Practice PCMH Monitor

The path for a practice to become a medical home may vary, but there are some steps that are particularly important for initial work, followed by focused work in other areas. This PCMH Monitor can assist practices in prioritizing activities and assessing progress over time. In the tables below, for each PCMH item on the left, consider how fully it has been implemented or functions in your practice. Fill in the circle next to each item that best reflects the completeness of implementation in your practice. If something is fully functional in your practice it means it is now common and routine.

Initial Changes – These are the initial steps that practices have to achieve in moving toward the new model of practice, through both preliminary work and then focused activity once the improvement team is formed.

Leadership	No, not at all ▽ Yes, completely ▽
1. PCMH project is understood and actively supported by senior leadership	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
2. QI teams and process provided with necessary time & resources	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
3. Leadership has created clear expectations, responsibilities, and accountability for the PCMH project (job descriptions, training, annual reviews)	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
4. Leadership proactively removes organizational barriers to change and improvement.	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
5. Culture of shared leadership created, with everyone sharing responsibility for change and improvement in the practice	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
Staff Engagement	No, not at all ▽ Yes, completely ▽
1. The staff has a basic understanding of the PCMH and the project	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
2. Staff members are actively and regularly involved in team meetings	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
3. Opportunities are provided for non-QI team members to be engaged/involved in change and improvement process	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
4. Communication infrastructure is built for bidirectional communication between QI team & rest of the practice	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
5. Staff participation in and contributions to improvement process are recognized and rewarded	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
QI Team Functioning	No, not at all ▽ Yes, completely ▽
1. Team meets regularly (at least twice a month)	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
2. Meetings well-organized - agendas, meeting summaries, prepared leaders and members	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
3. Team uses QI tools – AIMs, process mapping, PDSA	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
4. Team members do assignments and tasks, with good team accountability	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

5. Team functions at a high level with a sustainable, reflective QI process that deals effectively with challenges and conflict	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
Registry & Measures	No, not at all ▽ Yes, completely ▽
1. Identify clinically important conditions for initial collection of quality measures	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
2. Registry & specific measures chosen	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
3. Initial registry data upload completed	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
4. Workflow for maintaining registry data reliably implemented	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
5. Measures reported monthly internally and to project	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
6. Measures used as a central area of focus for practice's improvement activities	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
NCQA Recognition	No, not at all ▽ Yes, completely ▽
1. Project Manager and/or team identified	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
2. Gap analysis completed	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
3. NCQA Project Manager/team identified and working actively with QI teams to fill gaps	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
4. Progress on completion of element requirements	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
5. Recognized as a PCMH	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Next Steps – These are also very important, especially as next areas of focus depending on practice priorities after the primary changes are underway. Some of these steps may be dependent on the availability of revised payments or incentives, but many can be accomplished with existing resources.

Population Management	No, not at all ▽ Yes, completely ▽
1. Registry data are used to identify specified populations of patients (with initial focus on identified clinically significant conditions)	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
2. Patients with care or outcomes falling outside of acceptable range identified for more intensive care	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
3. Patient recall system designed and implemented to bring in patients for needed care	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

4. Flow sheet using registry data used for point of care decision support by care team	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
5. Care management system used to assist in care of patients needing additional assistance, mobilization of community resources, and/or contact between visits	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
Patient-Centered Care	No, not at all ▽ Yes, completely ▽
1. System implemented for including patient input & perspectives in ongoing improvement activities	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
2. "Patient experience" survey and other patient input used regularly (monthly or quarterly) to monitor practice performance across PCMH elements	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
3. Plan for integrating patient self-management support into the flow of the practice implemented	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
4. Shared care plans developed collaboratively with patients and families and then regularly reviewed to assess and monitor patient progress in accomplishing goals	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
5. Patients actively linked with community resources to assist with their self-management goals	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
Team-Based Care	No, not at all ▽ Yes, completely ▽
1. Care teams designated with regular team meetings	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
2. Team members have defined roles that optimally makes use of their training and skill sets	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
3. Protocols and standing orders implemented to better distribute workload throughout the team	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
4. Cross training developed and role barriers removed to improve response to patient needs	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
5. Practice teams use proactive communication for planned, between-visit patient interactions	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
Coordination of Care	No, not at all ▽ Yes, completely ▽
1. Local referral sources and community resources identified and information aggregated in central location for clinicians and staff to access	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
2. Collaborative agreements developed with key specialists and community resources for communication, coordination of care, and handoffs	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
3. Practice communicates actively with specialists and community resources to coordinate care based on patient's personalized shared care plan.	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

4. Team huddles used to discuss patient load for the day and plan for treatment, follow up and identification of team members involved in patient's care	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
5. Care coordinator used for subset of clinical population to ensure patient connectivity to outside providers and community resources	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
Access and Scheduling	No, not at all ▽ Yes, completely ▽
1. Every patient is assigned a personal physician, with a small care team to serve as back-up when the personal physician is unavailable.	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
2. The practice has a system to insure that patients are able to see their own clinician as often as possible, including tracking the percentage of patient visits that are with the patient's own chosen personal clinician.	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
3. Patients can reliably and quickly access their personal physician or a care team member to answer questions or deal with problems	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
4. Patients can reliably make an appointment with their personal physician or a care team member within defined and acceptable time periods	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
5. Patients can reliably access care from the practice after hours or on weekends	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Important Additional Area for Consideration – The integration of mental and behavioral health into care is a critical part of being a medical home – but is not specifically addressed in the NCQA standards.

Integration of Mental & Behavioral Health	No, not at all ▽ Yes, completely ▽
1. Practice actively screens for common mental health conditions	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
2. Each patient's personal care plan includes specific attention to health behavior change	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
3. Practice has access to mental and behavioral health consultants whose care is coordinated and integrated with the patients' care at the practice	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
4. There is a care manager in the practice trained to identify and monitor mental health issues	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
5. The care manager has skills in health behavior change (e.g., motivational interviewing, assessment of readiness to change, problem-solving therapy)	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Current Practice Climate - Practice climate may be an important general indicator of how well a practice can plan for and make change. Please rate your practice's current status (over the past two weeks) in the following areas. Note the change in the rating scale for this section.

Current Practice Climate	Low ▽ High ▽
1. General morale	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
2. Level of change fatigue	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
3. Level of chaos and disruptions	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
4. Confidence in our ability to accomplish change	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
5. Degree to which we are working well together	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Practice: _____

Date: _____