

Measure #76. The Joint Commission Patient-Centered Medical Home Self-Assessment Survey

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

*Indicates that the measure as a whole focuses on the Health care home model.

The Joint Commission Patient-Centered Medical Home Self-Assessment Survey

Purpose: To evaluate the coordination and comprehensiveness of patient-centered care in accordance with the principles of the patient-centered medical home (PCMH), in particular partnerships between the primary care clinician, interdisciplinary team, and patient.

Format/Data Source: A 66-item paper-based survey completed by health care organization administrators. The survey consists of 12 focus areas listed within 5 operational characteristics, which include: (1) patient-centeredness, (2) comprehensiveness, (3) coordination of care, (4) superb access to care, and (5) systems for quality/safety. Questions are answered in Yes/No responses, some of which required further written explanation.¹

Date: Measure released in 2011.²

Perspective: System Representative

Measure Item Mapping:

- **Establish accountability or negotiate responsibility:** I.A.1.e, I.B.1, I.C.3, II.B.1, II.B.4, III.A.1
- **Communicate:**
 - *Between health care professional(s) and patient/family:* I.A.1.a, I.A.1.b, I.A.1.c, I.A.1.d, I.A.1.e, I.A.1.f
 - *Within teams of health care professionals:* I.D.3
 - Interpersonal communication:
 - *Between health care professional(s) and patient/family:* I.D.2
 - Information transfer:
 - *Within teams of health care professionals:* V.A.1.f
- **Facilitate transitions:**
 - Across settings: II.A.1, III.A.2, III.A.3
 - As coordination needs change: II.A.2
- **Assess needs and goals:** I.D.1, II.A.2, II.B.5, II.B.6
- **Create a proactive plan of care:** I.C.2, I.E.3, III.A.4
- **Monitor, follow up, and respond to change:** V.A.1.b
- **Support self-management goals:** I.A.1.d, I.A.1.e, I.E.2, I.E.3, I.E.4, I.E.5, V.A.1.c
- **Align resources with patient and population needs:** I.D.4, I.E.2
- **Teamwork focused on coordination:** II.B.2, II.B.4
- **Health care home:** I.A.1.a-I.A.1.f, I.B.1, I.C.2-I.C.3, I.D.1-I.D.4, I.E.2-I.E.5, II.A.1-II.A.3, II.B.1, II.B.2, II.B.4-II.B.6, III.A.1-III.A.4, V.A.1.a-V.A.1.c, V.A.1.f*
- **Care management:** II.A.3
- **Medication Management:** I.A.1.e
- **Health IT-enabled coordination:** V.A.1.a, V.A.1.b, V.A.1.c, V.A.1.f

*The instrument as a whole focuses on the Health care home model. Only those items that map to at least one other care coordination domain are listed here.

Development and Testing: An expert panel developed the standards for the Joint Commission's PCMH option. After soliciting input from the field, draft standards were posted on the Joint Commission's website for comment and piloted in primary care settings. The Joint Commission's Board of Commissioners approved the finalized standards.²

Link to Outcomes or Health System Characteristics: None described in the source identified.

Logic Model/Conceptual Framework: None described in the source identified.

Country: United States

Past or Validated Applications*:

- **Patient Age:** Not Applicable
- **Patient Condition:** Not Applicable
- **Setting:** Primary Care Facility, Other Outpatient Specialty Care Facility

*Based on the sources listed below.

Notes:

- All instrument items are located online.²
- This instrument contains 66 items, of which 33 were mapped.
- A version of the survey specifically for ambulatory care practices that are owned/operated by an accredited hospital is also available from the measure steward.

Sources:

1. The Joint Commission Patient-Centered Medical Home (PCMH) Self-Assessment Tool web site. Available at:

http://www.jointcommission.org/joint_commission_primary_care_medical_home_self-assessment_tool___/. Accessed: May 10 2012.

2. Joint Commission on Accreditation of Healthcare Organizations. New Primary Care Medical Home Option for Accredited Ambulatory Care Organizations. Joint Commission Perspectives 2011;31(7):1-3.