Patient's Medical Home Assessment

FACILITATION GUIDE for Practices

A how-to guide to support facilitation of the PMH assessment & action planning with practice teams

Version 1.3

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Patient's Medical Home Background & Key Messages

Shifting the emphasis from the delivery of acute care to the delivery of primary health care is recognized as an essential priority for health system transformation. As part of this shift many countries are supporting the development of medical clinics to become Patients' Medical Homes (PMHs)[1].

The vision for primary health care in Alberta, as outlined in Alberta's Primary Health Care Strategy, is based on the Patient's Medical Home (PMH) set forth by the College of Family Physicians of Canada - where every Albertan has a personal family physician who works with a team of health care professionals to deliver and coordinate comprehensive primary care services for their patients.

Transformation to the PMH in Alberta will entail an enormous amount of change at the practice level. As well-established supports to primary care practices, Primary Care Networks (PCNs) will play an integral role in practices' transformational journeys. To support practices, PCNs will need to engage in their next stage of growth and development – *i.e.* PCN Evolution

In particular, investment and engagement of practice facilitators at the PCN level will be an essential element in practices' PMH transformations. Evidence supports the value add of the facilitator-practice team relationship when engaging in quality improvement work - a meta-analysis of practice facilitation within primary care settings concluded that 'primary care practices are 2.76 (95% CI, 2.18-3.43) times more likely to adopt evidence-based through practice facilitation' (Baskerville, Liddy, Hogg, 2012).

Equally important, PMH transformations will need to "make sense" at the primary care practice level - as such, each practice's journey will be unique. To be truly effective physicians and practice teams will need to engage in the "work" of transformation.

[1] Also commonly referred to as health homes, patient-health homes, patient-centred medical homes

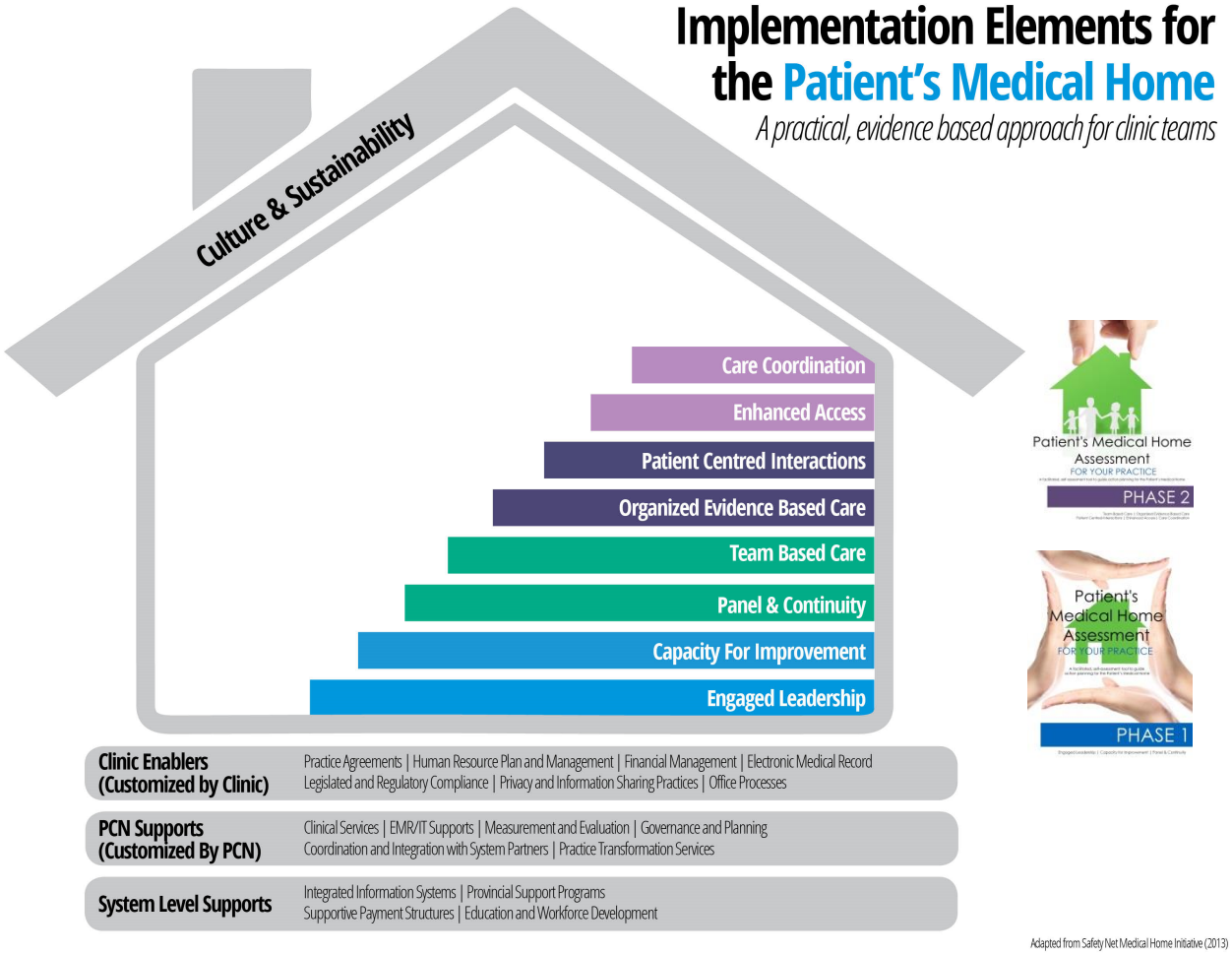
The Patient's Medical Home Assessment Tool for Practices

