Patient's Medical Home Assessment

FOR YOUR PRACTICE

A facilitated, self-assessment tool to guide action planning for the Patient's Medical Home

PHASE 2

Team Based Care | Organized Evidence Based Care
Patient Centred Interactions | Enhanced Access | Care Coordination

[1] Adapted from: Safety Net Medical Home Initiative (2013)   Version 1.4

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Support – Contact Information

- Please contact your Primary Care Network (PCN) to identify local supports available to you (*e.g.* Practice Facilitator)
- Should your practice require further assistance with the **Patient's Medical Home Assessment** or for general inquiries about the Patient's Medical Home, please contact the Accelerating Change Transformation Team (ACTT):

Email: actt@albertadoctors.org	Phone: 780.488.4350

Get Electronic Copies of Resources & Tools

Visit the ACTT PMH Assessments web page to get copies of all the resources and tools for the **Patient's Medical Home Assessment for Practices.**

For more Patient's Medical Home resources and tools go to the ACTT PMH web page.

How to Complete the Patient's Medical Home Assessment Phase 2

Before you get started

Has your team completed Phase 1 of the Patient's Medical Home Assessment?

The Patient's Medical Home Assessment tool for Practices consists of 3 phases. A readiness assessment to be completed by a practice leader and phase 1 which focuses on the first 3 Patient's Medical Home concepts/elements – *i.e.* **(1) Engaged Leadership**, **(2) Capacity for Improvement** and **(3) Panel and Continuity**. Phase 1 <u>must</u> be completed before Phase 2. If your team has not completed Phase 1 speak with your Practice Facilitator.

Who should complete Phase 2 of the Patient's Medical Home Assessment?

Similar to phase 1, identify team members with different roles within your practice to complete the assessment. A typical assessment team will have 3-7 members. An Practice Facilitator will be available to support your team with the assessment process.

Do we complete it as a group or individually?

Also like phase 1 – Gather together as a group with your Practice Facilitator. First - complete the assessment as individuals. Next – work together to generate your team's consensus scores. The consensus conversation will help if there is uncertainty. See the scoring and interpretation section of <u>this</u> document for more information about the team consensus process – <u>click here</u>

What do the different levels represent?

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

Item	Level D	Level C	Level B	Level A
Activity or process	- Scores reflect absent or minimal implementation of the key change addressed by the item	- Scores suggest that the first stage of implementing a key change may be in place, but that important fundamental changes have yet to be made	- Basic elements of the key change have been implemented - Practice still has significant opportunities to make progress with regard to one or more important aspects of the change	- Most, or all, of the critical aspects of the change are addressed - Item is well established in the practice

What do the different numbers represent?

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

Refer to the <u>next question</u> to review an example outlining how the assessment levels and numbers are connected and how you should complete the assessment.

How do I complete the assessment?

1. For each question, or item, there are 4 responses labelled Level D to A. Read each response and select the one you think best represents your practice/clinic at this point in time.
2. Once you have selected the response, circle 1 of the 3 numbers below it. Remember - each level has 3 numbers. Circle a **higher number** to indicate that the action described in that level is done **more consistently** or a **lower number** to indicate the action is done **less consistently** in your practice.

NOTE: **Only one number should be circled per question/item**. If you're uncertain, select a lower number.

Example

For question 13:

-   I think the *"Patients are encouraged to see their paneled provider and practice team… … by the team, but it is not a priority in appointment scheduling."*
-   I think my practice does the above <u>very consistently</u>
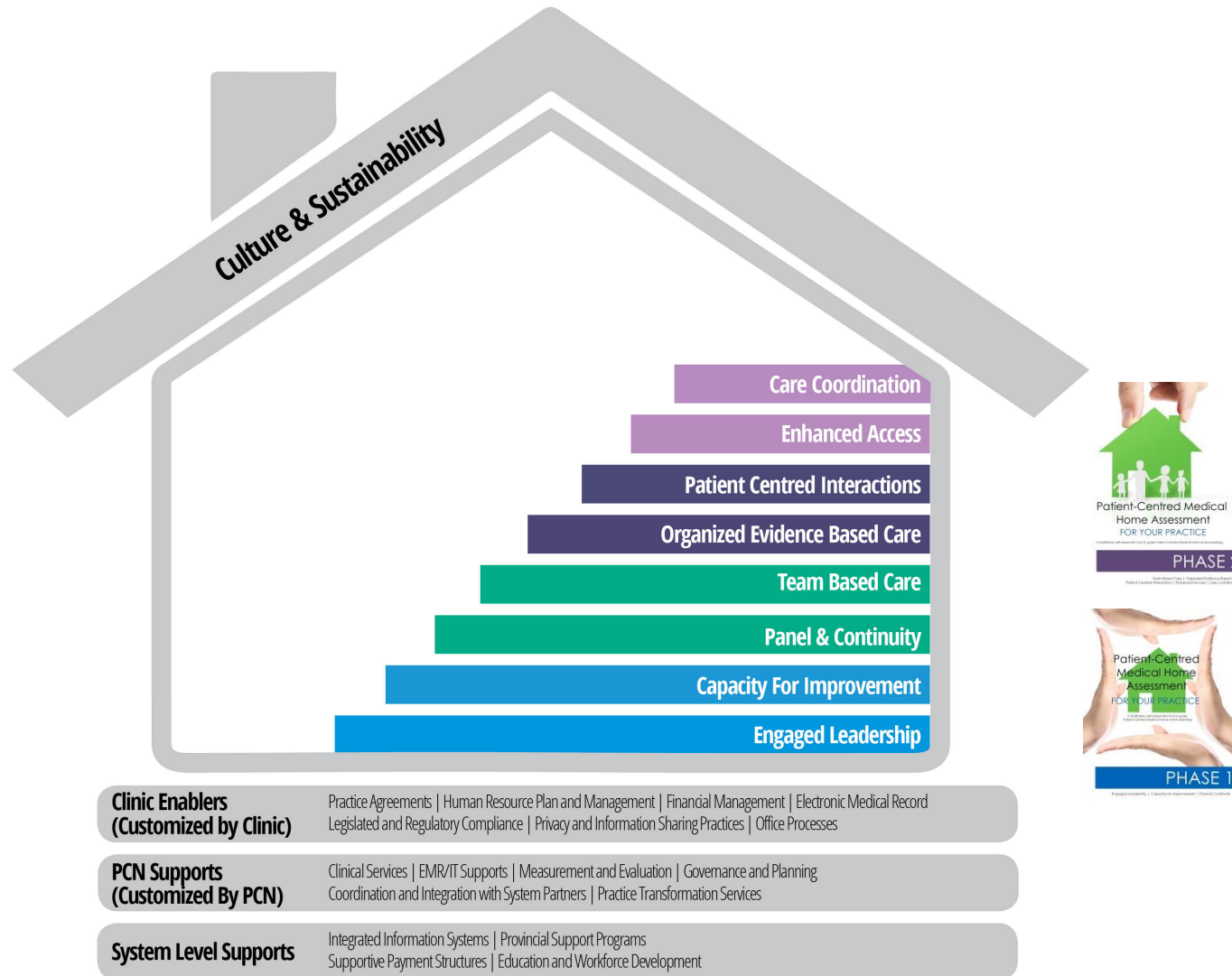-   Therefore, within Level C, I would circle the number 6

Item	Level D			Level C			Level B			Level A		
For example, 13. Patients are encouraged to see their paneled provider and practice team	… only at the patient's request.			… by the team, but it is not a priority in appointment scheduling.			… by the team and is a priority in appointment scheduling, but patients commonly see other providers because of limited availability.			… by the team, is a priority in appointment scheduling, and patients usually see their own provider or practice team.		
	1	2	3	4	5	(6)	7	8	9	10	11	12
I would describe the level of **CONSISTENCY** with which my practice does the action/process described above at this point in time as…	Low	Moderate	High	Low	Moderate	High	Low	Moderate	High	Low	Moderate	High

TIPS: Consider where your practice is on its Patient's Medical Home journey

-   Answer each question as honestly and accurately as possible
-   There is no advantage to overestimating item scores, and doing so may make it harder for change to be apparent when the assessment is repeated in the future
-   It is typical for teams to begin their improvement journey with average scores below "5" for some (or all) areas
-   It is also common for teams to initially believe they are providing more patient centred care than they actually are
-   Over time, as your understanding of patient centred care increases and you continue to implement effective practice changes, you should see your assessment scores change

Patient's Medical Home Assessment – Phase 2

Phase 2 of the assessment focuses on the remaining 5 implementation elements for the Patient's Medical Home – *i.e.* **(4) Team Based Care**, **(5) Organized Evidence Based Care**, **(6) Patient Centered Interactions**, **(7) Enhanced Access** and **(8) Care Coordination.**

