PATIENT CENTRED
Medical Home

Patient Centred Medical Home Self-assessment (PCMH-A)

Practice name: _____

Your name: _____

Date completed: _____

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The Patient-Centred Medical Home Assessment Version 4.0.

The MacColl Center for Health Care Innovation at Group Health Research Institute and Qualis Health; Seattle, WA. September 2014.

Western NSW Primary Health Network respectfully acknowledges the Traditional and Historical Owners, past and present, within the lands in which we work.

Introduction to the PCMH-A

The Patient Centred Medical Home Assessment (PCMH-A) is intended to help practices understand their current level of 'medical homeness' and identify opportunities for improvement. The PCMH-A can also help practices track progress toward practice transformation when it is completed at regular intervals.

The PCMH-A was developed by the MacColl Center for Health Care Innovation at the Group Health Research Institute and Qualis Health for the Safety Net Medical Home Initiative (SNMHI). The PCMH-A was extensively tested by the 65 practices that participated in the SNMHI, including federally qualified health centres (FQHCs), residency practices, and other settings, and is in use in a number of regional and national initiatives.

Before you begin

Identify a multidisciplinary group of practice staff

We strongly recommend that the PCMH-A be completed by a multidisciplinary group (e.g. GPs, practice nurses, practice manager, other operations and administrative staff) in order to capture the perspectives of individuals with different roles within the practice and to get the best understanding of 'the way things really work.'

We recommend that everyone complete the assessment individually, and that you then meet together to discuss the results, produce a consensus version, and develop an action plan for priority improvement areas.

We discourage practices from completing the PCMH-A individually and then averaging the scores to get a consensus score without having first discussed the results as a group. The discussion is a great opportunity to identify opportunities and priorities for PCMH transformation.

Have each practice location in your organisation complete an assessment

If your organisation has multiple locations, each practice should complete a separate PCMH-A. Practice transformation, even when directed and supported by practice leaders, happens differently at the practice level. Practice leaders can compare PCMH-A scores and use this information to share knowledge and cross-pollinate improvement ideas.

Consider where your practice is on the PCMH journey

Answer each question as honestly and accurately as possible. There is no advantage to over-estimating item scores and doing so may make it harder for real progress to be apparent when the PCMH-A is repeated in the future. It is fairly typical for teams to begin the PCMH journey with average scores below five for some or all areas of the PCMH-A.

It is also common for teams to initially believe they are providing more patient-centred care than they actually are. Over time, as your understanding of patient-centred care increases and you continue to implement effective practice changes, you should see your PCMH-A scores increase.

