2018 SIM PCMH Initiative Self-Assessment

Please click the link below to complete the self-assessment.
https://umich.qualtrics.com/jfe/form/SV_3w7Gh5vNqz5uAtf

Deadline for Responses: 5pm, February 6, 2018

The PCMH Initiative Self-Assessment Tool is intended to assess Participating Practices on their current Patient Centered Medical Home capabilities and identify opportunities for the Initiative to support participants in the future. The PCMH Initiative Self-Assessment Tool will also help sites track progress toward practice transformation when completed at regular intervals.

The PCMH Initiative Self-Assessment Tool was developed by the State of Michigan, Michigan Department of Health and Human Services and the various partners in the State Innovation Model and has been adapted from the following existing sources:

- Safety Net Medical Home Assessment (PCMH-A), MacColl Center for Health Care Innovation at the Group Health Research Institute and Qualis Health, Version 4 (2014 Agency for Healthcare Research and Quality Universal Precautions Toolkit 2nd Edition).
- Ten Attributes of Health Literate Health Care Organizations (Brach, C., et al) 2012.
- Building Blocks of Primary Care Assessment (BBPCA), Center for Excellence in Primary Care.
- Transforming Clinical Practice Initiative PAT 2.0, Transforming Clinical Practice Initiative.
- JCAHO PCMH Requirements - Behavioral Health, 2014, The Joint Commission.
- Optional Self-Assessment for Primary Care Home Certification for Ambulatory Health Care Centers, The Joint Commission, 2014.

Before you Begin
Identify a multidisciplinary group of practice staff. We strongly recommend that the PCMH Initiative Self-Assessment Tool be completed by a multidisciplinary group (e.g., providers, nurses, medical assistants, care managers, other operations and administrative staff) in order to capture the perspectives of individuals with different roles within the practice and to portray the most representative viewpoint of current capabilities. We recommend that staff members complete the assessment individually, and that you then meet together to discuss the results

and produce a consensus version for final submission via Qualtrics. This discussion is a great opportunity to identify opportunities and priorities for PCMH transformation.

Have each site in an organization complete an assessment
This tool is meant to be completed at the practice level, therefore in the case of Physician Organizations, or multi-site organizations (such as a Federally Qualified Health Center) each site should complete a separate PCMH Initiative Self-Assessment Tool. Practice transformation, even when directed and supported by consistent organizational leaders, happens differently at the site level. Organizational leaders can compare PCMH Initiative Self-Assessment Tool scores and use this information to share knowledge and cross-pollinate improvement ideas.

Consider where your practice is on the PCMH journey
Answer each question as honestly and accurately as possible. There is no advantage to overestimating item scores (e.g. self-assessment results will not be used in any manner which impacts practice payment), and doing so may make it more difficult for real progress to be apparent when the PCMH Initiative Self-Assessment Tool is repeated in the future.

Directions for Completing the Assessment
1. The tool has been divided into 8 sections, each of which provides a brief introduction to the information being gathered within that domain.
2. There are two types of questions included in this tool, multiple choice and Likert Scale. For the multiple choice questions, select the option that best reflects the situation in your organization. For the Likert Scale questions, select the point value in the row that best describes the level of care that currently exists in the site. The rows in this form present key aspects of patient-centered care. Some rows will include a description for each point value, others will provide descriptions at each extreme; however responses can range from 1-5 in either case.

PO and Practice Name
Organization Name (PO or independent practice)
Practice Name

▼

Please type your organization/practice name here if you cannot find it in the list.

_____

Main Contact Information (this is the person who will be contacted for questions regarding information in this survey)

- Name _____
- Role _____
- Phone _____
- Email _____

I. Engaged Leadership

Engaged leaders help to provide visible and sustained support for overall culture and process changes to improve quality, utilization and patient experience in medical homes. Engaged leaders ensure that the PCMH transformation effort has the time and resources needed to be successful and that providers and other care team members have protected time to conduct activities beyond direct patient care that are consistent with the medical home model. The following questions ask about the extent to which leaders are currently engaged and visible in your practice.

