Community Health Network of Connecticut, Inc.

PCMH 2011 Must Pass Elements Review

Element	Factors		How Factors Met	Date and Completed By:
The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for:	1A1 ☐	Providing same-day appointments (Critical Factor)		
	1A2 ☐	Providing timely clinical advice by telephone during office hours		
	1A3 ☐	Providing timely clinical advice by secure electronic messages during office hours		
	1A4 ☐	Documenting clinical advice in the medical record		
The Practice uses patient information, clinical data and evidence-based guidelines to generate lists of patients and to proactively remind patients/families and clinicians of services needed for:	2D1 ☐	At least three different preventive care services (Menu MU)		
	2D2 ☐	At least three different chronic care services (Menu MU)		
	2D3 ☐	Patients not recently seen by practice		
	2D4 ☐	Specific medications		
The care team performs the following for at least 75 percent of the patients identified in elements A and B:	3C1 ☐	Conducts pre-visit preparations		
	3C2 ☐	Collaborates with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit.		
	3C3 ☐	Gives the patient/family a written plan of care		
	3C4 ☐	Assesses and addresses barriers when the patient has not met treatment goals		

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	3C5 ☐	Gives the patient/family a clinical summary at each relevant visit		
	3C6 ☐	Identifies patients/families who might benefit from additional care management support		
	3C7 ☐	Follows up with patients/families who have not kept important appointments		
The practice conducts activities to support patients/families in self-management:	4A1 ☐	Provides educational resources or refers at least 50 percent of patients/families to educational resources to assist in self-management		
	4A2 ☐	Uses an EHR to identify patient-specific education resources and provide them to more then 10 percent of patients, if appropriate		
	4A3 ☐	Develops and documents self-management plans and goals in collaboration with at least 50 percent of patients/families (Critical Factor)		
	4A4 ☐	Documents self-management abilities for at least 50 percent of patient/families		
	4A5 ☐	Provides self-management tools to records self-care results for at least 50% of Pts./families.		
	4A6 ☐	Counsels at least 50 percent of patients/families to adopt healthy behaviors		
The practice coordinates referrals by:	5B1 ☐	Giving the consultant or specialist the clinical reason for the referral and pertinent clinical information		
	5B2 ☐	Tracking the status of referrals, including required timing for receiving a specialist's report		
	5B3 ☐	Following up to obtain a specialist's report		

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	5B4 ☐	Establishing and documenting agreements with specialists in the medical record if co-management is needed		
	5B5 ☐	Asking patients/families about self-referrals and requesting reports from clinicians		
	5B6 ☐	Demonstrating the capability for electronic exchange of key clinical information (e.g., problem list, medication list, allergies, diagnostic test results) between clinicians (Core MU)		
	5B7 ☐	Providing an electronic summary of the care record to another provider for more than 50 percent of referrals (Menu MU)		
The practice uses an ongoing quality improvement process to:	6C1 ☐	Set goals and act to improve performance on at least three measures from Element A		
	6C2 ☐	Set goals and act to improve performance on at least one measure from Element B		
	6C3 ☐	Set goals and address at least one identified disparity in care or service for vulnerable populations		
	6C4 ☐	Involve patients/families in quality improvement teams or on the practice's advisory council		