Population Health Management Capabilities Assessment Tool (PhmCAT)

What is the Population Health Management Capabilities Assessment Tool (PhmCAT)?

PhmCAT is a multi-domain assessment that is used to understand current population health management capabilities of primary care practices or community health centers. This self-administered tool can help organizations identify strengths and opportunities for improving population health management. It can also be used to assess changes over time if administered at multiple time points.

How was it developed?

PhmCAT was developed by Kaiser Permanente's Population Health Management Initiative (PHMI) team in consultation with a workgroup comprising representatives from the California Department of Health Care Services (DHCS), California Primary Care Association (CPCA), Partnership Health Plan, Alameda Health Consortium, and the University of Chicago. The tool assesses eight common domains across PHMI, Alternative Payment Methodology (APM), and Equity and Practice Transformation (EPT) deemed critical for effective population health management:

- Leadership & culture
- Business case for PHM
- Technology & data infrastructure
- Empanelment & access
- Care teams
- Patient-centered, population-based care
- Behavioral health
- Social health

The PhmCAT includes 50 questions total across the eight domains, most from validated or frequently used assessment tools. Each question is rated on a 10-point scale - 1 being low/not in place, 10 being high/in place.

How is it completed?

The PhmCAT is designed to be completed by a multi-disciplinary team within a primary care practice or community health center. The assessment asks about organizational systems and practices, as well as clinical practices, so the team must include diverse representation including people with clinical, operational, financial, data and patient-facing experience and expertise. If your organization is using the PhmCAT to guide improvement activities at a specific site, staff and clinicians from that site or practice should be involved in the team completing the assessment.

Each team member should complete the assessment individually, and then the team should come together to discuss responses and come to agreement on a consensus response for their practice on each question. This "consensus conversation" within the team is an important part of the process to learn from each other and reach a common understanding of current state. Results can be used by the team to identify opportunities and priorities for improvement. Many teams find an external coach or facilitator is helpful in guiding this consensus conversation.

What should you consider as you complete the assessment?

When answering each question, select the score that reflects where your practice is in its population health journey as honestly and accurately as possible. Each question has descriptions along the response scale to help explain what a given numerical score means. In most cases, these descriptions reflect a continuum from 0/not in place to 10/reliably, systemmatically present. In situations where multiple concepts are present in the descriptions, use the numbers within each category to indicate how many of the elements are present. There is no advantage to overestimating or upcoding scores, and doing so may make it harder for real progress to be apparent if the assessment is repeated in the future.

For items you don't have enough information to answer individually, please use the "don't know" response option. When the group comes together to discuss, the team should be able to determine an accurate rating for each item.

A Little About You

Name: _____

Organization Name: _____ [please do not use acronyms]

I work primarily at:

- ☐The organizational level (across all sites)
- ☐A specific clinic site/practice

If you work primarily at a clinic site/practice, please specify which site: _____

Which best describes your role?

- ☐ Advanced practice provider (NP, PA)
- ☐ Behavioral health provider
- ☐ Chief Executive Officer/Executive Director
- ☐ Chief Finance Officer/Finance Director
- ☐ Chief Medical Officer, Medical Director, or clinical leader
- ☐ Chief Operations Officer/Director, or operations manager
- ☐ Clinical support staff (e.g., medical assistant, community health worker, care coordinator, etc.)
- ☐ Data analytics/IT manager or staff
- ☐ Nurse
- ☐ Physician
- ☐ Quality improvement manager or staff
- ☐ Clinic/site manager or administrator
- ☐ Other, please specify _____

Leadership & Culture

Each item has a statement/topic on the left that can be completed, using the response scale, to reflect current state for your organization. In most cases, these responses reflect a continuum from 0/not in place to 10/reliably, systemmatically present. In situations where multiple concepts are present in the response descriptions, use the numbers within each category to indicate the extent to which all or some of the elements are present.

