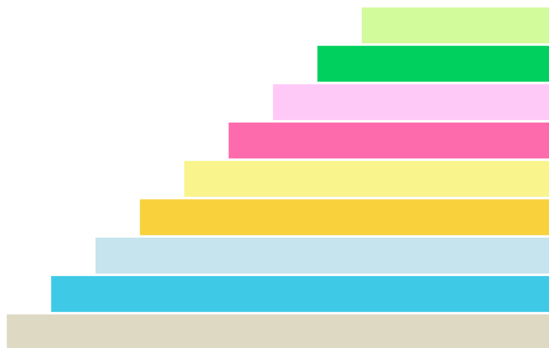


Primary Care Network PCN-Level Medical Home Assessment

A tool to assist PCNs to review their programs and guide their selection of future priorities

Introduction to the PCN Level Medical Home Assessment

Why participate in a PCN Level Medical Home Assessment?

- A Medical Home Assessment at the PCN level includes the elements and processes that have been demonstrated to support primary care in achieving quality patient care results. The assessment is a practical tool to assess PCN level processes, structures, activities and programs related to Medical Home concepts, and to support plans for advancement. For an outline of the Medical Home model, see Appendix A.
- The assessment can also help PCNs track progress toward Medical Home transformation at regular intervals, as desired. The tool is designed to allow PCNs to self-initiate re-assessment opportunities at a later date.
- The results of this facilitated assessment can be used by the PCN to set priorities and to create a customized Action Plan that outlines actions and supports to be further developed.
- The assessment is a resource to help a PCN prioritize and plan its quality improvement activities.

Who participates in the PCN Level Medical Home Assessment?

- Each PCN is invited to complete the Assessment.
- In order to capture the perspectives of individuals with different roles within the PCN, it is recommended that the assessment be completed by as many PCN team members as possible. Having multiple perspectives from different functional areas will provide a greater picture of how things operate within the PCN.
- Ideal participants in the Medical Home Assessment may include the Executive Director, at least one Board Member, Lead Physician(s), and other senior staff (e.g. Clinical Managers, Facilitators, Directors, Evaluator, etc.).
- Each practice will have the opportunity to participate in a Practice Level Medical Home Assessment, which is an additional step in the Medical Home Assessment initiative.

Completing the Medical Home Assessment

Before you get started

Who completes the PCN Level Medical Home Assessment?

Identify team members with different roles within your PCN to complete the assessment; a typical assessment team will have 3-10 members. Facilitators from the PMP and PCN PMO teams will be available to support your team with the assessment process.

Do we complete the assessment as a group or individually?

First, participants complete the assessment as individuals. Next, meet as a group with your facilitators and work together to discuss results and generate team consensus scores. The consensus conversation will help if there is uncertainty (see the scoring and interpretation section of this document for more information about this process).

Note: It is highly discouraged that participants' individual scores be averaged to form an overall group score without having discussions to build consensus as a group. The discussion is a great opportunity to identify opportunities and priorities for Medical Home transformation within the PCN.

What do the different levels in the assessment questions represent?

The responses to each question, or item, are categorized into levels D through A (as outlined below). The levels represent the degree to which a PCN has implemented the activity/process related to Medical Home concepts. Level D represents a PCN that has yet to consider the activity/process or has minimally implemented it, while Level A represents a PCN that has addressed and established the activity/process.

Item	Level D	Level C	Level B	Level A
Activity or process (key change)	Scores reflect absent or minimal implementation of the key change addressed by the question.	Scores suggest that the first stage of implementing a key change may be in place, but that important fundamental changes have yet to be made.	Scores suggest that basic elements of the key change have been implemented, but there is still significant opportunity to make progress with regard to one or more important aspects of the change.	Scores suggest that most, or all, of the critical aspects of the change are addressed and the activities or processes are well established within the PCN.

What do the different numbers in the assessment questions represent?

Each level has 3 numbers; this is how you will score the assessment. Circling a **higher number** <u>within a level</u> indicates the described action in that level is done **more consistently** in your practice; conversely, a **lower number** indicates the action is done **less consistently**.

Refer to the question below to review an example outlining how the self-assessment levels and numbers are connected and how you should complete the assessment.

How do I complete the assessment?

