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.

Practice Culture	
Leadership	
	No, not at all ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Yes, completely
1. PCMH project is understood and actively supported by team leader.	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
2. Project Team provided with necessary time and resources.	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
3. Team Leader 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. Team Leader 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
Current Practice Climate	
	Low ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ 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
Patient Centered Care	
Patient Centered Care	
	No, not at all ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Yes, completely
1. System implemented for including patient input and 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 performances 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

Staff Engagement	
	No, not at all ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Yes, completely
1. The staff has a basic understanding of the PCMH and the project.	
2. Staff members are actively and regularly involved in team meetings.	
3. Opportunities are provided for non-team members to be engaged/involved in change and improvement process.	
4. Communication infrastructure is built for bidirectional communication between project team and rest of the practice.	
5. Staff participation in, and contributions, to improvement process are recognized and rewarded.	
Team Approach to Care	
Team-Based Care	
	No, not at all ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Yes, completely
1. Care teams designated with regular team meetings.	
2. Team members have defined roles that optimally makes use of their training and skill sets.	
3. Protocols and standing orders implemented to better distribute workload throughout the team.	
4. Cross training developed and role barriers removed to improve response to patient needs.	
5. Practice teams use proactive communication for planned, between-visit patient interactions.	
Information System Support & Population Management	
Registry and Measures	
	No, not at all ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Yes, completely
1. Identify clinically important conditions for initial collection of quality measures.	
2. Registry and specific measures chosen.	
3. Initial registry data upload completed.	
4. Workflow for maintaining registry data reliability implemented.	
5. Measures reported monthly internally and to project.	
6. Measures used as a central area of focus for practice's improvement activities.	

Population Management	
	No, not at all ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Yes, completely
1. Registry data are used to identify specified populations of patients (with initial focus on identified clinically significant conditions).	
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 needs 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
Use of Guidelines	
Use of Guidelines	
	No, not at all ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Yes, completely
1. Determine current workflow in relation to chronic disease process chosen.	
2. Develop workflow process for adoption of evidence based guidelines to include review of roles and responsibilities of all team members.	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
3. Embed evidence based guidelines into daily workflow.	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
4. Provide skills-oriented interactive training programs for all staff.	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
5. Share guidelines and information with patients so they are able to work as part of your team.	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
Quality Improvement	
QI Team Functioning	
	No, not at all ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Yes, completely
1. Team meets are regularly (at least twice a month).	
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 to 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

Self-Management Support	
Self-Management Support	
	No, not at all … Yes, completely
1. Standardized screening and treatment protocols are in place for assessing emotional health.	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
2. Distribution of patient handouts are systematically documented in patients' charts.	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
3. Assist patient with setting self-management goals at every visit through problem-solving, action planning and follow-up.	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
4. Assists patients' with problem identification, listing of possible solutions, taking into account environmental, family, work, or community barriers.	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
5. Assess and monitor patients' progress including barriers, ongoing symptoms, and medication adherence, with support for behavior change that will do this? How will it be documented?	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
Coordination of Care	
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 hand-offs.	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
Mental Health	
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 patient's 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
Patient Access	
Access and Scheduling	
	No, not at all ⓿ Yes, completely ⓾
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 clinicians 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 week-ends.	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
NCQA Recognition	
	No, not at all ⓿ Yes, completely ⓾
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 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

Practice: _____

Date: _____

Sourced from : Perry Dickinson, University of Colorado School of Medicine-perry.dickinson@ucdenver.edu HealthTeamWorks, Denver, CO http://www/healthteamworks.org