1. Executive leaders[1]	…are focused on short-term business priorities.		…visibly support and create an infrastructure for quality improvement, but do not commit resources.		…allocate resources and actively reward quality improvement initiatives.			…strongly support continuous learning throughout the organization, review and act upon quality data, and have a long-term strategy and funding commitment to explore, implement and spread quality improvement initiatives.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

2. Clinical leaders[1]	…intermittently focus on improving quality.		…have developed a vision for quality improvement, but no consistent process for getting there.		…are committed to a quality improvement process, and sometimes engage teams in implementation and problem solving.			… consistently champion and engage care teams in improving patient experience of care and clinical outcomes and provide time, training, and resources to accomplish the work.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

3. The responsibility for conducting quality improvement activities[1]	…is not assigned by leadership to any specific group.		…is assigned to a group without committed resources.		…is assigned to an organized quality improvement group who receive dedicated resources.			…is shared by all staff, from leadership to team members, and is made explicit through protected time to meet, and with specific resources to engage in quality improvement.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

4. Our organization has[3]	…no dedicated staffing for advancing equity, diversity, and inclusion goals. Not allocated funding for staff and other resources needed to advance equity goals. Not identified Equity as a priority in strategic plan or specific grants or programs.			…hired or appointed a dedicated equity lead and/or expanded staff capacity to support and advance equity at our organization through prioritizing hiring/retaining bilingual staff, community health workers, and other related roles. Allocated minimal funding to provide dedicated time for staff to advance equity goals. Identified equity as a priority for some initiatives, when required by specific grants or programs.			…established an office, department, or unit specifically focused on equity. Internal equity workgroups involve staff at all levels and from diverse backgrounds that address concerns related to diversity, equity, and inclusion. Adequate funding has been allocated to advance equity goals. Systematically included equity as a priority across all strategic and operational initiatives.				Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

For the questions below, on a scale from 1 to 10, please indicate your level of agreement with each of the following statements.

5. People in this practice operate as a real team.[2]	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**
	Strongly disagree									Strongly agree	Don't know/ unsure

6. When we experience a problem at the practice, we make a serious effort to figure out what's going on.[2]	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**
	Strongly disagree									Strongly agree	Don't know/ unsure

7. Leadership at this practice creates an environment where things can be accomplished. [2]	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**
	Strongly disagree									Strongly agree	Don't know/ unsure

Business Case for Population Health Management

Each item has a capability listed on the left, please use the response scale that follows to best describe the current state for your organization. In most cases, these responses reflect a continuum from 0/not in place to 10/reliably, systemmatically present. In situations where multiple concepts are present in the response descriptions, use the numbers within each category to indicate the extent to which all or some of the elements are present.

8. The organization has a solid understanding of its current financial performance under its existing service delivery and payment models.[4]	Organization reports regularly on financial indicators for monitoring its overall operating margins and financial performance indicators required by key regulatory or funding entities (e.g., UDS, health plans).			Organization monitors key performance indicators and their trends including but not limited to days cash on hand, days in accounts receivable, net collection rates, net income, payer mix, and utilization rates.			Organization compares its key performance indicators to relevant state and local benchmarks to identify and implement strategies for improvement. Organization uses key performance indicators to identify and implement strategies for improvement. Organization staff is able to describe its financial health based on key performance indicators.				Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

9. The organization has experience and capacity to manage performance-based contracts.[4]	Organization has experience negotiating and managing fee for service volume-based and managed care contracts.			Organization has experience negotiating and managing pay-for-performance based contracts, and/or contracts with upside risk only.			Organization has (in house or contracted) experience negotiating downside risk-bearing contracts including experience analyzing the anticipated financial outcomes of such contracts. Organization uses its experiences under past contracts to inform current contracting strategies. Organization uses risk adjustment to support higher payments for higher need patients.				Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

10. The organization has analyzed the relationship between payment reform models and PPS or alternate payment methodology (APM) payment for Medicaid. [4]	Organizational finance, administrative, and clinical leaders understand the basis upon which the organization's current payment model is established (e.g., PPS, APM rate) the costs, and services it includes, and how it relates to actual average per-visit costs.			Organization has analyzed the degree to which payment reform incentives/ payment mechanisms would result in revenue exceeding existing PPS and/or APM rates. Organization has experience navigating state rate setting, managed care reconciliation, and/or scope change processes for PPS or APM when applicable.				Organization has analyzed the impact of proposed APMs on its revenues and operating cash flows.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

