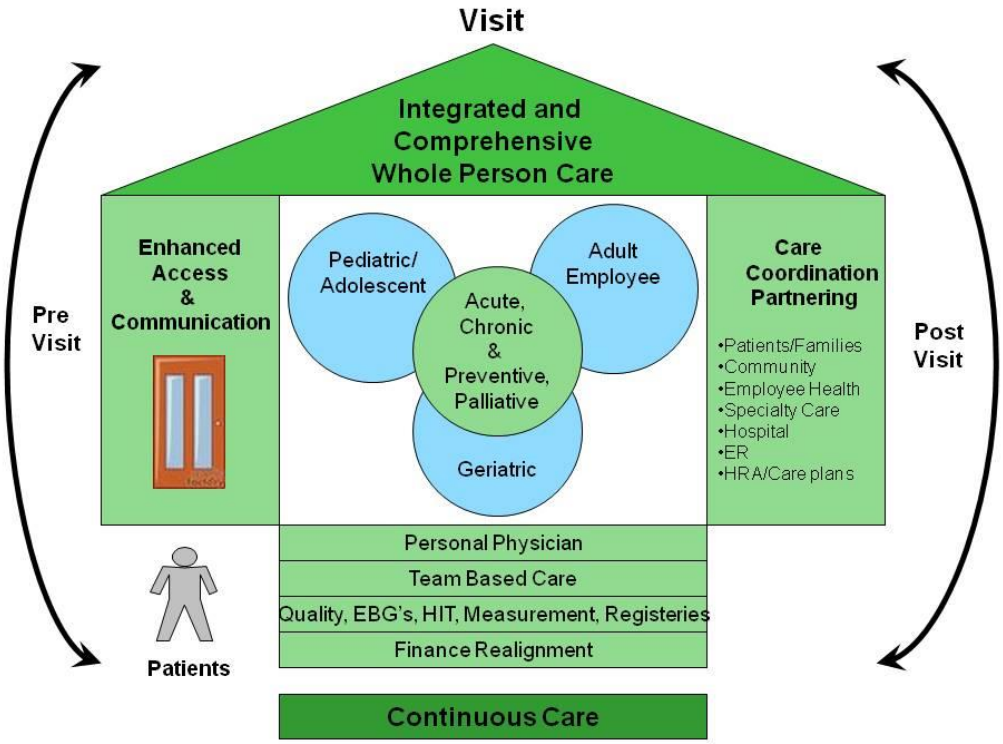
Clinical Microsystems

"The Place Where Patients, Families and Clinical Teams Meet"

MEDICAL HOME

Assessing, Diagnosing and Treating Your Primary Care Practice



www.clinicalmicrosystem.org

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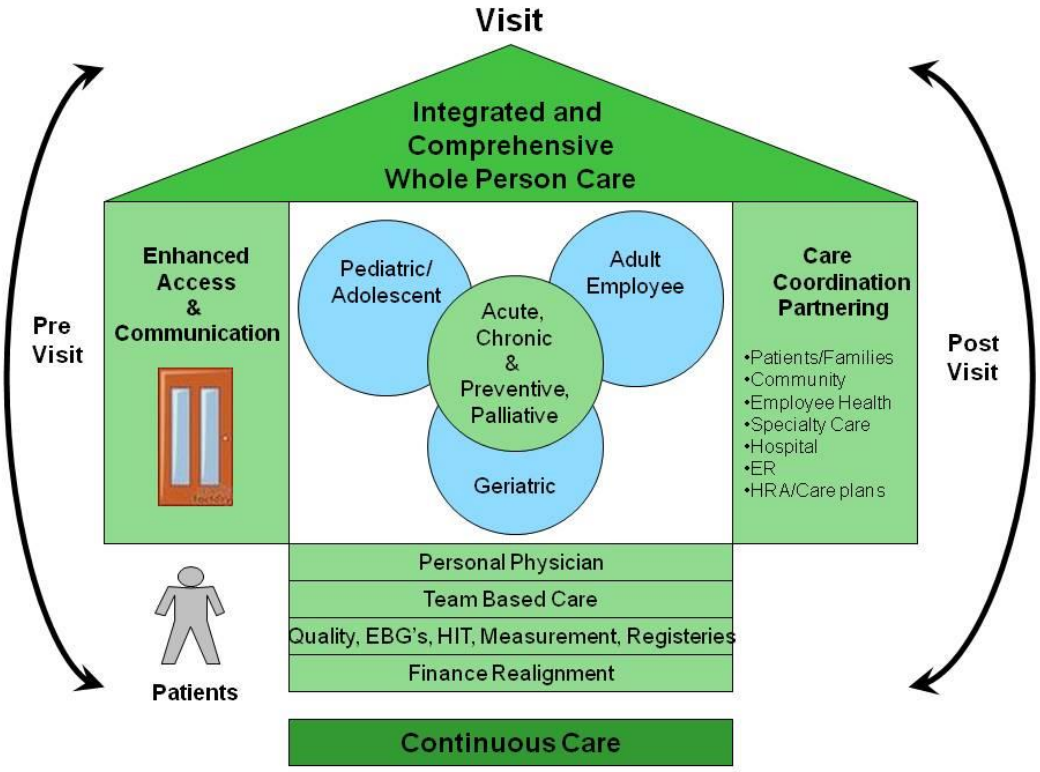
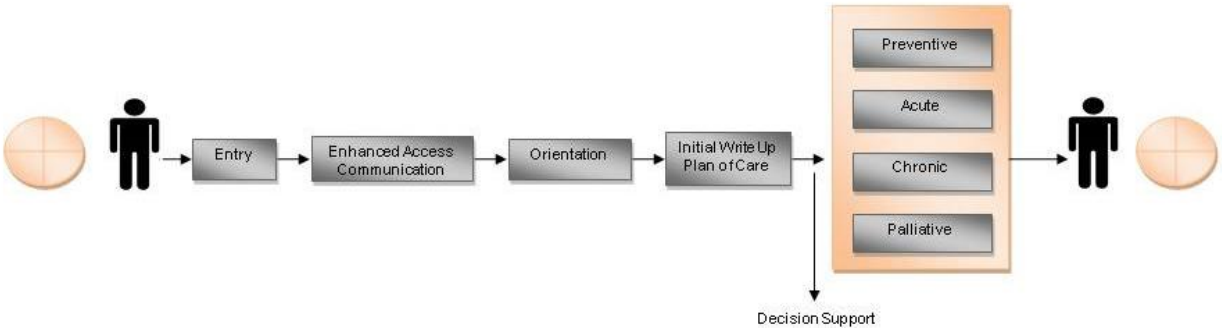
Medical Home Microsystem Care Model

Example





Note: We have developed this workbook with tools to give ideas to those interested in improving healthcare. "The Dartmouth Institute for Health Policy and Clinical Practice and the developers of this workbook are pleased to grant use of these materials without charge, providing that recognition is given for their development, that any alterations to the documents for local suitability and acceptance are shared in advance, and that the uses are limited to their own use and not for re-sale."

Strategies for Improving "The place where patients, families and clinical teams meet" into a Medical Home

A Microsystem Self-Assessment, Diagnosis and Treatment Plan to transform your care model into a Patient Centered Medical Home

The Institute of Medicine (IOM) 2001 *Crossing the Quality Chasm* report calls for standards and systems to measurably improve the quality of healthcare. The AAAP, AAFP, ACP and AOA have developed joint principles describing characteristics of a Patient Centered Medical Home (PCMH). The National Committee for Quality Assurance (NCQA) has created the Physician Practice Connection (PPC) tool and adapted it to the PCMH as the PPC-PCMH to assess and recognize primary care practice use of systems to ensure high quality care.

Clinical microsystems are the front-line units that provide most health care to most people. They are the places where patients, families and care teams meet. These Clinical Microsystems also include support staff, processes, technology and recurring patterns of information, behavior and results. Two or more microsystems are a mesosystem of care. One can see the mesosystem of care by documenting the patient health care journey. Moving from primary care MICROSYSTEM to a MESOSYSTEM signals the complexity of primary care and the multiple microsystems that are involved in the delivery of care requiring care coordination, communication and sharing of a common purpose.

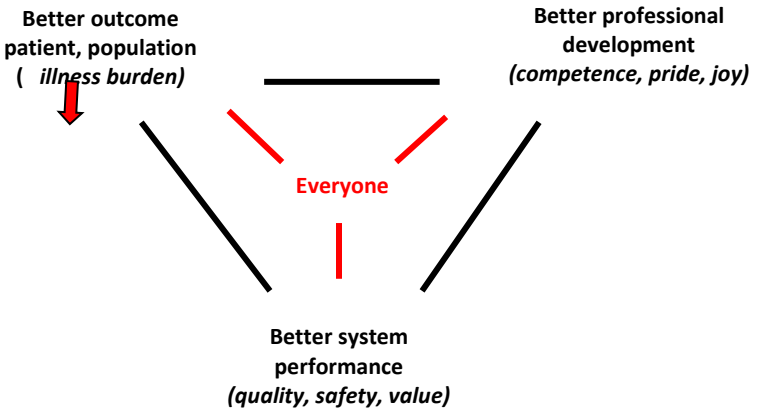
The primary care clinical microsystem is a medical home mesosystem where:

- The patient and the family are central to co-design of care
- Access to all forms of interactive care is timely and readily available
- Whole person comprehensive care is a priority
- Provider– Patient Partnership Relationships are crucial (including all providers: nurses, NP, PA, nursing assistants)
- Interdisciplinary team care is promoted
- Measurement is valued
- Quality, safety, and reliability are essential
- Efficiency and innovation are drivers
- Coordination is critical

By definition, a Medical Home is:

- A health care setting that facilitates partnerships and longitudinal relationships between individual patients, their personal providers, and their family.
- Where care is facilitated by registries, information technology, health information exchange
- That delivers care when and where needed.
- Where care is delivered in a culturally and linguistically appropriate manner.

Responding to the challenge of The Dartmouth Institute for Health Policy and Clinical Practice to get "everyone," involved in improvement to improve outcomes for patient populations, improved professional development and improved system design can be achieved through the development of the Primary Care Medical Home. This challenge is illustrated here:



Paul B Batalden and Frank Davidoff . What is "quality improvement" and how can it transform healthcare? *Qual. Saf. Health Care*, 2007

The Institute for Healthcare Improvement, IHI, describes the three critical goals of health care system design and re-design as the "Triple Aim™" (www.ihi.org)

–

- Improve the health of the population.
- Enhance the patient experience of care (including quality, access, and reliability); and
- Reduce, or at least control, the per capita cost of care

This Patient Centered Medical Home Assess, Diagnose and Treat workbook is an adapted version of the original Primary Care workbook with the purpose of providing guidance to any primary care practice to: improve the quality of primary care, transform a primary care practice into a Medical Home, improve results for patients and professionals, and increase likelihood of NCQA certification. (The NCQA-PPC tool is a strategic and operational tool that supplements the original Primary Care Clinical Microsystem Assess, Diagnose and Treat workbook. The adapted assessment will identify gaps in current and recommended processes to result in improved and newly designed processes that can lead to certification and recertification as a medical home.)

Please note: This standardized Assess, Diagnose and Treat workbook does not suggest these are the only tools, ideas and processes to consider. It is very important to recognize this workbook provides a starting place to consider adapting, modifying and adding to in your own special context. We only wish to offer a helpful guide and a starting place.

New professional roles such as Care Coordinators and Registry Coordinators, more optimized roles for existing professionals (nurse pre-visit work), new processes (pre visit flows) and new tools (chronic and preventive registries and reports) will support the primary care practice to be patient centered and introduce a ***population based continuous care visit model*** that promotes role optimization of all of the members of the frontline clinical microsystems and resources required to meet patient and family changing health care needs.

All health care professionals of the 21st Century – this includes front line clinical and support staff as professionals – will be able to provide exceptional care AND continuously improve care.

Clinical Microsystems are the building blocks that form health care systems and Accountable Care Organizations (ACOs). The overall health care system quality and value of care can be no better than the quality and value produced by the individual small systems such as the Medical Home.

The evaluation and optimization of the clinical microsystem and mesosystem is imperative to the successful establishment of a medical home. Well-defined, measured, and continuously evaluated and improved clinical and operational systems are integral to establishment and long term success of a patient centered medical home.

The cycle of continuous microsystem/mesosystem assessment and improvement can be a challenge to design and sustain. Finding the time to improve care can be difficult in the outpatient primary care practice. The only way to improve and maintain quality, safety, efficiency and flexibility is by blending assessment, diagnosis, and treatment with change, and redesign in the regular patterns and the daily habits of front-line interdisciplinary professionals, patients and families. The assessment of processes and systems, diagnosis and treatment will be part of routine process flows, so that in the course of providing care and services we are also monitoring, evaluating and improving our systems of care. This component is essential to maintaining a patient centered medical home.

This Assess, Diagnose and Treat workbook provides tools and methods that busy clinical teams can use to improve the quality and value of patient care as well as the work-life of all staff who contribute to patient care. These methods can be adapted to a wide variety of clinical settings, large and small, urban and rural, community based and academic. It is the essential first step in preparing any clinical practice to become a patient centered medical home.

The Path Forward

This workbook provides an organized guide for the path forward in assessing, diagnosing and treating your primary care practice to become a patient centered medical home. Just as you can assess, diagnose and treat patients, you can assess, diagnose and treat your clinical microsystem.

The Clinical Microsystem 5P model is central to assessing your primary care practice. The principles of the Medical Home and the 9 part NCQA components are woven throughout this workbook.

Improvement starts with assessment of current state to identify the gaps between the current state and a future state that uses recommended patient centered medical home elements. This workbook is designed to guide your clinical microsystem's journey to develop higher performing clinical microsystems that will enhance your ability to provide your patients with the level and quality of care required by the medical home and at the same time create a joyful workplace for all interdisciplinary professionals.

You can access more examples, tools and blank forms to customize to your setting at **www.clinicalmicrosystem.org**.

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Worksheets
Table of Contents

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The Path Forward

A Mesosystem Self-Assessment, Diagnosis and Treatment Plan

Step 1: Organize a "Lead Team"

Successful, sustainable cultural change requires the commitment and active involvement of all members of the clinical microsystem and mesosystem. To keep the microsystem and mesosystem on track and focused, an interdisciplinary "Lead Team" of representatives of roles from primary care and other associated microsystems in the mesosystem should be formed.

Step 2: Do the Assessment

Assess your microsystem using the "5Ps" as your guide. Review your current performance metrics.

- **Purpose**
- **Patients**
- **Professionals**
- **Processes**
- **Patterns**
- **Metrics That Matter**

Step 3: Make a Diagnosis

Based on Step 2, review your assessment and Metrics That Matter to make your diagnosis. You should select a "Theme and Aims" for improvement based on this diagnosis and your organization strategic priorities.

Step 4: Treat Your Microsystem/Mesosystem

Use scientific improvement methods and tools.

Step 5: Follow-up

Design and execute monitoring processes, outcomes and results. Move to your next improvement themes.

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STEP 1: Organize a "*Lead Interdisciplinary Team*"

Assemble a "Lead Team" to represent all disciplines and roles in your practice. Include MDs, RNs, NPs, clinical support staff, clerical staff, patients and families along with any other professionals who are regularly in the practice providing care and service.

Must dos:

- Lead Team should meet weekly to maintain focus, make plans and oversee improvement work
- Effective meeting skills should be used in the weekly meetings
- Monthly ALL staff meetings should be held to engage and inform all members of the practice
- Explore creative ways to communicate and stay engaged with all staff on all shifts, all microsystems and all days of the week. Use email, newsletters, listservs, paper, verbal, visual displays, communication boards and buddy systems
- Remember true innovation is achieved through active engagement of the patient and family with the Lead Team

STEP 2 Assess Your Primary Care Practice

Complete the "5Ps" Assessment. This process needs to be completed by the interdisciplinary team. Building common knowledge and insight into the microsystem by all members of the practice will create a sense of equal value and ability to contribute to the improvement activities.

