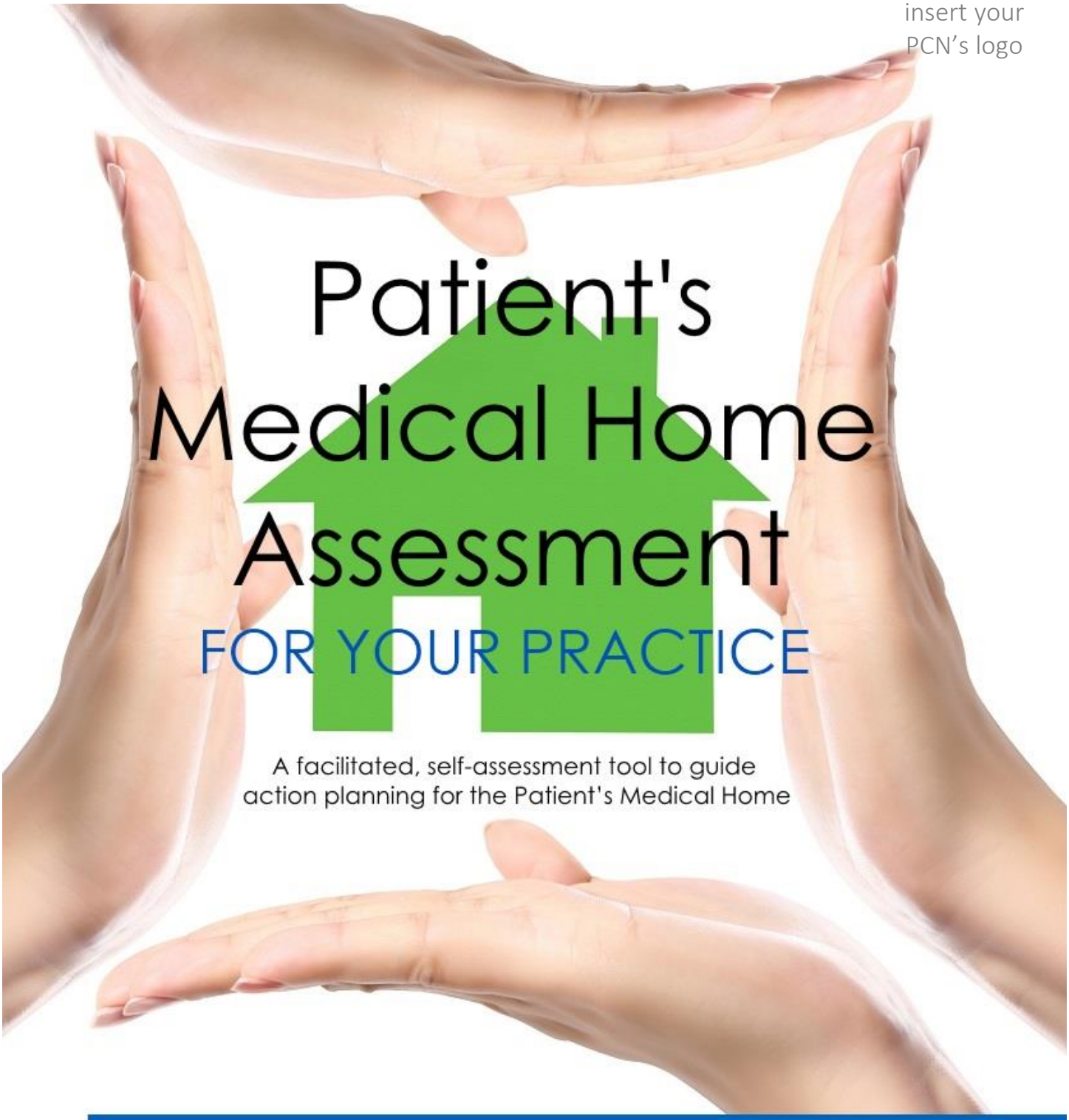
Contact ACTT to insert your PCN's logo



Patient's Medical Home Assessment

FOR YOUR PRACTICE

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

PHASE 1

Engaged Leadership | Capacity for Improvement | Panel & Continuity

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

Table of Contents

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 1

Before you get started

Who should complete it?

