

Measure #19. Patient-Centered Medical Home (PCMH) Survey of Structural Capabilities of Primary Care Practice Sites

CARE COORDINATION MEASURE MAPPING TABLE

	MEASUREMENT PERSPECTIVE		
	<i>Patient/Family</i>	<i>Health Care Professional(s)</i>	<i>System Representative(s)</i>
CARE COORDINATION ACTIVITIES			
Establish accountability or negotiate responsibility			
Communicate			
<i>Interpersonal communication</i>			
<i>Information transfer</i>			
Facilitate transitions			
<i>Across settings</i>			
<i>As coordination needs change</i>			
Assess needs and goals			
Create a proactive plan of care			
Monitor, follow up, and respond to change			■
Support self-management goals			□
Link to community resources			
Align resources with patient and population needs			■
BROAD APPROACHES POTENTIALLY RELATED TO CARE COORDINATION			
Teamwork focused on coordination			
Health care home			■
Care management			
Medication management			
Health IT-enabled coordination			□

Legend:

- = ≥ 3 corresponding measure items
- = 1-2 corresponding measure items

Patient-Centered Medical Home (PCMH) Survey of Structural Capabilities of Primary Care Practice Sites

Purpose: To measure the prevalence of recommended capabilities for medical home practices.

Format/Data Source: 13-item survey that addresses 13 structural capabilities across four main domains: (1) patient assistance and reminders, (2) culture of quality, (3) enhanced access, and (4) electronic health records.

Date: Measure published in 2008.¹

Perspective: System Representative(s)

Measure Item Mapping:

- **Monitor, follow up, and respond to change:** 2-5
- **Support self-management goals:** 1
- **Align resources with patient and population needs:** 10-12
- **Health care home:** 1-13
- **Health IT-enabled coordination:** 13

Development and Testing: The survey is based on evidence and findings from previously published literature, as well as existing surveys of physician group characteristics. It was revised from its original version to improve validity after cognitive testing by physicians was completed.¹

Link to Outcomes or Health System Characteristics: A survey of 308 adult primary care practices in Massachusetts revealed that larger and network-affiliated practices were more likely than smaller, non-affiliated practices to have implemented recommended medical home components.¹

Logic Model/Conceptual Framework: National Committee for Quality Assurance (NCQA) Standards for a Patient-Centered Medical Home.¹

Country: United States

Past or Validated Applications*:

- **Patient Age:** Not Applicable
- **Patient Condition:** Not Applicable
- **Setting:** Primary Care Facility

*Based on the source listed below and input from the measure developer.

Notes:

- All instrument items are located in the Appendix of the source article.¹
- This instrument contains 13 items; all 13 were mapped.

Source:

1. Friedberg MW, Safran DG, Coltin KL, et al. Readiness for the patient-centered medical home: Structural capabilities of Massachusetts primary care practices. *J Gen Int Med* 2008;24(2):162-9.