About the Assessment Tool

The Patient's Medical Home (PMH) Assessment Tool was developed to help practices understand their current level of "Medical Homeness" and identify opportunities for improvement. Along with other PMH tools and resources, the assessment was adapted from a demonstration project called the Safety Net Medical Home Initiative (2013) (SNMHI) to fit the Alberta context. Our assessment has been designed to be used with the support of an Practice Facilitator to guide teams through their assessment and action planning processes. If repeated at regular intervals, the assessment will help track a practice's PMH implementation progress.

In addition to tools and resources, the SNMHI approach has been adapted as a "roadmap" to support practice teams with the implementation of the PMH – *i.e.* it offers a practical, evidence based approach that was refined from key learnings experienced by the 65 clinic sites (from 5 states) that participated in the SNMHI over its 5 year duration. It is an approach practice teams in Alberta can apply and make their own.

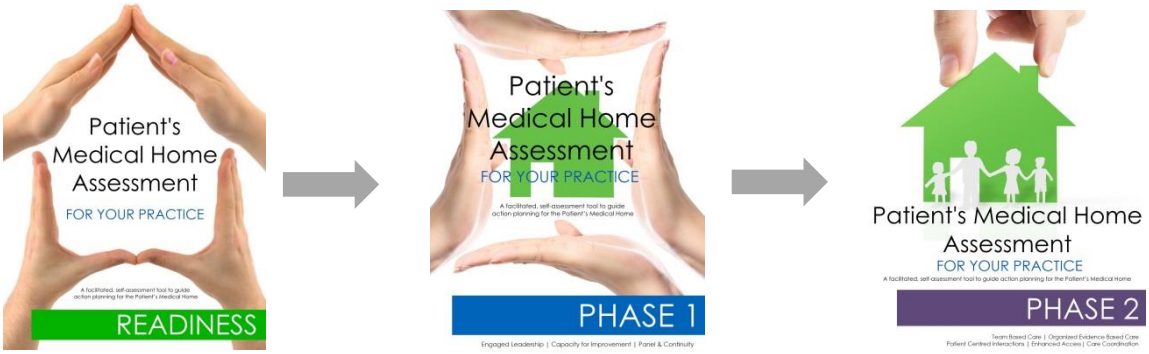
The approach (see image below) is complementary to the vision and framework developed for PCN Evolution. It highlights 8 change elements (divided into 4 stages) that were identified by the SNMHI (in reflection) as being key to achieving the PMH[2]. See Appendix A for a larger image.



