PCMH Strategic Planning, Quality Improvement, and Business Processes Tool

Strategic Process	Specific Strategy	Met? (Y/N)	Responsibility
Vision Statement	The vision statement includes language about establishing a patient-centered medical home (PCMH) for every patient.		
	Leadership has the ability to operationalize the vision by defining clear, actionable, measurable targets for staff at all levels in the organization.		
Business Planning	The business planning process explicitly includes PCMH improvement work, including allocating resources (staff/time/technology/tools) to the initiative, and areas of focus over an expected time period.		
	Staging and sequencing of the initiative does not compete with other business planning processes (e.g., EHR implementation), or protocol for conflict resolution exists to mitigate problems.		
	Business plan includes goals, expected results, and outcomes of the PCMH initiative.		
	Potential barriers to success are known and have assigned executive leaders and resources.		
Building a System of Improvement	Clinical and executive leaders have concrete plans for improvement over the proposed period of time to fully implement the PCMH.		
	Charter structure clearly outlines goals, metrics, and accountability.		
	Timeline states when PCMH Change Concepts for Practice Transformation reach full implementation.		
	Patient and family perspective is included.		
	Deliverables are specific, measureable, actionable, results-oriented, and timely.		
	Metrics/outcomes are associated with the deliverables.		
	Short and long-term needs are balanced.		

Strategic Process	Specific Strategy	Met? (Y/N)	Responsibility
Communication Strategy	An executive leader is assigned as the organizational champion to develop continuous communication around the PCMH initiative.		
	All executive leaders—including the board—actively support implementation of the PCMH.		
	A comprehensive communication plan identifies all potential ways of communicating the goals and progress with the PCMH initiative to staff, the board, providers, and the public.		
	Key behaviors, activities, and responsibilities related to the implementation of the PCMH initiative are embedded in employee job descriptions and performance review documents.		
Managing Team Improvement Activities	An executive leader is a sponsor for the PCMH initiative.		
	A regular (such as quarterly/monthly) review of PCMH progress is scheduled between sponsor and PCMH team to keep leadership up-to-date on effort.		
	Update is presented to board and executive leadership on regular and ongoing basis.		
	A systematic review of all strategic initiatives with clinical leaders, sponsors, and the board identifies the impact of various initiatives on one another.		
Data Capture Capability	Organization has a way to capture data.		
	Data are consistent and reliable.		
	If EHR is being implemented soon, clinical leaders most knowledgeable about PCMH are involved in the design/ interface with HIT support team.		
Training Leaders and the Board on Quality Improvement	Training is available for clinical leaders, executive leaders, and board members to ensure skills and competence in sponsoring quality improvement activities.		
	Leaders understand performance improvement data.		
	Existing training includes viewing the organization as a system.		

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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