Q1 **Executive Leaders in our practice…**

	Are only focused on short-term priorities (1)	Are interested in medical home advancement but overwhelmed with short term priorities (2)	Have promised but not taken action to begin to support practices to advance their medical home capabilities (3)	Have taken some actions to support medical home teams in improving the patient experience and clinical outcomes (4)	Consistently champion and engage interdisciplinary teams in improving patient experience and clinical outcomes (5)
	○	○	○	○	○

Q2 **Clinical Leaders in our practice (who may or may not also be Executive Leaders) …**

	Are new to population health and medical homes (1)	Show some understanding of population health, all-patient registries, and working cooperatively with care managers and coordinators (2)	To some extent support population health, all-patient registries, and working cooperatively with care managers and coordinators (3)	Often support population health, all-patient registries, and working cooperatively with care managers and coordinators (4)	Consistently support and champion population health, all-patient registries, and working cooperatively with care managers and coordinators (5)
	○	○	○	○	○

II. Care Management and Coordination Sustainability

Care management and coordination services are paid through the submission of Medicaid, Medicare and participating commercial payers G/CPT care management codes such as G9001 (Initial Assessment) and 99495 (Care Transition). These questions ask about your practice's approach to care management and coordination service billing, a key component of service sustainability.

Q3 **Who is responsible for G and CPT code billing in your practice?**

- ○ Our Practice Administrator
- ○ Care Manager(s) and/or Coordinator(s)
- ○ A billing vendor
- ○ Internal Billing & Coding staff
- ○ Our Physician Organization

Q4 **How does your practice record the documentation requirements for care management G/CPT codes?**

- ○ We do not bill for G/CPT care management codes currently
- ○ We capture the information required in written notes or in another form that is not integrated in the electronic clinical record.
- ○ We capture the documentation required in an electronic clinical record directly or a system which is integrated with our electronic record.

Q5 **Linking patients to supportive community-based resources…**

	. . .is not done systematically. (1)	. . . is limited to providing patients a list of identified community resources; by some teams. (2)	. . . is limited to providing patients a list of identified community resources; consistently by all teams. (3)	. . .is accomplished through a designated staff person or resource responsible for connecting patients with community resources. (4)	. . .is accomplished through active coordination between the health system, community service agencies and patients and accomplished by a designated staff person. (5)
	○	○	○	○	○

Q6 **Follow-up by the primary care practice with patients seen in the hospital. . .**

	. . . generally, does not occur because the information is not available to the primary care practice. (1)	. . .occurs only if the hospital alerts the primary care practice. (2)	. . .occurs because the practice makes proactive efforts to identify the patients (minimal electronic transfer of patient data is in place). (3)	. . .occurs because the primary care practice receives electronic hospital admission discharge transfer (ADT) alerts. (4)	. . .is done routinely because the primary care practice has ADT alerts, has arrangements in place with the hospital(s) to both track these patients and ensure that follow-up is completed within a few days. (5)
	○	○	○	○	○

III. Quality Improvement

A Quality Improvement strategy provides a framework and tools to plan, organize, and then to monitor, sustain, and spread the changes that data show are improvements. These questions ask about your organization's approach to addressing quality improvement, and the HIT tools that can be used as aids in assessing and achieving your goals.

Reminder: For the Likert Scale questions, select the point value in the row that best describes the level of care that currently exists in the site. Some rows will include a description for each point value, others will provide descriptions at each extreme; however responses can range from 1-5 in either case. Select the number across the range that best aligns with your practice environment.

Q7 **Clinical Leaders...**

	. . . intermittently focus on improving quality (1)	(2)	(3)	(4)	. . . consistently champion and engage interdisciplinary teams in improving patient experience of care and clinical outcomes (5)
	○	○	○	○	○

Q8 **Quality Improvement activities...**

	. . . are not identified (1)	. . . are not organized or supported consistently (2)	. . . are conducted on an ad hoc basis in reaction to specific problems (3)	. . . are conducted on a regular basis, but not within the context of a prevailing quality strategy (4)	. . . are based on a proven improvement strategy and used continuously in meeting organizational goals (5)
	○	○	○	○	○

Q9 **The responsibility for conducting Quality Improvement activities...**

	. . . is not defined (1)	. . . is not assigned by leadership to any specific group (2)	. . . is assigned to a group without committed resources (3)	. . . is assigned to an organized quality improvement group who receive dedicated resources (4)	. . . is supported by an organized quality improvement group and shared by all staff, and is made explicit through protected time and specific resources to engage in change (5)
	○	○	○	○	○

Q10 **An all-patient, all-payer registry...**

	. . . is not present (1)	. . . is currently being implemented (2)	. . . is present (installed), but not routinely used as a population health and quality improvement tool (3)	. . . is used on an ad hoc basis to produce data and reporting for specific purposes (4)	. . . is routinely used to produce reports to support population health management and inform quality improvement efforts (5)
	○	○	○	○	○

Q11 **An ONC certified Electronic Health Record that supports Meaningful Use...**