11. The organization leverages all available state and local assistance and funding to support service delivery and payment transformation efforts.[4]	Organization actively tracks grant and other funding opportunities that support service delivery transformation and payment reform initiatives.			Organization participates in local, state, and/or federal initiatives supporting service delivery and/or payment transformation (e.g., State Innovation Models, Transforming Clinical Practice Initiative, Comprehensive Primary Care Plus, etc.).			Organization partners with other organizations such as behavioral health and social service organizations to help shape service delivery and payment transformation funding priorities at the state, local, and/or federal level. Organization serves as the lead of state- and local-level payment initiatives that support efficiency and quality outcomes.				Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

12. Organization incorporates health equity into budget decisions by considering health disparities and how to allocate resources proportional to patient needs.[5]	Budgeting is done using a standard process without consideration of health equity or disparities. Resources are not allocated for specific patient populations proportional to needs.		Some budget is allocated for specific equity-focused initiatives (e.g., initiatives to address health disparities, engage certain patient populations), but the impact of how resources are allocated on health equity and disparities is not discussed across other operational or program areas.			Significant budget is allocated for health equity-focused initiatives. Organization is beginning to discuss how resources investments advance equity and address health disparities for the patient population, but discussions do not happen consistently and/or rely on a few champions to voice/elevate equity considerations.			Significant budget is allocated to advance the organization's equity goals, as well as specific initiatives. Organization discusses equity priorities in all budgeting decisions—including an assessment of which patient populations benefit and which might be harmed by decisions.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

Technology & Data Infrastructure

Each item has a capability listed on the left, please use the response scale that follows to best describe the current state for your organization. In most cases, these responses reflect a continuum from 0/not in place to 10/reliably, systemmatically present. In situations where multiple concepts are present in the response descriptions, use the numbers within each category to indicate the extent to which all or some of the elements are present.

13. The organization's health information technology (HIT) systems allow for use of internal and external data to support population health management.[4]	Organization exchanges information with some Managed Care Organizations (MCO)/ Independent Provider Associations (IPAs) in the form of ad hoc file sharing or static reports for quality measures.			Organization exchanges data with MCO/IPAs to receive eligibility data and some claim types for assigned patients (e.g., receive lab and imaging claims but not professional services or facility claims). Organization sends supplemental files to MCO/IPA for purposes of quality metrics/HEDIS or other specific requests by MCO/IPA.				Organization exchanges data with MCO/IPA and receives eligibility data and all claim types for patients, and this data is integrated into organization's electronic health record or population health systems to inform care in real time.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

14. The organization has in place an automated mechanism for providing real-time notifications to practice staff and care teams regarding patient status (e.g., ED visit, hospital admission and hospital discharge (Admit Discharge Transfer, ADT) data).[11]	Organization does not receive ADT feeds and does not have mechanism for real time notification.		Organization does receive ADT feeds, but notifications are not turned on to support clinical workflows.			Organization does receive ADT feeds with notifications. Clinical workflows do not incorporate ADT notifications, and care teams do not regularly use the information.			Organization has integrated ADT data into EMR/ population health systems and care teams use the information in real time for patient outreach and care management.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

15. The organization has the necessary skills, roles and staff to understand organization's existing data, explore new data sources, and present insights from data.[6]	Organization has limited to no analytics staff; analytic capabilities ebb and flow with staff turnover in informal roles/skills.		Organization has de facto roles for experts within the organization or assigned analyst roles are limited (i.e., part-time, or not the staff member's primary responsibility).		Organization has dedicated and centralized analytics staff exist that participate in cross functional teams and support data driven decision-making; analytics staff may be provided by a support organization (network, consortia, hospital) but not always sufficient for all analytics needs.			Organization has ensured that advanced analytics skills are in place (e.g., research scientist, clinical informaticist, epidemiologist); analysts promote advanced uses of data (e.g., predictive modeling) and build data literacy across the organization.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

