PaCT: Team Assessment

Date: _____

Team Name: _____

Directions:

Using a 1-5 scale, please circle the number that most closely represents your current state between the two statements below. On the left hand side are statements that might closely reflect current common behaviors in practice and on the right hand side are statements that may reflect a practice team's desired behavior. How to use the 1-5 scale:

- 1 = statement to the left most accurately reflects our clinic's current state
- 2 = we are closer to the left statement but making progress to move towards the right
- 3 = we have made considerable progress in this area, but still have a ways to go before we are at the desired state
- 4 = we are closer to the right statement but aren't reliably at the desired state
- 5 = statement to the right most accurately reflects our clinic's current state

If it is difficult to assign a rating to your clinic, please use your current understanding and best estimate.

We suggest using this assessment at the start of your improvement efforts in PaCT and again at six months to assess your progress. We will collect the baseline responses from you today and will introduce this assessment again at 6 months, along with your baseline responses, so you can reflect on your progress overtime. Questions you may want to consider:

- What is the range of responses across team members? What factors influenced this range of responses? How did team members in different roles differ in their responses?
- What were some of the highest scoring statements? What were some of the lower scoring statements?
- Where might you begin your improvement efforts?

Panel Identification, Maintenance and Management

We do not identify patients with complex health needs systematically using our EMR. →				Our team's panel list in the EMR clearly identifies those with complex health needs.
1	2	3	4	5
We don't know which of our patients are most likely to benefit from care planning. →				Our team has identified priority patients for care planning (e.g., complex health needs, rising risk, not managed, without a visit in the last year).
1	2	3	4	5
At appointments the physician manages only the issues identified at the visit. →				Our team prepares for each patient visit to proactively address health needs that may not be the primary reason for the patient's visit.
1	2	3	4	5

Team Activities

Our patients seek care from wherever they can get it, when they think they need it (e.g., other physicians, urgent or emergency care).				Our team encourages, facilitates and promotes continuity with our own patients.
1	2	3	4	5
Access for patients is limited by the physician's schedule, resulting in wait times for appointments.				Patients can access the most appropriate member of the care team, in a timely manner, when they need or want an appointment.
1	2	3	4	5
Our team makes care decisions based on our understanding of the most important medical needs.				Our team collaborates with the patient to develop a shared care plan that includes the patient's most important needs and what matters to him/her.
1	2	3	4	5
The physician alone supports the patient in care planning.				Team members work together, and with the patient, to support care planning.
1	2	3	4	5
A clinic visit is the primary or only method of interaction.				Our team uses a variety of ways to engage the patient most effectively (e.g., email, text, group visits, etc.).
1	2	3	4	5

Patient Self-Management Strategies

We manage patient care by disease and don't ask about other determinants of health that may impact the patient (e.g., low income, lack of support, etc.).	→			We consider the whole person by asking about life circumstances when planning care with the patient.
1	2	3	4	5
We give patients with the same conditions similar information and advice on improving their health.	→			We assess patients' existing knowledge and understanding of their condition(s), fill any gaps, and help them to connect to their own internal motivation for making changes for their health.
1	2	3	4	5
We provide standard healthy lifestyle advice.	→			We work closely with the patient to support and build his/her confidence in making health behaviour changes.
1	2	3	4	5
We review the care plan yearly.	→			We use the care plan as a living document that is revisited and revised, through discussion with the patient, throughout the year.
1	2	3	4	5
The physician is the only one who has access to the care plan.	→			Our patients and the team have access to the shared care plan and make it available to others (e.g. specialists and other care providers) as needed.
1	2	3	4	5
We assume that all members of the team are patient-centred in their interactions with patients.	→			As a team, we have a common set of principles for using patient-centred language and behaviour.
1	2	3	4	5

Evidence Based Clinical Decisions

The decision support tools used by our team are disease specific. 				Our team has access to decision support tools that have been customized for primary care using a 'whole person' approach.
1	2	3	4	5

Transitions of Care

We don't know what community resources are available or how to access them. 				Our team knows the resources available in our community and how to access them.
1	2	3	4	5

When we make referrals to specialists, we don't know if or when an appointment is booked. 				Our team, along with the patient, collaborates with specialty care and are informed and updated in real-time on referral status and outcomes.
1	2	3	4	5