Start with Purpose. Why does your primary care practice exist?
Raise this question to EVERYONE in your practice to create the best statement of purpose that everyone can buy into.

Assess Your Patients, Professionals, Processes and Patterns using the worksheets in the "Greenbook." The aim is to create the "Big picture" of your system to see beyond one patient at a time. Assessing the "5Ps" and then reflecting on their connections and interdependence often reveals new improvement and redesign opportunities.

Create a timeline for the assessment process. The whole workbook DOES NOT need to be completed within 2 weeks. Some microsystems have the capacity and resources to move quickly through the workbook in a short period of time. Many microsystems need to pace themselves through the workbook and complete the worksheets and assessment through a longer timeline. Some microsystems may need to start an important improvement immediately while starting the assessment process. In this case, the ongoing assessment will give you needed context and will help you make better improvements.

Remember however you choose to progress through the workbook, it MUST be done within the context of your interdisciplinary team.

Use the Data Review sheet to help outline and track which data and information will be retrieved in current systems and which data/info will be measured through a worksheet. Review the worksheets of the Assess, Diagnose and Treat Your Medical Home workbook. Determine which worksheets you will copy and use to collect new data and information. Which worksheets will you NOT use because you have data systems that can provide useful, timely data for you without a special effort?

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Microsystem Assessment of Data Sources and Data Collection Actions

- With your interdisciplinary team, review the Assess, Diagnose and Treat workbook-"The Greenbook". Use this form to determine which measures you can obtain from your organization and therefore, don't need to use the worksheets. Be sure the data is current and not months old.
- Determine which worksheets will be used. Plan who, when and how the worksheets will be completed.
- Decide who oversees the compilation of each worksheet or alternative data source.

Page/Type of Data	Data Source/Data Collection Action	Date/Owner
Page 8 B Know Your Patients		
B1. Estimated Age Distribution of Patients		
B2. Estimated Number of Unique Patients in Practice		
B3. Disease specific registries/outcomes		
B4. List Your Top Diagnosis/Conditions		
B5. Top Referrals		
B6. Reasons for Frequent Patient Visits to Practice		
B7. Clinical Microsystems-That You Interact With		
B8. Patient Satisfaction Scores (Patient Survey pg 9)		
(Chronic Care Survey pg 12-13)		
B9. Patient Population Census		
("Walk Through" pg 11)		
B10. Out of Practice Visits		
Page 8 C Know Your Professionals		
C1. Current Staff		
Float Pool		
On-Call		
C2. 3rd Next Available		
C3. Days of Operation		
C4. Hours of Operation		
C5. Services offered		
C6. Appointment Type(s)		
C7. Appointment Duration(s)		
C8. Staff Satisfaction Scores (Staff Survey pg 14)		
(Personal Skills Assessment pg 15-17)		
(Activity Survey pg 18)		
Page 8 D Know Your Processes		
D1. Create Flow Charts of Routine Processes		
D2. (Patient Cycle Time Tool pg 34-36)		
D3. (Core and Supporting Processes pg 37)		
D4. (High Level Flowchart pg 53)		
Page 8 E Know Your Patterns		
E1. Meetings (types, frequency)		
E2. Most Significant Pattern		
E3. Successful Change E4. Most Proud of		
E5. Nurse Triage Demand Tracking Log (pg 53)		
E6. Financial Picture		
(Unplanned Activity Tracking Card pg 54)		
(Telephone Tracking Log pg 56)		
(External Mapping pg 58)		

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Medical Home Profile

A. Purpose: Why does your practice exist?

Site Name:	Site Contact:	Date:
Practice Manager:	MD Lead:	Nurse Lead:

B. Know Your Patients: Take a close look into your practice, create a "high-level" picture of the PATIENT POPULATION that you serve. Who are they? What resources do they use? How do the patients view the care they receive?

Est. Age Distribution of Patients:	**%**
Birth-10 years	
11-18 years	
19-45 years	
46-64 years	
65-79 years	
80 + years	
% Females	
Est. # (unique) pts. In Practice	
Disease Specific Registries/Outcomes Pg. 24	
Living Situation	
Behavioral Health	
Language(s)	

List Your Top 10 Diagnoses/Conditions		**Top Referrals (e.g. Payor Group/Mix)**
1.	6.	
2.	7.	
3.	8.	
4.	9.	
5.	10.	

Patients who are frequent users of your practice and their reasons for seeking frequent interactions and visits – including Payor Mix/ Payor Group	**Other community, social service referrals you interact with regularly as you provide care (top agencies supporting patient care). *See External Mapping Tool***	**Rank Order Volume**
	% SNF	
	% Rehab	
	% Hospice	

Patient Satisfaction Scores	% Excellent

Pt Population Census: Do these numbers change by season? (Y/N)	**#**	**Y/N**
Patients seen in a day		
Patients seen in last week		
New patients in last month		
Disenrolling patients in last month		
Encounters per provider per year		

Out of Practice Visits/New/ Inc. Hospital D/C			
Urgent Care		Wal-Mart	
ER Visits		Hospital	

****Complete "Through the Eyes of Your Patient" pg 9***

C. Know Your Professionals: Use the following template to create a comprehensive picture of your practice. Who does what and when? Is the right person doing the right activity? Are roles being optimized? Are all roles who contribute to the patient experience listed? What hours are you open for business? How many and what is the duration of your appointment types? How many exam rooms do you currently have? What is the morale of your staff?

Current Staff	**FTEs**	**Comment/ Function**	**3rd Next Available**			**Cycle Time**
Enter names below totals Use separate sheet if needed			PE	Follow up	Acute	**Range**
MDs Total						
NP/PAs Total						
RNs Total						
Phone Triage/Teaching						
LPNs Total						
Panel MA/LNA Total						
Secretaries Total						
Care Coordinators						
Behaviorist/SW						
Others:						

Days of Operation	**Hrs.**	**Do you offer the following: (check all that apply)**	
Monday		❑Group Visit	❑EHR
Tuesday		❑E-mail	❑Disease Registry
Wednesday		❑Website	
Thursday		❑RN Clinic	
Friday		❑Phone Follow up	
Saturday		❑Phone Care Mgmt.	
Sunday		❑Protocols/Guidelines/Algorithm	

Practice Protocols (Check all that apply)	
❑Coumadin	❑ Scheduling Guidelines
❑Exam Rooms Stock	❑PT request for forms
❑Metric Training	❑ Referral Satisfaction
❑Ordering Process for Age Specific Preventive Health	❑Prescription Refills for Clinical Support
❑Pre-physical lab work	❑Protocols for Chronic Disease
❑Pre-visit work/planning	
❑Patient Visits	

Appoint. Type	**Duration**	**Comment:**

Staff Satisfaction Scores		**%**
How stressful is the practice?	% Not Satisfied	
Would you recommend it as a good place to work?	% Strongly Agree	

Do you use Float Pool? ____ Yes ____ No

What are your afterhours call?

***Each staff member should complete the Personal Skills Assessment and "The Activity Survey", pgs. 13-15**

D. Know Your Processes: How do things get done in the microsystem? Who does what? What are the step-by-step processes? How long does the care process take? Where are the delays? What are the "between" microsystems hand-offs?

1. **Track cycle time for patients from the time they check in until they leave the office using the Patient Cycle Time Tool. List ranges of time per provider on this table, pg. 16/17**
2. **Complete the Core and Supporting Process Assessment Tool, pg. 18**

E. Know Your Patterns: What patterns are present but not acknowledged in your microsystem? What is the leadership and social pattern? How often does the microsystem meet to discuss patient care? Are patients and families involved? What are your results and outcomes?

- Does every member of the practice meet regularly as a team?
- How frequently?
- What is the most significant pattern of variation?
- Do the members of the practice regularly review and discuss safety, reliability NS quality improvement issues?
- What have you successfully changed?
- What are you most proud of?
- What is your financial picture?

***Complete "Metrics that Matter", pgs. 23-24**

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Patients

- Patients have valuable insight into the quality and process of care we provide. Real time feedback can pave the way for rapid responses and quick tests of change. This "Point of Service" Survey can be completed at the time of the visit to give real time measurement of satisfaction.
- Use the Medical Home Profile to review *"Know Your Patients."* Determine if there is information you need to collect or if you can obtain this data within your organization. Remember the aim is to collect and review data and information about your patients and families that might lead to a new design of process and services.
- Conduct the Patient/Family Satisfaction Survey for 2 weeks with families if you currently DO NOT have a method to survey families. If you have a method, be sure the data is up to date and reflects the current state of your practice.

Patient/Family Satisfaction with Medical Home Access Survey "Point of Service"

Date: _____

Think about this visit.

1. How would you rate your satisfaction with getting through to the office by phone?

❑ **Excellent** ❑ **Very Good** ❑ **Good** ❑ **Fair** ❑ **Poor**

2. How would you rate your satisfaction with the length of time you waited to get your appointment today?

❑ **Excellent** ❑ **Very Good** ❑ **Good** ❑ **Fair** ❑ **Poor**

3. How would you rate your satisfaction with use of internet/patient portal in terms of this practice?

❑ **Excellent** ❑ **Very Good** ❑ **Good** ❑ **Fair** ❑ **Poor**

4. Did you see the clinician, or staff member, that you wanted to see today?

❑ **Yes** ❑ **No** ❑ **Did not matter who I saw today**

5. How would you rate your satisfaction with the personal manner of the person you saw today (courtesy, respect, sensitivity, friendliness)?

❑ **Excellent** ❑ **Very Good** ❑ **Good** ❑ **Fair** ❑ **Poor**

6. How would you rate your satisfaction with the time spent with the person you saw today?

❑ **Excellent** ❑ **Very Good** ❑ **Good** ❑ **Fair** ❑ **Poor**

Comments:

Thank You For Completing This Survey

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Patients

Medical Home Patient Viewpoint Survey (Sources: Medical Outcomes Study (MOS) Visit-Specific Questionnaire (VSQ),1993 Patient Utilization Questions, Dartmouth Medical School)

Today's Office Visit

Please rate the following questions about the visit you just made to this office.

		Excellent	Very Good	Good	Fair	Poor
1.	The amount of time you waited to get an appointment.	❑	❑	❑	❑	❑
2.	Convenience of the location of the office.	❑	❑	❑	❑	❑
3.	Getting through to the office by phone.	❑	❑	❑	❑	❑
4.	Ability to access this practice through the web/Internet	❑	❑	❑	❑	❑
5.	Ability to communicate with your care team via secure message/email	❑	❑	❑	❑	❑
6.	Length of time waiting at the office.	❑	❑	❑	❑	❑
7.	Time spent with the person you saw.	❑	❑	❑	❑	❑
8.	Explanation of what was done for you.	❑	❑	❑	❑	❑
9.	The technical skills (thoroughness, carefulness, competence) of the person you saw.	❑	❑	❑	❑	❑
10.	The personal manner (courtesy, respect, sensitivity, friendliness) of the person you saw.	❑	❑	❑	❑	❑
11.	The Clinician's sensitivity to your special needs or concerns.	❑	❑	❑	❑	❑
12.	Your satisfaction with getting the help that you needed.	❑	❑	❑	❑	❑
13.	Your feeling about the overall quality of the visit.	❑	❑	❑	❑	❑

General Questions

Please answer the general questions about your satisfaction with this practice.

14 If you could go anywhere to get health care, would you choose this practice or would you prefer to go someplace else?

❑ Would choose this practice ❑ Might prefer someplace else ❑ Not sure

15. I am delighted with everything about this practice because my expectations for service and quality of care are exceeded.

❑ Agree ❑ Disagree ❑ Not sure

16. In the last 12 months, how many times have you gone to the emergency room for your care?

❑ None ❑ One time ❑ Two times ❑ Three or more times

17. In the last 12 months was it always easy to get a referral to a specialist when you felt like you needed one?

❑ Yes ❑ No ❑ Does not apply to me

18. In the last 12 months how often did you have to see someone else when you wanted to see your personal doctor or nurse?

❑ Never ❑ Sometimes ❑ Frequently

19. Are you able to get to your appointments when you choose?

❑ Never ❑ Sometimes ❑ Always

20. Is there anything our practice can do to improve the care and services for you?

❑ No, **I'm satisfied** with everything ❑ Yes, **some things** can be improved ❑ Yes, **many things** can be improved

Please specify improvement: _____

21. Did you have any good or bad surprises while receiving your care?

❑ Good ❑ Bad ❑ No surprises

Please describe: _____

About You

22. In general, how would you rate your overall health?

❑ Excellent ❑ Very good ❑ Good ❑ Fair ❑ Poor

23. What is your age?

❑ Under 25 years ❑ 25 – 44 years ❑ 45 – 64 years ❑ 65 years or older

24. What is your gender? ❑ Male ❑ Female

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Patients

- Gain insight into how your patients experience your practice and the mesosystem of the Medical Home. One simple way to understand the patient experience is to experience the care. Members of the staff should do a "Walk Through" in your practice over a period of time to capture all the microsystem experiences in the Medical Home. Try to make this experience as real as possible; this form can be used to document the experience. You can also capture the patient experience by making an audio or videotape.

Through the Eyes of Your Patients

Tips for making the "Walk Through" most productive:

1. Determine with your staff where the starting point and ending points should be, taking into consideration making the appointment, the actual office visit process, follow-up and other processes.
2. Two members of the staff should role play with each playing a role: patient and partner/family member.
3. Set aside a reasonable amount of time to experience the patient journey. Consider doing multiple experiences along the patient journey at different times.
4. Make it real. Include time with registration, lab tests, new patient, follow-up and physicals. Sit where the patient sits. Wear what the patient wears. Make a realistic paper trail including chart, lab reports and follow-up.
5. During the experience note both positive and negative experiences, as well as any surprises. What was frustrating? What was gratifying? What was confusing? Again, an audio or video tape can be helpful.
6. Debrief your staff on what you did and what you learned.

Date: Staff Members:

Walk Through Begins When: _____ Ends When: _____

Positives	Negatives	Surprises	Frustrating/Confusing	Gratifying

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Patients

Staying healthy can be difficult when you have a chronic condition. We would like to learn about the type of help you get from your health care team regarding your condition. This might include your regular doctor, the nurse, or the physician's assistant who treats your illness.

Assessment of Care for Chronic Conditions ©

Over the past 6 months, when I received care for my chronic conditions, I was:

	None of the Time	A Little of the Time	Some of the Time	Most of the Time	Always
1. Asked for my ideas when we made a treatment plan.	❑1	❑2	❑3	❑4	❑5
2. Given choices about treatment to think about.	❑1	❑2	❑3	❑4	❑5
3. Asked to talk about any problems with my medicines or their effects.	❑1	❑2	❑3	❑4	❑5
4. Given a written list of things I should do to improve my health.	❑1	❑2	❑3	❑4	❑5
5. Satisfied that my care was well organized.	❑1	❑2	❑3	❑4	❑5
6. Shown how what I did to take care of myself influenced my condition.	❑1	❑2	❑3	❑4	❑5
7. Asked to talk about my goals in caring for my condition.	❑1	❑2	❑3	❑4	❑5
8. Helped to set specific goals to improve my eating or exercise.	❑1	❑2	❑3	❑4	❑5
9. Given a copy of my treatment plan.	❑1	❑2	❑3	❑4	❑5
10. Encouraged to go to a specific group or class to help me cope with my chronic condition.	❑1	❑2	❑3	❑4	❑5
11. Asked questions, either directly or on a survey, about my health habits.	❑1	❑2	❑3	❑4	❑5
12. Sure that my doctor or nurse thought about my values, beliefs, and traditions when they recommended treatments to me.	❑1	❑2	❑3	❑4	❑5
13. Helped to make a treatment plan that I could carry out in my daily life.	❑1	❑2	❑3	❑4	❑5
14. Helped to plan ahead so I could take care of my condition even in hard times.	❑1	❑2	❑3	❑4	❑5
15. Asked how my chronic condition affects my life.	❑1	❑2	❑3	❑4	❑5

Adapted from the original version, Dartmouth-Hitchcock, Version 2, February 2005, Medical Home Work Group Adapted June 2010, Version 2 December 2011.