1. The Medical Home Assessment includes 10 sections, or concepts, each of which has between 3-4 questions (refer to the Appendices for more information on the medical home and definitions/terminology).
2. For each question, or item, there are 4 responses labelled Level D to A, which represent the various stages of development toward supporting patient-centred medical homes. Read each response (D to A) first, then select the one you think best represents your PCN at this point in time.
3. Once you have selected the level, circle one of the three numbers below it. Circle a higher number to indicate that the action described in that level is more fully implemented or completed more consistently; circle a lower number to indicate the action is done less consistently or frequently by your PCN.

NOTE: **Only one number should be circled per question/item**. If you're uncertain, select a lower number. There will be opportunity to discuss scores as a group.

Example: If you believe your PCN's QI plan... "is in the early stages of development" AND the PCN is frequently engaging in a development process: circle #6

Item	Level D			Level C			Level B			Level A		
Example: A PCN quality improvement (QI) plan...	has not been developed.			is in the early stages of development.			is developed for PCN level quality improvement only.			is developed and supports the development of PCN and practice-level QI plans.		
Select one value	1	2	3	4	5	(6)	7	8	9	10	11	12
I would describe the level of **CONSISTENCY** with which my PCN completes the action/process described above at the current time as...	Low	Moderate	High	Low	Moderate	High	Low	Moderate	High	Low	Moderate	High

4. Review your subscale and overall score (at the end of the document). If you are using the electronic version, the subscale and overall scores will be automatically calculated based your responses. If you are using a paper version, add the numbers in each section to come up with subscale values, then add all scores to produce an overall score. Using the scores to guide you, think about opportunities for improvement.
5. Save your results and meet with the group and a facilitator to discuss results

Consider where your PCN is on the PMH Journey

Each individual should answer each question as honestly and accurately as possible. There is no advantage to overestimating item scores, and doing so may make it harder for progress to be apparent when the Assessment is repeated in the future. It is typical for teams to begin their improvement journey with average scores in Levels C or D for some (or all) areas. Over time, as the PCN's understanding of the requirements, programs and services needed to support PCN and practices (member clinics and PCN clinics) in their journey toward patient-centered medical homes increases, there should be an accompanying increase in Assessment scores.

PART 1: PCN SUPPORT FOR THE MEDICAL HOME – GOVERNANCE & COMMUNICATION

- Have long-term strategies to implement and spread quality improvement initiatives
- Use funding to support both clinical and change management programs
- Review PCN mission & vision regularly to ensure alignment with medical home objectives

Items	Level D			Level C			Level B			Level A		
1. PCN Board(s) and/or the Joint Governance Committee…	have not formally identified support for the medical home model as a strategic PCN priority.			have formally identified the medical home model as a strategic priority (e.g. mission statement; strategic objectives).			have implemented strategies that directly support at least one aspect of the medical home model within practices.			have implemented long-term strategies that directly support multiple aspects of the medical home model within practices.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
2. PCN initiatives/programs in support of the medical home model…	are minimal or do not exist.			are reviewed periodically for alignment to the PCN's strategic goals; programs are discontinued or re-aligned as necessary.			are routinely reviewed and adjusted based on achievement of strategic goals (using qualitative and quantitative results).			are reviewed annually by an Evaluation committee and PCN leadership, and incorporate multiple stakeholder perspectives and outcome measures.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
3. PCN funds/resources to support the medical home within practices…	are minimal or do not exist.			comprise a relatively small proportion of the overall PCN budget/resources, and are provided on a narrow and prescriptive basis.			comprise a significant proportion of the PCN budget/resources, and eligible uses are flexible to support practices at any stage of evolution.			comprise the major proportion of the PCN budget/resources, are flexible, and also incorporate PCN population-based planning.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
4. A communication plan for the PCN's role in the medical home initiative…	has not been developed.			is being developed to create awareness and build knowledge within the PCN and practices.			is developed and outlines the benefits and attributes of the medical home for the PCN, practices and patients.			is implemented and includes comprehensive stakeholder and community engagement to reinforce medical home concepts and enhance understanding.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
Total Score:				**Average Score (Total Score /4):**								

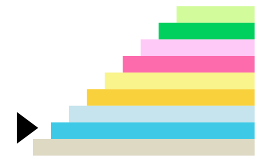
PART 2: PCN SUPPORT FOR THE MEDICAL HOME – MEASUREMENT & EVALUATION

- Include dedicated evaluation staff (or dedicated staff time) to provide measurement supports to practices
- Ensure evaluation strategies include defined outcome indicators, data sources, and support for information flow