16. The organization ensures accurate data within and across organizations.[6]	Data quality review does not occur with rigor or regularity in the organization. No effort to develop a Master Patient Index. (Master Patient Index identifies patients across separate data systems to ensure patients are only counted once and their records are accurately linked to them).		Data quality reviews occur and there are some operational processes in place to reconcile patient records with payer and/or hospital data, but the efforts are usually one-time efforts and not sustained on an ongoing basis.		Data quality tracking reports are produced on a regular basis and are integrated and aligned across the organization, including use of a Master Patient Index for some populations; common errors are assessed, and training occurs to address them.			Data collection and aggregation is highly automated with built-in data quality checks and exception reports; Master Patient Index assures accurate medical data across organizations; measures of data quality (e.g., % accuracy) prioritize and inform ongoing data quality efforts and trace errors to individuals for training.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

17. The organization has data tools (e.g., dashboard, scorecards) available, and results are communicated to allow staff at all levels to act on information.[6]	Required reporting combines data from multiple domains but the information is not widely accessible, and it is difficult to draw conclusions from the data in its present state (i.e., no dashboards or scorecards are produced).		Some teams or departments receive reports on performance at least quarterly and have basic dashboards and/or scorecards but they are not widely accessible or cascading.		Data tools are available, timely, and accessible to track performance on a monthly basis, but availability and use may vary across departments. Departmental and enterprise-wide data analysis (dashboards, scorecards) cascade to all levels of the organization with some exploration of integrating externally available data.			Information is used to manage and drive performance and improvement at all levels, with timely dashboards and scorecards available across the organization. Predictive analytics are used to inform care decisions in advance or at point of care. Analyses and visualizations incorporate internal and externally available data.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

18. The organization segments and disaggregates data on care processes or outcomes to target resources/interventions more precisely, and to identify patient populations with the greatest disparities in care or outcomes.[5]	Organization does not disaggregate data by race, ethnicity, language (REL) or other demographic factors		Organization does disaggregate data by demographic factors but have poor capture of REL for patients.			Organization does disaggregate data by REL for most/all patients in the practice and do so regularly when reviewing quality outcomes.			Organization does regularly disaggregate quality data by REL and target interventions and resources to groups with the greatest disparities.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

The next item has a statement/topic on the left that can be completed, using the response scale, to reflect current state for your organization. In most cases, these responses reflect a continuum from 0/not in place to 10/reliably, systemmatically present. In situations where multiple concepts are present in the response descriptions, use the numbers within each category to indicate the extent to which all or some of the elements are present.

19. Performance measures[1]	…are not available for the practice.		…are available for the practice but are limited in scope.			…are comprehensive—including clinical, operational, and patient experience measures—and available for the practice, but not for individual providers and care teams.			…are comprehensive—including clinical, operational, and patient experience measures—and proactively shared with individual providers and care teams.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

Empanelment & Access

Sub-domain: Empanelment

Each item has a statement/topic on the left that can be completed, using the response scale, to reflect current state for your organization. In most cases, these responses reflect a continuum from 0/not in place to 10/reliably, systemmatically present. In situations where multiple concepts are present in the response descriptions, use the numbers within each category to indicate the extent to which all or some of the elements are present.

20. Patients[1]	…are not assigned to specific practice panels.		…are assigned to specific practice panels but panel assignments are not routinely used by the practice for administrative or other purposes.			…are assigned to specific practice panels and panel assignments are routinely used by the practice mainly for scheduling purposes.			…are assigned to specific practice panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

21. Patients are encouraged to see their paneled provider and care team[1]	…only at the patient's request.		…by the care team but is not a priority in appointment scheduling.			…by the care team and is a priority in appointment scheduling, but continuity measures are not tracked, and patients commonly see other providers because of limited availability or other issues.			…by the care team and is a priority in appointment scheduling. Continuity measures are tracked and used by the practice, and patients usually see their own provider or care team.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

Sub-domain: Access

Each item has a statement/topic on the left that can be completed, using the response scale, to reflect current state for your organization. In most cases, these responses reflect a continuum from 0/not in place to 10/reliably, systemmatically present. In situations where multiple concepts are present in the response descriptions, use the numbers within each category to indicate the extent to which all or some of the elements are present.

