BUILDING BLOCKS OF PRIMARY CARE ASSESSMENT FOR TRANSFORMING TEACHING PRACTICES (BBPCA-TTP)

DIRECTIONS FOR COMPLETING THE SURVEY

This survey is designed to assess the organizational change of a primary care teaching practice as measured against the 10+3 Building Blocks of High Performing Academic Primary Care. The instrument is a modification of the Patient-Centered Medical Home Assessment Tool (PCMH-A), developed by the MacColl Center for Health Care Innovation (see below). The BBPCA-TTP incorporates some of the original items from the PCMH-A, reorganized into the framework of the 10+3 Building Blocks, and it includes a number of supplemental questions to examine areas not addressed by the PCMH-A.

1. **Answer each question from the perspective of one physical site (e.g., a practice, clinic).**

2. **For each row, mark the number that best corresponds to the level of care that is currently provided at your site. The rows in this form present key aspects of patient-centered care. Each aspect is divided into levels showing various stages in development toward a patient-centered medical home. The stages are represented by points that range from 1 to 12. The higher point values indicate that the actions described in that box are more fully implemented.**

3. **The BBPCA-TTF is designed to be complete in a group. The discussions engendered by these questions are as important as the final score. We recommend assembling a team of 4-6 people that include management, front line staff, and a patient advocate. Provide the instrument to group members in advance and encourage them to fill it out based on their experience and perspective. Then use the meeting time to discuss areas of discrepancy, particularly in cases where stakeholders provide scores in different Levels (A, B, C, or D).**

ACKNOWLEDGEMENT: This survey is derived from a public version of The Patient Centered Medical Home Assessment created for use in the Safety Net Medical Home Initiative by the MacColl Center for Health Care Innovation at Group Health Cooperative of Puget Sound. For additional information, please visit http://www.safetynetmedicalhome.org/

Background questions

1. Confirm the name of your organization:

Please provide name of your site:

2. How many people from your organization are participating in this assessment? ____

3. Which roles from your organization are participating in this assessment? (select all that apply)

- ❑1 Organization Medical Director
- ❑2 Organization Administrative Director
- ❑3 Organization Nursing Leader
- ❑7 Organization Quality Improvement Leader
- ❑4 Clinic Medical Director
- ❑6 Clinic Administrative Director
- ❑8 Clinic Provider
- ❑9 Clinic Nursing Staff (RN, LVN, MA)
- ❑10 Clinic Front Office Staff
- ❑5 Patient
- ❑18 Other: ____________________

4. Has your organization received PCMH recognition?

- ❑1 Yes, we have received PCMH recognition across all sites
- ❑2 Yes, we have received PCMH recognition at some sites
- ❑3 No, but we plan to pursue PCMH recognition
- ❑4 No, we do not plan to pursue PCMH recognition

----→ 5. If so, what is the highest level PCMH recognition achieved and from which organization?

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Block 1: Engaged leadership

Components	Level D	Level C	Level B	Level A
a. Executive leaders of the health system	…are focused on short-term business priorities.	…visibly support and create an infrastructure for quality improvement, but do not commit resources.	…allocate resources and actively reward quality improvement initiatives.	…support continuous learning throughout the organization, review and act upon quality data, involve patients in decisions, and have a long-term strategy and funding commitment to spread quality improvement initiatives.
Score	1 2 3	4 5 6	7 8 9	10 11 12
b. 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.
Score	1 2 3	4 5 6	7 8 9	10 11 12
c. Residency and clinic directors	…are poorly integrated, resulting in competition for priorities and resources between clinic and other components of the residency program.	…meet regularly to align goals, but their efforts are often stymied by decisions of higher-up leaders.	…work closely and have some authority to ensure that resident physicians can prioritize clinic sessions.	…work closely and have been given full authority to ensure that residents can prioritize clinic sessions.
Score	1 2 3	4 5 6	7 8 9	10 11 12
d. Goals and objectives for quality improvement	…do not exist.	…exist on paper, but are not widely known.	…are known by staff, but are only occasionally discussed in meetings.	…are the centerpiece of multi-disciplinary meetings aimed at developing strategies to meet objectives.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Block 2: Data-driven improvement using computer-based technology