Items	Level D			Level C			Level B			Level A		
5. The PCN's internal measurement capacity…	has not been developed.			is in the early stages of development or implementation.			is being implemented by general team members who have achieved streamlined data collection and feedback processes in at least one topic area.			includes dedicated staff/resources to support standardized data gathering, feedback to practices, and measurement supports for several topic areas.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
6. A PCN evaluation strategy…	has not been developed.			has been drafted, with definitions and data sources in development.			has been developed and includes outcomes, indicators, and data sources, but has only been implemented for 1-2 topic areas.			defines outcomes, indicators, data sources and required support for information and data sharing.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
7. Standard performance measures…	have not been developed.			have been drafted for practices but are limited in scope.			are comprehensive, including clinical, operational and patient experience measures.			are developed and include clinical, operational, and patient/provider experience measures, and results are fed back to practices for the purpose of quality improvement.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
Total Score:				**Average Score (Total Score /3):**								

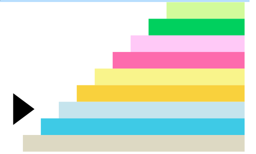
PART 3: PCN SUPPORTS FOR THE MEDICAL HOME – ENGAGED LEADERSHIP

- Provide visible and sustained leadership promoting the benefits of the medical home for patients and providers
- Support practices to build values enabling the development of staff hiring and training processes that align with a patient-centred medical home
- Ensure that the medical home transformation effort has the time and resources needed to be successful



Items	Level D			Level C			Level B			Level A		
8. Visible PCN leadership (champion/sponsor) for he Medical Home model…	is minimal or does not exist.			is in the early stages of planning; a champion has been identified.			is noticeable at selected events and team meetings, in selected communication, and the sponsor is visible to stakeholders.			is consistently present at strategic and operational discussions, and the engaged sponsor promotes medical home benefits for patients and providers.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
9. PCN executive leaders (Executive Director, Physician Leads, or equivalent roles)…	are not in alignment on the role of the PCN in supporting the medical home model.			are aligned and support the PCN role in developing/promoting the medical home model but have not yet implemented any initiatives.			have developed an infrastructure and programs that support practices to advance the medical home model.			have specific short and long term goals for PCN support of the medical home model included in an annual performance review.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
10. PCN Leadership…	is focused on short-term business priorities.			visibly supports and creates an infrastructure for quality improvement, but does not commit resources.			allocates resources and actively rewards quality improvement initiatives or programs and training.			supports continuous learning throughout the organization, reviews and acts upon quality data, and has a long-term strategy and funding to explore, implement and spread quality improvement initiatives and programs.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
Total Score:				**Average Score (Total Score /4):**								

PART 4: PCN SUPPORT FOR THE MEDICAL HOME – QUALITY IMPROVEMENT (QI)



- Choose and use Quality Improvement (QI) models and tools, such as Plan-Do-Study-Act (PDSA) cycles, process mapping, etc.
- Establish and monitor metrics to evaluate improvement efforts and outcome; ensure all staff understand the metrics for success
- Ensure that patients, families, providers, and care team members are involved in QI activities
- Optimize use of health information technology for proactive patient care

Items	Level D			Level C			Level B			Level A		
11. Quality improvement (QI) activities undertaken in the PCN…	are minimal or do not exist.			are conducted in an ad hoc basis in reaction to specific problems.			are based on a proven (evidence-based) improvement strategy in reaction to specific problems.			include funded time for QI team members, are embedded in an improvement strategy and used continuously in organization goals.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
12. A PCN quality improvement (QI) plan…	has not been developed.			is in the early stages of development.			is developed for PCN level quality improvement only.			includes engagement of patients/families and care teams, and supports the development of PCN and practice-level QI plans.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
13. Responsibility for conducting QI improvement activities and QI skill training…	is not assigned by leadership to any specific group, or activities are not available.			is assigned to a group without committed resources, and activities/training is accessed on an ad hoc basis by individual staff.			is assigned to an organized QI (PCN internal or external) that receives dedicated resources, and is accessible to all PCN and practice staff.			is shared by all staff, from leadership to clinical staff, and is made explicit through protected time to meet and specific resources to engage in QI.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
14. PCN support to practices in the use of EMRs…	is minimal or does not exist.			is in place and is being used to support clinical data capture.			is offered for clinical decision support processes and to share data with patients.			is also used routinely to support population management, PCN Evolution activities and QI efforts.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
Total Score:				**Average Score (Total Score /4):**								