22. Practice uses[11]	…some telehealth and alternative visits, but the operational and clinical standards for when to use telehealth and which modality to use have not been established.		…regularly offers telehealth and alternative visits. The operational and clinical standards for when to use telehealth and which modality to use are emerging, with some protocols for scheduling in-person, video, or audio consultation for some of the most common medical conditions.		…telehealth and alternative visits to improve access. The operational and clinical standards for when to use telehealth and which modality are becoming more established but there is inconsistent application of these standards; the practice does not consistently consider patient preference.			…telehealth and alternative visits frequently to improve access. The operational and clinical standards for when to use telehealth and which modality to use are well-established and consider quality of care, emerging evidence, and patient preference.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

23. Contacting the care team during regular business hours[1]	…is difficult.		…relies on the practice's ability to respond to telephone messages.			…is accomplished by staff responding by telephone within the same day.			…is accomplished by providing a patient a choice between email and phone interaction, utilizing systems which are monitored for timeliness.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

24. After-hours access[1]	…is not available or limited to an answering machine.		…is available from a coverage arrangement without a standardized communication protocol back to the practice for urgent problems.			…is provided by coverage arrangement that shares necessary patient data and provides a summary to the practice.			…is available per patient preference: email, phone, or in-person whether that is with the care team or with a provider in close contact with the care team who has access to patient information.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

Care Team & Workforce

Each item has a statement/topic on the left that can be completed, using the response scale, to reflect current state for your organization. In most cases, these responses reflect a continuum from 0/not in place to 10/reliably, systemmatically present. In situations where multiple concepts are present in the response descriptions, use the numbers within each category to indicate the extent to which all or some of the elements are present.

25. Practice support staff, like medical assistants[7]	…work with different provider(s)every day.		…are linked to provider(s) in dyads but are frequently reassigned and change from day-to-day.			…consistently work with the same provider(s) almost every day, but other clinical and support staff are not integrated into the care team.			…consistently work with the same provider(s) almost every day and their care team includes multidisciplinary roles such as nurses, community health workers, mental health specialists, and administrative personnel.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

26. Care team members[1]	…play a limited role in providing clinical care.		…are primarily tasked with managing patient flow and triage.			… provide some clinical services such as assessment or self-management support.			…perform key clinical service roles that match their abilities and credentials (i.e., work at the top of their license).		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

27. Workflows for care teams[8]	…are not documented and/or are different for each person or team.		…are documented but are not used to standardize workflows across the practice.			…are documented and are used to standardize practice.			…are documented, are utilized to standardize workflows, and are evaluated and modified on a regular basis.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

28. The practice[1]	…does not have an organized approach to identify or meet the training needs for providers and other staff.		…routinely assesses training needs and ensures that staff are appropriately trained for their roles and responsibilities.			…routinely assesses training needs, ensures that staff are appropriately trained for their roles and responsibilities, and provides some cross training to permit staffing flexibility.			…routinely assesses training needs, ensures that staff are appropriately trained for their roles and responsibilities, and provides cross training to ensure that patient needs are consistently met.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

29. Self-management support[1]	…is limited to the distribution of information (pamphlets, booklets).		…is accomplished by referral to self-management classes or educators.			…is provided by members of the care team trained in patient empowerment and problem-solving methodologies.			…is provided by members of the care team and is intentionally designed to be culturally and linguistically concordant with patient need (e.g., responsive to diverse cultural health beliefs and practices, preferred language, health literacy).		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

The item below has a capability listed on the left, please use the response scale that follows to best describe the current state for your organization. These responses reflect a continuum from 0/not in place to 10/reliably, systemmatically present. Where multiple concepts are present in the response descriptions, use the numbers within each category to indicate the extent to which all or some of the elements are present.