Components	Level D	Level C	Level B	Level A
a. Performance measures	…are not available for the clinical site.	…are available for the clinical site, but are limited in scope and not shared with clinicians, residents, or staff.	…are comprehensive – including clinical, operational, and patient experience measures – and available for the practice, but not for individual clinicians or residents.	…are comprehensive – including clinical, operational, patient experience, and resident performance measures – and fed back to individual clinicians and residents.
Score	1 2 3	4 5 6	7 8 9	10 11 12
b. Registry or panel-level data	…are not accessible in a useful or timely way.	…are available to assess and manage care for practice populations, but only for a limited number of diseases.	…are regularly available and routinely used by practice teams for pre-visit planning and patient outreach across a moderate set of diseases.	…are regularly available, routinely used, and easily adjusted by practice teams for pre-visit planning and patient outreach across a comprehensive set of diseases and risk states.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Block 3: Empanelment

Components	Level D	Level C	Level B	Level A
a. Patients	…are not assigned to specific practice panels and residents do not have designated panels.	…are assigned to specific practice panels, including residents, but panel assignments are not routinely used to measure and improve continuity of care.	…are assigned to specific practice panels, including residents, and panel assignments are routinely used to measure and improve continuity of care and for scheduling purposes.	…are assigned to specific practice panels, including residents, and panel assignments are routinely used to measure and improve continuity of care for scheduling purposes. Panels are continuously monitored and/or risk stratified to balance supply and demand.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Components	Level D	Level C	Level B	Level A
b. When resident physicians graduate	…their patients are not actively reassigned until the patient seeks care.	…their patients are reassigned, but do not receive any communication about the change. Receiving clinicians must read past notes to understand the patient's history and pending issues.	…their patients are reassigned and receive communication alerting them to their new provider; however, only ad hoc communication exists between transitioning residents about pending issues.	…their patients are reassigned and receive communication about their new provider, and there is active handoff of pending issues between transitioning providers.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Block 4: Team-based care

Components	Level D	Level C	Level B	Level A
a. Non-physician practice team members	…play a limited role in providing clinical care.	…are primarily tasked with managing patient flow and triaging phone calls.	…provide some clinical services such as assessment or self-management support.	…perform key clinical service roles that match their abilities and credentials.
Score	1 2 3	4 5 6	7 8 9	10 11 12
b. Clinicians (Faculty Physicians, Resident physicians, NP/PAs) and clinical support staff	…work in different pairings every day.	…are arranged in teams but are frequently reassigned.	…consistently work with a small group of clinicians or clinical support staff in a team.	…consistently work with the same clinician/clinical support staff person almost every day.
Score	1 2 3	4 5 6	7 8 9	10 11 12
c. Standing orders that can be acted on by non-physicians under protocol	…do not exist for the practice.	…have been developed for a few conditions but are not regularly used.	…have been developed for some conditions and are regularly used.	…have been developed for many conditions and are used extensively.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Block 5: Patient-team partnership