Directions for completing the assessment

1. Before you begin, please review the guidelines shown at the beginning of each part.

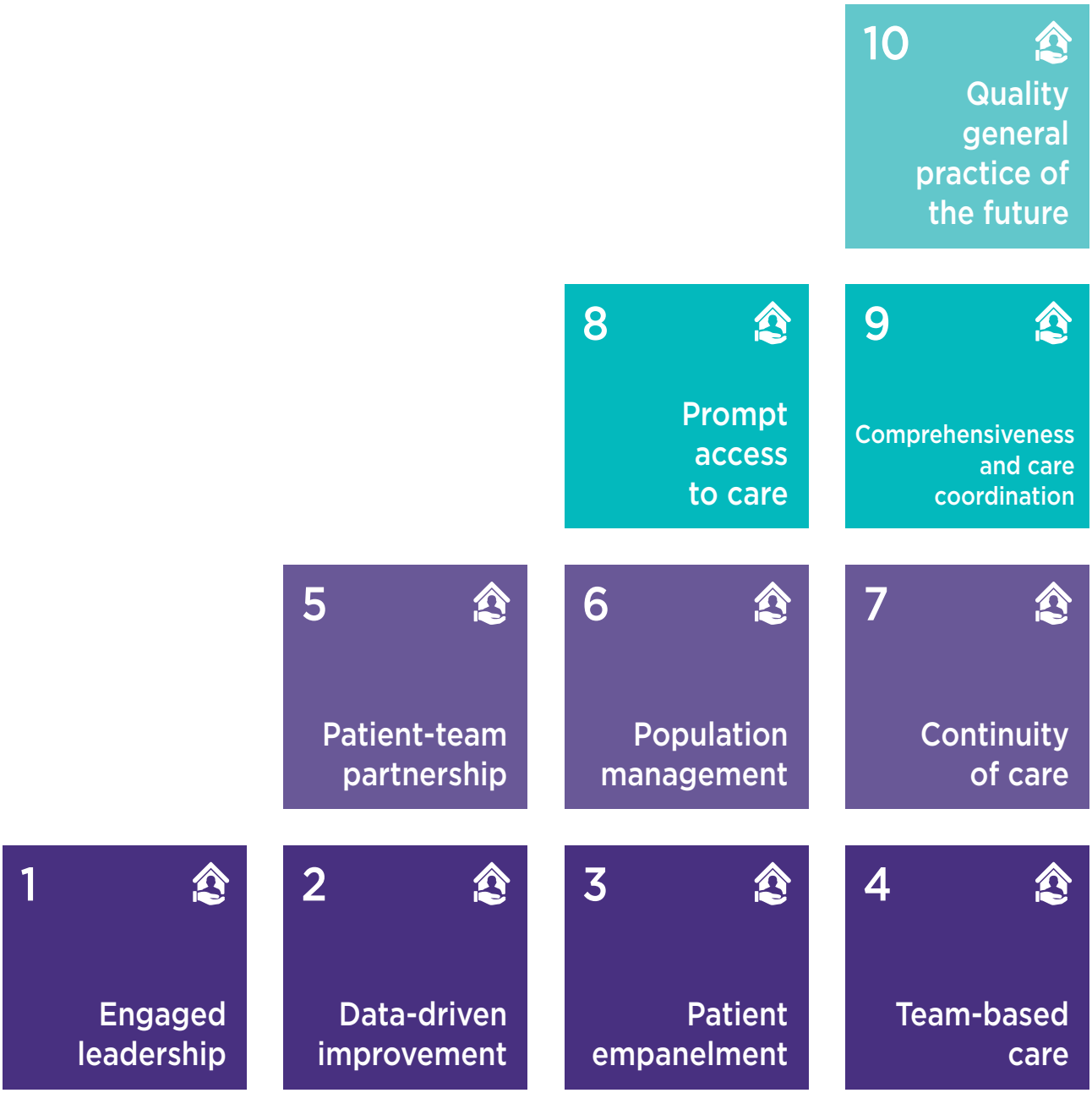
2. For each row, mark the point value that best describes the level of care that currently exists in the practice. The rows in this form present key aspects of patient-centred care.

   Each aspect is divided into levels (A through D) showing various stages in development toward a patient-centred medical home. The levels are represented by points that range from 1 to 12. The higher point values within a level indicate that the actions described in that box are more fully implemented.

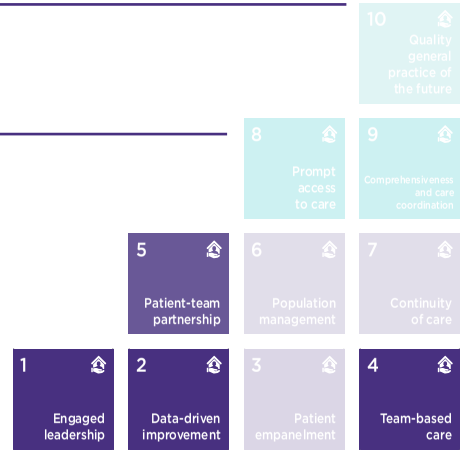
3. Encourage other members of your practice to also complete the self-assessment.

The 10 Building Blocks of High-Performing Primary Care

The 10 Building Blocks of High-Performing Primary Care is a conceptual model described by Bodenheimer et al. It identifies and describes the essential elements of primary care that facilitate exemplary performance. WNSW PHN, working closely with its general practice leaders and leveraging off international learnings, has used this as a framework to plan and implement its approach to PCMH.



PCMH-A Part 1: Engaged leadership



1a. Provide visible and sustained leadership to lead overall culture change as well as specific strategies to improve quality, spread, and sustain change.

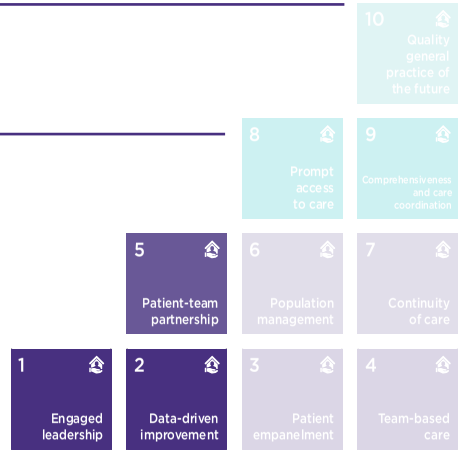
1b. Ensure that the PCMH transformation effort has the time and resources needed to be successful.