30. Recruit, hire, and develop a workforce that reflects the populations served.[3]	Organization does not currently have any formal strategies *(e.g., recruitment, hiring, training)* for increasing the diversity of staff.		Organization develops job postings that include language about commitment to equity/non-discrimination and makes an intentional effort to share job postings with community members. Qualifications emphasize the value of community experience and skills needed to advance health equity (e.g., *language capacity, understanding root causes, cultural humility, willingness to learn).*		Organization has written procedures to increase recruitment, hiring, retention, and promotion of staff reflective of populations served. It actively uses goals and metrics to assess progress in increasing staff diversity. Front-line staff, clinicians, and leaders have community experience.			Robust staff diversity reflects the populations served at all levels of the organization. Internal structures promote workforce diversity through recruitment, hiring, and retention. Hiring managers receive equity-related training on a recurring basis. Organization is taking efforts to reform classification minimum qualifications to remove barriers for underrepresented groups *(e.g., allowing equivalent experience to substitute for formal education*).			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

Patient-centered, Population-based Care

Each item has a statement/topic on the left that can be completed, using the response scale, to reflect current state for your organization. In most cases, these responses reflect a continuum from 0/not in place to 10/reliably, systemmatically present. In situations where multiple concepts are present in the response descriptions, use the numbers within each category to indicate the extent to which all or some of the elements are present.

31. Comprehensive, guideline-based information on prevention or chronic illness treatment[1]	…is not readily available in practice.		…is available but does not influence care.			…is available to the care teams and is integrated into care protocols and/or reminders.			…guides the creation of tailored, individual-level data that is available at the time of the visit.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

32. Registry or panel-level data[1]	…are not available to assess or manage care for patient populations.		…are available to assess and manage care for patient populations, but only on an ad hoc basis and not routinely used for pre-visit planning or patient outreach.			…are regularly available to assess and manage care for patient populations, and for pre-visit planning and patient outreach, but only for a limited number of conditions and risk states.			…are regularly available to assess and manage care for patient populations and are routinely used for pre-visit planning and patient outreach across a comprehensive set of conditions and risk states.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

33. When patients or assigned members are overdue for chronic and/or preventive care but do not come in for an appointment[8]	…the practice makes no effort to contact them and ask them to come in for care.		…the practice may contact them as part of special events or using volunteers, but outreach is not part of regular practice.			…the practice would contact them and ask them to come in for care, but clinical staff may not proactively act on overdue care items without patient-specific orders from the provider.			…the practice will contact them and ask them to come in for care, and clinical staff proactively act on overdue care items (e.g., distribute colorectal cancer screening kits) based on standing orders.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

34. Measuring patient and community priorities[1]	…is not consistently measured or is measured through a survey administered sporadically at the organization level.		…is accomplished through patient representation on boards. Patient input is regularly solicited through surveys.		…is accomplished by frequent input from patients and families using a variety of methods such as point of care surveys, focus groups, and ongoing patient advisory groups.		…is accomplished by getting frequent and actionable input from patients and families on all care delivery issues and incorporating feedback into quality improvement (QI) activities.		…is accomplished by incorporating patient and families' feedback into QI activities and developing a robust process for community engagement in planning and decision making.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

35. Involving patients in decision-making and care[1]	…is not a priority.		…is accomplished by providing patients with educational materials and/or class referrals.			…is supported and documented by care teams.			…is systematically supported by care teams trained in decision-making techniques and person-centered communication practices (e.g., trauma-informed care, motivational interviewing).		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

36. Visits[1]	…largely focus on acute patient problems.		…are organized around acute problems but with attention to ongoing illness and prevention needs if time permits.			…are organized around acute problems but with attention to ongoing illness and prevention needs if time permits. The practice also uses subpopulation reports to proactively call groups of patients in for care			…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 are met at each encounter.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