Culture & Sustainability

Care Coordination
Enhanced Access
Patient Centred Interactions
Organized Evidence Based Care
Team Based Care
Panel & Continuity
Capacity For Improvement
Engaged Leadership

Clinic Enablers (Customized by Clinic) — Practice Agreements | Human Resource Plan and Management | Financial Management | Electronic Medical Record Legislated and Regulatory Compliance | Privacy and Information Sharing Practices | Office Processes

PCN Supports (Customized By PCN) — Clinical Services | EMR/IT Supports | Measurement and Evaluation | Governance and Planning Coordination and Integration with System Partners | Practice Transformation Services

System Level Supports — Integrated Information Systems | Provincial Support Programs Supportive Payment Structures | Education and Workforce Development

Adapted from Safety Net Medical Home Initiative (2013)

Part 4: TEAM BASED CARE

Practices with well established Patient's Medical Home processes tend to:

- Establish and provide organizational support for care delivery teams accountable for the patient population/panel
- Link patients to a provider and care team so both patients and provider/care team recognize each other as partners in care
- Ensure that patients are able to see their provider or care team whenever possible
- Define roles and distribute tasks among team members to reflect the skills, abilities, and credentials of each person

Items	Level D			Level C			Level B			Level A		
13. Patients are encouraged to see their paneled provider and practice team	... only at the patient's request.			... by the team, but it is not a priority in appointment scheduling.			... by the team and is a priority in appointment scheduling, but patients commonly see other providers because of limited availability.			... by the team, is a priority in appointment scheduling, and patients usually see their own provider or practice team.		
	1	2	3	4	5	6	7	8	9	10	11	12
14. Multi-disciplinary practice team members	... play a limited role in providing clinical care.			... are primarily tasked with managing patient flow and triage.			... provide some clinical services such as self-assessment or self-management support.			... perform comprehensive clinical care service roles to the full scope of their abilities and credentials.		
	1	2	3	4	5	6	7	8	9	10	11	12
15. The multi-disciplinary team member profile (scope, skills and roles/responsibilities)	... is not developed.			... has not been reviewed based on the appropriateness for the panel population.			... has been amended to more closely meet the needs of the panel population.			... has been specifically selected to meet the needs of the panel population.		
	1	2	3	4	5	6	7	8	9	10	11	12

16. The practice training needs of providers and other staff	... is not identified or met.			... is routinely assessed to ensure that staff are appropriately trained for their roles and responsibilities.			... is routinely assessed to ensure that staff are appropriately trained for their roles and responsibilities, with some cross training to permit staffing flexibility.			... is routinely assessed to ensure that staff are appropriately trained for their roles and responsibilities, with some cross training to ensure that patient needs are consistently met.		
	1	2	3	4	5	6	7	8	9	10	11	12
17. Team standard practices for documentation, communication and handoffs	... are not developed.			... exist for specific disease conditions that have been prioritized.			... exist for general care services.			... are broadly implemented, continuously reviewed and improved.		
	1	2	3	4	5	6	7	8	9	10	11	12

PART 5: ORGANIZED EVIDENCE BASED CARE

Practices with well established Patient's Medical Home processes tend to:

- Use planned care according to patient need
- Identify high risk patients and ensure they are receiving appropriate care case management services
- Use point-of-care reminders based on clinical guidelines
- Enable planned interactions with patients by making up-to-date information available to providers and the care team at the time of the visit

Items	Level D			Level C			Level B			Level A		
18. Comprehensive guideline based information on prevention or chronic disease management	... is not readily available in practice.			... is available but does not influence care.			... is available to the team and is integrated into care protocols and/or reminders.			... guides the creation of tailored, individual-level data that is available at the time of the visit.		
	1	2	3	4	5	6	7	8	9	10	11	12
19. Visits	... largely focus on acute problems of patient.			... are organized around acute problems but with attention to ongoing illness and prevention needs if time permits.			... are organized around acute problems but with attention to ongoing illness and prevention needs if time permits. The practice uses sub-population reports to proactively call patient groups in for planned care visits.			... are organized to address both acute and planned care needs. Tailored guideline-based information is used in team huddles (virtually or face-to-face) to ensure all outstanding patient needs are met at each encounter.		
	1	2	3	4	5	6	7	8	9	10	11	12

