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## PATIENT-CENTERED MEDICAL HOME ASSESSMENT (PCMH-A)

### DIRECTIONS FOR COMPLETING THE SURVEY

This survey is designed to help systems and provider practices move toward the “state-of-the-art” in delivering patient-centered care in the context of a medical home. The results can be used to help your team identify areas for improvement. Instructions are as follows:

1. **Answer each question** from the perspective of one physical site (e.g., a practice, clinic, hospital, health plan).

Please provide name and type of site (e.g., Central Health Center/FQHC)

2. For each row, **circle the point value** that best describes the level of care that currently exists in the site. The rows in this form present key aspects of patient-centered care. Each aspect is divided into levels showing various stages in development toward a patient-centered medical home. The stages are represented by points that range from 1 to 12. The higher point values indicate that the actions described in that box are more fully implemented.

3. **Review your score on page 12. If taken on a computer**, this form will auto-calculate your score. **If taken in hard copy** (on paper) you will need to sum the points in each section (e.g., total part 1 score), calculate the average score (e.g., total part 1 score / # of questions), and enter these scores at the end of each section. Then sum all of the section scores and complete the average score for the program as a whole by dividing this by 8.

4. **Print a copy for yourself** by clicking here

PRINT A COPY

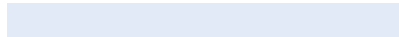
For more information about how to complete the survey, please contact Donna M. Daniel, PhD by calling 877-810-9266 or 206-288-2560, or by emailing [donnad@qualishealth.org](mailto:donnad@qualishealth.org)

## PART 1: EMPANELMENT

- 1a. Determine and understand which patients should be empanelled in the medical home, and which require temporary, supplemental, or additional services.
- 1b. Use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self management status, community and family need.
- 1c. Understand patient supply and demand and balance patient load accordingly.
- 1d. Enable feedback to team and for external reporting on processes of care and population outcomes.

Components	Level D	Level C	Level B	Level A
1. Patients	...are not assigned to specific practice panels.	...are assigned to specific practice panels but panel assignments are not routinely used by the practice for administrative or other purposes.	...are assigned to specific practice panels and panel assignments are routinely used by the practice mainly for scheduling purposes.	...are assigned to specific practice panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.
<b>Score</b>	<b>1      2      3</b>	<b>4      5      6</b>	<b>7      8      9</b>	<b>10    11    12</b>
2. Registry or panel-level data	...are not available to assess or manage care for practice populations.	...are available to assess and manage care for practice populations, but only on an ad hoc basis.	...are regularly available to assess and manage care for practice populations, but only for a limited number of diseases and risk states.	...are regularly available to assess and manage care for practice populations, across a comprehensive set of diseases and risk states.
<b>Score</b>	<b>1      2      3</b>	<b>4      5      6</b>	<b>7      8      9</b>	<b>10    11    12</b>
3. Registries on individual patients	...are not available to practice teams for pre-visit planning or patient outreach.	...are available to practice teams but are not routinely used for pre-visit planning or patient outreach.	...are available to practice teams and routinely used for pre-visit planning or patient outreach, but only for a limited number of diseases and risk states.	...are available to practice teams and routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases and risk states.
<b>Score</b>	<b>1      2      3</b>	<b>4      5      6</b>	<b>7      8      9</b>	<b>10    11    12</b>
4. Reports on care processes or outcomes of care	...are not routinely available to practice teams.	...are routinely provided as feedback to practice teams but not reported externally.	...are routinely provided as feedback to practice teams, and reported externally (e.g. to patients, other teams or external agencies) but with team identities masked.	...are routinely provided as feedback to practice teams, and transparently reported externally to patients, other teams and external agencies.
<b>Score</b>	<b>1      2      3</b>	<b>4      5      6</b>	<b>7      8      9</b>	<b>10    11    12</b>

Total Health Care Organization Score



Average Score (Health Care Org. Score/4)



## PART 2: CONTINUOUS TEAM-BASED HEALING RELATIONSHIPS

- 2a. Clearly link patients to a provider and care team so both the patients and provider/care team recognize each other as partners in care.
- 2b. Assure that patients are able to see their provider or care team whenever possible.
- 2c. Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.
- 2d. Cross-train care team members to maximize flexibility and ensure that patients' needs are met.

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

**Total Health Care Organization Score**

**Average Score (Health Care Org. Score/3)**

## PART 3: PATIENT-CENTERED INTERACTIONS

3a. Assess and respect patient and family values and expressed needs.

3b. Encourage patients to expand their role in decision-making, health related behaviors, and self management.