37. Care plans[1]	…are not routinely developed or recorded.		…are developed and recorded but only reflect providers' priorities.			…are developed collaboratively with patients and families and include self-management and clinical goals but are not routinely recorded or used to guide subsequent care.			…are developed collaboratively, include self-management and clinical management goals, are routinely recorded, and guide care at every subsequent point of service.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

38. Clinical care management services for high-risk patients[1]	…are not available.		… are provided by external care managers with limited connection to practice.			…are provided by external care managers who regularly communicate with the care team.			…are systematically provided by the care manager functioning as a member of the care team, regardless of location.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

39. Patients in need of specialty care or hospital care[1]	…cannot reliably obtain needed referrals to other providers or resources in the community		…can obtain needed referrals to other providers or resources in the community.		…can obtain needed referrals to other providers or resources in the community. Referrals are supported through referral relationships between organizations and the practice communicates relevant information to the organization receiving the referral in advance.			…can obtain needed referrals to other providers or resources in the community. Referrals are supported through referral relationships between organizations. The practice communicates relevant information in advance and follows-up in a timely manner after the visit occurs.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

40. Between visit communication regarding test results, care plan changes, referrals, or follow up after an ED visit or hospital discharge[1]	...generally does not occur because the information is not available to the primary care team.		…occurs on an ad hoc basis.			…systematically occurs in a way that is convenient to the practice.			…systematically occurs in a variety of ways that are convenient to patients.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

Behavioral Health

Each item has a statement/topic on the left that can be completed, using the response scale, to reflect current state for your organization. In most cases, these responses reflect a continuum from 0/not in place to 10/reliably, systemmatically present. In situations where multiple concepts are present in the response descriptions, use the numbers within each category to indicate the extent to which all or some of the elements are present.

41. **Adult** behavioral health services[1]	…are difficult to obtain reliably.		…are available from behavioral health specialists in the community but are neither timely nor convenient.		…are available from behavioral health specialists in the community and are generally timely and convenient.			…are readily available from behavioral health specialists who are on-site members of the care team or who work in a community organization with which the practice has a referral protocol or agreement in place. Practice routinely refers patients with higher behavioral health needs to specialty behavioral health providers within the organization or in the community.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

42. **Pediatric** behavioral health services.[1]	…are difficult to obtain reliably		…are available from behavioral health specialists in the community but are neither timely nor convenient.		…are available from behavioral health specialists in the community and are generally timely and convenient.			…are readily available from behavioral health specialists who are on-site members of the care team or who work in a community organization with which the practice has a referral protocol or agreement in place. Practice routinely refers patients with higher behavioral health needs to specialty behavioral health providers within the organization or in the community.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

Each item has a capability listed on the left, please use the response scale that follows to best describe the current state for your organization. In most cases, these responses reflect a continuum from 0/not in place to 10/reliably, systemmatically present. In situations where multiple concepts are present in the response descriptions, use the numbers within each category to indicate the extent to which all or some of the elements are present.

43. Organization screens patients to understand behavioral health conditions.[11]	Organization does not consistently screen patients for behavioral health conditions but is aware of and documents conditions when patients disclose behavioral health information.		Organization screens patients for behavioral health conditions in an ad hoc way, based on specific grant or program requirements.		Organization consistently uses an established behavioral health screening or assessment tool/process for certain behavioral health conditions (e.g., depression) or certain sub-sets of the patient population (e.g., pediatrics, patients with chronic conditions, etc.).			Organization has a comprehensive and universal screening or assessment tool/ process which identifies all patient behavioral health needs (including depression, anxiety, substance use, tobacco). Roles and workflows for screening are clearly defined and understood.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

44. Joint development of individualized treatment plan (ITP) by primary care providers (PCPs) and behavioral health providers (BHPs).[9]	PCPs and BHPs never develop a joint ITP for patients with behavioral health conditions.		PCPs and BHPs rarely develop a joint ITP for patients with behavioral health conditions.		PCPs and BHPs develop a joint ITP for patients with behavioral health conditions as needed.		PCPs and BHPs usually develop a joint ITP for patients with behavioral health conditions.		PCPs and BHPs always develop a joint ITP for patients with behavioral health conditions.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