Components	Level D	Level C	Level B	Level A
a. Patient comprehension of verbal and written materials	…is not assessed.	…is assessed and accomplished by assuring that materials are at a level and language that patients understand.	…is assessed and accomplished by hiring multi-lingual staff, and assuring that both materials and communications are at a level and language that patients understand.	…is supported at an organizational level by translation services, hiring multi-lingual staff, and training staff in health literacy and communication techniques assuring that patients know what to do to manage conditions at home.
Score	1 2 3	4 5 6	7 8 9	10 11 12
b. Comprehensive, guideline-based information on prevention or chronic illness treatment	…is available, but it is not integrated into the EHR in a meaningful way.	…is available, but it is integrated into the EHR in a way that results in excessive reminders such that the practice team ignores them.	…is available and integrated into the EHR, and it results in a useful number of timely recommendations.	…is available and integrated into the EHR, and it results in a useful number of timely recommendations for which it is easy to take action within the EHR.
Score	1 2 3	4 5 6	7 8 9	10 11 12
c. After visits summaries	… are not provided or are just printed and handed to patients.	…are reviewed by a team member who repeats aloud key aspects of the care plan and may highlight them on a printed summary.	…are reviewed by a team member who asks the patient to describe in his/her own words the care plan (teachback).	…are reviewed by a team member who asks the patient to describe in his/her own words the care plan (teachback) and guides the patient in making a personal action plan and identifying and addressing barriers to adherence to the plan.
Score	1 2 3	4 5 6	7 8 9	10 11 12
d. Developing resident physician skills in patient-centered communication	…is not a priority.	…is addressed through ad hoc feedback from preceptors.	…is addressed through didactic sessions and ad hoc feedback from preceptors.	…is prioritized by the program and is accomplished through systematic feedback on observed or simulated sessions.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Block 6: Population management

Components	Level D	Level C	Level B	Level A
a. A patient who comes in for an appointment and is overdue for preventive or chronic care (e.g., cancer screenings, diabetes lab work)	…will only get that care if they request it or their clinician notices it.	…might be identified as being overdue for needed care through a health maintenance screen or system of alerts, but this is inconsistently used.	…will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, but clinical assistants may not act on these overdue care items without patient-specific orders from the clinician.	…will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, and clinical assistants may act on these overdue care items (e.g., administer immunizations or distribute colorectal cancer screening kits) based on standing orders.
Score	1 2 3	4 5 6	7 8 9	10 11 12
b. When patients are overdue for preventive or chronic care (e.g., cancer screenings, diabetes lab work) but do not come in for an appointment	…there is no effort on the part of the practice to contact them to ask them to come in for care.	…they might be contacted as part of special events or using volunteers but outreach is not part of regular practice.	…they would be contacted and asked to come in for care, but clinical assistants may not act on these overdue care items without patient-specific orders from the clinician.	…they would be contacted and asked to come in for care, and clinical assistants may act on these overdue care items (e.g., distribute colorectal cancer screening kits) based on standing orders.
Score	1 2 3	4 5 6	7 8 9	10 11 12
c. Self-management support (health coaching)	…is limited to the distribution of information (pamphlets, booklets).	…is accomplished by referral to self-management classes or educators.	…is provided through goal setting and action planning with members of the practice team but is not done for every patient at every visit.	…is provided through goal setting and action planning by members of the practice team trained in health coaching and is done for every patient at every visit.
Score	1 2 3	4 5 6	7 8 9	10 11 12
d. Care management services for high risk patients	…are not available.	…are provided by external care managers with limited connection to practice.	…are provided by external care managers who regularly communicate with the care team.	…are systematically provided by the care manager functioning as a member of the practice team, regardless of location.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Components	Level D	Level C	Level B	Level A
e. Resident physicians	…have few resources for tracking the preventive and chronic care needs of their panels and must address any needs they identify within the patient visit.	…have time and access to tools to track preventive and chronic care needs of patients and are directly responsible for addressing these needs for their panel.	…may rely on clinic support staff to follow up with patient on a few select preventive or chronic care needs, but there may be little communication between residents and staff.	…learn skills in population management and coordinate with their interdisciplinary team to strategize and proactively manage their panels.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Block 7: Continuity of care

Components	Level D	Level C	Level B	Level A
a. Patients seeing their clinician (including residents) and practice team to which they are empaneled is encouraged	…only at the patient's request.	…by the practice team, but is not a priority in appointment scheduling.	…by the practice team and is a priority in appointment scheduling, but patients commonly see other clinicians because of limited availability or other issues.	…by the practice team, is a priority in appointment scheduling. Patients usually see either their own clinician, including residents, or a continuity figure.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Block 8: Prompt access to care