PART 5: PCN SUPPORT FOR THE MEDICAL HOME – PANEL

- Support practices to implement panel identification and management processes
- Review panel lists and identify/address any duplication of patients across practices
- Use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self-management status, and community or family need
- Provide practices with regular reports related to processes and outcomes for their patient panels

Items	Level D			Level C			Level B			Level A		
15. Patient panel lists…	are not available.			are available on an ad hoc basis but the PCN does not receive them from practices.			are received by the PCN from practices, but are not reviewed.			are received by the PCN from practices, reviewed for duplication and reports are shared with practices.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
16. PCN supports for panel identification and management at the provider level…	are minimal or do not exist.			are limited to providing general promotion of panel concepts.			are a priority within the PCN, and supports are implemented through PCN partnerships with external organizations.			are a priority within the PCN, and the PCN has internal capacity and resources to support practices in implementing panel processes.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
17. PCN supports for practices to develop panel-level disease registries or lists…	are minimal or do not exist.			are available on an ad hoc basis.			are regularly available to assess and manage panel populations, but only for a limited number of diseases or high risk patients.			are regularly available to assess and manage care for panel populations across a comprehensive set of diseases and risk states.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
18. PCN supports for practice-level reports on patient care/outcomes…	are minimal or do not exist.			are available to practices on an ad hoc basis.			are provided to practices on a regular basis, but types of reports are limited (e.g. patient satisfaction only).			are regularly provided to practices for multiple outcomes and care processes, and reports are used both within practices and the PCN for quality improvement.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
Total Score:				**Average Score (Total Score /4):**								

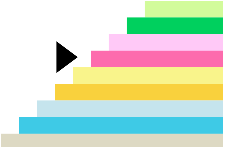
PART 6: PCN SUPPORT FOR THE MEDICAL HOME – CONTINUOUS & TEAM-BASED CARE

- Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members
- Establish and provide organizational support for care delivery teams accountable for the patient population/panel
- Ensure availability of providers and multi-disciplinary care team members to patients in the right place at the right time

Items	Level D			Level C			Level B			Level A		
19. The PCN's multi-disciplinary team member role definition (team complement)…	has not been developed.			has been developed but not reviewed for appropriateness based on panel population health needs.			has been revised based on the one-time identified needs of the patient population (e.g. condition-specific, such as CDM Nurse).			is routinely revised and care team members are engaged based on the ongoing needs of the clinic, geographic and panel population.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
20. PCN supports for PCN and practice staff training needs…	have not been developed.			are available on ad hoc basis, yet ensure PCN and practice staff is trained for individual responsibilities and roles.			assess training needs of PCN and practice staff, ensure staff is trained for responsibilities and roles, and encourage clinical cross-training on an ad hoc basis.			assess training needs of PCN and practice staff, ensure staff is educated in role optimization, and encourages full clinical cross-training.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
21. PCN standard practices for documentation, communication and handoff…	have not been developed.			have been developed for specific diseases or conditions that have been prioritized.			have been developed and implemented for a number of diseases, conditions, and general care services.			are broadly implemented, routinely reviewed, and modified to meet patient and practice needs.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
Total Score:				**Average Score (Total Score /3):**								

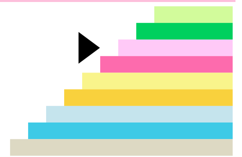
PART 7: PCN SUPPORT FOR THE MEDICAL HOME – ORGANIZED, EVIDENCE-BASED CARE

- Identify high risk patients and ensure they are receiving appropriate care and case management services
- Use point-of-care reminders based on clinical guidelines
- Develop and implement user friendly guidelines for team-based care, to better enable the prevention and treatment of chronic illness