Patients (continued)

Over the past 6 months, when I received care for my chronic conditions, I was:

	None of the Time	A Little of the Time	Some of the Time	Most of the Time	Always
16. Contacted after a visit to see how things were going.	❑1	❑2	❑3	❑4	❑5
17. Encouraged to attend programs in the community that could help me.	❑1	❑2	❑3	❑4	❑5
18. Referred to a dietitian, health educator, or counselor.	❑1	❑2	❑3	❑4	❑5
19. Told how my visits with other types of doctors, like an eye doctor or surgeon, helped my treatment.	❑1	❑2	❑3	❑4	❑5
20. Asked how my visits with other doctors were going.	❑1	❑2	❑3	❑4	❑5

Professionals

- Creating a joyful work environment starts with a basic understanding of staff perceptions of the practice. All staff members should complete this survey. Use a tally sheet to summarize results.
- Ask all practice staff to complete the Staff Survey. Often you can distribute this survey to any professional who spends time in your practice. Set a deadline of one week and designate a place for the survey to be dropped off. You may have an organization-wide survey in place that you can use to replace this survey, but be sure it is CURRENT data, not months old, and that you are able to capture the data from all professionals specific to the Primary Care Practice workplace.

Medical Home Staff Satisfaction Survey

1. I am treated with respect every day by everyone that works in this practice.

❑ **Strongly Agree** ❑ **Agree** ❑ **Disagree** ❑ **Strongly Disagree**

2. I am given everything I need—tools, equipment, and encouragement—to make my work meaningful to my life.

❑ **Strongly Agree** ❑ **Agree** ❑ **Disagree** ❑ **Strongly Disagree**

3. When I do good work, someone in this practice notices that I did it.

❑ **Strongly Agree** ❑ **Agree** ❑ **Disagree** ❑ **Strongly Disagree**

4. How stressful would you say it is to work in this practice?

❑ **Very stressful** ❑ **Somewhat stressful** ❑ **A little stressful** ❑ **Not stressful**

5. How easy is it to ask anyone a question about the way we care for patients?

❑ **Very easy** ❑ **Easy** ❑ **Difficult** ❑ **Very difficult**

6. How would you rate other people's morale and their attitudes about working here?

❑ **Excellent** ❑ **Very Good** ❑ **Good** ❑ **Fair** ❑ **Poor**

7. This practice is a better place to work than it was 12 months ago.

❑ **Strongly Agree** ❑ **Agree** ❑ **Disagree** ❑ **Strongly Disagree**

8. I would recommend this practice as a great place to work.

❑ **Strongly Agree** ❑ **Agree** ❑ **Disagree** ❑ **Strongly Disagree**

9. What would make this practice better for patients?

_____

10. What would make this practice better for those who work here?

_____

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Professionals

- Development of each member in the practice is a key to success for staff and the microsystem. The Personal Skills Assessment tool helps determine the education and training needs of staff. All staff members complete this survey and then discuss the action plan with leadership and other staff. A plan is developed to help members achieve goals so they can become the best they can be.
- This tool provides guidance for individual development plans along with assessing the "group" needs to plan larger learning and training sessions.

Medical Home Resources—Personal Skills Assessment

Name: _____ Unit: _____

Role: _____ Date: _____

Clinical Competencies:	**Want to Learn**	**Never Use**	**Occasionally**	**Frequently**
Please create your list of clinical competencies and evaluate.				
	❑	0	1	2
	❑	0	1	2

Clinical Information Systems (CIS):	**Want to Learn**	**Never Use**	**Occasionally**	**Frequently**
What features and functions do you use?				
Provider/On Call Schedule	❑	0	1	2
Patient Demographics	❑	0	1	2
Lab Results	❑	0	1	2
Pathology	❑	0	1	2
Problem List	❑	0	1	2
Electronic Health Record (EHR)	❑	0	1	2
Review Reports/Notes	❑	0	1	2
Documentation	❑	0	1	2
Direct Entry	❑	0	1	2
Note Templates	❑	0	1	2
Medication Lists	❑	0	1	2
Medication Ordering	❑	0	1	2
Action Taken on Surgical Pathology	❑	0	1	2
Insurance Status	❑	0	1	2
Durable Power of Attorney	❑	0	1	2
Radiology	❑	0	1	2
OR Schedules	❑	0	1	2

NOTE: CIS refers to hospital or clinical information systems used for such functions as checking in patients, electronic medical records, accessing lab and x-ray information. Customize your list of CIS features to determine skills needed by various staff members to optimize their roles.

Technical Skills:	**Want to Learn**	**Never Use**	**Occasionally**	**Frequently**
Please rate the following on how often you use them.				
CIS*	❑	0	1	2
E-mail	❑	0	1	2
Patient Portal Posting	❑	0	1	2
Digital/Voice Dictation	❑	0	1	2

Adapted from the original version, Dartmouth-Hitchcock, Version 2, February 2005, Medical Home Work Group Adapted June 2010, Version 2 December 2011.

Medical Home Resources—Personal Skills Assessment page 2

Name: _____ Unit: _____

Technical Skills cont'd:	**Want to Learn**	**Never Use**	**Occasionally**	**Frequently**
Please rate the following on how often you use them.				
Central Dictation/Digital/Voice	❑	0	1	2
Word Processing (e.g. Word)	❑	0	1	2
Spreadsheet (e.g. Excel)	❑	0	1	2
Presentation (e.g. Power Point)	❑	0	1	2
Database (e.g. Access or File Maker Pro)	❑	0	1	2
Patient Database/Statistics/Registries	❑	0	1	2
Internet/Intranet	❑	0	1	2
Printer Access	❑	0	1	2
Fax	❑	0	1	2
Copier	❑	0	1	2
Telephone System	❑	0	1	2
Voice Mail	❑	0	1	2
Pagers/Texting	❑	0	1	2
Tube System	❑	0	1	2

Meeting & Interpersonal Skills:	**Want to Learn**	**Never Use**	**Occasionally**	**Frequently**
What skills do you currently use?	❑	0	1	2
Effective Meeting Skills (brainstorm/multi-vote)	❑	0	1	2
Timed Agendas	❑	0	1	2
Role Assignments During Meetings	❑	0	1	2
Delegation	❑	0	1	2
Problem Solving	❑	0	1	2
Patient Advocacy Process	❑	0	1	2
Open and Effective Communication	❑	0	1	2
Feedback – provide and receive	❑	0	1	2
Managing Conflict/Negotiation	❑	0	1	2
Emotional/Spiritual Support	❑	0	1	2

Improvement Skills and Knowledge:	**Want to Learn**	**Never Use**	**Occasionally**	**Frequently**
What improvement tools do you currently use?				
Flowcharts/Process Mapping	❑	0	1	2
Trend Charts	❑	0	1	2
Control Charts	❑	0	1	2
Plan/Do/Study/Act (PDSA) Improvement Model	❑	0	1	2
Aim Statements	❑	0	1	2
Fishbones	❑	0	1	2
Measurement and Monitoring	❑	0	1	2
Surveys-Patient and Staff	❑	0	1	2
STAR Relationship Mapping	❑	0	1	2

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Medical Home Resources—Personal Skills Assessment page 3

Name: _____ Unit: _____

Primary Care Skills	Want to Learn	Never Use	Occasionally	Frequently
Please rate the following on how often you use them.	❑	0	1	2
	❑	0	1	2
	❑	0	1	2
	❑	0	1	2
	❑	0	1	2
	❑	0	1	2
	❑	0	1	2
	❑	0	1	2

Self-Management Skills:	Want to Learn	Never Use	Occasionally	Frequently
Please rate the following on how often you use them.	❑	0	1	2
	❑	0	1	2
	❑	0	1	2
	❑	0	1	2
	❑	0	1	2
	❑	0	1	2
	❑	0	1	2
	❑	0	1	2

Registry Management:	Want to Learn	Never Use	Occasionally	Frequently
Please rate the following on how often you use them.				
	❑	0	1	2
	❑	0	1	2
	❑	0	1	2
	❑	0	1	2
	❑	0	1	2
	❑	0	1	2
	❑	0	1	2

Motivational Interviewing:	Want to Learn	Never Use	Occasionally	Frequently
Please rate the following on how often you use them.	❑	0	1	2
	❑	0	1	2
	❑	0	1	2
	❑	0	1	2
	❑	0	1	2
	❑	0	1	2
	❑	0	1	2
	❑	0	1	2

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Professionals

- What do you spend YOUR time doing? What is your best estimation of how much time you spend doing it? The goal is to have the right person doing the right thing at the right time. The group can discuss which activities are or are not appropriate for the individual's level of education, training and licensure.
- You can start with one group of professionals such as MDs, NPs, RNs or clerical staff, assessing their activities using the Activity Survey. This estimate of who does what is intended to reveal, at a high level, where there might be mismatches between education, training, licensure and actual activities. It is good to eventually have all roles and functions complete this survey for review and consideration. Be sure to create the same categories for each functional role. Some groups may hesitate to make time estimates; if this happens, just ask them to list their activities for the first review.

Medical Home Activity Survey Sheet

Position: MD	% of Time
Activity: Direct Face to Face contact with patient Specific Items Involved: • Review chart history • Assess/diagnose patient • Determine treatment plan	30%
Activity: Minor Procedures	9%
Activity: See Patients in Hospital	2%
Activity: Patient follow up Specific Items Involved: • Answer patient messages and requests • Follow up phone calls • Respond to patient emails • Team huddles/care management meetings	10%
Activity: Dictate/Document Patient Encounter • Specific Items Involved: • Dictate encounter • Review transcriptions and sign off	25%
Activity: Complete Form Specific Items Involved: (eg.) • Review transcriptions and sign off • Referrals • Camp/school physicals	5%
Activity: Write Prescriptions/E-prescribe/Call-ins Specific Items Involved: •	5%
Activity: Manage Charts/EHR Specific Items Involved: •	5%
Activity: Evaluate Results Specific Items Involved: • Review results and determine next actions	5%
Activity: See Patients in Nursing Home Specific Items Involved: •	2%
Activity: Miscellaneous Specific Items Involved: • CME; attend seminars; attend meetings:	2%
Total	100%

Position: RN	% of Time
Activity: Triage Patient Issues/Concerns • Phone • Face to face • Email/Patient Portal	15%
Activity: Patient/Family Education Specific Items Involved: •	3%
Activity: Direct Patient Care Specific Items Involved: • Vaccines • Patient education • Self-management education • Independent visit for chronic disease follow up • Blood Draw • Assist provider with unstable patient. •	25%
Activity: Follow-up Phone Calls Specific Items Involved: • Answer patient phone call • Discuss patient with specialist • Discuss patient with hospital • Discuss patient with VNA • Discuss patient with pharmacy • Discuss patient with insurance company	20%
Activity: Review and Notify Patients of Lab Results Specific Items Involved: • Normal with follow-up • Drug Adjustments •	5%
Activity: Complete Forms Specific Items Involved: • Referrals • Camp/school physicals •	18%
Activity: Call in Prescriptions Specific Items Involved: •	5%
Activity: Team Interactions Specific Items Involved • Team Huddle • Review cases w/PCP	7%
Activity: Miscellaneous Specific Items Involved: • CME; attend seminars; attend meetings	2%
Total	100%

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Activity Occurrence Example:			
What's the next step? Insert the activities from the Activity Survey Here. Activities are combined by role from the data collected above. This creates a master list of activities by role. Fill-in THE NUMBER OF TIMES PER SESSION (AM and PM) THAT YOU PERFORM THE ACTIVITY. Make a mark by the activity each time it happens, per session. Use one sheet for each day of the week. Once the frequency of activities is collected, the practice should review the volumes and variations by session, day of week, and month of year. This evaluation increases knowledge of predictable variation and supports improved matching of resources based on demand.			
Role: RN	Date:	Day of Week:	
Visit Activities	AM	PM	Total
Triage Patient Concerns	7	7	14
Family/Patient Education	8	3	11
Direct Patient Care	21	21	42
Non-Visit Activities			
Follow-up Phone Calls	12	14	26
Complete Forms	11	8	19
Call in Prescriptions	6	10	16
Miscellaneous			15
Total	63	65	128

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Professionals

Activities

Access and Communication Processes

Based on education, license and training, which roles are best aligned with the listed processes?

1. Note current role and function in one colored pen
2. In second colored pen note best alignment for role optimization based on education, license and training.

	Receptionist	Secretary	LNA	CMA	Office Nurse	Triage Nurse	Care Coordinator	APRN PA	MD	Clinic Admin	Other/NA	Notes
Scheduling patients with a personal clinician for continuity of care												
Coordinates visits with multiple clinicians and/or diagnostic tests.												
Triages how soon a pt. needs to be seen												
Monitors Appointment Access												
Provides telephone advice on clinical issues												
Monitors secure e-mail appointment requests												
Identifies and arranges for language services												
Identifies and documents patient and families preferred method of communication												
Identifies patients preferred language												
Collects patient demographic and insurance information												

System for Clinical Data/Organizing Clinical Data

	Receptionist	Secretary	LNA	CMA	Office Nurse	Triage Nurse	Care Coordinator	APRN PA	MD	Clinic Admin	Other/NA	Notes
Identifies status of age appropriate preventive care services												
Identifies and documents allergies and adverse reactions												
Documents Body Mass Index												
Collects all relevant biometric and social data on all patients												
Orders laboratory tests												
Orders imaging tests												
Monitors outstanding pathology, lab and imaging reports												
Discusses and documents advance directives with patients												
Evaluates patient's behavioral health by the use of validated screening tools. (PHQ9, GAD7 e.g)												

Organizing Clinical Data

	Receptionist	Secretary	LNA	CMA	Office Nurse	Triage Nurse	Care Coordinator	APRN PA	MD	Clinic Admin	Other/NA	Notes
Documents and reviews Problem list with patients												
Medications reviewed and reconciled at each patients visit												
Consistently documents and reviews age-appropriate risk factors												

Documents narrative progress notes in a structured manner												
Performs and documents age appropriate standardized developmental testing												

Identifying Important Conditions

	Receptionist	Secretary	LNA	CMA	Office Nurse	Triage Nurse	Care Coordinator	APRN PA	MD	Clinic Admin	Other/NA	Notes
Identifies and evaluates practice's most frequently seen diagnoses												
Identifies and evaluates most important risk factors in the practice's patient population												
Identifies and evaluates at least three conditions that are clinically important in the practice's patient population.												

Use of System for Population Management

	Receptionist	Secretary	LNA	CMA	Office Nurse	Triage Nurse	Care Coordinator	APRN PA	MD	Clinic Admin	Other/NA	Notes
Ensures that patients get needed pre-visit tests												
Ensures patients medication refills needs are met												
Reminds patients of preventive care visits/testing												
Reminds patients of follow-up visits such as for a chronic condition												
Identifies and refers patients who might benefit from care management support.												

Identifies vulnerable populations and ensures they are referred to appropriate care and support.												

Guidelines for Important Conditions

	Receptionist	Secretary	LNA	CMA	Office Nurse	Triage Nurse	Care Coordinator	APRN PA	MD	Clinic Admin	Other/NA	Notes
Evaluates patient clinical registry reports for clinically important conditions and takes appropriate action												
Ensures/monitors that evidence-based diagnosis and treatment guidelines are used for clinically important conditions identified by clinic												

Preventive Service Clinician Reminders

	Receptionist	Secretary	LNA	CMA	Office Nurse	Triage Nurse	Care Coordinator	APRN PA	MD	Clinic Admin	Other/NA	Notes
Flags patient record (paper/electronic) to remind care providers of the guideline-based care when seeing the patient for the following:												
Age-appropriate screening tests												
Age-appropriate immunizations (e.g., influenza, pediatric)												
Age-appropriate risk assessments (e.g., smoking, diet, depression)												
Counseling (e.g., smoking cessation).												

