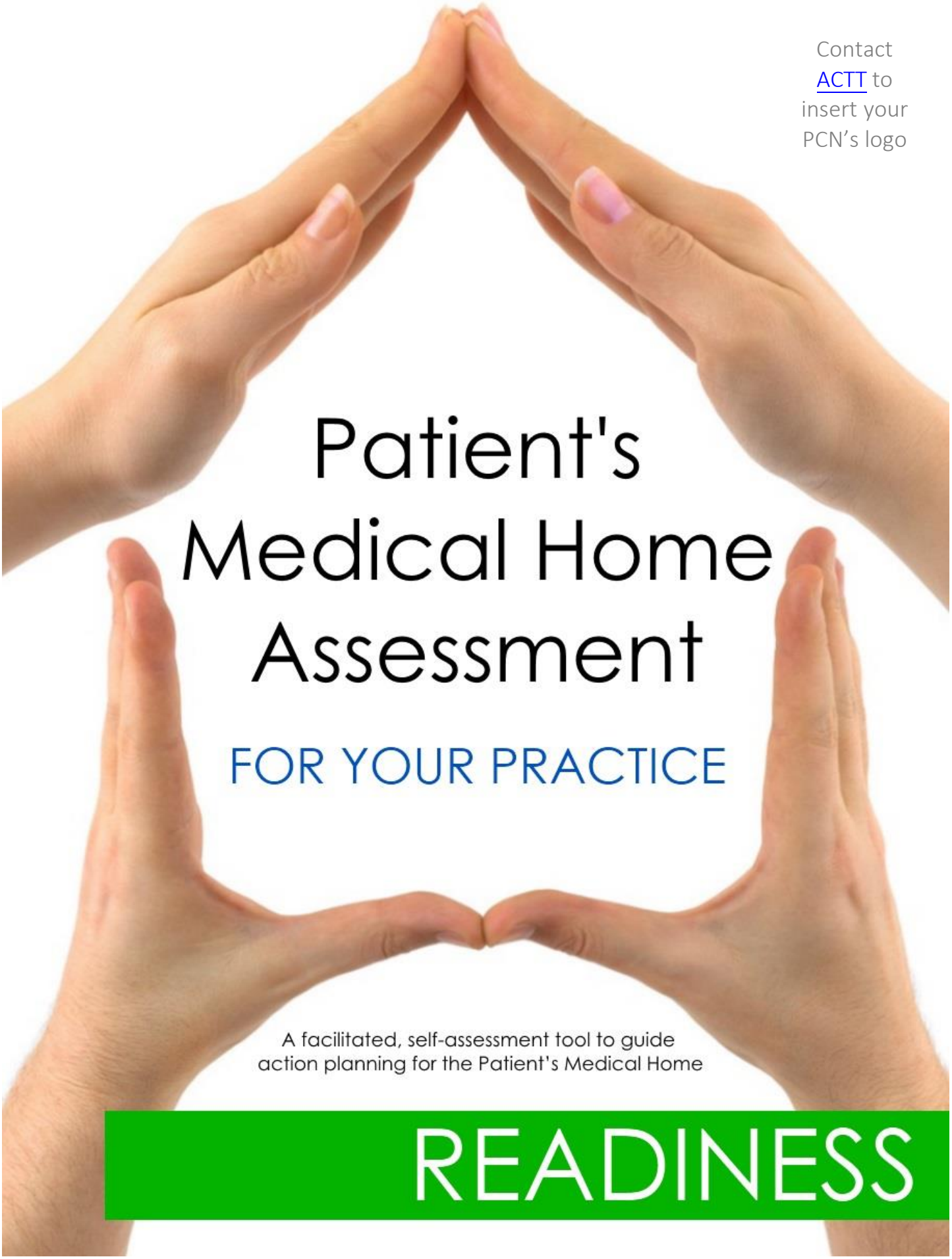
Contact ACTT to insert your PCN's logo



Patient's Medical Home Assessment

FOR YOUR PRACTICE

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

READINESS

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

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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

