PATIENT-CENTERED MEDICAL HOME ASSESSMENT (PCMH-A) FREQUENTLY ASKED QUESTIONS

October 2014

Background

Who developed the Patient-Centered Medical Home Assessment (PCMH-A) and why?

The PCMH-A was jointly developed by the MacColl Center for Health Care Innovation at the Group Health Research Institute and Qualis Health as part of the Safety Net Medical Home Initiative (SNMHI), a national demonstration project to help 65 primary care practice sites in five states become high-performing patient-centered medical homes (PCMH) (www.safetynetmedicalhome.org). The PCMH-A was extensively tested by the 65 practice sites that participated in the SNMHI, including federally qualified health centers (FQHCs), residency practices, and other settings.

The PCMH-A is based on a framework—the Change Concepts for Practice Transformation—to help guide primary care practices through the PCMH transformation process. "Change concepts" are general ideas used to stimulate specific, actionable steps that lead to improvement. The Change Concepts were derived from reviews of the literature and discussions with leaders in primary care and quality improvement. They are applicable to a wide range of primary care practice types and have been adopted by a number of regional and national initiatives nationwide.

Our framework includes eight change concepts in four stages:

- Laying the Foundation: Engaged Leadership and Quality Improvement Strategy
- Building Relationships: Empanelment and Continuous and Team-Based Healing Relationships
- Changing Care Delivery: Organized, Evidence-Based Care and Patient-Centered Interactions
- Reducing Barriers to Care: Enhanced Access and Care Coordination

Where can I learn more about the eight Change Concepts included in the PCMH-A?

More information can be found here: www.safetynetmedicalhome.org/change-concepts.

How does the PCMH-A differ from other assessment tools such as the Medical Home Implementation Quotient (MHIQ), Medical Home Index (MHI), or Medical Home Builder® (MHB) Practice Biopsy?

All tools are self-assessments designed to measure the degree of implementation of the PCMH Model of Care and identify opportunities for improvement. The PCMH-A was specifically developed to assess implementation of the Change Concepts for Practice Transformation. While all tools assess similar domains, there are important nuances. For example, the foundational characteristics of engaged leaders who support practice transformation are emphasized to a greater degree in the PCMH-A than other tools. Similarly, while all tools include assessments of population management or tracking of clinical quality measures at the organizational level, the direct assessment of panel assignment and management at the team level is highlighted in the PCMH-A.

Using the PCMH-A

Why should our site use the PCMH-A tool?

The PCMH-A is intended to help sites understand their current level of "medical homeness" and identify opportunities for improvement. Using the PCMH-A will help your practice understand where it is on the medical home journey and identify specific opportunities for improvement. If repeated at regular intervals, the PCMH-A will help track your practice's PCMH implementation progress. If your site has a practice coach, or is participating in a collaborative, your PCMH-A results can also help inform their technical assistance or planning efforts so they can better support your practice.

Is the PCMH-A score transferable to non-safety net practices?

Yes. The Change Concepts for Practice Transformation were not designed to be specific to the safety net, but rather an expectation for all medical homes. Organizations such as Indian Health Services, private practices, primary care associations, county health services departments, physician-owned practices, learning collaboratives, state health departments, and health management companies have all used the PCMH-A to measure progress and improvement.

How should we complete the PCMH-A?

First, identify a multidisciplinary group of practice staff, at each practice site in the organization, to complete an assessment.

We strongly recommend that the PCMH-A be completed by a multidisciplinary group (e.g., physicians, nurses, medical assistants, residents, other operations and administrative staff) in order to capture the various perspectives of individuals with different roles within the practice and get the best sense possible of 'the way things really work.'

- Each site should complete a separate PCMH-A. Practice transformation, even when directed and supported by organizational leaders, happens differently at the practice site level. Organizational leaders can compare PCMH-A scores between practice sites and use this information to share knowledge and cross-pollinate quality improvement (QI) ideas.

For each practice site, create a consensus assessment and action plan. We recommend that staff complete the assessment individually then meet to discuss the results and produce a consensus version. We discourage staff from simply averaging the scores—the consensus-reaching discussion is a great opportunity to identify opportunities and priorities for PCMH transformation. Once there is an agreement on the current status, the group can develop an action plan for priority improvement areas.

Answer each question as honestly and accurately as possible. There is no advantage to overestimating or upcoding item scores, and doing so may make it harder for real progress to be apparent when the PCMH-A is repeated in the future. It is fairly typical for teams to begin the PCMH journey with average scores below five for some or all areas of the PCMH-A. It is also common for teams to initially believe they are providing more patient-centered care than they actually are. Over time, as your understanding of patient-centered care increases and you continue to implement effective practice changes, you should see your PCMH-A scores increase.

What is the value of having multiple people complete the PCMH-A versus a single person from the QI or PCMH transformation team?