Components	Level D	Level C	Level B	Level A
a. The approach to providing same-day access relies on	…squeezing in urgent patients into a clinician's schedule.	…designating a "clinician of the day" who has slots open for urgent care.	…reserving a few slots in each clinician's daily schedule for urgent appointments.	…systematically implementing a schedule that reserves sufficient appointment slots each day to match documented historical demand.
Score	1 2 3	4 5 6	7 8 9	10 11 12
b. Contacting the practice team during regular business hours	…is difficult and often results in dropped calls and messages that are never returned.	… sometimes results in same-day responses but often takes longer depending on the practice's ability to respond to phone messages that day.	…is accomplished by staff consistently 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.
Score	1 2 3	4 5 6	7 8 9	10 11 12
c. After hours phone access	... is not available or limited to an answering machine.	…is available through an advice nurse or clinician. However, lack of access to the patient record and protocol-based care results in inability to resolve most issues directly.	…is available through an advice nurse or clinician who has access to the patient record and can provide basic protocol-based care to resolve some issues directly	…is available through an advice nurse or clinician who has access to the patient record and can provide a broad spectrum of protocol-based care to resolve most issues directly. The patient's care team is alerted to the issue and follow-up is conducted per clinic protocol.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Block 9: Coordination of care

Components	Level D	Level C	Level B	Level A
a. Medical and surgical specialty services	…are difficult to obtain reliably.	…are available from community specialists but are neither timely nor convenient.	…. are available from community specialists and are generally timely and convenient.	…are readily available from specialists who are members of the care team or who work in an organization with which the practice has a referral protocol or agreement.
Score	1 2 3	4 5 6	7 8 9	10 11 12
b. Behavioral health services	…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 onsite members of the care team or who work in an organization with which the practice has a referral protocol or agreement.
Score	1 2 3	4 5 6	7 8 9	10 11 12
c. Follow-up by the primary care practice with patients seen in the Emergency Room 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 these 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.
Score	1 2 3	4 5 6	7 8 9	10 11 12
d. 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 designated staff person.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Components	Level D	Level C	Level B	Level A
e. When the clinician/resident is not in clinic, responses to patient messages, test results, and refill requests	… are inconsistently addressed.	…are addressed on an ad hoc basis by other members of the care team.	…are consistently and promptly addressed by a designated person, but backup is provided by team members who may not know the patient.	…are consistently and promptly addressed by a designated person, and backup is provided by team members who know the patient.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Block 10: Template of the future

Components	Level D	Level C	Level B	Level A
a. The scheduling template for the clinic, including resident physicians	…only includes individual, face-to-face visits with clinicians.	…includes a few visit formats, such as visits with chronic care nurses and/or group visits.	…includes a variety of visit formats convenient to the patient, such as group visits, home visits, email or phone visits, visits with non-clinician members of the care team (e.g., RNs, MAs, pharmacists, social workers).	…includes a variety of visit formats. The number of clinician visits is reduced to allow time for group visits and e-visits, and a significant amount of care is provided through RN or MA visits or other alternatives to the clinician visit (e.g., RNs, MAs, pharmacists, social workers).
Score	1 2 3	4 5 6	7 8 9	10 11 12

