐ No
D.16	**If NO, do you have plans to move to electronic billing and scheduling?**	☐ Yes ☐ No
D.17	**Do you have an electronic patient registry?** (A patient registry is used internally by a practice to generate lists of patients by specific conditions to use for quality improvement, reductions of disparities, and outreach)	☐ Yes ☐ No
D.18	**If YES, does this registry apply to all of your patients?**	☐ Yes ☐ No
D.19	**If you track a subset of your population, please specify.**	
D.20	**Does your practice/center have a way to obtain reports?**	☐ Yes ☐ No
D.21	**If YES, what type of reports can be obtained?**	
D.22	**Are you sharing electronic record information with providers outside of your practice?**	☐ Yes ☐ No
D.23	**Are you actively working on sharing data with any other health service entity?**	☐ Yes ☐ No
D.24	**If YES, please list:**	
D.25	**Are there any health services entities with whom you wish you could share clinical data?**	☐ Yes ☐ No

D.26	**If YES, please list:**	
D.27	**Do you have the ability to generate prescriptions electronically?**	☐ Yes ☐ No
D.28	**If YES, does the e-prescribe function transmit to the pharmacy electronically?**	☐ Yes ☐ No
D.29	**If you do not presently have the ability to e-prescribe, do you have the plans to include this function?**	☐ Yes ☐ No
D.30	**If YES, when will you implement this function?**	☐ Before EHR Implementation ☐ During EHR Implementation ☐ After EHR Implementation ☐ No plans to Implement EHR

*Please complete all required fields marked by an asterisk *

E. SIGNATURE

Name of Representative Completing this Form *Date Submitted (mmddyyyy)*

F. ELECTRONIC SUBMISSION OF QUESTIONNAIRE

IMPORTANT: Please read the instructions before submitting.
It is important to download the file before filling out and save the file before submitting the document.
Please submit using the current form on the website, as the content is periodically revised.
This form was created using Adobe® Acrobat® 10 Pro Version 10.1.16.
It has been tested using Adobe® Acrobat® Reader 11 and Microsoft® Internet Explorer® 11.0.
The form should be submitted using an Adobe Acrobat application using Internet Explorer.
The free version of Acrobat Reader is available from Adobe at **http://get.adobe.com/reader/.**
SAVE THIS FORM! While editing the PCMH Readiness Evaluation Questionnaire, and when it is completed, save this form as a .pdf file with the following name: ***PracticeName_PCMHReadinessEval_mm-dd-yyyy.pdf.***
-- ANY DATA NOT SAVED WILL BE LOST --

By clicking the **SUBMIT** button at the bottom of this document, **after saving this form**, you certify that all information provided in the questionnaire is accurate and correct.

Clicking the submit button transmits the information to the ASO.

SUBMIT

If you have any questions about this PCMH Readiness Evaluation Questionnaire
contact the Medical ASO at **203.949.4194** or pcmhapplication@chnct.org.