EvidenceNow Practice Survey Codebook: CPCQ and PCMH-A

Variable Name/ Core-optional Status	Item
	We would like to learn about the strategies that your practice uses to improve cardiovascular preventive care (e.g., prescribing aspirin for patients at risk for ischemic vascular disease, providing tobacco cessation services for smokers, appropriately managing hypertension, and prescribing statins for high risk patients). **These questions should be completed by one senior member of the practice who has good insights into the clinical operations of the practice, such as a lead clinician or an office manager.**[1,2]
	Indicate the extent to which you agree or disagree that your practice has used the following **strategies to improve cardiovascular preventive care**:
CPCQ_Strat_Info_skills FOA Required	Providing information and skills-training ○ Strongly disagree……..1 ○ Somewhat disagree……..2 ○ Neither agree or disagree……..3 ○ Somewhat agree……..4 ○ Strongly agree……..5 ○ NA……..8
CPCQ_Strat_oplead_rolemdl FOA Required	Using opinion leaders, role modeling, or other vehicles to encourage support for changes ○ Strongly disagree……..1 ○ Somewhat disagree……..2 ○ Neither agree or disagree……..3 ○ Somewhat agree……..4 ○ Strongly agree……..5 ○ NA……..8
CPCQ_Strat_sys_change FOA Required	Changing or creating systems in the practice that make it easier to provide high quality care ○ Strongly disagree……..1 ○ Somewhat disagree……..2 ○ Neither agree or disagree……..3 ○ Somewhat agree……..4

[1] NOTE: CPCQ items are to stay together and in the order specified in this codebook in your collaborative's survey.

[2] For details on scoring CPCQ items see this article.

	○ Strongly agree……..…..5 ○ NA……...…..8
CPCQ_Strat_red_barr FOA Required	Removal or reduction of barriers to better quality of care ○ Strongly disagree……...1 ○ Somewhat disagree……...…..…...2 ○ Neither agree or disagree.……..3 ○ Somewhat agree……..……..4 ○ Strongly agree……...…...5 ○ NA……..8
CPCQ_org_teams FOA Required	Using teams focused on accomplishing the change process for improved care ○ Strongly disagree……..…..1 ○ Somewhat disagree……..…..2 ○ Neither agree or disagree……...3 ○ Somewhat agree……..…..4 ○ Strongly agree……..…..5 ○ NA……...…..8
CPCQ_use_nonclinician FOA Required	Delegating to non-clinician staff the responsibility to carry out aspects of care that are normally the responsibility of physicians ○ Strongly disagree……...1 ○ Somewhat disagree……..…..2 ○ Neither agree or disagree……..3 ○ Somewhat agree……..…...4 ○ Strongly agree……...5 ○ NA……..…...8
CPCQ_authorize FOA Required	Providing to those who are charged with implementing improved care the power to authorize and make the desired changes ○ Strongly disagree……..1 ○ Somewhat disagree……..…..2 ○ Neither agree or disagree……..3

	○ Somewhat agree……..…..4 ○ Strongly agree……...5 ○ NA……....8
CPCQ_periodic_measurement FOA Required	Periodic measurement of care quality for assessing compliance with any new approach to care ○ Strongly disagree……..1 ○ Somewhat disagree……...2 ○ Neither agree or disagree……..3 ○ Somewhat agree……..…..4 ○ Strongly agree……..…..5 ○ NA……..…..8
CPCQ_reporting_measurement FOA Required	Reporting measurements of practice performance on cardiovascular disease prevention measures (such as aspirin for patients at risk for ischemic vascular disease) for comparison with their peers ○ Strongly disagree……..…..1 ○ Somewhat disagree……..…..2 ○ Neither agree or disagree……...3 ○ Somewhat agree……..…...4 ○ Strongly agree……..…..5 ○ NA……..8
CPCQ_goals FOA Required	Setting goals and benchmarking rates of performance quality on cardiovascular disease prevention measures at least yearly ○ Strongly disagree……..…..1 ○ Somewhat disagree……..…..2 ○ Neither agree or disagree……..…..3 ○ Somewhat agree……...…..4 ○ Strongly agree……..……..5 ○ NA……..8
CPCQ_customize	Customizing the implementation of cardiovascular disease prevention care changes to the practice ○ Strongly disagree……..…..1

FOA Required	○ Somewhat disagree……..…...2 ○ Neither agree or disagree…….…..3 ○ Somewhat agree……...…..4 ○ Strongly agree……....5 ○ NA……..…...8
CPCQ_rapid_cycles FOA Required	Using rapid cycling, piloting, pre-testing, or other vehicles for reducing the risk of negative results for introducing organization-wide change in care ○ Strongly disagree……..1 ○ Somewhat disagree……...2 ○ Neither agree or disagree……..3 ○ Somewhat agree……..…..4 ○ Strongly agree……...5 ○ NA…….....8
CPCQ_design_care_clinician FOA Required	Deliberately designing care improvements so as to make clinician participation less work than before ○ Strongly disagree……...1 ○ Somewhat disagree……..…..2 ○ Neither agree or disagree……..3 ○ Somewhat agree……..…..4 ○ Strongly agree……...5 ○ NA…….....8
CPCQ_design_care_process FOA Required	Deliberately designing care improvements to make the care process more beneficial to the patient ○ Strongly disagree……..…..1 ○ Somewhat disagree……..……...2 ○ Neither agree or disagree……...3 ○ Somewhat agree……..…...4 ○ Strongly agree……..…...5 ○ NA……..8
CPCQ_Priority	Consider all of the priorities your practice has over the next year. On a scale from 1 to 10 where one is no priority at all and 10 is the highest priority, what is the priority that your practice's leadership places on improving cardiovascular disease preventive care?