45. Registry or panel-level data for behavioral health conditions[1]	…are not available to assess or manage care for patient populations.		…are available to assess and manage care for patient populations, but only on an ad hoc basis and not routinely used for pre-visit planning or patient outreach.			…are regularly available to assess and manage care for patient populations, and for pre-visit planning and patient outreach, but only for a limited number of behavioral health conditions and risk states.			…are regularly available to assess and manage care for patient populations and routinely used for pre-visit planning and patient outreach across a comprehensive set of behavioral health conditions and risk states.		Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

Social Health[10]

Each item has a capability listed on the left, please use the response scale that follows to best describe the current state for your organization. In most cases, these responses reflect a continuum from 0/not in place to 10/reliably, systemmatically present. In situations where multiple concepts are present in the response descriptions, use the numbers within each category to indicate the extent to which all or some of the elements are present.

46. Organization has leadership buy-in and commitment to identifying and addressing patients' social needs.[11]	In general, leaders express that addressing patients' social needs is "nice to have" or an optional add-on to our primary work of delivering clinical care.		Leaders generally express commitment to addressing patients' social needs but do not provide adequate resources.		Leaders generally express commitment to addressing patients' social needs and provide some resources but resources may not be adequate.			Leaders at every level (C-suite, departmental, people managers, etc.) express commitment to addressing patients' social needs and provide adequate resources. Patients' social needs are incorporated into strategic priorities and addressing social needs is included in the organization's model of care. Staff receive training and support to address patients' social needs.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

47. Organization screens patients to understand unmet social needs.[11]	Organization does not consistently screen patients for unmet social needs but is aware of and documents patients' social needs when they proactively report specific needs.		Organization screens patients for one or more unmet social needs in an ad hoc, inconsistent way, which may be required for a specific grant or program.		Organization has an established social needs screening or assessment tool/process, which is consistently used for certain sub-sets of the patient population (e.g., pediatrics, patients with chronic conditions, etc.) or for specific social needs (e.g., food, housing).			Organization has an established universal screening or assessment tool/process which comprehensively identifies patients' specific, addressable, and high impact social needs. Roles and workflows for screening are clearly defined and understood.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

48. Care teams adapt care plans (e.g., medications, action plans, referrals) based on an understanding of patients' social needs.[11]	Social needs data is unavailable for addressing patient need.			Social needs data is available to clinical teams at the point of care but not regularly used to change care plans.			Social needs data is available to clinical teams at the point of care and is regularly used to modify care plans as appropriate in partnership with patients and families.				Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

49. Organization has established referral relationships to connect patients with community resources at other practices or organizations. [11]	Organization provides patients and families with general guidance about community-based services and resources to address social needs but does not offer specific recommendations or referrals.		Organization has staff with dedicated time to refer patients and families to specific community-based services or resources to address social needs but leaves it to the patient to follow up. Additional referral support and follow up may be available for small cohorts or sub-sets of the patient population.			Organization has staff with dedicated time to provide a warm hand-off for referrals to community-based services or resources, but no consistent system is used to track or follow up on referrals. Tracking and follow up may be available for certain sub-sets of the patient population.		Organization has staff with dedicated time to provide a warm hand-off for all referrals to community-based services or resources and has a system to comprehensively track referrals and follow up to make sure the patient was seen.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

50. Organization identifies and pursues strategic partnerships and investments to address social needs.[4]	Organization participates in population-level community health assessments to understand the community's social needs and assets.		Organization participates in community-level health-related coalitions and committees and uses assessment data to collectively contribute to meeting patients' social needs.			Organization has formal community partnerships to address specific social needs of the target population. Organization has an established strategy to guide its partnerships and community investments.		Organization is involved with or leading multi-sectoral partnerships that focus on leveraging assets and addressing social needs and community-level systems of care. Organization invests in community assets to positively affect social health outcomes.			Don't know/ unsure
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**DK**

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