Care Management for Important Condition

	Receptionist	Secretary	LNA	CMA	Office Nurse	Triage Nurse	Care Coordinator	APRN PA	MD	Clinic Admin	Other/NA	Notes
Conducts pre-visit planning with clinician reminders												
Develops and documents individualized care plans												
Writes individualized treatment goals with patient												
Assess and documents patient progress toward goals												
Assesses barriers when patients have not met treatment goals												
Contacts patients who do not keep important appointments												
Reviewing longitudinal representation of patient's historical or targeted clinical measurements												
Follows up with patient post clinic visit when appropriate												

Continuity of Care

	Receptionist	**Secretary**	**LNA**	**CMA**	**Office Nurse**	**Triage Nurse**	**Care Coordinator**	**APRN PA**	**MD**	**Clinic Admin**	**Other/NA**	**Notes**
Identifies patients who have received care in another facility												
Ensure referring care providers/facilities are provided with relevant clinical information												
Contacts patients after discharge from facilities/ER												
Provide or coordinates follow-up care to patients/families who have been discharged from facilities/ER												

Manages referrals to other community based resources for patient support												
Provides on-going support to patients with chronic disease between office visits												

Self-Management Support

	Receptionist	Secretary	LNA	CMA	Office Nurse	Triage Nurse	Care Coordinator	APRN PA	MD	Clinic Admin	Other/NA	Notes
Assesses and documents patient/family preferences, readiness to change and self-management abilities												
Provides education and support in the language or medium that the patient/family understands												
Provides self-monitoring tools and education for patients' self-monitoring												
Connects patients/families to self-management support programs and community resources												
Provides a written care plan and monitoring tools to the patient/family												

Prescription Writing

	Receptionist	Secretary	LNA	CMA	Office Nurse	Triage Nurse	Care Coordinator	APRN PA	MD	Clinic Admin	Other/NA	Notes
Ensures patients obtain prescribed medications												
Ensures that all patient medications are documented and reconciled												

Provides patient with patient appropriate medication information												
Reviews patients payer specific formulary to ensure coverage or identify generic alternatives												
Evaluates patients record to identify potential drug/drug interaction, allergies and contraindications												

Test Tracking and Follow-up

	Receptionist	Secretary	LNA	CMA	Office Nurse	Triage Nurse	Care Coordinator	APRN PA	MD	Clinic Admin	Other/NA	Notes
Tracks all laboratory tests ordered until results are available to the clinician, flags overdue results												
Tracks all imaging tests ordered until results are available to the clinician, flags overdue results												
Flags abnormal test results, bringing them to a clinician's attention												
Follows up with patients/families for all abnormal test results												
Notifies patients/families of all normal test results												

System for Managing Tests

	Receptionist	Secretary	LNA	CMA	Office Nurse	Triage Nurse	Care Coordinator	APRN PA	MD	Clinic Admin	Other/NA	Notes
Orders lab tests												
Orders imaging tests												
Retrieves lab results												
Retrieves imaging text reports												

Routes test results to appropriate clinical personnel for review and notifies patients.												
Generates alerts for overdue tests												

Measures of Performance

	Receptionist	Secretary	LNA	CMA	Office Nurse	Triage Nurse	Care Coordinator	APRN PA	MD	Clinic Admin	Other/NA	Notes
Runs and evaluates reports on important clinical indicators noted below:												
Clinical outcomes (e.g., HbA1c levels for diabetics)												
Service data (e.g., backlogs or wait times)												
Patient safety issues (e.g., medication errors).												
Preventive care services (e.g. vaccination rates, colonoscopies, mammograms)												
Sets goals and takes appropriate action based on results												
Uses data to identify areas in need of improvement and works to improve them.												

This tool will support your medical home readiness assessment

Patient Experience Data

	Receptionist	Secretary	LNA	CMA	Office Nurse	Triage Nurse	Care Coordinator	APRN PA	MD	Clinic Admin	Other/NA	Notes
Evaluates patients satisfaction with their care experience												

Evaluates Staff/Provider satisfactions												
Evaluates patient/family confidence in self-care												
Sets goals and takes appropriate action based on satisfaction results												

Integration of Patient and Family Centered Primary, Behavioral and Mental Health Care

Instructions for Completing the Site Self-Assessment (SSA) Survey – 2008

We would like you to focus on your site's extent of integration for patient and family-centered primary care, behavioral and mental health care. The purpose of this assessment is: to assess your current state of integrated care, to engage in discussion with your interdisciplinary staff and to improve integration. Future repeat administrations of the SSA form will help show improvement at your site over time.

It is very desirable to obtain input from your team by completing this form; for example, you may ask team members to score it, discuss the scores in a team meeting, reach consensus or take the average of the individual scores. If that is not feasible, then the site manager may complete it individually. Please rate your patient care team(s) on the extent to which they currently do each activity. By patient care team we mean the staff that work together to manage integrated care for patients. This often, but not always, involves health care providers, behavioral health specialists and possibly case managers or health educators and front office staff.

Using the 1-10 scale in each row, circle one numeric rating for each of the 18 characteristics. If you are unsure or do not know, please give your best guess, and indicate to the side any comments or feedback you would like to give regarding that item. NOTE: *There are no right or wrong answers. If some of this wording does not seem appropriate for your project, please suggest alternative wording that would be more applicable, on the form itself.*

Thank you!

Identifying Information:

Name of your site:_____ Date:_____

Name of person completing the SSA form:_____ Your role:_____

Did you discuss these ratings with other members of your team? ❑Yes ❑No

Are these your site's ratings for: ❑ Current status ❑ Baseline status, as of about (month, year) _____

Adapted from the PCRS – Developed by the Robert Wood Johnson Foundation Diabetes Initiative, www.diabetesinitiative.org; also adapted from ACIC survey developed by the MacColl Institute for Healthcare Innovation, Group Health Initiative.

I. Integrated Services and Patient and Family-Centeredness (**Circle one NUMBER for each characteristic**)				
Characteristic	**Levels**			
1. Co-location of treatment for primary care and mental/behavioral health care	. . . does not exist; consumers go to separate sites for services **1**	. . . is minimal; but some conversations occur among types of providers; established referral partners exist **2 3 4**	. . . is partially provided; multiple services are available at same site; some coordination of appointments and services **5 6 7**	. . . exists, with one reception area; appointments jointly scheduled; one visit can address multiple needs **8 9 10**
2. Emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse) 2. (ALTERNATE: If you are a behavioral or mental health site, respond in terms of medical care needs)	. . . are not assessed (in this site) **1**	. . .are occasionally assessed; screening/assessment protocols are not standardized or are nonexistent **2 3 4**	. . .screening/assessment is integrated into care on a pilot basis; assessment results are documented prior to treatment **5 6 7**	. . . screening/assessment tools are integrated into practice pathways to routinely assess MH/BH/PC needs of all patients; standardized screening/ assessment protocols are used and documented. **8 9 10**
3. Treatment plan(s) for primary care *and* behavioral/mental health care	. . . do not exist **1**	. . . exist, but are separate and uncoordinated among providers; occasional sharing of information occurs **2 3 4**	. . .Providers have separate plans, but work in consultation; needs for specialty care are served separately **5 6 7**	. . . are integrated and accessible to all providers and care manager; patients with high behavioral health needs have specialty services that are coordinated with primary care **8 9 10**
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	. . . does not exist in a systematic way **1**	. . . depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases **2 3 4**	. . .evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers **5 6 7**	. . . follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently **8 9 10**
5. Patient/family involvement in care plan	. . . does not occur **1**	. . . is passive; clinician or educator directs care with occasional patient/family input **2 3 4**	. . . is sometimes included in decisions about integrated care; decisions about treatment are done collaboratively with *some* patients/families and their provider(s) **5 6 7**	. . . is an integral part of the system of care; collaboration occurs among patient/family and team members and takes into account family, work or community barriers and resources **8 9 10**

I. Integrated Services and Patient and Family Centeredness (Circle one NUMBER for each characteristic)				
Characteristic	**Levels**			
6. Communication with patients about integrated care	. . . does not occur **1**	. . . occurs sporadically, or only by use of printed material; no tailoring to patient's needs, culture, language, or learning style **2 3 4**	. . . occurs as a part of patient visits; team members communicate with patients about integrated care; encourage patients to become active participants in care and decision making; tailoring to patient/family cultures and learning styles is frequent **5 6 7**	. . .is a systematic part of site's integration plans; is an integral part of interactions with all patients; team members trained in *how* to communicate with patients about integrated care **8 9 10**
7. Follow-up of assessments, tests, treatment, referrals and other services	. . . is done at the initiative of the patient/ family members **1**	. . . is done sporadically or only at the initiative of individual providers; no system for monitoring extent of follow-up **2 3 4**	. . . is monitored by the practice team as a normal part of care delivery; interpretation of assessments and lab tests usually done in response to patient inquiries; minimal outreach to patients who miss appointments **5 6 7**	. . . is done by a systematic process that includes monitoring patient utilization; includes interpretation of assessments/lab tests for all patients; is customized to patients' needs, using varied methods; is proactive in outreach to patients who miss appointments **8 9 10**
8. Social support (for patients to implement recommended treatment)	. . . is not addressed **1**	. . . is discussed in general terms, not based on an assessment of patient's individual needs or resources **2 3 4**	. . . is encouraged through collaborative exploration of resources available (e.g., significant others, education groups, support groups) to meet individual needs **5 6 7**	. . . is part of standard practice, to assess needs, link patients with services and follow up on social support plans using household, community or other resources **8 9 10**
9. Linking to Community Resources	. . . does not occur **1**	. . . is limited to a list or pamphlet of contact information for relevant resources **2 3 4**	. . . occurs through a referral system; staff member discusses patient needs, barriers and appropriate resources before making referral **5 6 7**	. . . is based on an in-place system for coordinated referrals, referral follow-up and communication among sites, community resource organizations, and patients **8 9 10**

II. Practice/Organization (Circle one NUMBER for each characteristic)

Characteristic	Levels			
1. Organizational leadership for integrated care	. . . does not exist or shows little interest **1**	. . . is supportive in a general way, but views this initiative as a "special project" rather than a change in usual care **2 3 4**	. . . is provided by senior administrators, as one of a number of ongoing quality improvement initiatives; few internal resources supplied (such as staff time for team meetings) **5 6 7**	. . . strongly supports care integration as a part of the site's expected change in delivery strategy; provides support and/or resources for team time, staff education, information systems, etc.; integration project leaders viewed as organizational role models **8 9 10**
2. Patient care team for implementing integrated care	. . . does not exist **1**	. . . exists but has little cohesiveness among team members; not central to care delivery **2 3 4**	. . . is well defined, each member has defined roles/responsibilities; good communication and cohesiveness among members; members are cross-trained, have complementary skills **5 6 7**	. . . is a concept embraced, supported and rewarded by the senior leadership; "teamness" is part of the system culture; case conferences and team meetings are regularly scheduled **8 9 10**
3. Providers' engagement with integrated care ("buy-in")	. . . is minimal 1	. . . engaged some of the time, but some providers not enthusiastic about integrated care 2 3 4	. . . is moderately consistent, but with some concerns; some providers not fully implementing intended integration components 5 6 7	. . . all or nearly all providers are enthusiastically implementing all components of your site's integrated care 8 9 10
4. Continuity of care between primary care and behavioral/mental health	. . . does not exist **1**	. . . is not always assured; patients with multiple needs are responsible for their own coordination and follow-up **2 3 4**	. . . is achieved for some patients through the use of a care manager or other strategy for coordinating needed care; perhaps for a pilot group of patients only **5 6 7**	. . . systems are in place to support continuity of care, to assure all patients are screened, assessed for treatment as needed, treatment scheduled, and follow-up maintained **8 9 10**
5. Coordination of referrals and specialists	. . . does not exist **1**	. . . is sporadic, lacking systematic follow-up, review or incorporation into the patient's plan of care; little specialist contact with primary care team **2 3 4**	. . . occurs through teamwork & care management to recommend referrals appropriately; report on referrals sent to primary site; coordination with specialists in adjusting patients' care plans; specialists contribute to planning for integrated care **5 6 7**	. . . is accomplished by having systems in place to refer, track incomplete referrals and follow-up with patient and/or specialist to integrate referral into care plan; includes specialists' involvement in primary care team training and quality improvement **8 9 10**

II. Practice/Organization (Circle one NUMBER for each characteristic)

Characteristic	Levels			
6. Data systems/patient records	. . . are based on paper records only; separate records used by each provider **1**	. . . are shared among providers on an *ad hoc* basis; multiple records exist for each patient; no aggregate data used to identify trends or gaps **2 3 4**	. . . use a data system (paper or EMR) shared among the patient care team, who all have access to the shared medical record, treatment plan and lab/test results; team uses aggregated data to identify trends and launches QI projects to achieve measurable goals **5 6 7**	. . . has a full EMR accessible to all providers; team uses a registry or EMR to routinely track key indicators of patient outcomes and integration outcomes; indicators reported regularly to management; team uses data to support a continuous QI process **8 9 10**
7. Patient/family input to integration management	. . . does not occur **1**	. . . occurs on an *ad hoc* basis; not promoted systematically; patients must take initiative to make suggestions **2 3 4**	. . is solicited through advisory groups, membership on the team, focus groups, surveys, suggestion boxes, etc. for both current services and delivery improvements under consideration; patients/families are made aware of mechanism for input and encouraged to participate **5 6 7**	. . . is considered an essential part of management's decision-making process; systems are in place to ensure consumer input regarding practice policies and service delivery; evidence shows that management acts on the information **8 9 10**
8. Physician, team and staff education and training for integrated care	. . . does not occur **1**	. . . occurs on a limited basis without routine follow-up or monitoring, methods mostly didactic **2 3 4**	. . . is provided for some (e.g. pilot) team members using established and standardized materials, protocols or curricula; includes behavioral change methods such as modeling and practice for role changes; training monitored for staff participation **5 6 7**	. . . is supported and incentivized by the site for all providers; continuing education about integration and evidence-based practice is routinely provided to maintain knowledge and skills; job descriptions reflect skills and orientation to care integration **8 9 10**
9. Funding sources/resources	. . . are only from MeHAF grant; no shared resource streams **1**	. . . separate PC/MH/BH funding streams, but all contribute to costs of integrated care; few resources from participating organizations/agencies **2 3 4**	. . . separate funding streams, but some sharing of on-site expenses, e.g., for some staffing or infrastructure; available billing codes used for new services; agencies contribute some resources to support change to integration, such as in-kind staff or expenses of provider training **5 6 7**	. . . fully integrated funding, with resources shared across providers; maximization of billing for all types of treatment; resources and staffing used flexibly **8 9 10**

Processes

- Beginning to have all staff understand the processes of care and services in the practice is key to developing a common understanding and focus for improvement. Start with the high level process of a patient entering your practice by using the Patient Cycle Time tool. To get a sample, you can either assign someone to track all visits for a week, or encourage many people to contribute to the collection and completion of the cycle time tool worksheet for all visits in a week.
- Typically, other processes will be uncovered to measure and you can create time tracking worksheets like this template to measure other cycle times.

Medical Home Patient Cycle Time

Day: _____ **Date:** _____

Scheduled Appointment Time _____ **Provider you are Seeing Today** _____

Time	
	1. Time you checked in.
	2. Time you sat in the waiting room.
	3. Time staff came to get you.
	4. Time staff member left you in exam room.
	5. Time provider came in room.
	6. Time provider left the room.
	7. Time you left the exam room.
	8. Time you arrived at check out.
	9. Time you left practice.

Comments:

Processes

- Beginning to have all staff understand the processes of care and services in the practice is a key to developing a common understanding and focus for improvement. Start with the high level process of a patient entering your practice by using the Patient Cycle Time tool. You can assign someone to track all visits for a week to get a sample, or the cycle time tool can be initiated for all visits in a one week period with many people contributing to the collection and completion of this worksheet.
- Typically, other processes will be uncovered to measure and you can create time tracking worksheets like this template to measure other cycle times.