A multidisciplinary group (e.g., physicians, nurses, medical assistants, residents, other operations and administrative staff) will illuminate different perspectives across the practice. In instances where a single person completed the PCMH-A, we generally saw higher scores than compared to cases in which multiple staff contributed to scoring. Leadership and front-line staff may have different perspectives on whether policies and procedures are truly being implemented, what challenges exist on a day-to-day basis, and what information, resources, and protected time are needed to redesign processes for sustained improvements.

How frequently do you recommend sites take the PCMH-A?

The PCMH-A is sensitive to change at six-month intervals. However, some projects have used different frequencies.

Scoring

How are scores calculated?

Teams rate the practice on a 12-point scale for each of the 36 items. Item scores are averaged for each of the eight Change Concepts and an overall average score. The scores are also grouped into four levels: D (scores 1-3), C (scores 4-6), B (scores 7-9), and A (scores 10-12).

Why are there three scores in each level?

Practices are encouraged to use the three scores within a given level to indicate the extent of progress. For example, in question 21 (the first item in Patient-Centered Interactions) Level D, a score of one means the organization is just beginning to think about assessing patient and family values while a score of three means the organization has support for assessing patient and family values and a plan to do so, but the actual work of assessing has not yet begun. This mini-spectrum is designed to allow practices to indicate that progress is just beginning, underway, or well established within a level.

How do I interpret/translate the scores?

- Level D reflects absent or minimal implementation of the key change addressed by the item.
- Level C suggests that the first stages of implementing a key change may be in place, but that important fundamental changes have yet to be made.
- Level B scores are typically seen when the basic elements of the key change have been implemented, although the practice still has significant opportunities to make progress with regard to one or more important aspects of the key change.
- Level A indicates that most or all of the critical aspects of the key change addressed by the item are well established in the practice.

Even if a few scores are particularly low or particularly high, practices with mean scores in the Level D range have yet to implement many of the fundamental key changes needed to be a PCMH. Practices with average scores in the Level A range have achieved considerable success in implementing the key design features of the PCMH as described by the Change Concepts for Practice Transformation.

What causes variation in the scores over time?

PCMH-A scores may be influenced by the following:

- Knowledge about the Change Concepts (definitions, meaning, application in practice).
- Single staff person vs. multidisciplinary team scoring.
- Variation in the team members who are completing the PCMH-A.
- Improvements in practice processes and quality of care delivery.

How do we interpret decreases in scores over time?

Self-reported PCMH-A scores can decrease, particularly from first to second administration. This is typically not due to a decline in actual performance, but is associated with a more complete understanding of the Change Concepts. Declines can also be a reflection of intensive efforts to characterize the current state and identify opportunities for improvement. When a different group of multidisciplinary staff members completes the assessment at different times, particularly if the number of group members is small, increases or decreases in scores that are not associated with real change can occur.

Is analytical and reporting support available?

The public version of the PCMH-A auto-scores and provides a practice with instant results free of charge. For groups of practices interested in comparative scores or custom reports, Qualis Health can provide a custom data and reporting package for a fee. To learn more about this service, please see www.qhmedicalhome.org/consulting-services/assessment-planning.

What is the difference between the various versions of the PCMH-A?

Versions 1.x have 33 items (as opposed to the current 36) and are in the public domain.

Versions 2.x also contain 33 items and were customized for clients to include project-specific detail.

In versions 3.x, the Change Concepts were reordered to follow the PCMH transformation experience suggested by the learnings of the Safety Net Medical Home Initiative's 65 partner sites. Versions 3.x also includes two new items, tested over three administrations of the SNMHI. The new items are under the Quality Improvement Strategy and Patient-Centered Interactions Change Concepts.

In versions 4.x, one additional item was added under Organized, Evidence-Based Care. The new item addresses measurement of behavioral health outcomes (such as improvement in depression symptoms).

How do I compare results from previous versions of the PCMH-A (legacy versions with 33 items) if we are now using Version 4.0 with 36 items?

For the majority of SNMHI participants, the addition of the three new items did not substantially change the overall or Change Concept scores.

Have you assessed whether there is bias from a practice's self-report?

Not formally. In the SNMHI, we asked the practice coaches/Medical Home Facilitators (MHF) to assess each of the partner sites' PCMH-A self assessment and indicate whether they feel the score was too high, accurate, or too low. Preliminary findings show that MHF agreement with PCMH-A average scores by Change Concept varied by region, but generally MHFs agreed with the sites' self assessment about 80% of the time.

Has the tool been validated for assessment of practice transformation (or "medical homeness")?

The process used to validate the PCMH-A is described in detail in "Assessing Progress Toward Becoming a Patient-Centered Medical Home: An Assessment Tool for Practice Transformation".

What results have been achieved by sites using the PCMH-A in the SNMHI?