[2] More information on the 8 change concepts can be found at - www.safetynetmedicalhome.org/change-concepts

Overview of the Patient's Medical Home Assessment Tool for Practices

The Patient's Medical Home Assessment consists of 3 phases:



READINESS	PHASE 1	PHASE 2
WHO: Completed by a Practice Leader WHY: Assess team awareness and leader commitment to the Patient's Medical Home WHAT NEXT: Option to review the **Introduction to the Patient's Medical Home Package** as next step OR to move to the **Patient's Medical Home Assessment Phase 1**	WHO: Completed through a facilitated team process WHY: Assess engaged leadership, quality improvement and panel and continuity WHAT NEXT: Option to create a **Patient's Medical Home Action Plan for Phase 1** OR move to the **Patient's Medical Home Assessment Phase 2**	WHO: Completed through a facilitated team process WHY: Assess team based care, organized evidence based care, patient centred interactions, enhanced access and care coordination WHAT NEXT: Set priorities and create a **Patient's Medical Home Action Plan for Phase 2**

Supporting Assessment Tools & Resources

- Introduction to the Patient's Medical Home Package - a set of resources to guide practice leaders in introducing the value of becoming a Patient's Medical Home to physicians and teams
- Patient's Medical Home Action Plan - a workbook for clinic team members to assist them to identify and plan for improvements based on priorities identified when completing the Patient's Medical Home Assessment
- Facilitation Guide - a practical how-to guide to support those individuals who are facilitating the Patient's Medical Home Assessment and action planning with practice teams
- Visit actt.albertadoctors.org to access all the resources and tools related to the Patient's Medical Home Assessment for Practices

Supporting Practices with Their Patient's Medical Home Assessment

What is the Role of the Practice Facilitator?

The facilitator will help support clinics who have an interest in transitioning toward a Patient's Medical Home and will work closely with Clinic Leaders to help facilitate all 3 parts of the Patient's Medical Home Assessment (*i.e.* Readiness, Phase I and Phase II).

Getting Started – Introducing the Patient's Medical Home Assessment to Clinic Leaders

Getting Started Checklist What to prepare and points to discuss with Clinic Leaders about the Patient's Medical Home Assessment

Printed Resources

- ☐ The Introduction to the Patient's Medical Home Package – to provide background information about the Patient's Medical Home
- ☐ The Patient's Medical Home Assessment – Readiness – to be completed by Clinic Leader
- ☐ The Guide to the Implementation Elements for the Patient's Medical Home – to show the different elements, or concepts, that will be evaluated in Phase I and II
- ☐ Patient's Medical Home Assessment – Phase 1 - to share what the tool looks like, the types of questions, the number of questions, etc…

Discuss the Purpose of the Tool

- ☐ Developed for practices as a voluntary tool to assess routine activities that support the Patient's Medical Home
- ☐ Provides a "snap shot" of where practices are in their journey toward the Patient's Medical Home
- ☐ Allows teams to build a common understanding of team processes in the steps toward the Patient's Medical Home
- ☐ Helps practices set priorities and create customized action plans
- ☐ Provides a validated self-reflective tool that can be repeated over time

Review the Different Phases of the Patient's Medical Home Assessment Tool

- ☐ Readiness – To be completed by one practice leader. This tool helps teams decide if they are ready to complete the Patient's Medical Home Assessment – Phase 1 or use the Introduction to the Patient's Medical Home Package to increase the practice's readiness to move toward the Patient's Medical Home. You will support both pathways.
- ☐ Phase I – To be completed by a variety of practice team members and will be supported by you, the facilitator. Depending on the consensus scores, the team may, or may not, move to Phase II but rather build an "Action Plan" around gaps in Phase I.
- ☐ Phase II – To be completed by a variety of practice team members and will be supported by you, the facilitator.

