Medical Home for Pediatric Primary Care

Practice Survey

Does Your Practice Have the Organizational Capacity for Medical Home Improvement?

Important factors such as the people, processes, resources, and culture of your practice will affect your ability to build a strong medical home.

Directions:

Use this practice survey at the start of this EQIPP course and then periodically throughout the medical home improvement process to help your practice determine if it has the organizational capacity to:

- Work effectively as a collaborative, cross-disciplinary team to continuously improve the health care delivery and care processes of your medical home
- Identify, monitor and track pertinent patient information to provide and coordinate patient care
- Provide easy, convenient access to the practice as the patient's first contact for new or and ongoing health concerns
- Engage families as true partners in their child's care and work with families to improve their experience of care
- Provide and document planned, proactive, and comprehensive care
- Coordinate care across all settings

Finally, use the results of the survey and the information in this *EQIPP Medical Home for Pediatric Primary Care* course to create improvement plan(s) for your practice.

Develop a Cross-disciplinary Medical Home Improvement Team

1. Has your practice formed a team for medical home improvement?
   ❙ Yes ❙ No

*If **no** to question 1, skip to question 2; if **yes**, answer the following:*

1a. Does the team include family participation, a lead physician or nurse practitioner, and 1 or 1 key staff members?
❙ Yes ❙ No

1b. Does the team have a vision for medical home improvement?
❙ Yes ❙ No

1c. Has the team articulated the vision to the entire practice?
❙ Yes ❙ No

1d. Does the team meet regularly for reflection, problem solving, and to plan for practice innovations (e.g., from 60 to 90 minutes once or twice a month)?
❙ Yes ❙ No

1e. Does the team use a consensus agenda for meetings?
❙ Yes ❙ No

1f. Does the team keep minutes?
❙ Yes ❙ No

1g. Does the team rotate roles (eg, lead, facilitate, keep time, and take minutes) to foster full and active participation of all members?
❙ Yes ❙ No

1h. Does the team track PDSA results over time?
❙ Yes ❙ No

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1i. Does the team reflect on lessons learned from its tests of change?
❙ Yes ❙ No

1j. Does the team share results and progress with the rest of the practice staff?
❙ Yes ❙ No

1k. Does the team share results and progress with patients and families of the target population?
❙ Yes ❙ No

1l. Are the results of successful improvement cycles implemented practice wide?
❙ Yes ❙ No

Feedback
If your organization has formed a team for medical home improvement, it has taken an important first step toward building a foundation for innovation and change in your medical home. But, to transform your organization into a *highly functioning* medical home requires effective teamwork and team skills that are continuously improved. Tabulate your answers. The "No" answers point to areas for team development, and the "Yes" answers indicate areas of strength.

A highly functioning, cross-disciplinary improvement team:

- Practices habits of highly functioning teams (makes the commitment, gains and demonstrates leadership, uses ground rules for communication, secures facilitation support from within the organization, sets an agenda as a team, keeps minutes, assigns and completes homework, and follows through with plans).
- Includes, at a minimum, physician leadership with senior leader support, patient and family representation, and 1 or 2 key members of the primary care practice (such as a practice manager and a nurse who can develop the practice capacity for care coordination) and invites ad hoc members or others expressing interest.
- Articulates a clear vision for medical home improvement, and experiments with tests of change performing multiple PDSA cycles.
- Continuously evaluates and improves the management and facilitation of practice care processes related to the medical home.
- Meets regularly for reflection, problem solving, and planning for practice innovations (eg, 60 to 90 minutes once or twice a month).
- Engages and shares ideas with all staff for their input and participation and, when ready, practice-wide implementation.
- Continually reports progress to the entire practice, creating a culture of teamwork and improvement.
- In larger practices, encourages and supports formation of multiple improvement teams targeting specific improvement goals.

For improvement suggestions to close any gaps identified in this key activity, see *Potential Barriers and Suggested Ideas for Change: Develop a Team* provided in this EQIPP course.

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Know and Manage Your Patient Population

2. Has your practice developed at least one system of accessible and clinically useful information for your patient population such as a registry?