1c. Ensure that GPs and other practice team members have protected time to conduct activities beyond direct patient care that are consistent with the medical home model.

1d. Build the practice's values on creating a medical home for patients into staff hiring and training processes.

Items	Level D	Level C	Level B	Level A
1. Practice principals	…are focused on short-term business priorities. 1 2 3	…visibly support and create an infrastructure for quality improvement, but do not commit resources. 4 5 6	…allocate resources and actively reward quality improvement initiatives. 7 8 9	……support continuous learning throughout the practice, review and act upon quality data, and have a long-term strategy and funding commitment to explore, implement and spread quality improvement initiatives. 10 11 12
2. Clinical leaders	…intermittently focus on improving quality. 1 2 3	…have developed a vision for quality improvement, but no consistent process for getting there. 4 5 6	…are committed to a quality improvement process, and sometimes engage teams in implementation and problem solving. 7 8 9	…consistently champion and engage care teams in improving patient experience of care and clinical outcomes. 10 11 12
3. The practice's recruitment and training processes	…focus only on the narrowly defined functions and requirements of each position. 1 2 3	…reflect how potential new team members will affect the culture and participate in quality improvement activities. 4 5 6	…place a priority on the ability of new and existing staff to improve care and create a patient-centred culture. 7 8 9	…support and sustain improvements in care through training and incentives focused on rewarding patient-centred care. 10 11 12
4. The responsibility for conducting quality improvement activities	…is not assigned by leadership to any specific group. 1 2 3	…is assigned to a group without committed resources. 4 5 6	…is assigned to an organised quality improvement group who receive dedicated resources. 7 8 9	…is shared by all staff, from practice principals to team members, and is made explicit through protected time to meet and specific resources to engage in quality improvement. 10 11 12

PCMH-A Part 2: Quality Improvement (QI) strategy



2a. Choose and use a formal model for quality improvement.

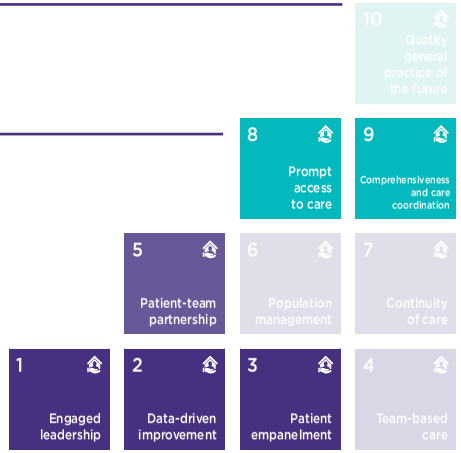
2b. Establish and monitor metrics to evaluate improvement efforts and outcomes, ensure all staff members understand the metrics for success.

2c. Ensure that patients, families, GPs, and care team members are involved in quality improvement activities.

2d. Optimise use of health information technology and clinical information systems such as PEN Clinical Audit Tool (PENCAT), formal PDSA cycles, or stratification of populations by race/gender.

Items	Level D	Level C	Level B	Level A
5. Quality improvement activities	…are not organised or supported consistently. 1 2 3	…are conducted on an ad hoc basis in reaction to specific problems. 4 5 6	…are based on a proven improvement strategy in reaction to specific problems. 7 8 9	…are based on a proven improvement strategy and used continuously in meeting practice goals. 10 11 12
6. Performance measures	…are not available for the practice. 1 2 3	…are available for the practice, but are limited in scope. 4 5 6	…are comprehensive—including clinical, operational, and patient experience measures—and available for the practice, but not for individual GPs. 7 8 9	…are comprehensive—including clinical,operational, and patient experience measures—and fed back to individual GPs. 10 11 12
7. Quality improvement activities are conducted by	…a centralised committee or department. 1 2 3	…topic specific QI committees. 4 5 6	…all care teams supported by a QI infrastructure. 7 8 9	…care teams supported by a QI infrastructure with meaningful involvement of patients and families. 10 11 12
8. Clinical information systems that optimise use of information	…are not present or is being implemented. 1 2 3	…are in place and are being used to capture clinical data. 4 5 6	…are used routinely during patient encounters to provide clinical decision support and to share data with patients. 7 8 9	…are also used routinely to support population management and quality improvement efforts. 10 11 12