Identify team members with different roles within your practice to complete the assessment. A typical assessment team will have 3-7 members. A Practice Facilitator will be available to support your team with the assessment process.

Do we complete it as a group or individually?

Gather together with your Practice Facilitator. First – each team member should complete the assessment on their own. 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 this document for more information about the team consensus process – click here

What do the different levels in the assessment questions represent?

The responses to each question, or item, are categorized into levels D through A (as outlined below). The levels represent the degree to which a 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 in the assessment questions represent?

Each level has 3 numbers. This is how you will score the assessment. Circling a **higher number** within a level 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 next question 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 1:

- I think the *"my practice clinical leaders … have developed a vision for quality improvement, but no consistent process for getting there."*
- I think my practice does the above very consistently
- Therefore, within Level C, I would circle the number 6

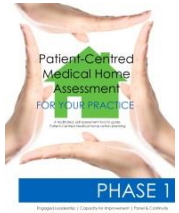
Item	Level D			Level C			Level B			Level A		
For example, 1. Our practice's clinical leaders	… intermittently focus on improving quality.			… have developed a vision for quality improvement, but no consistent process for getting there.			… are committed to a quality improvement process and sometimes engage teams in implementation and problem solving.			… consistently champion and engage clinical teams in improving patient experience of care and clinical outcomes.		
	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 at 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 1

Phase 1 of the assessment focuses on the first 3 implementation elements for the Patient's Medical Home – *i.e.* **(1) Engaged Leadership, (2) Capacity for Improvement** and **(3) Panel and Continuity**



Adapted from Safety Net Medical Home Initiative (2013)

Part 1: ENGAGED LEADERSHIP FOR THE PRACTICE

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

- Provide visible and sustained leadership to enable a cultural change as well as support specific strategies that will improve quality and spread change
- Ensure that the Patient's Medical Home transformation effort has the time and resources needed to be successful
- Ensure that providers and other care team members have protected time to conduct activities beyond direct patient care that are consistent with the Patient's Medical Home model
- Build the practice's values on creating a Patient's Medical Home for patients into staff hiring and training processes

Items	Level D	Level C	Level B	Level A
1. Our practice's clinical leaders	... intermittently focus on improving quality. 1 2 3	... have developed a vision for quality improvement, but no consistent process for getting there. 4 5 6	... are committed to a quality improvement process and sometimes engage teams in implementation and problem solving. 7 8 9	... consistently champion and engage clinical teams in improving patient experience of care and clinical outcomes. 10 11 12
2. The clinic's hiring and training processes	... focus on the specific defined functions and requirements of each position. 1 2 3	... meet all the criteria in Level D and reflect how potential hires will affect the culture and participate in quality improvement activities. 4 5 6	... meet all the criteria in Level C and place a priority on the ability of new and existing staff to improve care and create a patient centered culture. 7 8 9	... meet all the criteria in Level B and support and sustain improvements in care through hiring, training and incentives focused on rewarding patient centered care. 10 11 12
3. The responsibility for conducting quality improvement (QI) activities	... is not assigned by leadership to any specific group. 1 2 3	... is assigned to a group without committed resources. 4 5 6	... is assigned to an organized quality improvement group who receive dedicated resources. 7 8 9	... is shared by all staff, from leadership to team members and is made explicit through protected time to meet and specific resources to engage in QI. 10 11 12
4. Our practice leaders	... are not linked to specific areas of priority. 1 2 3	... are linked to specific areas of priority but without clear mandates or accountability. 4 5 6	... have clear mandates for priority areas. 7 8 9	... have clear mandates and supports as well as accountability related to their roles. 10 11 12

PART 2: QUALITY IMPROVEMENT (QI)