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FOA Required	○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 no priority ……. highest priority

	The rows in this form present key aspects of the level of care that currently exists in your practice. Each aspect is divided into levels (Level A through Level D.) The levels are represented by points that range from 1 to 12. The higher point values within a level indicate that the actions described in that box are more fully implemented. There are no right or wrong answers. For each row, indicate the point value that best describes the level of care that currently exists in your practice.
PCMH-A_QI_QI[3] Optional item	Quality improvement activities **Level D** are not organized or supported consistently …… 1,2,3 **Level C** are conducted on an ad hoc basis in reaction to specific problems …… 4,5,6 **Level B** are based on a proven improvement strategy in reaction to specific problems ……7,8,9 **Level A** are based on a proven improvement strategy and used continuously in meeting organizational goals ……10,11,12
PCMH-A_QI_Perfromance Measures Optional item	Performance measures **Level D** are not available for the clinical site……1,2,3 **Level C** are available for the clinical site, but are limited in scope……4,5,6 **Level B** are comprehensive – including clinical, operational, and patient experience measures – and available for the practice, but not for individual providers……7,8,9 **Level A** are comprehensive – including clinical, operational, and patient experience measures – and fed back to individual providers……10,11,12
PCMH-A_QI_Improvement activities Optional item	Quality improvement activities are conducted by **Level D** a centralized committee or department……1,2,3 **Level C** topic specific QI committees…..4,5,6 **Level B** all practice teams supported by a QI infrastructure…..7,8,9 **Level A** practice teams supported by a QI infrastructure with meaningful involvement of patients and families…..10,11,12

[3] PCMH-A Scoring: 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). For details on scoring CPCQ items see this article.

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PCMH-A_QI_EHR Optional item	An electronic health record that is meaningful-use certified **Level D** is not present or is being implemented……1,2,3	**Level C** is in place and is being used to capture clinical data…….4,5,6	**Level B** is used routinely during patient encounters to provide clinical decision support and to share data with patients……7,8,9	**Level A** is also used routinely to support population management…..10,11,12
PCMH-A_Empanelment_Patients Optional item	Patients **Level D** are not assigned to specific practice panels…..1,2,3	**Level C** are assigned to specific practice panels but panel assignments are not routinely used by the practice for administrative or other purposes……4,5,6	**Level B** are assigned to specific practice panels and panel assignments are routinely used by the practice mainly for scheduling purposes…..7,8,9	**Level A** are assigned to specific practice panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to…..10,11,12
PCMH-A_Empanelment_panel Optional item	Registry or panel-level data **Level D** are not available to assess or manage care for practice populations……1,2,3	**Level C** are available to assess and manage care for practice populations, but only on an ad hoc basis……4,5,6	**Level B** are regularly available to assess and manage care for practice populations, but only for a limited number of diseases and risk states……7,8,9	**Level A** are regularly available to assess and manage care for practice populations, across a comprehensive set of diseases and risk states…..10,11,12
PCMH-A_Empanelment_registries Optional item	Registries on individual patients **Level D** are not available to practice teams for pre-visit planning or patient outreach…..1,2,3	**Level C** are available to practice teams but are not routinely used for pre-visit planning or patient outreach…..4,5,6	**Level B** are available to practice teams and routinely used for pre-visit planning or patient outreach, but only for a limited number of diseases and risk states…..7,8,9	**Level A** are available to practice teams and routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases and risk states…..10,11,12
PCMH-A_Empanelment_care Optional item	Reports on care processes or outcomes of care **Level D** are not routinely available to practice teams…..1,2,3	**Level C** are routinely provided as feedback to practice teams but not reported externally…..4,5,6	**Level B** are routinely provided as feedback to practice teams, and reported externally (e.g., to patients, other teams or external agencies) but with team identities masked…..7,8,9	**Level A** are routinely provided as feedback to practice teams, and transparently reported externally to patients, other teams and external agencies…..10,11,12

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PCMH-A_Evidence_guide Optional item	Comprehensive, guideline-based information on prevention or chronic illness treatment			
	Level D is not readily available in practice…..1,2,3	**Level C** is available but does not influence care…..4,5,6	**Level B** is available to the team and is integrated into care protocols and/or reminders……7,8,9	**Level A** guides the creation of tailored, individual-level data that is available at the time of the visit…..10,11,12
PCMH-A_Evidence_visits Optional item	Visits			
	Level D largely focus on acute problems of patient……1,2,3	**Level C** are organized around acute problems but with attention to ongoing illness and prevention needs if time permits……4,5,6	**Level B** 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 planned care visits…..7,8,9	**Level A** 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…..10,11,12
PCMH-A_Evidence_Care plans Optional item	Care plans			
	Level D are not routinely developed or recorded…..1,2,3	**Level C** are developed and recorded but reflect clinicians' priorities only…..4,5,6	**Level B** are developed collaboratively with patients and families and include self-management and clinical goals, but they are not routinely recorded or used to guide subsequent care……7,8,9	**Level A** are developed collaboratively, include self-management and clinical management goals, are routinely recorded, and guide care at every subsequent point of service…..10,11,12
PCMH-A_Evidence_Clinical care Optional item	Clinical care management services for high risk patients			
	Level D are not available…..1,2,3	**Level C** are provided by external care managers with limited connection to practice…..4,5,6	**Level B** are provided by external care managers who regularly communicate with the care team…..7,8,9	**Level A** are systematically provided by the care manager functioning as a member of the practice team, regardless of location…..10,11,12