PCMH-A Part 3: Patient registration



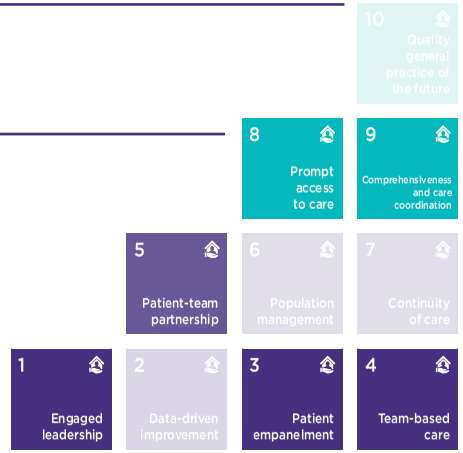
3a. Link patients to a primary GP and confirm assignments with GPs and patients, review and update assignments on a regular basis.

3b. Assess practice appointment supply and demand, and balance GP to patient ratio accordingly.

3c. Use practice data to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.

Items	Level D	Level C	Level B	Level A
9. Patients	…are not linked to a primary GP and care team. 1 2 3	…are linked to a primary GP and care team but not routinely used by the practice for administrative or other purposes. 4 5 6	…are linked to a primary GP and care team and routinely used by the practice mainly for scheduling purposes. 7 8 9	…are linked to a primary GP and care team and routinely used for scheduling purposes and monitored for GP to patient ratio. 10 11 12
10. Practice data	…are not available to assess or manage care for practice populations. 1 2 3	…are available to assess and manage care for practice populations, but only on an ad hoc basis. 4 5 6	…are regularly available to assess and manage care for practice populations, but only for a limited number of diseases and risk states. 7 8 9	…are regularly available to assess and manage care for practice populations, across a comprehensive set of diseases and risk states. 10 11 12
11. Patient records	…are not available to care teams for pre-visit planning or patient outreach. 1 2 3	…are available to care teams but are not routinely used for pre-visit planning or patient outreach. 4 5 6	…are available to care teams and routinely used for pre-visit planning or patient outreach, but only for a limited number of diseases and risk states. 7 8 9	…are available to care teams and routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases and risk states. 10 11 12
12. Reports on care processes or outcomes of care	…are not routinely available to care teams. 1 2 3	…are routinely provided as feedback to care teams but not reported externally. 4 5 6	…are routinely provided as feedback to care teams, and reported externally (e.g. to patients, other teams, or external agencies) but with team identities masked. 7 8 9	…are routinely provided as feedback to care teams, and transparently reported externally to patients, other teams, and external agencies. 10 11 12

PCMH-A Part 4: Continuous and team-based healing relationships



4a. Establish and provide practice support for care delivery teams accountable for the patient population.

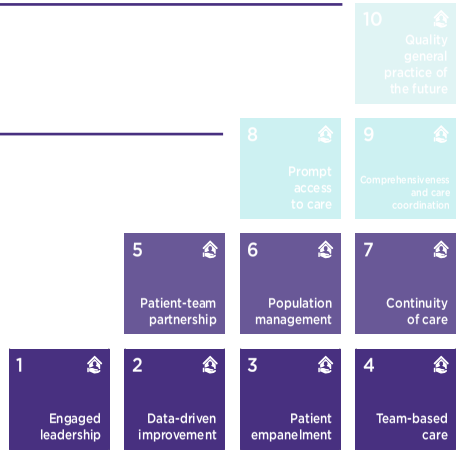
4b. Link patients to a primary GP and care team so both patients and the primary GP/care team recognise each other as partners in care.

4c. Ensure that patients are able to see their primary GP or care team whenever possible.

4d. Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.

