

# Measure #80. Patient-Centered Medical Home Assessment (PCMH-A) Tool

**CARE COORDINATION MEASURE MAPPING TABLE**

	MEASUREMENT PERSPECTIVE		
	<i>Patient/Family</i>	<i>Health Care Professional(s)</i>	<i>System Representative(s)</i>
<b>CARE COORDINATION ACTIVITIES</b>			
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			□
<b>BROAD APPROACHES POTENTIALLY RELATED TO CARE COORDINATION</b>			
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.

# Patient-Centered Medical Home Assessment (PCMH-A) Tool

**Purpose:** To assess implementation of the patient-centered medical home model at a site of care, identify opportunities for related improvement, and track progress towards strengthening the patient-centered medical home.

**Format/Data Source:** A 35-item survey to be completed by multidisciplinary groups of health care professionals (i.e., physicians, nurses, medical assistants, residents, administrative staff) to assess the current level of functional implementation of the patient-centered medical home model in a practice. The survey is comprised of eight change concept subscales, including (1) engaged leadership, (2) quality improvement strategy, (3) empanelment, (4) continuous and team-based healing relationships, (5) organized, evidence-based care, (6) patient-centered interactions, (7) enhanced care, and (8) care coordination. Responses are on a 12-point scale, with quadrants of scores (1-3, 4-6, 7-9, 10-12) divided among four levels of PCMH implementation (level A-D). Higher scores (i.e., level A) indicate more advanced implementation of the PCMH model.<sup>1</sup>

**Date:** Measure released in 2013.<sup>1</sup>

**Perspective:** System Representative(s)

## Measure Item Mapping:

- **Establish accountability or negotiate responsibility:** 29
- **Communicate:**
  - *Between health care professional(s) and patient/family:* 8, 21, 22, 35
  - *Within teams of health care professionals:* 19
  - *Across health care teams or settings:* 19, 32
  - Information transfer:
    - *Across health care teams or settings:* 28
- **Facilitate transitions:**
  - Across settings: 30, 31, 32, 33
- **Assess needs and goals:** 17, 20, 21
- **Create a proactive plan of care:** 18
- **Monitor, follow up, and respond to change:** 17, 32, 33
- **Support self-management goals:** 18, 23
- **Link to community resources:** 32, 34
- **Align resources with patient and population needs:** 19, 22
- **Teamwork focused on coordination:** 17
- **Health care home:** 8, 17, 18, 19, 20, 21, 22, 23, 28, 29, 30, 31, 32, 33, 34, 35\*
- **Care management:** 19
- **Health IT-enabled coordination:** 8

\*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:** None described in the sources identified.

**Link to Outcomes or Health System Characteristics:** In a study of 64 safety net practices from five states participating in a national demonstration project, independent observers agreed with practices' PCMH-A scores 82% of the time. In addition, practices that earned recognition as a PCMH by the National Committee for Quality Assurance early in the demonstration had higher PCMH-A scores than other sites. In addition, sites that engaged in and completed more medical home transformation activities by the end of the demonstration were more likely to report higher PCMH-A scores (personal communication, Donna Daniel, April 3, 2013).

**Logic Model/Conceptual Framework:** The instrument was developed based on the Change Concepts for Practice Transformation<sup>2</sup> and the 2008 National Committee for Quality Assurance PCMH standards.<sup>3</sup>

**Country:** United States

**Past or Validated Applications\*:**

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

\*Based on the sources listed below and input from the measure developers.

**Notes:**

- All instrument items are located online.<sup>1</sup>
- This instrument contains 35 items, of which 16 were mapped.

**Sources:**

1. Patient-Centered Medical Home Assessment (PCMH-A). Safety Net Medical Home Initiative. Available at: <http://www.safetynetmedicalhome.org/sites/default/files/PCMH-A.pdf>.
2. Wagner EH, Coleman K, Reid RJ, et al. The changes involved in patient-centered medical home transformation. *Prim Care* 2012;39(2):241-59.
3. National Committee for Quality Assurance. PCMH Standards & Guidelines. Available at: <http://www.ncqa.org/tabid/1016/Default.aspx>. Accessed: August 1, 2011.