3c. Assure communication with their patients in a culturally appropriate manner in a language and at a level that the patient understands.

3d. Provide self management support through collaborative goal setting and patient action planning.

Components	Level D	Level C	Level B	Level A
8. Assessing patient and family values and preferences	...is not done.	...is done, but not used in planning and organizing care.	...is done and providers incorporate it in planning and organizing care on an ad hoc basis.	...is systematically done and incorporated in planning and organizing care.
<b>Score</b>	<b>1 2 3</b>	<b>4 5 6</b>	<b>7 8 9</b>	<b>10 11 12</b>
9. Involving patients in decision-making and care	...is not a priority.	...is accomplished by provision of patient education materials or referrals to classes.	...is supported and documented by practice teams.	...is systematically supported by practice teams trained in decision making techniques.
<b>Score</b>	<b>1 2 3</b>	<b>4 5 6</b>	<b>7 8 9</b>	<b>10 11 12</b>
10. Patient comprehension of verbal and written materials	...is not assessed.	...is assessed and accomplished by assuring that materials are at a level and language that patients understand.	...is assessed and accomplished by hiring multi-lingual staff, and assuring that both materials and communications are at a level and language that patients understand.	...is supported at an organizational level by translation services, hiring multi-lingual staff, and training staff in health literacy and communication techniques (such as closing the loop) assuring that patients know what to do to manage conditions at home.
<b>Score</b>	<b>1 2 3</b>	<b>4 5 6</b>	<b>7 8 9</b>	<b>10 11 12</b>
11. Self-management support	...is limited to the distribution of information (pamphlets, booklets).	...is accomplished by referral to self-management classes or educators.	...is provided by goal setting and action planning with members of the practice team.	...is provided by members of the practice team trained in patient empowerment and problem-solving methodologies.
<b>Score</b>	<b>1 2 3</b>	<b>4 5 6</b>	<b>7 8 9</b>	<b>10 11 12</b>
12. The principles of patient-centered care	...are included in the organization's vision and mission statement.	...are a key organizational priority and included in training and orientation.	...are explicit in job descriptions and performance metrics for all staff.	...are consistently used to guide organizational changes and measure system performance as well as care interactions at the practice level.
<b>Score</b>	<b>1 2 3</b>	<b>4 5 6</b>	<b>7 8 9</b>	<b>10 11 12</b>

**Total Health Care Organization Score**

**Average Score (Health Care Org. Score/5)**

## PART 4: ENGAGED LEADERSHIP

- 4a. Provide visible and sustained leadership in overall culture change and specific strategies to improve quality and sustain and spread change.
- 4b. Establish a QI team that meets regularly and guides the effort.
- 4c. Build the practice's values on creating a medical home for patients into the staff hiring and training process.

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

**Total Health Care Organization Score**

**Average Score (Health Care Org. Score/4)**

## PART 5: QUALITY IMPROVEMENT (QI) STRATEGY

- 5a. Choose and use formal models for QI
- 5b. Establish and monitor metrics to evaluate improvement efforts and outcomes and provide feedback.
- 5c. Obtain feedback from patients/families about their healthcare experience and use information for quality improvement.
- 5d. Ensure that providers, staff and patients and families are involved in QI activities.

Components	Level D	Level C	Level B	Level A
17. Quality improvement activities	...are not organized or supported consistently.	...are conducted on an ad hoc basis in reaction to specific problems.	...are based on a proven improvement strategy in reaction to specific problems.	...are based on a proven improvement strategy and used continuously in meeting organizational goals.
<b>Score</b>	<b>1      2      3</b>	<b>4      5      6</b>	<b>7      8      9</b>	<b>10    11    12</b>
18. Performance measures	...are not available for the clinical site.	...are available for the clinical site, but are limited in scope.	...are comprehensive – including clinical, operational, and patient experience measures – and available for the practice, but not for individual providers.	...are comprehensive – including clinical, operational, and patient experience measures – and fed back to individual providers.
<b>Score</b>	<b>1      2      3</b>	<b>4      5      6</b>	<b>7      8      9</b>	<b>10    11    12</b>
19. Quality improvement activities are conducted by	...a centralized committee or department.	...topic specific QI committees.	...all practice teams supported by a QI infrastructure.	...practice teams supported by a QI infrastructure with meaningful involvement of patients and families.
<b>Score</b>	<b>1      2      3</b>	<b>4      5      6</b>	<b>7      8      9</b>	<b>10    11    12</b>

**Total Health Care Organization Score**

**Average Score (Health Care Org. Score/3)**

## PART 6: ENHANCED ACCESS

- 6a. Promote and expand access by ensuring that established patients have 24/7 continuous access to their care team via phone, email or in-person visits.
- 6b. Provide scheduling options that are patient- and family-centered and accessible to all patients.
- 6c. Help patients attain and understand health insurance coverage.