Items	Level D	Level C	Level B	Level A
13. Patients are encouraged to see their primary GP and care team	…only at the patient's request. 1 2 3	…by the care team, but is not a priority in appointment scheduling. 4 5 6	…by the care team and is a priority in appointment scheduling, but patients commonly see other GPs because of limited availability or other issues. 7 8 9	…by the care team, is a priority in appointment scheduling, and patients usually see their own primary GP or care team. 10 11 12
14. Non-GP care team members	…play a limited role in providing clinical care. 1 2 3	…are primarily tasked with managing patient flow and triage. 4 5 6	…provide some clinical services such as assessment or self-management support. 7 8 9	…perform key clinical service roles that match their abilities and credentials. 10 11 12
15. The practice	…does not have an organised approach to identify or meet the training needs for GPs and other staff. 1 2 3	…routinely assesses training needs and ensures that staff are appropriately trained for their roles and responsibilities. 4 5 6	…routinely assesses training needs, ensures that staff are appropriately trained for their roles and responsibilities, and provides some cross-training to permit staffing flexibility. 7 8 9	…routinely assesses training needs, ensures that staff are appropriately trained for their roles and responsibilities, and provides cross-training to ensure that patient needs are consistently met. 10 11 12

PCMH-A Part 5: Organised, evidence-based care



5a. Use planned care according to patient need.

5b. Identify high-risk patients and ensure they are receiving appropriate and coordinated care services.

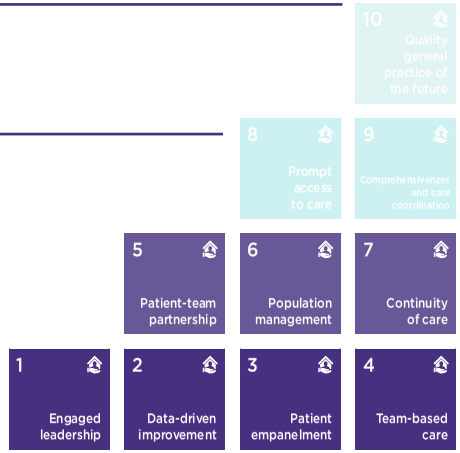
5c. Use point-of-care reminders based on clinical guidelines.

5d. Enable planned interactions with patients by making up-to-date information available to GPs and the care team at the time of the visit.

Items	Level D	Level C	Level B	Level A
16. Comprehensive, guideline-based information on prevention or chronic illness treatment	…is not readily available in practice. 1 2 3	…is available but does not influence care. 4 5 6	…is available to the care team and is integrated into care protocols and/or reminders. 7 8 9	…guides the creation of tailored, individual-level data that is available at the time of the visit. 10 11 12
17. Visits	…largely focus on acute problems of patients. 1 2 3	…are organised around acute problems but with attention to ongoing illness and prevention needs if time permits. 4 5 6	…are organised around acute problems but with attention to ongoing illness and prevention needs if time permits. The practice also uses PEN CAT reports to proactively call groups of patients in for planned care visits. 7 8 9	…are organised to address both acute and planned care needs. Tailored guideline-based information is used in team meetings to ensure all outstanding patient needs are met at each encounter. 10 11 12

Part 5 continued on next page.

PCMH-A Part 5: Organised, evidence-based care (continued)



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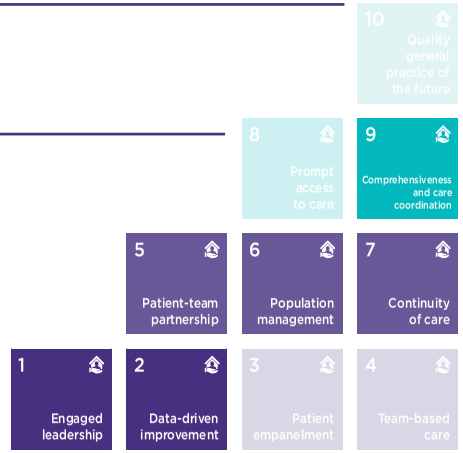
5b. Identify high-risk patients and ensure they are receiving appropriate and coordinated care services.

5c. Use point-of-care reminders based on clinical guidelines.

5d. Enable planned interactions with patients by making up-to-date information available to GPs and the care team at the time of the visit.