Final outcome data and changes over time are available in "The Safety Net Medical Home Initiative: Transforming Care for Vulnerable Populations".

PCMH Transformation and Recognition

How can the PCMH-A drive QI efforts that support transformation?

PCMH-A results can be used to create an action plan for PCMH implementation. Once opportunities for improvement are identified, your practice can use the tools and resources on the SNMHI website to support PCMH transformation and NCQA recognition. You can navigate these free resources by type, topic, or through the registry of tools and resources, which includes all resources and tools hosted on the website and those hyperlinked within documents on the website.

Discussion among leaders, clinicians, and administrative staff about PCMH-A results helps to create the transparent culture that is critical for true PCMH transformation. These discussions can also help build consensus for transformation priorities.

Now that we have taken the PCMH-A, how do we go about improving our scores?

Use the PCMH-A as a guide for digging deeper and identifying opportunities specific to your practice:

1. In a team meeting, distribute the PCMH-A results. Discuss your rating on each of the Change Concepts. If not everyone was involved in the self-assessment, you might re-open the discussion and bring relevant data to the table (e.g., empanelment, continuity).

2. Brainstorm what it would take to move up a level (e.g., D to C) and plan tests (PDSA cycles) for those process changes that your team believes will result in improved patient relationships with their care team.

   Each SNMHI Change Concept includes three to five "key changes." These provide a practice undertaking PCMH transformation with more specific ideas for improvement. Each practice must decide how to implement these key changes in light of their organizational structure and context.

   The Key Activities Checklist is a publicly available tool that offers examples of activities practices can adapt for progress towards implementation of the 32 key changes and was developed through the compilation of key activities reported by the 65 SNMHI sites as they pursued PCMH transformation. A checklist is provided for each Change Concept.

   For example, if your score on Continuous and Team-Based Healing Relationships indicates Level C, your brainstorm might generate the following change ideas to test:

   - A script for the receptionist about scheduling patients with their assigned primary care provider (PCP) or care team, see Scripting for Appointment Scheduling.
   - Give patients the choice of an earlier appointment with any provider or later appointment with their PCP/care team
   - Fully utilize the scope of an LPN to help meet the needs of patients in the care team panel to open up access to the PCP/care team

3. Use sequential PDSA cycles to test your predictions (e.g., schedulers will be very comfortable with using a script to encourage patients to see their own provider/care teams), start very small (Try it once! How did it go? Any surprises?). Build your learning as you test under varying conditions (different schedulers, different days) in order to adapt your process so that it achieves the desired results at your site. Do not forget to plan for collecting (just enough) data (e.g., number of times the scheduler used the script, number of times patients opted to see their own provider/care teams) to help you understand whether the new process is working the way you predict.

4. Continue testing and adapting activities until you can score your practice at the A level. Remember, this may take months to achieve.

What is the relationship between the PCMH-A and the NCQA PCMH Recognition Standards?

The PCMH-A measures the degree of implementation of the Change Concepts for Practice Transformation. There is a high degree of overlap between the Change Concepts and the 2014 NCQA PCMH Recognition Standards. To learn more about the similarities and differences, see the SNMHI's crosswalk between the Change Concepts for Practice Transformation and 2014 NCQA PCMH™ Recognition Standards and What is the Relationship Between NCQA PCMH Recognition and Practice Transformation, published in the SNMHI's Medical Home Digest (2012).

Administrative

Is my site/organization able to modify the PCMH-A?

Yes, the PCMH-A is in the public domain and may be used and modified. As the PCMH-A is getting more attention in the public domain, requests for adaptations are becoming more frequent. We do request that you consider the following:

- Contact Judith Schaefer at schaefer.jk@ghc.org at the MacColl Center for Health Care Innovation to discuss your organization's ideas on adaptation and send Judith your organization's final product. Your input is helpful for future potential revisions of the PCMH-A.
- Please note that altering the content of the assessment makes it impossible to compare results with data from other initiatives, but again all are welcome to customize it for use.
- Please include the following attribution: "Adapted from: Safety Net Medical Home Initiative. The Patient-Centered Medical Home Assessment Version 4.0. Seattle, WA: The MacColl Center for Health Care Innovation at Group Health Research Institute and Qualis Health; September 2014."

Is there a version of the PCMH-A available in a format other than PDF?

The PDF is the only version of the PCMH-A tool publicly available at this time.

Whom do I contact for additional questions about the PCMH-A?

For questions about the tool itself, please contact:
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Safety Net Medical Home Initiative

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The objective of the Safety Net Medical Home Initiative was to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative was administered by Qualis Health and conducted in partnership with the MacColl Center for Health Care Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon and Pittsburgh), representing 65 safety net practices across the U.S. For more information about the Safety Net Medical Home Initiative, refer to: www.safetynetmedicalhome.org.

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