Medical Home Patient Cycle Time – Phone Contact

Day: _____ **Date:** _____

Scheduled Appointment Time _____ **Provider you are Seeing Today** _____

Time	
	1. Time you phoned your provider's office
	2. Time you received call back from provider's office.
	3. Arrival to scheduled appointment
	4. Time with receptionist
	5. Time in waiting room
	6. Time to exam room
	7. Time provider arrived in exam room
	8. Time provider left exam room
	9. Time to check out

Comments:

Processes

- Beginning to have all staff understand the processes of care and services in the practice is a key to developing a common understanding and focus for improvement. Start with the high level process of a patient entering your practice by using the Patient Cycle Time tool. You can assign someone to track all visits for a week to get a sample, or the cycle time tool can be initiated for all visits in a one week period with many people contributing to the collection and completion of this worksheet.
- Typically, other processes will be uncovered to measure and you can create time tracking worksheets like this template to measure other cycle times.

Medical Home Patient Cycle Time – Internet Contact

Day: _____ **Date:** _____

Scheduled Appointment Time _____ **Provider you are Seeing Today** _____

Time	
	1. Time you contacted provider office via internet
	2. Time you received communication back from office
	3.
	4.
	5.
	6.
	7.
	8.
	9.

Comments:

Processes

- Review, adapt and distribute the Core and Supporting Processes evaluation form to ALL practice staff. Be sure the list is accurate for your practice and then ask staff to evaluate the CURRENT state of these processes. Rate each process by putting a tally (x) mark under the heading, which most closely matches your understanding of the process. Also mark if the process is a source of patient complaints.

- Many practices will enlarge this survey, display on a staff wall and invite each role to rate the various processes using an assigned colored pen by role.

- Tally the results to give the Lead Team an idea as to where to begin to focus improvement from the staff perspective.

- **Steps for Improvement:** Explore improvements for each process based on the outcomes of this assessment tool. Each of the processes below should be flowcharted in its' current state. Once you have flowcharted the current state of your processes and determined your Change Ideas, use the PDSA Cycle Worksheet to run tests of change and to measure.

Position:_____

Medical Home Know Your Processes **Core and Supporting Processes**								
Processes	**Works Well**	**Not a Problem**	**Small Problem**	**Real Problem**	**Totally Broken**	**Cannot Rate**	**We're Working On It**	**Source of Patient Complaint**
Scheduling								
Appointment System • Appt. types • Scheduled with personal provider • Appt. availability monitored								
Written standards/process for patient access and patient communication about visit prep								
Data used by team to monitor standards and monitors patient access and communication								
Written scheduling procedures								
Written procedure for assignment of new patients to practice								
Pre Visit Planning								
Paper or electronic based charting tools that identify patient needs and organize clinical information								
Process in place to remind and prepare patients, providers and staff for patients visit.								
Written procedure and process for orientation of new patients to practice								
Process and monitoring program in place for pre-authorization of services when required								

Medical Home Know Your Processes Core and Supporting Processes (continued)								
Processes	**Works Well**	**Not a Problem**	**Small Problem**	**Real Problem**	**Totally Broken**	**Cannot Rate**	**We're Working On It**	**Source of Patient Complaint**
Check In								
Patient information includes • Standard demographics								
• Language needs								
• Social needs								
Visit								
Evidence based guidelines for three conditions adopted and implemented								
Data used to identify important diagnoses and conditions managed by practice								
Patient self-management support. Non physician staff assist in patient self-management								
Making referrals- Written procedure and monitoring in place								
Electronic prescription writer system and processes for prescribing and renewals								
Written procedure for ordering diagnostic testing. (order sets, standing orders)								
Prevention assessment and activities documented and reviewed with patients								
Education for patients | families new diagnosis.								
Barriers to learning assessed and documented.								
Palliative care management								
New patient work ups standardized and specific to patients' needs								
Post Visit								
Diagnostic testing and reporting • Abnormal test flagging								
• Patient notification process								
Billing and Coding written procedure and process in place								
Patient satisfaction monitored and data shared and evaluated for improvement								

Medical Home Know Your Processes
Core and Supporting Processes (continued)

Processes	Works Well	Not a Problem	Small Problem	Real Problem	Totally Broken	Cannot Rate	We're Working On It	Source of Patient Complaint
Between Visit								
Non physician staff roles optimized, implement and monitor care plan								
Post hospital, ER, urgent care discharge coordination to ensure follow up and care plan implementation and education								
Answering Phones • Nurse triage protocols								
• Documentation of phone encounters								
Messaging • Turnaround time for message returns established and monitored								
• Message handling procedure in place for clinical and non clinical staff.								
Systems and process performance measurements are established, reported and evaluated for improvement.								
Clinic monitors/measures clinical outcomes data and takes action to improve. (By provider/practice/disease state etc.)								

Processes

Introduction: This is a tool for the collection of data and information that we have found helpful in our reflection to prepare for improvement and transformation.

Assessment of Primary Care Resources and Supports for Chronic Disease Self-Management (PCRS) [1,2,3]

Background and User Guide

Purpose

This survey was developed by the Advancing Diabetes Self-Management (ADSM) Program of the Robert Wood Johnson Foundation *Diabetes Initiative*. The ADSM grantees wanted an instrument that would further delineate and facilitate assessment of the self- management component of the Chronic Care Model. The purpose of the PCRS is to help primary care settings focus on actions that can be taken to support self-management by patients with diabetes and/ or other chronic conditions. Specific goals are that it:

1. Function as a self-assessment, feedback and quality improvement tool
2. Characterize optimal performance of providers and systems as well as gaps in resources, services and supports
3. Promote discussion among patient care team members that can help build consensus for change and plans for improvement
4. Give teams a way to measure progress over time.

[1] http://diabetesinitiative.org/lessons/tools.html

[2] Brownson CA, Miller D, Crespo R, Neuner S, Thompson JC, Wall JC, Emont S, Fazzone P, Fisher EB, Glasgow RE. Development and Use of a Quality Improvement Tool to Assess Self-Management Support in Primary Care. *Joint Commission Journal on Quality and Patient Safety*. 2007 Jul;33(7):408-16.

[3]Shetty G, Brownson CA. Characteristics of Organizational Resources and Supports for Self Management in Primary Care. *The Diabetes Educator*. 2007 Jun;33(Suppl 6):185S-192S.

Assessment of Primary Care Resources and Supports for Chronic Disease Self Management (PCRS)

Who should use this tool?

This tool was developed for primary health care settings interested in improving self-management support systems and service delivery. It is to be used with multi-disciplinary teams (e.g. physicians, mid-level practitioners, nurses, educators, medical assistants, behavioral health specialists, social workers, dieticians, community health workers or others) that work together to manage patients' health care. We suggest that teams use it periodically (e.g., quarterly, semi-annually) as a way to monitor their progress and guide the integration of self-management supports into their system of health care.

Why another assessment tool?

The PCRS can be used along with other tools such as the Assessment of Chronic Illness Care (ACIC).[4] While it is consistent with and complementary to the ACIC, the PCRS focuses exclusively and more comprehensively on self-management support. Using the PCRS to initiate quality improvement processes should lead to improved patient and staff competence in self-management processes and improved behavioral and clinical outcomes among patients.

How is the PCRS organized?

This survey tool consists of 16 characteristics of self-management support that are separated into two categories: patient support and organizational support. (Definitions provided in the Appendix). Below the characteristic name are descriptions of four levels of performance from lowest (D) to highest (A).

- D is the lowest level; it is an indication of inadequate non-existent activity.
- C pertains to the patient-provider level. At this level, implementation is sporadic or inconsistent; patient-provider interaction is passive.
- B pertains to the team level. At this level, implementation is done in an organized and consistent manner using a team approach; services are coordinated.
- A is the highest level; it assumes the B level **plus** system-wide adoption and integration of that aspect of self-management support.

With the exception of level D, each level has three numbers from which to select. This allows team members to consider *to what degree* their team is meeting the criteria described for that level; that is, *how much* of the criteria and/ or *how consistently* their team meets this criteria.

[4] Bonomi AE, Wagner EH, Glasgow RE, VanKorff R. Assessment of chronic illness care (ACIC): a practical tool to measure quality improvement. *Health Services Research.* 2002 Jun;37(3):791-820.

Developed March 2006 by the *Diabetes Initiative* with support from the Robert Wood Johnson Foundation® in Princeton, New Jersey. Revised December 2008.

Assessment of Primary Care Resources and Supports for Chronic Disease Self Management (PCRS)

Completing the PCRS:

- Each member of the team fills out the assessment independently, reflecting a specified period of care delivery (e.g., last quarter) for a specific group of patients (e.g., those with specific condition, those seen by certain patient care teams, etc.).
- Using the 1 - 10 scale provided, respondents circle one numeric rating for each of the 16 characteristics.
- There are no right or wrong answers; scores are based on individuals' knowledge, experience and observation of how well the team is addressing the characteristic shown.
- When finished, team members may transfer their numeric answers onto the score sheet at the end of the survey. The score sheet can be returned to the person coordinating the assessment so scores can be compiled for team review and discussion.

Using the results:

- When all members have completed the tool, it is recommended that the team meet to share comments, insights and rationale for scores. To facilitate the discussion, the person coordinating the assessment may want to prepare a summary list of the results so that team members can easily see the range of scores on each item, the average score for each item or other helpful information. (Note: if the assessments are being filled out *during* a team meeting, results can be recorded in real time as part of the discussion.).
- Discussion should NOT be focused on "right" or "wrong", but rather *why* various ratings were given. The value of this tool is not in the number each member assigns, but in the improvement process that is initiated by discovery of discrepancies or gaps in capacity. Discrepancies in scores offer an important opportunity for discussion that can lead to improved communication and team function.
- Based on the discussion and consensus among members, teams may choose to develop quality improvement plans in one or more areas of self-management support.
- Using the PCRS periodically gives teams a way to measure the impact of their improvement processes and facilitates the integration of self-management supports into their system of care.

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Assessment of Primary Care Resources and Supports for Chronic Disease Self-Management (PCRS)
Individual Instructions for Completing the PCRS *

We are using this tool, the Assessment of Primary Care Resources and Supports for Chronic Disease Self-Management (PCRS), to help us monitor and improve our support for patient self-management. Although the survey can be answered regarding any of a number of chronic illness conditions, for today we would like you to **rate the care your team provides for your _____patients** only.

Each team member's perspective is unique and valuable. For this reason, please **complete the survey independently,** before discussing your ratings with other team members.

When considering your responses to each item, **use the previous ____ months** as the time frame.

Using the 1 - 10 scale in each row, **give one numeric rating** for each of the 16 characteristics. Please rate your patient care team on the extent to which it addresses each self-management characteristic for those patients specified above. (Definitions of characteristics are provided in the Appendix following the survey).In general, to warrant a rating in the highest category (8, 9 or 10), that characteristic of self-management support should be consistently and systematically integrated into care in a way that is sustainable.

There are no right or wrong answers. If you are unsure or do not know, please give your best guess, and make notes on the side (or in the comment section of the score sheet) regarding any thoughts or questions you have about that item.

Transfer your scores to the score sheet and return the score sheet (or a copy of it) to the person coordinating the assessment,_____(name), by_____(date). Please make sure you also complete the descriptive information in the box at the top of the page.

After all team members have completed their surveys individually, scores will be aggregated and the team will meet to discuss the results. Feel free to **bring your completed assessment to the meeting** for reference.

If you have any questions, need assistance or clarification, please contact_____ (name) at _____ (contact info). Thank you.

** The team leader or designated assessment coordinator should complete this form and distribute it with the PCRS to team members. The instructions may be tailored as appropriate for your setting.*

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Assessment of Primary Care Resources and Supports for Chronic Disease Self Management (PCRS)

To be filled in by the assessment coordinator:

Site/Location:_____ Team_____

Focus of assessment or patient population under consideration (e.g., those with specific condition, those seen by certain patient care teams):

_____ Time period under consideration:_____

To be completed by respondent: My role in team:_____ My profession: _____

PATIENT SUPPORT: (circle one NUMBER for each characteristic)

Characteristic	Quality Levels			
	D	**C**	**B**	**A (B plus these)**
1. Individualized Assessment of Patient's Self- Management Educational Needs	. . . is not done 1	. . . is not standardized and/or does not consistently include most self-management components* 2 3 4	. . . is standardized, fairly comprehensive and documented prior to initial goal setting; takes into account language, literacy and culture; assesses patient's self-management knowledge, behaviors, confidence, barriers, resources, and learning preferences. 5 6 7	. . . is an integral part of planned care for chronic disease patients; results are documented, systematically reassessed and utilized for planning with patients. 8 9 10
2. Patient Self-Management Education	. . . does not occur 1	. . . occurs sporadically or without tailoring to patient skills, culture, educational needs, learning styles or resources 2 3 4	. . . plan is developed with patient (and family, if appropriate) based on individualized assessment; is documented in patient chart; all team members generally reinforce same key messages 5 6 7	. . . is documented in patient charts; is an integral part of the care plan for patients which chronic diseases; involves family and community resources; is systematically evaluated for effectiveness 8 9 10

*e.g., for diabetes: physical activity, healthy eating, emotional health, medication management, monitoring, reducing risks and managing daily roles and activities

Assessment of Primary Care Resources and Supports for Chronic Disease Self Management (PCRS)

PATIENT SUPPORT: (circle one NUMBER for each characteristic) continued				
Characteristic	**Quality Levels**			
	D	**C**	**B**	**A (B plus these)**
3. Goal Setting/Action Planning	. . . is not done 1	…occurs but goals are established primarily by health care team rather than developed collaboratively with patients 2 3 4	…is done collaboratively with all patients/ families and member(s) of their health care team; goals are specific, documented and available to any team member; goals are reviewed and modified periodically 5 6 7	…is an integral part of care for patients with chronic diseases; goals are systematically reassessed and discussed with patients; progress is documented in patient charts 8 9 10
4. Problem-Solving Skills	. . . are not taught or practiced with patients 1	. . . are taught and practiced sporadically or used by only a few team members 2 3 4	. . . are routinely taught and practiced using evidence –based approaches and reinforced by members of the health care team 5 6 7	. . . is an integral part of care of people with chronic diseases; takes into account family, community and environmental factors; results are documented and routinely used for planning with patients. 8 9 10
5. Emotional Health	. . . is not assessed 1	. . . is not routinely assessed; screening and treatment protocols are not standardized or are nonexistent 2 3 4	. . . assessment is integrated into practice and pathways established for treatment and referral; patients are actively involved in goal setting and treatment choices; team members reinforce consistent goals 5 6 7	. . . systems are in place to assess, intervene, follow up and monitor patients' progress and coordinate among providers; standardized screening and treatment protocols are used 8 9 10

Assessment of Primary Care Resources and Supports for Chronic Disease Self Management (PCRS)

PATIENT SUPPORT: (circle one NUMBER for each characteristic) continued				
Characteristic	**Quality Levels**			
	D	**C**	**B**	**A (B plus these)**
6. Patient Involvement	. . . does not occur 1	. . . is passive; clinician or educator directs care with occasional patient input 2 3 4	. . . is central to decisions about self-management goals and treatment options; is encouraged by health care team and office staff 5 6 7	. . . is an integral part of the system of care; is explicit to patients; is accomplished through collaboration among patients and team members; takes into account environmental, family, work or community barriers and resources 8 9 10
7. Patient Social Support	. . . is not addressed 1	. . . is discussed in general terms, not based on an assessment of patient's individual needs or resources 2 3 4	. . . is encouraged through collaborative exploration of resources available to meet individual needs (e.g. significant others, education groups, support groups) 5 6 7	. . . systems are in place to assess needs, link patients with services and follow up on social support plans using household, community, or other resources 8 9 10
8. Linking to Community Resources	. . . does not occur 1	. . . is limited to a list or pamphlet of contact information for relevant resources 2 3 4	. . . occurs through a referral system; term discusses patient needs, barriers and resources before making referral 5 6 7	. . . systems are in place for coordinated referrals, referral follow-up and communication among practices, resource organizations and patients 8 9 10