20. Care plans for patients within the panel with chronic needs	... are not routinely developed or recorded.			... are developed and recorded but reflect providers' priorities only.			... are developed collaboratively with patients and families and include self-management and clinical goals, but they are not routinely recorded or used to guide subsequent care.			... are developed collaboratively, owned by the patient, include self-management and clinical management goals, are routinely recorded, and guide care at every subsequent point of service.		
	1	2	3	4	5	6	7	8	9	10	11	12
21. Registries for specific disease or high-risk patients	... do not exist.			... can be produced, though with no strategy to manage or care plan based on the registry.			... are produced, maintained and assigned to someone within the clinic to manage.			... are produced, maintained, with comprehensive team approach to care planning and pro-active care delivery for these populations.		
	1	2	3	4	5	6	7	8	9	10	11	12
22. Management of problem lists, medication list and medication reconciliation	... are not routinely developed or recorded.			... are routinely developed and recorded but reflect only providers' priorities.			... are routinely developed and managed in a standard way across the practice for selected priorities.			... are routinely reviewed by and managed across the practice for all patients.		
	1	2	3	4	5	6	7	8	9	10	11	12

PART 6: PATIENT CENTERED INTERACTIONS

Practices with well established Patient's Medical Home processes tend to:

- Respect patient and family values and expressed needs
- Encourage patients to expand their role in decision-making, health-related behaviors and self-management
- Communicate with their patients in a culturally appropriate manner, in a language and at a level that the patient understands
- Provide self-management support at every visit through goal setting and action planning
- Obtain feedback from patients/family about their healthcare experience and use this information for quality improvement

Items	Level D			Level C			Level B			Level A		
23. Assessing patient and family values and preferences	… is not done.			… is done, but not used in planning and organizing care.			… is done and providers incorporate it in planning and organizing care on an informal basis.			… is systematically done and incorporated in planning and organizing care.		
	1	2	3	4	5	6	7	8	9	10	11	12
24. Involving patients in decision-making and care	… is not a priority.			… is accomplished by provision of patient education materials or referrals to classes.			… is supported and documented by practice teams.			… is systematically supported at the patient care and service delivery level by practice teams trained in patient engagement.		
	1	2	3	4	5	6	7	8	9	10	11	12
25. Patient comprehension of verbal and written materials	… is not assessed.			… is assessed and accomplished by ensuring that materials are at a level and language that patients understand.			… is assessed and accomplished by ensuring that both materials and communications are at a level and language that patients understand.			… are coordinated to offer translation services and training staff in effective communication techniques (such as closing the loop) ensuring that patients know what to do to manage conditions at home.		
	1	2	3	4	5	6	7	8	9	10	11	12

26. Self-management support	... is limited to the distribution of information (*e.g.* pamphlets, booklets).			... is accomplished by referral to self-management classes or educators.			... is provided by goal setting and action planning with members of the practice team.			... is provided by members of the practice team trained in patient empowerment, and problem-solving methodologies.		
	1	2	3	4	5	6	7	8	9	10	11	12
27. The principles of patient-centered care	... are included in the clinic's vision and mission statement.			... meet all the criteria in Level D <u>and</u> are a key practice priority and included in training and orientation.			... meet all the criteria in Level C <u>and</u> are explicit in job descriptions and performance metrics for all staff.			... meet all the criteria in Level B <u>and</u> are consistently used to guide practice level changes and measure system performance as well as care interactions at the practice level.		
	1	2	3	4	5	6	7	8	9	10	11	12
28. Advanced care planning	... is not done.			... is done but not routinely.			... is done routinely by some physicians and/or team members.			... is done routinely across the practice.		
	1	2	3	4	5	6	7	8	9	10	11	12

PART 7: ENHANCED ACCESS

Practices with well established Patient's Medical Home processes tend to:

- Promote and expand access by ensuring that established patients have 24/7 continuous access to their care team via phone, email or in-person visits
- Provide scheduling options that are patient and family centered and accessible to all patients