Items	Level D			Level C			Level B			Level A		
22. PCN support/resources for guidelines or programs on prevention or health promotion…	have not been planned.			have been planned and resources are implemented on an ad hoc basis by practices.			include systematic integration of best practices into care protocols, guidelines, or reminders by all practices.			include integration of best practices into care protocols, guidelines or reminders, and PCN funded programs or campaigns.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
23. PCN support/resources for practice level guidelines for team-based care…	have not been planned.			have been planned and resources are implemented on an ad hoc basis by practices.			have been developed through a process that includes selection and systematic endorsement for a few guidelines.			includes a comprehensive approach to selection, endorsement, and team education related to multiple guidelines.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
24. Templates for practice level clinical standing orders…	have not been planned.			have been developed on an ad hoc basis by practices.			are developed, standardized and promoted by the PCN for all practices.			are developed by physician led sub-committees, standardized and supported by the PCN to all practices.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
25. Comprehensive, guideline- based information on chronic illness…	has not been researched or supported systematically.			is available for 1-2 conditions, but may not be widely publicized or promoted throughout the practices.			for more than 1 condition is available to practices and is integrated into care protocols, guidelines, or reminders.			for multiple conditions is available to practices, and is used to guide the creation of documentation and individual care plans.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
Total Score:				**Average Score (Total Score /4):**								

PART 8: PCN SUPPORT FOR THE MEDICAL HOME – PATIENT-CENTERED INTERACTIONS

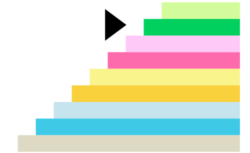


- Communication with patients is in a culturally appropriate manner, in a language and at a level that the patient understands
- Self-management support is offered at every visit through goal setting and action planning
- Feedback is obtained from patients/family about their healthcare experience and this information is used for quality improvement

Items	Level D			Level C			Level B			Level A		
26. Support for practices to enhance patient comprehension of verbal and written materials…	has not been developed.			is accomplished through development of materials in the most prevalent languages.			is provided through standardized materials available at multiple levels of comprehension and the most prevalent languages.			are coordinated to offer translation (as required) and training in health literacy, effective patient communication techniques and patient-centred care principles.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
27. Self-management support and strategies…	are limited to the production of information (pamphlets, booklets).			are delivered by the PCN (or PCN-linked AHS) self-management classes or educators.			encourage individualized patient goal setting and action planning with practices.			include funding change management support for new approaches and training in empowerment and problem solving methodologies.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
28. The principles of patient-centered care…	are included in the PCN's vision and mission statement.			are key PCN priorities and are included in training and orientation.			are explicitly written in job descriptions and performance metrics for all staff.			are consistently used to guide PCN changes and measure system performance as well as care interactions at the practice level.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
29. PCN protocols and measurement of patient-centred interactions (patient experience)…	has not been developed, or is accomplished through satisfaction surveys developed on an ad hoc basis by practices.			is accomplished through patient representation on boards and a PCN-developed satisfaction survey completed at the discretion of practices.			is accomplished by seeking input from patients/families using a variety of methods (e.g. point of care surveys, focus groups, ongoing patient advisory groups) at an annual or greater basis.			is accomplished by seeking frequent and actionable input from patients/families on care delivery through standardized tools and methods, and utilizing feedback in QI activities.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
Total Score:				**Average Score (Total Score /4):**								

PART 9: PCN SUPPORT FOR THE MEDICAL HOME – ENHANCED ACCESS

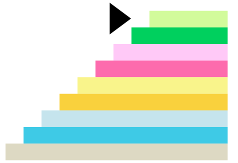
- Promote and expand access by ensuring attached patients have 24/7 continuous access to their care team via phone, email or in-person visits
- Support education to increase efficiency and quality by shaping demand, supply, access and continuity
- Ensure that patients can access the right provider at the right time



Items	Level D			Level C			Level B			Level A		
30. PCN support to practices for planning after-hours access…	has not been developed.			is available on an ad hoc basis to practices.			is provided at the PCN governance level by planning after-hours support options.			Is funded and supported through the development of standardized after-hours and technological tools and PCN support policies.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
31. PCN support for strategies to increase access, efficiency and continuity…	has not been developed.			is in the early stages of development or are shared with practices on an ad hoc basis.			is endorsed by the PCN and strategies are delivered to clinics through internal champions and/ or external programs.			Includes strategies delivered to practices by internal champions, external programs, and/or PCN funded trainers, and the PCN continuously updates strategies based on evidence.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
32. PCN support for patient access to a multi-disciplinary team…	has not been developed.			is available through referral to a centralized PCN or AHS location.			is available through a care team member housed in a practice site, with limited availability (1 per week or less).			is routinely available by patient self-referral, patient portal or access within a practice, and includes information continuity to the primary provider.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
33. PCN strategies to support un-attached patients looking for a physician…	have not been developed.			are in the early stages of development.			are being provided through strategies developed by governance committees.			are being provided through innovative strategies that are continuously updated and adapted for local conditions.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
Total Score:				**Average Score (Total Score /4):**								