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Assessment of Primary Care Resources and Supports for Chronic Disease Self Management (PCRS)

ORGANIZATIONAL SUPPORT: (circle one NUMBER for each characteristic)

Characteristic	Quality Levels			
	D	**C**	**B**	**A (B plus these)**
1. Continuity of Care	. . . does not exist 1	. . . is limited; some patients have an assigned primary care provider (PCP); planned visits and routine lab work occur sporadically 2 3 4	. . . is achieved through assignment of patients to a PCP or designated primary care team member, scheduling of routine planned visits with appropriate team members, and involvement of most team members in ensuring patients meet care guidelines 5 6 7	. . . systems are in place to support continuity of care, to assure all patients are assigned to a provider or team member, to schedule planned visits and to track and follow up on all patient visits and labs 8 9 10
2. Coordination of Referrals	. . . does not exist 1	. . . is sporadic, lacking systematic follow-up, review or incorporation into the patient's care plan 2 3 4	. . . occurs through team and office staff working together to document, track and review completed referrals and coordinate with specialists in adjusting the patient's care plan 5 6 7	. . . is accomplished by having systems in place to track incomplete referrals and follow up with patients and/or specialists to complete referrals 8 9 10
3. Ongoing Quality Improvement (QI)	. . . does not exist 1	. . . is possible because organized data are available, but practice has not initiated specific QI projects in this area 2 3 4	. . . is accomplished by a patient care team that uses data to identify trends and launches QI projects to achieve measurable goals 5 6 7	. . . uses a registry, electronic medical record or other system to routinely track key indicators of measurable outcomes; is done through a structured and standardized process with administrative support and accountability to management 8 9 10

Assessment of Primary Care Resources and Supports for Chronic Disease Self Management (PCRS)

ORGANIZATIONAL SUPPORT: (circle one NUMBER for each characteristic) continued				
Characteristic	**Quality Levels**			
	D	**C**	**B**	**A (B plus these)**
4. System for Documentation of Self-Management Support Services	. . . does not exist 1	. . . is incomplete or does not promote documentation (e.g., no forms in place) 2 3 4	. . . includes charting or documentation of care plan and self-management goals; is used by the team to guide patient care 5 6 7	. . . is an integral part of patient medical records; information is easily accessible to all team members and organized to see progression; charting or documentation includes care provided by all care team members and referral specialists 8 9 10
5. Patient Input	. . . does not occur 1	. . . mechanisms exist, but are not promoted; input solicited sporadically 2 3 4	. . . is solicited through focus group, surveys, suggestion boxes, or other means for both service and service delivery improvements under consideration; patients are made aware of mechanisms for input and invited or encouraged to participate 5 6 7	. . . is an essential part of management's decision-making process; systems are in place to ensure consumer input regarding practice policies and service delivery; there is evidence that management acts on information 8 9 10
6. Integration of Self-Management Support into Primary Care	. . . does not exist 1	. . . is limited to special projects or to select teams 2 3 4	. . . is routine throughout the practice; team members reinforce consistent strategies 5 6 7	. . . is built into the practice's strategic plan; is routinely monitored for quality improvement and visibly supported by leadership 8 9 10

Assessment of Primary Care Resources and Supports for Chronic Disease Self Management (PCRS)

ORGANIZATIONAL SUPPORT: (circle one NUMBER for each characteristic)				
Characteristic	**Quality Levels**			
	D	**C**	**B**	**A (B plus these)**
7. Patient Care Team (<u>internal</u> to the practice)	. . . does not exist 1	. . . exists but little cohesiveness among team members 2 3 4	. . . is well defined; each member has defined roles and responsibilities; there is good communication and cohesiveness among members; members are cross-trained have complementary skills 5 6 7	. . . is a concept embraced, supported and rewarded by the senior leadership; "teamness" is part of the system culture; case conferences or team reviews are regularly scheduled 8 9 10
8. Physician, Team and Staff Self-Management Education and Training	. . . does not occur 1	. . . occurs on a limited basis without routine follow-up or monitoring 2 3 4	. . . is provided for some team members using established and standardized curricula; practice assesses and monitors performance 5 6 7	. . . is supported and incentivized for all key team members; continuing education is routinely provided to maintain knowledge and skills; job descriptions reflect skills and orientation to self management 8 9 10

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Assessment of Primary Care Resources and Supports for Chronic Disease Self Management (PCRS)

Site/Location:_____ Team_____

Focus of assessment or patient population under consideration ():_____

My role in team:_____ My profession: _____ Date:_____

Summary Score Sheet

Please transfer the rating (1-10) that you gave each characteristic onto this sheet. The person who coordinated the assessment may ask for a copy of this sheet or your survey so that team results can be aggregated and presented for discussion at a team meeting.

I. Patient Support	**Score (number selected)**	**II. Organizational Support**	**Score (number selected)**
1. Individualized Assessment		1. Continuity of Care	
2. Self-Management Education.		2. Coordination of Referrals	
3. Goal Setting/Action Planning		3. Ongoing Quality Improvement	
4. Problem-Solving Skills		4. Systems for Documentation of SMS	
5. Emotional Health		5. Patient Input	
6. Patient Involvement		6. Integration of SMS into Primary Care	
7. Patient Social Support		7. Patient Care Team	
8. Link to Community Resources		8. Education and Training	
Total Score		**Total Score**	

Comments: (use reverse side if needed and/or write comments directly on the survey and provide a copy to the assessment coordinator:

Assessment of Primary Care Resources and Supports for Chronic Disease Self-Management (PCRS)

Appendix: Definitions of self-management support characteristics in the PCRS

PATIENT SUPPORT

1. **Individualized assessment of patient's self-management educational needs:** The process of determining patient-specific educational needs, barriers, skills, preferences, learning styles and resources for self-management.

2. **Self-management education:** An interactive, collaborative and ongoing process of providing information and instruction to support people's ability to successfully manage their health condition, their daily life activities, and the emotional changes that often accompany having a chronic condition.

3. **Collaborative goal setting:** The process of providers and patients working together on identifying something the patient wants to accomplish and agreeing on a plan for getting started. Well formulated goals are "SMART" (Specific, Measurable, Action-oriented, Realistic, and Time-limited).

4. **Problem solving skills:** Skills patients can learn and use to overcome barriers to healthy self-management. The process involves a series of steps: identifying the problem or barrier, identifying possible solutions, selecting and implementing the one that seems best, evaluating the results, and planning next steps accordingly.

5. **Emotional health:** Mental or emotional health generally refers to an individual's thoughts, feelings and moods. Good mental health is defined in the Surgeon General's report as "the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and cope with adversity." Difficult emotions, on the other hand, run the gamut from stress and anxiety to depression and psychopathology and can be a barrier to healthy self-management.

6. **Patient involvement in decision making:** Patient involvement means that patients—and their families—are involved in planning and making decisions about the patient's health care. In this approach, patients are viewed as key members of the health care team and have access to useful information to promote health and manage disease. Patient involvement implies shared decision making about care and ensuring that the patient's values guide all clinical decisions.

7. **Patient social support:** The assistance or help that is accessible to a patient through their social ties to others including family, friends, neighbors and peers. Social support can take many forms such as emotional support, tangible assistance, information or helpful feedback.

8. **Link to community resources:** Community resources include programs, services, and environmental features that support self- management behaviors. Programs and services that support self-management may be available through community agencies, schools, faith-based organizations or places of work. Examples of environmental supports include safe, accessible and affordable places for physical activity and for buying healthy foods.

Assessment of Primary Care Resources and Supports for Chronic Disease Self management (PCRS)

ORGANIZATIONAL SUPPORT

1. **Continuity of Care:** The coordination and smooth progression of a patient's care over time and across disciplines. Continuity of care is supported by systems that use a team approach to care, schedule planned visits and follow up on visits and lab work.

2. **Coordination of referrals:** Effective collaboration and communication among primary care providers and specialists. Coordination of referrals is supported by systems that track referrals, monitor incomplete referrals, and ensure follow-up with patients and/or the specialists to complete referrals.

3. **Ongoing Quality Improvement:** The process of using data on a regular basis to identify trends, undertake processes to improve aspects of service delivery, and measure the results. Patient care teams often use the Plan, Do, Study, Act (PDSA) rapid cycle improvement process to facilitate the improvement process.

4. **System for Documentation of Self-Management Support Services:** Standardized processes used by members of the patient care team to record patient self-management goals and progress notes into patient charts (or electronic medical records) and routinely monitor their progress.

5. **Patient Input:** The ideas, suggestions and feedback from patients about the services and quality of care provided by your team or health care setting. This occurs when there are systems or procedures in place to solicit input thought such mechanisms as focus groups, surveys, suggestion boxes, or patient advisory committees.

6. **Integration of Self-Management Support into Primary Care:** Integration occurs when self-management support is a fundamental and routine part of all chronic illness care.

7. **Patient Care Team:** A patient care team is a multidisciplinary group (e.g. physicians, mid-level practitioners, nurses, educators, medical assistants, behavioral health specialists, social workers, dieticians, community health workers or others) that works together to manage a patient's health care.

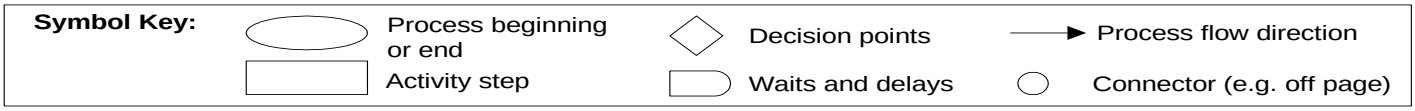
8. **Physician, Team and Staff Self-Management Education & Training:** Opportunities for members of the patient care team to increase their knowledge and improve skills and practices for improving self-management support. Health care systems can support continuing education and training by setting an expectation for excellence, offering training to all team members, ensuring that new team members have access to orientation and training, assessing and monitoring performance and providing incentives for the adoption of new practices and skills.

Developed March 2006 by the *Diabetes Initiative* with support from the Robert Wood Johnson Foundation® in Princeton, New Jersey. Revised December 2008.

Processes

- Deming has said, “If you can’t draw a picture of your process you can’t improve anything.” He is referring to the improvement tool of process mapping. With your interdisciplinary team, create a high level flow chart of the appointment process or the entire treatment experience. Start with just ONE flow chart. Eventually you will wish to create flowcharts for many different processes in-and-between your practice. Keep the symbols simple!
- Review the flowchart to identify unnecessary rework, delays and opportunities to streamline and improve.

Medical Home High Level Flowchart
Focus on a Process – “Messaging”



Patterns

- Patterns are present in our daily work and we may or may not be aware of them. Patterns can offer hints and clues to our work that inform us of possible improvement ideas. The Unplanned Activity Tracking Card is a tool you can ask staff to carry to track patterns of interruptions, waits and delays in the process of providing smooth and uninterrupted patient care. Start with any group in the staff. Give each staff member a card to carry during a shift, to mark each time an interruption occurs when direct patient care is delayed or interrupted. The tracking cards should then be tallied by each person and within each group to review possible process and system redesign opportunities. Noticing patterns of unplanned activities can alert staff to possible improvements.
- This collection tool can be adapted for any role in the Primary Care Practice to discover interruptions in work flow. Circles in the example indicate processes to further evaluate for possible improvements.

Medical Home Unplanned Activity Tracking Card

Unplanned Activity Tracking

Name: _____

Date: _____ Time: _____

Place a tally mark for each occurrence of an unplanned activity	Total
Interruptions	
• Phone	
• Secretary	
• RN	
• Provider	
Hospital Admissions	
Patient Phone Calls	
Pages	
Missing Equipment	
Missing Supplies	
Missing Chart: Same Day Patient	
Missing Chart: Patient	
Missing Test Results	
Other	

Unplanned Activity Tracking

Name: _____

Date: _____ Time: _____

Place a tally mark for each occurrence of an unplanned activity	Total
Interruptions	
• Phone 𝍸 𝍸 𝍸	(15)
• Secretary	
• RN 𝍸 𝍸	(10)
• Provider	
Hospital Admissions 𝍸 𝍸 II	(12)
Patient Phone Calls	
Pages 𝍸 𝍸 𝍸 𝍸	20
Missing Equipment	
Missing Supplies 𝍸	5
Missing Chart: Same Day Patient	
Missing Chart: Patient 𝍸 𝍸	(10)
Missing Test Results	
Other	

Patterns

- Patterns can be found through tracking the volumes and types of telephone calls. Review the categories on the telephone tracking list to ensure they reflect the general categories of calls your practice receives. Ask clerical staff to track the telephone calls over the course of a week to find the patterns of each type of call and the volume peaks and valleys.
- Put a tally mark each time one of the phone calls is for one of the listed categories. Total the calls for each day and then total the calls in each category for the week. Note the changes in volume by the day of the week and am/pm.

Medical Home Telephone Tracking Log															
Week of _____	**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**		**Saturday**		**Sunday**		**Week Total**
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	
Appointment for Today															
Total															
Appointment for Tomorrow															
Total															
Appointment for Future															
Total															
Test Results															
Total															
Nurse Care															
Total															
Prescription Refill															
Total															
Referral Information															
Total															
Need Information															
Total															
Message for Provider															
Total															
Talk with Provider															
Total															
DAY TOTAL															

Patterns

Nurse Triage Demand Tracking Log

This tracking log will assist you in understanding the nurse triage phone call volume, why patients are calling, and what actions the RNs are taking. These data can help identify opportunities to change processes and roles to support the RN to function in roles to support patient care. Put a tally mark each time one of the phone calls is for one of the listed categories. Total the calls for the day and then total for the week for each category. Note which days are "high volume" days and sessions, which are high volume. Monday, Tuesday, and Friday are typical high volume days in office Practices. See the next page for an example.