Components	Level D	Level C	Level B	Level A
20. Appointment systems	...are limited to a single office visit type.	...provide some flexibility in scheduling different visit lengths.	... provide flexibility and include capacity for same day visits.	...are flexible and can accommodate customized visit lengths, same day visits, scheduled follow-up and multiple provider visits.
<b>Score</b>	<b>1      2      3</b>	<b>4      5      6</b>	<b>7      8      9</b>	<b>10    11    12</b>
21. Contacting the practice team during regular business hours	...is difficult.	...relies on the practice's ability to respond to telephone messages.	...is accomplished by staff responding by telephone within the same day.	...is accomplished by providing a patient a choice between email and phone interaction, utilizing systems which are monitored for timeliness.
<b>Score</b>	<b>1      2      3</b>	<b>4      5      6</b>	<b>7      8      9</b>	<b>10    11    12</b>
22. After hours access	...is not available or limited to an answering machine.	...is available from a coverage arrangement without a standardized communication protocol back to the practice for urgent problems.	...is provided by coverage arrangement that shares necessary patient data and provides a summary to the practice.	...is available via the patient's choice of email, phone or in-person directly from the practice team or a provider closely in contact with the team and patient information.
<b>Score</b>	<b>1      2      3</b>	<b>4      5      6</b>	<b>7      8      9</b>	<b>10    11    12</b>
23. A patient's insurance coverage issues	...are the responsibility of the patient to resolve.	...are addressed by the practice's billing department.	...are discussed with the patient prior to or during the visit.	...are viewed as a shared responsibility for the patient and an assigned member of the practice to resolve together.
<b>Score</b>	<b>1      2      3</b>	<b>4      5      6</b>	<b>7      8      9</b>	<b>10    11    12</b>

**Total Health Care Organization Score**

**Average Score (Health Care Org. Score/4)**

## PART 7: CARE COORDINATION

- 7a. Link patients with community resources to facilitate referrals and respond to social service needs.
- 7b. Have referral protocols and agreements in place with an array of specialists to meet patients' needs.
- 7c. Proactively track and support patients as they go to and from specialty care, the hospitals and the emergency department.
- 7d. Follow-up with patients within a few days of an emergency room visit or hospital discharge.
- 7e. Test results and care plans are communicated to patients.

Components	Level D	Level C	Level B	Level A
24. Medical and surgical specialty services	...are difficult to obtain reliably.	...are available from community specialists but are neither timely nor convenient.	... are available from community specialists and are generally timely and convenient.	...are readily available from specialists who are members of the care team or who work in an organization with which the practice has a referral protocol or agreement.
<b>Score</b>	<b>1      2      3</b>	<b>4      5      6</b>	<b>7      8      9</b>	<b>10    11    12</b>
25. Behavioral health services	...are difficult to obtain reliably.	...are available from mental health specialists but are neither timely nor convenient.	...are available from community specialists and are generally timely and convenient.	...are readily available from behavior health specialists who are onsite members of the care team or who work in a community organization with which the practice has a referral protocol or agreement.
<b>Score</b>	<b>1      2      3</b>	<b>4      5      6</b>	<b>7      8      9</b>	<b>10    11    12</b>
26. 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.	...obtain needed referrals to partners with whom the practice has a relationship.	...obtain needed referrals to partners with whom the practice has a relationship and relevant information is communicated in advance.	...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.
<b>Score</b>	<b>1      2      3</b>	<b>4      5      6</b>	<b>7      8      9</b>	<b>10    11    12</b>

PART 7: CARE COORDINATION CONTINUED ON PAGE 9

## PART 7: CARE COORDINATION CONTINUED

- 7a. Link patients with community resources to facilitate referrals and respond to social service needs.
- 7b. Have referral protocols and agreements in place with an array of specialists to meet patients' needs.
- 7c. Proactively track and support patients as they go to and from specialty care, the hospitals and the emergency department.
- 7d. Follow-up with patients within a few days of an emergency room visit or hospital discharge.
- 7e. Test results and care plans are communicated to patients.

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

**Total Health Care Organization Score**

**Average Score (Health Care Org. Score/6)**

## PART 8: ORGANIZED, EVIDENCE-BASED CARE

- 8a. Use Planned Care interactions according to a comprehensive set of patient needs.
- 8b. Assure access to care management resources to provide more intensive support to high risk patients.
- 8c. Use point of care reminders based on clinical guidelines.
- 8d. Enable planned interactions with patients by making up-to-date information available to providers and care team at the time of the visit.