Items	Level D	Level C	Level B	Level A
18. Care plans	…are not routinely developed or recorded. 1 2 3	…are developed and recorded but reflect GPs' priorities only. 4 5 6	…are developed collaboratively with patients and families and include self-management and clinical goals, but they are not routinely recorded or used to guide subsequent care. 7 8 9	…are developed collaboratively, include self-management and clinical management goals, are routinely recorded, and guide care at each subsequent appointment. 10 11 12
19. Coordinated care management services for high-risk patients	…are not available. 1 2 3	…are provided by external care coordinators with limited connection to practice. 4 5 6	…are provided by external care coordinators who regularly communicate with the care team. 7 8 9	…are systematically provided by the care coordinators functioning as a member of the care team, regardless of location. 10 11 12
20. Mental health, alcohol abuse and behaviour change outcomes (such as improvement in depression symptoms)	…are not measured. 1 2 3	…are measured but not tracked. 4 5 6	…are measured and tracked on an individual patient-level. 7 8 9	…are measured and tracked on a population-level for the entire practice with regular review and quality improvement efforts employed to optimise outcomes. 10 11 12

PCMH-A Part 6: Patient-centred interactions



6a. Respect patient and family values and expressed needs.

6b. Encourage patients to expand their role in decision-making, health-related behaviours, and self-management.

6c. Communicate with their patients in a culturally appropriate manner, in a language and at a level that the patient understands.

6d. Provide self-management support at every visit through goal setting and action planning.

6e. Obtain feedback from patients/family about their healthcare experience and use this information for quality improvement.

Items	Level D	Level C	Level B	Level A
21. Assessing patient and family values and preferences	…is not done. 1 2 3	…is done, but not used in planning and organising care. 4 5 6	…is done and GPs incorporate it in planning and organising care on an ad hoc basis. 7 8 9	…is systematically done and incorporated in planning and organising care. 10 11 12
22. Involving patients in decision-making and care	…is not a priority. 1 2 3	…is accomplished by provision of patient education materials or referrals to classes. 4 5 6	…is supported and documented by care. 7 8 9	…is systematically supported by care teams trained in decision-making techniques. 10 11 12
23. Patient comprehension of verbal and written materials	...is not assessed. 1 2 3	…is assessed and accomplished by ensuring that materials are at a level and language that patients understand. 4 5 6	…is assessed and accomplished by hiring multi-lingual staff, and ensuring that both materials and communications are at a level and language that patients understand. 7 8 9	…is supported at a practice level by translation services, hiring multi-lingual staff, and training staff in health literacy and communication techniques (such as closing the loop), ensuring that patients know what to do to manage conditions at home. 10 11 12

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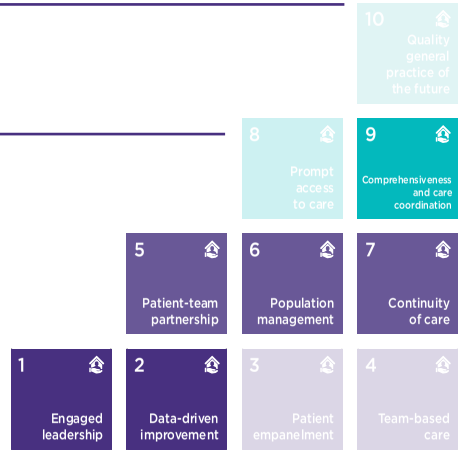
PCMH-A Part 6: Patient-centred interactions (continued)



6a. Respect patient and family values and expressed needs.

6b. Encourage patients to expand their role in decision-making, health-related behaviours, and self-management.

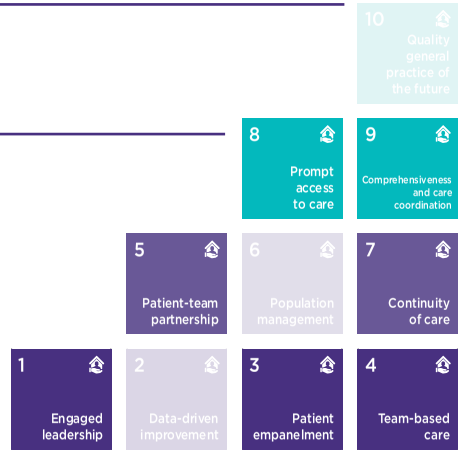
6c. Communicate with their patients in a culturally appropriate manner, in a language and at a level that the patient understands.

6d. Provide self-management support at every visit through goal setting and action planning.

6e. Obtain feedback from patients/family about their healthcare experience and use this information for quality improvement.