Week of	Phone Advice		Check with Provider for Advice		Message for Provider		Appointment for Today		Appointment for Tomorrow		Appointment for Future		Test Results		Prescription Refill		Referral Information		Other		Other		Total
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	
Monday																							
Total																							
Tuesday																							
Total																							
Wednesday																							
Total																							
Thursday																							
Total																							
Friday																							
Total																							
Saturday/ Sunday																							
Total																							
Weekly Total																							

Nurse Triage Demand Tracking Log

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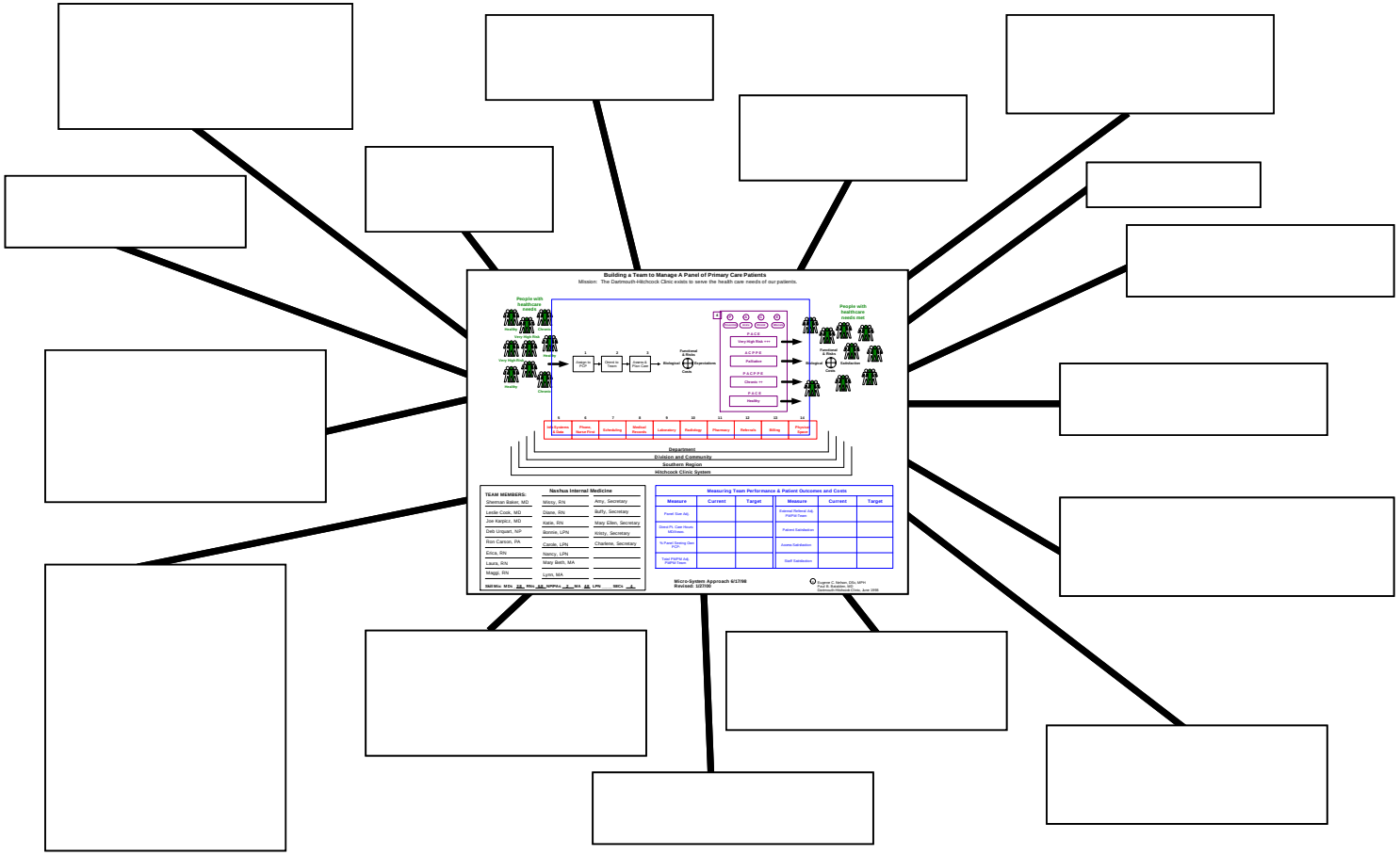
Week of	Phone Advice		Check with Provider for Advice		Message for Provider		Appointment for Today		Appointment for Tomorrow		Appointment for Future		Test Results		Prescription Refill		Referral Information		Other		Other		Total
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	
Monday	///// /////	///// ////	///// /////	////	///// ///// /////	///// ///// //	///// /////	///// //	///// /////	/////	///// //	/////	/////		/////	//	///// /	/////	///// /////	///// /	///// /////	/////	
Total	10	9	10	4	15	12	10	7	10	5	7	5	5		5	2	6	5	10	6	10	5	158
Tuesday	///// /	///// ///	///// /////	////	///// ///// /	///// /////	/////	/	///// /////	///// //	///// ///	/////	////		/////	////	/////	/	///// /////	///// ///	///// //	/////	
Total	6	8	10	4	11	10	5	1	10	7	8	5	4		5	4	5	1	10	8	7	5	134
Wednesday	///	///	///// /	///// //	/////	/////	///		/////	//	/////	//	/////	/	/////		///// /	/////	/////	/////	///// ////	/////	
Total	3	3	6	7	5	5	3		5	2	5	2	5	1	5		6	5	5	5	9	5	92
Thursday	///// ///	///// ////	///// ///// ///	////// ////// //////	///// ///	/////	///// /	/////	///// /////	///// /	/////	/////	/////	/////	/////	/	/////	///	///// /////	///// //	/////	/////	
Total	8	9	13	18	8	5	6	5	10	6	5	5	5	5	5	1	5	3	10	7	5	5	149
Friday	///// /////	///// ///// /////	///// ////		///// /////	///// /////	///// ///// /	///// /////	///// /////	///// /////	///// ///// //	///// /////	/////	//	///// /	/////	///// //	/////	///// /	/////	///// /////	///// ///	
Total	10	15	9		10	10	11	10	10	9	12	10	5	2	6	5	7	5	6	5	10	8	175
Saturday/ Sunday	////				///		//		/////	///	//				//		///		/////		/		
Total	4				3		2		5	3	2				2		3		5		1		30
Weekly Total	41	44	48	33	52	42	37	23	50	32	39	27	24	8	28	12	32	19	46	31	42	28	738

PATTERNS
External Mapping

External mapping is visual diagram of the systems that effect your patient population. The map provides a tool to look at which systems within your department and outside of your department impact our patients. They may include VNA, pharmacy, dietary, and others. They may have a big or small impact on the patient.

Exploring the external context of the clinical microsystem for improving the health of a given subpopulation of patients…



Place a bold line around the rectangle of the "most important contributors" to the improved health of the subpopulation. Illustrate the relationships with a blue line. Add an arrow head if the direction of the relationship is clear. If the relationship can be significantly improved, use red for the line.

Metrics That Matter

- Measures are essential for microsystems to make and sustain improvements and to attain high performance. All clinical microsystems are awash with data but relatively few have rich information environments that feature daily, weekly and monthly use of Metrics That Matter (MTM). The key to doing this is to get started in a practical, doable way; and to build out your Metrics That Matter and their vital use over time. Some guidelines for your consideration are listed below. Remember these are just guidelines and your microsystem should do what makes sense in the way of collecting, displaying and using Metrics That Matter.

Medical Home Metrics That Matter

1. **W**hat? Every microsystem has vital performance characteristics, things that must happen for successful operations. Metrics That Matter (MTMs) should reflect your microsystem's vital performance characteristics.

2. **W**hy? The reason to identify, measure and track MTMs is to ensure that you are not "flying blind." Safe, high quality and efficient performance will give you specific, balanced and timely metrics that show:
   a. When improvements are needed
   b. If improvements are successful
   c. If improvements are sustained over time, and
   d. The amount of variation in results over time

3. **H**ow? Here are steps you can make to take advantage of MTMs.

Lead Team

Work with your Lead Team to establish the need for metrics and their routine use.
Quality begins with the intention to achieve measured excellence.

Balanced Metrics

Build a balanced set of metrics to provide insight into what's working and what's not working.
Some categories to consider are: process flow, clinical, safety, patient perceptions, staff perceptions, operations, and finance/costs. Avoid starting with too many measures.
Every metric should have an operational definition, data owner, target value and action plan.
Strongly consider using the "national" JCAHO* and CMS* metrics whenever they are relevant to your microsystem. Consider other "vital" metrics based on your own experience, strategic initiatives and other "gold standard" sets such as measures from NQF* and professional organizations like ASTS*.

Data Owner

Start small and identify a data wall owner(s) who is guided by the Lead Team.
Identify a data owner(s) for each metric. The owner will be responsible for getting this measure and reporting it to the Lead Team. Seek sources of data from organization wide systems.
If the needed data is not available, use manual methods to measure. Strive to build data collection in the flow of daily work.

Data Wall Displays

Build a data wall and use it daily, weekly, monthly, and annually.
Gather data for each metric and display it on the "data wall" reporting:

- Current value
- Target Value
- Action Plan to improve or sustain level

Display metrics as soon as possible–daily, weekly, monthly metrics are most useful–using visual displays such as time trend charts and bar charts.

Review and Use

Review your set of metrics on a regular basis—daily, weekly, monthly, quarterly, annually.
Use metrics to make needed improvements whenever possible.
Make metrics fun, useful and a lively part of your microsystem development process. Discuss Metrics That Matter frequently and take action on them as needed.

* JCAHO, Joint Commission on Accreditation of Healthcare Organizations
CMS, Centers for Medicare and Medicaid Services
NQF, National Quality Foundation
ASTS, American Society of Thoracic Surgeons

Adapted from the original version, Dartmouth-Hitchcock, Version 2, February 2005, Medical Home Work Group Adapted June 2010, , Version 2 December 2011.

Metrics That Matter

- Review the currently determined "best metrics" your practice should be monitoring.
- Review NCQA Concepts/Standards to help determine areas of focus.
- List your current performance in these metrics and what the targets are.

Medical Home Metrics That Matter			
Name of Measure	**Definition & Data Owner**	**Current & Target Values**	**Action Plan & Process Owner**
General Metrics			
Access			
3rd Available Appointment ##			
Staff Morale			
Staff Satisfaction ##			
Voluntary Turn Over ##			
Work days lost per employee per year #			
Safety & Reliability			
Identification of high risk patient diagnosis & associated medications that put patient at risk, (e.g. Coumadin, Insulin) & related tests you must track.			
Patient Satisfaction			
Overall ##			
Access ##			
Finance			
Patient-Centered Outcome Measures *			
Assessment of Care for Chronic Conditions ##			
Visit www.doqit.org for Data Submission Process information			

# Denotes OSHA Safety Log measure
Denotes IHI Whole System Measures (2004)

Metrics That Matter

Medical Home Metrics That Matter			
Name of Measure	**Definition & Data Owner**	**Current & Target Values**	**Action Plan & Process Owner**
***Patient-Centered Outcome Measures* ***			
Coronary Artery Disease (CAD)			
Antiplatelet Therapy			
Lipid Profile Measured			
Drug Therapy for Lowering LDL Chol.			
LDL Cholesterol Control			
Beta-Blocker Therapy-Prior MI			
ACE Inhibitor Therapy			
Blood Pressure Control			
Heart Failure (HF)			
Left Ventricular Function (LVF) Assess.			
Left Ventricular Function (LVF) Testing			
Patient Education			
Beta-Blocker Therapy			
ACE Inhibitor Therapy			
Weight Measurement			
Blood Pressure Screening			
Warfarin Therapy for Pts with Atrial Fib			
Diabetes Mellitus (DM)			
HbA1c Measured			
Lipid Measurement			
HbA1c Management Control (HbA1C>9, <7)			
LDL Cholesterol Level			
Blood Pressure Control			
Urine Microalbumin Testing			
Eye Exam/Foot Exam			
Age Specific Preventive Care (PC)			
Influenza Vaccination			
Pneumonia Vaccination			
Blood Pressure Measurement			
Lipid Measurement			
LDL Cholesterol level			
Colorectal Cancer Screening			
Breast Cancer Screening			
Tobacco Use			
Tobacco Cessation			
Hypertension (HTN)			
Blood Pressure Control			
Plan of Care			

* Center for Medicare and Medicaid Services (CMS)
American Medical Association (AMA) Physician Consortium for Performance Improvement
National Diabetes Quality Improvement Alliance (Alliance)
National Committee for Quality Assurance (NCQA)
US Preventive Guidelines

Step 3 Diagnose

With the Interdisciplinary Lead Team review the 5Ps assessment, Metrics That Matter, and with consideration of your organizational strategic plan, select a first "theme," (e.g., access, safety, flow, reliability, patient satisfaction, staff morale, prevention, supply and demand) for improvement.

- The purpose of assessing is to make an informed and correct overall diagnosis of you microsystem.
- First, identify and celebrate the strengths of your system.
- Second, identify and consider opportunities to improve your system.
  - The opportunities to improve may come from your own microsystem—based on assessment, staff suggestions and/or patient and family needs and complaints.
  - The opportunities to improve may come from outside your microsystem—based on a strategic project or external performance/quality measures.
  - Look not only at the detail of each of the assessment tools, but also synthesize all of the assessments and Metrics That Matter to "get the big picture" of the microsystem. Identify linkages within the data and information. Consider:
    - Waste and delays in the process steps. Look for processes that might be redesigned to result in better functions for roles and better outcomes for patients.
    - Patterns of variation in the microsystem. Be mindful of smoothing the variations or matching resources with the variation in demand.
    - Patterns of outcomes you wish to improve.
- It is usually smart to pick or focus on one important "theme" to improve at a time, and work with all the "players" in your system to make a big improvement in the area selected.
- Suggestions on how to make your diagnosis and select a theme follow next.

Diagnose Your **Medical Home**

Write your Theme for Improvement

Overall Theme "Global" Aim Statement

Create an aim statement that will help keep your focus clear and your work productive:

We aim to improve: _____
(Name the process)

In: _____
(Clinical location in which process is embedded)

The process begins with: _____
(Name where the process begins)

The process ends with: _____
(Name the ending point of the process)

By working on the process, we expect: _____
(List benefits)

_____

_____

It is important to work on this now because: _____
(List imperatives)

_____

_____

_____

Step 4 Treat Your **Medical Home**

Draft a clear aim statement and way to measure the aim using improvement models—PDSA (Plan-Do-Study-Act) and SDSA (Standardize-Do-Study-Act).

- Now that you've made your diagnosis and selected a theme worthy of improving, you are ready to begin using powerful Change Ideas, improvement tools, and the scientific method to change your microsystem.
- This begins with making a specific aim and using Plan-Do-Study-Act (PDSA), which is known as the "model for improvement."
- After you have run your tests of change and have reached your measured aim, the challenge is to maintain the gains that you have made. This can be done using Standardize-Do-Study-Act (SDSA), which is the other half of making improvement that has "staying power."
- You will be smart to avoid totally reinventing the wheel by taking into consideration best known practices and Change Ideas that other clinical teams have found to really work. A list of some of the best "Change Ideas" that might be adapted and tested in your practice follows the aim statement worksheet.

Specific Aim Statement

Create a specific aim statement that will help keep your focus clear and your work productive.

We will ❑ improve ❑ increase ❑ decrease

The ❑ quality ❑ number/amount of ❑ percentage of:

_____

(process)

By:_____

(percentage)

OR

From:_____

(baseline/state/number/amount/percentage)

To/By:_____

(describe the change in quality or state the number/amount/percentage)

By:_____

(date)

Example: We will increase the number of patients who receive Flu vaccinations from 24% to 100! By May 1st.

Adapted from the original version, Dartmouth-Hitchcock Version 2, February 2005, Medical Home Work Group Adapted June 2010, Version 2 December 2011.

Treat Your **Medical Home**

- Once you have completed the assessment and diagnosis of your practice and have a clear theme to focus on, review current best practice and Change Ideas to consider.
- The Change Ideas will continue to develop as more field testing is done and more colleagues design improvements.

Medical Home Change Ideas to Consider:

You will find additional support and tools at the websites listed below

Change Ideas to Improve Access to Care http://www.clinicalmicrosystem.org/access.htm

1. Implement a patient recall system
2. Implement Advanced Access Scheduling
3. Offer telephone visits to appropriate, interested patients
4. Allow e-mail/secure messaging
5. Have follow up visits with team nurses, PharmD's, other primary care team members for guideline-based, protocol-driven care (i.e. HTN, depression, diabetes follow up)
6. Design group visits or Shared Medical Appointments http://www.clinicalmicrosystem.org/sma.htm

Change Ideas to Improve Interaction

7. Use nurses or health coaches to provide self-management coaching
8. Embed wellness/prevention into every encounter
9. Improve telephone system: avoid call backs, minimize triage, and measure dropped calls
10. Create a practice website
11. Improve the appearance of waiting rooms, corridors, and exam rooms

Change Ideas to Improve Quality, Safety, and Reliability

12. Use nursing to help manage care transitions (inpatient/outpatient)
13. Use a patient registry to track routine preventive and chronic illness care items
14. Implement panel management process.
15. Assign clerical staff to obtain all needed records and data in advance of patient visit
16. Assign nursing/clerical staff to coordinate care between primary care and specialty consultative services
17. Utilize clinical reminders
18. Track, measure, and report on quality measures
19. Embed medication reconciliation into every visit

Change Ideas to Improve Vitality

20. Train all staff in continuous improvement
21. Create a "data dashboard"
22. Create a microsystem website/SharePoint site
23. Utilize "daily huddle" process with MDs, RNs and clerical staff to review yesterday, plan for today, tomorrow and the coming week (pg28)

*visit www.ihi.org and www.clinicalmicrosystem.org for the latest ideas

Consider the Change Concepts on page 295 of The Improvement Guide by Langley, Nolan, Nolan, Norman and Provost (1996). The main change categories are listed below.