   ❙ Yes ❙ No

*If **no** to question 2, skip to question 3; if **yes**, answer the following:*

2a. Does your system or registry associate each patient with a primary care pediatrician or physician-led team?
❙ Yes ❙ No

2b. Does your system or registry identify patients with special health care needs?
❙ Yes ❙ No

2c. Is the system or registry used for population health or condition management purposes to identify or proactively remind clinicians and patients/families of needed services?
❙ Yes ❙ No

2d. Is the system or registry used to track appropriate protocols, best available practice, or clinical measures suggested by scientific evidence for the conditions listed in the registry?
❙ Yes ❙ No

2e. Does the system or registry track the following through resolution (or indicate declined by the patient and family):

2e.1. Laboratory tests
❙ Yes ❙ No

2e.2. Procedures
❙ Yes ❙ No

2e.3. Referrals
❙ Yes ❙ No

2e.4. Protocols
❙ Yes ❙ No

2e.5. Recommended actions
❙ Yes ❙ No

2f. Has your practice analyzed records and/or contacted patients in your system or registry to identify their needs for care coordination services?
❙ Yes ❙ No ❙ Not applicable, population typically does not require care coordination services

2g. Does your practice have processes to ensure that the system or registry is used routinely by appropriate care team members who are trained to use the tool?
❙ Yes ❙ No

2h. Does your practice have processes to keep the system or registry data up-to-date?
❙ Yes ❙ No

2i. Does your practice have processes to continuously evaluate and improve the effectiveness of the system or registry or to expand and improve it?

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❙ Yes ❙ No

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Does your practice know and manage its patient populations effectively? Tabulate your answers. The "No" answers point to areas for improvement, and the "Yes" answers indicate areas of strength. The ability to identify and manage your practice's patient population by age, sex, condition, and other factors is essential to:

- Support the core functions of primary care and the management of chronic conditions of individual patients including, coordination of care.
- Examine groups and sub-groups of patients to discern patterns and trends in patient care over time.
- Establish a proactive patient reminder system for health maintenance visits, immunizations, screenings, laboratory tests, imaging studies, referrals, medication refills, and other services.
- Track laboratory tests and imaging studies ordered, and their results.
- Track referrals to specialists and therapists, and their reports and recommendations.

In addition, knowing and managing your patient population can help your practice make informed financial and operational decisions by helping to predict revenues, costs, and operating efficiencies. This knowledge will enable your practice to formulate strategic and operational plans and set priorities. It can also help your practice prepare to apply for and potentially meet the NCQA (National Committee for Quality Assurance) Physician Practice Connections® Patient Centered Medical Home (PPC-PCMHTM) recognition program or other medical home recognition requirements.

For improvement suggestions to close any gaps identified in this key activity, see *Potential Barriers and Suggested Ideas for Change: Know and Manage Your Population* provided in this EQIPP course.

Enhance Access to Care

3. How well does your practice promote enhanced access to care and quality communication?

3a. Does it offer expanded appointment hours such as in the early morning, in the evening, or on weekends to accommodate after-school and work schedules?
❙ Yes ❙ No

3b. Does it offer same-day appointments so patients get the care they need on the day they need it?
❙ Yes ❙ No

3c. Does it have procedures for urgent care after hours – eg, phone access with physician support 24/7 and a physician on call within your practice or community?
❙ Yes ❙ No

3d. Does it offer alternate ways to interact with patients such as phone, fax, e-mail, and the Web?
❙ Yes ❙ No

3e. When patients or families call with medical concerns, can they speak directly with a nurse or pediatrician – whether right away or within 24 hours?
❙ Yes ❙ No

3f. Does your practice consider the culture, language, and literacy level of the patient and family and use helpful ways to explain terms clearly and encourage questions?
❙ Yes ❙ No

3g. Does it routinely communicate the following to patients and families — eg, via a brochure and/or Web site:
3g.1. Office hours

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❙ Yes ❙ No

3g.2. Steps for medical concerns outside of office hours
❙ Yes ❙ No

3g.3. Response expectations
❙ Yes ❙ No

3h. Does your practice pre-determine appropriate appointment length in order to optimize the visit and physician, patient, and family time?
❙ Yes ❙ No

3i. Does it pre-arrange special accommodations for patients who need them?
❙ Yes ❙ No

3j. Does it identify bottlenecks in patient flow and then use this information to improve office wait time?
❙ Yes ❙ No

3k. Does it help families who do not have insurance find ways to pay for needed services? (Methods can include providing funding information or offering alternate payment methods.)
❙ Yes ❙ No

Feedback
Enhanced access to care – gaining access to the practice as the first contact for new or and ongoing health concerns and meeting patients' needs with greater ease, less stress, and reduced time away from work and school – increases patient satisfaction, improves health outcomes and decreases costs.

How accessible is your practice to patients and families? Tabulate your answers. The "No" answers point to areas of accessibility that need improvement, and the "Yes" answers indicate areas of strength. For improvement suggestions to close any gaps identified in this key activity, see *Potential Barriers and Suggested Ideas for Change: Enhance Access to Care* provided in this EQIPP course.