PART 10: PCN SUPPORT FOR THE MEDICAL HOME – CARE COORDINATION

- Link patients with community resources to facilitate referrals and respond to social service needs
- Integrate behavioral health and specialty care into care delivery through co-location or referral protocols
- Track and support patients when they obtain services outside the practice
- Encourage follow-up with patients within a reasonable timeframe (less than a week) of an emergency room visit or hospital discharge



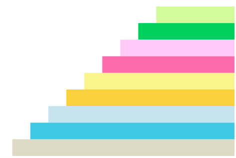
Items	Level D			Level C			Level B			Level A		
34. Access to PCN-level referral and usage data for specialty, hospital or community services…	is not available.			is available for some services but not used for quality improvement activities.			is available for 1-2 services, is reviewed, and is used to develop protocols and agreements.			is available for 3 or more services, is reviewed and used to address vertical integration issues, and to develop protocols and agreements.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
35. Coordination of care for patients in need of specialty care or hospital care…	is not systematically supported by the PCN.			includes systematic efforts to assist in communication from specialty care, but PCN supports, programs or services are not yet developed.			includes PCN support or resources to assist practices so that timely, appropriate referrals are provided and communication from specialty care is received in a timely manner.			includes PCN support or resources to assist practices so that timely, appropriate referrals are facilitated, communication to/from specialty care is received, and patient follow-up is scheduled in a timely manner.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
36. Linking patients to supportive community-based resources…	is not systematically supported by the PCN.			is limited to a list of identified community resources provided in an accessible format.			is accomplished by a designated staff/resource responsible for connecting patients with community resources.			is accomplished by a designated staff/resource and PCN coordination, as well as through information sharing between the health system, community service agencies and patients/families.		
Select one value	1	2	3	4	5	6	7	8	9	10	11	12
Total Score:							**Average Score (Total Score /3):**					

Facilitating the Team Consensus Score:

1. Once individual PCN staff members have completed the assessment, meet as a group to discuss your scores. Individual scores for each question do not need to be provided to the PCN, as the group consensus process enables a group conversation to build consensus on the category scores.
2. It is highly recommended that PCNs avoid merely averaging the scores of all participants. The facilitated discussion is a great opportunity to share information and build a common understanding where your PCN is and what might be its priorities.
3. Once the PCN has calculated the consensus score, the assessment tool is complete and the team will work on reviewing priority areas as a follow-up activity.
4. Following completion of the assessment tool, the team will work on developing an action plan for priority improvement areas.

Scoring Summary

Change Concept	Average Subscale Score
PCN Specific (Part 0)	
GOVERNANCE/COMMUNICATION	
MEASUREMENT/EVALUATION	
Laying the Foundation (Parts 1 & 2)	
ENGAGED LEADERSHIP	
QUALITY IMPROVEMENT (QI)	
Building Relationships (Parts 3 & 4)	
PANEL	
CONTINUOUS & TEAM-BASED CARE	
Changing Care Delivery (Parts 5 & 6)	
ORGANIZED, EVIDENCE-BASED CARE	
PATIENT-CENTERED INTERACTIONS	
Reducing Barriers to Care (Parts 7 & 8)	
ENHANCED ACCESS	
CARE COORDINATION	
AVERAGE PROGRAM SCORE (Sum of average scores for all x change concepts/x)	