Items	Level D			Level C			Level B			Level A		
29. Appointment systems	... are limited and waiting times (*e.g.* Third Next Available Appointment measure -TTNA) for appointments are not monitored.			... provide some flexibility in scheduling different visit lengths and wait times (TTNA) are monitored.			... provide flexibility and include capacity for same day visits and wait times (TTNA) are monitored.			... are monitored for TTNA, supply and demand , are flexible and can accommodate customized visit lengths, same day visits, scheduled follow-up, and multiple provider visits.		
	1	2	3	4	5	6	7	8	9	10	11	12
30. Contacting the practice team during regular business hours	... is limited to direct phone or walk in contact during office hours.			... relies on the practice's ability to respond to telephone messages.			... is accomplished by staff responding by telephone within the same day.			... is accomplished by providing a patient a choice between email and phone interaction, utilizing systems which are monitored for timeliness.		
	1	2	3	4	5	6	7	8	9	10	11	12
31. After-hours access	... is not available or limited to an answering machine.			... is available but without a standardized communication protocol back to the practice for urgent problems.			... is provided by coverage arrangement that shares necessary patient data and provides a summary to the practice.			... is available via the patient's choice of email, phone or in-person directly from the practice team or a provider closely in contact with the team and patient information.		
	1	2	3	4	5	6	7	8	9	10	11	12

Continue on next page...

32. A patient's access to a multi-disciplinary team	... is through a provider referral only to services outside of the Medical Home.			... is through a provider referral only to services within the Medical Home.			... is available through patient self-referral outside or within the Medical Home.			... is available through patient self-referral and includes information continuity to primary provider within the Medical Home.		
	1	2	3	4	5	6	7	8	9	10	11	12

PART 8: CARE COORDINATION

Practices with well established Patient's Medical Home processes tend to:

- Link patients with community resources to facilitate referrals and respond to social service needs
- Integrate behavioral health and specialty care into care delivery through co-location or referral protocols
- Track and support patients when they obtain services outside the practice
- Follow-up with patients within a few days of an emergency room visit or hospital discharge
- Communicate test results and care plans to patients/families

Items	Level D			Level C			Level B			Level A		
33. Referral processes to specialty services	... are done but not followed up.			... are done and followed up to ensure a patient is scheduled for needed service.			... are followed up to ensure patients are scheduled and there is a reliable process to receive the information/results from at least one specialty programs.			... are followed up to ensure patients are scheduled and there is a reliable process to receive the information/results from most specialty programs.		
	1	2	3	4	5	6	7	8	9	10	11	12
34. Behavioral health services, such as social services and mental health supports	... are difficult to obtain reliably.			... are available from mental health specialists but are neither timely nor convenient.			... are available from community specialists and are generally timely and convenient.			... are readily available from behavior health specialists who are on-site members of the care team or who work in a community organization with which the practice has a referral protocol or agreement.		
	1	2	3	4	5	6	7	8	9	10	11	12

35. Patients in need of specialty care, hospital care, or supportive community-based resources	... cannot reliably obtain needed referrals to Primary Care Network (PCN) or Alberta Health Services (AHS) and community programs with which the practice has a relationship.			... obtain needed referrals to PCN/AHS and community programs with which the practice has a relationship.			... obtain needed referrals to PCN/AHS and community programs with which the practice has a relationship, relevant information is communicated in advance.			... obtain needed referrals to PCN/AHS and community programs with which the practice has a relationship and relevant information is communicated in advance, and timely follow-up after the visit occurs, with flow of information back to the practice.		
	1	2	3	4	5	6	7	8	9	10	11	12
36. Follow-up by the primary care practice with patients seen in the emergency room (ER) or hospital	... generally does not occur because the information is not available to the primary care team.			... occurs only if the ER or hospital alerts the primary care practice.			... occurs because the primary care practice makes proactive efforts to identify patients.			... is done routinely because the primary care practice has arrangements in place with the ER and hospital to both track these patients and ensure that follow-up is completed within a few days.		
	1	2	3	4	5	6	7	8	9	10	11	12
37. Linking patients to supportive community-based resources	... is not done systematically			... is limited to providing patients a list of identified community resources in an accessible format.			... is accomplished through a designated staff person or resource responsible for connecting patients with community resources.			... is accomplished through active coordination between the health system, community service agencies and patients and accomplished by a community service planning group and implemented by a designated staff person.		
	1	2	3	4	5	6	7	8	9	10	11	12

Continue on next page…

38. Test results and care plans	... are not communicated to patients.			... are communicated to patients based on an ad hoc approach.			... are systematically communicated to patients for positive results in a way that is convenient to the practice.			... are systematically communicated to patients for positive and negative results in a variety of ways that are convenient to patients, including patient portals to their own information.		
	1	2	3	4	5	6	7	8	9	10	11	12