Provide family-centered care

4. How "family-centered" is your practice?

4a Does your practice attempt to learn from families about their experience of care (eg, face-to-face inquiries, focus group discussions, use of a family survey tool) ?
❙ Yes ❙ No

*If **no** to question 4a, skip to question 4b; if **yes**, answer the following:*

4a.1 Does it share family feedback from families with all staff?
❙ Yes ❙ No

4a.2 Does it use family feedback for planning practice innovations to improve patient satisfaction and/or care delivery?
❙ Yes ❙ No

4b. Does your practice routinely ask patients/families about how the child is feeling, growing, and behaving? (A pre-visit contact form can collect this information in advance of the visit.)
❙ Yes ❙ No

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4c. Is your facility physically accessible from curbside to examination room?
❙ Yes ❙ No

4d. Does your practice identify and fulfill special accommodation needs in advance of visits?
❙ Yes ❙ No

4e. Does it help families connect with family support organizations that can provide information, resources, and encouragement?
❙ Yes ❙ No

Feedback
The "family-centered medical home" is a model of care emphasizing accessible, comprehensive, coordinated care that includes the active involvement of the patient and family in health care decisions.

Is your practice regularly inviting patients and families to actively participate in their child's care and to help improve their experience of care? Tabulate your answers. The "No" answers point to areas needing improvement, and the "Yes" answers indicate areas of strength. For improvement suggestions to close any gaps identified in this key activity, see *Potential Barriers and Suggested Ideas for Change: Provide Family-centered Care* provided in this EQIPP course.

Provide and Document Planned, Proactive, Comprehensive Care

5. Is your practice organizationally ready to provide and document planned, proactive, and comprehensive care for the 3 main functions of primary care: preventative care, acute illness management, and chronic condition management?

5a. Does your practice document all patient encounters, including office visits, phone, and e-mail communications, home visits, and hospital visits?
❙ Yes ❙ No

5b. Does it systematically plan for patient encounters (eg, collect pre-visit data, review the patient chart, assemble consultation reports, lab tests, and emergency department records, identify patient and parent concerns, arrange for anticipated tests, immunizations, imaging procedures, and ensure that adequate time is scheduled for the visit)?
❙ Yes ❙ No

5c. For **preventive care encounters**, does your practice incorporate prompts (guided encounter forms, Post-it notes, etc.) based on AAP/Bright Futures periodicity schedule for age-appropriate developmental screenings and risk assessments?
❙ Yes ❙ No

5d. Does it systematically identify and contact patients who are behind schedule for preventive services?
❙ Yes ❙ No

5e. For **acute illness encounters** prevalent in your practice, does your practice incorporate prompts based on evidence-based or consensus guidelines where possible (eg, otitis media or gastroenteritis)?
❙ Yes ❙ No

5f. For **chronic condition management encounters**, does your practice incorporate condition-specific prompts based on evidence-based or consensus guidelines and linkages to the patient's comprehensive care plan?
❙ Yes ❙ No

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5g. For **patients age 14 and older,** does your practice incorporate prompts for health care transition planning that include what services need to be provided, by whom, when, and how they will be financed?
❙ Yes ❙ No

5h. Does your practice systematically track, follow-up, and document test results, referrals, and other activities?
❙ Yes ❙ No

5i. Does it have processes to communicate test results and their implications to patients and families?
❙ Yes ❙ No

5j. Does it systematically use the patient's medical summary or comprehensive care plan to follow patients' progress?
❙ Yes ❙ No

5k. Does your practice review and update the summary or plan with the patient and family regularly?
❙ Yes ❙ No

Feedback
Patients and their families benefit from having continuous, longitudinal, and comprehensive care. An effective medical home proactively identifies, manages, documents, and follows-up on patients' preventive, acute, and chronic health care needs. It systematically plans for patient encounters to optimize the visit and ensure the best possible care is delivered.

How effectively does your practice deliver and document planned, proactive, comprehensive care? Tabulate your answers. The "No" answers point to areas needing improvement, and the "Yes" answers indicate areas of strength. For improvement suggestions to close any gaps identified in this key activity, see *Potential Barriers and Suggested Ideas for Change: Provide and Document Planned, Proactive, Comprehensive Care* provided in this EQIPP course.

Coordinate Care Across All Settings

6. Is your practice organizationally ready to coordinate care for patients' conditions and health care needs across all settings?

6a. Does it have a care coordination plan that specifies who will perform care coordination tasks and identifies patient subpopulations that will benefit from linkages to needed services and resources?
❙ Yes ❙ No
❙ Yes ❙ No

6b. Does it have care support/education materials for situations and conditions prevalent in your patient population that also consider the language and literacy level of patients and families?
❙ Yes ❙ No

6c. Does it have and maintain an organized list of community resources?
❙ Yes ❙ No

6d. Does it help families connect with needed services (eg, transportation, durable equipment, home care, language translation, and smoking cessation).
❙ Yes ❙ No

6e. For patients whose care is co-managed with another provider, does your practice have reliable processes to communicate your responsibilities and those of the other provider (eg, a written co-management agreement)?
❙ Yes ❙ No

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Feedback

Care coordination is crucial to the provision of planned, proactive care and requires processes for coordinating and co-managing care to ensure timely and optimal communication and information exchange. Care coordination promotes continuity across all of the patient's conditions and health care needs, both within the primary care medical home, as well as between the patient's medical home and other providers and settings. Optimally delivered co-managed care also addresses local issues such as coordination with schools and linkage to community-based organizations.