	. . . is not present (1)	. . . is currently being implemented (2)	. . . is used routinely during patient encounters to document services rendered and capture important patient care data (3)	. . . is used routinely to provide clinical decision support and share information with patients, in addition to documenting services and capturing data (4)	. . . is used routinely during patient encounters to provide clinical decision support and to share data with patients, and is also routinely used to produce reports to support population health management and inform quality improvement efforts (5)
	○	○	○	○	○

IV. Medical Neighborhood & Clinical-Community Linkages

The complexity of modern clinical care demands specialization, and high quality healthcare must ensure that patients receive care from those people and institutions best trained and equipped to provide a service, whether it be a surgical procedure, a medical evaluation, support for lifestyle change, or financial advice. Access to and the reliable exchange of information is important to ensuring patients receive the care they need to progress in their own health journey.

Q12 **Patients in need of clinical referrals for…**

	...cannot reliably obtain needed referrals to partners (1)	...needed referrals to partners are available but not consistently, or may unavailable in a timely manner (2)	...needed referrals to partners with whom the practice has a relationship are consistently available in a timely manner (3)	...needed referrals to partners with whom the practice has a relationship are available and timely, follow-up after referrals occurs but is	...needed referrals to partners with whom the practice has a relationship are available and timely, relevant information is communicated in advance, and timely follow-up after the referral occurs (5)

				inconsistent (4)	
Cardiology	○	○	○	○	○
Pain Management	○	○	○	○	○
Gastroenterology	○	○	○	○	○
Orthopedics	○	○	○	○	○
Psychiatry/ Behavioral Health	○	○	○	○	○
Substance Abuse	○	○	○	○	○
Obstetrics/ Gynecology	○	○	○	○	○
Physical Medicine & Rehabilitation (PMR)	○	○	○	○	○
Rheumatology	○	○	○	○	○
Ophthalmology	○	○	○	○	○
Hematology/Oncology	○	○	○	○	○
Endocrinology	○	○	○	○	○
Neurology	○	○	○	○	○
Nephrology	○	○	○	○	○
Other (specify)	○	○	○	○	○
Other (specify)	○	○	○	○	○

Q13 **Patients in need of community-based resource referrals for…**

	...cannot reliably obtain needed referrals to partners (1)	...needed referrals to partners are available but not consistently, or may unavailable in a timely manner (2)	...needed referrals to partners with whom the practice has a relationship are consistently available in a timely manner (3)	...needed referrals to partners with whom the practice has a relationship are available and timely, follow-up after referrals occurs but is inconsistent (4)	...needed referrals to partners with whom the practice has a relationship are available and timely, relevant information is communicated in advance, and timely follow-up occurs after the referral (5)
Local Public Health department	○	○	○	○	○
Community Action Agency	○	○	○	○	○
Employment / Job Skills / Career Support Agency	○	○	○	○	○
Food Bank / Food Pantry / Meals on Wheels	○	○	○	○	○
Vocational / Workforce Training Program	○	○	○	○	○
Housing Assistance	○	○	○	○	○
Refugee Services	○	○	○	○	○
Domestic violence shelter	○	○	○	○	○
Transportation assistance	○	○	○	○	○
Legal assistance	○	○	○	○	○
Utility assistance	○	○	○	○	○
DHS	○	○	○	○	○
Other (specify)	○	○	○	○	○

V. Integrated Behavioral Health Care

Integrating care is vital to addressing all the healthcare needs of individuals with mental health and substance use problems—regardless of whether primary care services are integrated into behavioral health systems, or vice versa. Primary care settings have become a gateway for many individuals with behavioral health and primary care needs.

Reminder: For the Likert Scale questions, select the point value in the row that best describes the level of care that currently exists in the site. Some rows will include a description for each point value, others will provide descriptions at each extreme; however responses can range from 1-5 in either case. Select the number across the range that best aligns with your practice environment.

Q14 **Describe your collaboration with behavioral health services:**

	Minimal collaboration. Mental health providers and primary care providers work in separate facilities, have separate systems, and communicate sporadically. (1)	Basic collaboration at a distance. Primary care and behavioral health providers have separate systems at separate sites, but now engage in periodic communication about shared patients. Communication occurs typically by telephone or letter. Improved coordination is a step forward compared to completely disconnected systems. (2)	Basic collaboration on-site. Mental health and primary care professionals have separate systems but share the same facility. Proximity allows for more communication, but each provider remains in his or her own professional culture. (3)	Close collaboration in a partly integrated system. Mental health professionals and primary care providers share the same facility and have some systems in common, such as scheduling appointments or medical records. Physical proximity allows for regular face-to-face communication among behavioral health and physical health providers. There is a sense of being part of a larger team in which each professional appreciates his or her role in working together to treat a shared patient. (4)	Close collaboration in a fully integrated system. The mental health provider and primary care provider are part of the same team. The patient experiences the mental health treatment as part of his or her regular primary care. (5)
	○	○	○	○	○