A. Eliminate Waste
B. Improve Workflow
C. Optimize Inventory
D. Change the Work Environment
E. Enhance the Producer/Customer Relationship
F. Manage Time
G. Manage Variation
H. Design Systems to Avoid Mistakes
I. Focus on the Product or Service

Langley G, Nolan K, Nolan T, Norman T, Provost L. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. 1st ed. The Jossey-Bass Business & Management Series. San Francisco, CA: Jossey-Bass Publishers; 1996: xxix, 370.

Huddle Sheet

- What can we proactively anticipate and plan for in our work day/week? At the beginning of the day, hold a review of the day, review of the coming week and review of the next week. Frequency of daily review is dependent on the situation, but a mid-day review is also helpful.
- This worksheet can be modified to add more detail to the content and purpose of the huddles.

Huddle Sheet

Practice: _____ Date: _____

Aim: Enable the practice to proactively anticipate and plan actions based on patient need and available resources, and contingency planning.

Follow-ups from Yesterday

"Heads up" for Today: (include special patient needs, sick calls, staff flexibility, contingency plans)

Meetings:

Review of Tomorrow and Proactive Planning

Meetings:

Plan-Do-Study-Act PDSA

Complete the Plan-Do-Study-Act worksheet to execute the Change Idea in a disciplined measured manner, to reach the specific aim.

***P**lan* → How shall we PLAN the pilot? Who? Does what? When? With what tools? What baseline data will be collected?

Tasks to be completed to run test of change	Who	When	Tools Needed	Measures

Do → What are we learning as we DO the pilot? What happened when we ran the test? Any problems encountered? Any surprises?

Study → As we study what happened, what have we learned? What do the measures show?

Act → As we ACT to hold the gains or abandon our pilot efforts, what needs to be done? Will we modify the change? Make a PLAN for the next cycle of change.

The Lead Team should continue to meet weekly to review progress in the design of the PDSA and then during the execution of the test of change in a pilot format to observe and learn about the Change Idea implementation. Remember to always test Change Ideas in small pilots to learn what adaptations and adjustments need to be made before implementing on a larger scale. Data collection and review during the testing is important to answer the question: How will we know if the Change Idea is an improvement?

Once the PDSA cycle is completed and the Lead Team reviews the data and qualitative findings, the plan should be revised or expanded to run another cycle of testing until the aim is achieved.

When the Change Idea has been tested and adapted to the context of the clinical microsystem and the data demonstrates that the Change Idea makes an improvement, the Lead Team should design the Standardize-Do-Study-Act (SDSA) process to ensure the process is performed as designed. During this process it is important to continually learn and improve by monitoring the steps and data to identify new opportunities for further improvement. You will realize you will move from “PDSA” to “SDSA” and back to “PDSA” in your continuous improvement environment. New methods, tools, technology or best practice will often signal the need to return to PDSA to achieve the next level of high performance. You want to be able to go from “PDSA” to “SDSA” and back to “PDSA” as needed. The Scientific method is a two-way street that uses both experimentation (i.e., PDSA) as well as standardization (i.e., SDSA).

Standardizing Current Best Process and Holding the Gains

Standardize-Do-Study-Act SDSA

Standardize the process (specify what roles do what activities in what sequence with what information flow). A good way to track and standardize process is through the creation of a Primary Care Practice Playbook. The Playbook is the collection of process maps to provide care and services that all staff are aware of and accountable for. The Playbook can be used to orient new staff, document current processes and contribute to performance appraisals.

Do the work to integrate the standard process into daily work routines to ensure reliability and repeatability.

Study at regular intervals. Consider if the process is being "adhered" to and what "adjustments" are being made. Review the process when new innovations, technology or roles are being considered. Review what the measures of the process are showing.

Act based on the above, maintain or "tweak" the standard process and continue doing this until the next "wave" of improvements/innovations takes place with a new series of PDSA cycles.

S*TANDARDIZE* → How shall we **STANDARDIZE** the process and embed it into daily practice? Who? Does what? When? With what tools? What needs to be "unlearned" to allow this new habit? What data will inform us if this is being standardized daily?

Tasks to be completed to run test of change	Who	When	Tools Needed	Measures
*Playbook-Create standard process map to be inserted in your Playbook.				

DO → What are we learning as we ***DO*** the standardization? Any problems encountered? Any surprises? Any new insights to lead to another PDSA cycle?

STUDY → As we ***STUDY*** the standardization, what have we learned? What do the measures show? Are there identified needs for change or new information or "tested" best practice to adapt?

ACT → As we ***ACT*** to hold the gains or modify the standardization efforts, what needs to be done? Will we modify the standardization? What is the Change Idea? Who will oversee the new PDSA? Design a new PDSA cycle. Make a PLAN for the next cycle of change. Go to PDSA Worksheet.

Step 5 Follow-Up

- Monitor the new patterns of results and select new themes for improvement.
- Embed new habits into daily work: daily huddles, weekly Lead Team meetings, monthly “town hall” meetings, data walls, and storyboards.

Follow-Up

Improvement in health care is a continuous journey.

The new patterns need to be monitored to ensure the improvements are sustained. Embedding new habits into daily work with the use of “huddles” to review and remind staff, as well as weekly Lead Team meetings keeps everyone focused on improvements and results that can lead to sustained and continuous improvements.

Data walls, storyboards and monthly all-staff meetings are methods to embed new habits and thinking for improvement.

The Lead Team should repeat the process for newly recognized themes and improvements that are identified in the assessment and Metrics That Matter.

Assessing Your Practice Discoveries and Actions		
Know Your Patients	**Discoveries**	**Actions Taken**
1. Age Distribution	1. 30% of our patients > 65 years old	1. Designated special group visits to review specific needs of this age group including physical limitations, dietary considerations.
2. Disease Identification	2. We do not know what percent our patients have diabetes.	2. Staff worked with IT to develop a report to identify all of their patients who had diabetes on their problem list.
3. Health Outcomes	3. We do not know what the range of HgA1C is for out patients with diabetes of if they are receiving appropriate ADA recommended care in a timely fashion.	3. Staff conducted a review of 50 electronic medical records during a lunch hour. Using a tool designed to track outcomes; each member of the staff reviewed 5 records and noted their findings on the audit tool.
4. Most Frequent Diagnosis	4. We learned we had a large number of patients with stable hypertension and diabetes, seeing the physician frequently. We also learned that during certain season we had huge volumes of acute diseases such as URI, Pharyngitis and poison ivy.	4. Designed and tested a new model of care delivery for stable hypertension and diabetes optimizing the RN role in the practice using agreed upon guidelines, protocols and tools.
5. Patient Satisfaction	5. We don't know what patients think unless they complain to us.	5. Implemented the "point of service" patient survey that patients completed and left in a box before leaving the practice.
Know Your Professionals	**Discoveries**	**Actions Taken**
1. Provider FTE	1. We were making assumptions about provider time in the clinic without really understanding how much time providers are OUT of the Clinic with hospital rounds, nursing home rounds, etc.	1. Changed our scheduling processes, utilized RNs to provide care for certain subpopulations.
2. Schedules	2. Several providers are gone at the same time every week, so one provider is often left and the entire staff works overtime that day.	2. Evaluated the scheduling template to even out each provider's time to provide consistent coverage of the clinic.
3. Regular Meetings	3. The doctors meet together every other week. The secretaries meet once a month.	3. Entire practice meeting every other week on Wednesdays.
4. Hours of Operation	4. The beginning and the end of the day are always chaotic. We realized we are on the route for patients between home and work and want to be seen when we are not open.	4. Opened one hour earlier and stayed open one house later each day. The heavy demand was managed better and overtime dropped.
5. Activity Surveys	5. All roles are not being used to their maximum. RNs only room patients and take vital signs, medical assistants doing a great deal of secretarial paperwork and some secretaries are giving out medical advice.	5. Roles have been redesigned and matched to individual education, training and licensure.
Know Your Processes	**Discoveries**	**Actions Taken**
1. Cycle Time	1. Patient lengths of visits vary a great deal. There are many delays.	1. The staff identified actions to eliminate, steps to combine, and learned to prepare the charts for the patient visit before the patient arrives. The staff also holds daily "huddles" to inform everyone on the plan of the day and any issues to consider throughout the day.
2. Key Supporting Processes	2. None of us could agree on how things get done in out practice.	2. Detailed flow charting of our practice to determine how to streamline and do in a consistent manner.
3. Indirect Patient Pulls	3. The providers are interrupted in their patient care process frequently. The number one reason is to retrieve missing equipment and supplies from the exam room.	3. The staff agreed on standardization of exam rooms and minimum inventory lists that were posted inside the cabinet doors. A process was also determined on WHO and HOW the exam rooms would be stocked regularly and through the use of an assignment sheet, a person was identified and held accountable.
Know Your Patterns	**Discoveries**	**Actions Taken**
1. Demand on the Practice	1. There are peaks and lows of the practice depending on day of the week, session of the day or season of the year.	1. Resources and role are matched to demand volumes. Schedules are created which match resources to variation.
2. Communication	2. We do not communicate in a timely way, nor do we have a standard form to communicate.	2. Every other week practice meeting to help communication and e-mail use of all staff to promote timely communication.
3. Cultural	3. The doctors don't really spend time with non-doctors.	3. The staff meetings heightened awareness of behaviors has helped improve this.
4. Outcomes	4. We really have not paid attention to our practice outcomes.	4. Began tracking and posting on a data wall to keep us alter to outcomes.
5. Finances	5. Only the doctors and the practice managers know about the practice money.	5. Finances are discussed at the staff meetings and everyone is learning how we make a difference in our financial performance.

Assessing Your Practice Discoveries and Actions		
Common High Yield Wastes	**Recommended Method to Reduce Waste**	**Traps to Avoid**
1. Exam rooms not stocked or standardized – missing supplies or equipment	- Create Standard Inventory supplies for all exam rooms. - Design process for regular stocking of exam rooms with accountable person - Standardize and utilize all exam rooms	- Don't assume rooms are being stocked regularly – track and measure. - Providers will only use "their own" rooms - Providers cannot agree on standard supplies; suggest "testing"
2. Too many appointment types which create chaos in scheduling	- Reduce appointment types to 2-4 - Utilize standard building block to create flexibility in schedule.	- Frozen schedules of certain types - Use one time (e.g. 10-15 minute "building blocks")
3. Poor communication amongst the providers and support staff about clinical sessions and patient needs.	- Conduct daily morning "huddles" to provide a forum to review the schedule, anticipate needs of patients, plan supplies/ information needed for a highly productive interaction between patient and provider.	- People not showing up for scheduled huddles. Gain support of providers who are interested, test ideas and measure results - Huddles last longer than 15 minutes, use a work sheet to guide huddle - Don't sit down
4. Missing information in patient record for patient visit.	- Review patient medical record BEFORE the patient arrives – recommended the day before to ensure information and test results are available to support the patient.	- Avoid doing record review when patient is present - If you have computerized test results, don't print the results
5. Confusing messaging system	- Standardize messaging processes for all providers - Educate/ train messaging content - Utilize a process with electronic prioritizing methods and alerts.	- Providers want their "own" way – adding to confusion to support staff and decreases ability for cross coverage - Content of message can't be agreed upon – test something
6. High prescription renewal request via phone.	- Anticipate patient needs - Create "reminder" systems in office, e.g. posters, screensavers - Standardize information, use patient portal	- Doesn't need to be the RN – Medical assistants can obtain this information
7. Staff frustrated in roles and unable to see new ways to function.	- Review current roles and functions using activity survey sheets - Match talent, education, training, licensure to function - Optimize every role - Eliminate functions	- Be sure to focus on talent, training and scope of practice not individual people.
8. Appointment schedules have limited same day appointment slots.	- Evaluate follow-up appointments and return visit necessity. - Extend intervals of standard follow-up visits - Consider RN visits - Evaluate the use of protocols and guidelines to provide advice for homecare- www.icsi.org - Consider phone care, Telemedicine	- Don't set a certain number of same day appointments without matching variations throughout the year.
9. Missed disease-specific/ preventive interventions and tracking.	- Utilize the flow sheets to track preventative activities and disease-specific interventions. - Run routine reports from EMR to monitor patient visits, results. - Review patient record before patient visits - Create registries to track subpopulation needs.	- Be alert to creating a system for multiple diseases and many registries.
10. Poor communication and interactions between members.	- Hold weekly staff meetings to review practice outcomes, staff concerns, improvement opportunities. - Education and Development	- Hold weekly meetings on a regular day, time and place - Do not cancel – make the meeting a new habit
11. High no-show rate	- Consider improving same day access - Reminder systems	- Automated reminder telephone calls are not always well received by patients
12. Patient expectations of visit not met, resulting in phone calls and repeat visits.	- CARE vital sign sheet- www.howsyourhealth.org - Evaluating patient at time of visit if their needs were met	- Use reminders and patient portal to question patient about needs being met - New habits not easily made.

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Today's Visit Experience of Care Survey

Team Instructions

- Conduct the Patient/Family Today's Visit Survey for 2 weeks if you currently DO NOT have a method to frequently monitor and use feedback about the experience of care.
- Choose from a menu of questions that interest your team and matter to your patients.
- If you have a method, be sure the data is up to date and reflects current state of your practice.
- Sample 50 patients over 2 weeks, random selection from daily schedule.

Clinicians reinforce to patient/family the value of their feedback to the team for improving their care experience.

Survey Question Sources:
Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Ambulatory Care Experiences Survey (ACES)
Primary Care Assessment Survey (PCAS)
Components of Primary Care Index (CPCI)
Patient Enablement Index (PEI)
Communication Assessment Tool (CAT)
www.Howsyourhealth.

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Today's Visit Survey - Experience of Care **Date**

Think about your visit to the office <u>today</u> and how you experienced the care that we provided. Your feedback about today is important to us so that we can continuously improve your experience.

Date: _____

1. I got this appointment as soon as I thought I needed it.
   ❑ Strongly Agree ❑ Agree ❑ Disagree ❑ Strongly Disagree

2. I saw the person today that I think of as my personal doctor or nurse.
   ❑ Strongly Agree ❑ Agree ❑ Disagree ❑ Strongly Disagree

3. Today's visit was well organized and I did not wait more than a few minutes in the waiting room or exam room to be seen.
   ❑ Strongly Agree ❑ Agree ❑ Disagree ❑ Strongly Disagree

4. The doctor spent enough time with me today to address my questions and concerns about my health.
   ❑ Strongly Agree ❑ Agree ❑ Disagree ❑ Strongly Disagree

5. I was given easy to understand instructions about what I can do to take better care of my health.
   ❑ Strongly Agree ❑ Agree ❑ Disagree ❑ Strongly Disagree

6. All staff was very friendly and as helpful as I thought they should be.
   ❑ Strongly Agree ❑ Agree ❑ Disagree ❑ Strongly Disagree

7. I got exactly the care I wanted and needed today, how I wanted and needed it.
   ❑ Strongly Agree ❑ Agree ❑ Disagree ❑ Strongly Disagree

8. I am confident that I can manage and control most of my health problems.
   ❑ Strongly Agree ❑ Agree ❑ Disagree ❑ Strongly Disagree

9. If I have any questions when I leave here today, I can get advice quickly if I need it by calling this office.
   ❑ Strongly Agree ❑ Agree ❑ Disagree ❑ Strongly Disagree

10. I was listened to today, taken seriously, and respected as a care partner.
    ❑ Strongly Agree ❑ Agree ❑ Disagree ❑ Strongly Disagree

11. I participated in decision making about my health concerns at the level I wanted to.
    ❑ Strongly Agree ❑ Agree ❑ Disagree ❑ Strongly Disagree

12. Things were explained to me fully and clearly today.
    ❑ Strongly Agree ❑ Agree ❑ Disagree ❑ Strongly Disagree

Is there anything else you would like to tell us about what we could have done to improve your care experience today?

Thank You For Helping Us Improve Your Care Experience