Patient's Medical Home Assessment – Readiness

Each practice will need to complete a readiness assessment to determine whether the team should move to phase 1 of the assessment or if they would benefit from an introduction to the Patient's Medical Home.

A review:

- ✓ The readiness assessment is to be completed by one practice leader
- ✓ This tool helps teams decide if they are ready to complete the Patient's Medical Home Assessment – Phase 1 or use the Introduction to the Patient's Medical Home Package to increase the practice's readiness to move toward the Patient's Medical Home - you, the facilitator, will support both pathways.

In preparation for conducting the readiness assessment with a Practice Leader you may want to do the following:

Readiness Assessment Preparation
Please refer to the Getting Started Checklist above Review Terms, Definitions and Acronyms (provided by PCN Evolution) – click here

Patient's Medical Home Assessment – Phase 1

Planning with Clinic Leaders

Before facilitating Phase 1 of the assessment with the practice team meet with the Clinic Leader to plan. When meeting with Clinic Leaders you may want to consider the following:

Planning with Clinic Leaders (before team completes Phase 1 of the assessment)

Develop a clinic leadership plan

- ☐ Review and discuss the objectives of the assessment
- ☐ Help the clinic leadership develop key messages to "launch" the assessment with their team; this could include key messages around the Patient's Medical Home, the assessment, the goals, and the environment for honest feedback
- ☐ Plan for built in time to have clinic leadership present key messages some time prior to the completion of the assessment
- ☐ Review your role
- ☐ Advise that the ideal team includes a variety of team members but should have less than 10 people to help with consensus scoring
- ☐ Review when and how the team will be filling out their assessment. The average time to fill out Phase 1 of the Patient's Medical Home Assessment is 20 minutes
- ☐ Review how to fill out the assessment using the 12 point scale
- ☐ Gain clarity for 2 areas in the assessment and share this with the participants PRIOR to filling out the assessment:
    - ☐ Have the Clinic Leaders define what is meant by "Clinical Leaders" in the Engaged Leadership Section; they may want it to mean a Clinic Manager or Physicians
    - ☐ In the Quality Improvement Section, have the Clinic Leaders define if they are evaluating a particular QI project or general QI processes in the clinic

The Individual Assessments

Gather the team together and have each person complete the assessment on their own before you begin the team consensus process (see next section). As outlined in the checklist above it's important to have a variety of people who fulfill different roles in the practice to participate and that team members are comfortable with the task. Instructions to complete Phase 1 and 2 of the assessment are included in the assessment tools.

Building the Team Consensus

Once everyone has completed their assessment on their own you can begin the team consensus scoring process. The facilitator will help the team **produce a consensus score for each question rather than averaging their scores**. We discourage staff from simply averaging the scores—the consensus-reaching discussion is a good opportunity to identify opportunities and priorities for Patient's Medical Home transformation.

You may want to consider the following "consensus basics".

Tips for Consensus Building

- Review your role and the purpose of the assessment
- Explain that a consensus score will occur for each question
- Share the benefit of a consensus score vs averaging the score. This allows for teams to discuss processes and gaps together
- Provide norms around sharing scores and building a safe environment; all participants will be asked for their score and everyone has a say; remind the team that some of the questions will be rating the work of people sitting around the table and to be sensitive
- Manage group dynamics and ensure balanced participation by all members
- Alert the team if the discussion has gone off topic or is getting "stuck"
- Try not to offer opinions; just guide discussions
- Ask questions

Tips to Avoid Repetition When Coming to Consensus with Each Question

Group Level Consensus: Ask the group to raise their hand if they scored the question in Level A, or B, or C or D. You will likely notice a cluster of scores in one or two levels. This is a low risk way to quickly get a sense of where to begin narrowing the score.

Round Table Consensus: Go around the table and ask for the participant's score. Make sure to record the scores so you know how many repeated scores there are. This quickly allows for everyone to participate and no one is singled out.