Q15 **Does your practice currently conduct behavioral health screenings?**

	Not at all, or not regularly (1)	(2)	Currently developing a standard workflow/process to do so (3)	(4)	Yes, utilizing a standardized tool(s) such as SBIRT or PHQ-9 (5)
	○	○	○	○	○

VI. Population Health

The goal of focusing on a population of patients is to ensure that every established patient receives optimal care, whether he/she regularly comes in for visits or not.
Reminder: For the Likert Scale questions, select the point value in the row that best describes the level of care that currently exists in the site. Some rows will include a description for each point value, others will provide descriptions at each extreme; however responses can range from 1-5 in either case. Select the number across the range that best aligns with your practice environment.

Q16 **Panel Assignment**

	Patients are not assigned to specific provider panels. (1)	(2)	(3)	(4)	Practice has assigned all patients to a provider panel and has confirmed the assignments with providers and patients. Assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand. Practice reviews and updates panel assignments regularly. (5)
	○	○	○	○	○

Q17 **Patient Risk Assessment and Treatment**

	Practice does not have a defined process for identifying patient risk level. (1)	(2)	(3)	(4)	Practice has successfully implemented and documented a tested process that identifies patient risk level and includes follow up by the patient's care team with care appropriate to the risk level identified. (5)
	○	○	○	○	○

Q18 **Systematic Patient Outreach**

	When patients are overdue for chronic care (e.g., diabetes lab work) or preventive care but do not come in for an appointment there is no effort on the part of the practice to contact them to ask them to come in for care. (1)	(2)	When patients are overdue for chronic or preventive care they are proactively contacted and asked to come in for care. (3)	(4)	In addition to proactively contacting patient with overdue care, members of the clinical team may act on these overdue care items (e.g., complete lab work) based on standing orders. (5)
	○	○	○	○	○

Q19 **Point of Care Assessment and Treatment**

	A patient who comes in for an appointment and is overdue for preventive care (e.g., cancer screenings) or chronic care (e.g., diabetes lab work) will only get that care if they request it or their provider notices it. (1)	(2)	(3)	(4)	A patient who comes in for an appointment and is overdue for preventive care or chronic care will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently. (5)
	○	○	○	○	○

Q20 **Planning Visits**

	Visits largely focus on acute problems of patient. (1)	(2)	(3)	(4)	Visits are organized to address both acute and planned care needs. Tailored, guideline-based information is used in team huddles to ensure all outstanding patient needs, including medication reconciliation, are met at each visit. (5)
	○	○	○	○	○

Q21 **The responsibility for conducting population health management activities**

	…is not defined (1)	…is not assigned by leadership to any specific group (2)	…is assigned to a group without committed resources (3)	…is assigned to an organized staff group who receive dedicated resources (4)	…is supported by an organized staff group and shared by all staff, and is made explicit through protected time and specific resources to engage in these activities. (5)
	○	○	○	○	○

Q22 **Gap in Care Reports**

	Practice does not collect data on care gaps for its population of patients. (1)	(2)	(3)	(4)	Practice analyzes gaps in care reports for prevention and chronic conditions/other diagnoses prevalent in the practice's patient population, and has a system in place to regularly act on the data, including outreach to individual patients needing intervention. (5)
	○	○	○	○	○

VII. Team Based Care

Well-functioning care teams have been shown to improve practice efficiency, quality of care, and staff satisfaction. Practices can draw on the expertise of a variety of clinical and non-clinical team members to ensure that patients get the care they need.

Reminder: For the Likert Scale questions, select the point value in the row that best describes the level of care that currently exists in the site. Some rows will include a description for each point value, others will provide descriptions at each extreme; however responses can range from 1-5 in either case. Select the number across the range that best aligns with your practice environment.