How well does your practice coordinate care across all settings? Tabulate your answers. The "No" answers point to areas needing improvement for providing family-centered care, and the "Yes" answers indicate areas of strength. For improvement suggestions to close any gaps identified in this key activity, see *Potential Barriers and Suggested Ideas for Change: Coordinate Care Across all Settings* provided in this EQIPP course.

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Appendix

Consensus Agenda

The facilitator collects issues for discussion from all parties to ensure that all issues team members want to discuss have been collected and prioritized. The agenda becomes a "road map" for the meeting. The time allotted for each agenda item can be written next to the discussion item. It is a good idea to order the items on the basis of their time dependencies and importance in case time runs out. Once the agenda has been agreed on, the facilitator sticks to the schedule unless the group consents to do otherwise.

Special Health Care Needs

Children with special health care needs are defined by the Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (MCHB) as:

> *"those who have or are at increased risk for a chronic physical, development, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally"*

Comprehensive Care Plan

For patients with complex conditions, a **comprehensive care plan** includes an expanded medical summary, an emergency treatment plan, and a dynamic, explicit plan of care, also known as an action plan. View an example.

Action Plan

An **action plan** is a dynamic, explicit plan of care for patients with active issues, pending actions, and unresolved needs that clearly identifies the issues and concerns, includes agreed-on goals, and identifies actions planned, persons responsible (including nonmedical sources of care), anticipated time frames, and, where possible, resolutions. The action plan may be simple or complex as dictated by patient need and may unfold across multiple visits. View an example action plan.

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Periodicity Schedule

The Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

View the 2008 periodicity schedule in pdf format.

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Medical Summary

A **basic** medical summary is a history of medical information that includes the following:

- Basic demographics and contact information
  - Patient and family, with guardianship identified, if applicable
  - Contact information for patient and family, including cell phone numbers and e-mail addresses
  - Medical home
  - Emergency contacts
- Key medical, surgical, and injury history
- Current medications, including medication reconciliation
- Allergies
- Immunization record
- Insurance information
- Special instructions

Patients with chronic conditions benefit from an **expanded** medical summary that includes the following:

- Basic demographics and contact information
  - Patient and family, with guardianship identified, if applicable
  - Medical home, including primary care provider and care coordinator
  - Emergency contacts
  - Specialists
  - Therapists
  - Home health agency
  - School attended and school contacts
- Chronic condition(s)
  - Secondary diagnoses
  - Complications
- Key medical, surgical, and injury history
  - Presence of surgically implanted devices or prostheses
  - Important hospitalizations
  - Key laboratory data and imaging results
- Medications
  - Current medications, including medication reconciliation
  - Past medications and reactions
  - Medication precautions, including medications needed during procedures (eg, subacute bacterial endocarditis prophylaxis) and those to be avoided
- Special diets and dietary restrictions
- Allergies
- Immunization record
- Insurance information
- Special instructions, including input from family/patient regarding personal qualities, strengths, preferences

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Co-management Letter or Agreement

Co-management letters or agreements are intended to help define communications and coordinate the work and roles among primary care providers, specialists, and patients and their families. These communications specify a child's diagnosis, tests or studies needed, and the explicit responsibilities of each clinician and of their shared pediatric patients and their families. They also spell out the parameters and details of how timely consultative information and feedback will be provided.

Co-management agreements make clear what activities will occur at the level of primary care and specialty care as well as the duration or period that co-management is desired or requested (short-term, long-term, indefinitely). They help set up explicit processes for exchanges among family approved/named communicating partners.

See **sample** co-management agreement and letter:

Transition Health Care Plan or Checklist

It is recommended that by the time a patient is 14 years old, the youth, family, and health care team create an individualized written health care transition plan or checklist. At a minimum, this plan includes what services need to be provided, who will provide them, when they will be provided, and how they will be financed. Patients with chronic conditions need a transition plan with expanded elements related to the patient's condition or disability. It is recommended that the plan follow the AAP transition guidelines and be reviewed and updated annually and whenever there is a transfer of care.

See **A Consensus Statement on Health Care Transitions for Young Adults With Special Health Care Needs.** *Pediatrics.* 2002:110(suppl):1304–1306 and an example **transition checklist**.

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