Items	Level D	Level C	Level B	Level A
24. Self-management support	…is limited to the distribution of information (e.g. pamphlets, booklets). 1 2 3	…is accomplished by referral to self-management classes or educators. 4 5 6	…is provided by goal setting and action planning with members of the care team. 7 8 9	…is provided by members of the care team trained in patient empowerment and problem-solving methodologies. 10 11 12
25. The principles of patient-centred care	…are included in the practice's vision and mission statement. 1 2 3	…are a key practice priority and included in training and orientation. 4 5 6	…are explicit in job descriptions and performance metrics for all staff. 7 8 9	…are consistently used to guide practice changes and measure system performance as well as care interactions at the practice level. 10 11 12
26. Measurement of patient-centred interactions	…is not done or is accomplished using a survey administered sporadically at the practice level. 1 2 3	…is accomplished through patient representation on boards and regularly soliciting patient input through surveys. 4 5 6	…is accomplished by getting frequent input from patients and families using a variety of methods such as point-of-care surveys, focus groups, and ongoing patient advisory groups. 7 8 9	…is accomplished by getting frequent and actionable input from patients and families on all care delivery issues, and incorporating their feedback in quality improvement activities. 10 11 12

PCMH-A Part 7: Enhanced access



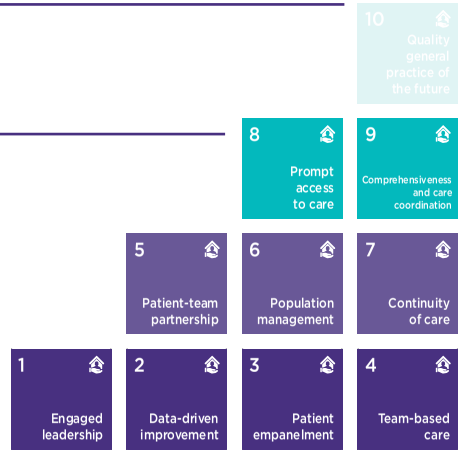
7a. Promote and expand access by ensuring that established patients have continuous access to care by phone or in-person visits and after hours.

7b. Provide appointment options that are patient- and family-centred and accessible to all patients.

7c. Help patients understand any out of pocket expenses that may be incurred.

Items	Level D	Level C	Level B	Level A
27. Appointment systems	…are limited to a single office visit type. 1 2 3	…provide some flexibility in scheduling different visit lengths. 4 5 6	…provide flexibility and include capacity for same day visits. 7 8 9	…are flexible and can accommodate customised visit lengths, same day visits, scheduled follow-up, and multiple primary GP visits. 10 11 12
28. Contacting the care team during regular business hours	…is difficult. 1 2 3	…relies on the practice's ability to respond to telephone messages. 4 5 6	…is accomplished by staff responding by telephone within the same day. 7 8 9	…is accomplished by providing a patient a choice of interactions, utilising systems which are monitored for timeliness. 10 11 12
29. After-hours access	...is not available or limited to an answering machine. 1 2 3	…is available from an after hours service without a standardised communication protocol back to the practice for urgent problems. 4 5 6	…is provided by an after hours service that shares necessary patient data and provides a summary to the practice. 7 8 9	…is available via the patient's choice of telephone or in-person directly from the care team or an after hours service closely in contact with the team and patient information. 10 11 12
30. A patient's out-of-pocket expenses	…are the responsibility of the patient to resolve. 1 2 3	…are addressed by the practice's administration team. 4 5 6	…are discussed with the patient prior to or during the visit. 7 8 9	…are viewed as a shared responsibility for the patient and an assigned member of the practice to resolve together. 10 11 12

PCMH-A Part 8: Care coordination



8a. Link patients with community resources to facilitate referrals and respond to social service needs.

8b. Integrate behavioural health and specialty care into care delivery through co-location or referral protocols.

8c. Track and support patients when they obtain services outside the practice.

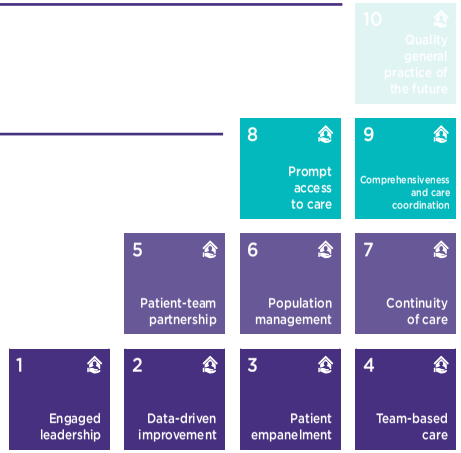
8d. Follow-up with patients within a few days of an emergency room visit or hospital discharge.