Academic Practice Supplemental Block A: Resident Scheduling

Components	Level D	Level C	Level B	Level A
a. Residents' clinic schedules are made	…entirely secondary to resident's inpatient and other duties, and therefore are irregular, with frequent long intervals between clinic times.	…with some efforts at a regular resident presence in clinic, often made difficult due to residents' inpatient and other duties.	… with some priority given to clinic's needs for regularity and advance notice, although there are some unpredictable changes and long intervals between significant time in clinic.	… collaboratively between the clinic and hospital leadership, with consistent and deliberate priority given to the clinic's needs for regularity and advance notice, with short intervals between significant time spent in clinic, maintaining stable resident-staff teamlets and providing resident-patient continuity.
Score	1 2 3	4 5 6	7 8 9	10 11 12
b. Time spent in clinic over the course of residency	… minimally meets accreditation guidelines for training programs.	… regularly meets accreditation guidelines for training programs.	… goes beyond accreditation guidelines for training programs.	… maximizes the amount of time in clinic to prioritize ambulatory training.
Score	1 2 3	4 5 6	7 8 9	10 11 12
c. Residents' time in outpatient and inpatient duties	…frequently occur on the same day.	… are sometimes divided onto different days, but are still commonly scheduled within the same day.	…are mostly divided onto different days, but there still are occasional times where inpatient and outpatient duties are scheduled on the same day.	… are fully divided, and residents are able to concentrate and engage fully on outpatient duties when in clinic
Score	1 2 3	4 5 6	7 8 9	10 11 12
d. Considering both precepting duties and caring for their own panels, clinic faculty consist of	… a large group of attendings who individually are in the clinic only 1-2 half days per week.	… a large group of attendings with a few faculty members who are in clinic regularly.	… a core group of faculty who are in clinic more than 50% of their week.	… a small group of core faculty who are in clinic the majority of the time and are committed to and invested in improving the clinic..
Score	1 2 3	4 5 6	7 8 9	10 11 12

Academic Practice Supplemental Block B: Resident engagement

Components	Level D	Level C	Level B	Level A
a. Residents	… are not involved in clinic functioning outside of direct patient care duties.	… are involved with clinic improvement projects that are not well integrated with overall transformation efforts or clinic priorities.	… are consistently engaged in clinic QI efforts related to clinic priorities, but which end when the resident leaves the clinic	… are integral members of clinic transformation priorities and consistently engage in the clinic as improvement leaders working with multidisciplinary teams on QI initiatives that are integrated into a longer term framework for sustainability
Score	1 2 3	4 5 6	7 8 9	10 11 12
b. Residents	… receive no designated training in QI, PCMH, or practice transformation and rarely attend clinic QI meetings.	… receive a few didactics on QI, PCMH, and practice transformation.	… have a designated curriculum on QI, PCMH, and practice transformation.	… have a designated curriculum on QI, PCMH, and practice transformation and have opportunities to apply concepts learned via hands-on experiences and regularly attend clinic QI meetings.
Score	1 2 3	4 5 6	7 8 9	10 11 12
c. Resident clinic-based education involves	… solely attending/precepting physicians, with little interaction with other care team members	… some interaction with non-physician team members in meetings or limited team-building activities	… substantial interaction with team members to understand their roles in clinic, such as by shadowing and collaborative problem solving with RNs, MAs, behavioral health, etc.	… teaching and feedback from various team members such as RNs, MAs and behavioral health to support training in the context of high functioning teams, regular interdisciplinary partnership in collaborative problem solving
Score	1 2 3	4 5 6	7 8 9	10 11 12

Academic Practice Supplemental Block C: Resident work-life

Components	Level D	Level C	Level B	Level A
a. Residents satisfaction and experience of work in the clinic	… is infrequently or not assessed.	… is assessed, with inconsistent procedures to share or respond to feedback.	… is routinely assessed, with some system to respond to feedback.	… is routinely and effectively assessed, with an effective system in place to respond actively and promptly to feedback.
Score	1 2 3	4 5 6	7 8 9	10 11 12
b. Residents are	… consistently dissatisfied with their clinic experience.	… neutral about their clinic experience.	… satisfied and generally positive about their clinic experience.	… consistently engaged and excited about their clinic and working in primary care.
Score	1 2 3	4 5 6	7 8 9	10 11 12
c. The residency program	… has no or few activities focusing on wellness and resiliency.	… has some activities on wellness and building resiliency, though overall impact feels limited.	… has several activities designed to build wellness and resiliency, with generally positive response from residents.	…has a robust program for wellness and resiliency that utilizes diverse and creative approaches, and is responsive to individual styles among residents.
Score	1 2 3	4 5 6	7 8 9	10 11 12