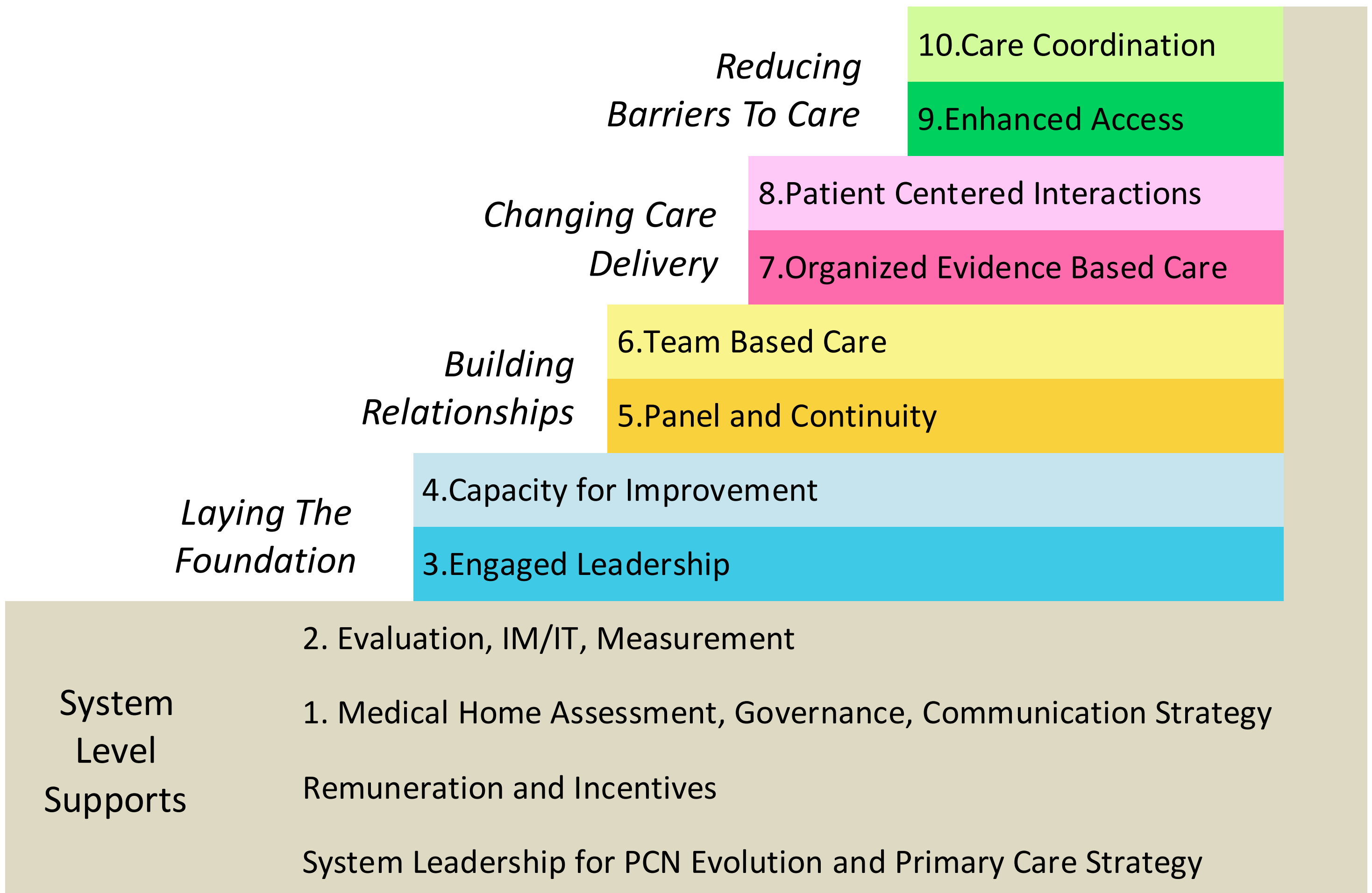
What Does It Mean?

The PCN Level Medical Home Assessment includes 39 items and ten sections each scored on a 1 to 12-point scale. Scores are divided into four levels, A through D. The overall score is the average of the ten subscales, or Change Concept, scores.

Average scores for each change concept and for all items on the PCN Assessment can be categorized as Level D through A, with similar interpretations. Even if a few item scores are particularly low or particularly high, on balance a PCN with average scores in the Level D range has yet to implement many of the fundamental key changes needed to support its practices towards the Medical Home model. Those with average scores in the Level A range have achieved considerable success in implementing supports for practices to enable key design features of the Medical Home model.

Appendix A: The Steps to a Medical Home

The medical home is an evidence based approach to organizing quality patient centred care within primary care practices. The medical home is where a patient has an ongoing relationship with a physician and team, and all of their health care needs are coordinated.



Adapted from Safety Net Medical Home Initiative 2013 (March 20, 2014)

The Accelerating Change Transformation Team (ACTT) in Alberta will work with PCNs to build their capacity to support primary care practices.