8e. Communicate test results and care plans to patients/families.

Items	Level D	Level C	Level B	Level A
31. Medical and surgical specialty services	…are difficult to obtain reliably. 1 2 3	…are available from community specialists but are neither timely nor convenient. 4 5 6	…are available from community specialists and are generally timely and convenient. 7 8 9	…are readily available from specialists who are members of the care team or who work in a practice with which the practice has a referral protocol or agreement. 10 11 12
32. Mental health services	…are difficult to obtain reliably. 1 2 3	…are available from mental health specialists but are neither timely nor convenient. 4 5 6	…are available from community specialists and are generally timely and convenient. 7 8 9	…are readily available from mental health specialists who are members of the care team or who work in a community with which the practice has a referral protocol or agreement. 10 11 12
33. Patients in need of specialty care, hospital care, or supportive community-based resources	…cannot reliably obtain needed referrals to partners with whom the practice has a relationship. 1 2 3	…obtain needed referrals to partners with whom the practice has a relationship. 4 5 6	…obtain needed referrals to partners with whom the practice has a relationship and relevant information is communicated in advance. 7 8 9	…obtain needed referrals to partners with whom the practice has a relationship, relevant information is communicated in advance, and timely follow-up after the visit occurs. 10 11 12

Part 8 continued on next page.

PCMH-A Part 8: Care coordination (continued)



8a. Link patients with community resources to facilitate referrals and respond to social service needs.

8b. Integrate behavioural health and specialty care into care delivery through co-location or referral protocols.

8c. Track and support patients when they obtain services outside the practice.

8d. Follow-up with patients within a few days of an emergency room visit or hospital discharge.

8e. Communicate test results and care plans to patients/families.

Items	Level D	Level C	Level B	Level A
34. Follow-up by the practice and care team with patients seen in the Emergency Department (ED) or hospital	...generally does not occur because the information is not available to the primary care team. 1 2 3	…occurs only if the ED or hospital alerts the primary care practice. 4 5 6	…occurs because practice makes proactive efforts to identify patients. 7 8 9	…is done routinely because the practice has arrangements in place with the ED and hospital to both track these patients and ensure that follow-up is completed within a few days. 10 11 12
35. Linking patients to supportive community-based resources	…is not done systematically. 1 2 3	…is limited to providing patients a list of identified community resources in an accessible format. 4 5 6	…is accomplished through a designated staff person or resource responsible for connecting patients with community resources. 7 8 9	…is accomplished through active coordination between the health system, community service agencies and patients and accomplished by a designated staff person. 10 11 12
36. Test results and care plans	…are not communicated to patients. 1 2 3	…are communicated to patients based on an ad hoc approach. 4 5 6	…are systematically communicated to patients in a way that is convenient to the practice. 7 8 9	…are systematically communicated to patients in a variety of ways that are convenient to patients. 10 11 12

Western NSW Primary Health Network (WNSW PHN) acknowledges this document has been adapted for use in Australia by Northern Queensland Primary Health Network (NQPHN) with permission from the following source:

Safety Net Medical Home Initiative

The Patient-Centred Medical Home Assessment Version 4.0

The MacColl Center for Health Care Innovation at Group Health Research Institute and Qualis Health; Seattle, WA. September 2014.

Australian version development by NQPHN, email: info@nqpcmh.com.au

Safety Net Medical Home Initiative

This is a product of the Safety Net Medical Home Initiative, which was supported by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice and policy. The views presented here are those of the author and not necessarily those of The Commonwealth Fund, its directors, officers, or staff. The Initiative also received support from the Colorado Health Foundation, Jewish Healthcare Foundation, Northwest Health Foundation, The Boston Foundation, Blue Cross Blue Shield of Massachusetts Foundation, Partners Community Benefit Fund, Blue Cross of Idaho, and the Beth Israel Deaconess Medical Center. For more information about The Commonwealth Fund, refer to www.cmwf.org

The objective of the Safety Net Medical Home Initiative was to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centred medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative was administered by Qualis Health and conducted in partnership with the MacColl Center for Health Care Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon, and Pittsburgh), representing 65 safety net practices across the U.S.

For more information about the Safety Net Medical Home Initiative, refer to www.safetynetmedicalhome.org.

PATIENT CENTRED
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