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

- Establish and monitor metrics to assess improvement efforts and outcomes; ensure all staff members understand the metrics for success
- Optimize use of health information technology to provide proactive patient care
- Ensure that patients, families, providers, and care team members are involved in quality improvement (QI) activities
- Choose and use QI models and tools, such as PDSA cycles, process mapping, etc…

Items	Level D	Level C	Level B	Level A
5. Quality improvement (QI)activities undertaken in our clinic	… are not organized or supported consistently. 1 2 3	… are conducted on an informal basis in reaction to specific problems identified by specific staff members. 4 5 6	… are based on a proven improvement strategy in reaction to specific problems identified by patients or by specific staff members. 7 8 9	… are based on a proven improvement strategy and used continuously in meeting goals for our clinic through input from patients and staff. 10 11 12
6. Our clinic's performance measures	… are not collected, monitored or available to support change. 1 2 3	… are available, but are limited to one type of data (*e.g.* specific clinical element). 4 5 6	… are comprehensive - including clinical, operational and patient experience measures and are available for the practice, but not for individual providers. 7 8 9	… are comprehensive - including clinical, operational and patient experience measures - and are fed back to individual providers. 10 11 12
7. Our quality improvement (QI)activities are conducted by	… a centralized group or committee. 1 2 3	… topic specific QI groups or committees. 4 5 6	… all practice team members as part of our practice's culture of continuous QI. 7 8 9	… all practice team members, with patient and family involvement, as part of our practice's culture of continuous QI. 10 11 12
8. An electronic medical record (EMR) that supports pro-active patient care	… is not present or is being implemented. 1 2 3	… is in place and is being used to capture clinical data. 4 5 6	… is used routinely during patient encounters to provide clinical decision support and to share data with patients. 7 8 9	… meets all the criteria in Level B and is also used routinely to support population management and quality improvement efforts. 10 11 12

PART 3: PANEL & CONTINUITY

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

- Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis
- Assess practice supply and demand and balance patient load accordingly
- Use panel data and registries to proactively contact, educate and track patients by disease status, risk status, self-management status and community and family need

Items	Level D	Level C	Level B	Level A
9. Patients	... are not assigned to specific practice panels. 1 2 3	... are assigned to specific practice panels but panel assignments are not routinely maintained for accuracy or used for administrative or other purposes. 4 5 6	... are assigned to specific practice panels and panel assignments are maintained for accuracy and routinely used by the practice mainly for scheduling purposes. 7 8 9	... are assigned to specific practice panels, maintained for accuracy, and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply, demand and continuity. 10 11 12
10. Registry or panel level data	... are not available to assess or manage care for practice populations. 1 2 3	... are available to assess and manage care for practice populations, but only on an informal basis. 4 5 6	... are regularly available to assess and manage care for practice populations, but only for a limited number of diseases and risk states. 7 8 9	... are regularly available to assess and manage care for practice populations, across a comprehensive set of diseases and risk states. 10 11 12
11. Registries on individual patients	... are not available to practice teams for pre-visit planning or patient outreach. 1 2 3	... are available to practice teams but are not routinely used for pre-visit planning or patient outreach. 4 5 6	... are available to practice teams and routinely used for pre-visit planning or patient outreach, but only for a limited number of diseases and risk states. 7 8 9	... are available to practice teams and routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases and risk states. 10 11 12

Continue on the next page…

12. Reports on care processes or outcomes of care	... are not routinely available to practice teams.			... are routinely provided as feedback to practice teams but not reported externally.			... are routinely provided as feedback to practice teams and reported externally (*e.g.* to patients, other teams or external agencies) but with team identities masked.			... are routinely provided as feedback to practice teams and anonymous summaries are transparently reported externally to patients, other teams and healthcare groups such as Alberta Health Services (AHS).		
	1	2	3	4	5	6	7	8	9	10	11	12