Volunteer Consensus: Ask the group to volunteer their score. This works well in teams that have trust. A volunteer score is just the start as you must gain the score from every participant.

Interpreting the Team Consensus Scores

- **If less than eight rows scored a '5' or above in Phase 1**, work with the team to complete the Patient's Medical Home Action Plan for Phase 1. This tool will help your team prioritize areas for improvement. Review supports available to your team for leadership, quality improvement and panel/continuity improvements.
- **If eight rows or more scored at '5' or above**, have your team move on 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.

Facilitating the Team's Phase 1 Action Planning

- See the Tips for Facilitating the Team's Action Planning section below
- Optional - see Appendix C of the assessment tool to learn how to average the team consensus scores. Averaging the consensus scores by each section or overall may help teams gain further insight on opportunities for improvement or could be useful to assess their progress over time

Patient's Medical Home Assessment – Phase 2

Considerations for Support Your Practice Team with Phase 2

The process for facilitating completion of Phase 2 of the assessment will require many of the same skills and considerations you will have applied in Phase 1. Gather team members together as a group and have them complete the assessment on their own before working together to generate their consensus scores.

Team members should be familiar with the process of completing the assessment. Depending on the circumstances (*e.g.* new team members, a large time gap since completing Phase 1) you may want to suggest a 'refresher' of the instructions. You may also want to meet with the Clinic Leader(s) to reiterate points mentioned in the Planning with Clinic Leaders Checklist noted above for Phase 1. As Phase 2 covers the remaining 5 implementation elements for the Patient's Medical Home it will take more than 20 minutes to complete.

Interpreting the Team Consensus Scores

When interpreting their team consensus scores:

- **If less than eight rows scored a '5' or above in Phase 2**, work with the team to complete the Patient's Medical Home Action Plan for Phase 2. Ensure you're familiar with the 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**, work with the team to complete a Patient's Medical Home Action Plan to continue on with their quality improvement work in establishing/enhancing their Patient's Medical Home.

Facilitating the Team's Phase 2 Action Planning

- See the Tips for Facilitating the Team's Action Planning section below.
- Optional - see Appendix C of the assessment tool to learn how to average the team consensus scores. Averaging the consensus scores by each section or overall may help teams gain further insight on opportunities for improvement or could be useful to assess their progress over time.

Tips for Facilitating the Team's Action Planning

The Patient's Medical Home Action Plan tool can be used for Phase 1 and 2. Once the team is ready to build an action plan you may want to consider the following:

Forming an Improvement Team:

- Review the 'Quality Improvement Guide' found on the ACTT website
- Invite a variety of team members to be part of the improvement team - remember that the "people who do the work need to change the work"
- Facilitate improvement team norms – how often to meet, when to meet, how to share information, etc…

Setting Improvement Priorities with the Team:

- Facilitating a discussion around the questions found in this section of the Patient's Medical Home Action Plan will allow the team to identify what is important to them
- Have the team identify one to three improvement priorities and record them in the action plan
- If possible, encourage teams to link identified priorities to meaningful care gaps or clinical priorities. For example, does this priority benefit patient outcomes?