Q23 **A patient's individualized care plan. . .**

	...is not developed or documented consistently for all relevant patients (1)	(2)	...is developed only by the physician/provider (3)	(4)	...is consistently developed by the interdisciplinary primary care team along with patient involvement (5)
	○	○	○	○	○

Q24 **Monitoring a patient's progress towards achieving treatment goals. . .**

	...is completed only by the physician/provider (1)	(2)	(3)	(4)	...is consistently completed by the interdisciplinary primary care team (5)
	○	○	○	○	○

Q25 **The responsibility to track the care provided when patients are referred to an external organization. . .**

	...is not in place (1)	...is not assigned to anyone in the practice (2)	...is assigned to specific team member(s) in the practice without committed resources (3)	...is assigned to specific team member(s) in the practice with committed resources (4)	...is shared by designated interdisciplinary team member(s) with a process in place to consistently and proactively track the care provided for all patents and communicate with the patient and/or external organization as needed to coordinate/monitor care (5)
	○	○	○	○	○

Q26 **Workflows for the physician office clinical team. . .**

	...have not been documented and/or are different for each person or team (1)	(2)	(3)	(4)	...have been documented, are known and utilized by all care team members, and the workflows are evaluated and modified to improve efficiency (5)
	○	○	○	○	○

Q27 **Standing orders that can be acted on by non-independent provider members of the care team. . .**

	...do not exist in the practice (1)	...have been developed for some conditions but are not regularly used by care teams (2)	...have been developed for some conditions and are regularly used (3)	...have been developed for many conditions and are regularly used (4)	...have been developed for many chronic conditions and are used extensively on a regular basis by all care teams (5)
	○	○	○	○	○

VIII. Patient and Family Caregiver Engagement, Health Literacy & Shared Decision Making

Patient and family caregiver engagement is often defined as the extent to which patients are interested in participating in choices about their health care, responsibly taking ownership of those choices and adhering to their care plans (ideally co-created with care teams), and taking an active role in improving their health. Practices and providers can play an important role in facilitating and encouraging patient and caregiver engagement and in building patient and caregiver capacity for engagement.

Q28 **Patient Partnership in Self-Management Support and Collaborative Goal-Setting…**

	...is limited to the distribution of information (pamphlets, booklets) (1)	...is accomplished by referral to self-management classes or educators (2)	...is facilitated and action plans developed with patients and members of the practice team (3)	...is provided to patients by members of the practice team trained in patient empowerment and problem-solving methodologies (4)	...is provided to patients and their involved caregivers by members of the practice team trained in patient empowerment and problem-solving methodologies (5)
	○	○	○	○	○

Q29 **Patient and Family Advisory Council and/or Patient and Family Advisor Input …**

	...is a new concept for our practice (1)	...is a concept that our practice has discussed but not taken action on (2)	...occurs to some extent through organized collection of and action on patient input and feedback from surveys, comment cards, etc. (3)	...occurs through regular communication and meetings with patient and family advisors and/or advisory councils (4)	...occurs through regular communication and meetings with patient and family advisors and/or advisory councils and has resulted in demonstrated improvements or changes (5)
	○	○	○	○	○

Q30 **Do you encourage patient engagement in their treatment and health goals? (Select all that apply)**

- [ ] Clinicians help patients choose health improvement goals and develop action plans to take manageable steps toward goals.
- [ ] The practice encourages patients to express how they like to make shared decision making
- [ ] The office promotes patients to bring a friend or family member to help them at the doctor's appointment
- [ ] Our practice follows up with patients to determine if their action plan goals have been met
- [ ] The practice will provide patients with visuals and resources to be able to see progress towards their health goals. The practice continues to check in with patients to make sure the goals have not changed and there are no new barriers.

Q31 **How does staff communicate with patients of low health literacy?** (Select all that apply)

- [ ] Staff members speak clearly (e.g., use plain, everyday words and speak at a moderate pace)
- [ ] Our practice creates an environment that encourages our patients to ask questions, using tools such as the ASK ME 3 Campaign (e.g., asking "What questions do you have?"

instead of “Do you have any questions?”) and encourages them to be involved with their care

☐ Staff members use audio or visual aids to help explain various health issues in plain language and afterwards uses the teach back method to measure patient understanding

☐ Our practice uses a combination of these methods depending on the patient's level of understanding and need

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Q32 **How is feedback given back to the patient after an appointment or test?** (Select all that apply)

☐ Patients do not receive after-visit summaries

☐ After visit summaries, lab and test results are mailed to patients

☐ Staff members contact patients between office visits to follow up on plans and test results made during the visit

☐ All after-visit summaries, lab and test results are put onto a patient portal that patients are encouraged to access

☐ All after-visit summaries, lab and test results are put onto a patient portal that our staff assist patients in accessing and understanding

Q33 **Comments/Notes - Please add any additional or clarifying information that may be helpful in understanding the information submitted in this survey. Click "Submit" to send the completed survey.**

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