Scoring & Interpreting the Patient's Medical Home Assessment -Phase 1

Facilitating the Team Consensus Scores

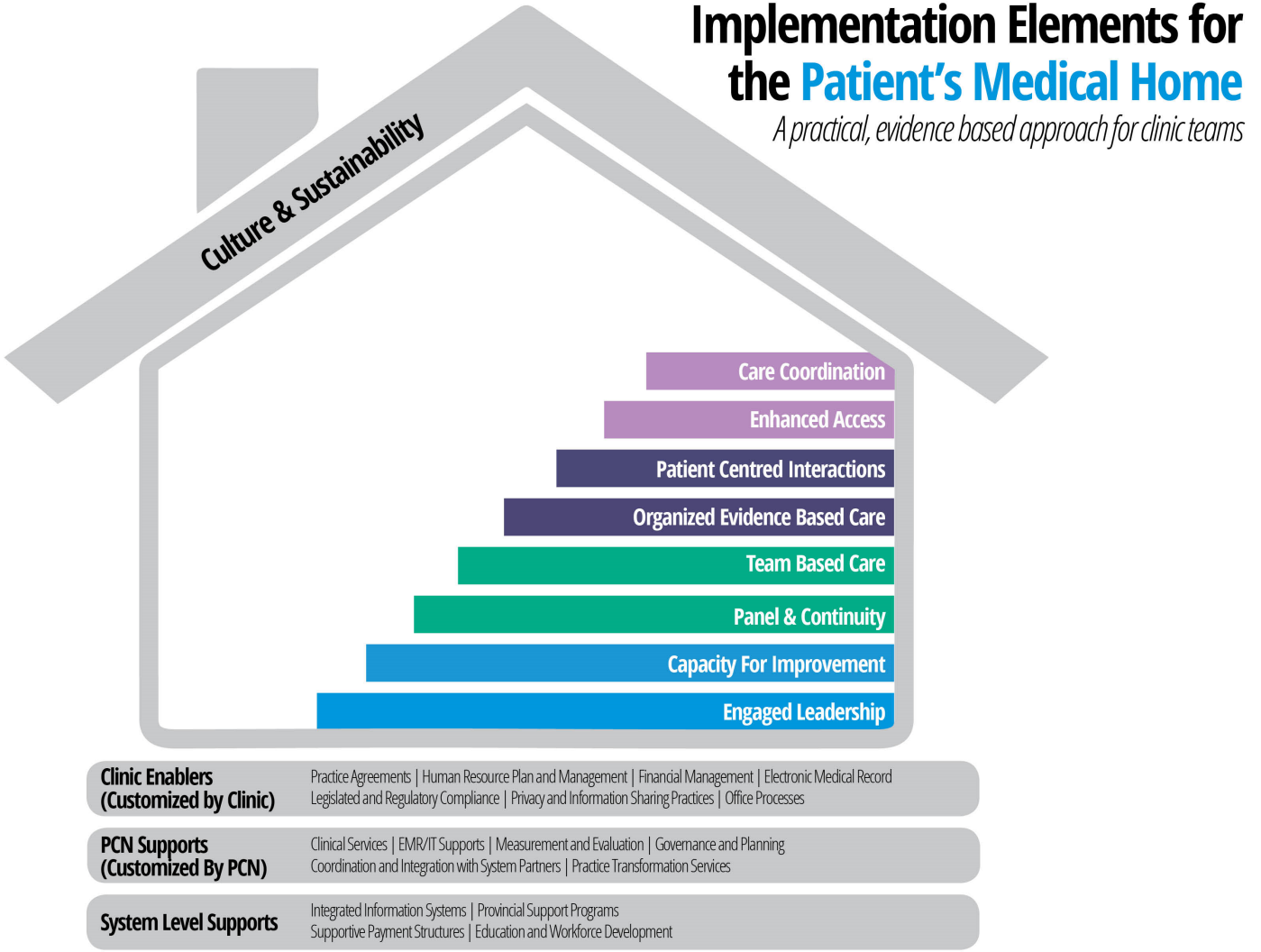
- Once individual team members have completed the assessment, meet as a group with your Practice Facilitator to discuss your scores
- Your Practice Facilitator will help the team produce a consensus score for each question
- We discourage practices from merely averaging the scores to get a consensus 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 Team Consensus Scores