Scoring & Interpreting the Patient's Medical Home Assessment –Phase 2

Facilitating the <u>Team</u> Consensus Scores

- Once individual team members have completed the assessment meet as a group with your Practice Facilitator to discuss your scores
- Your **Practice Facilitator will help the team produce a consensus score for each question**
- **We discourage practices from merely averaging the scores to get a consensus score;** the discussion is a good opportunity to share information and build a common understanding of your priorities
- Once the group has generated a consensus score for each question your Practice Facilitator will help you with interpreting your results

Interpreting the <u>Team</u> Consensus Scores

- **If less than eight rows scored a '5' or above in Phase 2**, work with your Practice Facilitator to complete the **Patient's Medical Home Action Plan** for Phase 2. Also, speak with your Practice Facilitator about other supports available to your team for building relationships, changing care delivery and reducing barriers to care.
- **If eight rows or more scored at '5' or above**, congratulations! You have worked hard to build these routines into your practice, and are obviously committed to continuous quality improvement. Please use the **Patient's Medical Home Action Plan** to plan your next area of focus
- See Appendix C for additional ways to summarize your team's consensus scores

Appendix A – The Implementation Elements for the Patient's Medical Home

The Patient's Medical Home (PMH) is where a patient has an ongoing relationship with a physician and team, and all of their health care needs are coordinated. For primary care practices the PMH offers a team based approach to organize and deliver quality patient centred care. To support this work the following practical, evidence based implementation elements can be used to guide practice teams in their PMH transformations. These elements are complementary to the 10 pillars for the PMH developed by the College of Family Physicians of Canada (CFPC) and put forth in the PCN Evolution vision and framework.

Implementation Elements for the Patient's Medical Home
A practical, evidence based approach for clinic teams

Culture & Sustainability

- Care Coordination
- Enhanced Access
- Patient Centred Interactions
- Organized Evidence Based Care
- Team Based Care
- Panel & Continuity
- Capacity For Improvement
- Engaged Leadership

Clinic Enablers (Customized by Clinic)
Practice Agreements | Human Resource Plan and Management | Financial Management | Electronic Medical Record
Legislated and Regulatory Compliance | Privacy and Information Sharing Practices | Office Processes

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Coordination and Integration with System Partners | Practice Transformation Services

System Level Supports
Integrated Information Systems | Provincial Support Programs
Supportive Payment Structures | Education and Workforce Development

Adapted from Safety Net Medical Home Initiative (2013)

Appendix B – Terms, Definitions & Acronyms

Click here to access terms, definitions and acronyms (provided by PCN Evolution).

Learn more about **PCN Evolution**:

actt@albertadoctors.org

780-488-4350

Appendix C – Calculating Team Consensus Score Averages

Once you and your facilitator have generated your team's consensus scores (per question) and determined next steps (see the Interpreting the Team Consensus Scores section above) you may choose to summarize your scores in other ways. For example, practice leaders and teams may find averaging consensus scores for each section of the assessment or generating an overall consensus score average for phase 2 useful. An application for these averages could be to assess your team's progress over time.

 Please consider the following when calculating your team's average consensus scores:

Generating an Average Consensus Score for each Section of the Patient's Medical Home Assessment

1. Add up your team's consensus scores for the section of interest
2. THEN divide your answer by the total number of questions in that section
3. Round your team's consensus score to the nearest whole number

For example:

1. Add up your team's consensus scores:

   $6 + 8 + 5 + 7 = 26$

2. Divide your answer by the number of questions in the section

   26/4 questions = 6.5

3. Your team's average consensus score for the enhanced access section is **7**

Record Your Team's Average Consensus Scores For Each Section Of The Assessment

BUILDING RELATIONSHIPS (Part 4)

TEAM BASED CARE	

CHANGING CARE DELIVERY (Parts 5 & 6)

ORGANIZED EVIDENCE BASED CARE	
PATIENT CENTERED INTERACTIONS	

REDUCING BARRIERS TO CARE (Parts 7 & 8)

ENHANCED ACCESS	
CARE COORDINATION	

Generating an Overall Average Consensus Score for Phase 2 of the Patient's Medical Home Assessment

1. Add up ALL your team's consensus scores (you should have 26 numbers)
2. THEN divide your answer by 26 (the total number of questions in Phase 2)
3. Round your team's overall consensus score to the nearest whole number

Use the example provided in the previous section for guidance if needed.

Record Your Team's OVERALL Average Consensus Score For Phase 2 Of The Assessment

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