Components	Level D	Level C	Level B	Level A
30. Comprehensive, guideline-based information on prevention or chronic illness treatment	...is not readily available in practice.	...is available but does not influence care.	...is available to the team and is integrated into care protocols and/or reminders.	...guides the creation of tailored, individual-level data that is available at the time of the visit.
<b>Score</b>	<b>1      2      3</b>	<b>4      5      6</b>	<b>7      8      9</b>	<b>10    11    12</b>
31. Visits	...largely focus on acute problems of patient.	...are organized around acute problems but with attention to ongoing illness and prevention needs if time permits.	...are organized around acute problems but with attention to ongoing illness and prevention needs if time permits. The practice also uses subpopulation reports to proactively call groups of patients in for planned care visits.	...are organized to address both acute and planned care needs. Tailored guideline-based information is used in team huddles to ensure all outstanding patient needs are met at each encounter.
<b>Score</b>	<b>1      2      3</b>	<b>4      5      6</b>	<b>7      8      9</b>	<b>10    11    12</b>
32. Care plans	...are not routinely developed or recorded.	...are developed and recorded but reflect providers' priorities only.	...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.	...are developed collaboratively, include self-management and clinical management goals, routinely recorded and guide care at every subsequent point of service.
<b>Score</b>	<b>1      2      3</b>	<b>4      5      6</b>	<b>7      8      9</b>	<b>10    11    12</b>
33. Clinical care management services for high risk patients	...are not available.	...are provided by external care managers with limited connection to practice.	...are provided by external care managers who regularly communicate with the care team.	...are systematically provided by the care manager functioning as a member of the practice team, regardless of location.
<b>Score</b>	<b>1      2      3</b>	<b>4      5      6</b>	<b>7      8      9</b>	<b>10    11    12</b>

**Total Health Care Organization Score**

**Average Score (Health Care Org. Score/4)**

**Briefly describe the process you used to fill out the form** (e.g., each team member filled out a separate form and reached consensus in a face-to-face meeting; filled out by the team leader in consultation with other team members as needed).

## SCORING SUMMARY

(Bring forward average score at end of each section to this page)

1. Empanelment	<input type="text"/>
2. Continuous Team-Based Healing Relationships	<input type="text"/>
3. Patient-Centered Interactions	<input type="text"/>
4. Engaged Leadership	<input type="text"/>
5. Quality Improvement (QI) Strategy	<input type="text"/>
6. Enhanced Access	<input type="text"/>
7. Care Coordination	<input type="text"/>
8. Organized, Evidence-Based Care	<input type="text"/>
<b>Overall Total Program Score (Sum of all scores)</b>	<input type="text"/>
<b>Average Program Score (Total program Score/8)</b>	<input type="text"/>

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## WHAT DOES IT MEAN?

The PCMH-A is organized such that the highest “score” (a “12”) on any individual item, subscale, or the overall score (an average of the eight PCMH-A subscale scores) indicates optimal support for chronic illness. The lowest possible score on any given item or subscale is a “1”; which corresponds to limited support for patient-centered care. The interpretation guidelines are as follows:

**Between “1” and “3” = limited support for patient-centered care**

**Between “4” and “6” = basic support for patient-centered care**

**Between “7” and “9” = reasonably good support for patient-centered care**

**Between “10” and “12” = fully developed patient-centered care**

It is fairly typical for teams to begin a collaborative with average scores below “5” on some (or all) areas the PCMH-A. After all, if everyone was providing optimal patient centered care, there would be no need for a patient centered medical home collaborative or other quality improvement programs. It is also common for teams to initially believe they are providing more patient centered care than they actually are. As you progress in the your quality improvement efforts, you will become more familiar with what an effective system of care involves. You may even notice your PCMH-A scores “declining” even though you have made improvements; this is most likely the result of your better understanding of what optimal patient-centered care looks like. Over time, as your understanding of optimal care increases and you continue to implement effective practice changes, you should see overall improvement on your PCMH-A scores.

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### Safety Net Medical Home Initiative

This is a product of the Safety Net Medical Home Initiative, which is 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 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 receives 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](http://www.cmwf.org).

The objective of the Safety Net Medical Home Initiative is to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative is administered by Qualis Health and conducted in partnership with the MacColl Institute for Healthcare Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, and Pittsburgh), representing 65 safety net practices across the U.S. For more information about the Safety Net Medical Home Initiative, refer to: [www.qhmedicalhome.org/safety-net](http://www.qhmedicalhome.org/safety-net).

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Form more information about this survey, please contact:  
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