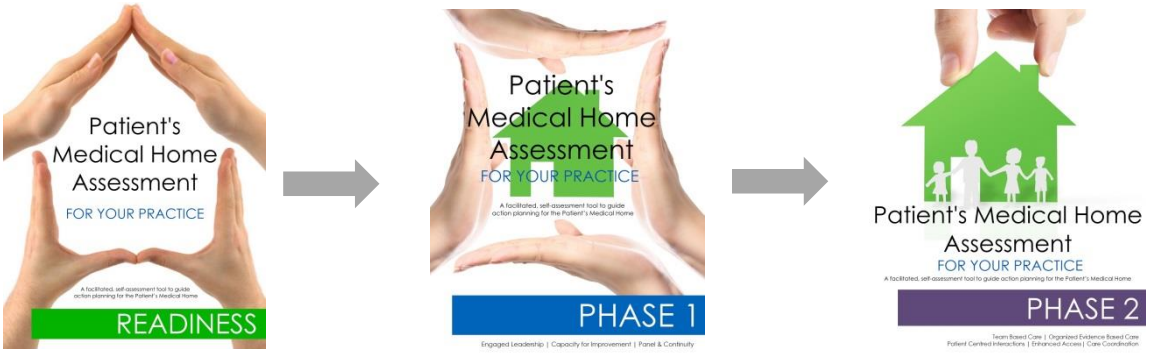
Get Electronic Copies of Resources & Tools

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.

About the Patient's Medical Home Assessment for Practices

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



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

IMPORTANT NOTE: **Phase I** and **Phase 2** are designed to be **facilitated.**

A **Facilitation Guide** has been developed to support a trained facilitator with this process. To learn more about facilitation support available to your practice contact your PCN.

Alternatively, contact the Accelerating Change Transformation Team (ACTT):
actt@albertadoctors.org | 780.488.4350 |

Why do a Patient's Medical Home Assessment?

- A **Patient's Medical Home Assessment** will help primary care practices identify the changes required for patient-centred care within their practices
- The **Patient's Medical Home Assessment** will give clinical practices the ability to assess their own processes and activities related to key Patient's Medical Home implementation concepts (*e.g.* leadership, quality improvement, panel, etc...); see Appendix A – Implementation Elements for the Patient's Medical Home– to review all the key concepts
- The results of this facilitated, self-assessment can then be used by the practice to set team priorities and to create a customized **Patient's Medical Home Action Plan**

Who can participate in the Patient's Medical Home Assessment?

- Any practice team is eligible
- A practice team can be as small as a physician and a receptionist or as large as many physicians and multi-disciplinary team members
- It is recommended that the assessment be completed by as many team members as possible [*e.g.* physicians, nurses, medical office assistants (MOAs), inter-disciplinary team members, office administration] in order to capture the perspectives of individuals with different roles within the practice; this will also provide the best sense of the way things really work

Will my clinical practice have support during and after the Patient's Medical Home Assessment?

- Many Primary Care Networks (PCNs) are developing a support plan to assist their members (for example, this may include access to a facilitator)
- Facilitators will help teams generate consensus scores from their individual assessments and the development of their **Patient's Medical Home Action Plans**
- Tools and resources are available to support practice teams with their improvement journeys. Contact your PCN to learn more or visit the ACTT website to access tools and resources for this work. Also visit the ACTT PMH web page for more Patient's Medical Home tools and resources.

How does my team get started?

The **Patient's Medical Home Assessment** for Practices has been adapted from an international assessment tool that was designed to support all clinical practices at whatever stage of improvement they may be at. In Alberta, there is an **Introduction to the Patient's Medical Home Package** available for leaders to use to help prepare their team to participate in this assessment.

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:** 7880.488.4350 |

Patient's Medical Home Assessment Tool - Readiness

CIRCLE the answer which best represents your current practice.

1. Are you familiar with the term 'Patient's Medical Home' and the concepts it represents?

   No Not sure Somewhat Yes

2. If yes to #1, have you and other clinic leaders promoted the concepts of the Patient's Medical Home to your staff team?

   No Not sure Somewhat Yes

3. If yes to #2, is your practice committed to moving towards being a Patient's Medical Home?

   No Not sure Some of us Yes

4. Does your clinic have a formal plan (for example – business plan) outlining your priorities for the Patient's Medical Home?

   No Not sure Yes

5. Does your team meet to discuss work planning and improvements?

   No Yes

   a. If yes, how often?

      Never Every two months Monthly Weekly

   b. On average, how many hours does your team have for planning and improvement meetings each month?

      Less than one hour One hour Two hours or more

6. Does your practice have access to a trained facilitator to support improvement? This could be someone within the clinic or within the PCN who provides regular support to your team.

   No Yes

7. Have you and your team started working on ways to get and maintain an accurate list of your panel?

   No Not sure Somewhat Yes

Answering 'yes' to the questions above is predictive of readiness to proceed to Phase 1 of the Patient's Medical Home Assessment. Based on your knowledge of your current practice readiness, please check one of the following:

- ☐ We are in the earliest stages of moving our practice towards the Patient's Medical Home and will be using the **Introduction to the Patient's Medical Home Package** and a facilitator to help us move forward.
  OR
- ☐ We have started our work towards the Patient's Medical Home. We'd like to proceed with the **Patient's Medical Home Assessment – Phase 1**

(refer to the support contact information section of this document for information or resources if needed)

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

[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