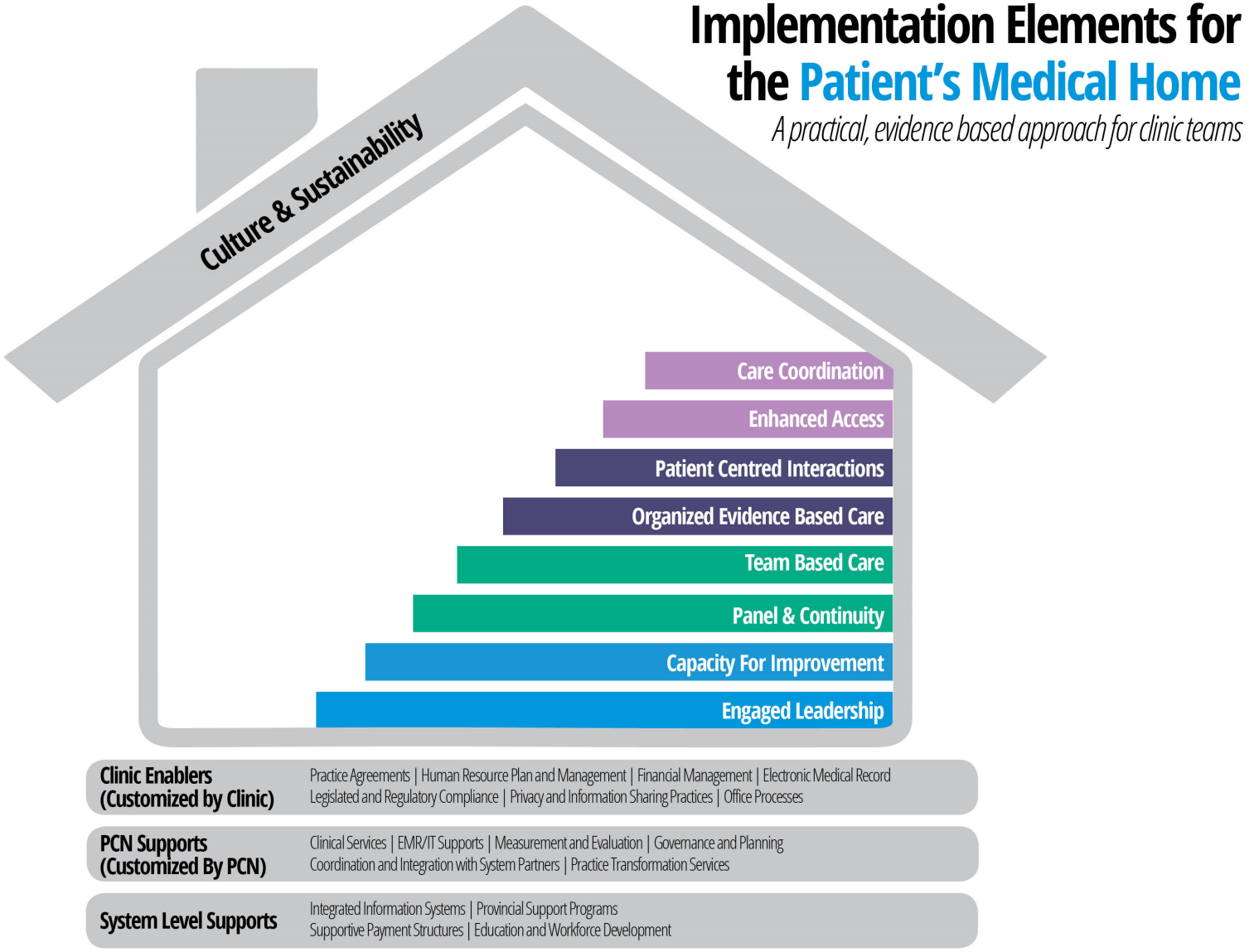
Creating an Aim Statement:

- A good aim statement clearly identifies the following:
    - What are we trying to accomplish?
    - How will we know if a change is an improvement?
    - What changes can we make that will result in improvement?
- Help define and clarify the SMART objectives of a good aim statement (SMART - Specific, Measurable, Achievable, Relevant, Time limited)
- Help them create aim statements for each of their identified clinical improvement priorities; use EXAMPLE aim statement if needed
- Help them outline the steps they need to take to achieve their aim statements by filling in the rest of the clinic priority table; use EXAMPLE provided if needed

Tips for Identifying Major Milestones

- Help the team identify milestones that mark specific points along the timeline to accomplishing the priority identified in their aim statement
- Milestones help team know if they are on track to accomplishing their greater goal
- Milestones can be significate achievements and can be celebrated

Appendix A: the Implementation Elements for the Patient's Medical Home



Adapted from Safety Net Medical Home Initiative (2013)