- If less than eight rows scored a '5' or above in Phase 1, work with your Practice Facilitator to complete the **Patient's Medical Home Action Plan** for Phase 1. This tool will help your team prioritize areas for improvement. Also, speak with your Practice Facilitator about other supports available to your team for leadership, quality improvement and panel/continuity improvements
- If eight rows or more scored at '5' or above, then please continue to the **Patient's Medical Home Assessment – Phase 2** - repeat the process of having each individual complete his/her assessment first, then discuss the results through a facilitated discussion for the final team consensus scores
- 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.



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 1 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:

Part 1: ENGAGED LEADERSHIP FOR THE PRACTICE

Practices with well established Patient-Centred Medical Home processes tend to:

- Provide visible and sustained leadership to enable a cultural change as well as support specific strategies that will improve quality and spread change
- Ensure that the Patient-Centred Medical Home transformation effort has the time and resources needed to be successful
- Ensure that providers and other care team members have protected time to conduct activities beyond direct patient care that are consistent with the Patient-Centred Medical Home model
- Build the practice's values on creating a Patient-Centred Medical Home for patients into staff hiring and training processes

Items	Level D		Level C			Level B			Level A		
1. Our practice's clinical leaders	... intermittently focus on improving quality.		... have developed a vision for quality improvement, but no consistent process for getting there.			... are committed to a quality improvement process and sometimes engage teams in implementation and problem solving.			... consistently champion and engage clinical teams in improving patient experience of care and clinical outcomes.		
	1	2	3	4	5	**6**	7	8	9	10	11	12
2. The clinic's hiring and training processes	... focus on the specific defined functions and requirements of each position.			... meet all the criteria in Level D and reflect how potential hires will affect the culture and participate in quality improvement activities.			... meet all the criteria in Level C and place a priority on the ability of new and existing staff to improve care and create a patient centered culture.			... meet all the criteria in Level B and support and sustain improvements in care through hiring, training and incentives focused on rewarding patient-centered care.		
	1	2	3	4	5	6	7	**8**	9	10	11	12
3. The responsibility for conducting quality improvement (QI) activities	... is not assigned by leadership to any specific group.			... is assigned to a group without committed resources.			... is assigned to an organized quality improvement group who receive dedicated resources.			... is shared by all staff, from leadership to team members and is made explicit through protected time to meet and specific resources to engage in QI.		
	1	2	3	4	**5**	6	7	8	9	10	11	12
4. Our practice leaders	... are not linked to specific areas of priority.			... are linked to specific areas of priority but without clear mandates or accountability.			... have clear mandates for priority areas.			... have clear mandates and supports as well as accountability related to their roles.		
	1	2	3	4	5	6	**7**	8	9	10	11	12

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 engaged leadership section is **7**

Date of Assessment: _____

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

LAYING THE FOUNDATION (Parts 1 & 2)

ENGAGED LEADERSHIP	
QUALITY IMPROVEMENT (QI)	

BUILDING RELATIONSHIPS (Part 3)

PANEL & CONTINUITY	

Generating an Overall Average Consensus Score for Phase 1 of the Patient's Medical Home Assessment

1. Add up ALL your team's consensus scores (you should have 12 numbers)
2. THEN divide your answer by 12 (the total number of questions in Phase 1)
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.

Date of Assessment: _____

Record Your Team's OVERALL Average Consensus Score For Phase 1 Of The Assessment

[1] Adapted from: Safety Net Medical Home Initiative. The Patient-Centered Medical Home Assessment Version 3.1. Seattle,WA: The MacColl Center for Health Care Innovation at Group Health Research Institute and Qualis Health; May 2013